First MEDICAL HEALTH PLAN, INC.

IMC SALUD
RED DE PROVEEDORES
INTERNATIONAL MEDICAL CARD

PROVIDERS GUIDELINES 2021

CONTENTS

1 INTRODUCTION

Congratulations! And welcome to First Medical Health Plan, Inc. (FMHP) Provider Network for Vital, the Puerto Rico Government Health Plan. As a FMHP Provider you are an important part of our healthcare services delivery team and we thank you for joining us as we pursue our commitment to improving the health and well-being of our Enrollees.

FMHP has developed these Provider Guidelines (Guidelines) to be distributed to all Network Providers, summarizing the Vital Plan Program. The Guidelines include recommendations to be used as a resource and reference guide to comply with duties and obligations pursuant to the Vital Plan, and your contract with FMHP. You may use it to get information related to the responsibility to verify Eligibility, provide Covered Services, ID Cards, Preferential Turns, FMHP's Care Management Policies and Procedures, Credentialing and Recredentialing processes, Billing and Claim procedures, Complaint, Grievance, and Appeal procedures, HIPAA requirements, Fraud, Waste and Abuse compliance, Quality Improvement Programs, among others. The Guidelines have been developed in accordance with the following 42 CFR 438.236 requirements and comply with the Puerto Rico Health Insurance Administration (PRHIA):

- They are based on valid and reliable clinical evidence or a consensus of Providers in the field;
- They consider the needs of the Enrollees and are adopted in consultation with Providers; and
- They are reviewed and updated periodically, as appropriate.

Please share this information with your office staff to assist us in providing quality healthcare services. Remember, this document does not replace the signed Provider Contract that you currently have with FMHP. If you have any questions related to the information provided in the Guidelines or need additional information, please feel free to contact our Provider Services

Center toll free number at 1-844-347-7802. Our office hours are Monday through Friday from 7:00 a.m. to 7:00 p.m. You can also access our webpage at www.firstmedicalvital.com.

During the COVID-19 Pandemic, we continue with our commitment to offer quality health services to our enrollees through our Provider Network for Vital. We are following the Centers for Disease Control and Prevention guidelines, and rigorous safety measures, including social distancing, for the safety of our Providers, Enrollees and Employees.

We encourage our Provider Network to continue implementing safety measures, which may include Telehealth/ telemedicine services for Enrollees as well as Provider services such as our Provider Call Center and our Credentialing Department. FMHP provided the contact information for these departments further below.

2 OVERVIEW

The Puerto Rico Health Insurance Administration (PRHIA), a public corporation of the Government of Puerto Rico was created by Act. 72 of September 7, 1993 and was amended by Act. 1 of January 8, 1994, to negotiate and contract Managed Care Organizations (MCOs) to provide services to a medically indigent mixed population including not only the Medicaid and CHIP populations, but also other eligible individuals who qualify. The PRHIA will also monitor and evaluate services provided to ensure compliance, quality, and cost effectiveness.

Since 2015, First Medical Health Plan, Inc. (FMHP), a local company with forty-three (43) years of experience in the healthcare industry in Puerto Rico, is an official agency for the Government Health Plan provision of health care services. Through our Provider Network, Enrollees receive appropriate and timely access to Covered Services, including facilitating and promoting access to preventive care. FMHP developed programs to support and collaborate with smaller primary care practices to provide coordinated health and social services to complex-needs patients.

FMHP also works in innovative ways with Primary Medical Groups (PMGs) with critical masses of patients, suitable to support FMHP with specific roles in the Care Management process. We base these Care Management strategies on published and outcome-based activities which include administration of medical assessments, care planning, facilitation of access to necessary medical services, care coordination, medical evaluation and advocacy for options and services, including addressing socioeconomic determinants, while promoting enrollee quality and cost-effective outcomes. The success of our integrated model is based on strong communication ties with FMHP staff and health care providers.

2.1 Customer Service Offices

FMHP has nineteen (19) Customer Service Offices to assure timely access to healthcare services to our Vital Plan Enrollees. We strive to deliver high quality service for the Enrollees and Providers and to promote a culture of compliance that harmonizes with our day-to-day business operations. Our Customer Service Representatives will help you achieve a strong culture of compliance, providing assistance on regulatory matters and ensuring you are equipped to comply with the healthcare industry's regulatory regime.

Customer Service Offices

FMHP pursues a positive business relationship with our Network Providers that serve the Vital Plan Enrollees. These Guidelines provide information about how we work together to:

- Ensure appropriate and timely access to Covered Services, including facilitating and promoting access to preventive care;
- Provide Island-wide coverage and access to Covered Services;
- Increase quality and continuity of care;
- Decrease inappropriate use of health care resources, for example, emergency room visits for non-emergency situations;
- Achieve and maintain cost-effectiveness and efficiency;
- Promote provider-base care coordination models that address social determinants of health.
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- Establish cost saving initiatives, programs, and value-based payment models to address High Cost-High Needs (HCHN) Program.
- Encourage provider groups to leverage island-based best practices and maintain existing Enrollee-provider relationships.

2.2 CONTACT INFORMATION

Please register on FMHP's Provider Web Portal at www.firstmedicalvital.com. By registering, you can access online member eligibility, claims status, claims submissions, authorization status, and authorization submissions.

Providers Contact Center

FMHP has a Provider Contact Center to assist you with questions or concerns you may have while providing services to the Vital Plan Enrollees, such as; (i) eligibility/identification and

appropriate and timely responses regarding requests for prior-authorizations; (ii) Changes in Provider information, including group or clinic name, address, telephone number, Medicare number or Federal Tax ID number; (iii) Your effective date and anticipated date for accepting new Enrollees; (iv) Credentialing and Recredentialing process; (v) Claims- billing and claims submissions, payments, reimbursement, fee schedules, coding; (vi) Grievances and Appeals process; (vii) FMHP policies and procedures, among others. Contact Center Representatives are available to assist Providers from 7:00 a.m. to 7:00 p.m. Monday through Friday, excluding Puerto Rico holidays.

Department	Phone Number	Fax Number	Address
Provider Service Call Center	1-844-347-7802	787-626-2207	International Medical Card PO Box 144090 Arecibo, PR 00614-4090
Credentialing Department	787-878-6909 Ext. 7530, 7529	787-650-2730 787-300-3920	

FMHP has an automated system available during non-business hours. You can leave us a message. We will return your messages on the next Business Day.

Enrollees Service Line

FMHP's Enrollees Service Line handles all telephone and written inquiries regarding benefits, eligibility, ID Card, selecting or changing Primary Medical Groups (PMG) or Primary Care Providers (PCP), Prior-Authorization status and Members complaints, among others. Contact Center Representatives are available to assist Enrollees from 7:00 a.m. to 7:00 p.m. Monday through Friday, excluding holidays. The FMHP's Medical Advice Line is available 24-hours-a-day, seven-days-a-week, to orient Enrollees on health matters.

Department	Phone Number	TTY/TDD
Customer Service Call Center	1-844-347-7800	1-844-347-7805
Medical Advice Line	1-844-347-7801	1-844-347-7804

Medical Affairs Service Center

The Medical Affairs Service Center will assist you on patient admissions, Prior Authorization requests, among other health issues related to our Vital Plan Enrollees. The Medical Affair Division performs Case Management for beneficiaries who will benefit from Case Management services.

Department	Phone Number
Prior-Authorization	Fax: 787-626-2102, 787-626-2207
Patient Admissions (InHealth Hospital Reviewers) inpatient@inhealth-pr.com	787-622-3000, Ext. 8334, 8369, 8368, 8372, 8371, 8364, 8374, 8304, 8295, 8367 Fax: 787-999-1744
Special Registry	787-626-2110
Obstetrics	787-626-2111
Discharge Planning	787-626-2113
Pharmacy PA	1-844-347-7807

Claims Contact Service

FMHP requires Providers to submit claims electronically through a clearinghouse or FMHP's secure Provider Portal. To verify the status of your claim, please use the Provider Portal or call our Provider Contact Center Representatives at the numbers listed above. Also, you can submit your claims to FMHP Claims Department at the following address:

Claims Submission by Mail:
First Medical Health Plan, Inc. Claims Department Urb. Villa Caparra, Marginal Buchanan #530, Guaynabo, PR 00966

3 SERVICE MODEL

3.1 FMHP'S SERVICE MODEL

FMHP's Integrated Service Model provides to Vital Plan Enrollees' timely access to medically necessary physical and mental health services for (i) the prevention, diagnosis, and treatment of health impairments; (ii) the ability to achieve age-appropriate growth and development; or (iii) the ability to attain, maintain, or regain functional capacity. FMHP's Integrated Service Model is focused on ensuring the efficient utilization of the funds assigned to the Vital Plan, through integrated and coordinated services.

FMHP's Service Model offers flexibility to Enrollees to access preventive care services and treatment through the PMGs and our Preferred Provider Network (PPN). At the time of enrollment, the Enrollee must select a PMG and a PCP. Services received through the PMG and/or PPN will not require a referral or a co-payment. In addition, specialists, and subspecialists within the PPN will be able to issue prescriptions without the need of a countersignature from the PCP. Enrollees will have the right to select the pharmacy of their preference if it is a Vital Plan participating pharmacy. Enrollees that choose to access health care services outside of the PPN are subject to referrals from the PCP and the applicable co-payments. Therefore, prescriptions for medications issued from these Providers require a countersignature from their PCP.

