PROVIDER MANUAL 2008

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FOREWORD

Dear Participating Provider:

Thank you for your participation in Atlantis Health Plan. Atlantis Health Plan is a managed care organization licensed by New York State to provide and manage healthcare benefits through its various product offerings.

Atlantis Health Plan's objective is to provide affordable quality care to our members through access to the provider network and to provide management services to enhance the process.

The Provider Manual has been designed to help you and your office staff understand the Atlantis Health Plan delivery program and to assist in incorporating program activities and procedures into your office practice with minimal disruption. The manual is an ongoing resource for you and your staff. Changes and supplements to the manual will be forwarded from time to time and should be kept with the manual for easy reference. You also may visit the Atlantis website at www.atlantishp.com for updates or contact Atlantis Health Plan's Provider Relations Department at 877-667-3627 (select 2).

To the extent that any provision of this manual is inconsistent with any provision of your contract with Atlantis Health Plan, the terms of your contract will prevail.

To the extent that any provision of this manual is inconsistent with any provision of Atlantis Health Plan's member agreement, the terms of the member agreement will prevail.

You are a valuable member of our healthcare delivery team, and we look forward to a long and mutually productive relationship.

Sincerely,

Sury Anand, MD
Chairman/CEO

ATLANTIS HEALTH PLAN CORPORATE INFORMATION

Corporate Headquarters

Atlantis Health Plan, Inc.
45 Broadway Suite 300
New York, NY 10006

Phone: 212-747-0877
Fax: 212-747-0843

Important Telephone Numbers

Member/Provider Services	866-747-8422
Utilization Management	800-270-9072
Prescription Drug Plan	888-341-8570
Behavioral Health Services	866-477-9740
Vision Services	866-747-8422

ATLANTIS HEALTH PLAN CARE DELIVERY SYSTEM AND PROVIDER NETWORK

PRIMARY CARE PROVIDER

A primary care provider (PCP) is a participating physician (general practitioner, family practitioner, internist, or pediatrician) who has agreed to provide primary care services to members.

Participating physicians who assume the role of PCPs are responsible for coordinating members' health care. This function involves providing primary care services, coordinating overall medical care and record maintenance, determining an appropriate treatment plan, making referrals to specialists when necessary, and providing 24-hour, seven-day coverage.

At the time of enrollment, a member is required to choose a PCP who will be responsible for all care provided to that member. The selection of the PCP is the member's choice, and Atlantis Health Plan (AHP) does not attempt to influence the member in this decision. If the member fails to select a PCP at the time of enrollment, AHP will assign a PCP based on the member's geographical proximity to the provider. The member can change this selection by calling Member Services at 866-747-8422 with the PCP information. Three PCP changes are allowed per member per contract year. This rule also applies when members elect to have a specialist as their PCP.

Please note that enrollees with ***qualifying conditions*** may request a specialist as a PCP. **Qualifying conditions** include a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized care over a prolonged period of time. Please see the ***Specialist as Primary Care Provider section*** for guidelines that determine when it is necessary for a specialist to coordinate primary and specialty care.

SPECIALIST PROVIDER

Providers who assume the role of specialist providers provide specialty services to members only after the appropriate prior referral by the PCP* and shall submit to the referring physician as soon as possible a report on the findings and treatment of the member. In proceeding with a continuing course of treatment, including hospitalization or referral of the member to another specialist, concurrence of the PCP must be obtained.

***Female members may obtain primary and preventive obstetric and gynecologic services from a qualified participating provider of such services twice per calendar year and care related to pregnancy without prior approval or referral from their PCP. Pregnancy care shall include HIV pretest counseling with clinical recommendation of testing for all pregnant women. Those women and their newborns have access to services for positive management of HIV disease as well as psychosocial support and case management for medical, social, and addictive services.**

SPECIALIST AS PRIMARY CARE PROVIDER

In the event that a new member upon enrollment, or a member upon diagnosis, has a life-threatening condition or disease or a degenerative and disabling condition or disease that requires specialized care for a prolonged period of time, he or she may request to elect an AHP specialist as his or her PCP. As the designated specialist/PCP, you are responsible for providing and coordinating all of the member's primary and specialty care. You will be able to order tests, arrange procedures, and provide referrals and medical services in the same capacity as a PCP.

To become a specialist/PCP, you must have the necessary qualifications and expertise to treat the member's condition or disease. Such referral shall be pursuant to a treatment plan approved by AHP, in consultation with the PCP if appropriate, the specialist, and the enrollee or the

enrollee's designee. This election will be permitted only if the AHP medical director, after consulting with you and the original PCP, agree that the member's care would most appropriately be coordinated in this manner.

You, the specialist, the original PCP, and/or the member may call AHP's Utilization Management Department and request this election.

ACCESS TO A SPECIALTY CENTER

Members with qualifying conditions may request access to a Specialty Center. The member must be diagnosed as having a life-threatening condition or disease or degenerative and disabling condition or disease, either of which requires specialized medical care over prolonged period of time. Evaluation of a member's condition will be discussed between the AHP medical director and requesting provider to determine whether such a referral is appropriate.

The referral will be provided pursuant to a treatment plan that has been developed by the Specialty Center and approved by the AHP medical director. To request a referral to a Specialty Center, the PCP, the specialist, or the member may call the AHP Utilization Management Department.

The guidelines for determining when a referral to a Specialty Center is appropriate include the standards of care that the plan will use to determine when a member's disease or condition is life threatening or degenerative and disabling.

A member or provider can elect to use a nonparticipating center if AHP's network does not include an appropriate center or specialist. In such an instance, AHP will authorize treatment at no additional cost beyond what the member would otherwise pay for services received in the network. To make the election, the PCP or specialist must call AHP's Utilization Management Department to precertify the request.

REFERRALS

The decision to refer a member to an in-network provider is at the discretion of the treating provider and based on medical necessity. The treating provider should not refer a member to an out-of-network provider if he or she does not have out-of-network benefits. If a referral is made to an out-of-network provider, the member must have out-of-network benefits.

If a member does not have out-of-network benefits and it is the opinion of the PCP that the member's condition requires a referral to a specialist who is not in the AHP's provider network, the PCP must contact AHP Utilization Management Department to preauthorize the request. The request needs to be authorized by AHP's medical director. Once approved, the PCP, out-of-network specialist, and member will be notified in writing of the disposition. The notification outlines the scope of the referral.

Please note: ***Female members are entitled to self-refer for primary and preventive obstetric and gynecologic services from a qualified participating provider of such services up to twice per calendar year in addition to care related to pregnancy. Members may use follow-up visits to a qualified participating provider for primary and preventive obstetric and gynecologic services required because of such visits or because of an acute gynecologic condition***. The member and/or the qualified participating provider must keep the PCP informed of any services that have been provided.

STANDING REFERRALS

AHP members who need ongoing care from an in-network specialist may receive a standing referral. A member's PCP should contact AHP's Utilization Department to precertify the request, which will be reviewed by the medical director for appropriateness. If approved, a standing

referral to a specialist will be issued. All parties will be notified verbally and in writing of all final determinations. The referral shall be made pursuant to a treatment plan approved by AHP in consultation with the PCP, specialist, and the member or member's designee. The treatment plan may limit the number of visits or the period during which such visits are authorized and may require regular updates to the PCP about the specialty care. PCPs should refer to a participating specialist and can only refer to an out-of-network provider if no other specialist for a specific service is in the AHP network. If this scenario should arise, the visit to the out-of-network specialist must be authorized by AHP's Utilization Management Department. The services should add no additional cost beyond what enrollees pay for AHP's in-network services.

EMERGENCY CARE

An emergency condition is defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect that the absence of immediate medical attention to result in (1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy; (2) serious impairments to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.

A **prudent layperson** is considered to be a person who is without medical training and who draws on his or her practical experience when making a decision regarding whether emergency medical treatment is needed. A prudent layperson will be considered to have acted reasonably if other similarly situated laypersons who would have believed, on the basis of observation of the medical symptoms at hand, that an emergency medical treatment was necessary.

Treatment of emergency conditions do not require prior authorization.

THE ATLANTIS HEALTH PLAN MEMBER

IDENTIFICATION OF ATLANTIS HEALTH PLAN MEMBERS

AHP reimburses physicians only for services rendered to eligible members. Providers (or their office staff) are responsible for verifying each member's eligibility prior to treatment. All members have an identification card that must be presented each time services are requested. A copy of the AHP identification card follows. Please examine all data on the card carefully to determine the member's eligibility and extent of coverage. The complete member number must be used when submitting claims to AHP.

