HOME HEALTH AGENCY PROVIDER MANUAL

WELCOME TO THE PHCN HEALTH NETWORK

Congratulations and welcome to the Professional Health Care Network (PHCN). By becoming a PHCN Provider, you are part of an exciting collaborative, best-in-class group of health and wellness experts, community partners and thought leaders. Our network providers strive to make a difference in the lives of individuals who wish to retain their independence and live longer, healthier lives.

For more than 25 years, PHCN has worked to ensure home health care is delivered to the highest standards. Through our robust network of home health care providers, patients have the access they need to expert, cost-effective, home-based clinical care.

THE PHCN PROVIDER MANUAL

The PHCN Provider Manual can be used as an operational road map. This document provides an overview of your obligations as a PHCN Provider.

PHCN'S COMMITMENT

All of us at PHCN share a commitment to providing the highest standards of service and delivery. We recognize quality and coordination of services is one of our most defining characteristics. We will work together to help you successfully deliver care while positively impacting your business. The PHCN Operations team will provide you the expertise, training, metrics, and opportunities to be a successful member of the PHCN Provider Network.

OUR SOLUTIONS

A full range of skilled and non-skilled home care through our exclusive network. Services provided:

- RN Evaluation
- Skilled Nursing Visit
- Physical Therapy Evaluation and Visits
- Occupational Therapy Evaluation and Visits
- Speech Therapy Evaluation and Visits
- MSW
- Home Health Aide
- Single point of contact for all homecare referrals and service coordination
- Access to a steady stream of patients – PHCN matches patients with local providers, ensuring patients have rapid access to the help they need, when they need it.
- Access to performance metrics and benchmarks – designed to help each member agency identify opportunities for improvement.

PERFORMANCE STANDARDS

As a participant of PHCN, you are required to:

- Obtain prior authorization from PHCN for home health services.
- Provide timely, high quality, compassionate care to patients.
- Provide written notices regarding changes in your organization to PHCN within a timely manner.
- Maintain 24 hour nurse on-call coverage, 7 days per week and respond to patient and/or PHCN within 30 minutes of call, including weekends, evenings, and holidays, unless otherwise specified by contract.
- Provide oral/written language assistance and TTY services at no cost to the members.
- Receive and serve members regardless of race, color, age, national origin, cultural needs, religion, gender identity, sexual orientation, disability, linguistic needs or health condition.
- Submit Claims for authorized services to PHCN at least monthly and within the timely filing timeframe in your MSA. Claims must be submitted to the designated address for claims, our portal, or via clearinghouse.
- Providers shall not submit Claims to the primary Health Plan for services/products unless directed to do so by PHCN in writing.
- No member will be sent a bill for covered services or for services in which payment was denied due to failure to comply with the Master Service Agreement ("MSA") or this Provider Manual.
- Provider shall collect deductibles, co-payments and/or co-insurance from patients as identified and instructed by PHCN. Providers are paid for authorized covered services in accordance with their rates found in the MSA, less any applicable deductibles, co-payments and/or co-insurance due from patients.
- Provider will promptly return any overpayments received for services provided to PHCN per the MSA.
- Provider agrees not to charge the patient where payments were denied for services that were deemed not medically necessary.

- Provider agrees to not charge the patient for such services in advance of provision of the service unless the patient agrees in writing to accept the financial responsibility.

- Provider shall submit completed OASIS (within 5 days) and any pertinent medical records (including wound measurements and photos) for authorization purposes with the initial start of care and/or with the re-authorization request. Uploads of the OASIS can be done through the PHCN website under the Upload tab titled “OASIS Upload”. Quality assessment, quality improvement, incident reports/notification, clinical outcomes, program evaluation, and other reports upon request of PHCN’s personnel and cooperate fully with any audits conducted by PHCN. Requested records must be provided to PHCN at no charge and within the timeframes requested.

  NOTE: If Provider fails to provide records within the requested timeframe in order to substantiate services billed, payments on the claims that are in subject of the record request may be reversed and recovered through fund request or offset.

IMPORTANT CONTACT INFORMATION

Website: https://www.prohcn.com

CALL CENTER INFORMATION

Monday through Friday: 8:00 am to 6:00 pm; Saturday and Sunday: 8:30 am to 5:30 pm (MST)
After hours, all hours are in Local Time

Contact Information:

Main Line	(888) 705-5274

Department	Email	Fax
Credentialing	credentialing@prohcn.com	(877) 327-1519
Provider Relations	providernetwork@prohcn.com	(877) 327-1530
Contract Management	ContractManagement@prohcn.com	
Re-authorizations	PHCNCMfax@prohcn.com	(877) 225-9710
Claims issues/questions	claims@prohcn.com	(602) 995-3030

PATIENT HEALTH PLAN AND ELIGIBILITY

PHCN will check member benefits and eligibility at start of care and with each re-authorization request. PHCN guarantee's payment for services provided during the eligibility check and authorization period.

PHCN'S UTILIZATION MANAGEMENT PROCESS

Utilization Management is the evaluation of the appropriateness, medical necessity, and efficiency of healthcare services according to established criteria or guidelines under the provisions of the applicable health benefit plan. The PHCN UM program serves to implement a comprehensive integrated process that actively evaluates and manages utilization of home health care resources delivered to all members, and to actively pursue identified opportunities for improvement.

When PHCN is responsible for conducting a review of the medical necessity of a proposed service, the following is our standard medical necessity definition:

- Assure that high quality service is delivered to the member at the appropriate time.
- Appropriate and consistent with the diagnosis of the treating Provider and the omission of which could adversely affect the eligible Patient's medical condition;
- Process used for decision making is based on appropriateness of care and services and compatible with standards of medical practice in the community.
- Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
- PHCN does not offer incentives nor are medical staff compensated to deny medically appropriate services to members.
- Not provided solely for the convenience of the Patient or the convenience of the Health Care Provider or hospital; and
- Not primarily custodial care unless custodial care is a covered service or benefit under the Patient's evidence of coverage.

The UM Program seeks to:

- Coordinate the delivery of care that is aligned with Health Plan, State and Federal Regulatory guidelines.
- Promote the efficient Utilization of services/resources.
- Monitor patterns of Utilization over time to increase consistency in UM decision making and delivery of care.
- Improve continuity of care and patient outcomes through effective care coordination and specificity to each patient.
- Initiates needed operational revisions to prevent problematic issues from reoccurring.
- Enhance physicians and patient satisfaction by facility access, enhancing awareness of medical necessity and appropriateness of services.

- Promotes and ensures the integration of utilization management with quality monitoring and improvement, risk management and case management activities.

Our Utilization Management (UM) department applies nationally recognized utilization criteria and regionally developed medical policies and standards of care for utilization management reviews. Criteria are available to providers and practitioners upon request by calling 888-705-5274 faxing877-225-9710 , emailing PHCMFAX@PROHCN.COM or by mail at 7600 N. 16th St. #140, Phoenix, AZ 85020. Once the request is received, our staff will respond with the requested criteria via fax, email, or mail.

UTILIZATION MANAGEMENT RESPONSIBILITIES

Providers have the following Utilization Management responsibilities:

- Provide and maintain appropriate documentation to establish the existence of medical necessity.
- Obtain authorization prior to beginning services/products. Services/products performed without authorization may be denied for payment, and any such denial of payment is not billable to the patient by the Provider.
- Verify the information on the Authorization Form (member name, date of birth, address of where services will be provided, discipline, number of visits/units (as applicable), start and stop date, agency name, contact and location) upon receipt. While the PHCN utilization management staff work to assure the accuracy of the information on the Authorization Form, mistakes can occur. Should you identify an error, call PHCN within 24 hours to correct the error.
- Notify PHCN if patient is not homebound and/or refuses services.
- Notify PHCN to report a serious member incident and/or sentinel event.
- Notify PHCN if the services ordered will not meet the needs of the patient. You may be asked to assist in identifying alternatives and discussing with PHCN and the ordering physician.
- Participate in clinical case conferences as requested.
- Respond to all requests for contact from PHCN within 24 hours.
- Respond to all requests for contact from the Health Plan case manager within 1 business day. PHCN will act as a liaison when a Health Plan case manager requests information. Providers should not initiate contact with a Health Plan case manager unless directed to do so by PHCN.
- If requested by PHCN, provide assessment reports, progress reports, organization forms or other organization documents must be provided within 48 hours of request. QIO appeal documents and signed NOMNC must be provided immediately upon request as QIO appeals are same day.
- Verify all initial physician orders with the physician and obtain physician orders for additional services/products as necessary.
- Provide all other documentation and records which may be requested by PHCN, in addition to re-authorization requests, within the time frames set in the request.

The required information generally includes, but is not limited to, the following:

1. Patient's first and last name
2. Patient's date of birth
3. Patient's insurance company and insurance subscriber ID number
4. Patient's physical address (not PO Box) including zip code
5. Patient's phone number/Emergency Contact (if available)
6. Patient gender
7. Diagnosis
8. If recently discharged from hospital or other inpatient setting, face sheet
9. Ordering and primary physician first and last name, full address, and telephone number
10. History and Physical and/or face to face evaluation (as applicable) along with notes related to requested disciplines.
11. Signed physician orders for services for which authorization is being requested, orders must be complete.