The Integrated Model of Service provides both physical and behavioral health services to ensure optimal detection, prevention, and treatment of physical and behavioral health illness. The model requires the placement of a psychologist or other type of Behavioral Health Provider as part of the PMG. The Behavioral Health Provider shall be available to provide assessment, screening, consultation, and Behavioral Health Services to Enrollees. This is known as Co-Location. On the other side, a Behavioral Health Facility shall provide adequate space and resources for a PCP to provide care and consultations in a confidential setting. This is known as

Reverse Co-location. FMHP's Quality Assessment and Performance Improvement Program will effectively monitor the program's elements.

Our Care Management Program emphasize prevention, continuity of care, and coordination of care, including between settings of care and appropriate discharge planning for short and long-term hospital and institutional stays. To comply with our Service Model, PMGs must offer services from Monday to Saturday during regular hours from 8:00 a.m. to 6:00 p.m. In addition, each PMG must have adequate staff to offer urgent medical services during extended hours from Monday through Friday between 6:00 p.m. and 9:00 p.m. When Enrollees present an emergency or urgent situation, they may visit any Emergency Room or Diagnosis and Treatment Center (*CDT*, by its Spanish acronym) in Puerto Rico. Emergency Room services are available seven (7) days a week, twenty-four (24) hours a day. All prescriptions issued at an Emergency Room or CDT, because of the treatment received in any of these facilities, do not require the countersignature of the Enrollees PCP. The Pharmacy will dispense enough medication to cover the treatment until the next day. In some cases, emergency services may be covered outside of Puerto Rico.

FMHP has contracted the PMGs which include a Preferred Provider Network (PPN) to guarantee access to medical-hospital services. Through this network, Enrollees will be able to receive services without the need of referrals. Physicians in these PMGs will be responsible for providing health care services under the coordinated care model. Using a PPN, the PMG reduces the delays for medically needed services, which consequently improves the service provided and Enrollee satisfaction, among others. PMGs and PPN have a professional agreement with a preferred network of providers, which consist of, but is not limited to:

- Clinical Laboratories and Radiology
- Specialists and Subspecialists
- Hospitals and Emergency Rooms

- Independent Urgency Centers
- Others

Some benefits under the Vital Plan include the administrative functions of Care Management and a Wellness Plan, which are intended to coordinate care for Enrollees with certain health care conditions specified in the High Cost-High Needs (HCHN) Program, or other Enrollees with an identified need for additional coordination. The HCHN Program is a coordinated model of care focused on conditions that may require intensive use of health care services, always monitor by a dedicated team of Providers to ensure compliance with care plan, and a specialized care management services. These Enrollees will be registered under this Special Coverage and will have direct access to Specialists, Subspecialists, and other Providers within and outside the PPN. Including services provided during extended hours as required by the Enrollees' medical conditions, to ensure integration of Physical and Behavioral Health needs, without the need of a referral and a countersignature from their PCP for services related to their registered condition. Outcomes for Enrollees with select conditions in the HCHN Program will be subject to performance metrics.

4 ENROLLMENT AND ELIGIBILITY

4.1 ELIGIBILITY

4.1.1 ELIGIBILITY PROCESS

The Puerto Rico Medicaid Office is responsible for evaluating and determining if a person is eligible for the Medicaid Program based on specific eligibility requirements. FMHP does not discriminate against individuals eligible to enroll and will not use any policy or practice that has the effect of discriminating based on religion, race, color, national origin, sex, sexual orientation, gender identity, or disability, preexisting condition, or need for health care services. In general terms, eligible individuals are:

- American Citizens or Puerto Rico residents identified and certified by the Department, as provided by Section 1 of Article VI of Act No. 72 of September 7, 1993.
- People with low or no income.
- Federal Medicaid Program population, over 65 years of age, blind, disabled, and pregnant women.
- Children under CHIP Program.
- Government employees, retirees, and their dependents whose payroll is processed by the Treasury Department.
- Members of the Police Department of Puerto Rico, their widows/widowers and children that survive them.
- Veterans.
- Children under state custody through ADFAN.
- Survivors of domestic violence through the Women's Advocate.

Once Medicaid certifies that an individual is eligible, they will give them an MA-10 Form entitled "Notice of Action Taken on Application and/or Re-Assessment" which certifies Medicaid eligibility. The MA-10 Form specifies the dates considered as the eligibility period of enrollment. Once the Enrollee is eligible for the Vital Plan benefits, they may access covered services using the MA-10 Form. FMHP will issue via regular mail an Identification Card within five (5) business days of sending the Notice of Enrollment to the new Enrollee.

4.1.2 Enrollment Process

FMHP will follow the process described below to complete the Enrollment Process for an eligible individual:

- Receive and process the Eligibility File from PRHIA.

- Auto-Assign, when applicable, a PMG and a PCP.
- Auto enroll all Enrollees in the FMHP's Membership System.
- Issue and mail the ID Card to the Enrollee.
- If the Enrollee chooses to pick up the enrollment package, FMHP will provide it (including the ID Card) at an identified location.
- The Enrollee will have ninety (90) days to request a change in PMG and PCP. If the Enrollee opts to change the PCP, a new ID Card will be issued and mailed to him/her.
- A "Welcome Package" will be mailed to Enrollees no later than five (5) business days upon the completion of the Auto Enrollment process. Information included in the package consists of:
    - Notice of Enrollment;
    - ID Card;
    - Enrollee Handbook; and
    - Provider Directory
        - The Enrollee Handbook and Provider Directory are electronically available through www.firstmedicalvital.com. The Enrollee may also request a paper or electronic copy by calling the Customer Service Department or visiting our Service Offices around the Island.

4.1.3 Disenrollment Process

Once FMHP receives notification that an Enrollee is no longer eligible, the disenrollment process is initiated, and will be effective on the date specified by PRHIA. Within the next five (5) business days, FMHP will notify the Enrollee in person or by mail of the effective termination date. FMHP will encourage Enrollees to maintain their benefit coverage and avoid termination by complying with the Medicaid Program local office rules and regulations regarding the

certification process. Enrollees will receive notifications thirty (30), sixty (60), and ninety (90) days prior to the termination of coverage. With these notifications FMHP will initiate an Enrollee orientation process to encourage the completion of the recertification process and avoid benefit coverage termination.

In addition, FMHP will notify all enrollees, at least on an annual basis, of their disenrollment rights. This notification will clearly explain the process for exercising their disenrollment rights, as well as provide enrollees with all the available alternatives based on their specific circumstance.

4.1.4 Enrollee Identification Card

All Enrollees are issued an Identification Card. This ID Card must be used to receive covered services. Below you will find a sample of the FMHP Enrollee ID Card that must be presented by the Enrollee at the time of service.

Unique Region

Virtual Region

Please Note:

- This Enrollee ID Card does not guarantee eligibility. It is for identification purposes only.
- Each provider has a duty to verify eligibility. Eligibility must be verified prior to each visit through the Provider Portal. Failure to verify eligibility may result in non-payment of claims.

- If the Enrollee does not have an ID Card, you must call the Customer Service Department to validate the eligibility.
- Members may have a copy of their MA-10 Certification Form. This form may be used as proof of Membership until an Enrollee ID Card is issued and mailed.

4.2 Medicare Coverage

Dual Eligible Beneficiaries enrolled in the Vital Plan are eligible (with limitations) for Covered Services, with the addition of some coverage of Medicare cost sharing.

4.2.1 Dual Eligible Beneficiaries

Dual Eligible Beneficiaries Who Receive Medicare Part A only

FMHP will provide regular Vital Plan coverage excluding those services covered under Medicare Part A (hospitalization). However, FMHP shall cover hospitalization services after the Medicare Part A coverage limit has been reached. Any cost sharing payment responsibility will be assigned according to the payment schedule determined by Medicaid. FMHP shall not cover the Medicare Part A premium or Deductible.

Dual Eligible Beneficiaries Who Receive Medicare Part A and Part B

FMHP will provide regular Vital Plan coverage excluding those services covered under Medicare Part A and Part B. However, FMHP shall cover hospitalization services after the Medicare Part A coverage limit has been reached. Any cost sharing payment responsibility will be assigned according to the payment schedule determined by Medicaid. FMHP will cover the Medicare Part B deductibles and coinsurance. FMHP will not cover the Medicare Part A premium or Deductible.

Dual eligible Members enrolled in a Medicare Part C and/or Platino Plan are not eligible for services under Vital Plan.

4.2.2 Cost Sharing

Enrollees shall pay cost sharing amounts, as applicable based on the Enrollee's eligibility category which is specified in the Enrollee ID Card.

Medicaid and CHIP Enrollees shall have no cost sharing responsibilities for services provided within FMHP's Preferred Provider Network (PPN). Under no circumstances, will co-payments be charged for Medicaid and CHIP eligible children under twenty-one (21) years of age.

5 Vital Plan Benefits

Through Vital Plan's Provider Network, FMHP will provide Basic and Behavioral Health care services to all Enrollees with the primary goal of improving health status or, in instances where the Enrollee's health is not amenable to improvement, maintaining the Enrollee's current health status by implementing measures to prevent any further deterioration of his or her health status. The following Benefit Chart includes the basic coverage services and the eligible groups for the basic benefit coverage under Vital Plan.

5.1 Benefit Chart

Basic Coverage	Vital Plan Eligible Groups Covered
Preventive Services	All
Diagnostic Test Services	All
Outpatient Rehabilitation Services	All
Medical and Surgical Services	All
Emergency Transportation Services	All (Services outside of Puerto Rico are only available for Medicaid and CHIP Eligible).
Maternity and Pre-Natal Services	All
Emergency Services	All (Services outside of Puerto Rico are only available for Medicaid and CHIP Eligible).
Hospitalization Services	All

Behavioral Health Services	All
Pharmacy Services	All (Note: Claims processing and adjudication services provided by PBM are not covered under the PRHIA Contract).

