

Provider Manual



This Provider Manual is designed to assist physicians, facilities, ancillary providers and their staff with a convenient method of accessing important information about GHI.

Introduction

In August 2002, the Centers for Medicare and Medicaid Services (CMS) announced that Group Health Incorporated (GHI) had been approved as a carrier for the Medicare Advantage PPO Demonstration program. GHI launched its Medicare Advantage product, GHI Medicare Choice PPO, in early 2003. CMS' goal in creating the demonstration program was to give Medicare eligible individuals more flexibility and more options in choosing their health care coverage. GHI developed its Medicare Advantage program keeping these goals in mind. GHI Medicare Choice PPO is designed to give Medicare enrollees the option of obtaining benefits from in and out-of-network providers. In addition, there are no referrals needed to see specialists or out-of-network providers.

In January 2006, GHI launched its Medicare Part D program. GHI currently offers:

- GHI Medicare Choice PPO. This is a Medicare Advantage Prescription Drug Plan which consists of medical, hospital and pharmacy benefits.
- GHI Medicare Prescription Drug Plan. This is a freestanding prescription drug program for those individuals who have Medicare hospital and medical coverage through another entity.

Following are some of the guidelines and requirements for GHI's Medicare Advantage programs and Medicare Part D Programs. As they are government programs, most of this manual has been developed based upon federal statutes and regulations.

Please note that this manual has been divided into two (2) sections. Section I applies to GHI's Medicare Advantage plans. Section II applies to GHI's Medicare Part D Prescription Drug Plans. To the extent that a member has GHI Medicare Choice (which includes medical, hospital and pharmacy benefits), the relevant section will depend on the type of benefit being requested and/or reviewed. For example, if a medical service is being appealed, section I will apply; if a pharmacy benefit is being appealed, section II will apply.

GHI MEDICARE CHOICE PPO PROVIDER MANUAL

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SECTION I

GHI MEDICARE CHOICE **PPO**

MEDICAL & HOSPITAL **BENEFITS**

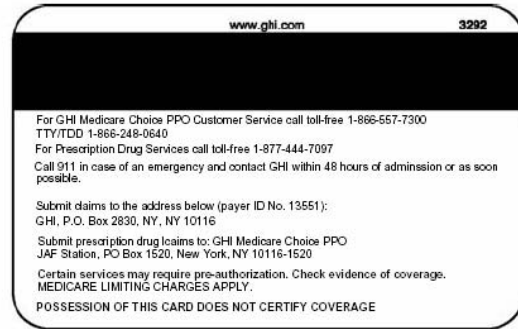
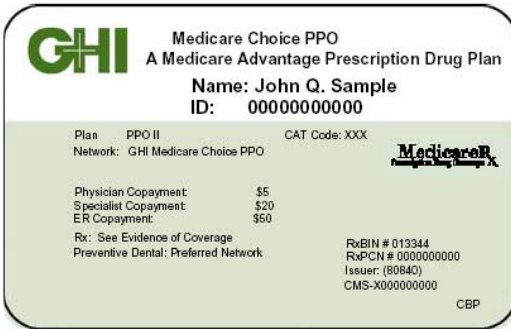
Service Area and Benefits

GHI Medicare Choice PPO currently offers benefit plans within the five (5) boroughs of New York City, Rockland, Westchester, Nassau, Suffolk, Putnam, Dutchess, Orange and Ulster Counties. To obtain copies of the Summary of Benefits or the Evidence of Coverage for our various benefit plans, please go to <http://www.ghi.com/default.aspx?page=439>

For information regarding our dual eligible plans or our employer plans, please contact GHI Medicare Choice PPO at 866-557-7300 Monday through Friday 8 a.m. to 8 p.m.

Sample ID Card

Enrollees must use their GHI Medicare Choice PPO ID card to be eligible for benefits through GHI Medicare Choice PPO. Enrollees should not show you their red, white and blue card for Original Medicare. If they use their red, white, and blue Medicare card instead of their GHI Medicare Choice PPO ID card while they are a member of GHI Medicare Choice PPO, the Medicare program will not pay for these services and neither will GHI Medicare Choice PPO. They will have to pay the full cost of the service(s). Here is a sample card to show you what the GHI Medicare Choice PPO ID card looks like.



Pre-Certification

- In-network providers are responsible for obtaining any necessary pre-certifications. Providers who do not obtain pre-certification (or provide notification as required) for GHI Medicare Choice PPO enrollees will be penalized; payment may be reduced or denied.
- All elective in-patient hospital admissions must be pre-certified at least ten (10) days prior to the admission to determine medical appropriateness, and whether a requirement of a Second Surgical Opinion exists.
- In the event of an emergency admission, notification should be provided to GHI Medicare Choice PPO within 48 hours or as soon as reasonably possible.
- If the admission is for maternity care, the subscriber is requested to notify GHI Medicare Choice PPO within the first three (3) months of pregnancy and then upon delivery.
- Letters confirming pre-certification are sent to the enrollee, the physician and the facility at the time of approval, along with a telephone call to the provider and enrollee.

Information Needed for Pre-certification

The following information must be provided for pre-certification:

- a) Enrollee Name
- b) Certificate Number
- c) Category Number, if applicable
- d) Diagnosis
- e) Name of Contact Person
- f) Telephone Number and Address of Physician who will be rendering care
- g) Place of service (inpatient/outpatient, etc.)
- h) Procedure, service, or supply and date to be rendered or supplied
- i) Medical Necessity
- j) Number of Services Requested and frequency
- k) COB
- l) Relevant Medical History.

In addition, the following information must also be provided in the case of a facility admission:

- a) Date of Admission
- b) Date of birth
- c) Hospital Name

- d) Hospital Telephone Number
- e) Any Additional Information Pertinent to the Admission
- f) Projected length of stay

Pre-certification Approval

Pre-certification approval is based on the following:

1. Benefit coverage
2. Nationally established Clinical Protocols
3. Medical Necessity
4. CMS Guidelines

Appropriateness of Admission

- The professional staff (Registered Nurses) will confirm medical necessity utilizing the Milliman USA Healthcare Management Guidelines for in-patient medical/surgical admissions and procedures, GHI Medicare Choice PPO Medical Policy for outpatient and specialty programs.
- The Milliman Guidelines also recommend a length of stay. GHI Medicare Choice PPO's utilization determinations regarding appropriateness of inpatient length of stay are made in conjunction with the attending physician and hospital utilization department based upon the enrollee's pertinent clinical information.

Emergency Admissions

- The enrollee and/or the facility must notify GHI Medicare Choice PPO within 48 hours or as soon as reasonably possible in the event of an emergency admission
- An enrollee or facility may leave a message on GHI Medicare Choice PPO's message line at **866-557-7300**. All calls will be returned the following business day.

For questions or to obtain pre-certification, please contact GHI Medicare Choice PPO at 866-557-7300 Monday through Friday 8 a.m. to 6 p.m.

GHI Medicare Choice PPO Pre-certification List

The services on the attached list must be pre-certified before they are rendered. In order to begin the pre-certification process, you should print out the prior authorization form below and fax the form to 877 508-2643. If you have questions, you may reach GHI by telephone at 866-557-7300. For covered in-network services which require pre-certification, you are responsible for obtaining the pre-certification. For covered out-of-network services which require pre-certification, the enrollee is responsible for obtaining the pre-certification. **Note**

that if pre-certification is not obtained when it is required, the services may not be covered or a substantial penalty may be imposed. You may not balance bill an enrollee if you (the provider) fail to obtain pre-certification.