PRIOR-AUTHORIZATION AND RE-AUTHORIZATION PROCESS

In accordance with the policies and procedures of Professional Health Care Network (PHCN), the following information is provided in summary. If you have any questions, please contact the Intake or Utilization Management Department:

- Our regular business hours are Monday to Friday from 8am to 6pm.
- Our Intake and Review Department is also available on weekends and major holidays from 8:30am to 5:30pm.
- Our staff is available to answer questions you may have. Contact our main number at 888-705-5274, and the receptionist queue will direct you to the correct department.

PRIOR AUTHORIZATION PROCESS FOR A NEW REFERRAL

To upload a new patient referral, go to www.prohcn.com, click on **"Upload, Referral/Prior Auth"** in upper right corner or click here.,

Complete all form fields on the Initial Authorization Form, which can be found by clicking here.

Once form fields are completed, drag and drop the referral into the upload area located at the bottom of the page (**ONE referral per upload)**

If multiple referrals are being loaded, the above process **MUST** be followed for each patient referral, otherwise your referrals may be lost in transmission.

If you have any questions regarding the upload process, please call PHCN at 888-705-5274 and speak with the reception or Intake Team.

Initial authorization is typically given in four (4) week increments. All re-authorizations are typically given in two (2) week increments.

The following Medicare tips have been provided when submitting for prior-authorization:

A complete referral is needed. A complete referral includes:

1. A good order, which consists of:
    - The phrase home health.
    - At least one opening discipline- SN (nursing), PT (physical therapy), OT (occupational therapist) or ST (speech therapy). The disciplines, MSW, and HHA can be on the order but not without one of the opening disciplines.
    - A skill for the clinician to perform e.g., Skilled nursing for medication management and home safety eval. If there is wound care, specific instructions.
    - Signature or electronic signature by an MD, DO, DPM, PA, or NP.
    - Current date, discharge date, or date in the future when you would like the care to start.
2. Patient demographics
3. H&P/Progress Notes/Therapy Notes- these need to be within the last 90 days prior to the start of care and/or within 30 days after the start of care and support the need for the services being ordered.
4. Insurance Information

Services not in-scope to PHCN:

- Custodial Care (ADLs, cooking, cleaning, etc.)
- IVs
- DME
- Wound Care Supplies
- Nutritionists
- Psychiatric Services

RE-AUTHORIZATION PROCESS

Re-authorization requests may be submitted at any time. However, requests will only be processed during regular business hours. All reauthorization requests must be uploaded through the Reauthorization Upload Portal on the PHCN web page under the Uploads tab, or by clicking here.

RE-AUTHORIZATION RESPONSIBILITIES

- A reauthorization or concurrent review is required to continue services.
- Obtaining a re-authorization is the responsibility of the Provider. A copy of the reauthorization form can be found here.
- Providers must submit requests for re-authorization at least 48 hours prior to the expiration of the authorization.
- Provider must submit clinical status/documentation and objective reasons for re-authorization prior to authorization expiration.

RETRO-AUTHORIZATIONS

PHCN will issue retro initial start of care/prior authorizations requests up to 72 hours from start of care. All authorization requests are subject to approval/denial determination; balance billing a member for services deemed medically unnecessary is not permitted.

OASIS REQUIREMENTS

The Outcome and Assessment Information Set ("OASIS") data collection requirements apply to Medicare certified home health agencies (HHAs) and to Medicaid home health providers in States where those agencies are required to meet the Medicare Conditions of Participation. PHCN requires a copy of the completed OASIS within 5 days of start of care. The comprehensive assessment requirement currently applies to all patients regardless of pay source, including Medicare, Medicaid, Medicare Advantage, Medicaid managed care, and private pay/including commercial insurance. The comprehensive assessment must include OASIS items for all skilled Medicare, Medicaid, and Medicare or Medicaid managed care patients with the following exceptions: patients under the age of 18, patients receiving maternity services, patients receiving only chore or housekeeping services, and patients receiving only a single visit in a quality episode. Section 704 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 suspended OASIS data collection for non-Medicare and non-Medicaid patients. The transmission requirement currently applies to Medicare and Medicaid patients receiving skilled care only.

Note: The Medicare PPS reimbursement system requires a PPS (HHRG/HIPPS) code to be submitted on the claim of any Medicare PPS patient under 18 or receiving maternity services. While the OASIS data set was not designed for these population types, and is not required by regulation to be collected, in these rare instances, HHAs desiring to receive payment under Medicare PPS would need to collect the data necessary to generate a HHRG/ HIPPS code. The HHA is not required to transmit these data to the State. (You can read or download the December 2003 notice from:

http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopofPage

SECURE FILE UPLOADS

PHCN has created a secure sFTP site that can be used to transfer data between PHCN and our Network Providers. The features of the site allow us to meet all security requirements for protecting the participant's health information, while eliminating the complexities of other shared site data transfer options.

NOTICE OF MEDICARE NON-COVERAGE (NOMNC)

COMPLIANCE WITH CMS NOTICE OF MEDICARE NON-COVERAGE REQUIREMENT

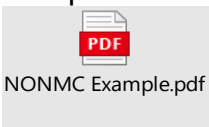
Providers are required to comply with applicable state and federal laws. With respect to Medicare patients who are discharged from home health care, CMS requires Providers to timely issue a Notice of Medicare Non-Coverage (NOMNC) to the patient. The following are some steps Providers should take to ensure compliance with this NOMNC requirement:

- Prior to discharging a patient from home health services, determine whether the patient is a Medicare Advantage member.
- If the patient is a Medicare Advantage and/or DSNP member, provide the patient with a NOMNC letter at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. Please note that the patient or the patient's authorized representative must sign and date the notice.
- Utilize the approved CMS NOMNC letter template and complete the template letter as directed by CMS.

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/Instructions-for-Notice-of-Medicare-Non-Coverage-NOMNC.pdf

Providers will be periodically audited for compliance with this important Medicare requirement. Failure to comply may result in non-payment of NOMNC visits and corrective action being imposed.

Sample NOMNC



PROVIDER BILLING AND CLAIMS PAYMENT GUIDELINES

GENERAL CLAIMS

Claims are processed based upon authorization. For all plans, providers are responsible for confirming eligibility and benefits with the patient's health plan for ongoing or add-on services. Failure to do so could lead to claim rejections and denials. It is imperative to check eligibility and benefits to ensure the patient's plan has not changed.

To expedite payment of claims, the Provider should match the billable services against the authorization and your contracted Provider crosswalk. Claims for services, date of service or units that do not exactly match the authorization may be rejected or denied in part or in whole. Alternatively, if the Provider bills for a higher level of service, equipment, or supply than the level authorized, payment may be made in accordance with the rate associated with the authorized service, equipment or supply, and Provider will accept that rate as payment in full. Claims will be paid based on the lower of the Provider's usual billed charge or the contracted/negotiated rate.

Authorization of services is not a guarantee of payment, and payment of services rendered is subject to the patient's eligibility and coverage on the date of service, the medical necessity of the services rendered, coverage requirements, the applicable payer's payment policies, including, but not limited to, applicable payer's claim coding and bundling rules, PHCN's claim coding and bundling rules and compliance with the Provider's contract with PHCN.

By submitting a claim for payment to PHCN, the Provider is certifying that it has met the above requirements, that the service has been rendered and that it has a record of all necessary documentation to support the foregoing. Claims that are not submitted within the time frames set forth in the Provider Agreement and in accordance with the requirements of the Provider Agreement, this Provider Manual and the applicable health plan may be denied.

CLEAN CLAIM REQUIREMENTS

Claims must be submitted electronically or on standard paper claims forms (CMS 1500 or UB- 04). Home Health Providers must submit claims on an 837I or UB-04. Our required clean claim data elements for both electronic and paper claims include the following:

- Patient's name, Subscriber ID number (including any prefix and/or suffix as appropriate), Address, Relationship to Subscriber, Gender, and Date of Birth
- Insurance name, group name and group number
- Subscriber name, address, and gender
- Place of service code
- Primary diagnosis code(s)
- V codes will not be accepted as the primary diagnosis code and Provider is expected to follow all ICD coding rules
- Rendering Provider's name, service location, and billing address

- Rendering Provider's National Provider Identifier (NPI) number, Federal Tax ID number, Medicaid ID number (Medicaid network Providers only), and Taxonomy Code
- Individual line level charge for each service
- Number of invoiced units for each claim line
- PHCN's HCPCSS/ CPT code(s) and modifier combination
- NDC codes, NDC description, NDC unit of measure, and NDC units (i.e., prescription drugs)
- Date of Service (FROM and to required; FROM date must be before the claim receipt date and before or equal to the to date)
- Whether the patient's condition is related to employment, auto accident or other accident
- Other insurance information (if other insurance, include other insured's name, Date of Birth, other insurer's name, group, or policy number)
- Coordination of benefits information for secondary claims (Explanation of Payment from Primary Carrier)
- Authorization number
- Revenue Code (Institutional Claims)
- HIPPS code on all home health claims submitted for Medicare Advantage members
- Description of miscellaneous code

Claims missing required information or containing incorrect required information may not be processed. Paper claims without the correct required information may be returned, and the Provider will be informed of the information that is missing or incorrect. Claims submitted electronically without correct required information may be rejected by the clearinghouse with corresponding reasons for the rejection. Such incomplete claims must be resubmitted by the Provider to PHCN so that a complete or clean claim is received by PHCN within the original timely filing timeframe as specified below subject to applicable law.

