PROVIDER MANUAL

Life in Full COLOR. Your Health at Your PACE.

TABLE OF CONTENTS

SECTION 1: INTRODUCTION 4

1.1 ABOUT PACE AND INNOVATIVE INTEGRATED HEALTH 4
1.2 PARTICIPANT ELIGIBILITY 5
1.3 PACE SERVICES 6
1.4 THE MEDICAL MANAGEMENT APPROACH AT PACE 6
1.5 INTERDISCIPLINARY TEAM CARE PLANNING 6
1.6 IIH FACILITIES AND CONTACT INFORMATION 7

SECTION 2: PARTICIPANT ENROLLMENT 8

2.1 INTAKE AND ASSESSMENTS 8
2.2 PACE ENROLLMENT 9
2.3 PARTICIPANT BILL OF RIGHTS 9
2.4 GRIEVANCE POLICY AND PROCESS 12
2.4 APPEALS POLICY AND PROCESS 12
2.5 PARTICIPANT RESPONSIBILITIES 14

SECTION 3: IIH PARTICIPANT GRIEVANCE PROCESS 15

3.1 HOW PARTICIPANTS MAY FILE GRIEVANCES 16
3.2 DOCUMENTATION OF GRIEVANCES 16
3.3 GRIEVANCE REVIEW OPTIONS 16
3.4 HOW PROVIDERS MAY ASSIST WITH THE PARTICIPANT GRIEVANCE PROCESS 17
3.5 PARTICIPANT COMPLAINTS ABOUT PROVIDERS 17

SECTION 4: PARTICIPANT APPEAL PROCESS 18

4.1 FILING AN APPEAL 18
4.2 STANDARD AND EXPEDITED APPEALS 19
4.3 THE DECISION ON THE APPEAL 20
4.4 EXTERNAL REVIEW OPTIONS FOR APPEAL (MEDI-CAL) 20
4.5 EXTERNAL REVIEW OPTIONS FOR APPEAL (MEDICARE) 21
4.6 HOW PROVIDERS MAY ASSIST WITH THE PARTICIPANT APPEALS PROCESS 21

SECTION 5: PROVIDER RIGHTS AND RESPONSIBILITIES 22

5.1 PROVIDER RESPONSIBILITIES 22
5.2 CONTRACTED PROVIDER RESPONSIBLE FOR CONTINUITY OF CARE 22
5.3 PROVIDER RIGHTS AND APPEAL PROCESS 23

SECTION 6: QUALITY IMPROVEMENT PROGRAM **24**
6.1 QUALITY IMPROVEMENT OVERVIEW 24
6.2 QUALITY IMPROVEMENT PROGRAM GOALS 24
6.3 QUALITY IMPROVEMENT AND MANAGEMENT 24
6.4 QUALITY EXPECTATIONS FOR MEDICAL SPECIALISTS 24
6.5 QUALITY IMPROVEMENT PROVISIONS FOR PROVIDERS 25
6.6 CREDENTIALING OVERVIEW 25
6.7 HOW TO COMPLETE THE INITIAL CREDENTIALING PROCESS 25
SECTION 7: CLAIMS SUBMISSION AND PROCESS **26**
7.1 FORMS 26
7.2 CLAIMS PROCESSING OVERVIEW 26
7.3 ELECTRONIC CLAIMS SUBMISSION 27
7.4 HOW TO SUBMIT ELECTRONIC CLAIMS TO IIH 27
7.5 GUIDELINES FOR HARD COPY CLAIMS SUBMISSION TO IIH 27
7.7 HARD COPY CLAIMS SUBMISSION TO IIH 29
7.8 CO-PAYMENTS 29
7.9 ADJUSTED, DENIED OR CONTESTED CLAIMS 29
SECTION 8: AUTHORIZATION FOR SERVICES **31**
8.1 INTERDISCIPLINARY TEAM APPROVAL REQUIREMENTS 31
8.2 SERVICES NOT IN CONCURRENCE WITH IIH PCP 32
8.3 DOCUMENTING A SERVICE REFERRAL 32
8.4 EXCEPTIONS TO AUTHORIZATION REQUIREMENTS 32
8.5 DENIAL, DEFERRAL, OR MODIFICATION OF A SERVICE REQUEST 33
8.6 PRESCRIPTION DRUG BENEFITS 33
8.7 DISCHARGE PLANNING 33
8.8 TRANSPORTATION SERVICES 33
8.9 INTERPRETER SERVICES 33
SECTION 9: SENSITIVE AND CONFIDENTIAL SERVICES **34**
9.1 TESTING 34
9.2 DISCLOSURE OF TEST RESULTS 34
9.3 DISCLOSURE OF BILLING INFORMATION 34
9.4 SEXUALLY TRANSMITTED DISEASES (STD) 35
9.5 HIV/AIDS TESTING 35
9.6 ACCESS FOR THE DISABLED 35
9.7 INFECTIOUS DISEASE REPORTING 36
9.8 DETAILED MEDICAL RECORDS STANDARDS 37

9.9 MEDICAL RECORD CONTENT 38

SECTION 10: ADDITIONAL RESOURCES AND INFORMATION 40

INTERPRETING AND TRANSLATION SERVICES 40

HEALTH EDUCATION PROGRAM 40

SECTION 1: INTRODUCTION

Innovative Integrated Health (IIH) welcomes you as a contracted provider for PACE. We thank you for your commitment to helping us fulfill our mission to enable frail, underserved, and multiethnic senior communities to enjoy an improved quality of life and age at home with dignity. With your partnership, we can support this population by providing high-quality health and human services through an innovative world-class delivery system.

PACE's Program of All-Inclusive Care for the Elderly is a comprehensive healthcare and wellness program designed to help seniors live happy, healthy lives at home with the assistance of PACE services. By joining our network of providers, you play a key role in improving health outcomes for IIH participants by providing essential specialty care services.

This provider manual is designed to help you and your staff navigate the administrative processes of providing health care services to IIH participants. We aim to ensure that your partnership with IIH works well for you, your staff, and your patients. This manual supplement and does not replace or supersede the agreement between you and IIH. We will update the provider manual periodically in accordance with the agreement and respond to changes in our operational processes and regulatory requirements. If there is any discrepancy between the terms of this manual and the agreement, the terms of the agreement will govern.

Your satisfaction with IIH is important to us. We welcome and encourage your feedback about this manual or any other aspect of this partnership. For clarification, questions, or comments about your role as a contracted provider for IIH, please contact our Provider Services Department at **(888) 755-8448** or **ProviderServices@innovativeih.com**.

1.1 ABOUT PACE AND INNOVATIVE INTEGRATED HEALTH

PACE is a unique program for adults over 55 whose health status requires ongoing medical care and supportive services.

During the 1970s, a San Francisco-based program now known as On Lok Lifeways developed an innovative model called Program of All-Inclusive Care for the Elderly (PACE). The PACE model introduced a wide range of medical and social services designed to keep frail seniors in the community and out of institutions. Under a special waiver, Medicaid and Medicare provided On Lok Lifeways a monthly allowance for each participant, and it was On Lok Lifeway's responsibility to arrange and provide individualized medical and social services to serve each participant best.

PACE gained public policy permanency with Medicare provider status in the late 1990s. Federal regulations delineated the requirements under Medicare and Medicaid (Medi-Cal in California) for PACE programs in November 1999 and amended them in October 2002. In late 2001, the Centers for Medicare and Medicaid Services (CMS) approved the first PACE agreement. By November 2003, all PACE demonstration projects had transitioned with CMS approval into permanent PACE provider status.

Innovative Integrated Health opened the doors to Fresno PACE in 2014, establishing the first PACE program in California's Central Valley. In 2020, IIH opened its second Central Valley location in Bakersfield, followed by Orange County PACE two years

later. Through our three successful programs, IIH currently serves over 1,800 participants across Central and Southern California.

IIH receives fixed payments (capitation) from the Centers for Medicare and Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) based on the frailty level of our population. We assume entire financial risk for all care needed by our participants.

IIH grew out of our commitment to meet the medical and social services needs of the frailest members of our communities. Our programs offer an important alternative when nursing home care and placement might otherwise be the only option. With a highly trained, multicultural, and multilingual staff, IIH provides essential medical, social, and supportive services to a culturally diverse population of senior participants. We take pride in caring for our seniors, ensuring their medical needs are met, and helping them live full lives in their homes as an alternative to nursing home care.