5.2 EXCLUSIONS FROM BASIC COVERAGE [1]

The following services are excluded from all Basic Coverage:

1. Expenses for personal comfort material or services, such as, telephone, television, or toiletries.
2. Services rendered by close family relatives (parents, children, siblings, grandparents, grandchildren, or spouses).
3. Weight control treatment (obesity or weight gain) for esthetic reasons. Procedures determined Medically Necessary to address morbid obesity shall not be excluded.
4. Sports medicine, music therapy, and natural medicine.
5. Services, diagnostic tests, or treatment ordered or offered by naturopaths, naturists, or iridologists.
6. Health certificates, except as provided in (Preventive Services).
7. Epidural anesthesia services.
8. Educational tests or services.
9. Peritoneal dialysis or hemodialysis services (covered under Special Coverage, not Basic Coverage).
10. Home Health and Hospice care for Adults.
11. Services received outside the territorial limits of Puerto Rico, except as provided in (Emergency Transportation) and (Emergency Services).

[1] Subject to change by PRHIA.

The Provider must be aware of the Regulatory Letters that are published by First Medical Health Plan, Inc. on our website: www.firstmedicalvital.com.

12. Expenses incurred for the treatment of conditions resulting from services not covered under Vital Plan (maintenance prescriptions and required clinical laboratories for the continuity of a stable health condition, as well as any emergencies which could alter the effects of the previous procedure, are covered).
13. Judicially ordered evaluations for legal purposes.
14. Travel expenses, even when ordered by the PCP.
15. Psychological, psychometric, and psychiatric tests and evaluations to obtain employment or insurance, or for purposes of litigation.
16. Eyeglasses, contact lenses, and hearing aids for adults.
17. Acupuncture services.
18. Sex change procedures.
19. Organ and tissue transplants, except skin, bone, and corneal transplants. Such skin, bone and corneal transplants shall be covered only in accordance with PRHIA's written standards providing for similarly situated individuals to be treated alike, and, for any restriction on facilities or practitioners providing such services, to be consistent with the accessibility of high-quality care to Enrollees; and
20. Mechanical respirators and ventilators with oxygen supplies are covered without limits as required by local law to Enrollees under age twenty-one (21).
21. All Durable Medical Equipment (DME) is not covered; however, DME may be covered on a case-by-case basis under an exceptions process according to FMHP's policies and procedures.
22. Polysomnography studies.
23. Clinical labs processed outside of Puerto Rico.
24. Outpatient uses of fetal monitor.
25. Treatment services for infertility and/or related to conception by artificial means including tuboplasty, vasovasostomy, and any other procedure to restore the ability to procreate.

26. Services, treatments, or hospitalizations because of a provoked nontherapeutic abortion or associated complications are not covered. The following are provoked abortions:
    a. Dilatation and curettage (CPT Code 59840);
    b. Dilatation and expulsion (CPT Code 59841);
    c. Intra-amniotic injection (CPT Codes 59850, 59851, 59852);
    d. One or more vaginal suppositories (for example, Prostaglandin) with or without cervical dilatation (for example, Laminar), including hospital admission and visits, fetus birth, and secundines (CPT Code 59855);
    e. One or more vaginal suppositories (for example, Prostaglandin) with dilatation and curettage or evacuation (CPT Code 59856); and
    f. One or more vaginal suppositories (for example, Prostaglandin) with hysterectomy (omitted medical expulsion) (CPT Code 59857).
27. Differential diagnostic interventions up to the confirmation of pregnancy are not covered.
28. Hospitalization for services that would normally be considered outpatient services or for diagnostic purposes only, is not a Covered Service under Vital Plan.
29. Medications delivered directly to Enrollees by a Provider that does not have a pharmacy license, except for medications that are traditionally administered in a doctor's office, such as injections.
30. The following HIV/AIDS medications are excluded from the PRHIA FMC: Viread, Emtriva, Truvada, Fuzeon, Atripla, Epzicom, Selzenxtry, Intelence, Isentress, Edurant, Complera and Stribild.

5.3 Mental Health Benefit

FMHP offers all Enrollees specialized mental health services. These benefits are administered by APS Healthcare of Puerto Rico (APS). APS has eighteen (18) facilities distributed through the Island to provide quality of mental health care services. Its multidisciplinary team integrated

by Psychiatrist, Psychologist, Social Workers, Addition Counselors, General Doctors and Nurses will provide services and resources to Adults and Children with the urgency that our Enrollees observe to live better lives. APS has a service line available 24-hours-a-day, seven-days-a-week. They also have referral services for a variety of behavioral health issues, such as:

- Depressive Disorders;
- Schizophrenia Spectrum;
- Bipolar and Related Disorders;
- Alcohol and drug dependency; and
- Anxiety Disorders.

APS has a trained clinical team to answer questions and help identify behavioral health issues related to medical conditions like diabetes. They can create integrated treatment plans for Enrollees in which they will:

- Identify barriers to adherence of medication treatment; and
- Educate the Enrollee to organize, prioritize, and implement suggested self-management strategies.

5.4 Integration Model

FMHP understands the importance of the integration of primary and behavioral health care to promote healthy and productive outcomes that will enhance the quality of life of Vital Plan Enrollees. Taking that into consideration, FMHP Integration Plan is consistent with the Four Quadrant Integration Model, a collaborative Care Program Model in which PCPs, care managers and psychiatric consultants work together to provide care and monitor the Enrollee's progress.

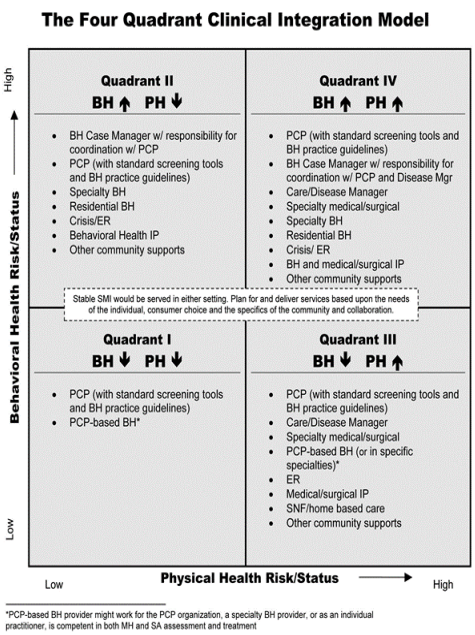
In this model, the Enrollee is screened, diagnosed, and receives treatment from the PCP in the primary care setting. If the patient is diagnosed with a mild psychiatric condition, the PCP can provide treatment, including prescribing drugs. If determined that the Enrollee has a moderate

to severe mental health condition or is at risk of developing one, the Enrollee is referred to behavioral clinical services and/or to a psychiatrist for treatment and therapeutic plan recommendations.

There are many ways to access Behavioral Health Services in a primary care setting, these include; patient walk-in, self-referral, referrals from PCP or specialists, Mental Health Providers, Call Center, Government Agencies and/or from any facilities such as hospitals or clinics.

The Four Quadrant model is not intended to be prescriptive about what happens in each quadrant, but to serve as a conceptual framework for collaborative planning in each local system.

The figure below describes the Four Quadrant Integration Model:



FMHP continuously works in Care Management initiatives, Prevention and Education Programs for Enrollees and Providers, and in collaboration and integration of services across PMG/PCPs. FMHP's Enrollees will benefit from a transformed healthcare model through our comprehensive, island-wide network of providers and our behavioral health partner, APS Healthcare Puerto Rico (APS). Contracted and licensed professional will provide behavioral services to Vital Plan Enrollees and facilitate access to necessary medical services, care coordination, medical evaluation and advocacy for options and services, including addressing socioeconomic determinants.

Behavioral Health Services are integrated through Co-location and Reverse Co-location models. The Co-location model uses specialized mental health clinicians who provide services at the same site as PCP. While, the Reverse Co-location model has a PCP (physician or nurse) in a psychiatric specialty setting to monitor the physical health of patients. Behavioral health service facilities must have at least one PCP and registered nurse on-site available at a minimum, between 8:00 a.m. and 6:00 p.m., five business days per week.

As part of the preventive assessment, the Integrated Model requires that the PCP administer the screening tools to identify potential mental health cases. These Enrollees shall be referred to the Primary Mental Health Provider to receive prompt treatment to avoid an increase in symptoms. FMHP guarantees that all Enrollees will receive appropriate behavioral care through our health delivery system. This system includes the following services:

- Comprehensive evaluation and stabilization of symptoms;
- Medication; and
- Referrals to appropriate level of care based on patient outcomes.

5.5 Pharmacy Benefit

5.5.1 Covered Drugs Formulary

The Pharmacy Coverage Benefits offered by the Vital Plan is a comprehensive one, as it includes physical, mental, and dental health medications. The pharmacy benefit, as mandated by the PRHIA, has a Formulary Medication Covered (FMC) in addition to an Excluded Formulary List, and the Exception Medication List (*LME*, by its Spanish acronym), which includes a list of all the drugs covered. PRHIA also have available some other formularies and sub-formularies based on specialty or services such as FMC for Physical Health, Mental Health, Ob/Gyn, Oncology, Dental, Nephrology, HIV-AIDS, Integrated Emergency Formulary (*FEI*, by its Spanish acronym) and sub-formularies for Physical Health and Mental Health.