Regarding services delivered, the claim must include a description of the service provided as well as the relevant HCPCS, CPT or revenue code and applicable modifier(s). Claims without a description of the service provided will be returned.

BILLING CODES

Only contracted procedure codes and authorized services will be paid. Provider must only use procedure codes and HCPC codes that are detailed in the Provider Agreement or Authorization. Services will use the relevant Medicare G-code set on the authorization which contain revenue codes and modifiers. The claim must match the exact billing code set found on the authorization; otherwise, it will be denied.

Example: If the authorization contained a revenue code and modifier, the claim shall contain a revenue code and modifier. If the authorization for did not include a revenue code, please contact your PHCN home health liaison to correct the authorization.

All Medicare home health claims shall contain a HIPPS code per CMS mandate. Only one HIPPS score shall be entered on a claim, otherwise the claim will be denied. The HIPPS code rate shall always be zero; otherwise, the claim will be denied. The HIPPS code shall have a revenue code of 0023; otherwise, the claim will be denied. The HIPPS score service date shall be the first service date pertaining to the HIPPS code. It is the agency's responsibility to research other CMS rules regarding HIPPS code to ensure accurate claim filing. Inaccurate specification of HIPPS codes will result in claim rejection or denial.

TIMELY FILING

Clean claims must be filed as instructed by PHCN within the time frame described in the corresponding MSA or within the period of time required by applicable law if longer. Claims received by PHCN after the filing deadline may be denied, and Providers cannot bill the patient for such services. Note that PHCN may pay some claims that were not submitted timely to PHCN if we believe there may still be time to timely bill and receive payment from the Health Plan. However, please be aware that, if the Payer does not pay the claim in full, PHCN may later deny the claim for failure to timely file and recoup the prior payment.

HOW TO UPLOAD CLAIMS:

- To upload claim, go to prohcn.com, click on upload in upper right corner.
- Complete all fields, then follow the instruction below:
- Submit claims in a PDF format only
- Name your claims file as follows: **"agencyname.phcn or pc"**
- Load all PHCN and PC claims separate, regardless of the dates, into 1 file, up to 150 claims per file. You do not need to make a separate file for each month, the only reason you should have multiple files is if you have PHCN claims and PC claims, and/or more than 150 of each.
- For corrected claims name your file as follows: **"agencyname.correctedclaims.phcn or pc".**
    - 1st page should be your letter stating why you are rebilling the attached claims.
    - 2nd page should be your 1st claim, marked as corrected or resubmittal.
    - 3rd page should be the documentation to support the reason for resubmitting.
- Then start with the next claim and so on
- All resubmitted claims should be in one file, when resubmitting multiple claims at one time.
- Submit claims throughout the month. We would prefer claims be submitted, either one time per week or every other week, rather than one time per month at cut off. Remember cut off is the 8th of each month at 12:00 noon, any claims received after 12:00 noon will not be paid on the 15th of the current month, but rather the 15th of the following month.

If you have any questions regarding our upload feature please email claims@prohcn.com.

Claims submitted without all required information may be rejected or denied.

ELECTRONIC EDI CLAIMS

If you are using practice management software to submit claims electronically, your system needs to be set up with the ***payer ID: 26748*** All Medicare claims sent to Availity shall be sent in 837i format.

PAPER CLAIMS

Must be submitted on the Professional 1500 HCFA Claim Form Version 02/12, any claims submitted on 1500 Version 08/05 will be rejected as of April 1, 2014 (Please review CMS changes for further detail). Copies of the form cannot be used for submission. Data must be typed not handwritten. Authorization number must include any hyphens (entire auth #- 123456-1-1234) Box 23. NPI # of rendering location must be in Box 32a. Any claims not in this standard format will be denied and/or rejected.

Paper claims should be mailed to:

PHCN
ATTN: Billing
7600 N. 16th ST., STE 140
Phoenix, AZ 85020

PROVIDER PAYMENT

The Provider Agreement rate is payment in full for covered services and is all inclusive. Provider is not entitled to receive additional compensation for covered services, including but not limited to, compensation for copies of records, sales tax, reports, or other services contemplated by the Provider Agreement. No billing to the patient or Health Plan of the difference between the negotiated or contracted rate and the Provider's billing rate is permitted.

Reimbursement Status - Providers should email claims@prohcn.com to check their claim's reimbursement status.

PROVIDER PAYMENT RECONSIDERATIONS

Provider reconsiderations must be received by PHCN within 45 calendar days of the provider's receipt of the explanation of payment. Our Claims Unit will complete the review of your

reconsideration request within 45 calendar days of the date the Claims Unit receives all information necessary to review your request for reconsideration. We will communicate the results of our review of your request for reconsideration in writing which may include payment and an explanation of payment.

If the claim was rejected or denied: Rejected claims can be resubmitted without submitting a reconsideration request. If the original claim has been altered in response to the denial. Only original claims that do not require changes in response to the denial should be submitted as a claim's reconsideration request. Claims requiring correction to address the issue causing the denial, should be submitted as corrected claims. Your request for reconsideration must be received by PHCN at the designated address within 45 days after the date of our explanation of payment, or within the period of time permitted by applicable law if longer.

After receipt of your completed request for reconsideration, we will research your concern and respond to you as soon as possible. If the request for reconsideration is resolved in your favor, the claim will be adjusted, and an explanation of payment (EOP) issued. If it is not resolved in your favor, you may submit a review to the reconsideration in writing.

DISPUTE RESOLUTION

Should the provider contest the determination, they must submit a formal request for re-determination within sixty (60) days of the date of determination. PHCN will acknowledge receipt of request within five (5) business days.

Provider's formal request for re-determination must include the patient's name, ID number, date of birth, dates of service in question and the reason for reconsideration

Upon receipt of the request, a determination is made within thirty (30) days and a Contractor Notice of Decision ("Decision") letter is sent back to the provider

The provider's right to request a hearing by filing a written request to the contractor no later than thirty (30) days after the date the provider receives the decision.

Please note that, if changes are required to the original claim, in lieu of submitting a request for reconsideration, Providers should submit a corrected claim in accordance with our corrected claim process.

RETROSPECTIVE CLAIMS REVIEW

Paid claims can be subject to retrospective audits and Providers have the obligation to maintain and make available documentation to support the medical necessity of services rendered and billed.

Such documentation must be made available to PHCN and/or the applicable Health Plan at no cost to PHCN or the Health Plan and within the timeframes requested. PHCN may recover any payment for services determined not to meet medical necessity or benefit requirements, including recovery through recoupment.

Note: Please see the grid below indicating the recoupment timelines for Medicaid, Medicare, and Commercial claims. If PHCN does not receive a response within the specified timeframes, we will initiate the recoupment process and deduct the overpayment from future remittances.

Business	Provider Request for Reconsideration	Recoupment Process
Medicare	60 Days	After the 60 days of the date of the Letter
Medicaid	45 Days	After the 45 days of the date of the Letter
Commercial	35 Days	After the 35 days of the date of the Letter

RESTRICTION ON BALANCE BILLING

PHCN Network Providers may not bill a patient or that patient's insurance company (if the insurance company is an PHCN client) during the reconsideration process or for a balance remaining after a decision has been made on an PHCN Network Provider reconsideration.

ACCESS TO EMR/MEDICAL RECORDS

MEDICAL RECORDS

PHCN network providers must keep accurate and complete patient medical records which are consistent with 45 CFR 156, financial, and other records pertinent to PHCN patients. Such records enable providers to render the most appropriate level of health care service to patients. They will also enable PHCN to review the level and appropriateness of the services rendered. To ensure the patient's privacy, medical records should be kept in a secure location. PHCN requires providers to maintain all records for adult patients for at least 10 years after the final date of service unless a longer period is required by applicable state law. Pediatric records should be retained for 10 years or the age of majority plus state statute of limitations, whichever is longer. In some states, the statute of limitations does not start until the patient turns 18.

REQUIRED INFORMATION

To be considered a complete and comprehensive medical record, the beneficiary's medical record (file) should include, at a minimum: complete Oasis assessment and evaluation of the patient,

clearly establishing the patient's condition at the start of treatment in addition to a Plan of Care from each discipline. Ongoing clinical notes showing how the treatment relates to the Plan of Care and what progress the clinician notes since prior visit. Patients with wound care should have measurements and color photos at each visit.
Medical records should be accessible at the home health agency site and/or clinician level if EMR accessible. All medical services received by the patient, including inpatient, ambulatory, ancillary, and emergency care, should be documented, and prepared in accordance with all applicable state rules and regulations and signed by the medical professional rendering the services.

Providers must maintain complete medical records for patients in accordance with the standards set forth below:

- Patient's name, and/or medical record number must be on all chart pages.
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken language translation or communication assistance must be included.
- All entries must be complete, legible, and maintained in detail.
- All entries must be dated and signed or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented. Medication review and reconciliation is performed and documented on OASIS.
- An up-to-date immunization record is established for pediatric patients, or an appropriate history is made in chart for adults.
- Evidence that preventive screening and services are offered in accordance with PHCN practice guidelines.
- Appropriate subjective and objective information pertinent to the patient's presenting complaints is documented in the history and physical.
- Past medical history (for patients seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed, including instructions to the patient.
- Signed and dated required consent forms are included.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate are documented.
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans.
- Health teaching and/or counseling is documented.