When a member arrives in the office, office staff should determine if the member is eligible for services and if the member is in fact an active member of AHP. Enrollment can be verified by contacting AHP Member Services at 866-747-8422. The member must display his or her AHP identification card. If the member presents him- or herself as enrolled and has been declared as ineligible by AHP, the member is responsible for the charges associated with the care provided.

For emergency admissions, the hospital shall confirm member eligibility status by calling AHP within 48 hours of admission.

ATLANTIS HEALTH PLAN MEMBERSHIP CARD

FRONT OF CARD

Classic-Plus

ATLANTIS HEALTH PLAN

NO REFERRAL REQUIRED

Member: JOHN Q PUBLIC POS
ID NO.: XXXXXXXXX-XX Effective: XX/XX/XX Plan A $20 E
PCP: JANE DOE (212) 123-4567
Office Visit: [PCP Copay] RX: XX/XX/XX
LAB: [Copay] XRAY: (Copay) ER: (Copay)
BIN: XXXXXX PCN: XXXXX
RXGRP: XXXXXXX

Catalyst Rx® A HealthExtras® Company

BACK OF CARD

ATLANTIS HEALTH PLAN, INC 45 Broadway, Suite 300 New York, NY 10006

MEMBERS: For emergency care go to the nearest emergency room or dial 911. Please notify Atlantis within 48 hours of admission or as soon as possible. If you choose to receive out-of-network services, you will be responsible for notifying Atlantis in advance of all non-emergency admission, all surgeries, and certain other elective outpatient services and diagnostic procedures.

Member Services	1-866-747-8422
Pre-Certification	1-800-270-9072
Prescription Services	1-888-341-8570
Behavioral Health Services	1-866-477-9740
Mail Claims to:	Atlantis Health Plan Claims Processing Dept POB 4656 Houston, TX 77210-4656

WebMD electronic payor ID 13853

PHYSICIANS & HOSPTIALS: Pre-certification is required for all surgeries, non-emergency admissions and certain other services, as listed in the Provider Manual. Emergency admissions must be reported to Atlantis within 48 hours of admission.

COVERED SERVICES

AHP provides its members with comprehensive benefit packages that afford the basic primary, preventive, and specialty care necessary for good health. Covered services include

Adult periodic physical examinations
Allergy testing and treatment
Ambulance services
Ambulatory surgical services or procedures
Blood and blood products
Care for emergency conditions
Chemotherapy
Chiropractic care*
Diabetic equipment and education
Diagnostic imaging studies or tests
Durable medical equipment*
Hemodialysis
Home health care
Hospice care
Inpatient care
Laboratory and diagnostic procedures

Maternity care
OB/GYN services
Mammography
Medical supplies
Mental health*
Organ transplants
Pap tests
Physical Therapy
Preadmission testing
Prosthetics
Radiation
Rehabilitative services*
Second opinions
Skilled nursing facility*
Substance abuse*
Well-child care

* Not applicable to Healthy New York members

Some medical procedures, services, and medical supplies are either specifically excluded from contractual covered services or are subject to preexisting condition exclusion for a specific time period. However, some employer groups may have purchased additional benefit riders to enhance the core benefits package.

Covered services must be medically necessary and appropriate. **Medically necessary or medical necessity** is defined as the following.

A service, treatment, procedure, equipment, drug, device, or supply provided by a hospital, physician, or other provider of health care that is required to identify or treat a member's bodily injury or sickness and which is determined by AHP to be:

1. Consistent with the symptom(s) or diagnosis and treatment of the member's bodily injury or sickness.
2. Appropriate under the standards of acceptable medical practice to treat that bodily injury or sickness.
3. Not solely for the convenience of the member, physician, hospital, or other provider of health care.
4. The most appropriate service, treatment, procedure, equipment, drug, device, or supply that can be safely provided to the member.
5. The most economical manner of accomplishing the desired result.

Not all of the covered services listed previously require preauthorization**. Please refer to the Quick Reference Authorization Guide.**

AHP's Member Services Department may be contacted Monday–Friday from 9 am–5 pm to clarify covered services or services requiring preauthorization. **This verification should be done prior to rendering the service**. **In contracting with AHP, you agreed to accept AHP's reimbursement, as stated in the Participating Physician Agreement, as payment in full, less any patient copayment. Therefore, AHP members may not be billed any additional amounts for covered services or for services needing preauthorization that were rendered but not authorized.**

Instances may occur, however, when a member may elect to receive medical care for contractually excluded services or services determined by AHP to **not** be medically necessary. In such instances, you are required to advise the member prior to providing the service that the service is not covered and that AHP will not assume responsibility for payment; clearly state the cost that the member must assume. AHP highly recommends that a member sign a waiver accepting liability in such instances.

CONTINUITY OF CARE

Members receiving continuity of care from a provider leaving the network may continue an ongoing course of treatment with that provider during a transitional period.

The transitional period shall continue up to 90 days from the date of the provider termination or the exhaustion of benefits, whichever comes first, or if the member has entered the second trimester of pregnancy, for a transitional period that includes the provision of postpartum care directly related to the delivery.

Continuity of care will be authorized by AHP if the provider signs an agreement accepting AHP's established reimbursement rates as payment in full, adheres to AHP's quality improvement requirements, provides medical information related to the care, and adheres to AHP's policies and procedures. Precertification by the Utilization Management Department is required.

TRANSITIONAL CARE

Qualifying new members may continue an ongoing course of treatment with a current (non-network) provider for a transitional period.

The policy is applicable if member has a life-threatening or degenerative and disabling condition for transitional period of up to 60 days from the effective date of enrollment. If the member has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period shall include postpartum care directly related to the delivery.

Care will be authorized by AHP if the provider signs an agreement accepting AHP's established rates as payment in full, adheres to AHP's quality improvement requirements, provides medical information related to care, and adheres to AHP's policies and procedures. Precertification by AHP's Utilization Management Department is required.

MEMBERS' RIGHTS

AHP members are entitled to obtain complete current information concerning a diagnosis, treatment and prognosis from a physician or other provider in terms and language they can understand. When it is not advisable to give such information to the member, the information will be made available to an appropriate person on the member's behalf. In addition, the member is entitled to receive information from a physician or other provider necessary to give informed consent prior to the start of any procedure or treatment. Lastly, member's have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of the action.

BENEFIT EXCLUSIONS AND LIMITATIONS

The following are benefits that are not covered regardless of whether they are medically necessary. If these services are provided, the member is responsible for payment. Please note that additional exclusions apply for Healthy New York members.

1. Preexisting Conditions: In the absence of creditable coverage, treatment for preexisting conditions will not be covered for 11 months from the enrollment date (the first day of the coverage for the individual or, if earlier, the first day of the waiting period that must pass with respect to an individual before the member is eligible to be covered for benefits). **Note: The preexisting condition limitation does not apply to members of large groups.**
2. Experimental/Investigational Treatments: In general, the AHP does not cover experimental and investigational drugs and treatments. However, AHP shall cover an experimental and investigational drug and treatment approved by an external appeal agent certified by the state. If the external appeal agent approves coverage of an experimental and investigational treatment that is part of a clinical trial, AHP will cover only the costs of services required to provide treatment to the member according to the design of the trial. AHP shall not be responsible for the costs of the investigational drugs or devices, the costs of non-healthcare services, the costs of managing research, or costs that would not be covered under the member's Certificate of Coverage for nonexperimental or noninvestigational treatments.

This exclusion does not apply to certain non–FDA-approved prescribed drugs recognized for the treatment of certain types of cancer by the American Medical Association Drug Evaluations, American Hospital Formulary Service Drug Information, or U.S. Pharmacopoeia Drug Information, or drugs that have been recommended by a review article or editorial comment in a major peer-reviewed professional journal.

3. Outpatient prescription drugs, unless a pharmacy rider has been added

4. Inpatient alcohol and substance abuse rehabilitation, unless coverage has been added by a rider to the group contract

5. Illness, accident, treatment or medical conditions arising from (1) war or acts of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the Armed Forces or units auxiliary thereto; (2) aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline; and (3) suicide, attempted suicide, or intentionally self-inflicted injury. *Behavioral health care for attempted suicide is a covered service*.