The drugs listed on the FMC are preferred drugs for Vital Plan. These drugs have been selected based on safety, effectiveness, high quality, bioequivalent availability, and cost. Physicians are required to only prescribe drugs listed on the FMC. The pharmacy benefit requires the use of FDA-AB rated bioequivalent generics as first choice. The FMC identifies these drugs with their names in small letters in bold. Brand name appears only as a reference. The FMC also identifies those drugs that must go through a management process which is detailed below, for your reference:

Management Process and Process Description
Prior-Authorization: Drugs that require prior-authorization are identified on the FMC with "PA". The Provider can initiate the process of requesting a prior-authorization for a drug by either calling the PBM at 1-866-999-6221/1-866-989-6221, the FMHP Pharmacy Department at 1-844-347-7806, or by sending the prescription to the following fax number: 1-844-347-7807. The prescription must include all the information required by, along with the member ID number, diagnosis for which the drug is intended and the Physician NPI. Laboratory results or test results that support the use of the drug should be provided by the prescriber to the health plan.
Step Therapy: Drugs that require step therapy are identified on the FMC with "ST". These drugs have a clinical protocol that needs to be followed. These are usually second line therapy since there are first line drugs that must have been tried and failed for these drugs to be prescribed.
Quantity Limit: Drugs with quantity limits are identified on the FMC with "LC". These are drugs in which the pharmacy will not be able to process a quantity greater than the limit that has been established. Limits are based on the FDA indications and the manufacturer recommendations for each drug.
Age Limit: Drugs with age limits are identified on the FMC with "AL". These are drugs that have an age limit established. These limits are based on the FDA indications and the manufacturer recommendations for each drug.

5.5.2 Exception Process

FMHP must ensure that FMC drugs are used whenever possible. However Non-FMC drugs can be covered subject to the following criteria, as established by the PRHIA:

- FMHP shall cover drugs included on the Excluded Drug List (*LME*, by its Spanish acronym). However, as part of the exception process, upon the prescriber's request indicating that no drug listed on the FMC is clinically effective for the Enrollee.
- FMHP shall cover a drug that is not included on either the FMC or Master Formulary, provided that the drug is not in an experimental stage and that the drug has been approved by the FDA for the treatment of the condition.

The Provider must also:

1. Show that the drug doesn't have a bioequivalent on the market.
2. Show that the drug is clinically indicated because:
    a. The Enrollee is already taking an FMC drug that is contraindicated with the FMC alternatives, and there is documented literature of the possible adverse events if both drugs are taken.
    b. History of adverse drug reaction by the Enrollee to the FMC alternatives.
    c. Therapeutic failure to all the alternatives on the FMC.
    d. Other special circumstances.

5.5.3 Countersignature Requirement

Prescriptions written by a Provider outside the PPN may be filled only upon countersignature from the Enrollee's PCP or other assigned PCP from the PMG. A countersignature request submitted to the PCP shall be signed within three (3) calendar days of the request, or within twenty-four (24) hours of the request if the Enrollee's health is in danger. FMHP shall not require a PCP countersignature on prescriptions written by a Provider within the PPN.

5.5.4 EXCLUDED DRUGS [2]

The following drugs or categories of drugs are excluded from the pharmacy benefit through Vital Plan:

1. Medications delivered to Enrollees from Providers that do not have a pharmacy license; except for medications that are traditionally administered at the doctor's office, such as injections.

   The following drugs used for the treatment of HIV/AIDS:

   a. Viread®; Emtriva®; Truvada®; Fuzeon®; Atripla®; Epzicom®; Selzentry®; Intelence®; Isentress®;

   b. Edurant; Complera; Stribild.

Providers should refer Enrollees for whom these medications are medically necessary to *Centros de Prevención y Tratamiento de Enfermedades Transmisibles* (*CPTET*, by its Spanish acronym) or community-based organizations where the Enrollees may be screened to determine whether they are eligible for the AIDS Drug Assistance Program (ADAP).

5.6 DENTAL BENEFIT

FMHP will cover the following dental services:

1. All preventative and corrective services for children under age twenty-one (21) mandated by the EPSDT requirement.
2. Pediatric Pulp Therapy (Pulpotomy) for children under age twenty-one (21).
3. Stainless steel crowns for use in primary teeth following a Pediatric Pulpotomy.
4. Preventive dental services for Adults.
5. Restorative dental services for Adults.

[2] Subject to change by PRHIA.

6. One (1) comprehensive oral exam per year.
7. One (1) periodical exam every six (6) months.
8. One (1) defined problem-limited oral exam.
9. One (1) full series of intraoral radiographies, including bite, every three (3) years.
10. One (1) initial periapical intraoral radiography.
11. Up to five (5) additional periapical/intraoral radiographies per year.
12. One (1) single film-bite radiography per year.
13. One (1) two-film bite radiography per year.
14. One (1) panoramic radiography every three (3) years.
15. One (1) Adult cleaning every six (6) months.
16. One (1) Child cleaning every six (6) months.
17. One (1) topical fluoride application every six (6) months for Enrollees under nineteen (19) years old.
18. Fissure sealants for life for Enrollees up to fourteen (14) years old (including deciduous molars up to eight (8) years old when Medically Necessary because of cavity tendencies).
19. Amalgam restoration.
20. Resin restorations.
21. Root canal.
22. Palliative treatment.
23. Oral surgery.
24. General anesthesia (accordance with Act No. 352 of December 22, 1999 and normative number 18-0712 of PRHIA).
    - When a pediatric dentist, an oral or maxillofacial surgeon, licensed by the Government of Puerto Rico, pursuant to Act No. 75 of August 8, 1925, as amended, determines that the condition or condition of the patient is significantly complex in accordance with the established criteria;

- When the patient due to age, disability, or incapacity is unable to resist or tolerate pain, or cooperate with the treatment indicated in dental procedures;
- When the infant, child, adolescent or person with physical or mental impairment has a medical condition in which it is indispensable to carry out the dental treatment, under general anesthesia in an ambulatory surgical center or in a hospital, and which could otherwise represent a significant risk to the patient's health; or
- When local anesthesia is ineffective or contraindicated due to an acute infection, anatomical variation, or allergic condition.

You can access www.inmediata.com to verify the availability of dental services for an Enrollee. You can also reference the billing guide for dental services available on the FMHP Vital website at www.firstmedicalvital.com.

5.7 Emergency and Urgent Care Benefit

There are differences between a “medical emergency” and “urgently needed care”. A “medical emergency” is when an Enrollee has medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. “Urgently needed care” is when an Enrollee needs medical attention right away for an unforeseen illness or injury, and it is not reasonable, given the situation, for the Enrollee to get medical care from other Plan Providers. In these cases, the Enrollee’s health is not in danger. The main difference between an urgent need for care and a medical emergency is in the danger to the Enrollee’s health.

FMHP does not require prior authorization for emergency or urgent care. Claims billed for an emergency or urgent care visit will be covered. Although the claims system is designed to

suspend claims for certain services that usually require prior authorization, a claim for emergency or urgent care services should not be suspended, the claims examiner can override the authorization requirement and pay the claim.

5.7.1 Medical Emergency

Enrollees can receive covered emergency medical care whenever needed. Ambulance services are also covered in situations where other means of transportation in Puerto Rico would endanger the Enrollee's health. If an Enrollee has a medical emergency:

1. The Enrollee should get medical help as quickly as possible. They should call 9-1-1 for help or go to the nearest emergency room. The Enrollee does not need to get an approval or a referral from the PCP for emergency care.
2. FMHP will need to be involved in following up with the emergency care, therefore, make sure that FMHP knows about the Enrollee's emergency.
3. FMHP will talk with Providers who are providing emergency care to help manage and follow up on the care. When emergency care Providers indicate that the Enrollee's condition is stable and the medical emergency is over, what happens next is called "post-stabilization care." Follow-up care (post-stabilization care) will be covered according to Medicaid guidelines in general, we will try to arrange for Plan Providers to take over the care as soon as the Enrollee's medical condition is stabilized.

5.7.2 Urgently Needed Care

For urgently needed care, Enrollees may visit either Plan or Non-Plan Provider. If an Enrollee has a sudden illness or injury that is not a medical emergency, the Enrollee should call his/her doctor or FMHP for the Enrollee to go to the nearest contracted urgent care facility.

When the Enrollee is outside the service area, FMHP covers urgently needed care received from Non-Plan Providers. If the Enrollee needs urgent care while outside the plan's service area we recommend that, whenever possible, the Enrollee contact their PCP. In addition, if

treated for an urgent care condition while out of the service area we recommend that the Enrollee return to the service area to get follow-up care from Plan Providers. However, we will cover follow-up care that an Enrollee gets from Non-Plan Providers outside the plan's service area if the care still meets the definition of "urgently needed care."

5.8 Special Coverage Benefit

FMHP ensures that the Special Coverage Benefit is designed to provide services for Enrollees with special health care needs caused by serious illnesses. Upon receipt of a special coverage notification, with all the required information included, FMHP will evaluate the information and registers those Enrollees who, based on the information received, qualify. The intent of this registry is for Enrollees to have immediate access to the required medically needed services and access to specialists appropriate to the Enrollee's conditions and identified care needs.

An Enrollee registered in the Special Coverage Benefit, will be allowed to receive, without the need of a referral from the PCP, all services encompassed within the scope of their Special Coverage Condition and any other condition that arrives related or not, including but not limited to medications, laboratories, diagnostic tests, and other procedures. However, a Consultation Form between the PCP and specialists is highly encouraged to guarantee appropriate communication between physicians managing the same Enrollee and to support the continuity of care.

All requests for Special Conditions Registry must be sent
by fax to the following number: 787-626-2110.