1.2 PARTICIPANT ELIGIBILITY

To be eligible to participate in PACE by IIH, an adult must be:

- 55 years of age or older.
- Live in the designated service area.
- Meet the level of care equal to nursing home services as determined by the Department of Health Care Services.
- Able to live safely in the community with the support of PACE services at the time of enrollment.

1.3 PACE SERVICES

1.4 THE MEDICAL MANAGEMENT APPROACH AT PACE

The PACE medical management approach includes the following:

- Integration of medical, social, and supportive services.
- Interdisciplinary Team Care Planning consists of primary care providers, nurse practitioners, nurses, social workers, physical therapists, registered dietitians, and others.
- Primary care management of specialty and institutional services.
- Continuous monitoring of medical conditions and supervision of health and safety.

1.5 INTERDISCIPLINARY TEAM CARE PLANNING

Care planning for IIH members, which are known as "participants", is managed by an Interdisciplinary Team (IDT) of healthcare professionals responsible for assessing and treating our participants and meeting their care needs. The assessment and documentation process are referred to as **care planning**. The IDT must complete the participant's care plan upon enrollment and every six months thereafter. The members of the IDT meet with the participant and family member(s), if applicable, to assess the participant's needs and create a care plan that works in collaboration with each of the other disciplines. This care plan is integral to the PACE model of care and is used as a guide for the IDT to manage the participant's needs.

As a contracted provider for IIH, your input in the participant's care is essential. Your referral notes will be documented in the participant's medical record so that the care plan can be adjusted, as necessary. Should you have questions regarding this process, please contact the IIH social worker or center manager at your local, contracted PACE facility:

1.6 IIH FACILITIES AND CONTACT INFORMATION

2042 Kern Street Fresno, CA 97321	**1800 Height Street Bakersfield, CA 93305**	**1125 N. Magnolia Anaheim, CA 92801**
fresnopace.org (559) 400-6420	**bakersfieldpace.org (661) 872-3860**	**ocpace.org (714) 798-9044**
Authorizations **Phone:** (888) 755-8448 **Fax:** (855) 779-9584 **Email:** authorizations@innovativeih.com	**Authorizations** **Phone:** (888) 755-8448 **Fax:** (855) 824-5660 **Email:** authorizations@innovativeih.com	**Authorizations** **Phone:** (888) 755-8448 **Fax:** (855) 866-0877 **Email:** authorizations@innovativeih.co
Claims claims@innovativeih.com	**Claims** claims@innovativeih.com	**Claims** claims@innovativeih.com
Clinic (559) 570-2722	**Clinic** (661) 493-8425	**Clinic** (714) 855-3259
Scheduling (888) 755-8448	**Scheduling** (888) 755-8448	**Scheduling** (888) 755-8448
TTY Line 711	**TTY Line** 711	**TTY Line** 711

SECTION 2: PARTICIPANT ENROLLMENT

2.1 INTAKE AND ASSESSMENTS

If a senior adult decides to apply for PACE, an IIH Community Health Advisor will set up an informational presentation and/or tour with our Intake Specialist. This meeting may occur at home or at the designated PACE facility. The Intake Specialist will determine eligibility, answer any questions the senior and/or their caregiver(s) may have, and schedule intake assessments. The PACE intake and enrollment process includes three primary stages:

- Initial Eligibility Determination.
- Level of Care Assessment.
- Home Safety Visit.

INITIAL ELIGIBILITY DETERMINATION

As described in Section 1, a senior adult must meet four criteria to be eligible to participate in PACE:

- Must be 55 years of age or older.
- Live in the designated service area.
- Meet the level of care equal to nursing home services as determined by the California Department of Health Care Services (DHCS).
- Able to live safely in the community with the support of PACE services at the time of enrollment.
- Our intake specialist will confirm eligibility requirements before moving forward with scheduling two pre-enrollment assessments.

LEVEL OF CARE ASSESSMENT

The Level of Care assessment is performed by a registered nurse who will review medical information to determine the senior's healthcare needs. This information is collected and submitted to DHCS, which reviews the assessment to determine whether the applicant meets the level of care required to enroll in the program.

HOME SAFETY ASSESSMENT

The Home Safety Assessment is performed by a member of our care team who visits the senior's home to determine whether their living conditions meet standards that allow them to live safely in the community with the support of PACE services. At this time, we will also assess the need for personal care and home health assistance to enhance the enrollee's quality of life at home. PACE participants must have stable housing at the time of enrollment to meet the “live safely in the community” requirement to join the program.

2.2 PACE ENROLLMENT

A senior's enrollment into PACE is effective the first day of the calendar month following the date IIH receives the signed signature page of the Enrollment Agreement, and which follows the completion of the three stages of the enrollment process.

Seniors who enroll in PACE are referred to as participants. All IIH participants are issued a unique identification card, which includes their assigned IIH participant number. This number is assigned upon enrollment to maintain the privacy and confidentiality of records and avoid using protected personal health information (PHI) as a mechanism for identification.

To verify a participant's PACE eligibility, please call the PACE facility in your designated service area. Contact information may be found in Section 1.

2.3 PARTICIPANT BILL OF RIGHTS

IIH is committed to providing the highest quality of care that promotes the autonomy of the individual participant and instills cooperation between the participant, the family or caregiver, and the IIH providers. To provide an environment that promotes privacy and dignity for each participant and achieves the highest quality of care, all participants are informed of their rights.

- The Intake Specialist makes IIH participants aware of their rights in three formats:
    - A separate document that can be used at intake and annually thereafter to remind participants of their rights.
    - Two sections of the Participant Enrollment Agreement Terms and Conditions, a document which is provided and explained at enrollment.
    - An addendum to the Enrollment Agreement.
- The Participant Bill of Rights is displayed prominently throughout our PACE facilities and is included in the Participant Enrollment Agreement Terms and Conditions.

RESPECT AND NON-DISCRIMINATION

Participants always have the right to considerate and respectful care from all IIH staff and contracted providers and under all circumstances. Participants have the right not to be discriminated against in delivering required PACE services based on race, ethnicity, national origin, religion, sex, sexual orientation, age, mental or physical disability, or payment source. Specifically, participants have the right to be assured of the following:

- The participant has the right to be treated with respect.
- The participant has the right to protection against discrimination.
- The participant has the right to information and assistance.
- The participant has the right to a choice of providers.
- The participant has the right to access emergency services.
- The participant has the right to participate in treatment decisions.

- The participant has the right to have their health information kept private.
- The participant has the right to file a complaint.
- The participant has the right to leave the program at any time.
- The participant has the right to contact 1-800-MEDICARE for information or to make a complaint.
- The participant has the right to reasonable and timely access to specialists as indicated by your health condition and consistent with current clinical practice guidelines.
- The participant has the right to receive necessary care across all care settings, up to and including placement in a long-term care facility when the PACE organization can no longer maintain you safely in the community through the support of PACE services.

INFORMATION DISCLOSURE

Participants have the right to receive accurate, easy-to-understand information and assistance in making informed healthcare decisions. Specifically, the participant has the right to be informed by IDT, or a designee, verbally or in writing of the following:

- PACE Services are available from IIH.
- Participant Enrollment Agreement Terms and Conditions, including rights and any fees, fully explained in a manner understood by the participant.
- Rights and responsibilities of participants and of the rules and regulations governing participation in PACE, as evidenced by an acknowledgment signed by the participant.
- The participant's health and functional status.

CHOOSING A PROVIDER

Participants have the right to choose healthcare providers from within the IIH network, specifically regarding the following:

- Selecting a primary care provider (PCP) from the PACE-assigned Primary Care Physicians (PCPs) and medical specialists from within the PACE network.
- Requesting that a qualified specialist for women's health services furnish routine or preventive women's health services.
- Having access to sexually transmitted disease (STD) services and confidential HIV counseling and testing.
- Being able to notify a PACE physician, PACE staff member, or social worker to request a second medical opinion, when desired.
- Disenrolling from PACE without cause at any time.

ACCESS TO EMERGENCY SERVICES

Participants have the right to access emergency health care when and where the need arises without prior authorization by the IDT. Coverage for emergency services does not cover emergency services outside the United States except for emergency services requiring hospitalization in Canada or Mexico. In these situations, PACE may cover certain health care and services provided at a Canadian or Mexican hospital and only in the case if the Canadian or Mexican hospital is closer or easier to reach than any hospital in the United States.