For a complete list of services requiring prior authorization, please visit:
<http://www.ghi.com/pdf/FocusedAmbRevPreauth2007-06.pdf>

For a copy of the prior authorization form, please visit:
<http://www.ghi.com/pdf/PriorAuthFormMedicare2007-07-15.pdf>

Timeframes for Organizational Determinations

Organization determinations (including requests for pre-certification) will be made in a timely fashion as set forth below.

Standard Requests

- Providers (or enrollees as appropriate) will be notified of a determination within 14 calendar days after GHI receives the request.
- This may be extended for up to 14 calendar days. An individual may file a grievance if they disagree with the reason given for the extension. The procedure for filing a grievance is described later in this manual.

Expedited Requests

- Providers (or enrollees as appropriate) will be notified of a determination within 72 hours after GHI receives the request.
- If the request does not meet the criteria for an expedited request, the individual will be notified and the request will automatically be transferred to a standard request. A determination will be made within 14 days of the date that the request becomes a standard request.

Contracted Vendors

The following vendors are considered in-network. Pre-certification, if required (based upon the list above), must be obtained by these vendors.

ValueOptions – Pre-certification for those mental health services listed above must be obtained by calling either GHI Medicare Choice PPO's service number 866-557-7300 or ValueOptions at 866-318-7595. All claims for mental health services should be sent to ValueOptions, P.O. Box 1377, Latham, NY 12110

CareCore National - Pre-certification for those radiology services listed above must be obtained by calling either GHI Medicare Choice PPO's service number 866-557-7300 or CareCore at 800-835-7064. All claims for radiology services should be sent to GHI Medicare Choice PPO, P.O. Box 2830, New York, NY 10116-2830.

Prism - Pre-certification for those chiropractic services listed above must be obtained by calling either GHI Medicare Choice PPO's service number 866-557-7300 or Prism at 866-284-2901. All claims for chiropractic services should be sent to GHI Medicare Choice PPO, P.O. Box 2830 New York, NY 10116-2830.

Quest Diagnostics – All lab services must be performed by Quest Diagnostics. All other lab vendors will be considered out-of-network. Enrollees should call 800-377-8448 to find a location near them.

Davis Vision – All vision benefits must be obtained by Davis Vision. All others will be considered out-of-network. Enrollees should call 800-999-5431 to find a location near them.

Doral Dental – Dental benefits for GHI Medicare Value PPO enrollees are provided through Doral Dental. Claims for dental services should be sent to Doral Dental 12121 N. Corporate Parkway Mequon, WI 53092. Pre-certification for dental services can be obtained by calling 800-508-6782

Coordinated Transportation Solutions (CTS) - Non-emergency transportation services for New York City residents are covered through Medicaid for enrollees who are dually eligible for both Medicare and Medicaid. GHI contracts with CTS to provide these services. To arrange for transportation services, please call CTS at 800-778-0818.

Express Scripts Inc. (ESI) – ESI is the pharmacy benefit manager for the GHI Medicare Prescription Drug Plans. To obtain order forms and get information about filling prescriptions by mail, please call ESI at 866-533-8515.

Health Insurance Plan of Greater NY (HIP) – is the retail pharmacy benefit manager for the GHI Medicare Choice PPO plans (including GuildNet). To obtain order forms and get information about filling prescriptions by mail, please call Pharmacy Services at 1-877-444-7097. Mail order pharmacy services for GHI Medicare Choice PPO plans are through Medco Health Solutions, Inc. (Medco). For questions or assistance with mail order services, please call Medco at 1-800-820-9726 anytime, day or night.

Complex Case Management

The Large/Complex Case Management Program monitors the appropriateness of cost-effective care. Case Managers identify through objective assessment of the patient, family and treatment plan, enrollees considered at high risk for incurring extensive health care expenses, or requiring extensive, continued medical care for chronic or catastrophic illness.

Large/Complex Case Management Criteria

1. Specific diagnoses such as: ALS, Amputations, Cardiomyopathy, Cerebrovascular Accident, Coma, CHF, ESRD, Major Burns, Major Head Injuries and Trauma.
2. Potential High Dollar Cases
3. Multiple Admissions (depending on diagnosis) or ER use
4. Transplants
5. Frail Elderly
6. Subscriber's Request – Patient or family requesting assistance
7. AIDS and HIV – For information about the availability of Experienced HIV Providers and HIV Specialist PCPs Case Management Assessment for Enrollees with HIV Infection, providers should contact GHI's Case Management Department at the number below.

Clinical Guideline and Reference Guides

- GHI Case Managers utilize clinical protocols of Milliman USA
 - Medicare Clinical Guidelines

Telephone Contacts

Complex Case Management

866-557-7300

Hours

Monday to Friday
8a.m. to 6 p.m.

Disease Management

GHI offers Disease Management programs for diabetes, chronic obstructive pulmonary disease (COPD) and heart failure, at no additional cost to our GHI Medicare Choice PPO members. Our programs are designed to compliment the care our members receive. We offer scheduled out-bound calls, and on-going education. Referrals into the programs come through Health Risk Assessment, self-referral or directly through you, the provider. The program goals are:

- Higher compliance with physician instructions
- Increased patient condition knowledge
- Symptom improvement and/or stabilization
- Reduction in inappropriate utilization
- Positive health behavior changes

Please call our direct toll free number at 1- 877-244-4466 for information or to refer a member into one of our Diabetes, COPD, or Heart Failure programs.

Standards of Timeliness for Appointments and In-Office Waiting Times

GHI has established timeframes for appointments and in-office waiting times for each type of service. These timeframes take into account the immediacy of enrollee needs and common waiting times for comparable services in the community. In-office waiting times should be kept to a minimum and should not exceed one hour.

Standards for appointments shall be as follows:

- Medically necessary services shall be available to enrollees 24 hours a day, 7 days a week. This includes requiring primary care physicians to have appropriate backup for absences;
- Adult preventive visits – appointments should be available within 4 weeks of the request;
- Non-urgent specialist visits – appointments should be available within 4-6 weeks of the request;
- Non-urgent sick visit – appointments should be available within 48-72 hours, as clinically indicated;
- Urgent care – enrollees should be seen the same day (or within 24 hours)

Provider Complaint Procedure

If a provider is dissatisfied with a determination made by GHI that relates directly to the provider, the provider has the right to file a complaint requesting (verbally or in writing) that GHI reconsider or review the determination.

All complaints must be filed within one year of the date of service, event, or incident that precipitated the complaint. Complaints may be filed orally or in writing. A written acknowledgement will be sent to the provider within 15 days after the date the complaint was received by GHI. It will include a request for any additional information needed to resolve the complaint and will identify the name, address and phone number of the individual or the department which has been designated to respond to it.

GHI will complete its review of any complaint and provide a written notice of determination within 45 days after GHI's receipt of all necessary information. If the complaint cannot be resolved within the 45 day period, the provider will be notified of the status of the complaint.

- Written complaints should be mailed to:

**GHI Medicare Choice PPO
P.O. Box 4296
Kingston, New York 12402-4296**

Verbal complaints can be initiated by calling **866-557-7300**.

Any and all complaints filed by a provider on behalf of an enrollee will follow the Enrollee Grievance and Appeal Procedures set forth below including the timeframes, etc.

Enrollee Grievance and Appeal Procedures

Grievances

For those enrollees who have a complaint, we encourage them to first call Member Services at 866-557-7300. We will try to resolve any complaint that an enrollee might have over the phone. If we cannot resolve an enrollee's complaint over the phone, we have a formal procedure to review complaints.