- For patients 10 years and over, appropriate notations concerning use of tobacco, alcohol, and substance use (for patients seen three or more times substance abuse history should be queried).
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months, or as needed.
- Evidence that the patient is not placed at inappropriate risk by a diagnostic or therapeutic problem.
- Confidentiality of patient information and records are protected.
- Evidence that an advance directive has been offered to adults 18 years of age and older.

ACCESS TO RECORDS AND AUDITS BY PHCN

Subject only to applicable State and federal confidentiality or privacy laws, Provider shall permit PHCN or its designated representative access to Provider's Records, at Provider's place of business in this State during normal business hours, or remote access of such Records, in order to audit, inspect, review, perform chart reviews, and duplicate such Records. If performed on site, access to Records for the purpose of an audit shall be scheduled at mutually agreed upon times, upon at least thirty business days prior written notice by PHCN or its designated representative, but not more than sixty (60) days following such written notice. There will be no other fees charged to the PHCN for this access.

EMR ACCESS

Providers will grant PHCN access to Provider's Electronic Medical Record (EMR) for necessary audits. There will be no fees charged to PHCN for this access.

MEDICAL RECORDS RELEASE

All patient medical records are confidential and must not be released without the written authorization of the patient or their parent/legal guardian, in accordance with state and federal law and regulation. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need-to-know basis.

PHCN and the treating home health agency are covered entities under HIPAA and allowed to disclose patient information with each other without the need to obtain authorization from patients.

All release of specific clinical or medical records for Substance Use Disorders must meet Federal guidelines at 42 CFR Part 2 and any applicable State Laws.

PROVIDER COMPLAINTS

PHCN maintains a provider complaint system that permits a provider to bring forward concerns such as quality of care concerns, administrative functions, credentialing issues, including proposed actions and claims. Provider complaints should be communicated to the Provider Relations Team. The assigned Provider Relations representative is responsible to investigate each complaint using the appropriate statutory, regulatory, and contractual provisions.

PATIENT COMPLAINT REPORTING REQUIREMENTS

PHCN is not delegated to resolve grievances by our health plan payer partners. However, PHCN does track and investigate all member complaints and will share with the treating home health agency for resolution and record to the health plan through our internal PI/QM Program. Therefore, for a grievance PHCN staff and Network Providers are directed to refer the complainant to their health plan for resolution.

The fact that a complaint was filed does not necessarily establish wrongdoing but serves as an opportunity to evaluate applicable programs and make any appropriate changes.

PROVIDER CREDENTIALING AND RE-CREDENTIALING

CREDENTIALING

In order to participate in the PHCN network each providers' licensed branches must be credentialed individually. Satellite offices are not recognized for this purpose.

Our credentialing process requires, but is not limited to, the following:

- Completed PHCN Credentialing Application. The application must contain a current signature of the CEO, Administrator, or other appropriate designated representative, attesting that all information provided in conjunction with the application is true, correct, and complete.
- Copy of current home health license
- Copy of W-9 form
- Copy of Medicare certification letter (if applicable)
- Copy of Medicaid certification letter (if applicable)
- Copy of most recent on-site survey (including, if applicable, plan of correction and state acceptance letter showing deficiencies corrected)
- Proof of professional and general liability insurance. Required limits are generally one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in aggregate; a copy of current fidelity bond for fifty thousand dollars ($50,000) or other crime and theft coverage in an amount satisfactory to PHCN

- Claims/Malpractice History for the last three (3) years
- Workers' compensation insurance
- Copy of CLIA waiver form (if applicable)
- Copies of all accreditation certificates (if applicable)
- Ownership Disclosure form
- Copy of non-discrimination statement or policy
- Copies of current accreditation or certification. If not accredited, provider must provide a copy of the most recent State or Federal Survey or Inspection Report and the approval letter from the State regarding the Emergency Action Plan.
- Copies of compliance program materials including proof of annual trainings (i.e. Current versions of CMS compliance, fraud, waste and abuse, HIPAA privacy/security and other applicable AHCCCS or health plan required trainings)

If you are an existing provider adding a new location contact your Contract Manager in order to add the new location to your agreement. The Contract Manager will provide the appropriate documents needed to credential the new location.

RE-CREDENTIALING

PHCN Network Providers are re-credentialed every three years. However, PHCN may request documents at any point during the three year credentialed period. This may occur for documents set to expire within the credentialed period, or if a Provider is subject to, exclusion from government programs, malpractice or quality of care/service issues. In addition, if a Provider adds or acquires a new location, subsidiary, or affiliate, that location or entity must be credentialed - this includes instances where a site currently credentialed through PHCN is being acquired by another provider/entity (PAR or non-PAR).

The standard re-credentialing process begins approximately six (6) months before to the credentialing anniversary date. Our re-credentialing process requires, but is not limited to, the following:

- Completion of PHCN's re-credentialing application
- Copy of current home health license
- Copy of Medicare certification letter (if applicable)
- Copy of Medicaid certification letter (if applicable)
- Copy of most recent on-site survey (including, if applicable, plan of correction and state acceptance letter showing deficiencies corrected)
- Proof of professional and general liability insurance. Required limits are generally one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in aggregate; a copy of current fidelity bond for fifty thousand dollars ($50,000) or other crime and theft coverage in an amount satisfactory to PHCN
- Claims/Malpractice History for the last three (3) years

- Workers' compensation insurance
- Copy of CLIA waiver form (if applicable)
- Copies of all accreditation certificates (if applicable)
- Ownership Disclosure form (if changed)
- Copy of non-discrimination statement or policy
- Copies of current accreditation or certification. If not accredited, provider must provide a copy of the most recent State or Federal Survey or Inspection Report and the approval letter from the State regarding the Emergency Action Plan.
- Copies of compliance program materials including proof of annual trainings (i.e. Current versions of CMS compliance, fraud, waste and abuse, HIPAA privacy/security and other applicable AHCCCS or health plan required trainings)

All questions and concerns related to the re-credentialing process should be directed to the Credentialing department. They can be reached at credentialing@prohcn.com.

EMPLOYEE BACKGROUND SCREENINGS

Background screenings must be completed for all individuals with access to PHCN information or provide services to participants. Background screening should include at a minimum, criminal records, education and employment history, civil records, and references. Background screening should also ensure applicants do not have a history of the following offenses:

- Computer related or information technology crimes
- Fraudulent practices, false pretenses and frauds, and credit card crimes
- Forgery and counterfeiting
- Violations involving checks and drafts
- Misuse of medical or personnel records
- Felony theft

Any individual with a history of the above *offenses* is disqualified from providing services for PHCN and should be immediately removed from participation. PHCN must be notified of any individual removed due to a disqualifying offense. The Network Provider is required to report this information to PHCN at the time of removal.

WORKFORCE AND PROVIDER EXCLUSION MONITORING

PHCN is required to monitor State and Federal Exclusion and Preclusion lists to ensure only eligible individuals and providers provide services to the PHCN participants.

According to the Office of the Inspector General (OIG) PHCN must exclude Network Providers convicted of any of the following from participation in all Federal health care programs:

- Medicare fraud, as well as any other offenses related to the delivery of items or services under Medicare
- Patient abuse or neglect
- Felony convictions for other health care-related fraud, theft, or other financial misconduct
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

The OIG may also impose permissive exclusions on other grounds, including:

- Misdemeanor convictions related to health care fraud other than Medicare or Medicaid fraud, or misdemeanor convictions for unlawfully manufacturing, distributing, prescribing, or dispensing controlled substances
- Suspension, revocation, or surrender of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity
- Providing unnecessary or substandard services
- Submitting false or fraudulent claims to a Federal health care program
- Engaging in unlawful kickback arrangements
- Defaulting on health education loan or scholarship obligations

Excluded Providers may not participate in Federal health care programs for a designated period. With limited exception, an excluded provider may not bill Federal health care programs (including, but not limited to, Medicare and Medicaid for services he or she orders or performs. Additionally, an employer or a group practice may not bill for an excluded provider's services. At the end of an exclusion period, an excluded provider must seek reinstatement; reinstatement is not automatic.

The OIG maintains a list of excluded parties called the List of Excluded Individuals/Entities (LEIE). Prior to hire, and monthly thereafter, the Network Provider will perform a review of State and Federal Exclusion lists to ensure no employees, contractors, subcontractors, vendors, or shareholders of privately-owned organization with at least five percent (5%) ownership are listed on the following exclusion list:

- Office of Inspector General's List of Excluded Individuals and Entities located at: https://exclusions.oig.hhs.gov
- System for Award Management Excluded Parties List Service: https://www.sam.gov
- Specially Designated National List: https://sanctionssearch.ofac.treas.gov

Individuals found to be on an exclusion list are NOT eligible to provide services for PHCN and must be immediately removed. Network Providers must notify PHCN of any individuals removed from participating in the PHCN network due to an exclusion at the time of removal.

The Network Provider shall attest quarterly that the applicable OIG, SAM, CMS Preclusion Lists and State Medicaid exclusion reviews (if applicable), have been completed at least monthly, and that any individuals identified as excluded have been removed from providing services for PHCN.