6. Cosmetic surgery performed primarily to improve the appearance of a portion of the body that is not medically necessary, including, but not limited to ear piercing, rhinoplasty, liposuction, and related surgery

   *This exclusion does **not** include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect, nor breast surgery following a mastectomy to achieve symmetry.*

7. Routine foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet

8. Treatment provided in a government hospital or benefits provided under Medicare or other government program (except Medicaid)

9. Benefits to the extent provided for any loss or portion thereof for which mandatory automobile no fault benefits are recovered or recoverable

10. Benefits provided under any state or federal workers' compensation, employers' liability, or occupational disease law

11. Services rendered and separately billed by employees of hospitals, laboratories, or other institutions

12. Services performed by a member of the member's immediate family. Immediate family includes the following degrees of relationship: (1) husband and wife; (2) natural parent, child, or sibling; (3) adopted child and adoptive parent; (4) stepparent, stepchild, stepbrother, and stepsister; (5) father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; and (6) grandparent and grandchild. Please note that the immediate family definition is not based on household member status.

13. Services for which no charge is normally made

14. Dental services (such as care, treatment, filling, removal of teeth and/or treatment of diseases of teeth, gums, or temporomandibular joint), including, but not limited to, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, temporomandibular joint dysfunction therapy, alveolectomy, and treatment of periodontal disease. *Care or treatment of sound natural teeth necessary because of accidental injury is a covered benefit for 12 months following the date of such injury, except for dental care or treatment necessary because of congenital disease or anomaly.*

15. Eyeglasses, contact lenses, and examinations for the prescription or fitting thereof, *unless coverage has been added by a rider to the group contract*

16. Rest cures, custodial care, and transportation

17. Coverage while outside the United States, its possessions, or the countries of Canada and Mexico, except for emergency services

18. Autologous blood services

19. Wigs or any other appliance or procedure related to hair loss, regardless of the disease or injury causing the hair loss

20. Living donor fees and transportation costs of nonexperimental organ transplant

21. Experimental organ transplants, unless recommended by an external appeal agent

22. Contraceptive devices, even if prescribed for a medical condition other than birth control, and birth control pills, unless coverage has been added by a rider to the group contract

23. Artificial means of achieving pregnancy, including in vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers, reversal of elective sterilizations, sex change procedures, cloning, medical or surgical services, or procedures that are deemed by New York State regulations and/or the American Society for Reproductive Medicine to be experimental or investigational

24. Treatment for learning and behavioral disorders, including nonmedical treatment for mental retardation, except to the extent that such benefits are either medically necessary or required to be provided by applicable law

25. Obesity surgery and weight reduction programs *except to the extent that such benefits are either medically necessary or required to be provided by applicable law*

26. Personal items, including but not limited to telephone and television rentals, during an inpatient hospital stay

27. Reports, tests, or procedures not directly related to treatment of the member, including physical examinations for employment, school, camp, or premarital requirements

28. Orthotic devices, including but not limited to arch supports, corrective shoes, elastic hose, braces, scoliosis devices, cervical collars, corsets, canes, crutches, hearing aids, false teeth, or special supplies or equipment

29. Nonstandard-type prosthetic devices, unless deemed medically necessary; replacement of prostheses, *unless required because of growth*; and artificial organs, except where such artificial organs are deemed medically necessary. Artificial organs are not covered if the treatment is experimental or investigational in nature, unless recommended by an external appeal agent.

30. Sex, marital, or religious counseling, including sex therapy and treatment of sexual dysfunction unless medically necessary

31. Transsexual surgery or related services where no organic basis exists

32. Travel immunizations

33. Acupuncture

34. Private-duty nursing unless medically necessary

35. "No-show" provider charges for broken appointments

36. Any other item or service not explicitly delineated as a covered service in the member's certificate of coverage

Healthy New York–Specific Exclusions

37. Behavioral health for the treatment of mental, nervous, or emotional disorders

38. Substance abuse diagnoses and treatment, detoxification, or rehabilitation

39. Vision and Hearing Care: Coverage is not provided for eyeglasses, hearing aids, and examination for the prescription and fitting thereof.

40. Skilled nursing facility care

41. Ambulance

42. Durable medical equipment and prosthetics

43. Cardiac rehabilitation

44. Speech therapy

45. Occupational therapy

46. Subluxation: Coverage is not provided for care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing interference and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column.

47. Home oxygen equipment, including emergency oxygen inhalers, portable preset oxygen units, and oxygen administration equipment

CLAIMS AND BILLING

HEALTH CARE FINANCING ADMINSTRATION (HCFA)

AHP requires providers to bill using the HCFA 1500 claim form. The guidelines for completion are the same as required by Medicare when billing, including complete patient information, date of service, commonly performed procedural codes, place of service codes, appropriate ICD-9 diagnosis, and charges for services to include number of units or time when necessary.

Claims Submission

Paper Claims
Mail to:
P.O. Box 4656
Houston, TX 77210-4656

Electronic Filing
Payor ID# 13853

Filing Limits

- 60 days from date of service
- Members may not be billed for services submitted after the filing limit.

Payment Policies

AHP uses a combination of Current Coding Initiatives (CCI) and internal claim processing payment guidelines. Payment guidelines for most commonly performed procedural codes can be requested and are published in the provider newsletters. These policies will soon be made available on the AHP website in the provider section.

COPAYMENTS

AHP members are required to pay all necessary copayments at the time services are rendered. Please refer to the copayment amounts on the member's identification card.

EXPLANATION OF BENEFITS AND PAYMENTS (EOB)

Providers are requested to bill AHP for all medical services rendered to members less the copayment collected. An EOB will be forwarded upon completion of claim processing. The report will provide a summary of services, payment information, cost-sharing responsibilities on the part of the payment, and reasons for the payment determinations.

COORDINATION OF BENEFITS (COB)

COB is an important part of AHP's overall objective of providing health care to members on a cost-effective basis. It is required by state statute and insurance carriers in situations where members have more than one insurance coverage. AHP members may not be billed, either up front or after the fact, for covered services rendered except for any copayments for which the member may be responsible. Circumstances may also exist where you, as a contracted provider, are excluded from billing another carrier for balances even if a member has other insurance. Your contract with APH requires you to accept AHP's payment as payment in full. The following procedure should be implemented when dealing with all AHP members, whether their coverage is primary or secondary.

1. Office patients will pay the copayment at the time of visit. Bill the primary carrier for the visit according to your usual fees.

2. If AHP is the secondary insurance, attach the explanation of benefits from the primary carrier and send the claim for the remaining balance to AHP.

3. Under no circumstances may the member be directly billed except for the copayment due.

Members with primary insurance other than AHP may choose not to participate as an AHP member and wish to continue using only their primary benefits (this will be an unusual circumstance). In this case, you may obtain a written waiver from the member stating that he or she does not wish to participate as an AHP member, explaining that AHP will not be responsible for any payments of any kind associated with the member's care. Under these circumstances, the provider may bill according to their usual methods. This waiver must be in writing and attached to the member's chart for future verification, should it be required.

Because members accept AHP benefits by their participation in the COB program, they are legally responsible to adhere to the rules and regulations required of all AHP members such as use of the PCP and/or prior approval for out-of-plan services. If any of these regulations are violated, reimbursement will not be forthcoming or reduced. Specific questions regarding COB should be directed to AHP's corporate office.

CLAIM RECONSIDERATION

AHP has adopted a claim reconsideration process for contracted providers, facilities, and ancillary providers to ensure better response to claims issues and questions. The process also will enable AHP to more accurately track common issues and questions that arise so that consideration can be made regarding the revision of claim payment policy and procedures to align with fair industry standards.

Following are some examples of claim issues or inquiries that may be sent for reconsideration. You will need to complete the AHP Claim Reconsideration Form and send supporting information (**bolded**) before your claim can be reviewed.

- Late filing: Claims must be submitted by par providers within 60 days of the date of service, although bills are often accepted as many as 90 days from the date of service performed. **Submit proof of timely filing.**
- Fee schedule issues: When requesting review of a claim where codes were bundled or unbundled, keep in mind that Atlantis applies Centers for Medicare and Medicaid Services coding guidelines in addition to the Plan's own internal guidelines (approved by the Atlantis Board of Directors).**Submit correct coding initiative edit and payment references or office and operative notes to justify your claim. Please note: Per American Medical Association guidelines, documentation must be submitted for review when using modifier 25. Use of the modifier alone does not support separate payment.**
- Lack of medical necessity determinations: In cases where no authorization was obtained or clinical information is pending and has not been received. *Upon receipt of the reconsideration, these claims will be sent to the Appeals Department for a utilization management determination*. **Submit clinical information to justify medical necessity.**
- Fee schedule and payment issues: Please express your concerns in writing and make sure you have submitted your most current information to Atlantis. **Submit current W-9 if you are changing or adding a practice location or have obtained a new tax ID number.**

All requests for reconsideration should be submitted to AHP within 60 days from the date of the original explanation of benefit. Reconsiderations submitted after this time frame will not be considered without a valid explanation. AHP will respond within 45 days from receipt of the reconsideration request.