- An enrollee or their representative must file a grievance no later than 60 days after the event or incident that precipitated the grievance. Grievances may be filed orally or in writing. All grievances submitted in writing will be responded to in writing. Grievances submitted orally may be responded to either orally or in writing unless the enrollee requests a written response. All grievances related to quality of care, regardless of how the grievance is filed, will be responded to in writing. GHI will notify the enrollee of its decision expeditiously based upon the individual's health status, but no later than 30 days after the date GHI receives the grievance. This time period may be extended by up to 14 days if the enrollee requests such an extension or GHI can justify the need. If GHI extends the timeframe, the enrollee will be immediately notified. All responses will include a description of how to file a written complaint with IPRO.

Denials

Any time a service is denied to an enrollee, a letter must be issued. Note that a denial means that even after full consideration and discussion of medical necessity and/or reasons why the service may not be appropriate, the enrollee still requests that the service(s) be provided. If a discussion results in a "denial", please contact GHI Medicare Choice PPO at 866-557-7300 so that the appropriate documentation including appeal rights may be provided to the enrollee. If after such discussion, an enrollee no longer requests the service or feels that it is not the most appropriate course of action, this is not a "denial" and no letter need be issued.

Appeals

Appeals may be filed by a GHI Medicare Choice PPO enrollee or their authorized representative. An authorized representative may be a friend, relative or doctor. If a GHI Medicare Choice PPO enrollee would like to name an authorized representative, both the enrollee and the authorized representative must sign and date a statement giving the representative permission to act on behalf of the enrollee. Upon request, GHI will provide a form for appointing a representative.

There are two types of appeals that may be filed by GHI Medicare Choice PPO enrollees (or their authorized representative) – a standard appeal or an expedited appeal. Standard appeals must be in writing. Expedited appeals may be oral or written.

Expedited appeals may be initiated by calling 866-557-7300 or writing to us at GHI Medicare Choice PPO, PO Box 4296, Kingston, New York 12402-4296.

Standard appeals may be initiated by writing to us at GHI Medicare Choice PPO, PO Box 4296, Kingston, New York 12402-4296.

Standard Appeals

- A standard appeal must be filed within 60 calendar days of GHI's initial adverse determination. This may be extended for good cause. The enrollee may file a grievance if he/she disagrees with the extension.
- GHI's review begins when we receive the request.
- GHI will make a determination within 30 calendar days. This may be extended for good cause. The enrollee may file a grievance if he/she disagrees with the extension.
- If GHI overturns the initial adverse determination for a request of service, we will authorize or provide the requested service as expeditiously as the enrollee health requires, but no later than thirty (30) calendar days of the date GHI received the request for reconsideration (or no later than upon expiration of an extension).
- If GHI decides to uphold the initial adverse determination, either in whole or in part, (or if GHI fails to provide the enrollee with a decision on the reconsideration within the relevant time frame) GHI will automatically forward the case to Center for Health Dispute Resolution (CHDR).
- If CHDR overturns GHI's determination, GHI will authorize the service under dispute within 72 hours or provide the service as expeditiously as the enrollee's health requires, but no later than fourteen (14) days from the date GHI receives notice reversing the determination.

Expedited Appeals

Expedited appeals shall be permitted in following cases:

- Where the case involves a denial of continued or extended health care services
 - Where the case involves a denial of additional services for an enrollee undergoing a course of continued treatment; or
 - Where the case involves a prospective or concurrent denial and the enrollee's provider believe that an immediate appeal is warranted.
- GHI will make a determination within 72 hours if a longer period could jeopardize the health of the enrollee. This may be extended for up to 14 days if requested by the enrollee or GHI provides justification for the extension. The enrollee may file a grievance if he/she disagrees with the extension.
 - If the request for an expedited appeal is denied, GHI will give the enrollee prompt oral notice, and subsequently deliver, within 3 calendar days, a written letter that:
 - Explains that GHI will process the enrollee's request using the 30-day timeframe for standard reconsiderations;
 - Informs the enrollee of the right to file a grievance if he or she disagrees with the organization's decision not to expedite;
 - Informs the enrollee of the right to resubmit a request for an expedited reconsideration with any physician's support; and
 - Provides instructions about the grievance process and its timeframes.

- For an expedited appeal, if GHI fails to notify the enrollee within 72 hours or within the extended timeframe, the request will automatically be forwarded to CHDR.
- If on reconsideration of the decision, GHI overturns the initial adverse determination for a service, we will authorize the requested service as expeditiously as the health condition of the enrollee requires but no later than 72 hours after GHI receives the request for a reconsideration (or no later than upon expiration of an extension).
- If GHI upholds the initial adverse decision, either in whole or in part, GHI will forward the entire case file to CHDR within 24 hours of the determination. CHDR will make a determination within seventy-two (72) hours after receipt of the case, or by the fourteen (14) calendar day extension.
- If CHDR overturns the expedited appeal, GHI will authorize the service under dispute as expeditiously within 72 hours (or sooner) from the date GHI receives CHDR's notice.

Fast Track Appeals

Note that this section applies to skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities.

Fast Track appeals are available only after the required notices as set forth in the next section are provided.

- If the patient does not agree that coverage should end, they may request an expedited review of the case by IPRO. IPRO will notify GHI if a patient has contacted them.
 - For enrollees receiving services through a home health agency or comprehensive outpatient rehabilitation facility, GHI will furnish a detailed notice called a Detailed Explanation of Notice Coverage (DENC) directly to the enrollee explaining why services are no longer necessary or covered.
 - For enrollees receiving services through a skilled nursing facility, GHI will furnish a detailed notice called a Detailed Explanation of Notice Coverage (DENC) to the provider explaining why services are no longer necessary or covered.
 - The provider is responsible for delivery of the DENC to the enrollee.
- The expedited review process generally will be completed within less than 48 hours of the enrollee's request for a review.
- GHI will not be financially liable for additional days and/or associated services which result from a provider's failure to issue the NOMNC in the timeframes outlined below. The provider may not balance bill the enrollee for any costs associated with its failure to comply with these requirements.

All documentation must be retained by the provider in an appropriate fashion.

Hospital and Facility Requirements (applicable to HHAs, SNFs and CORFs)

Hospital Requirements

Effective July 1, 2007, hospitals must deliver written notice of an enrollee's rights to every Medicare Advantage member who is an inpatient. The hospital must use the **standardized CMS notice**.

- Hospitals must issue the notice within 2 calendar days of the day of admission, and obtain the signature of the beneficiary or his or her representative to indicate that he/she received and understood the notice.
 - The notice must be signed and dated by the enrollee or their representative. If an enrollee refuses to sign the notice, the hospital may annotate the notice to indicate the refusal, and the date of refusal will be considered the date of receipt of the notice.
- The notice, or a copy of the notice, must also be provided to each beneficiary within 2 calendar days of the day of discharge.
 - Signature at discharge is not required; however, the hospital must be able to document that it was delivered. Follow up notification is not required if the notice is delivered within 2 calendar days of discharge. Prior to discharging an enrollee from the inpatient hospital level of care, the physician who is responsible for the enrollee's inpatient care must concur with the discharge decision.
- An enrollee has the right to request an immediate review by the QIO when a Medicare Advantage organization (GHI) or the hospital (as its delegate) with physician concurrence determines that inpatient care is no longer necessary. An enrollee who wishes to exercise the right to an immediate review must submit a request to the QIO that has an agreement with the hospital. The request must be made no later than the day of discharge and may be in writing or by telephone. When the QIO receives the enrollee's request for an immediate review, they will notify GHI and the hospital that the enrollee has filed a request for an immediate review. The QIO will determine whether the hospital delivered valid notice based upon the requirements set forth above (signed, dated, delivery date, etc.). GHI must supply any requested information as soon as possible, but no later than noon of the day after the QIO notifies GHI that a request for an expedited determination has been received from the enrollee.
- In response to a request from GHI, the hospital must supply all information that the QIO needs to make its determination, including a copy of any and all notices provided.
 - The hospital must furnish this information as soon as possible, but no later than by close of business of the day GHI notifies the hospital of the request for information.
 - At the discretion of the QIO, the hospital must make the information available by phone or in writing (with a written record of any information not transmitted initially in writing).
- Medicare Advantage enrollees who make a timely request for an expedited QIO review of a discharge decision will continue to be protected from financial liability (other than applicable coinsurance and deductible) until noon of the day after the QIO issues its decision. Note that this only applies when the enrollee requests an immediate QIO review; there is no financial protection if the individual requests an expedited reconsideration. There is also no financial protection during this period if the hospital files the request for QIO review on behalf of the member.