The Preclusion List is sent to PHCN on a monthly basis from the health plans to ensure that providers and prescribers caring for our patients are not on the list. A list of providers and prescribers who are precluded from receiving payment for Medicare Advantage items or services are sent and reviewed on a monthly basis. MA plans and therefore PHCN, are required to deny payment for a health care services furnished by an individual or entity on the Preclusion List.

COMPLIANCE PROGRAM

Each of our Network Providers are required to have an effective compliance program with standards for ethical behavior. For your development purposes, detailed below are the 7 Guiding Principles of an Effective Compliance Program.

1. Written compliance policies and procedures and standards of conduct
2. A designated compliance officer and compliance committee
3. Effective training and education
4. Effective lines of communication
5. Conducting internal monitoring and auditing
6. Enforcement of standards through well-publicized disciplinary guidelines
7. Prompt response to detected problems through improvement actions

CHANGES AND UPDATES TO THE NETWORK PROVIDER MANUAL

As business updates or policy changes are made and shared through the Network Provider Manual, PHCN will give thirty (30) days prior notification before the changes are effective to ensure our Network Providers continue their path of success. If an immediate change is mandated by State or Federal guidance, or by a PHCN payer, 30-day notice may not be possible, but PHCN will make every effort to determine a fair and reasonable effective date.

PATIENT RIGHTS AND RESPONSIBILITIES

PATIENT RIGHTS

Providers must comply with the rights of patients as set forth below:

1. To participate with providers in making decisions about their health care. This includes working on any treatment plans and making care decisions. The patient should know any possible risks, problems related to recovery, and the likelihood of success. The patient shall not have any treatment without consent freely given by the patient or the patient's legally authorized surrogate decision-maker. The patient must be informed of their care options.
2. To know who is approving and who is performing the services or treatment. All likely services and the nature of the problem should be explained clearly.
3. To receive the benefits for which the patient under each contracted health plan.
4. To be treated with respect and dignity.
5. To privacy of their personal health information, consistent with state and federal laws, and PHCN policies.
6. To receive information or make recommendations, including changes, about PHCN's organization and services, the PHCN Network of providers, and patient rights and responsibilities.
7. To candidly discuss with their providers appropriate and medically necessary care for their condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from the patient's primary care provider about what might be wrong (to the level known), treatment, and any known likely results. The provider must tell the patient about services that may or may not be covered by the plan, regardless of the cost. The patient has a right to know about any costs they will need to pay. This should be told to the patient in a way that the patient can understand. When it is not appropriate to give the patient information for medical reasons, the information can be given to a legally authorized person. The provider will ask for the patient's approval for treatment unless there is an emergency and the patient's life and health are in serious danger.
8. To refuse treatment for any condition, illness or disease without jeopardizing future treatment, and to be informed by the provider(s) of the medical consequences.
9. To see their medical records.
10. To have access to a current list of network providers.
11. To adequate access to qualified medical practitioners and treatment or services regardless of age, race, creed, sex, sexual orientation, national origin, or religion. Sex discrimination includes, but is not limited to, discrimination on the basis of pregnancy, gender identity and sex stereotyping.

12. To access medically necessary urgent and emergency services 24 hours a day and seven days a week.
13. To receive information in a different format in compliance with the Americans with Disabilities Act, if the patient has a disability.
14. To refuse treatment to the extent the law allows. The patient is responsible for their actions if treatment is refused or if the provider's instructions are not followed. The patient should discuss all concerns about treatment with their primary care provider or other provider. The primary care provider or other provider must discuss different treatment plans with the patient. The patient must make the final decision.
15. To know the name and job title of people providing care to the patient, especially in a home setting.
16. To have access to an interpreter when the patient does not speak or understand the language of the area.
17. To execute an advance directive for health care decisions. An advance directive will assist the primary care provider and other providers to understand the patient's wishes about the patient's health care. The advance directive will not take away the patient's right to make their own decisions. Examples of advance directives include:
    - Living Will,
    - Health Care Power of Attorney,
    - "Do Not Resuscitate" Orders.

    Patients also have the right to refuse to make advance directives. Patients may not be discriminated against for not having an advance directive.

PATIENT RESPONSIBILITIES

Patients are responsible for the following:

1. To treat all health care professionals and staff with courtesy and respect.
2. To give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about their health. The patient should make it known whether they clearly understand their care and what is expected of them. The patient needs to ask questions of their provider, so they understand the care they are receiving
3. To understand their benefits, cost sharing amounts and other health plan information.
4. To review and understand the information they receive about PHCN and from their health plan. The patient needs to know the proper use of covered services.
5. To understand their health problems and participate, along with their health care providers in developing mutually agreed upon treatment goals to the degree possible.
6. To supply, to the extent possible, information that PHCN and/or their

providers need in order to provide care.

7. To follow the treatment plans and instructions for care that they have agreed on with their health care providers.
8. To understand their health problems and tell their health care providers if they do not understand their treatment plan or what is expected of them. The patient should work with their providers to develop mutually agreed upon treatment goals. If the patient does not follow the treatment plan, the patient has the right to be advised of the likely results of their decision.
9. To follow all health benefit plan guidelines, provisions, policies, and procedures.

PROVIDER RIGHTS AND RESPONSIBILITIES

Provider Rights:

1. To be treated by their PHCN patients and other healthcare workers with dignity and respect.

2. To receive accurate and complete information and medical histories for patients' care.

3. To expect other network providers to act as partners in patients' treatment plans and provide adequate medical information to begin services.

4. To expect patients to follow their health care instructions and directions.

5. To make a complaint against PHCN and/or a patient.

6. To have access to information about PHCN quality improvement programs, including program goals, processes, and outcomes that relate to patient care and services.

7. To contact Provider Services with any questions, comments, or problems.

8. To collaborate with other health care professionals who are involved in the care of patients.

9. To not be excluded, penalized, or terminated from participating with PHCN for having developed or accumulated a substantial number of patients in PHCN with high cost medical conditions.

10. To collect patient copayments, coinsurance and deductibles.

Provider Responsibilities:

Providers must comply with each of the items listed below**:**

1. To help or advocate for patients to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
   - Recommend new or experimental treatments,
   - Provide information regarding the nature of treatment options,
   - Provide information about the availability of alternative treatment options, therapies, consultations, or tests, including those that may be self-administered,
   - Be informed of risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options.
2. To serve patients with fairness, dignity, and respect.
3. To not discriminate against patients on the basis of race, color, gender, national origin, limited language proficiency, religion, age, health status, existence of a pre-existing mental or physical disability/condition including pregnancy and/or hospitalization, the expectation for frequent or high cost care.
4. To maintain the confidentiality of patients' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
5. To give patients a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice and scope of service.
6. To provide patients with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.
7. To allow patients to request restriction on the use and disclosure of their personal health information.
8. To provide patients, upon request, access to inspect and receive a copy of their personal health information, including medical records.
9. To provide clear and complete information to patients - in a language they can understand - about their health condition and treatment, regardless of cost or benefit coverage, and allow patient participation in the decision-making process.
10. To tell a patient if the proposed medical care or treatment is part of a research experiment and give the patient the right to refuse experimental treatment.
11. To allow a patient who refuses or requests to stop treatment the right to do so, as long as the patient understands that by refusing or stopping treatment the condition may worsen or be fatal.
12. To respect patients' advance directives and include these documents in their medical record.
13. To allow patients to appoint a parent/guardian, family patient, or other representative if they can't fully participate in their treatment decisions.

14. To allow patients to obtain a second opinion, and answer patients' questions about how to access health care services appropriately.
15. To participate in PHCN data collection initiatives, such as HEDIS and other contractual or regulatory programs, and allow use of provider performance data.
16. To review clinical practice guidelines distributed by PHCN.
17. To comply with the PHCN Medical Management programs.
18. To give PHCN timely, written notice if provider is leaving/closing an operation/agency.
19. To verify patient eligibility.
20. To invite patient participation in understanding any medical or behavioral health problems that the patient may have and to develop mutually agreed upon treatment goals, to the extent possible.
21. To object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds.
22. To file complete and accurate claims with PHCN.