PARTICIPATION IN TREATMENT DECISIONS

Participants have the right to participate fully in all decisions related to their care. If the participant lacks decision-making capacity, the family member or caregiver will be asked to designate a conservator, who will act as the substitute decision-maker. The participant has the right to:

- Participate in developing and implementing the plan of care, including knowledge of the services to be provided, frequency of services, and treatment objectives.
- Receive an explanation of treatment options in a culturally competent manner, make health care decisions, including the right to refuse treatment, and be informed of the consequences of those decisions. Assistance may be provided through an interpreter, amplification, or hearing aids.
- Request a reassessment by the IDT.
- Receive an explanation of advance directives and establish them.
- Receive information about the participant's health and functional status from the IDT.
- Receive reasonable advance notice in writing of plans for the participant's transfer to another treatment setting and the justification for the transfer.

CONFIDENTIALITY OF HEALTH INFORMATION

IIH participants have the right to communicate with their healthcare providers confidentially and are entitled to safeguard their health information as protected health information (PHI). Other participant rights include:

- Reviewing and copying their medical records and requesting amendments to those records.
- Receiving confidential treatment of all information contained in their health record.
- Obtaining their written consent for the release of information to persons not otherwise authorized under law to receive it.
- Providing written consent that limits the degree of information and the persons to whom the information may be given.

2.4 GRIEVANCE POLICY AND PROCESS

Grievance: A grievance is a written or oral statement expressing dissatisfaction with service delivery or the quality of care furnished.

- IIH participants, their representatives, and family members have a right to have their complaints and grievances addressed by knowledgeable people, in a timely, reasonable, and consistent manner, without concern that making a complaint or grievance will negatively affect their treatment in any manner.
- No participant or other individual who submits a complaint about IIH's practices shall be subject to retaliation for filing a complaint.
- A complaint can be made to any IIH staff member or contractor; therefore, all staff and contractors must understand the IIH grievance process:
    - The IIH formal participant grievance policy must be followed if a grievance is filed because **this is a regulatory requirement.**
    - The staff member receiving the grievance will document the details on the grievance reporting form.
    - The Quality Improvement Department (QI) will process all grievances.
    - The grievance will be resolved, and the complainant will be notified of the resolution within a timely manner, not to exceed thirty (30) calendar days of receiving the grievance.
    - A written copy of the resolution will be mailed to the complainant.
    - The QI analyst will track, aggregate, and analyze information on all grievances. This information will be used in the internal QI program.
    - All grievances will be maintained in a confidential manner.
- If a participant is dissatisfied with the resolution of the grievance investigation, they will be notified that they can take further action by informing the QI analyst or designee. If the participant wishes to pursue the grievance further, they have the right to appeal. The QI analyst or designee will initiate additional investigation activities and provide results to the complainant.
- Please refer to Sections 3 of this IIH Provider Manual for more information about the participant grievance process.

2.4 APPEALS POLICY AND PROCESS

Appeal: An appeal is a participant’s action taken with respect to IIH’s noncoverage of, or non-payment for, a service, including denials, reductions, or termination of services.

- Whenever the IDT denies or modifies a request for services or payment the participant has the right to appeal this decision.
- Typical appeals may be Service Determination Request (SDR) denials of increased home care services, durable medical equipment, increase in center day attendance.
- An Appeal must first begin with a SDR before an appeal can be processed.

- Upon enrollment and at least annually thereafter and whenever the interdisciplinary team denies a request for services or payment, IIH will give a participant written information on the appeals process.
- IIH will inform the participant/designated representative orally and in writing of his or her right to appeal against the decision regarding the disposition of a Service Determination Request (SDR). The Appeal rights will describe both the standard and expedited appeals process, including the right to, and conditions for, obtaining expedited consideration of an appeal of a denial of service.
- IIH will give all parties involved in the appeal a reasonable opportunity to present evidence in person as well as in writing.
- IIH will provide assistance to the participant in filing their appeal and assist the participant in determining which process to follow, the Medicare or Medicaid appeal process, if applicable.
- An appropriately credentialed, impartial third party who was not involved in the original action and who does not have a stake in the outcome of the appeal will review the appeal and make a determination about the denial or approval of service.
- Appeals will be responded to and resolved as expeditiously as the participant's health condition requires, but no later than thirty (30) calendar days after IIH receives the appeal.

2.5 PARTICIPANT RESPONSIBILITIES

At PACE, participants and their caregiver(s) play crucial roles in maintaining a high-quality, satisfying care program. IIH participants are encouraged to establish an open line of communication with those providing care and to be accountable for the responsibilities listed below. Providers should familiarize themselves with the participant's responsibilities as well.

IIH participants have the responsibility to:

- Provide necessary and complete information for care, be involved in the development of the individualized plan of care.
- Report to the IDT if they do not clearly understand participant expectations.
- Follow the prescribed treatment and care plan developed for them and take prescribed medications as directed.
- Provide accurate information to the medical and other professional staff, following instructions and cooperating with care providers.
- Report unexpected changes in their medical condition to the provider responsible.
- Voice any dissatisfaction with the PACE center to the IIH Executive Director, Center Manager, Social Worker, Care Plan Coordinator, or Personal Care Attendant.
- Show consideration of the rights of the other participants and all program personnel.
- Attend the PACE center on the days specific to the participant's plan of care and notify the PACE center if the participant is unable to come to the center on appointed days.
- Receive all medical care from their PACE physicians or specialists and notify IIH if they become sick or injured.
- Inform an IIH staff member if the participant is traveling so that IIH can instruct the participant how to receive medical services or emergency care if they become ill while away.
- Notify IIH within 48 hours, or as soon as possible, if the participant is away from home and an emergency arises.

SECTION 3: IIH PARTICIPANT GRIEVANCE PROCESS

IIH participants have the right to a fair and efficient process for resolving differences with IIH, PACE, or IIH contracted providers, including a rigorous system for internal review by the organization and an independent system of external review, including the right specifically to:

- Encouragement and assistance to voice grievances to IIH staff and outside representatives of the participant's choice, free of any restraint, interference, coercion, discrimination, or reprisal by the IIH staff.
- The ability to appeal any treatment decision of IIH, its employees, or contractors through a grievance process described in the Participant Enrollment Agreement Terms and Conditions.

IIH staff share responsibility for participants' care and their satisfaction with the services they receive. The IIH participant grievance process was established to address the participants' concerns or dissatisfactions about the services provided.

A. Participants receive written information on the grievance process at enrollment and annually thereafter.

B. IIH respectfully handles all grievances and maintains the confidentiality of a participant's grievance throughout and after the process is completed. IIH shall only release information related to grievances to authorized individuals.

C. If the participant filing the grievance does not speak English, an interpreter or translation services will be available to facilitate the process.

D. All materials describing the grievance process are available in the following languages: English, Spanish, Vietnamese, Korean and other languages as applicable.

E. IIH shall maintain a toll-free number **(888) 756-4774** for filing grievances and hearing-impaired participants (**711**).

F. Upon enrollment, annually, and upon request, IIH shall provide written information about the grievance process to participants and or their representatives.

G. Procedures for filling grievances

   1. Grievances may be filed by telephone by calling the IIH QI Department at **(888) 756-4774**.
   2. Grievances may also be filed at the participant's designated PACE center.

IIH expects providers to be familiar with the outlined grievance procedures as established. Any method of transmission of the participant's grievance information from one staff member to another is in the strictest confidence, in adherence with the Health Insurance Portability and Accountability Act (HIPAA) regulations.

IIH staff shall not discriminate against a participant because a grievance was filed and shall continue furnishing the participant with all services at the frequency provided in the current plan of care during the grievance process.

3.1 HOW PARTICIPANTS MAY FILE GRIEVANCES

Participants and/or their representatives may voice a grievance to an IIH staff member in person, by telephone, or in writing to a PACE center.

A grievance form from the IIH QI department or the participant's designated PACE center will be available. The grievance form is also available on the IIH website at www.innovativeih.com.

Any IIH staff member can assist a participant or their representative with filing a grievance if assistance is required.