- The hospital may not charge GHI (or the enrollee) if (i) the hospital (acting on behalf of the enrollee) filed the request for immediate QIO review; and (ii) the QIO upholds the non-coverage determination made by GHI.
- If coverage of the hospital admission was never approved by the GHI or the admission does not constitute emergency or urgently needed care, GHI is liable for the hospital costs only if it is determined on appeal that the hospital stay should have been covered by GHI.
- The QIO determination is binding upon the enrollee, physician, hospital, and GHI except in the following circumstances: (i) if the enrollee is still an inpatient in the hospital and is dissatisfied with the determination, he/she may request a reconsideration (financial protection will not apply); or (ii) if the enrollee is no longer an inpatient in the hospital and is dissatisfied with this determination, the enrollee may appeal to an ALJ, the MAC, or a federal court, as provided for under the Medicare Advantage regulations.

Facility Requirements (applicable to HHAs, SNFs and CORFs)

- The provider must provide a Notice of Medicare Non-Coverage (NOMNC) to the enrollee informing them that coverage will be terminated at least two days before the termination will occur. If the enrollee's services are expected to be fewer than two days in duration, the provider should notify the enrollee at the time of admission.
 - If services are not being provided in an institutional setting, the notice should be given to the enrollee no later than the next to last time services are furnished.
 - The NOMNC, which is a CMS standardized form, must be signed and dated by the enrollee indicating that they have received the notice and understand its contents. If an enrollee refuses to sign the notice, the provider may annotate the notice to indicate the refusal, and the date of refusal will be considered the date of receipt of the notice.
 - A copy of the signed and dated NOMNC must be provided to GHI's Utilization Review Department by fax (877 508-2643) within 24 hours of the time it is signed and dated.

Provider Balance Billing

- Provider may not bill, charge, or otherwise seek payment from a GHI Medicare Choice PPO enrollee for covered services (except as set forth below), including a failure by GHI Medicare Choice PPO to make payment to the Provider.
- Provider may collect copayments, coinsurance and deductibles as appropriate from enrollees. Provider shall not bill or seek payment from GHI Medicare Choice PPO enrollees for services rendered except for non-covered services so long as Provider has informed the enrollee of the charges prior to performing the service(s).
- Under no circumstance shall Provider bill or seek payment from a GHI Medicare Choice PPO enrollee for a service for which payment is denied or reduced as a result of a failure of the Provider to comply with utilization management requirements.
- Services that are not reasonable and necessary under Original Medicare program standards are not covered.
- Hospitals, which balance bill for non-covered services are obligated to provide prior written notice to GHI Medicare Choice PPO enrollees of their potential liability. Hospitals must provide:
 - A good faith estimate of the costs; and
 - The amount of any deductible, coinsurance, and copayment that may be due in addition to the balance billed amount.

For questions, including requests for pre-certification, please call 866-557-7300.

Billing and Claim Information

All claims must be submitted to GHI within the greater of 90 days from the date of service or the timeframe set forth within your participating provider contract with GHI.

Paper Claims Submission

All paper claims should be submitted to:

GHI Medicare Choice PPO
PO Box 2830
New York NY 10116-2830

GHI encourages you to submit claims on a HCFA 1500 claim form. Submission of HCFA 1500 claim forms helps GHI to process claims most efficiently. Please note that it is no longer necessary to provide the enrollee's Group or Category number when submitting your claims. GHI uses the subscriber's identification number for claims processing purposes. When entering the procedure and diagnosis codes on the claim form, use CPT-4 and ICD-9 codes.

Electronic Claims Submission

Electronic claims should be submitted in the same manner in which they are submitted for GHI commercial business.

GHI accepts claims via the Envoy-WebMD claims clearinghouse network, and PMS Vendors and Billing Services who have implemented the GHI/NSF specification for direct claim submissions. To ensure claims are accepted by GHI, please adhere to the following electronic claim guidelines:

- Use your GHI Payer ID# 13551. (required for submission via Envoy-WebMD)
- Enter your 7 digit GHI Provider Number into the appropriate claim data field of your practice management system.
- Verify the enrollee's name and date of birth for accuracy.
- Verify that the enrollee's address is entered correctly.
- Use a service address, not a billing address.

Electronic Claims Status Checking

For electronic claims submitted via the Envoy-WebMD claims clearinghouse network, GHI has implemented the Envoy-WebMD Claim Status Level 2 functionality.

Claims Payment

GHI will promptly adjudicate and pay claims for Medicare Advantage enrollees within the timeframe mandated under the Medicare Advantage regulations or as otherwise set forth in the provider contract. GHI shall pay all emergency and urgent care claims, as well as all out-of-area dialysis claims, as set forth under the regulations.

Note: For all covered services, GHI will reimburse the provider the agreed upon contract amount for the service(s). This amount shall be considered payment in full for the service(s). Providers may not balance bill enrollees for covered services.

Additional Requirements for the GHI Medicare Value Plan

Overview of the GHI Medicare PPO Value Plan (a dual eligible plan)

The GHI Medicare PPO Value Plan is a plan for individuals who are eligible for both Medicare and Medicaid. The plan is available to individuals residing in the five boroughs of New York City as well as in Rockland and Westchester Counties. The covered benefits for this plan are set forth in the section entitled Brief Benefit Descriptions.

CMS and the New York State Department of Health worked together to design this new plan; as a result, there are a few additional provider requirements. Currently, in order for a provider to be fully reimbursed for a dually eligible member, the provider must bill both GHI and New York State. Under this plan, providers do not have to bill New York State; providers can now expect payment in full from GHI. GHI will work with the State so no secondary billing is needed.

The benefits provided to individuals enrolled in the GHI Medicare PPO Value Plan are, for the most part, considered to be both Medicare and Medicaid benefits. That is, if an individual was enrolled solely in Medicare, they would still be entitled to receive most of these benefits (although they might be enrolled in a different plan with different cost sharing); the same can be said of Medicaid. In those instances where a benefit would have been covered by both Medicare and Medicaid, if an enrollee chooses to appeal the service, they may appeal using either the Medicare or Medicaid process; it is the enrollee's choice. However, if a benefit would have only been provided through Medicaid (transportation for example), a complaint may be filed through the Medicaid process in the event that the benefit is denied. The same is true for those services that are provided solely through Medicare (chiropractic for example). Enrollees will be notified of the available methods for appeal at the time that that a service is denied. The Medicare appeals procedures and timeframes are set forth in the section of this document entitled Enrollee Grievance and Appeal Procedures. The Medicaid complaint and appeals procedures and timeframes are set forth below.