CULTURAL COMPETENCY

PHCN views Cultural Competency as the measure of a person or organization's willingness and ability to learn about, understand, and provide excellent customer service across all segments of the population. It is the active implementation of a system-wide philosophy that values differences among individuals and is responsive to diversity at all levels in the community and within an organization and at all service levels the organization engages in outside of the organization. A sincere and successful Cultural Competency program is evolutionary and ever-changing to address the continual changes occurring within communities and families. In the context of health care delivery, Cultural Competency is the promotion of sensitivity to the needs of patients and incorporates cultural considerations that include, but are not limited to the following: race, ethnicity, primary language, age, geographic location, gender identity, sexual orientation, English proficiency, physical abilities/limitations, spiritual beliefs and practices, economic status, family roles, literacy, diverse populations. It accommodates the patient's culturally- based attitudes, beliefs and needs within the framework of access to health care services and the development of diagnostic and treatment plans and communication methods in order to fully support the delivery of competent care to the patient. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions, and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

PHCN is committed to the development, strengthening, and sustaining of healthy provider/patient relationships. Patients are entitled to dignified, appropriate care. Provider services should meet the unique needs of every enrollee regardless of race, ethnicity, culture, language proficiency, or disability. In all interactions, providers are expected to act

in a manner that is sensitive to the ways in which the patient experiences the world. When healthcare services are delivered without regard for cultural differences, patients are at risk for sub-optimal care. Patients may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.
As part of PHCN's Cultural Competency Program, providers must:

- Facilitate patient access to Cultural and Linguistic Services, including Informing patients of their right to access free, quality medical interpreters, and signers, accessible transportation, and TDD/TTY services
- To support informing patients of their right to access free language services, it is recommended that providers post nondiscrimination notices and language assistance taglines in lobbies and on websites. Language assistance taglines notify individuals of the availability of language assistance the top 15 languages utilized in Arizona as identified by the ACA 1557, and include at least one tagline in 18 point font.
- Provide medical care with consideration of the patients' primary language, race ethnicity and culture;
- Participate in cultural competency training annually and ensure that office staff routinely interacting with patients have also been given the opportunity to participate in, and have participated in, cultural competency training;
- Ensure that treatment plans are developed with consideration of the patient's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, gender identity, sexual orientation, and other characteristics that may influence the patient's perspective on health care;
- Ensure an appropriate mechanism is established to fulfill the provider's obligations under the Americans with Disabilities Act including that all facilities providing services to patients must be accessible to persons with disabilities. Additionally, no patient with a disability may be excluded from participation in or be denied the benefits of services, programs or activities of a public facility, or be subjected to discrimination by any such facility.

PHCN considers mainstreaming of patients an important component of the delivery of care and expects providers to treat patients without regard to race, color, creed, sex, gender identity, religion, age, national origin ancestry, marital status, sexual orientation, health status, income status, physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- Denying a patient a covered service or availability of a facility; and
- Providing an PHCN patient a covered service that is different or in a different manner, or at a different time or at a different location than to other "public" or private pay patients (examples: separate waiting rooms, delayed appointment times).

Providers may take the cultural competency training online to meet annual cultural competency training requirements. Providers are able to participate in training opportunities administered by the State, nationally recognized organizations, or raining provided by other organizations. For additional information regarding resources and trainings, visit:

- On the Office of Minority Health's website, you will find "A Physician's Practical Guide to Culturally Competent Care." By taking this course online, you can earn up to nine CME credits, or nine contact hours for free. The course may be found at: https://cccm.thinkculturalhealth.hhs.gov/
- Think Cultural Health's website includes classes, guides and tools to assist you in providing culturally competent care. The website is: http://www.thinkculturalhealth.hhs.gov/
- The Health Care Literacy website which offers a toolkit as a way for primary care practices to assess their services for health literacy considerations, raise awareness of their entire staff, and work on specific areas. The toolkit can be found at http://www.ahrg.gov/professionals/quality- patient-safety/quality-resources/tools/literacy-tookit/index.html

AMERICANS WITH DISABILITIES ACT

Provider Accessibility Initiative (PAI) is committed to providing equal access to quality health care and services that are physically and programmatically accessible for patients living with disabilities and their companions. "Physical access" also known as "architectural access" refers to a person with a disability's ability to access buildings, structures, and the environment. "Programmatic access" refers to a person with a disability's ability to access goods, services, activities, and equipment. The goal of PAI is to increase percentage of practitioner locations within our network that meet minimum federal and state disability access standards.
PAI covers people with physical, mental, cognitive, or intellectual limitations such as difficulty walking, balancing, climbing, seeing, hearing, reading, understanding, or remembering.

As PHCN moves closer to full inclusion of people with disabilities through policy and practice integration, provider directory accessibility information display, and architecture barrier removal, it is important to understand that disability is just one aspect of a person's full complex life and each person should be seen as an individual, not a disability. The key to creating an acceptable environment for providing health for people living with disabilities is to treat each individual with respect and equality.

- Do not be overly friendly or condescending toward individuals with disabilities
- Use appropriate greetings, such as shaking hands
- Challenge derogatory language and jokes
- Take ownership for making everyone feel welcome and accepted

When providing assistance:

- First, ask if help is needed
- Be sure to understand what is needed and offer only what is needed
- Don’t take over; just help
- Speak directly to the person rather than through someone else, such as a sign language interpreter
- Don’t be afraid to make a mistake.
- Made a mistake? Apologize, correct, learn, and move on
- Use common sense and a positive attitude
- Always think of the person first
- Be generous with yourself
- Unsure of what to do or say? Ask!

PHCN strives to assist providers in meeting the requirements in Title II and Title III of the ADA and Section 504 which requires that medical care providers provide individuals:

- Full and equal access to healthcare services and facilities; and

- Reasonable modifications to policies, practices, and procedures when necessary to make healthcare available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services

The term "disability" means, with respect to an individual -

- A physical or mental impairment that substantially limits one or more of the major life activities of such individual;
- A record of such an impairment; or
- Being regarded as having such an impairment.

An individual meeting any one of the above three tests, is considered to be an individual with a disability for purposes of coverage under the Americans with Disabilities Act.

General prohibitions against discrimination:

- No qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity.

- A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of disability --

    - Deny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit, or service;

- Afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;

- Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;

- Provide different or separate aids, benefits, or services to individuals with disabilities or to any class of individuals with disabilities than is provided to others unless such action is necessary to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others;

- Aid or perpetuate discrimination against a qualified individual with a disability by providing significant assistance to an agency, organization, or person that discriminates on the basis of disability in providing any aid, benefit, or service to patients of the public entity's program;

- Deny a qualified individual with a disability the opportunity to participate as a patient of planning or advisory boards;

- Otherwise limit a qualified individual with a disability in the enjoyment of any right, privilege, or opportunity enjoyed by others receiving the aid, benefit, or service.

- A public entity may not deny a qualified individual with a disability the opportunity to participate in services, programs, or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.

- A public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration:

    - That have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability;
    - That have the purpose or effect of defeating or

    - substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities; or

    - That perpetuate the discrimination of another public entity if both public entities are subject to common administrative control or are

agencies of the same State.

- A public entity may not, in determining the site or location of a facility, make selections
    - That have the effect of excluding individuals with disabilities from, denying them the benefits of, or otherwise subjecting them to discrimination; or
    - That have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the service, program, or activity with respect to individuals with disabilities.
- A public entity, in the selection of procurement contractors, may not use criteria that subject qualified individuals with disabilities to discrimination on the basis of disability.
- A public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination on the basis of disability, nor may a public entity establish requirements for the programs or activities of licensees or certified entities that subject qualified individuals with disabilities to discrimination on the basis of disability. The programs or activities of entities that are licensed or certified by a public entity are not, themselves, covered by this part.
- A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.
- A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered.
    - Nothing in this part prohibits a public entity from providing benefits, services, or advantages to individuals with disabilities, or to a particular class of individuals with disabilities beyond those required by this part.
    - A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.
        - Nothing in this part shall be construed to require an individual

with a disability to accept an accommodation, aid, service, opportunity, or benefit provided under the ADA or this part which such individual chooses not to accept.

- Nothing in the Act or this part authorizes the representative or guardian of an individual with a disability to decline food, water, medical treatment, or medical services for that individual.

- A public entity may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids or program accessibility, that are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part.

- A public entity shall not exclude or otherwise deny equal services, programs, or activities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.

Providers must ensure their websites meet compliance with Section 508 Accessibility Standards. Section 508 is a federal law that requires agencies to provide people with disabilities equal access to electronic information and data comparable to those who do not have disabilities.

NONDISCRIMINATION OF HEALTH CARE SERVICE DELIVERY

PHCN complies with the guidance set forth in the final rule for Section 1557 of the Affordable Care Act, which includes notification of nondiscrimination and instructions for accessing language services in all significant Patient materials and physical locations that serve our Patients.

All Providers who join the PHCN Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR).

PHCN requires Providers to deliver services to PHCN patients without regard to race, color, national origin, age, disability, or sex. Providers must not discriminate against patients based on their payment status and cannot refuse to serve based on varying policy and practices and other criteria for the collecting of patient financial responsibility from PHCN patients.

Section 1557 of the Patient Protection and Affordable Care Act is the nondiscrimination provision of the Affordable Care Act (ACA). The law prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Section 1557 builds on long-standing and familiar Federal civil rights laws: Title VI of the Civil Rights Act of 1964, Title

IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975. Section 1557 extends nondiscrimination protections to individuals participating in:

- Any health program or activity any part of which received funding from HHS
- Any health program or activity that HHS itself administers
- Health Insurance Marketplaces and all plans offered by issuers that participate in those Marketplaces.

For more information, please visit http://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html

FREQUENTLY ASKED QUESTIONS

Q: Where do I contact for help?
A: Please see contact list on page 7 of this manual.

Q: Which health plans are PHCN contracted with and what product lines?
A: See attachment B

Q : What services are PHCN contracted for with the health plans?
A: Skilled Home Health Services (SN, PT, OT, ST, MSW, HHA)

Q: Is there an online provider portal?
A: Our website is www.prohcn.com and you can link to the portal from there

Q: What services require a referral or a prior authorization?
A: All home health and related services require a referral and/or a prior authorization.