Any claim with a date of service more than a year old will not be eligible for reconsideration.

Claim Reconsideration Forms can be obtained via mail, fax, or e-mail or by calling Atlantis Member Services toll free at 866-747-8422. Forms also can be downloaded from AHP's website www.atlantishp.com in the provider section.

Mail your completed Claim Reconsideration Forms and supporting documentation to:

Claims Reconsideration Unit
Atlantis Health Plan
45 Broadway, Ste.300
New York, NY 10006

OFFICE PRACTICE AND FACILITY STANDARDS

APPOINTMENTS

Members will make their own arrangements for appointments at their PCP's office and with specialists.

Providers agree (1) not to differentiate or discriminate in the treatment of their members as to the quality of services delivered to members because of race, sex, age, religion, place of residence, handicap, health status, or source of payment and (2) to observe, protect, and promote the rights of members.

Providers agree to provide timely care in compliance with AHP's policies and procedures, which are consistent with the Federal Americans with Disabilities Act. The specific time frames for care are listed below.

PCP/Specialty (other than mental health)

Urgent: 48 hours
Routine: four (4) weeks

As required by New York State Department of Health HMO regulations and National Committee on Quality Assurance standards, AHP will track and evaluate issues relating to waiting times for appointments, appropriateness of referrals, and other indications of capacity. This will include, but is not limited to, the tracking of member grievances, as well as conducting random access and availability surveys.

COVERAGE ARRANGEMENTS

Participating physicians shall ensure, or make arrangements for, 24-hour, seven-day-per-week coverage to all members.

Participating physicians agree that in the event of their absence, a coverage arrangement will be made with a physician who is, whenever possible, a participating physician within AHP's network. Participating physicians also agree that, in the event of coverage by a nonparticipating physician it will be the responsibility of the participating physician to ensure that the nonparticipating physician will (1) accept the fee from AHP as full payment for services delivered to member; (2) accept AHP's peer-review procedures; and (3) look solely to AHP for compensation for covered services provided to members and shall at no time bill or otherwise seek additional compensation for covered services from members, except for applicable copayments. AHP must be notified in advance, or as soon as is reasonably possible, of the use of a nonparticipating provider in a coverage arrangement.

MEDICAL RECORD STANDARDS

The following AHP medical record standards have been established to ensure that the providers within AHP's network document good professional practice and appropriate management of the healthcare of its members. AHP believes that comprehensive documentation is an essential component to the delivery of quality medical care.

Access and Confidentiality

The U.S. Department of Health and Human Services, the New York State Department of Health, and AHP have the right to inspect at reasonable times all records, specifically any medical records, maintained by physicians pertaining to members. AHP reserves the right to copy any and all such

records for the purposes of assessing quality of care, coordinating medical care evaluations and audits, and determining on a concurrent basis the medical necessity and appropriateness of care provided to members. In the case of the New York State Department of Health, the Department shall determine such other purposes for having access to members' medical records.

Participating physicians are required to cooperate in the transfer of member's medical records to other participating providers, and to assume any associated cost. Participating physicians agree that member's medical records and information shall be treated as confidential so as to comply with all applicable state and federal laws and regulations regarding the confidentiality of medical records and information.

Confidentiality of HIV-Related Information

Provider must develop policies and procedures to assure confidentiality of HIV-related information. Policies and procedures must include

- Initial and annual in-service education of staff and contractors
- Identification of staff allowed access and limits of access
- Procedure to limit access to trained staff (including contractors)
- Protocol for secure storage (including electronic storage)
- Procedures for handling requests for HIV-related information
- Protocols to protect people with or suspected of having HIV infection from discrimination.

Documentation of Individual Medical Records

Every member will have an individual record showing the following documentation.

1. Every page in the record contains the patient's name and ID number.
2. The biographical information includes address, employer, home and work telephone numbers, marital status, and emergency contact information.
3. All entries in the medical record are signed by the person who made the entries.
4. All entries are dated.
5. The record is legible to someone other than the author. A second reviewer examines any record judged to be illegible by one physician reviewer.
6. Significant illness and medical conditions are indicated on the problem list.*
7. Medication allergies and adverse reactions are prominently noted in the record. If the patient has no allergies or history of adverse reactions, this is appropriately noted in the record.*
8. Past medical history is easily identified and includes patient, family, social, and environmental aspects of health as well as serious accidents, operations, and illnesses. For children and adolescents, past medical history relates to prenatal care, birth, operations, and childhood illnesses.*
9. For patients aged 14 or older, appropriate notations concerning use of cigarettes, alcohol, and substance abuse are made.
10. The history and physical document appropriate subjective and objective information for presenting complaints.
11. Laboratory and other studies are ordered, as appropriate.
12. Working diagnosis is consistent with findings.*
13. Treatment plans are consistent with diagnosis.*
14. Encounter forms or notes have notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or as needed.
15. For prenatal care: Centralized recording for the provision of prenatal care and all related services
16. Consultation, laboratory, and imaging reports filed in the chart are initialed by the PCPs, or some other method is used to signify review. Consultation reports and/or diagnostic tests (normal or abnormal results) have an explicit notation in the record of follow-up plans.

17. There is evidence that preventive screening and services are offered in accordance with the organization's practice guidelines.
18. Unresolved problems from previous office visits are addressed in subsequent visits.
19. If a consultation is requested, the consultant's note must be in the record.
20. An immunization record has been initiated for children or an appropriate history has been made in the medical record for adults.
21. Patient education is appropriate to diagnosis and/or patient needs.

*Problem list which includes allergies, history, diagnoses, treatment plans and appropriate treatment are areas that the National Committee on Quality Assurance has identified as "critical elements" of the medical record.

Medical Record Maintenance

1. Medical information must follow a logical and consistent format.
2. The record should contain documentation that the PCP coordinates and manages care of the member including all services provided by the PCP and referral specialists as well as other nonphysician services (e.g., physical therapists, diagnostic or laboratory services, home health care).
3. Information should be contained in a manner that will not easily be lost (i.e., forms are secured within a folder, individual records established for each patient).

The medical record system should provide a mechanism to ensure member confidentiality.

Medical Record Retention

Participating physicians shall retain all members' medical records for a period that shall end not less than six years after the last date on which such member received medical services from physician or cessation of the Plan's operation. For minors, six years after such member shall have reached the age of majority under New York law, whichever period is longer

UTILIZATION MANAGEMENT

A Utilization Management Program is in place to ensure that medical decision making is based on appropriateness of care and service. All clinicians and administrative staff work collaboratively to ensure that AHP members have timely access to high quality care and appropriate healthcare resources. AHP does not compensate practitioners or other individuals conducting utilization review for denial of service or coverage.

AHP's Utilization Management Department is open Monday–Friday from 9 am–5 pm and can be reached toll free at 800-270-9072. If you are unable to contact us during these times, you may leave a message at the toll-free number and/or fax your request at any time to an AHP secured line at 212-747-8375. A Utilization Management coordinator will contact you within the next business day of the receipt of the request.

PROSPECTIVE REVIEW

Prospective review is required for all elective inpatient admissions, outpatient surgical procedures, certain diagnostic and treatment procedures, home health, home infusion therapy, durable medical equipment, physical therapy, and occupational therapy services.

Admitting physicians, providers, and hospital staff use a designated toll-free number to call the Utilization Management Department to initiate the preauthorization process. Preauthorization requests are triaged and handled at the appropriate Utilization Management reviewer level. Decisions regarding prospective authorization will be completed within three (3) business days or less after AHP receives the necessary information with which to render a medically necessary decision. The member or his or her designee and his or her provider will be notified by telephone and in writing of the determination. The telephonic notification of the determination may be delegated to you the provider, by the Plan.