In addition to the above, if a benefit would have only been provided through Medicaid, the timeframe for providing pre-certification (if applicable for the service) will be the Medicaid timeframe (set forth below). This is different than the timeframe set forth on page 15 of this Manual. The timeframes set forth on page 15 will continue to apply to those services that are considered to be both Medicare and Medicaid benefits; these include most inpatient and outpatient services.

Pre-Certification

Requests for pre-certification will be made in a timely fashion as set forth below.

Three work (business) days after we get the needed information, we will decide your case. We will let the enrollee or their designee and their provider know our decision by telephone and in writing.

If an enrollee has been getting care or treatment that should be continued, or if more services are needed, we will review the request and make our decision within one (1) business/workday after we get the information we need. We will let the enrollee or their designee and their provider know our decision by telephone and in writing.

If we are checking on care that was given in the past, we will decide within 30 calendar days. If we decide without speaking to the enrollee's provider, their provider may ask to speak to our Medical Director. Our Medical Director will talk to the enrollee's provider within one (1) business/workday.

If we do not approve a request, we will tell you and the enrollee the reason in writing and give the enrollee, their designee and their doctor appeal rights. Any options with respect to requesting an appeal from GHI or the State will be explained.

Complaints and Appeals

At the time that a service is denied, the enrollee will receive a denial notice. The notice will inform the enrollee that if he or she initially chooses to pursue the Medicare appeal procedures, they will be precluded from also complaining or appealing through Medicaid. However, if the enrollee initially chooses to pursue the Medicaid complaint and appeal procedures, the enrollee has up to 60 days from the day of GHI's notice of denial of coverage to pursue a Medicare appeal, regardless of the status of the Medicaid complaint or appeal. The Medicare appeals procedures and timeframes are set forth in the section of this document entitled Enrollee Grievance and Appeal Procedures. The Medicaid complaint procedures and timeframes are set forth below.

Timeframes for Complaint Resolution by GHI

GHI will provide written acknowledgment of the complaint including the name, address and telephone number of the individual or department handling the complaint within fifteen (15) business days of receipt of the complaint. Complaints will be resolved whenever a delay would significantly increase the risk to an enrollee's health within forty-eight (48) hours after receipt of all necessary information. Complaints will be resolved in the case of requests for referrals or determinations concerning benefits covered by the contractual benefit package within thirty (30) days after the receipt of all necessary information. All other complaints will be resolved within forty-five (45) days after the receipt of all necessary information.

Appeals

The enrollee or designee has no less than sixty (60) business days after receipt of the notice of the complaint determination to file a written appeal. Within fifteen (15) business days of receipt of the appeal, GHI will provide written acknowledgment of the appeal including the name, address and telephone number of the individual designated to respond to the appeal. GHI will indicate what additional information, if any, must be provided for GHI to render a decision. Appeals will be decided and notification provided to the enrollee no more than two (2) business days after the receipt of all necessary information when a delay would significantly increase the risk to an Enrollee's health; thirty (30) business days after the receipt of all necessary information in all other instances.

External Appeals and Fair Hearings

If, after going through the appeals process, the denial has not been overturned, the enrollee may be eligible to file an external appeal through the New York State Insurance Department by calling 1-800-400-8882. GHI will provide the enrollee with instructions on how to file an external appeal. In addition, after the initial adverse determination, the enrollee may proceed directly to external appeal if the enrollee and GHI jointly agree to waive the internal appeal process.

In some cases, an enrollee may also ask for a fair hearing from New York State. Enrollees may request a fair hearing by calling 1-800-342-3334, by faxing the request to 518-473-6735 or by sending their request by mail. Requests should be sent to the Fair Hearing Section, NYS Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201.

An enrollee may ask for both a fair hearing and an external appeal. If they request both, the decision of the fair hearing officer will be the one that counts.

Provider Requirements for the GHI PPO Value Plan

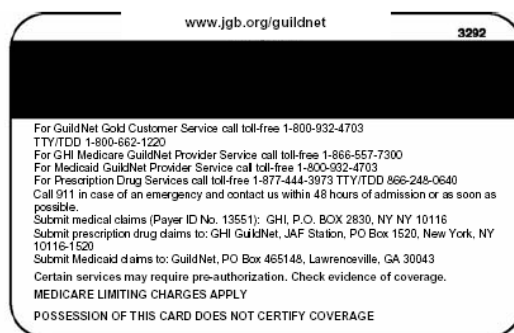
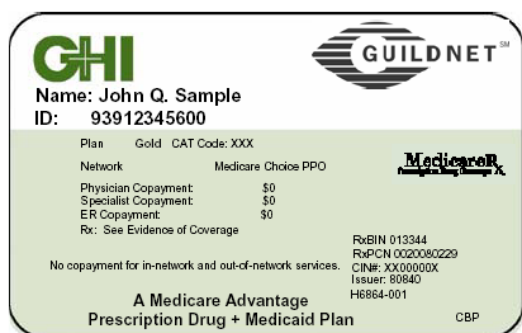
Providers will be required to comply with the following provisions when providing care to GHI Medicare PPO Value Plan enrollees:

- Providers must comply with professional medical standards of practice, GHI Medicare Choice PPO's practice guidelines, and all applicable federal, state, and local laws. These include but are not limited to, standards established by the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, and the U.S. Task Force on Preventive Services. These standards and laws indicate that family planning counseling is an integral part of primary and preventive care.
- Providers shall educate their members about the risk and prevention of sexually transmitted disease (STD), screen and treat members for STDs, report cases of STD to the Local Public Health Agency, and cooperate in contact investigation, in accordance with existing state and local laws and regulations.
- Providers shall report TB cases to the Local Public Health Agency.
- Providers shall refer those members determined to have HIV infection for clinically appropriate services. Providers shall report positive HIV test results and diagnoses and known contacts of such persons to the New York State Commissioner of Health. In New York City, these shall be reported to the New York City Commissioner of Health and Mental Hygiene.

For a copy of GHI's policy regarding HIV reporting or any other GHI policies related to HIV services, please contact our Case Management Department at 866-557-7300. GHI has adopted the New York State Department of Health AIDS Clinical Practice Guidelines. We encourage our providers to develop and implement policies to maintain the confidentiality of HIV information.

GuildNet

Beginning January 1, 2008, GHI will be performing certain services for GuildNet's Medicare Advantage members. You may see members in your office who have both the GHI logo and the GuildNet logo on their ID cards (a copy of the ID card is attached below). You should provide services to these members and submit the claims to GHI. Claims should be submitted to the address set forth on page 39 (see the section entitled GHI Medicare Choice PPO). Payment will be made in accordance with your contract with GHI for the Medicare Advantage line of business, as applicable. For prior authorization for a service for a GuildNet member, please call GHI's Customer Service Department at 1-866-557-7300.