3.2 DOCUMENTATION OF GRIEVANCES

1. An IIH staff member will ensure the participant has written information regarding the grievance process. The IIH staff member will document the grievance on the grievance report form on the day of receipt of the grievance or as soon as possible after the occurrence of the events.
2. The IIH QI department shall ensure documentation of complete details of the grievance so that the grievance may be resolved within 30 days; the participant may take further action if they are unsatisfied with the resolution.
3. If a resolution is not reached within 30 calendar days, the participant and his or her representative shall receive written notice of the status and estimated completion date of the grievance resolution.
4. The IIH QI department shall acknowledge the participant's grievance within five calendar days of receipt of the grievance. It shall coordinate the investigation, designate the appropriate PACE staff participants to take corrective action(s), and report the grievance to the interdisciplinary team (IDT).
5. Upon IIH's completion of the investigation and reaching a final resolution of the grievance, the participant will receive written notification with a report describing the reason for the grievance, a summary of actions taken to resolve the grievance, and options to pursue if the participant is not satisfied with the resolution of the grievance. This occurs within 30 calendar days of receipt of the grievance.

3.3 GRIEVANCE REVIEW OPTIONS

If the participant is dissatisfied with the resolution of the grievance, the participant may pursue other options as described below. If the situation represents a serious health threat, the participant and or his or her representative need not complete the entire grievance process nor wait 30 calendar days to pursue the options listed below.

If the participant is eligible for Medi-Cal only, or Medi-Cal and Medicare, they are entitled to pursue the grievance with the California Department of Health Care Services (DHCS) by contacting or writing to:

Integrated Systems of Care Division (ISCD) ISCDCompliance@dhcs.ca.gov or PACE@dhcs.ca.gov

At any time during the grievance process, whether the grievance is resolved or unresolved, the participant and or their representative may request a state hearing from the California Department of Social Services by contacting or writing to:

California Department of Social Services State Hearings Division
PO Box 944243, Mail Station 19-17-37
Sacramento, CA 94244-2430
Telephone: 800-952-5253
Facsimile: 916-651-5210 or 916-651-2789
TDD: 800-952-8349

Participants must request a state hearing within 90 days of receiving the letter for the resolved grievance. The participant and or their representative must speak at the state hearing or have someone else speak on their behalf, such as a relative, friend, or attorney.

IIH assures that every grievance is handled consistently and that there is communication among the individuals responsible for reviewing or resolving grievances. To ensure all participant concerns are addressed and resolved, IIH will also maintain appropriate documentation to utilize the information in IIH's QI program.

3.4 HOW PROVIDERS MAY ASSIST WITH THE PARTICIPANT GRIEVANCE PROCESS

IIH grievance procedures enable participants and their families to express any concerns, grievances, or dissatisfactions they may have so that IIH may promptly and respectfully resolve them. When appropriate, the provider may assist the participant in filing a grievance.

As a provider of PACE services for IIH, the provider may become aware of a participant with a problem or complaint about IIH, its policies, or its providers. In this case, please inform the participant or their representative to call the Grievances Toll Free Number at **(888) 756-4774** which will then provide information on the participant grievance procedure and a grievance form.

The grievance form is in the **For Providers** section of the IIH website at: www.innovativeih.com.

3.5 PARTICIPANT COMPLAINTS ABOUT PROVIDERS

A provider may be notified of a complaint filed against them by a participant or their representative. If a grievance related to services provided by an IIH contracted provider arises, the IIH QI Department shall notify the contracted provider.

SECTION 4: PARTICIPANT APPEAL PROCESS

All IIH staff share responsibility for the care and satisfaction that participants receive. The appeals process enables the participant and or their representative the opportunity to respond to a decision made by the IDT regarding a request for a service or payment of a service.

1. If the participant wishes to file an appeal at any time, IIH staff are available to assist. If English is not the participant's primary language, an interpreter or translation services will be available in the participant's preferred language.
2. Participants will not be discriminated against because they filed an appeal. IIH will continue to provide the participant's care plan during the appeals process.
3. Confidentiality of the appeal will be always maintained throughout and after the appeals process, including, but not limited to, transmission of appeal information from one IIH staff member to another in adherence to Health Insurance Portability and Accountability Act (HIPAA) regulations; information pertaining to the appeal will only be released to authorized individuals.
4. Participants will receive written information on the appeals process at enrollment, annually thereafter, and whenever the IDT denies, defers, or modifies a request for services or refuses to pay for a service. Information includes, but is not limited to:
    - Procedures for filing an appeal, including participant's external appeal rights under Medi-Cal and Medicare.
    - The telephone number for the filing of an appeal received in person or by telephone: Participant's designated IIH Social Worker or IIH QI department: (**888) 756-4774.**
5. A participant and/or his or her representative may file a written appeal at the participant's designated PACE center.
6. Contracted providers are accountable for all appeal procedures established by IIH and will be monitored by IIH for compliance with this requirement on an annual or as-needed basis.
7. All written materials describing the appeal process are available in the following languages: English, Spanish, Vietnamese, Korean and other languages as applicable.
8. IIH shall maintain a toll-free number (**855) 785-2584** to file an appeal and for hearing-impaired participants (**TDD/TTY: 711**).

4.1 FILING AN APPEAL

1. The appeal process is available to any participant, their representative, or treating provider who disputes the denial of payment, the denial, deferral, or modification of service by the primary care provider (PCP), or any IDT member qualified to make referrals.
2. A participant may file any appeal for denial, deferral, or modification of a service or payment for a service verbally or in writing.

4.2 STANDARD AND EXPEDITED APPEALS

1. Depending on the case's urgency, a participant may file an appeal as standard or expedited.
2. A participant may file a standard appeal verbally or in writing with any IIH staff member within 180 calendar days of a denial of service or payment. IIH may extend the 180-day limit for good causes determined by IIH.
3. A participant may file an expedited appeal verbally or in writing to IIH if the participant or provider believes that the participant's life, health, or ability to regain maximum function would be seriously jeopardized without the provision of the service in dispute.
4. For participants enrolled in Medi-Cal, IIH shall continue to furnish the disputed service if the following conditions are met:
    - IIH is proposing to reduce or terminate services currently being furnished to the participant; and
    - The participant requests continuation of the service, understanding that he or she may be liable for the cost of the contested service if the determination is not made in their favor.
5. Under the circumstances listed above, IIH shall only discontinue the disputed service for which an appeal was filed once the appeal process concludes.
6. The IIH QI department shall acknowledge a standard appeal in writing within five business days of the initial receipt of the request by IIH.
7. For an expedited appeal, the IIH QI department shall inform the participant or representative within one business day by telephone or in-person that the request for an expedited appeal was received and explain their additional appeal rights, as applicable.
8. IIH shall document all appeals expressed verbally or in writing on the day the request is received or as soon as possible after the event or events that precipitated the appeal in an appeal log.

    Appeals are documented on the appeals form by the participant, their representative, or a treating provider on behalf of the participant. Complete information is required so the appeal can be resolved promptly. For access to the appeals form, please contact the participant's IIH social worker or the QI department at **(888) 756-4774** or refer to the **For Providers** section of the IIH website at: www.innovativeih.com.

    a) In the event of insufficient information, the IIH QI department shall take all reasonable steps to contact the participant, their representative, or other appropriate parties to the appeal to obtain the missing information to resolve the appeal within the designated time frames for an expedited or standard appeal.
    b) All individuals involved with the appeal, including the participant or representatives, shall be given written notice of the appeals process and reasonable opportunity to present evidence or submit relevant facts for review to IIH, either verbally or in writing.
    c) For a standard appeal, the IIH QI department shall inform the participant in writing of the decision to reserve or uphold the decision within 30 calendar days of receipt of an appeal or more quickly if the participant's health condition requires it.
    d) For an expedited appeal, IIH shall resolve the appeal as promptly as the participant's

health condition requires but no later than 72 hours after receipt of the request for appeal.

e) The IIH QI department shall provide the participant and or their representative and the Department of Health Care Services (DHCS) with a written statement of the final disposition or pending status of an expedited appeal within 72 hours of receipt of the appeal.

f) If the 72-hour time frame needs to be extended, the PACE Executive Director shall justify to DHCS the need for an extension. The participant shall be notified, both verbally and in writing, by the IIH QI department of the pending status and the reason for the delay with the appeal. IIH shall inform the participant of the anticipated date by which the appeal decision shall be determined.