In cases where a member requires elective hospital admission, the admitting physician agrees to contact AHP Utilization Management Department to secure a precertification for the admission at least seven (7) days in advance of the scheduled hospitalization. Additionally, the admitting physician agrees to cooperate and participate in a coordinated discharge planning.

CONCURRENT REVIEW

Concurrent review is the process of determining whether requests for continued or extended services are medically necessary or appropriate at the level of care desired, based on current professionally acceptable care and criteria.

AHP provides notice of such determination to the member or the member's designee or provider by telephone and in writing within one business day of receipt of the necessary information.

In the case of an emergency hospital admission, the hospital is responsible for notifying AHP of the admission. Participating hospitals should notify the Utilization Management Department within 48 hours of the admission. Within 24 hours or one (1) business day after AHP is notified of an emergency room admission, AHP will notify the PCP of record by telephone. A registered nurse (RN) or clinical peer reviewer reviews all emergency admissions on the first business day following the admission notification and receipt of clinical notes for appropriateness of inpatient stay. The attending physician, hospital, and member or his or her designee will be notified by telephone and in writing within one (1) business day of the length of stay that is approved and that continuation of stay will be determined subject to concurrent review.

Notification for services that do not meet medical necessity will include information regarding the member's right to appeal and the process to be undertaken should the member, designee, or provider chooses to exercise appeal rights.

DISCHARGE PLANNING

When discharge needs are anticipated or when institutional placement is required, discharge planning should be initiated as soon as possible after the member's admission to the hospital. Discharge planning includes preparation of the patient for the next level of care and arrangement for placement in the appropriate care setting. The attending physician and/or the hospital discharge planner should contact AHP's Utilization Management Department.

When the attending physician indicates that discharge planning is indicated, AHP's Utilization Management staff will assist with the process in any possible way. Discharge planning referrals must use participating providers and/or facilities unless an out-of-plan request is preauthorized by AHP's medical director.

RETROSPECTIVE REVIEW

Retrospective utilization review is the process of determining medical necessity after a service has been provided, based on current professionally accepted standards of care and criteria used in the preauthorization and concurrent review processes for the same conditions and diagnoses.

Decisions regarding retrospective review will be completed within 30 days or less after AHP receives the necessary information with which to render a decision. The member and provider will be notified in writing of any determination. In the event of an adverse determination, the clinical basis for the denial and instructions for an appeal will be included in the letter.

AHP may reverse a preauthorized treatment, service, or procedure on retrospective review pursuant to PHL 4905(5) when

a. Relevant medical information presented to AHP upon retrospective review is materially different from the information that was presented during the preauthorization review
b. The information existed at the time of the preauthorization review but was withheld or not made available
c. AHP was not aware of the existence of the information at the time of the preauthorization review and had it been aware of the information, the treatment, procedure, or service would not have been preauthorized.

Failure by AHP to make a determination within the required time periods set forth in Article 49 of the Public Health Law shall be deemed to be an adverse determination subject to internal appeal.

INITIAL ADVERSE DETERMINATIONS

Initial adverse determinations (clinical denials) will be made only by an AHP clinical peer reviewer when requested health services or a level of care are not certified because they fail to meet the established written utilization review criteria of AHP for medical necessity and appropriateness. AHP will exercise due diligence and will not exercise the denial option until all efforts have been made to resolve the issue with the PCP, specialist, and/or member. A clinical peer reviewer is a physician who possesses a current and valid nonrestricted license to practice medicine; a healthcare professional other than a licensed physician who, where applicable, possesses a current and valid nonrestricted license, certification, or registration; or, where no provision for a license or certificate exists, is credentialed by the national accrediting body appropriate to the profession and is in the same profession or specialty as the healthcare provider who typically manages the medical condition.

Notice of an initial adverse determination is made in writing within 24 hours of the determination and includes

- The reasons for the determination
- The clinical rationale

- Instructions on how to initiate a standard, expedited appeal or an external appeal should the enrollee and AHP waive the internal appeal rights
- Notice of availability of the clinical review criteria on which the determination was based, upon request of the member or the member's designee
- Specification of any additional information, which should be provided to or obtained by the plan in order to render a decision on the appeal.

CLINICAL APPEALS

A member has the right to designate a representative to file an appeal. Appeals may be filed in writing to the Grievance and Appeals Department, Atlantis Health Plan 39 Broadway, New York, NY 10006 or by telephone by calling 212-747-8246. AHP will send a written acknowledgment of receipt of the filing of the appeal to the appealing party within fifteen (15) days of the date of the filing of the appeal. Atlantis Health Plan (AHP) will review and resolve all appeals received from the member, the member's designee or practitioner regarding initial determinations within sixty (60) days of AHP's receipt of all necessary information to make a determination.

AHP will assign a clinical peer reviewer other than the one who rendered the initial adverse determination to conduct the appeal. Various types of appeals and time frames for responses are provided for, depending on the following circumstances under which the initial adverse determination was made.

1. Reconsideration

Except in cases of adverse determinations made during retrospective review, when an adverse determination is made without attempting to discuss the plan of care with the healthcare provider who specifically recommended the healthcare service, procedure or treatment under review, the provider may request a **reconsideration** of the adverse determination.

Reconsideration will occur within one (1) business day of receipt of the request, and will be conducted between the member's healthcare provider and the clinical peer reviewer who made the initial determination (or a designated substitute if the original reviewer is not available).

If the adverse determination is upheld after reconsideration, AHP will issue a written notice of adverse determination. The member, the member's designee, or the member's healthcare provider then may proceed to further appeal the decision using either the expedited appeal or the standard appeal, as defined below.

2. Expedited Appeal

Except in cases of adverse determinations made during retrospective review, an Expedited appeal is allowed in situations involving

a. Continued or extended health care services, procedures or treatments or additional services for a member undergoing a course of continued treatment prescribed by a healthcare provider
b. The healthcare provider believes an immediate appeal is warranted.

Within one (1) business day of receiving notice of an expedited appeal, AHP will give the member's healthcare provider reasonable access to a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination. AHP will facilitate resolution of this appeal by sharing or obtaining information from the provider either by phone or facsimile.

The clinical peer reviewer will render a determination within two (2) business days of receipt of necessary information to conduct the appeal.

Expedited appeals, which do not result in a resolution satisfactory to the appealing party, may be further appealed through the standard appeal process, as defined below, or a request can be made for an external appeal.

If the appeal is upheld, AHP will issue a final adverse determination (FAD). Written notice of the FAD will be transmitted to the member within 24 hours of rendering the determination. Such notice will include the following.

a. A clear statement describing the basis and clinical rationale for the denial as applicable to the enrollee
b. A clear statement that the notice constitutes the final adverse determination
c. The member's coverage type
d. The name and full address of AHP
e. AHP's contact person and his or her telephone number
f. A description of the healthcare service that was denied, including, as applicable and available, the name of the facility and/or provider proposed to provide the treatment, and the developer/manufacturer of the healthcare service
g. A statement that the member is eligible for an external appeal and the applicable timeframes for requesting an appeal
h. A clear statement (bold letters) that the 45-day time frame for an external appeal pursuant to Article 49 begins upon receipt of the FAD, regardless of whether or not a second level appeal is requested, and that by choosing to request a second level appeal, the time may expire for an external appeal request.

3. **Standard Appeal** is available in the situations described above.

These appeals may be filed in writing or by telephone by the enrollee or his/her designee. To file a standard appeal of an initial adverse determination, an appealing party has no less than forty-five (45) days after the member receives a notice of initial adverse determination and AHP receives all necessary information to conduct the appeal.

AHP will send written acknowledgment of receipt of the appeal to the appealing party within 15 days of the date of the receipt. **If the Plan requires information to conduct the appeal, the Plan will identify, and request the necessary information from member and the member's provider, in writing, within fifteen (15) days of receipt of appeal. In the event that only a portion of such necessary information is received, the Plan will request the missing information, in writing, within five (5) business days of receipt of the partial information**. AHP will assign a clinical peer reviewer other than the one who rendered the adverse determination. The FAD will be rendered within 60 days after receipt of necessary information to conduct the appeal. Within two (2) days of the determination the member, his or her designee, and the provider are notified by telephone and in writing of the decision.
If the IAD is upheld,

- The member and practitioner are notified of the decision. *This notification constitutes a final adverse determination (FAD) which includes the information as described above for the FAD of an expedited appeal.*
- The notification instructs the member of his or her right to a Level 2 appeal which is optional.
- In addition, the FAD instructs the member of his or her right to an external appeal through a state-approved external appeal agent, the 45-day filing limit from the receipt of the FAD and that the time frame may expire, and the opportunity for an external appeal lost if the member chooses a second level of internal appeal.
- The letter will include an external appeal application.