Other GHI Medicare Choice PPO Information

- Enrollees must permanently reside in one of the following counties: New York, Bronx, Queens, Kings Richmond, Rockland, Westchester, Orange, Ulster, Putnam, Dutchess, Nassau or Suffolk in order to be eligible for GHI Medicare Choice PPO. In-network services may be obtained from GHI Medicare Choice PPO contracting providers in any of the above counties.
- Pursuant to the Federal Patient Self-Determination Act, hospitals, skilled nursing facilities, home health agencies, providers of home health care and hospices must maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the provider. Providers must document in an individual's medical record whether or not the individual has executed an advance directive. Providers must provide written information to such individuals concerning:
 - An individual's rights under state law to make decisions regarding medical care; and
 - The provider's (or facility's) written policies with regard to implementing such rights.
- GHI Medicare Choice PPO has signed an agreement with IPRO, a QIO, which conducts various independent quality review activities. GHI has agreed to work with IPRO to the extent necessary to perform these activities.
- GHI Medicare Choice PPO does not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in GHI Medicare Choice PPO on the basis of health status (ESRD excluded).
- No referrals are needed to access care by contracting or non-contracting providers. Some services may require pre-certification (please see the section regarding pre-certification for a complete list of these services) or may not be covered when rendered by an out-of-network provider.
- GHI Medicare Choice PPO enrollees have direct access to mammography and influenza vaccines as well as to women's specialists for routine and preventive services.
- No additional copayment beyond an office visit copayment, if applicable, may be charged for the influenza vaccine or the pneumococcal vaccine.
- GHI Medicare Choice PPO shall not prohibit or restrict any provider from disclosing to any enrollee, patient, or designated representative any information that the provider deems appropriate regarding a condition or a course of treatment with an enrollee including the availability of other therapies, tests, etc. GHI Medicare Choice PPO shall not prohibit or restrict a health care professional, acting within the lawful scope of practice, from advocating on behalf of an individual who is a patient and enrolled under GHI Medicare Choice PPO. Providers shall not be prohibited from discussing the risks, benefits, and consequences of treatment or non-treatment with the enrollee, patient or designated representative. Patients shall have the opportunity to refuse treatment and to express preferences about future treatment decisions.
- Services shall be provided in a culturally competent manner consistent with professionally recognized standards of care. Providers shall not discriminate based upon health status factors. Providers shall ensure that their office hours do not discriminate against Medicare enrollees relative to other members.

- GHI Medicare Choice PPO receives federal payments under the Medicare Advantage program. It complies with all laws and regulations applicable to entities receiving federal funds including, but not limited to, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act and the Rehabilitation Act of 1973.
- Provider shall comply with all applicable Medicare laws and regulations.
- Provider acknowledges that Medicare Advantage Plans are accountable to CMS for any functions and responsibilities set forth in the Medicare Advantage regulations. Any services delegated to another entity (provider, vendor, subcontractor, etc) shall be in accordance with the delegation requirements of the CMS regulations. Provider further acknowledges and agrees that pursuant to the Medicare Advantage regulations, the applicable Medicare Advantage Plan or its designee will monitor Provider's performance hereunder and, along with CMS, shall have the right to terminate the Agreement with the provider, vendor, etc. with respect to providing services to Medicare Advantage Covered Persons if Provider does not perform satisfactorily hereunder. Notwithstanding the above, any services or other activities performed by a provider, vendor, contractor, or subcontractor, etc. shall be consistent with the agreement between GHI and the provider, vendor, etc. and be consistent with GHI's contractual obligations with CMS.
- Provider agrees to audits and inspections by CMS and/or its designees, and to cooperate, assist and provide information as requested.
- All providers must maintain documents for at least ten (10) years or ten (10) years from the age of majority.
- Neither GHI, nor its subcontractors may perform any activities under the Medicare Part C contract at a location outside of the United States without the prior written approval of CMS.
- Provider shall maintain member health records in accordance with professional standards. Health records shall include at least the following: presenting complaints, diagnosis, treatment plans, information about allergies and adverse reactions, information about advance directives and past medical history. GHI shall have the right to audit Provider's medical records as they relate to GHI Medicare Choice PPO enrollees.
- Provider agrees to maintain enrollee health records in accordance with standards established by GHI Medicare Choice PPO, which shall take into account professional standards. Enrollee health records shall (a) identify the enrollee; (b) identify all providers who participate in the enrollee's care and information on services furnished by these providers; (c) a problem list, including significant illnesses and medical and psychological conditions for the enrollee; (d) presenting complaints, diagnoses, and treatment plans for the enrollee; (e) prescribed medications, including dosages and dates of initial or refill prescriptions for the enrollee; (f) information on allergies and adverse reactions (or a notation that the patient has no known allergies or history of adverse reactions); (g) information on advance directives; and (h) past medical history, physical examinations, necessary treatments, and possible risk factors for the enrollee relevant to the particular treatment. GHI Medicare Choice PPO shall monitor and assess enrollee records with respect to improving content, legibility, organization and completeness of the records.

- Provider agrees to safeguard beneficiary privacy and confidentiality and assure accuracy of beneficiary health records.
- Provider agrees to provide reasonable continuity of care as required by the Medicare Advantage regulations to beneficiaries eligible for such care.
- Upon Provider's termination from GHI Medicare Choice PPO, GHI shall do the following:
 - Make a good faith effort to notify affected enrollees of a provider's termination thirty (30) days prior to the effective date of the termination;
 - Provide the affected provider with a written notice explaining the reasons for the termination or suspension as well as the right to a notice and hearing as required by the Medicare Advantage rules and regulations.
- GHI Medicare Choice PPO does not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his/her license.
 - GHI does not discriminate against health care professionals in terms of participation, reimbursement or indemnification.
 - GHI does not discriminate against professionals who serve high-risk populations or who specialize in the treatment of costly conditions.
 - GHI will provide a written notice to the provider(s) of the reason it is declining to accept that provider or group of providers.

False Claims Act and Anti-Kickback Statute

Medicare Part D and the Deficit Reduction Act of 2005 require Part D Sponsors to provide education to contractors and agents, including providers, about pertinent laws related to fraud and abuse. In particular, this includes the False Claims Act and the Anti-Kickback Statute. Providers should ensure that their personnel are familiar with these requirements.

False Claims Act

Neither GHI nor its Employees or agents may submit false or fraudulent claims to the federal government. The federal False Claims Act makes it illegal to (1) knowingly present, or cause to be presented, a false or fraudulent claim for payment to the federal government; (2) knowingly make, use, or cause to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspire to defraud the Government by getting a false or fraudulent claim allowed or paid; (4) have possession, custody, or control of property or money used, or to be used, by the Government and, intending to defraud the Government or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt; (5) authorize to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true; (6) knowingly buy, or receive as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; (7) knowingly make, use, or cause to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government. "Knowingly" includes acting not only with actual knowledge but also with deliberate ignorance or reckless disregard of the facts.

The federal government may impose fines of up to \$10,000 per claim and treble damages (i.e., three times the amount of actual damages) for False Claims Act violations. GHI submits claims, as well as data and reports that are used for payment purposes, to the federal government under several health benefit programs, including Medicare Advantage and Medicare Part D. To avoid liability under the False Claims Act, it is critical that all employees, vendors and contractors ensure that these submissions are complete and accurate. The False Claims Act might be violated, for example, if an employee, vendor or contractor knowingly submits to the Centers of Medicare and Medicaid Services:

- Erroneous encounter data.
- Cost reports reflecting non-covered services or misallocated administrative expenses.
- Inaccurate or incomplete discount or rebate information.
- False enrollment reports.
- Misleading bid information.

In addition to the federal False Claims Act, New York State and New York City have each enacted a False Claims Act. Both are modeled upon the federal False Claims Act. Like the federal False Claims Act, those items set forth above are prohibited under both the New York State (NYS) and the New York City (NYC) False Claims Acts. An individual who knowingly violates these acts will be liable for three times the amount of damages which the NYS or NYC sustains because of the act or acts of an individual. In addition, a civil penalty of between \$6,000 and \$12,000 may be imposed for each violation of the NYS False Claims Act and a penalty of \$5,000 and \$15,000 may be imposed for each violation of the NYC False Claims Act. In each instance (under the NYS and NYC Acts), the court is authorized to reduce the fine to two times the amount of damages if the alleged violator (i) provided full

information to the Commissioner of Investigation, or the investigating agency or official(s), within 30 days of receiving the information; (ii) cooperated with any subsequent government investigation; and (iii) at the time the individual provided information about the violation, no action had commenced with respect to the violation and the individual did not have any actual knowledge that an investigation was underway. To impose liability under each Act, it is not necessary for the court to find a specific intent to defraud. Like the federal False Claims Act, simply presenting a false claim is a violation even if the claim has not paid and no money has been expended. Also, like the federal False Claims Act, both the NYS and NYC False Claims Acts encourages whistleblowers to come forward by rewarding them with a percentage of the recovery. It should be noted that the NYS State False Claims Act does not apply to claims, records, or statements made under the tax law.