Q. How do I get a referral or prior authorization?
A: Please see page 11 of this manual.

Q: Is there an after hours/weekend or emergency contact?
A:

- Our regular business hours are Monday to Friday from 8am to 6pm.
- Our Intake and Review Department is also available on weekends and major holidays from 8:30am to 5:30pm (MST)
- Our staff is available to answer questions you may have. Contact our main number at 888-705-5274 and the receptionist will direct you to the correct department.

Q: Why can't PHCN provide visits for the whole certification period?
A: PHCN must review all services; the frequency of the review is up to the Nurse who reviews the request. The Nurse and/or Medical Director must make sure that Medical Necessity is met.

Q: What is the purpose of Home Therapy?
A: The purpose of Home Therapy is to teach and train a home exercise program and to advance the patient to an Outpatient facility if needed.

Q: How long does it take the Health Plan to make a determination if the case has to be escalated for determination?
A: For Medicare Expedited requests the Health Plan has 72 hours to make a determination and 14 days for routine requests. For Medicaid Expedited requests the Health Plan has 48 hours to make a determination and 7 days for Routine requests.

Q: What happens if a patient's insurance terminates during care?
A: The Provider must check eligibility every month and also ask the patient if he or she has changed Health Plans. Should this occur, the Provider must contact the new Health Plan and ask for an authorization. The services should be reimbursed by the new Health Plan as a Continuity of Care.

Q: What happens when a Physician will not sign the Plan of Care?
A: The Provider must call PHCN and speak to a Representative from Home Health and they will get the Health Plan involved to assist in getting the POC signed.

Q: Can a follow up request for Home Health be faxed to PHCN?
A: No, all Concurrent requests must be submitted via the Portal.

Q: Can I call PHCN to ask questions regarding Home Health?
A: Yes, we welcome calls to the Utilization Management Department with your questions; see the contact list for names and extensions.

Q: Can I obtain orders from the MD offices directly, start care, then obtain the auth after?
A: No, orders must be faxed to PHCN and the auth needs to be issued prior to item(s) being delivered.

Q: Can I verify eligibility on the PHCN Provider Portal?
A: No, eligibility must be checked on the individual plan website. You can call during normal business hours 888-705-5274

QUALITY STANDARDS AND COMPLIANCE

PHCN has developed and implemented compliance and quality standards to ensure our Network Providers provide high quality services to our participants. We look forward to partnering with you to monitor program performance and we are committed to supporting you in making process adjustments to ensure your success.

The following items are an integral part of our quality and compliance program.

PROVIDER ASSESMENTS

The initial Network Provider contracting process begins with a series of evaluations that are designed to assure all safeguards are in place for program success. PHCN has created compliance and security questionnaires that capture vital information about your current systems and practices of your organization. Once we have evaluated this information, we will collaborate with you to recommend any necessary adjustments. We are committed to assisting our Network Providers by sharing information and resources.

INFORMATION AND SECURITY POLICY AND PROCEDURE REVIEWS

The Information and Security assessment will capture information about your data systems, data security, and policies and procedures your staff follow for workstation security, and how you safeguard and protect participant's protected health information (PHI) and personally identifiable information (PHI) information.

The Organization Assessment facilitates information sharing about compliance policies and procedures, Code(s) of Conduct, and hiring practices that include background checks and reviews of health care exclusion lists as regulatorily required.

PRIVACY AND INFORMATION SECURITY STANDARDS

Network Providers must establish effective privacy and information security standards that enable alignment with HIPAA Privacy and Security requirements.

Minimum requirements for information security include:

1. Staff computer password requirements:
    a. Password length of 8-12 Characters
    b. Meets complexity guidelines (i.e., a mixture of 3 or more character types: A-Z; a-z; 0-9; !@#$, etc.)
    c. Must be changed every 90 days

d. May not use 4 previous passwords

2. Device Lockout/Screen Lock:
    a. Activates after 5 minutes of inactivity
    b. Requires re-credentialing for access

3. Encryption:
    a. All confidential information must be encrypted with FIPS 140-2 compliance cryptographic controls while not in use or while in transit.

    b. HIPAA encryption is recommended under federal regulation by the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR), but what is it and why do you need it? The HIPAA Security Rule sets specific safeguards that must be in place to protect ePHI. Although not specifically mandated, encryption is the best way to protect ePHI and reduce the probability of a breach of your patients' or customers' sensitive health data.

AUDIT AND REVIEW ACTIVITIES

To ensure the accuracy of results, PHCN performs reviews of submitted data and conducts audits on a routine and continual basis. Additionally, PHCN is regularly audited by health plan payer partners, which may require us to request information from our Network Providers.

Types of Audits:

1. Data Validation and Claims Reviews:
    a. Randomly executed Network Provider audits that help ensure the accuracy of submitted participant engagement data.
    b. Exception audits conducted when the data submitted by a Network Provider contains suspicious findings or trends differently than peer submissions.

2. Regulatory Compliance and Oversight Activities:
    a. PHCN may audit at any time (annually or as necessary) policies and procedures you have implemented related to compliance and information security.
    b. If a compliance issue, complaint, or grievance has been conveyed to PHCN by one of our payer partners, PHCN may contact you for additional information. A rapid turnaround may be required (as little as 1 business day) to meet regulatory requirements. If this is necessary, a time frame will be communicated to you along with the incident details for you to research and respond.

3. Program Assessments:
    a. Together, and on a routine basis, our organizations will review outcomes and program results. This allows the opportunity to exchange ideas and share information that is intended to continually improve participant outcomes.

In the event PHCN Health conducts an audit, please make every effort to assist us by responding to requests for data and other information in a timely manner, as described in the information request you will receive from PHCN.

IMPROVEMENT ACTION PLAN (IAP)

Upon completion of an audit or assessment PHCN may draft an Improvement Action Plan request to address identified deficiencies and other areas of non-compliance with PHCN requirements. Network Providers must:

1. Complete the Improvement Action Plan Request within 30 days of the date of the assessment or audit activity. Due dates are typically identified within the Improvement Action Plan Request Template that is sent to Network Providers.
2. Ensure all submitted Improvement Actions adequately address the areas of nonconformance.
3. Assure each Improvement Action has assigned responsibility. This may be an individual or department.
4. Improvement Actions should be completed in an appropriate amount of time. PHCN recommends improvement action completion timeframes, to ensure success. PHCN also reserves the right to request an IAP be completed within a specific timeframe as necessary to address contractual or regulatory needs.

IMPROVEMENT ACTION PLAN ASSESSMENT

All submitted Improvement Action Plans will be reviewed to ensure responses address the identified deficiency or nonconformance. PHCN will take into consideration the overall size and complexity of the Network Provider when assessing the submitted IAP. PHCN will perform an assessment of the submitted Improvement Action Plan to ensure all requirements are adequately addressed. PHCN will assess the overall level of effectiveness.

IMPROVEMENT ACTION MONITORING

PHCN will perform monthly IAP Monitoring. During the IAP Monitoring process, the Provider will receive requests for updates via email on all IAP items that have not been completed. The Network Provider will respond to all monthly update requests within 5 business days of receipt of the request.

IMPROVEMENT ACTION PLAN COMPLETION AND CLOSE OUT

To close out an Improvement Action Plan, PHCN must receive sufficient information demonstrating completion of the IAP. This can include but is not limited to:

- Policies and Procedures;
- Audit Logs;
- Screen shots;
- Proof of education and training
- Re-audit of the deficiency(s).

OUTSTANDING IAPS AND FAILURE TO MEET IAP OBJECTIVES OR TIMELINES

Failure to submit an IAP within the identified timeframe may result in suspension or removal of the Network Provider from participation in the PHCN Network. If a Network Provider fails to meet its Improvement Action obligations, PHCN reserves the right to take disciplinary action as outlined above in this document.

APPENDIX A – COMPLIANCE AND FWA PROGRAMS

COMPLIANCE AND FWA PROGRAMS

Per CMS guidelines, all employees that work with Medicare, Medicare Advantage, or Medicaid patients need to complete the CMS General Compliance Training and Medicare Fraud, Waste, and Abuse Training upon hire and annually thereafter. This includes both office and field employees. The training courses can both be accessed via the following link:

https://www.fhcp.com/documents/Fraud-Waste-Abuse-Training.pdf

As a PHCN contracted provider you need to ensure that all employees are up to date with this training. You must keep all certificates, records, or logs of completion, which we may request of you at any time.
If we receive a “successful sent” notice with no reply from you, it means that you are in compliance or are completing compliance. If this is not the case, or if you have any questions, please reach out to the provider network email - providernetwork@prohcn.com

Compliance is everyone’s business and PHCN expects the same diligence and dedication from its provider network in these important endeavors.

FRAUD, WASTE AND ABUSEOVERVIEW

Fraud, Waste and Abuse is a serious concern for all parties; insurers and premium-payers, government and taxpayers, consumers and healthcare partners - and is a costly reality no one can afford to overlook. In response to these realities, Congress, through the Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically established health care fraud as a federal criminal offense, with the basic crime carrying a federal prison term of up to 10 years in addition to significant financial penalties.

Congress also mandated the establishment of a nationwide "Coordinated Fraud and Abuse Control Program," to coordinate federal, state, and local law enforcement efforts against health care fraud.

To ensure early detection and investigation, PHCN has established multiple channels through which employees, participants, Network Providers, and other entities may report suspected fraud, waste, or abuse. PHCN disseminates written and electronic policies to all employees, and First Tier, Downstream, and Related Entities (FDRs), or other parties that

furnish or otherwise authorize the furnishing of health care items or services; perform billing or coding functions; or are involved in the monitoring of participant health on behalf of PHCN.