For a Level 2 appeal, the member must submit a verbal or written request within 15 calendar days of his or her receipt of the Level 1 decision or the FAD. Within three (3) business days of receipt of the Level 2 appeal request, AHP will send an

acknowledgment letter to the member and practitioner. The acknowledgment letter will include

- The name, address and telephone number of the Utilization Management coordinator
- Specification of any additional information needed to take to the Level 2 Appeal Committee for review if applicable.

Once the requested documentation has been received, the appeals record is given to a clinical peer reviewer, who is different from the reviewer who made the Level 1 appeal determination, or to the Appeals Committee, whichever meets earlier. The Appeals Committee members include

- Medical directors and the clinical peer reviewer (other than the reviewer at Level 1)
- Health Services vice president and Director
- Utilization Management appeals manager
- Utilization Management coordinators

Within two (2) days of the Level 2 committee meeting and within forty-five (45) days of receipt of the Level 2 appeal request, the member, his or her designee, and the provider are notified by telephone and in writing of the Appeals Committee's decision.

If the Appeals Committee upholds the Level 1 determination, the member, member's designee, and the practitioner are notified of the decision. The notification identifies the reason for the decision, including clinical rationale if applicable, notice of availability of clinical review criteria upon which the determination was based, upon request of the member or the member's designee.

Failure by AHP to make an appeal determination within the applicable time periods set forth in Article 49 of the Public Health Law shall be deemed to be a reversal of AHP's initial adverse determination.

EXTERNAL APPEAL PROCEDURE:

Members, the member's designee, and, in connection with a retrospective adverse determination, the member's healthcare provider shall have the right to request an external appeal when

a. The enrollee has had coverage of a health service, which would otherwise be covered, denied on appeal, in whole or in part, on the grounds that such healthcare service is not medically necessary, and
b. The healthcare plan has rendered a final adverse determination with respect to such a healthcare service, or both the plan and the member have jointly agreed to waive any internal appeal.

or

a. The member has had coverage of a healthcare service denied on the basis that such service is investigational or experimental and such denial has been upheld on appeal, or both AHP and the member have jointly agreed to waive any internal appeal, and
b. The member's attending physician has certified that the enrollee has a life-threatening or disabling condition or disease for which (i) standard health services or procedures have been ineffective or would be medically inappropriate, (ii) more beneficial standard health procedure or service covered by AHP does not exist, or (iii) a clinical trial exists, and
c. The enrollee's attending physician—who must be licensed, board certified, or board eligible qualified to practice in the area appropriate to treat the member's life-threatening or disabling condition or disease—must have recommended either a health service or procedure, including a pharmaceutical product, within the meaning of the above that, based on two documents from the available medical and scientific

evidence, is likely to be more beneficial than any covered health service or a clinical trial for which the member is eligible, and

d. The specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for AHP's determination that the health service is experimental or investigational.

The application for an external appeal must be made within 45 days of the member's receipt of the notice of a final adverse determination or within 45 days of when the member and AHP jointly agree to waive the internal appeal process. If the member and AHP jointly agree to waive the internal appeal process offered by AHP, the FAD information will be provided to the member simultaneously with the letter agreeing to the waiver. The letter agreeing to such waiver and the information required above will be provided to the enrollee within 24 hours of the agreement to waive Atlantis's internal appeal process.

Members lose their right to an external appeal if they do not file an application for the appeal within 45 days from their receipt of the final adverse determination from the AHP Level 1 appeal process.

AHP has a Level 2 appeal process available to its members; however, this internal process is optional. Regardless of the fact that a member opts to access this level of appeal, if he or she intends on filing an external appeal application, it must be filed with the New York State Department of Insurance within 45 days from the member's receipt of the notice of a final adverse determination from the AHP Level 1 internal appeal process to be eligible to be reviewed by an external appeal agent.

The external appeal application contains clear instructions for completion. To file an external appeal, the member is required to include $50 with the application. This money will be returned to the member if the appeal is decided in the member's favor. Members may be able to obtain a waiver of this fee if they meet AHP's criteria for hardship. Instructions on how to obtain a waiver of the external appeal fee may be obtained by calling the Utilization Management Department. Notwithstanding the foregoing, AHP will not require the member to pay any such fee if such fee shall pose a hardship to the member as determined by the plan.

To request an application for an external appeal of a retrospective final adverse determination, the healthcare provider may contact AHP. AHP will send the external appeal application within three (3) business days from the date it receives a request for the application. The application will provide clear instructions for completion. To file an external appeal, the healthcare provider must include $50 with the application. The money will be refunded if the external appeal agent overturns AHP's adverse determination. **The healthcare provider may not charge the member for this fee.**

AHP will transmit the member's medical and treatment records pursuant to an appropriately completed release or releases signed by the member or by a person authorized pursuant to law to consent to health care for the member, and in case of medical necessity appeals, transmit the clinical standards used to determine medical necessity for healthcare services within three (3) business days of notification regarding the identity and address of the external reviewer agent to which the case has been assigned or within 24 hours for an expedited appeal. In no event will AHP take longer than two (2) business days to transmit information requested by the external appeal agent or within 24 hours for expedited appeals.

An external appeal agent must decide a standard appeal within 30 days of receiving the member's application for an external appeal from the state. If the agent needs additional information from the member, member's provider, and AHP, the agent will have an additional five (5) days, if necessary, to make a determination. If the agent determines that the information submitted to it is materially different from that considered by AHP, the external appeal agent will forward the additional information immediately to AHP but no later than 24 hours after receipt. AHP will have up to three (3) additional business days to reconsider or affirm its decision. The

member and AHP will be notified within two (2) business days of the agent's decision. The external appeal agent's decision is binding to both parties. However, AHP is not responsible to provide the health services if the member is no longer an enrollee of or insured by the AHP at the time of the external appeal agent's reversal of the FAD.

If the member's physician can attest that a delay in providing the recommended treatment would pose an imminent or serious threat to the enrollee's health, the external appeal agent will make an expedited decision within three (3) days of the request. Every reasonable effort by the external review agent will be made to notify the member and AHP of the decision by telephone or fax, followed immediately by written notification.

If the adverse determination is overturned by the external review agent or AHP reverses a denial that is the subject of an external appeal request, an authorization will be created to enable the member to receive the health services in question and the appropriate approval letters sent to the member and provider. If a claim is outstanding, the denial code will be changed and adjudicated for payment.

AHP will be financially responsible for the external appeal agent's fee. If AHP reverses its denial after an external appeal agent is assigned but prior to the assignment of a clinical peer reviewer, it will pay only an administrative fee.

QUALITY ASSURANCE AND IMPROVEMENT

AHP's Quality Assurance/Quality Improvement Program is an integrated, comprehensive program that incorporates review and evaluation of all aspects of the healthcare delivery system; outcomes of patient care and service are the focus of the evaluation process. Components of the integrated program include focused studies, peer review, risk management, credentials and recredentialing verification, compliance with external regulatory and accreditation agencies, utilization management, case management, medical record review, monitoring of key indicators, and medical care and healthcare services evaluation. The program is designed to comply with federal and state HMO quality improvement regulations.

The purpose of the quality improvement program is to promote the provision of preventive and therapeutic health services, proactively address issues that might negatively affect quality of care, and ensure the timely identification, assessment, and resolution of known or suspected problems that negatively impact the health and well-being of members.

Operational components of the program include precontractual onsite evaluations of practitioner and medical group or Independent Physicians Association offices; hospitals, home healthcare agencies, and freestanding outpatient surgery centers also will undergo a systematic precontractual review to confirm that the health delivery organization has been reviewed and approved by a recognized accrediting body, and is in good standing with federal and state regulatory bodies. If the organization has not been accredited, it too shall undergo an onsite evaluation. Precontractual evaluations are performed to assess the quality of care and services provided by prospective AHP providers. Structural elements of the quality of care and services are assessed. Ongoing evaluations are performed to ensure that contracted providers continue to provide quality of care and service and/or have corrected previously identified problems.

- Other operational components of the quality improvement program includes application of Health Plan Employer Data Information Set (HEDIS) and Quality Assurance Reporting Requirements measures and methodology and collection and analysis of HEDIS data, medical record documentation assessments, preventive service assessments, medical care evaluations, access monitoring, and the development of quality improvement standards.