Whistleblower Protections under the False Claims Act

The federal False Claims Act provides that private parties may bring an action on behalf of the United States. These private parties are known as “*qui tam relators*”. The federal False Claims Act provides protection to *qui tam relators* who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the federal False Claims Act. Remedies include reinstatement with comparable seniority that the individual would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys’ fees. Under New York’s Labor Law, employers are prevented from taking any retaliatory actions (i.e. discharge, suspension or demotion of an employee, or other adverse employment action taken against an employee in the terms and conditions of employment) against an employee discloses, or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer that is in violation of law, rule or regulation which violation creates and presents a substantial and specific danger to the public health or safety, or which constitutes health care fraud. An employee who has been the subject of a retaliatory personnel action may institute a civil action for relief within one year after the alleged retaliatory personnel action was taken.

Anti-kickback Statute

The Anti-Kickback Statute provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable (or reimbursable) under the Medicare or other Federal health care programs (including Medicaid and state health care programs). For purposes of the anti-kickback statute, “remuneration” includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind. A violation of the Anti-Kickback Statute is a felony punishable by up to five years imprisonment, a fine of not more than \$25,000 or both. Individuals or entities may be prohibited from participating in federal health care programs.

GHI participates in a number of federal health care programs, including Medicare Advantage, Medicare Part D, Medicaid Managed Care, Family Health Plus and Child Health Plus . The Anti-Kickback Statute applies to all transactions relating to or involving these lines of business. Examples of the types of activity that might violate the Anti-Kickback Statute include, but are not limited to the following:

- Compensating agents or brokers based on the claims experience of the individuals they enroll.

- Receiving “rebates” from Vendors in advance of the implementation of a contract that are not reflected as rebates or discounts in the contract (sometimes referred to as “rebates”) as an inducement for doing business with the Vendor.
- Accepting payments (other than legitimate discounts or rebates) from pharmaceutical manufacturers as an inducement for including the manufacturer’s drugs on GHI’s formulary.
- Accepting payments (other than legitimate discounts) from health care providers as an inducement for including the provider in GHI’s network.

Notwithstanding the above, there are some practices which fall within the safe harbor regulations. The safe harbor regulations specify various payment and business arrangements that, although potentially capable of inducing referrals of business reimbursable under the Federal health care programs, would not be treated as criminal offenses under the Anti-Kickback Statute. In particular, the safe harbor regulations address investments in small health care joint ventures, space rental, equipment rental, personal services and management contracts, sale of retiring physicians' practices to other physicians, discounts, employee compensation and certain shared-risk arrangements. To be protected by a safe harbor, an arrangement must fit squarely in the safe harbor. However, failure to comply with a safe harbor provision does not mean that an arrangement is per se illegal.

Any violation or possible violation of the Anti-Kickback Statute should be reported to GHI’s Compliance and Privacy Office. To the extent possible, GHI will maintain the confidentiality of the reporting individual or entity during the investigation. Individuals are required to cooperate in any internal or external investigations of possible violations.

SECTION II

MEDICARE PART D
PHARMACY BENEFITS

FOR

GHI MEDICARE CHOICE PPO

&

GHI MEDICARE PRESCRIPTION DRUG
PLAN

Overview

This section provides an overview of GHI's Medicare Part D plans as well as a brief description of the appeals process. GHI offers two (2) Medicare Part D Prescription Drug Plans.

GHI Medicare Prescription Drug Plan

GHI offers the GHI Medicare Prescription Drug Plan to Medicare enrollees in New York State who do not have prescription drug coverage through a Medicare Advantage Prescription Drug Plan. This is a free-standing Medicare Part D plan available to Medicare beneficiaries. For more information about the prescription drug benefits covered by this Plan, please go to <http://www.ghi.com/Default.aspx?Page=440>

For the Medicare Prescription Drug Plan formulary, please go to:
<http://www.ghi.com/default.aspx?Page=459>

GHI Medicare Choice PPO Plan

GHI also offers the GHI Medicare Choice PPO Plan. This is a Medicare Advantage Prescription Drug Plan. This plan provides medical, hospital and pharmacy coverage to GHI's Medicare Advantage enrollees. Please see Section I for information about the medical and hospital benefits. For complete benefit information including the prescription drug benefits, please go to <http://www.ghi.com/default.aspx?Page=439>.

For the GHI Medicare Choice PPO formulary, please go to:
<http://www.ghi.com/default.aspx?Page=453>

Customer Service for GHI's Medicare Part D plans

GHI Medicare Choice PPO

Phone: 877-444-7097 for retail services; for mail order services, call 1-800-820-9726

GHI Medicare Prescription Drug Plan (freestanding drug program)

Phone: 800-585-5786

ID Card

Enrollees must use their GHI Prescription Drug Card to be eligible for Medicare Part D benefits through the GHI Medicare Prescription Drug Plan. Below is a sample card to show you what the ID card looks like. For a copy of the GHI Medicare Choice PPO ID card, please see page 7.

 EXPRESS SCRIPTS Prescription Drug Plan RxBIN 003858 RxPCN A4 RxGrp Issuer 80840 ID Name   CMS - S5966 001	<p><u>Visit www.GHI.com</u></p> Member Service: 1-800-585-5786 Pharmacy Help Desk: 1-800-824-0898 TTY/TDD: 1-800-899-2114
	Submit Pharmacy claims to: Express Scripts, Inc. PO Box 66583 St. Louis, MO 63166

Enrollee Grievance and Appeal Procedures

Grievances

A grievance is any complaint other than one that involves a coverage determination. An enrollee may file a grievance if they have any type of problem with us or one of our network pharmacies that does not relate to coverage for a prescription drug. For example, an enrollee would file a grievance if they have a problem with things such as waiting times when they fill a prescription, the way a network pharmacist or others behave, being able to reach someone by phone or get the information they need, or the cleanliness or condition of a network pharmacy.

A coverage determination is a decision:

- not to provide or pay for a Part D drug because the drug is not medically necessary, the drug is obtained from an out-of-network pharmacy, or the drug is not on GHI's formulary;
- about an exceptions request from the tiering structure;
- about an exceptions request for a non-formulary Part D drug;
- about the amount of cost sharing for a drug.

Failure to make a decision about one of the above in a timely manner when a delay would adversely affect the health of the enrollee is also considered a coverage determination.

An enrollee or their representative must file a grievance no later than 60 days after the event or incident that precipitated the grievance. Grievances may be filed orally or in writing. All grievances submitted in writing will be responded to in writing. Grievances submitted orally may be responded to either orally or in writing unless the enrollee requests a written response. All grievances related to quality of care, regardless of how the grievance is filed, will be responded to in writing. GHI will notify the enrollee of its decision expeditiously based upon the individual's health status, but no later than 30 days after the date GHI receives the grievance. This time period may be extended by up to 14 days if the enrollee requests such an extension or GHI can justify the need. If GHI extends the timeframe, the enrollee will be immediately notified. Expedited grievances will be responded to within 24 hours. All responses will include a description of how to file a written complaint with IPRO.