4.3 THE DECISION ON THE APPEAL

1. An independent and impartial third-party renders appeal decisions.
2. When the decision of an appeal is in favor of a participant that is, the decision to deny, defer or modify a service or payment of service is reversed, the following shall apply:
    a. The IIH QI department shall provide a written response to the participant or representative within 30 calendar days of receiving a standard appeal or sooner if the participant's health condition requires it.
    b. For an expedited appeal, IIH shall provide the participant permission to obtain the disputed service or provide the service as quickly as the participant's health condition requires, but no later than 72 hours after receiving a request for an expedited appeal.

4.4 EXTERNAL REVIEW OPTIONS FOR APPEAL (MEDI-CAL)

The Medi-Cal external appeal process option is available to participants enrolled in Medi-Cal only or Medicare and Medi-Cal.

If the participant and or representative chooses to appeal using the Medi-Cal external process, the IIH QI department shall assist the participant and forward the appeal to:

California Department of Social Services State Hearings Division
PO Box 944243, Mail Station 19-17-37
Sacramento, CA 94244-2430
Telephone: 1-800-952-5253
Facsimile: (916) 651-5210 or (916) 651-2789
TDD: 1-800-952-8349

IIH shall only discontinue services for which an external appeal is filed once the process concludes. If the participant and or their representative decides to pursue a state hearing, they must request the state hearing within 90 days from the day of the Notice of Action (NOA), in which the participant receives notification of the denial, deferral, or modification of service, or denial of payment for a service.

4.5 EXTERNAL REVIEW OPTIONS FOR APPEAL (MEDICARE)

The Medicare external appeals process option is available to participants enrolled in Medicare only or Medicare and Medi-Cal.

- A Medicare enrollee may appeal IIH's decision using Medicare's external appeals process.
- Standard appeals are resolved within 30 calendar days after the filing of the appeal; expedited appeals are resolved within 72 hours, with a possible 14-day extension.
- The Medicare appeals entity will notify IIH of the review results.
- If the decision is not in the participant's favor, there are further levels of appeal; upon request, the IIH QI department will assist a participant in further pursuing the appeal.

4.6 HOW PROVIDERS MAY ASSIST WITH THE PARTICIPANT APPEALS PROCESS

The provider may assist the participant in requesting an expedited appeal if the provider or participant believes that the participant's life, health, or ability to get well is in danger without the service they want. To view the Appeal for Reconsideration of Denial form, providers may refer to the **For Providers** section of the IIH website at: www.innovativeih.com.

SECTION 5: PROVIDER RIGHTS AND RESPONSIBILITIES

5.1 PROVIDER RESPONSIBILITIES

Participants may choose their primary care provider (PCP) from among the IIH primary care physicians. The PCP is the primary care provider who is assigned to the participants and is part of the interdisciplinary team. Most PCPs for participants are retained on staff by IIH, although some PCPs may be contracted providers. Most PACE contracted providers are medical specialists.

5.2 CONTRACTED PROVIDER RESPONSIBLE FOR CONTINUITY OF CARE

In the event of contract termination, the provider shall acknowledge responsibility for the continuity of care for IIH participants receiving a course of treatment under the provider's care for an acute or severe chronic condition at the time of contract termination. Eligible participants have the right to request that the terminated provider continue to provide, and be compensated for, those services that IIH covers.

A. ELIGIBILITY FOR CONTINUITY OF CARE

An IIH participant is eligible for continuation of care if they experience an acute or severe chronic condition. A critical condition is defined as a medical problem involving a sudden onset of symptoms due to disease, illness, or other medical problems requiring prompt medical attention and a limited duration.

A severe chronic condition means a medical condition due to disease, illness, or other medical problem or medical disorder that is serious and results in either of the following:

- Persists without full care or worsens over an extended period.
- Requires ongoing treatment to maintain remission or prevent deterioration.

B. CONTRACTED PROVIDER RESPONSIBILITY

Contracted providers will be responsible for providing continuing care under the following conditions:

- The contracted provider's termination or non-renewal was voluntary.
- The contracted provider agrees in writing to be subject to the same contractual terms and conditions of their agreement, including, but not limited to, credentialing, hospital privileges, utilization review, peer review, and quality assurance requirements.
- The contracted provider agrees in their contract to accept the payment rates and payment methodologies outlined in the agreement.
- The extent and duration of the continuation of covered services will be as follows:

1. If the requesting participant is undergoing a course of treatment from the provider for an acute condition or serious chronic condition, the provider will furnish services on a timely and appropriate basis for up to 90 days, or a longer period, if necessary, for the transfer to another provider, as determined by IIH and in consultation with the terminated provider, consistent with good professional practices.
2. This continuity of care will not require IIH to cover services or provide benefits that are not otherwise covered under the terms and conditions of PACE.

5.3 PROVIDER RIGHTS AND APPEAL PROCESS

IIH will make every effort to assist a provider in resolving complaints or problems encountered while providing health care to IIH participants. Please see **Section 8: Authorization for Services** of the IIH Provider Manual or contact their designated PACE center for utilization management and prior authorization issues. For billing and payment submissions, please see **Section 7: Claims Submission and Process** of the Provider Manual.

If your claim has been denied for any reason, you have the right to submit an appeal for redetermination. Providers have 365 calendar days from the date of the original denial to submit an appeal. IIH has 30 days to finalize determination of an appeal from the date received. Appeals should be mailed to PEAK TPA with all corresponding documents:

PEAK TPA / INNOVATIVE INTEGRATED HEALTH
ATTN: APPEALS DEPT
PeakTPA
P.O. Box 21631
Eagan, MN 55121
OR e-mailed directly to PEAK TPA
Intake@eclusive.com
Subject Line: Claim Appeal Submission

SECTION 6: QUALITY IMPROVEMENT PROGRAM

6.1 QUALITY IMPROVEMENT OVERVIEW

IIH has a Quality Improvement (QI) program. The QI program enables IIH to measure, assess and improve important aspects of healthcare delivery and the healthcare outcomes of our participants.

6.2 QUALITY IMPROVEMENT PROGRAM GOALS

The IIH QI program adheres to the National Committee on Quality Improvement (NCQA) principles. QI objectively and systematically monitors and evaluates the quality and appropriateness of participant care quarterly, and ad hoc across the entire continuum of care delivered by IIH and reports results to the Quality Improvement Committee and the IIH Board of Directors. The goals of the review process are to assure high-level quality care and to identify, assess and reduce problems affecting care to an acceptable level.

The QI program is reviewed and revised annually. The IIH Board of Directors reviews results and subsequently approves the QI program for the year.

6.3 QUALITY IMPROVEMENT AND MANAGEMENT

As part of the QI program, providers are monitored for:

- Participant access to care and availability of care and services.
- Compliance with IIH QI policies and procedures.
- Participant satisfaction with provided services.
- Coordination of care by the PCP, medical specialists, mental health providers, and community facilities caring for the participant.
- Cultural and linguistically appropriateness of care, including availability of bilingual staff and telephonic language assistance services.
- Program performance and resource utilization management.

By monitoring services and addressing problems as they arise, IIH aims to keep its mission and vision of providing quality, affordable care services for the well-being of the frail elderly and to lead the movement to improve care for its participants continually.

6.4 QUALITY EXPECTATIONS FOR MEDICAL SPECIALISTS

Upon receiving authorization from IIH, the contracted medical specialist will:

- Set specialty appointment within 14 days of the request.
- Communicate findings of the visit to the PCP, including recommendations for further diagnostic procedures or therapy.
- Coordinate lab and X-ray request(s) with the designated PACE center.
- Maintain medical records consistent with state and federal regulations.

- Comply with IIH QI policies and procedures.
- Contact IIH to refer to another medical specialist within IIH's contracted provider network.
- Provide continuity of care services to IIH participants upon termination of a provider's contract.

6.5 QUALITY IMPROVEMENT PROVISIONS FOR PROVIDERS

In addition to complying with the IIH credentialing requirements detailed in this section, the provider must cooperate and comply with QI provisions, including coordination of care, accessibility standards, office waiting time, participant satisfaction surveys, grievance and appeal activities, and communication regarding unusual incidents.