The **Board of Directors** has the ultimate responsibility for the approval, oversight, and implementation of the Quality Improvement Program. The medical directors and the Quality Improvement chairperson are responsible for monitoring the implementation of the Quality Improvement Program and ensuring that corrective actions are implemented when problems are identified. The activities of the Quality Improvement Committee are reported to the Board of Directors during the board meetings. A yearly work plan is submitted, approved, and evaluated by the Board throughout the year. The senior vice president for Health Services is responsible for coordinating the implementation of the operational components of the program under the direction of the medical directors and the chairperson. The director for Health Services and the Utilization Management and Quality Improvement coordinators assist the Health Services senior vice president in programmatic activities.

CREDENTIALING AND RECREDENTIALING GUIDELINES

INITIAL CREDENTIALING SUBMISSION AND REVIEW

It is AHP's policy that all participating practitioners shall complete the initial credentialing process before they can treat an AHP member. These practitioners include

- Physicians (MD)
- Doctors of osteopathy (DO)
- Doctoral-level and master-level psychologists (PhD, MS)
- Chiropractors (DC)
- Dentists (DDS/DMD)
- Optometrists (OD)
- Podiatrists (DPM)
- Certified nurse midwives (CNM) and nurse practitioners (NP)
- Master-level clinical social workers (MSW)
- Physical therapists (PT), occupational therapists (OT), speech/language therapists (ST)
- Audiologists
- Certified nurse anesthetists (CRNA)
- Nutritionists (RD)

The Credentialing Committee, as designated by the AHP Quality Improvement Committee, is responsible for the oversight of all participating practitioners. The Credentialing Committee recommendations will be reviewed, discussed, and acted on by AHP's medical director, senior management, and the Quality Improvement Committee as appropriate.

AHP may delegate credentialing and recredentialing activities as appropriate. If any portion of the credentialing or recredentialing process is delegated, AHP's Delegated Credentialing and Recredentialing Policy will be followed. AHP shall retain the right to approve new practitioners, providers, and sites; to determine whether current participating practitioners should be recredentialed; and to terminate or suspend individual practitioners and providers. AHP shall monitor the effectiveness of delegates' credentialing and recredentialing processes at least annually.

INITIAL APPLICATION SUBMISSION AND REVIEW

The clinician must send a completed application form and the minimum qualification documents to AHP below. The application procedures and qualification requirements may be requested in writing from the Credentialing Department of AHP.

- Curriculum vitae that outlines current position or a complete work history in the application, including months and years (any gap must be explained)
- Copy of current malpractice face sheet and completed professional liability insurance section in the application
- Explanation of coverage arrangements if he or she does not have hospital admitting privileges
- Copy of confirmation of registration to sit for board certification examination, as applicable or copy of board certification
- Signed and dated release or attestation
- Applications with signatures dated more than 150 days may be returned.
- Any change to the signature date must be initialed and dated.
- Completed W-9 form
- Three (3) peer references in lieu of board certification.

AHP will verify the following from the primary verification source (issuing body)

- Current, valid professional license
- Valid Drug Enforcement Administration or Controlled Dangerous Substances certificate
- Clinical privileges at the hospital designated by the practitioner as the primary admitting facility
- Education and training of practitioner including residency completion and school graduation.

If an illegible and/or incomplete application packet is submitted, or if required attachments are missing, the application packet will be returned to the clinician in its entirety with a cover letter detailing the missing or incomplete items. Occasionally, AHP needs to send a letter requesting further clarification once processing has begun. The clinician will be given two (2) weeks to submit the requested information. If the information is not received within two (2) weeks of the date of AHP's letter, the application will be withdrawn from processing. AHP will reactivate the initial credentialing process after all requested materials are submitted.

If a clinician's initial application is approved, the clinician is sent a welcome package with the provider's identification number and effective date. *A provider's effective date is the date of the committee approval.*

RECREDENTIALING APPLICATION AND REVIEW

All participating practitioners shall undergo and complete a recredentialing review every three (3) years. A recredentialing application and three (3) follow-up reminders are automatically sent to the clinician's last known address. If a recredentialing application is not submitted, it will result in administrative termination and will require a new initial credentialing process for the clinician to re-affiliate with AHP. AHP may use a recredentialing source such as Aperture for recredentialing verification. When this happens, an Aperture representative will contact the clinician in lieu of an AHP representative.

The clinician must send a completed application form and the following required documents to AHP.

- Copy of current (unexpired) malpractice face sheet (or complete the professional liability insurance section in the application)
- Copy of current Drug Enforcement Administration certificate
- Written explanations requested throughout the application, as applicable, that are satisfactory to AHP's Credentialing Committee
- Explanation of coverage arrangements if the clinician no longer has admitting privileges
- Copy of the confirmation of registration to sit for board certification examination, as applicable
- Signed and dated release or attestation (Any change to the signature date must be initialed and dated.)

Once the recredentialing application is received and processing has begun, further clarification may be requested. The clinician will be given two (2) weeks to submit the requested information. If the information is not received within two (2) weeks of the date of the letter, the application will be presented to AHP's Credentialing Committee without the documentation required with a recommendation for termination. If the affiliation is terminated, the clinician will have the right to appeal. AHP will reactivate the recredentialing process if all necessary documentation is received and the clinician's application and documentation have not expired.

When considering applications for recredentialing, the Credentialing and Peer Review Committee takes into consideration the clinician's past performance within the AHP network, including quality improvement data, member complaints, clinical occurrences, and licensing board complaints.

AHP does not send notification to providers who are recredentialed.

SITE VISIT

AHP will conduct and document a structured site review before initial credentialing and/or to evaluate the site and office facilities and medical record-keeping practices of practitioners identified as having areas of concern (i.e., member complaints) and/or practitioners who have opened new offices or moved location from the time of initial credentialing. The survey will include at least the following:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space
- Evaluation of medical record-keeping practices
- Confidentiality and maintenance of medical records;
- Performance against established medical record documentation standards
- Availability of appointments in accordance with AHP standards
- Performance goals for the above items
- Evidence that the results of the office site review was shared with the provider

NOTIFICATION OF DENIAL OR TERMINATION

If a clinician's initial application is denied, or if an existing affiliation is terminated, a letter is sent to the clinician documenting the reason for the action and outlining the clinician's appeal rights. A termination is not effective until the appeal process is concluded, except in limited circumstances.

CONFIDENTIALITY

The Credentialing Department is responsible for ensuring the confidentiality of all information received and maintained in the credentialing and recredentialing processes. Information derived from peer-review functions is protected from subpoena and discovery by state immunity laws, except as otherwise provided by law. This includes proceedings, reports, and records of a peer review specialty committee.

REVIEW OF INFORMATION ON FILE BY PROVIDER

With the exception of information determined by AHP to be peer-review protected, the clinician has the right to request in writing his or her file information and to subsequently review and correct any erroneous information obtained by AHP to support its evaluation of a clinician's credentialing application.

Send written request to:

Credentialing Manager
Atlantis Health Plan
45 Broadway, Suite 300
New York, NY 10006

PERFORMANCE EVALUATIONS

AHP is responsible for offering its members qualified and competent providers who will be accountable for the delivery of appropriate and medically necessary care and services. AHP is responsible for regularly informing healthcare providers of information maintained by AHP to evaluate the performance or practice of healthcare professionals. AHP has, with its providers, developed standards, criteria, and methodologies to collect and analyze healthcare professional profiling data to be used in the evaluation of the providers' performance. AHP shall provide any such information and profiling data and analysis to healthcare professionals. AHP shall provide on a periodic basis and upon the request of a healthcare professional the information, profiling data and analysis used to evaluate the provider's performance. Any profiling data used to

evaluate the performance or practice of a healthcare professional shall be measured against stated criteria and/or an appropriate group of healthcare professionals using similar treatment modalities and serving a comparable patient population. Each healthcare professional shall be given the opportunity to discuss the unique nature of the healthcare professional's patient population that may have a bearing on the healthcare provider's profile and to work cooperatively with AHP to improve performance.

A. Responsibility

The Credentialing Department is responsible for requesting data from the various departments and committees to include in a summary report evaluating the provider's performance against preestablished and preapproved criteria sixty (60) days prior to the planned presentation of a provider profile to the Credentialing Committee.