Phone Numbers and Addresses for Grievances:

For GHI Medicare Prescription Drug Plan (freestanding drug program):

Express Scripts, Attn: Director of Grievances, PO Box 66517, Saint Louis, MO 63166-6517; phone by calling 1-866-533-8512; or fax to 1-800-305-1686.

For GHI Medicare Choice PPO:

P.O. Box 4296, Kingston, NY 12402

Coverage Determinations (see definition above)

Coverage determinations may be requested by a GHI Medicare Choice PPO enrollee, a GHI Medicare Prescription Drug Plan member or their authorized representative. An authorized representative may be a friend, relative or doctor. If an enrollee would like to name an authorized representative, both the enrollee and the authorized representative must sign and date a statement giving the representative permission to act on behalf of the enrollee. Upon request, GHI will provide a form for appointing a representative.

For requests for standard coverage determinations, GHI will notify the enrollee (and prescribing physician as appropriate) of the determination as expeditiously as possible but no later than 72 hours after receipt of the request for the coverage determination, or for an exceptions request, the physician's supporting statement (if one is provided).

For requests for expedited coverage determinations, written notice of the determination will be provided by GHI to the enrollee (and prescribing physician as appropriate) of the determination as expeditiously as possible but no later than 3 business days of the date of the request, (or for an exceptions request, no later than 3 business days after receipt of the physician's supporting statement (if one is provided)). If the request is granted, GHI will provide notice to the enrollee (and prescribing physician as appropriate) within 24 hours of receiving the request (or for an exceptions request in which a non-formulary drug is requested) or within 24 hours of receiving the physician's supporting statement. If the expedited request is denied, GHI will make the determination within 72 hours of request of physician's statement and give prompt oral notice of the denial which explains (1) GHI's standard process; (2) informs the enrollee of the right to file expedited grievance; (3) informs the enrollee of the right to resubmit the request with a physician's supporting documentation; and (4) provides instructions about GHI's grievance process and its timeframes. Note that expedited coverage determinations are not permitted for payment requests.

Phone Numbers and Addresses for Coverage Determinations:

For GHI Medicare Prescription Drug Plan (freestanding drug program):
Express Scripts, Inc., Attention: Prior Authorization Part D, Mail Route BL0345, 6625 West 78th St., Bloomington, MN 55439. or fax it to 1-877-837-9522.

For GHI Medicare Choice PPO:
Phone 1-877-444-7097, 1520 JAF Station, New York, NY 10116-1520

Exceptions Process

Providers may request an exception in the following instances:

- If GHI's formulary tiering structure has changed mid-year and an enrollee is adversely affected by the change; OR
- To request coverage of a non-formulary drug.

In order for an exception to be evaluated, the provider must provide supporting documentation that the formulary drug would not be as effective (or has been ineffective) and/or would have adverse effects. Note that certain high cost drugs may not be eligible for the exceptions process. All drugs approved under the exceptions process must meet the definition of a Part D drug. In addition, a provider's statement does not necessarily result in an automatic favorable determination.

Enrollees will be notified of changes to the formulary (including cost sharing changes) as they occur. For changes to the GHI Medicare Prescription Drug Plan formulary, please go to: <http://www.ghi.com/default.aspx?Page=459>

For changes to the GHI Medicare Choice PPO formulary, please go to: <http://www.ghi.com/default.aspx?Page=453>

Phone Numbers and Addresses for Exceptions Process:

For GHI Medicare Prescription Drug Plan (freestanding drug program):
GHI Medicare Prescription Drug Plan (freestanding drug program):
Express Scripts, Inc., Attention: Prior Authorization Part D, Mail Route BL0345, 6625 West
78th St., Bloomington, MN 55439. or fax it to 1-877-837-9522.

For GHI Medicare Choice PPO:
Pharmacy Services, PO Box 1520 JAF Station, New York, NY 10116-1520
877-444-7097

Re-determinations

An enrollee who has received an adverse coverage determination may request that it be re-determined. For standard re-determinations, an enrollee or their representative must make written request within 60 calendar days of the notice of the coverage determination. This may be extended if the enrollee shows good cause (this must be in writing and give the reason that it was not filed timely). For expedited re-determinations, an enrollee or their prescribing physician may make an oral or written request for coverage. GHI will promptly decide whether to expedite the request.

For a standard re-determination, if the request is granted, GHI will make the determination and give notice within 7 calendar days of receiving the request. If the request is granted in whole or in part, GHI will notify the enrollee in writing within 7 calendar days of receiving request for re-determination. If the request is for payment, payment will be effectuated within 7 calendar days of receiving request. Note that expedited re-determinations are not permitted for payment requests.

For an expedited re-determination, if the request is granted, GHI will make the determination and give notice within 72 hours of receiving the request. If additional medical information is needed, the enrollee and prescribing physician will be notified immediately. If the request for an expedited re-determination is denied, GHI will make the determination within 7 days of the request and give prompt oral notice of the denial. The denial will (1) explain the standard process; (2) inform the enrollee of the right to file an expedited grievance; (3) inform the enrollee of the right to resubmit the request with the physician's supporting documentation; and (4) provide instructions about GHI's grievance process and its timeframes.

Phone Numbers and Addresses for Re-determinations:

For GHI Medicare Prescription Drug Plan (freestanding drug program):
Express Scripts, Inc., Attention: Prior Authorization Part D, Mail Route BL0345, 6625 West
78th St., Bloomington, MN 55439.

For GHI Medicare Choice PPO:
P.O. Box 4296, Kingston, NY 12402

Contact Information

GHI Medicare Choice PPO

For general questions, including member services, provider relations, complaints and requests for pre-certification of medical and hospital services, please call Customer Service at **866-557-7300**.

Pharmacy Customer Service (including coverage determinations):

GHI Medicare Choice PPO 877-444-7097;

For retail services for GHI Medicare Choice PPO members (including GuildNet), call 1-877-444-7097; for mail order services through Medco, call 1-800-820-9726

Claims for GHI Medicare Choice PPO for **medical and hospital benefits** should be submitted to:

GHI Medicare Choice PPO
P.O. Box 2830
New York, New York 10116-2830

Claims for GHI Medicare Choice PPO **prescription drug benefits** should be submitted to:

Pharmacy Services
PO Box 1520 JAF Station
New York, NY 10116-1520

All other correspondence for GHI Medicare Choice PPO should be submitted to:

GHI Medicare Choice PPO
P.O. Box 4296
Kingston, New York 12402-4296

GHI Medicare Prescription Drug Plan

For general questions, including member services, provider relations, complaints and requests for pre-certification of medical and hospital services, please call Customer Service at **866-557-7300**.

For pre-certification of prescription drugs, please call Express Scripts Inc. at **800-417-8164**.

Medicare Part D Customer Service:

GHI Medicare Prescription Drug Plan (freestanding drug program) 800 585-5786

Claims for **Medicare Part D prescription drug benefits** for GHI Medicare Prescription Drug Plan (freestanding drug plan) and GHI Medicare Choice PPO should be submitted to:

Express Scripts Inc.
P.O. Box 66773
St. Louis, Missouri 63166-6773
ATTN: Claims Department

All other correspondence for GHI Medicare Prescription Drug Plan should be submitted to:

GHI
Pharmacy Operations
441 Ninth Avenue
New York, New York 10001



GHI Medicare Choice PPO
P.O. Box 4296
Kingston, NY 12402-4296
Call Toll-Free 1-866-557-7300
Or TDD/TTY 1-877-208-7920 for hearing impaired.