6.6 CREDENTIALING OVERVIEW

The IIH credentialing process aims to verify that participating physicians and other professionals have the necessary and appropriate credentials to provide their services to IIH participants. Providers interested in contracting with IIH may initiate the credentialing process by contacting IIH's Provider Relations department at providerservices@innovativeih.com. The information listed below informs the provider of the credentialing process.

In conducting the credentialing and re-credentialing processes, IIH verifies specific information, including:

- California licensure.
- Current professional liability insurance or self-insurance.
- The provider's primary admitting facility.
- Exclusions, suspensions or ineligibility, and preclusions to participate in any state or federal healthcare program.
- Valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate.
- Education and training, including board certification (if the provider states on the application that they are board certified).
- Work history.
- Status of clinical privileges.
- History of professional liability claims.

6.7 HOW TO COMPLETE THE INITIAL CREDENTIALING PROCESS

Providers interested in contracting with IIH must be credentialed. Contact the Provider Relations Manager for your location to begin the credentialing process. All providers will be re-credentialed every three years. A notification will be sent to you before your re-credentialing due date.

SECTION 7: CLAIMS SUBMISSION AND PROCESS

IIH providers rendering services to IIH participants must submit claims using the current version of the CMS-1500 claim form for professional services, a CMS 1450 (a.k.a UB-04) form for facility services, or an American Dental Association (ADA) form for dental services. When submitting the claim, please be sure to include all required data elements to ensure timely payment. Providers must follow all Medi-Cal and or Medicare rules and regulations for billing.

7.1 FORMS

Contracted Fee-For-Service (FFS) providers rendering services to PACE participants must submit claims using a CMS-1500 claim form (outpatient visit). Facilities must use a UB-04 form (both inpatient and outpatient visits) to submit claims. Dental claims must be submitted using an American Dental Association (ADA) form.

Copies of both the CMS-1500 and UB-04 forms may be downloaded from the CMS website at: CMS Forms List. The American Dental Association (ADA) form may be downloaded from the American Dental Association website at: www.ada.org

7.2 CLAIMS PROCESSING OVERVIEW

IIH recognizes that a key component of quality health care is timely and efficient medical claims processing. IIH processes medical claims primarily per Medi-Cal and Medicare guidelines and utilizes key industry standard codes and guidelines to promote timely and efficient processing of paper and electronic claims. Contained below is a summary description of IIH's claims processing steps.

Claims Filing Time Frames

PACE follows the Centers for Medicare and Medicaid Services (CMS) and Medi-Cal guidelines for timely filing of claims. Providers should file claims within the applicable time frames.

- Providers have one year from the date of service to submit a claim for covered services, unless otherwise specified within the contract.
- IIH will deny claims not submitted within the appropriate time frame.

Edits/Audits

- IIH processes all claims on a first-in, first-out basis.
- All claims are subject to a comprehensive series of checks called "edits" and "audits." The checks validate all data information to determine if the claim should be paid, contested or denied.
- Edit/audit checks review:
  - Data validity.
  - Prior authorization and medical record requirements as applicable.
  - Participant enrollment in IIH on date of service.
  - Provider eligibility on date of service.
  - Procedure/diagnosis, and procedure/modifier compatibility.

- Other insurance coverage.
- Potential for claim duplication.

- IIH will provide a clear and accurate explanation of the specific reasons for adjusted, denied, or contested claim.

7.3 ELECTRONIC CLAIMS SUBMISSION

IIH accepts claims in both electronic and hard copy formats. This section provides information about electronic claims submission, including Electronic Data Interchange (EDI) claims.

IIH strongly encourages electronic claims submission. The following are some benefits of submitting claims electronically to IIH:

- Electronic claims submission is cost-effective.
- Providers receive an electronic confirmation of claim submission (from the clearinghouse).
- Electronic submission promotes effective utilization of staff resources.

7.4 HOW TO SUBMIT ELECTRONIC CLAIMS TO IIH

EDI Claims

IIH has contracts with a data clearinghouse to receive EDI claims. To register and submit electronically, contact one of the vendors listed below:

Change Healthcare
(866) 371-9066
Payeroutreach_EDI@changehealthcare.com
www.changehealthcare.com

IIH Payer Identification Numbers

Provider should use the following IIH payer identification (ID) numbers when sending claims electronically to IIH.:

- **Innovative Integrated Health, Inc.: Payer ID "99660"** — For submission of all claim types (UB-04, 1500, and American Dental Association [ADA]).

  NOTE: The payer ID number is for all IIH locations.

7.5 GUIDELINES FOR HARD COPY CLAIMS SUBMISSION TO IIH

While electronic submission is recommended, IIH accepts claims in both electronic and hard copy formats. This section provides information about hard copy claims submission, including guidelines for how to complete the claim form, important tips and relevant billing addresses.

This section explains the basic billing guidelines required for IIH processing of hard copy medical CMS 1500 and UB-04 claim forms. Copies of both the CMS 1500 and UB-04 forms may be downloaded from the CMS website at: CMS Forms List

Following these guidelines helps ensure that IIH can pay a provider's hard copy claim quickly and accurately:

1. **Type in Designated Area Only**

   All claims are scanned, so it is important that providers input data on the claim form only in the designated fields. Be sure the data falls completely within the text space and is properly aligned. This will ensure that claims are scanned accurately and avoid rejections or payment delays.

2. **Font Requirement**

   On a 1500 claim form, type all information using capital letters and 10-point font-size or larger for clarity and accuracy.

3. **Use Alpha or Numeric Characters Only**

   Use only alphabetical letters or numbers in data entry fields as appropriate. Only use symbols such as "$, #, cc, gm" or positive (+) and negative (–) signs when entering information in the Specific Details/Explanation/Remarks or the Reserved for Local Use fields of the claim form.

4. **Do Not Use Highlighting Pens**

   Please do not highlight information. When the form and attachments are scanned on arrival at IIH, the highlighted area will show up as a black mark, covering the information highlighted.

5. **Follow the Date Format**

   Enter dates in the six-digit format (MMDDYY) without slashes. Refer to the sections of this guide covering claims form completion for appropriate billing form instructions and for additional date format information.

6. **Cover Corrections**

   Do not strike over errors. Do not use correction fluid. Do not use correction tape.

7. **Be Sure to Reference Claim Fields or Procedures on Attachments**

   Attached documents for medical claim forms and Provider Dispute Resolution forms should clearly reference the claim field number or procedure that requires additional documentation.

   a. The claim field number on the attachment should be legible, underlined or circled in black ballpoint pen. Allow adequate line space between each claim field number description.

   b. Attach undersized documentation to an 8 1/2 x 11-inch sheet of 20-lb. white bond paper with non-glare tape. Cut oversized attachments in half (e.g., Explanation of Medicare Benefits, Medicare Remittance Notice, Remittance Advice), and tape each half to a separate 8 1/2 x 11- inch white sheet of paper: staple attachments in the top right corner of the form.

Note: Do not highlight or use tape to fasten attachments to the claim form. Do not use original claims as attachments since they may not be interpreted as original claims. Carbon copies of documentation are not acceptable.

OTHER IMPORTANT TIPS WHEN SUBMITTING BILLS TO IIH

1. **Timely Filing**

   IIH has timely filing guidelines, which allow the provider one year from the date of service to submit a claim, unless specified differently within the contract. For claim resubmission, the provider has one year from the date of the claim determination. IIH will deny claims not submitted within the appropriate time frame. The claim may be submitted for reconsideration with documentation showing that the claim was submitted timely (e.g., retro eligibility issue).

2. **Paper Claims and Submission**

   When submitting paper claims to IIH, providers should send the original claim form and retain a copy for their records.

3. **Submission Standards**

   Providers should not submit multiple claims stapled together. Stapling original forms together indicates the second form is an attachment, not an original form to be processed separately.

4. **Unacceptable Forms**

   Carbon copies, photocopies, facsimiles, or forms created on laser printers are not acceptable for claims submission and processing.

7.7 HARD COPY CLAIMS SUBMISSION TO IIH

To submit a claim in hard copy format to IIH, please mail to:

PEAK TPA- IIH Claims Department
P.O. Box 21631
Eagan, MN 55121

7.8 CO-PAYMENTS

There are no co-payments or deductibles for PACE participants.

7.9 ADJUSTED, DENIED OR CONTESTED CLAIMS

IIH will provide a written clear and accurate explanation of the specific reasons for such action for adjusted, denied, or contested claims.