The following conditions are considered under the Special Coverage Registry and the registry is granted after the diagnosis is confirmed by laboratory results and specialized studies:

- Aplastic Anemia: The registry may be referred by the PCP or the Hematologist managing the Enrollee's condition. FMHP requires to provide a certification of diagnosis by the Hematologist managing the Enrollee's care plan with evidence of the following information: (i) Absolute Neutrophils Count; (ii)Platelets levels; (iii) Reticulocyte count; and (iv) Results of the Bone Marrow Aspiration or Biopsy.
- Autism: Provisional Special Coverage: (i) Certification of risk by the primary care physician and evidence of the screening tool utilized. Permanent Special Coverage: (i) Diagnosis certification by a clinical psychologist, school psychologist, counselor psychologist, neurologist, psychiatrist, or a pediatrician development specialist. Professionals should have training or experience in the area of Autism, as required by the Protocol of Autism from the Department of Health of PR. (ii) Evidence of the relevant screening tests according to the Protocol of Autism from the Department of Health of PR.
- Rheumatoid Arthritis: This registry may be referred by the PCP or the Rheumatologist managing the Enrollee's condition. To register an Enrollee, FMHP must receive a certification of diagnosis by the Rheumatologist managing the Enrollee's care plan with evidence of the following information: (i) Diagnosis certification by the rheumatologist in accordance with the criteria established by the American College (ii) Evidence of laboratory tests: (a) Rheumatoid Factor; (b) ESR; (c) ANA Test; (d) CRP. (iii) Pertinent radiologic studies; and (vii) Evidence of treatment with a DMARD medication.
- HIV Positive factor and/or Acquired Immunodeficiency Syndrome ("AIDS"): This registry may be referred by the PCP, Specialists, and staff from the Health Department's Regional Immunology Clinics or by other qualified Providers. The following information is required for the registry of HIV/AIDS cases: (i) Evidence of the result of any of the following laboratories; (a)Western Blot positive, (b) positive HIV Viral load, (c) positive 4th generation test with validation of the subtypes of antibody or Antigen for acute infection.

- Tuberculosis: FMHP requires to submit a certification from the Pneumologist with the treatment plan and the following evidence: (i) Tuberculin test results; (ii) Chest X ray report; (iii) Sputum samples for AFB and culture for M. tuberculosis or Bronchial lavage results when sputum samples can't be collected; (iv) Biopsy of the affected site, if applicable; and (v) HIV test results.
- Leprosy: This registry may be referred by the PCP or the specialist managing the Enrollee's condition. The following information is required for the registry: (i) Evidence of the skin biopsy; (ii) Evidence of positive cultures for the infection; and (iii) Certification of the condition by an Infectologist or Dermatologist.
- Systemic Lupus Erythematosus (SLE): This registry may be referred by the PCP or the specialist managing the Enrollee's condition. A certification of the diagnosis by the Rheumatologist and evidence of the following laboratory tests is required for the registry: (i) ANA Test; (ii) Anti-dsDNA; (iii) Anti-Sm; and (iv) Anti-Phospholipids.
- Cystic Fibrosis: This registry may be referred by the PCP or the specialist managing the Enrollee's condition. A certification of the diagnosis from the Pneumologist and the following evidence is required for the registry: (i) Sweat Test Results; and (ii) Evidence of the treatment.
- Cancer: This registry may be referred by the PCP or the specialist managing the Enrollee's condition. (i) A certification of the diagnosis by the Hematologist/Oncologist or the specialists managing the Enrollee's care plan with evidence of the following information is required for the registry: (a) Care Plan; (b) Estimated dates of beginning and end of the treatment; and (ii) Evidence of the diagnosis with biopsy results. (iii) In cases where the biopsy can't be collected, FMHP will consider the evidence from diagnostic radiologic studies supporting the diagnosis. FMHP will provide the specific documents to be completed by the specialists when requesting the registry of an Enrollee with cancer.

- Hemophilia: This registry may be referred by the PCP or the specialist managing the Enrollee's condition. (i)A certification of the diagnosis by the Hematologist with (ii)evidence of the Coagulation factors laboratory tests is required for the registry.
- Children with Special Needs: The registry for Children with Special Needs includes the prescribed conditions in the Special Needs Children Diagnostic Manual Codes (Except: Asthma and Diabetes, which are included in the Disease Management Program; Psychiatric Disorders; and Intellectual disabilities. This registry may be referred by the PCP or the specialist managing the Enrollee's condition. A certification of the diagnosis and the care plan by the Specialist managing the Enrollee's condition, with the following evidence is required for the registry: (i) The diagnosis must be based on the Addendum provided with the diagnosis to be considered for the registry of Children with Special Needs; (ii) Laboratories or studies results pertinent to the diagnosis; (iii) Evidence of performed or pending surgeries related to the diagnosis; (iv) Current pharmacologic therapy.
- Scleroderma: This registry may be referred by the PCP or the Dermatologist or Rheumatologist managing the Enrollee's condition. A certification of the diagnosis by the Dermatologist or Rheumatologist managing the Enrollee's care plan with evidence of the following information is required for the registry: (i) ANA Test with positive results; (ii) Skin Biopsy; and (iii) Care Plan. Guidelines for the diagnosis of Scleroderma from the American College of Rheumatology will be used for the determination of the registry criteria.
- Multiple Sclerosis: This registry may be referred by the PCP or the Neurologist managing the Enrollee's condition. A certification of the diagnosis by the Neurologist managing the Enrollee's care plan with description of the physical evaluation, neurologic episodes, signs or symptoms, and evidence of the following information is required for the registry: (i) Brain MRI or when necessary Spinal Cord MRI results of lumbar puncture. (ii) Laboratory results. (iii) Conditions resulting from self-inflicted damage or because of a felony or negligence by an Enrollee.

- [3]Chronic Renal Disease in levels three (3), four (4), and five (5): This registry may be referred by the PCP or the Specialist managing the Enrollee's condition. A certification of the diagnosis by the PCP or the Specialist managing the Enrollee's care plan with evidence of the following information is required for the registry: (i) Calculated GFR taking in consideration the gender and race of the Enrollee when using the formula. For reference about the Calculated GFR formula, please consult the National Kidney Foundation website: www.kidney.org; and (ii) Recent pertinent blood test results including creatinine levels and studies. FMHP requires PCPs and Specialists to send information of Enrollees in all stages of Chronic Renal Failure (1-5), to include them in FMHP's Medical Management Programs. However, only Stages 3-5 are part of the Special Coverage Registry.
- Obstetric: This registry may be referred by the PCP or the Obstetrician managing the Enrollee's condition. A pregnancy certification by the Obstetrician is required for the registry. FMHP will provide a specific form with all the elements required for this registry.
- Post-transplant: Immunosuppressive medicine and clinical laboratories required for the maintenance treatment of post-surgical patients or transplant patients, to ensure the stability of the Enrollee's health, and for emergencies that may occur after said surgery, are part of the Special Coverage. This registry may be referred by the PCP or the Specialist managing the Enrollee's condition. The following information is required for the registry: (i) Certification of the specialist with evidence of the transplant and the care plan; (ii) Immunosuppressant therapy used. (iii) Skin, bone, and corneal transplants are covered under Vital coverage. Other transplants are excluded from the coverage. The registry ends when the Enrollee stops using the immunosuppressant.
- Cases of Adults with Phenylketonuria (PKU): This registry may be completed by the PCP or Geneticist managing the Enrollee's condition. The following information is required for the registry: (i) Treatment history; (ii) Evidence of genetic study results.

[3] Levels 1 and 2 does not qualify for registry under Special Coverage. Included in the Basic Coverage.

- Pulmonary Hypertension: Diagnosis certification and treatment plan by the Pneumologist or Cardiologist and evidence of supporting test (s)
- Palliative Treatment for Cancer: Beneficiaries diagnosed with cancer who do not have active treatment for this condition, such as radiotherapy, chemotherapy, targeted therapy or hormonal therapy, who will begin or are receiving palliative treatment for pain management. This registry may be referred by the PCP or the specialist managing the Enrollee's condition and certify that the beneficiary has completed his active treatment for his condition and will begin with palliative treatment for pain management.

FMHP Special Coverage includes the following Medically Necessary services that the Enrollee requires to treat his/her condition:

a. Coronary and intensive care services, without limit;
b. Maxillary surgery;
c. Neurosurgical and cardiovascular procedures, including pacemakers, valves, and any other instrument or artificial devices (Prior-Authorization required);
d. Peritoneal dialysis, hemodialysis, and related services (Prior-Authorization required);
e. Pathological and clinical laboratory tests that are required to be sent outside Puerto Rico for processing (Prior-Authorization required);
f. Neonatal intensive care unit services, without limit;
g. Radioisotope, chemotherapy, radiotherapy, and cobalt treatments; and
h. Treatment of gastrointestinal conditions, treatment of allergies, and nutritional services in autism patients.

The following procedures and diagnostic tests are covered, when Medically Necessary, but require a Prior-Authorization approval:

a. Computerized Tomography;
b. Magnetic resonance test;

c. Cardiac catheters;
d. Holter test
e. Doppler test;
f. Stress tests;
g. Lithotripsy;
h. Electromyography;
i. Single-photon Emission Computed Topography ("SPECT") test;
j. Orthopantomogram ("OPG") test;
k. Impedance Plethysmography;
l. Other neurological, cerebrovascular, and cardiovascular procedures, invasive and noninvasive;
m. Nuclear imaging;
n. Diagnostic endoscopies;
o. Genetic studies;
p. Up to fifteen (15) additional (beyond the services provided under Basic Coverage) physical therapy treatments per Enrollee's condition per year when indicated by an orthopedist, physiatrist, or chiropractor after Prior-Authorization;
q. General anesthesia, including for dental treatment of special-needs children; and
r. Hyperbaric Chamber.