Performance Evaluation Categories

1. Utilization Review
Analysis of the use of ancillary services, medication, inpatient and outpatient services to identify patterns including under-utilization or overutilization of services.

2. Quality Assurance and Improvement
Continuous quality monitoring activities are designed to detect current or potential problems impacting patient care.
Quality Improvement Monitoring includes parameters from the following sources:

- HEDIS
- New York State Department of Health Quality Assurance Reporting Requirements
- National Committee on Quality Assurance

3. Medical Care Evaluations
Medical care evaluations promote the peer review process. Medical care audits provide an objective assessment of the processes and outcomes of care. Medical care evaluations (problem-focused auditing) are performed to ensure that the care provided by providers and other healthcare professionals is appropriate, timely, effective, and consistent with current national and community standards of practice.

4. Preventive Service Audits
Preventive service audits are performed to determine provider compliance with professionally agreed disease prevention standards. Preventive service audits are designed to ensure that members have access to and are using available preventive healthcare services.

5. Onsite Facility Assessments
Onsite facility assessments are performed to assess the quality of care and services provided by prospective or contracted providers. Structural elements of quality care and services are evaluated. Components assessed during an on-site evaluation include:

- Facility appearance
- Environment
- Access to service
- Administrative structure and function
- Policy and procedure manuals
- Personnel
- Member care
- Fire, safety, and emergency
- Member care services
- Ancillary services
- Medical records
- Safety and emergency procedures

6. Access and Availability Assessment
Access and availability audits are performed to identify problems or potential problems relating to appointment availability and scheduling that result in delay of care and service and are based on the access and availability standards. Access audits also are performed to ensure that members have access to needed care and services 24 hours per day, seven days per week.

7. Claims Review
This includes review of claims to detect and document coding errors, including unbundling, fragmentation, upcoding, mutually exclusive procedures, and duplicate, obsolete or invalid codes.

8. Medical Records Standards and Review
A medical record review must be conducted at least on a biennial basis for all primary care providers with more than 50 members and two years of participation in AHP. The medical record review will be conducted so that the confidentiality of member records is protected. The provider is required to provide copies of the medical records to AHP offices for review. Provider medical records must be legible with current details organized and comprehensive to facilitate the assessment of the appropriateness of care rendered.

9. Member Satisfaction Surveys
Consumers tend to evaluate the quality of health care differently than healthcare practitioners; therefore, input from members is included in any evaluation of the quality of care and services. Members can provide information pertaining to the following.

- Access and availability of care and services
- Provider attitude and behavior
- Satisfaction with care and service
- Reasons for disenrollment

10. Member Complaints and Grievances
Member complaints and grievances are used as a source of information about quality of care issues. Detailed documentation is required for tracking and reporting purposes and effective resolution.

C. Corrective Actions
Corrective action by the participating provider may be required. The medical director may take the following actions with individual practitioners to assure quality of care and service to members.

- Direct consultation and education with the practitioner
- 100% review of practitioner claims
- Mandatory second opinions for surgical care
- Limit practitioner privileges
- Impose “no new patients” status
- Hold all payment of claims
- Conduct focused review of ambulatory or hospital care
- Suspend or terminate the Practitioner Agreement
- All sanctions are subject to appeal.

TERMINATION OF CONTRACT

AHP will initiate a termination under the following circumstances:

- Suspension or revocation of the physician’s license, certificate, or other legal credential authorizing the physician to practice medicine or osteopathy

- Suspension or revocation of the physician's DEA number or other right to prescribe controlled substances
- An indictment, arrest, or conviction for a felony or for any criminal charge which might in any way impair the physician's capacity to carry out his or her duties
- The lapse of professional liability insurance required under the contract agreement
- Physician no longer has clinical privileges at any HMO participating hospital
- Repeated failure to participate in or cooperate with AHP's utilization review policies and procedures
- The death of physician (if physician is in solo practice), or the death of any physician who is a member of the group constituting physician which renders such group unable to perform the obligations performed under the provider agreement for a period in excess of 30 days
- Failure to participate in or cooperate with AHP's quality assurance program or repeated failure to provide high-quality, cost-effective health care to members, as measured by standards of care adopted from time to time
- Suspension or permanent preclusion from participating in the New York State Medical Assistance Program or the federal Medicare program

When AHP determines to terminate a contract with a physician, the notification of the proposed termination by AHP to the healthcare professional will be sent via certified mail, return receipt requested. The notice to terminate shall contain

- The reasons for the proposed action
- Notice that provider has the right to request a hearing or review, at the professional's discretion, before a panel appointed by AHP
- A time limit of not less than 30 days within which the professional may request a hearing
- A time limit for a hearing date which will be held within 30 days after the date of receipt of the request for a hearing.

No healthcare provider's contract will be terminated, or refused renewal, solely because the provider has

- Advocated on behalf of a member
- Filed a complaint against AHP
- Appealed a decision of AHP
- Provided information or filed a report pursuant to PHL 4406-c regarding prohibitions of plans
- Requested a hearing or review pursuant to PHL 4406-d and following sections.

The procedures for the proposed hearing are as follows.

- The hearing panel will be comprised of three (3) people appointed by AHP. At least one panel member shall be a clinical peer in the same discipline or same specialty as the person under review. The panel may consist of more than three members, provided the number of clinical peers constitutes one-third or more of the total membership.
- The hearing panel shall render a decision in a timely manner. Decisions will include one of the following and will be provided in writing to the healthcare professional: reinstatement, provisional reinstatement with conditions set forth by AHP, or termination.
- A decision by the hearing panel to terminate a healthcare professional shall be effective not less than 30 days after receipt by the healthcare professional of the hearing panel's decision.
- AHP shall permit a member to continue an ongoing course of treatment for a transition period of up to 90 days or, if the member has entered the second trimester of pregnancy at the time of the provider's termination, for a transitional period that includes the provision of postpartum care directly related to the delivery, subject to provider agreement.

Providers are not eligible for a hearing or review if they have been terminated because of a case involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the healthcare professional's ability to practice. Under these circumstances, the provider's contract with the Plan will terminate immediately. The Credentialing Manager will terminate the provider in the Credentialing System and the provider will be removed from the network.

In no event shall termination be effective earlier than 60 days from receipt of the notice of termination.

By contractual agreement, the practitioner has 30 days to request an appeal of the decision. If the practitioner does appeal the decision within the required 30 days, the following will take place.

1. The practitioner is notified of receipt of the request for appeal.
2. The practitioner's appeal is brought before the Appeals Committee within 30 days.
3. The practitioner has the opportunity to be present at the Appeals Committee hearing.
4. The practitioner has the opportunity to be represented by legal counsel.
5. The practitioner is notified of the decision of the Appeals Committee in writing within 30 days of the hearing date.

AHP, as an Article 44 Health Maintenance Organization, has a duty to report specific actions taken in relation to a provider. The mandatory reporting includes the following.

1. Termination of a healthcare provider's contract for reasons relating to alleged mental or physical impairment, misconduct, or impairment of member safety or welfare
2. The voluntary or involuntary termination of a contract or other affiliation with such organization to avoid the imposition of disciplinary measures
3. The termination of a healthcare provider contract in the case of a determination of fraud or in a case of imminent harm to a patient health

The reports will contain the provider's full name, medical license number, address, account and date of event or incident, description of actions taken by the health plan, including date of termination of a contract or withdrawal and contact people at AHP.

Pursuant to Section 230 of the Public Health Law for the State of New York, "any remedial action lasting more than 30 days and/or termination will be reported to the Office of Professional Discipline or the Office of Professional Medical conduct and the National Practitioner Data Bank." In addition, AHP is legally obligated to report to the appropriate professional disciplinary agency within 30 days of obtaining knowledge of any information that reasonably appears to show that a health professional is guilty of professional misconduct.

NONRENEWAL OF CONTRACT

The contract with AHP allows for the nonrenewal of the contract by either party provided several requirements are met. **Exercising the option of nonrenewal does not constitute a termination.** The requirements include

- Either party may exercise a right of nonrenewal at the expiration of the contract period.
- If no specific expiration date is indicated, the date is considered to be January 1 occurring after the contract has been in effect for one year.
- A nonrenewal decision by either party requires a 60-day notice.

Care to members will continue for a transition period of up to 90 days subject to provider agreement from the date of notice to the member, or the exhaustion of benefits, whichever comes first, or, if the member has entered the second trimester of pregnancy, for a transitional period that includes the provision of postpartum care directly related to the delivery.