POTENTIAL BILLING DISCREPANCIES

Should billing discrepancies occur, IIH will try to resolve the discrepancy. We may request a copy of the medical record or supplemental information. We will supply a written, clear and accurate explanation detailing the necessity for the request.

PENDING CLAIMS

Claims that fail an edit, or audit check, will "pend" for review by a claims examiner who will identify the reason for the pended status and examine the scanned image of the claim and attachments (if hard copy received).

SERVICES PROVIDED WITHOUT PRIOR AUTHORIZATION

<u>Claims for non-emergency services provided without prior authorization will be denied.</u>

PROBLEMATIC CLAIMS

Claims for which IIH establishes reasonable grounds for suspicion of possible fraud, waste, and abuse, or unfair billing practices will be forwarded to the PACE Compliance Department.

CLAIMS PAYMENTS

IIH will pay claims to providers within 30 business days from receipt by IIH. Claims that successfully pass the processing cycle will be adjudicated per regulatory guidelines and or the specific contracted rate. Providers shall not seek additional payments from Medi-Cal and Medicare, other insurance companies or PACE participants.

If providers would like to file for Electronic Funds Transfer (EFT) payments, please complete the Electronic Funds Transfer (EFT) Authorization Agreement located on the IIH Website, for Providers section.

GETTING ANSWERS TO CLAIMS QUESTIONS

For claims questions, contact the PEAK TPA Provider Services at **(952) 400-7600**, Monday through Friday, from 8 a.m. to 12 p.m. and 1p.m to 5 p.m. CST or email intake@eclusive.com (please do not submit claims to this email address).

SECTION 8: AUTHORIZATION FOR SERVICES

IIH relies on the professional judgment of its staff and primary care providers (PCPs) to make medical care decisions. The interdisciplinary team (IDT) also makes decisions in their respective disciplines.

IIH provides comprehensive medical and long-term care services to keep participants safe in the community. IIH participants receive primary care without prior authorization requirements. The following procedures must be followed for all other services provided to IIH participants:

- IIH must authorize all non-emergency services before services are rendered. A Prior Authorization Request Form must be completed for all provider services recommended or requested unless those services have been ordered/referred by the IIH PCP.
- Providers who render emergency services must notify IIH within 24 hours or the next business day after that service has been rendered.
- The provider will receive an authorization packet before the participant visits.

To access the Prior Authorization Request Form, please call the IIH Authorizations team at **(661) 493-8421**, or refer to the **For Providers** section of the IIH website at www.innovativeih.com.

Emergency services do not require prior authorization by IIH. IIH covers both Emergency and Urgent Care services when our members are temporarily out of our service area but still in the United States or its territories.

The Authorization Packet includes the reason for referral and the scope of the requested service and will consist of an alpha-numeric authorization number. A provider must respond to the referring IIH PCP in writing regarding the professional opinion, recommended treatment plan, and anticipated follow-up care. The IIH Medical Records team will call the provider's office to request these notes shortly after services are rendered. All additional services a provider recommends, including referrals to other providers, diagnostic tests, and treatments, must be requested on the Prior Authorization Request Form and explicitly authorized by IIH.

8.1 INTERDISCIPLINARY TEAM APPROVAL REQUIREMENTS

The interdisciplinary team will consider the services listed below for approval based on the authorization criteria, medical necessity, and or ability for the service to improve the participant's quality of life significantly:

- Home care service.
- PACE center attendance.
- Long-term care placement.

8.2 SERVICES NOT IN CONCURRENCE WITH IIH PCP

As described above, all additional services a provider recommends, including referrals to other providers, diagnostic tests, and treatments, must be authorized explicitly by IIH.

8.3 DOCUMENTING A SERVICE REFERRAL

Once the PCP has decided to refer a participant to an off-site provider, the PCP or designee will generate a referral order. IIH will authorize the order and contact the provider's office to arrange the appointment.

The Authorization Packet includes the following:

- Designated PACE center address, telephone number, and authorization number (providers rendering services to IIH participants should place the authorization number on a CMS-1500 claim form for professional services).
- Participant's full name, date of birth, and participant number.
- Copy of the participant member ID card.
- Who authorized the referral, date of authorization, and reason for consultation.
- Relevant history and notes.

IIH will fax the Authorization Packet to the provider's office in advance. When services are rendered, the provider will complete visit notes, including a professional opinion, recommended treatment plan, anticipated follow-up care, and a Request for Prior Authorization Form as needed. All additional services recommended by the provider must be explicitly authorized by IIH.

The IIH Medical Records team will call the provider's office to confirm the visit and request these notes shortly after services are rendered.

To access the Request for Prior Authorization Form, please call the IIH Authorizations department at **(661) 493-8421** or refer to the **For Providers** section of the IIH website at www.innovativeih.com.

8.4 EXCEPTIONS TO AUTHORIZATION REQUIREMENTS

There are specific categories of care for which no authorization is required. IIH covers **emergency services** and **urgent care services** when a participant is temporarily out of the approved service area but still in the United States. Coverage for emergency services does not cover emergency services outside the United States except for emergency services requiring hospitalization in Canada or Mexico. IIH may pay for certain health care and services provided at a Canadian or Mexican hospital in these situations.

This only occurs if the Canadian or Mexican hospital is closer than any hospital in the U.S.

Emergency Services include inpatient, or outpatient services furnished immediately in or outside the service area because of an emergency medical condition. An emergency medical condition is a medical condition that is manifested by acute symptoms of

sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of a participant in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Urgent Care Services are covered services necessary to prevent severe deterioration of the health of a participant resulting from unforeseen illness, injury, prolonged pain, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the participant returns to the IIH PACE service area.

8.5 DENIAL, DEFERRAL, OR MODIFICATION OF A SERVICE REQUEST

IIH shall review all authorizations submitted by Specialists and will determine whether to create an order for any specialist recommendations. Some requests will be presented to the IDT for review and approval. If the request is denied or modified, the IDT will issue a Notice of Action for Service Delivery Request. The letter will provide the reason for denial, deferral, or modification and then instructs the participant or the participant's representative to file an appeal if they disagree with the action.

8.6 PRESCRIPTION DRUG BENEFITS

Each participant enrolled in IIH is entitled to Medicare and Medi-Cal covered services, including prescription drugs. The participant's PCP is responsible for managing the participant's care, including prescription drugs; the PCP will also review recommendations for drug therapy. IIH will not assume financial responsibility for unauthorized drugs or medications dispensed by a non-network pharmacy except in the case of an emergency. IIH participants do not pay co-payments or deductibles for covered services, including prescription drug coverage benefits.

8.7 DISCHARGE PLANNING

Upon discharge from an inpatient hospital, the IIH PCP or designee coordinates discharge planning with the hospital.

8.8 TRANSPORTATION SERVICES

IIH provides or otherwise arranges transportation to and from the provider's service location. IIH may also designate a representative to escort the participant as needed.

8.9 INTERPRETER SERVICES

As detailed in the Interpreting and Translation Services description in **Section 10: Additional Resources and Information**, PACE shall arrange interpreting or translation services when appropriate.

SECTION 9: SENSITIVE AND CONFIDENTIAL SERVICES

9.1 TESTING

All providers must obtain written consent for confidential HIV testing, except when a treating physician or surgeon recommends the test or is provided at an alternative test site. Under these circumstances, a physician or surgeon may obtain verbal informed consent from the participant.

9.2 DISCLOSURE OF TEST RESULTS

The provider must obtain consent to disclose a participant's HIV test results (California Health and Safety Code, Section 120980). The provider must obtain a participant's written authorization before each disclosure of an HIV test result. Under the law, a physician or surgeon may disclose a participant's test result to a person believed to be the spouse, sexual partner, or person with whom the participant has shared hypodermic needles, but only if the physician or surgeon provided education and counseling to the participant and attempted to obtain the participant's voluntary consent to notify their contacts. The physician or surgeon is prohibited from disclosing identifying information about the participant during the notification (California Health and Safety Code, Section 121015).

9.3 DISCLOSURE OF BILLING INFORMATION

When a participant is tested by someone other than the PCP, the participant may elect to:

- Sign a release of confidential information to send medical records and the bill to PACE.
- Allow billing information to be sent to IIH but decline the release of medical records.
- Choose complete anonymity and refuse to release any information.