6 MEDICAL MANAGEMENT

For over forty-three (43) years, FMHP has dedicated its efforts to improving the quality of life of our plan participants through the planning and implementation of medical services coverage of the highest quality in a cost-effective manner. Because, when our enrollees are healthy, they can live a better life. Therefore, we have developed these Medical Management Program to provide assistance interpreting certain standards benefit plans and to ensure that our Network Providers meet all relevant requirements mandated by the Centers for Medicare

and Medicaid Services (CMS), Puerto Rico Health Insurance Administration (PRHIA), and FMHP's Policies and Procedures.

FMHP will pay for services identified as a covered benefit and medically necessary. FMHP has sole discretion to conduct a medical necessity review of all requests for authorization and claims, within the specified time frame governed by PRHIA contract. This review may take place prospectively, concurrent, or retrospectively. FMHP will utilize approved and established approved criteria to determine medical necessity and will not deny or unreasonably delay medically necessary services to Vital Plan Enrollees.

6.1 Utilization Management Program

FMHP's Utilization Management Program ensure that Vital Plan Enrollees have timely access to appropriate, medically necessary, and cost-effective health care services, in a cultural competent decision making process, that ensures an equal access to high-quality health care; health care that is respectful and responsive to the needs of diverse Enrollees. The Utilization Management Program addresses such issues as: preventive care, in-patient services, and ambulatory care.

The main goals of the Utilization Management Program are to assure quality, relevant care while promoting appropriate utilization of medical services and Plan resources. The objectives of the Utilization Management Program are to:

1. Provide a structured process to continually monitor and evaluate the delivery of health care and services to Enrollees.
2. Improve clinical outcomes by the collaboration, system-wide, to identify, develop and implement clinical practice guidelines that address key health care needs of Enrollees.
3. Improve Provider and Enrollee satisfaction by: Assessing and improving Utilization Management satisfaction data from Provider and Enrollee surveys.

The Utilization Review Staff is responsible for obtaining all pertinent clinical indications and medical record information needed to perform assessments of service authorizations. The Utilization Management Staff is responsible for the application of utilization review criteria/guidelines (Milliman Care Guidelines®) to each individual case, to maintain consistency in the decision-making process and for referral to the Medical Director when criteria are not met. The Utilization Management Department Staff is responsible of identifying all potential or actual quality of care issues, and cases of over and underutilization of health care services, during all components of review and authorization.

FMHP uses the Milliman Care Guidelines® for Inpatient Utilization Management through its delegated entity for hospital Utilization Review. The Utilization Management Staff, and Medical Directors are not financially compensated to encourage underutilization or denials. Utilization Management delegated entities will not permit or provide compensation or anything of value to its employees, agents, or contractors, based on a percentage of the amount by which a claim is reduced for payment or the number of claims or the cost of services for which the person has denied authorization or payment; or any other method that encourages a decision to deny, limit, or discontinue a Medically Necessary Covered Service to any Enrollee.

The Utilization Management Committee provides direction and oversight the Utilization Management Program. This committee:

1. Evaluates the Program effectiveness and performance.
2. Analyze under and over-utilization patterns, and recommend initiatives and strategies, as needed.
3. Recommend corrective actions based on clinical trends or changes in the standards of care.
4. Review and approve guidelines for the delivery of health services to Enrollees.
5. Oversee and monitor all delegated Utilization Management activities.

6.1.1 Evidence Based Clinical Practice Guidelines

To offer quality health services to Vital Plan Enrollees, on an annual basis the FMHP's Clinical Practice Review Committee approves and adopts Clinical Practice Guidelines (CPGs) for prevention, diagnostic and management of physical and mental health. These Guidelines recognized national and international level corresponds to the standards of care and clinical treatments for specific conditions.

We encourage all Providers to use the FMHP's Clinical Practice Guidelines, to collaborate with the quality and consistency of health care management. For detailed information and links of the approved and adopted CPGs, please refer to the Attachment #1: Clinical Practice Guidelines Notification. For your convenience, you can also get the updated CPGs on our website www.firstmedicalvital.com.

6.1.2 Referral Policies

In some cases, FMHP requires a referral to provide certain services. A written Referral from the PCP will be required when an Enrollee needs access to specialty care and services within FMHP's General Network but outside the PPN; and to access services from Out-of-Network Providers (except for Emergency Services).

A Referral for either the General Network or out-of-network services must be provided by the PCP during the same visit but no later than twenty-four (24) hours of the Enrollee's request. When a Provider does not make the Referral in the required timeframe specified, or refuses to make a Referral, FMHP will issue an Administrative Referral. Neither FMHP nor any Provider will impose a requirement that Referrals be submitted for the approval of Committees, Boards or Medical Directors. FMHP will strictly enforce this directive and will issue an Administrative Referral whenever it deems medically necessary.

If the Provider access cannot be met within the PPN within thirty (30) calendar days of the Enrollee's request for the covered service, the PMG will refer the Enrollee to a specialist within the General Network, without the imposition of co-payments. However, the Enrollee will return to the PPN specialist once the PPN specialist is available to treat him/her.

FMHP will ensure that PMG's comply with the rules stated by PRHIA contract concerning the Referrals process, so Enrollees are not forced to change PMG's to obtain needed Referrals. FMHP, will not require a Referral from a PCP when an Enrollee seeks care from a Provider in the PMG's PPN.

6.1.3 Prior-Authorization

FMHP will ensure that Prior-Authorization is provided for the Enrollee in the following timeframes, including on holidays and outside of normal business hours:

- The decision to grant or deny a Prior-Authorization will not exceed seventy-two (72) hours from the time of the Enrollee's Service Authorization Request for all Covered Services. In cases where the Enrollee's Provider determines that the Enrollee's life or health could be endangered by a delay in accessing services, the Prior-Authorization must be provided as expeditiously as the Enrollee's health requires, but no later than twenty-four (24) hours from the receipt of the request.
- FMHP can request an extension, of up to fourteen (14) calendar days, to the PRHIA when Medical Affairs justifies a need for the extension to collect additional information. The extension must be in the Enrollee's best interest. The Enrollee or the Provider can also request an extension.
- If an extension is granted, FMHP must provide the Enrollee a written notice of the reason behind granting the extension and inform the Enrollee of the right to file a grievance if he or she disagrees with that decision. The notice of the determination

must be sent as expeditiously as the Enrollee's health condition requires and no later than the expiration date of the extension.

For services that require Prior-Authorization, the Service Authorization Request shall be submitted promptly by the Provider for FMHP evaluation, to provide the authorization within the applicable timeframe. Requests for all covered services will not exceed seventy-two (72) hours from the time of the Enrollee's Service Authorization Request; except, where the Enrollee's Provider determines that his/her life or health could be endangered by a delay in accessing services, the Prior-Authorization must be provided as expeditiously as the Enrollee's health requires, but no later than twenty-four (24) hours from the receipt of the request.

Any denial, unreasonable delay, or rationing of medically necessary services to Enrollees is expressly prohibited. FMHP assures compliance with this prohibition from Network Providers or any other entity related to the provision of Behavioral Health services to Enrollees.

FMHP employees are appropriately licensed and trained professionals to supervise all Prior-Authorization decisions and will specify the type of personnel responsible for each type of Prior-Authorization in its policies and procedures. Any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, is made by a Provider who possesses the appropriate clinical expertise for treating the Enrollee's condition. For service authorization requests for dental services only licensed dentists are authorized to make determinations.

Neither a Referral nor Prior-Authorization shall be required for any Emergency Service, and notwithstanding whether there is ultimately a determination that the condition for which the Enrollee sought treatment in the emergency room was not an emergency medical condition or psychiatric emergency. FMHP will not require a Prior-Authorization or Referral for Dental services.

6.1.4 SERVICES AND PROCEDURES THAT REQUIRE PRIOR-AUTHORIZATION

The following services and procedures require a Prior-Authorization:

1. Neurosurgical Procedures, Injection of Anesthetic Agents for Neurologic Block, and Neurostimulators;
2. Cardiovascular Procedures, Pacemakers, Cardioverter Defibrillator (Insertion, replacement, or removal), Valves, and any other instrument or artificial devices;
3. Radiation Therapy;
4. Computerized Tomography;
5. Magnetic Resonance Imaging;
6. Nuclear Imaging;
7. Lithotripsy;
8. Single-photon Emission Computed Topography ("SPECT") test;
9. Ocular Orthopantomogram ("OPG") test;
10. Impedance Plethysmography (IPG);
11. Diagnostic Endoscopies;
12. Genetic Studies;
13. Physical Therapy- Limited to a maximum of fifteen (15) treatments per Enrollee condition per year, unless Prior-Authorization of an additional fifteen (15) treatments is indicated by an orthopedist or physiatrist;
14. General Anesthesia and Dental Procedures;
15. Hyperbaric Chamber;
16. Mammoplasty;
17. Maxillofacial surgery (Le Fort);
18. ERCP;
19. Gastric Bypass for Morbid Obesity;
20. Colonoscopy and Virtual Colonoscopy;
21. Stereotactic Radiosurgery;
22. EEG; and

23. Prosthetics, including the supply of all extremities of the human body including therapeutic ocular prosthetics, segmental instrument tray, and spine fusion in scoliosis and vertebral surgery;
24. Non-emergency Transportation;
25. J Codes;
26. Direct Medical Equipment and Supplies: Case by Case Review;
27. Wound Care.

6.1.5 Denial Process

FMHP will evaluate all Prior-Authorization requests. If the medical information related to the request indicates that it does not meet with the applicable criteria for approval the Utilization Management Review Specialist will refer it to the Medical Director for the medical review process. The Medical Director may:

- Approve the request;
- Contact the care physician or attending physician for additional medical information;
- Contact the care physicians or attending physician to discuss an alternative treatment plan; or
- Deny the request.