WHAT IS FRAUD, WASTE AND ABUSE?

- Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the person or some other person. Fraud involves making false statements or misrepresentation of material facts to obtain some benefit or payment for which no entitlement would otherwise exist. The acts may be committed for the person's own benefit or for the benefit of another party. To be considered fraud, the act must be performed knowingly, willfully, and intentionally.

- Waste – An over-utilization of services, or practices that result in unnecessary costs. Waste also refers to useless consumption, mismanagement or careless expenditure without adequate return, or an act or instance of wasting. Providing services that are not medically necessary is considered waste. Billing errors are often referred to as waste.

- Abuse –Practices that are inconsistent with sound fiscal business, or medical practices, and result in an unnecessary cost to the health insurers, or in reimbursement for services that fail to meet professionally recognized standards for health care.

FRAUD AND ABUSE CRITERIA

The following is a list of criteria used by PHCN to detect fraud, waste, and abuse (FWA).

1. Evidence of knowledge and intent
2. Intentional duplicate billings
3. Up-coding - billing for more expensive services or procedures than were provided or performed
4. Intentional miscoding
5. Misrepresentation of services - misrepresenting non-covered treatments as medically necessary covered treatments for purposes of obtaining payment
6. Billing for services not rendered
7. Evidence of false or altered documents
8. Evidence of intentional missing documentation
9. Evidence of irregularities following sanctions for same problem
10. Evidence of unlicensed or excluded professional or facility at time of services
11. Evidence of management knowledge of fraudulent activity

12. Reports of material irregularities by more than one reliable source
13. And, all of the following criteria must be met:
    a. Pattern of occurrence of irregularities
    b. Actual loss to a governmental or commercial insurance program
    c. Loss would be considered material for nature and type of activity
14. Or, at least one of the following criteria is met:
    a. Direct personal knowledge of fraudulent activity by known reliable individual
    b. PHCN documented audit findings that show suspected fraud
    c. Report showing evidence of suspected fraud from a government or law enforcement agency

WHAT IS THE ROLE OF THE NETWORK PROVIDER IN PREVENTING AND DETECTING FRAUD, WASTE AND ABUSE?

Network Providers who furnish services or perform billing or coding functions must be cognizant of potential fraud and abuse potential within the PHCN delivery system and are obligated to report actual or alleged occurrences of FWA to the PHCN Compliance Department.

At a minimum, to prevent and detect FWA, Network Providers should have the following in place:

- Internal controls, policies and procedures that are designed to prevent and detect fraud, waste, and abuse activities.
- Operational policies and controls (as appropriate for service delivery) such as claims edits, prior authorization requirements, utilization and quality management oversight, provider profiling, provider education, post-processing review of claims, and improvement action plans.

WHAT ARE THE POTENTIAL DISCIPLINARY ACTIONS OF FRAUD, WASTE AND ABUSE?

If an allegation of fraud, waste or abuse is substantiated, PHCN disciplinary actions may include one or more of the following:

- Initiation of contract remedies including an improvement action plan
- Mandatory remedial training and education
- Referral of the substantiated allegations to Law Enforcement
- Referral of the substantiated allegations to other regulatory authorities
- Other civil remedies as allowed by state and federal law
- Contract termination

HOW DOES A PROVIDER REPORT AN INCIDENT OF SUSPECTED FRAUD, WASTE AND ABUSE?

Any Network Provider who suspects fraud, waste or abuse is responsible for reporting all allegations to PHCN. Reports may be submitted in written or verbal form and may be submitted anonymously. PHCN Health has established a Fraud and Abuse Hotline for anonymous reporting. Initial reports of suspected fraud, waste and abuse are kept strictly confidential.

- PHCN Fraud and Abuse Hotline (internal & external use): (602) 242-7917
- Via email at providernetwork@prohcn.com
- See the U.S. Department of Health and Human Services website at: www.hhs.gov for additional information on the topic of Fraud, Waste and Abuse.

PREVENTING FRAUD, WASTE AND ABUSE

Although no precise measure of health care fraud exists, those intent on abusing Federal health care programs can cost taxpayers billions of dollars while putting patients' health and welfare at risk. The impact of these losses and risks magnifies as our Network Providers serve a growing number of participants.

Defrauding the Federal Government and its programs is illegal. Committing health care fraud exposes individuals or entities to potential criminal and civil liability, and may lead to imprisonment, fines, and penalties. Criminal and civil penalties for health care fraud reflect the serious harms associated with health care fraud and the need for aggressive and appropriate intervention. Providers and health care organizations involved in health care fraud, risk exclusion from participating in all Federal health care programs and risk losing their professional licenses.

It is important that each Network Provider develop and implement anti-fraud processes to address any allegation of fraud, waste, and abuse. Network Providers must ensure all staff appropriately adhere to your fraud, waste, and abuse policies.

Additional resource information and context is available to you in Appendix A, *Fraud Waste and Abuse Overview*.

REPORTING AN INCIDENT OR SUSPECTED FRAUD AND ABUSE

Any individual who suspects fraud, waste or abuse is required to report the specifics to PHCN's attention, either in writing or by phone to the PHCN Compliance Office. Because of the importance of reporting these situations and facilitating ease for our Network Providers, PHCN has established a Fraud and Abuse Hotline that also allows for

anonymous reporting. Initial reports of suspected fraud, waste and abuse are kept strictly confidential.

- By phone, contact the confidential and anonymous Compliance Hotline: 602-242-7917

Additional resource:
Fraud, Waste & Abuse Toolkit – Healthcare Fraud and Program Integrity
Fraud Prevention Toolkit | CMS

USE OF OFFSHORE VENDORS

Except as otherwise approved by PHCN in writing, Home Health Agency Provider and any of its agents, employees or sub-contractors may not perform or engage with business partners/vendors or related entities to perform any functions or services under this agreement with PHCN from a location outside of the United States. This includes no transmission of member PHI from outside of the United States.

PHCN

APPENDIX B - HEALTH PLAN INFORMATION

MANAGED PLAN LIST

Partner	Geography	Plan(s) Under Management
BlueCross BlueShield	AZ – County specific	• For plans under P3 Health Partners – Blue Advantage - Blue MA Classic – Pima County • For plans under P3 Health Partners – Blue Advantage - Blue MA Standard – Santa Cruz County • For plans under P3 Health Partners – BluePathway Plan 2 HMO – Pima County
Amerigroup	AZ – Pima county	• All plans with a P3 Health Partners IPA
Centene	AZ – Statewide	• All AZ Complete plans (note: SN, PT, OT, HHA. ST only if patient is under 21. MSW only if patient has mental health benefits.) • All AmBetter Marketplace plans • All AllWell MA plans • Care1st AHCCCS plans • WellCare – all plans except IPA – Arizona Priority Care
Cigna HMO	AZ – Statewide	• 4011MR • 4010MR • 4108M • 4153M1 • 4100DB • 4225M1 • 4178M • 4119 • 4123M • 4173M1 • 4185M • 4051MR • 4050MR • 4040MR • 4010MR • 4910TR • 4911TR • 4941TR • 4060MR • 4061MR • 4080MR • 4081MR
Humana	AZ – Statewide	• All MA HMO plans • All MA PPO plans

Partner	Geography	Plan(s) Under Management
United Healthcare	AZ – Statewide	• PIN 19537 Pinal Health Care Network • PHH 21266 Phoenix Direct Hospital Network • RAS 19534 Rural Area Secure • MT1 19535 Metro Tucson Network • MT2 19781 Metro Tucson Network • MT3 19798 Metro Tucson Network • MT5 26522 Metro Tucson Network • MT6 26523 Metro Tucson Network • 33274 Northwest Allied Physicians EXCLUDING: • OptumCare
Humana	CO – Statewide	• Humana Value Plus H5216-195 PPO • HumanaChoice H5216-223 PPO • HumanaChoice H5216-078 PPO • HumanaChoice H5216-137 PPO • Humana Honor H5216-213 PPO • Humana Gold Plus H0028-047 HMO • Humana Gold Plus H0028-025 HMO
Humana	NM – Statewide	• HumanaChoice H5216-137 PPO • HumanaChoice H5216-007 PPO • HumanaChoice H5216-078 PPO • HumanaChoice H5216-196 PPO • Humana Value Plus H5216-199 PPO • Humana Honor H5216-213 PPO • Humana Gold Plus H0028-019 HMO
Anthem MediBlue	NV – Las Vegas	• For plans under P3 Health Partners – H4346-017 – Mediblue Plus HMO • For plans under P3 Health Partners – H4346-018 – Mediblue Coordination Plus HMO
Alignment	NV – Las Vegas	• All plans under P3 Health Partners
HomeTown Health	NV – Las Vegas	• For plans under P3 Health Partners – Value RX Complete Plans

GENERAL CONTACT INFORMATION

PHCN: 888-705-5274/ FAX: 877-612-7066
APS: 877-767-2385
Phoenix Area Agency on Aging: 602-264-4357
New Mexico Area Agency on Aging: 505-768-2084
Colorado Area Agency on Aging: 303-480-6700
Nevada Area Agency on Aging: 702-486-3545