NOTE: A claim submitted without a name to determine eligibility for services will not be paid by IIH.

9.4 SEXUALLY TRANSMITTED DISEASES (STD)

In accordance with IIH procedures, prior authorization is required in the event the participant wishes to go to an out-of-network provider for STD diagnosis and treatment**.**

Providers are responsible for filing all required reports on STD diagnosis and treatment as required by law. Such reporting should be documented in the participant's medical record. Providers are responsible for informing the participant of this reporting activity.

Providers are encouraged to ask the participant to authorize the release of diagnosis and treatment information to the participant's PCP to ensure continuity of care. The provider must inform participants of their right to refuse or agree to disclose such information. Medical records must be in accordance with state law and professional practice standards regarding confidentiality.

9.5 HIV/AIDS TESTING

In accordance with IIH procedures, prior authorization is required in the event the participant wishes to go to an out-of-network provider for HIV counseling and testing.

IIH policy ensures that participants receive information regarding access to confidential HIV counseling and testing.

Providers should advise any participant who goes to an out-of-network confidential test site to sign a release of information form to allow submission of their name on the claim. IIH will only reimburse the provider for a claim submitted with the name on the claim to determine service eligibility.

According to California law, providers must report AIDS cases to the County Public Health Department, Division of Communicable Disease Control and Prevention. AIDS is a reportable condition and does not require consent from the participant. Providers are required to report the names of individuals diagnosed with AIDS.

9.6 ACCESS FOR THE DISABLED

All IIH facilities and contracted provider facilities should be accessible and useable by individuals with disabilities in accordance with the Americans with Disabilities Act of 1990. Access includes physical, alternative, and communication accommodations.

PHYSICAL ACCOMODATIONS

Physical accommodations should include:

- Wheelchair access, ramp.
- Water availability.
- Elevators with floor selection within reach.
- Designated parking spaces.
- An accessible bathroom or alternative access to the bathroom in the building.
- Handrails in the bathrooms.
- Hallways and exits must not be locked to impair wheelchair access.
- IIH will evaluate the PACE center for access to people with disabilities during the facility site reviews.

ALTERNATIVE ACCOMODATIONS

Contracted providers in older facilities that lack accessibility should make alternative arrangements for treating disabled participants. If finding an alternative is impossible, a provider should refer the participant to a provider who can meet the participant's needs.

COMMUNICATION ACCOMODATIONS

In addition, providers should make appropriate language and communication accommodations, such as providing sign language interpretation, telecommunications devices for people who are deaf or hard of hearing (TDD/TTY), and or interpreters.

DETAILED INFECTION CONTROL STANDARDS

IIH providers and contracted providers are to maintain and follow infection control policies and procedures. Providers are responsible for training all staff in universal precautions and hand washing, the use and maintenance of the autoclave, cleanup of blood spills, isolation procedures, and disposal of biohazardous waste.

9.7 INFECTIOUS DISEASE REPORTING

Each provider office must have an established procedure to meet regulations for reporting infectious diseases to the local health authority (California Administrative Code, Title 17). Providers may request recommendations on treatment procedures from the local public health department. Using a current version of reportable diseases, providers must perform necessary and required epidemiological follow-up and institute preventive measures per the local public health department's instructions.

REPORTING FORM FOR PARTICIPANTS

Providers must complete the Confidential Morbidity Report (available from the local public health department) and send it to the local authorities. The date the report was sent should be documented in the participant's medical record.

CONFIDENTIALITY

Information about participants with reportable infectious diseases will be kept confidential and protected from unauthorized disclosure as required by California law.

REPORTABLE DISEASES/ADDITIONAL REPORTING REQUIREMENTS

When reporting certain infectious diseases, providers must also provide additional specific information regarding hepatitis and STDs:

HEPATITIS REPORT

- Type.
- Type-specific laboratory findings.
- Source of exposure.

SEXUALLY TRANSMITTED INFECTIONS REPORT

- Information as to causative agent.
- Syphilis-specific laboratory findings.
- Complications of gonorrhea or chlamydia infections.

9.8 DETAILED MEDICAL RECORDS STANDARDS

All IIH providers and contracted providers must have a medical record for each participant and maintain procedures for storage, filing, retrieval, protection of confidentiality, and release of information.

MAINTENANCE

Providers must specify a staff member to maintain medical records to assure records are:

- Secured from unauthorized use.
- Stored in one central medical records area.
- Kept current and accessible for care.
- Organized into sections.
- Securely fastened.
- Filed in a manner that assures the ability to retrieve them, either alphabetically by last name, first, middle, or numerically using a terminal digit, serial, or uniquely assigned numbering system.

CONFIDENTIALITY

While the physical medical record belongs to the provider, the information in the record belongs to the participant and must be protected from unauthorized disclosure.

The medical records department manager or office manager shall be responsible for maintaining, monitoring, and enforcing staff compliance in keeping member information confidential and in the release of member information when requested by the member, or under other conditions of release, in accordance with IIH Policy, and IIH HIPAA privacy policies.

Federal HIPAA privacy regulations require that participants complete the "Authorization to Release Health Information" form to authorize IIH to use or disclose participants' Protected Health Information (PHI) to another person or organization. To view the Authorization to Release Health Information form, please visit the **For Providers** section of the IIH website at: www.innovativeih.com.

Federal HIPAA privacy regulations allow participants the right of access to inspect and obtain a copy of their health information contained in a Designated Record Set by completing the Authorization to Release Health Information form. However, this right does not apply to information compiled reasonably anticipating, or using in, a civil, criminal, or administrative action or proceeding. To view the Authorization to Release Health Information form, please visit the **For Providers** section of the IIH website at: www.innovativeih.com.

9.9 MEDICAL RECORD CONTENT

IIH providers and contracted providers must meet the standards for medical record documentation in accordance with the National Committee on Quality Assurance (NCQA) and by the state Medi-Cal Program Regulations (Title 22 of the California Code of Regulations). Each medical record must comply with the standards summarized below.

PATIENT IDENTIFICATION

Each page in the medical record contains the participant's name or ID number.

PERSONAL BIOGRAPHICAL INFORMATION

Personal biographical data includes but is not limited to name and address, age and birth date, sex, telephone number, emergency contact person and nearest relative (phone numbers for each), plan identification, Medi-Cal number, and preferred language.

ENTRIES

All entries in the medical record contain author identification and are made in accordance with acceptable legal or documentation standards.

The record shall reflect the findings of each visit or encounter, including, but not limited to, recording the date of service, chief complaints, follow-up from previous visits, tests or therapies ordered, treatment plan and diagnosis or medical impression, any physical, psychosocial, or educational needs identified during the encounter, and abnormal results.

LEGIBILITY

The records shall be in a legible handwritten or printed format.

SPECIFIC CONDITIONS

There is a distinct and separate problem list that includes all significant illnesses and medical conditions, including allergies and adverse reactions. If the participant has no known history of adverse reactions, this is appropriately noted on the problem list.

A separate medication list is maintained for all current medications. The list includes medication name, strength, dosage, frequency, route, and start or stop dates. Also, note discontinued medications on the medication list.

Documentation of appropriately obtained informed consent forms is maintained.

MEDICAL HISTORY

Past medical history is easily identified and includes serious accidents, operations, significant health problems, reactions to drugs, and personal habits such as alcohol, drugs, smoking, sexual activity, and diet.

History and physical records contain appropriate subjective and objective information pertinent to the participant's presenting complaints.

Appropriate history of immunization records is maintained.

PREVENTIVE HEALTH SERVICES

Documentation of all clinical preventive services is included in the participant's medical record.

DIAGNOSES, TREATMENT, AND FOLLOW UP

- Laboratory studies and other studies as ordered and appropriate.
- Working diagnoses are consistent with findings.
- Treatment plans are consistent with diagnoses.
- 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.
- Unresolved problems from previous visits are addressed in subsequent visits.

Founded in 2011, Innovative Integrated Health is a premier multi-ethnic integrative healthcare provider focused on superior care management for elderly persons residing in the Central Valley counties of Fresno, Kern and Tulare, as well as in Orange County. With culturally diverse members, and a highly-trained, multi-ethnic and multilingual staff, we ensure that your loved ones are cared for, their medical needs are met, they are able to get around and continue to live full lives in the comfort of their own home.

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