FMHP will assure that all denial notifications are handled in a timely manner. Enrollees, Authorized Representatives, and Physicians are informed by an outbound call and are explained their appeal rights. The Enrollee and Provider will receive a written denial notice whether coverage is denied in whole, in part, or discontinued. The notification will include the appeal rights, reconsideration process and timeframes.

Enrollees or their Authorized Representatives may file an appeal to an adverse determination verbally by calling the following number 1-844-347-7800 or in writing by sending a fax to

787-300-3931 with all the pertinent information supporting the appeal or any new information not provided during the initial prior-authorization process.

6.1.6 Second Opinions

FMHP shall provide a second opinion in any situation when there is a question concerning a diagnosis, the options for surgery, or alternative treatments of a health condition when requested by any Enrollee, or by a parent, guardian, or other person exercising a custodial responsibility over the Enrollee. The second opinion must be provided by a qualified Network Provider, or, if a Network Provider is unavailable, the Contractor shall arrange for the Enrollee to obtain a second opinion from an Out-of-Network Provider. The second opinion shall be provided at no cost to the Enrollees.

6.1.7 Utilization Review Program Components

The Hospital Utilization Review Program components are designed to effectively reduce, and alert unnecessary and costly hospital stays and to assist with identifying alternative treatment settings. The program components include: (1) Admission Notification Program; (2) Pre-admission review and admission review; (3) Concurrent review; (4) Discharge Planning; (5) Retrospective Review; (6) Ancillary Services; (7) Skilled Nursing Facility; (8) Inpatient Rehabilitation Facility (IRE) Review; (9) Case Management; and (10) Emergency Room Utilization Review.

6.1.8 Notification of Acute Care Facility Admissions

FMHP requires facilities to notify all Hospital Inpatient admissions (including deliveries) and discharges for hospital services to be covered. This information must be reported to:

InHealth Hospital Care Department During works days, and before 10:00 a.m.		787-622-3000 Ext. 8334, 8369, 8368, 8372, 8371, 8362, 8364, 8374, 8304, 8295, and 8367
		inpatient@inhealth-pr.com
		787-999-1744

The InHealth Hospital Use and Review Department will verify the Enrollee's eligibility on the date that the medical services were rendered. If the Enrollee is eligible to receive the services, the InHealth Coordinator will provide the reference number to the hospital provider.

Admissions and Discharges occurring after 10:00 a.m., may be registered on the next workday. However, we stress the need to keep a correct census. The provider shall have a maximum of three (3) workdays from the date of admission to report it to the InHealth Hospital Use and Review Department to request the case reference number.

In cases where an admission is notified retrospectively the hospital shall bring the case to the Concurrent Review Nurse (CRN) assigned to your hospital who is responsible for obtaining the reference number if the case meets the criteria established in this Description of the InHealth Physical Health Operational Hospital Review Processes.

6.1.9 Concurrent Review

Refers to the review of the patient's clinical file while he/she is still admitted in the hospital facility. Admissions created will be available immediately so that the Concurrent Review Nurse (CRN) may begin reviewing the case using the clinical guidelines adapted by InHealth (MCG, formerly known as *Milliman Care Guidelines*) as a frame of reference.

The hospital is responsible for making all files of admitted patients available for review (including ER admissions) and easing the review process during the work hours of Mondays

through Fridays, from 8:00 a.m. to 5:00 p.m. The facility will have a period of no more than ninety (90) calendar days, after the discharge date, to submit the file to our CRN for closure.

6.1.10 Discharge Planning

The hospital provider shall report all patient discharges from the Government Health Plan, Vital, within three (3) workdays from the date when the patient was discharged through the telephone number previously mentioned.

Reporting Schedule: Regular work hours are from Monday to Friday, from 7:30 a.m. to 5:00 p.m. Admissions and discharges may also be reported during weekends by fax at 787-999-1744 the reference number for admissions reported during weekends shall be provided on the next workday.

6.1.11 Retrospective Review

The facility will have a period of no more than ninety (90) calendar days, from the date of discharge, to submit the file to the CRN for InHealth. The CRN shall take no more than fifteen (15) workdays to complete the case review process.

If a file is submitted after its expiration (ninety [90] calendar days after the date of discharge), it will not be audited by our staff. The file will be sealed with a recommendation for administrative denial.

6.1.12 Appeals Process

The facility will have a period of thirty (30) calendar days from the close date to request in writing the appeals process to InHealth Grievance Department to the following address:

Hospital Facility Appeals InHealth
UM Inpatient Department
PO Box 71114
San Juan, PR. 00936-8014

6.1.13 Emergency Room Utilization Review

FMHP will conduct retrospective Emergency Room Utilization Review (ER-UR) to evaluate records of emergency room high utilizers and quality issues, including overutilization patterns.

6.1.14 Ambulance Service

FMHP will cover emergency transportation in compliance with Puerto Rico laws and regulations. Sea, air, and land transportation will be covered within Puerto Rican territory limits in cases of emergency. Emergency transportation does not require prior authorization. Emergency aerial transportation is provided and paid by the PRHIA under a separate contract. FMHP may coordinate the provision of emergency aerial transportation on behalf of its Enrollees when medically necessary utilizing the provider designated by the PRHIA.

6.2 Care Management Program

FMHP has developed the Care Management Program to improve the health of Vital Plan Enrollees. This program includes subprograms and projects designed to coordinate services and provide support for Enrollees with special needs. These subprograms and projects are based on clinical and non-clinical criteria. The following sections describe each subprogram, project, its processes, and services, and explains how these are integrated to achieve the main goal.

6.2.1 Care Program Management Statement

FMHP's Care Management Program defines a collaborative process between the Enrollee, Primary Care Physician (PCP), Primary Medical Group (PMG), Specialists, Subspecialists, Providers, and the Plan's Subprograms as an integrated system to help our Enrollees to address their necessities. While the High Cost-High Needs Program is a coordinated model of care focused on conditions that may require intensive use services, monitoring and interventions by a dedicated team of Providers to ensure compliance with plans of care and specialized care management services.

Enrollees' health medical management support is worked through evidenced-based medicine, best practices, and quality of care protocols to achieve their unique needs and goals. Main activities such as assessments to identify physical, behavioral, and social determinant needs, individualized care plan and coordination of services are performed. Clinical and non-clinical dedicated staff along with an interdisciplinary care team is appointed to conduct the Program. This team manages decision support and alliances with communities' resources. Quality of services, health outcomes, program and individual case results, enrollee satisfaction and individual case managers' performance are some of the key elements to determine the effectiveness of the Care Management Program.

6.3 Enrollee Program Goals

FMHP's Care Management Program main goal is to coordinate available and accessible services while supporting and guiding enrollees to recover and improve their health. The Program objectives are:

1. To ensure that the enrollee with intensive use services and special health needs that requires a course of regular monitoring of care or treatment, receives needed services in a supportive, efficient, timely, and cost-effective manner with quality of care.
2. To continually perform the activities of assessment, planning, coaching, education, and advocacy for enrollees throughout the continuum of care, consistent with evidence based clinical guidelines.
3. To collaborate and communicate with the enrollee/family, the PCP and other health care providers in the implementation of the care plan that is driven by the enrollee's goals for health improvement.
4. To accomplish the goals established in the individual enrollee's care plan.
5. To provide enrollees and their families with information and education that promotes self-care management.
6. To educate and involve the enrollee and family in the coordination of services.

7. To assist enrollees across the transition between settings of care; appropriate discharge planning for short and long-term hospital and institutional stays settings, by providing information and support.
8. To maintain the enrollee in the setting that best aligns with an enrollee's preferences, while being clinically appropriate to manage a condition and medical needs.
9. To assist enrollees in optimizing use of available benefits.
10. To improve enrollee and provider satisfaction.
11. To assure timely interventions that increase effectiveness and efficiency of care delivery.
12. To promote the effective utilization and monitoring of health care resources while ensuring that services arranged or coordinated are appropriate for the enrollee.
13. To promote the health, independence, and optimal functioning of enrollees.
14. To ensures optimum therapeutic outcomes for enrollees through improved medication adherence and reducing adverse drug interactions.
15. To promote preventive health services.

6.4 Enrollee Program Description

Our Care Management Program is driven by quality-based outcomes such as: improved/maintained functional status, improved/maintained clinical status, enhanced quality of life, Enrollee satisfaction, adherence to the care plan, improved Enrollee safety, cost saving and autonomy. The program includes a set of Enrollee-centered, goal-oriented, culturally relevant, and logical steps to assure that an Enrollee receives needed services in a supportive, effective, efficient, timely and cost-effective manner. It also emphasizes prevention, continuity of care and coordination of care, which advocates for, and links enrollees to, services as necessary across Providers and settings.

The Care Management Program main areas are:

1. Early identification of Enrollee's who have or may have special needs;
2. Assessment of Enrollee's needs;

3. Development of a care plan;
4. Referrals and assistance to ensure timely access to Providers;
5. Coordination of care actively linking the Enrollee to Providers, medical services, residential, social, behavioral, and other support services where needed;
6. Progress status and monitoring of events;
7. Continuity of care; and
8. Follow-up and documentation.

6.5 Care Management Program Components

6.5.1 Evidence Based Clinical Practice Guidelines

FMHP conducts its medical review and evaluation of health care services utilizing nationally recognized policies, standards of care, and evidence based clinical guidelines. Examples of such health care services include inpatient and outpatient care, medications, and other services required for coordinating care for the enrollees.

FMHP staff uses such policies, standards, and guidelines from the Centers for Medicare and Medicaid Services (CMS) and its carriers, national professional organizations (e.g. American Diabetes Association, American Heart Association) and other federal government organizations such as the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention (CDC), and the Agency for Health Care Research and Quality (AHRQ).
See more details related to the Evidenced Based Guidelines in the section related to Utilization Management Program.

6.5.2 Program Staff and Interdisciplinary Care Team (ICT)

FMHP has contracted clinical and non-clinical staff to conduct the care management activities under its Program, subprograms, and projects. The staff receives training related to policies, procedures and documents governing the Care Management Program components. Changes on count and type of health professionals are made according to the profile of population that

is managed and as a result of gaps identified in the annual evaluation of the Program. The Care Management Program health professional staff is composed of:

- Physicians
- Health Educators
- Registered Nurses/Case Management
- Pharm-D
- Social Workers

FMHP has adopted an Interdisciplinary Care Team (ICT) Committee composed by a team of health and administrative professionals. The ICT is responsible for providing oversight to the Enrollee's care planning and care management processes, assuring compliance of the established processes, analyzing quality trends, and assisting on complex cases by providing their expertise in management of certain medical/behavior health conditions. The ICT also coordinates and identifies referrals needed and ensure engagement with Providers.

6.5.3 Assessment Process

A population assessment will be performed once the utilization data is received from PRHIA. For all new plan Enrollees First Medical will make its best efforts to perform a Health Needs Assessment within ninety (90) calendar days of the effective date of enrollment to identify population health and social needs. Then, an updated assessment will be conducted annually. An enrollee profile is established to perform program activities. For Enrollees who qualify for the Care Management/High Cost-High Needs Programs, an individualized assessment will be performed within thirty (30) calendar days of referral to the programs to identify physical, behavioral, or social needs. A Plan of Care is developed according to the identified needs considering the actual treatment plan performed by the enrollee PCP to ensure the enrollee complies with the establish goals for improvement.

6.5.4 Roles and Responsibilities of FMHP's Care Management Program Staff

The clinical and non-clinical staff that conduct the care management activities under its Program, subprograms and projects receive appropriate training related to PRHIA contract requirements, FMHP's policies and procedures, and documents governing FMHP's Care Management Program and its subprograms.

FMHP's Care Management Program is based on a collaborative practice model to include Physician and support-service Providers. In general, the PCP's role is to lead the efforts to assess Enrollee's condition and health needs, develop a treatment plan, with the Enrollee's participation, and in consultation with any specialists caring for the Enrollee. PCPs will monitor adherence to clinical guidelines and protocols, promote the pre-approved educational materials to be used and support program rollout to ensure outcomes.

6.5.5 Eligibility Criteria for FMHP's Care Management Program and its Subprograms

FMHP requires that PCPs (as well as PMGs) have implemented an effective system that includes policies, procedures, and practices to identify any Enrollee in need of care management services. To assure compliance with this requirement all new Enrollees in a PMG must be screened using behavioral and physical tools to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening.

Any Enrollee identified as Care Management Program potential will have a comprehensive needs assessment from their PCP who will address the enrollee's greatest need. The PCP will also identify those who have conditions specified as HCHN and/or who require intensive assistance, extended services as required by the Enrollees' medical conditions, as well as, ongoing care coordination and management as appropriate, in the primary care setting.

The FMHP' Care Management Program serves Enrollees through its subprograms and projects. The following table summarizes FMHP's Care Management Subprograms and its enrollment criteria:

Care Management Subprogram	Enrollment Criteria
High Cost-High Need Enrollees Program (Model of Care)	First Medical will identify a specific cohort of enrollees with specific conditions who have elevated costs or needs such as the following to enroll these beneficiaries in the High Cost-High Need Program: • Pulmonary Disease: Asthma, COPD, Diabetes (Type 1 and 2), Severe Heart Failure, Hypertension, ADHD, and Chronic Depression. • Condition(s) from the Special Condition Program such as Cancer, End Stage Renal Disease, Multiple Sclerosis, Rheumatoid Arthritis and Autism, Children and Youth with Special Healthcare Needs, Hemophilia. • Behavioral Health Needs (Serious Mental Illness (SMI) or a Serious Emotional Disturbance (SED)).
Special Coverage Care Program	FMHP will use the following criteria or methodology to enroll beneficiaries in the Special Coverage Care Program: • Enrollees with special conditions as defined by PRHIA. • Data from claims sources or encounter data to identify potential eligible population. Once Enrollees with any of the condition's diagnosis identified, PCPs is contacted to review and submit the corresponding form and the required documentation for registration. • Special Registration Forms completed by the Primary Care Physician or Specialist for the special conditions

	as specified by PRHIA and detailed in the Special Coverage Section.
Case Management Program	FMHP will use the information of all Enrollees who experience a critical event such as the following to enroll beneficiaries in the Case Management Program: • Inpatient acute care; Skilled Nursing services; Home care, and others that requires continuity of care at home. Those services will be coordinated according to benefits and regulations. Additionally, those Enrollees diagnosed with the following illness or behavioral disability will be enrolled in the Program: • Serious Mental Illness ("SMI"); or Serious Emotional Disability ("SED"); • Enrollees participating in the Buprenorphine Program will be considered. The multiple avenues of referrals to receive the services of the Case Management Program are: • Discharge planning referral; Utilization Management referral; Enrollee self-referral; Primary Care Physician referral; Primary Medical Groups referral; Care Management Programs and Projects referral; High Cost-High Need Management referral; Special Coverage Management referral; Transitional Care Management referral; High Utilizer Program ER Quality Project referral; Prenatal/Maternal-High Risk referral.

Transitional Care Management Program	FMHP will use a daily electronic census to identify those Enrollees transitioning between different care settings such as the following to enroll them in the Program: • Hospitals, home health care, skilled nursing facility, rehabilitation facility, and outpatient surgery centers.
High Utilizer Program/ Emergency Room Quality Project	FMHP will use the following criteria to enroll beneficiaries in the High Utilizer Program/Emergency Room Quality Project: • Any Enrollee with a serious health condition who meets the definition of high utilizer might be referred and or identification be made through claims history evaluation. • Enrollees with readmission, within or less than, thirty (30) days after a discharge. • All Enrollees with seven (7) or more Emergency Room visits within a twelve (12) month period.
Prenatal/Maternal Care Management Program	All pregnant women will be registered and enrolled in the Program *"Healthy Mom, Healthy Baby"* by their Obstetrician/Gynecologist or by their PMG completing the corresponding Referral Form. The Form can be delivered through mail, web/secure email, or fax. Also, the enrollees will have the opportunity to register through the FMHP website.
Autism Case Management Program	All Enrollees with any signal of positive developmental delay findings from the implementation of the ASQ to the child's parents, and positive findings to M-CHAT performed as early as possible (18-30 months). The referral is processed for the corresponding pediatric specialist to establish the diagnosis.

	Provider shall submit at the register forms, the following screening and test: • Pregnancy test, HIV test, PHQ, 4P plus, Tweak and Edinburgh.

6.5.6 ACTIVITIES AND INTERVENTIONS OF THE PCP

Program Setting	Activity/Function
High Cost-High Need Enrollees Program (Model of Care)	Review and approve patient enrollment criteria, Comprehensive health needs assessment evaluation, Develop a treatment according to needs identified, monitoring follow-up and documentation, including the revision of the treatment plan when the Enrollee's circumstances or needs change significantly, or upon the reassessment of needs, at least every twelve (12) month in compliance with guidelines, protocols and educational material to enhance and support programs developed.
Special Coverage Program	Complete the Registration Form for the Enrollees with special conditions determined by PRHIA.
Physical and Behavioral Case Management Program	Refer the Enrollee and discuss results, current discharge plans, or any other pertinent medical information to coordinate the services or required care with the case manager.
Transitional Care Management Program	Review the alerts of transition sent by FMHP and perform Enrollee follow-up during the post discharge process.
Emergency Room Quality Project	Support the quality initiatives to improve the appropriate use of ER.
Prenatal/Maternal Care Management Program	Complete the Registration Form, support FMHP's EPSDT strategy and support the programs activities.

7 FMHP's Quality Assessment and Performance Improvement Program

FMHP has a Quality Assessment Performance Improvement Program in compliance with applicable regulations and regulatory agencies. The program's mission is to promote and continuously improve the quality of clinical care (physical and behavioral) and the quality of services provided to Enrollees from health service providers and FMHP.

The members of the FMHP Board of Directors are responsible for the administration of the Program, delegating the responsibility of the implementation to the FMHP Regulatory Affairs Vice President. The Corporate Quality Director is responsible for the daily operations of the Quality Department and the operational components of the FMHP QAPI Program. All FMHP employees are responsible for offering quality service to the Enrollees.

Quality Advisory Board/Quality Committee Structure

The Quality Advisory Board/Quality Committee of FMHP is responsible for the development, implementation, and general surveillance of the FMHP's QAPI Program. Oversight areas include the services offered (physical or behavioral health services) and their quality, rights and responsibilities of the beneficiary/enrollee, patient safety, medical policies and guidelines, credentialing and recredentialing of the provider, satisfaction of beneficiaries/enrollees and suppliers and the quality execution of the operational areas. The Quality Advisory Board/Quality Committee of FMHP evaluates the results of quality improvement activities, utilization results, health outcomes and the actions that have been carried out to provide recommendations based on the reports of the various subcommittees and the results of the Quality Work Plans.

FMHP QAPI Monitoring Tools

The FMHP QAPI Monitoring Tools are designed to track the performance of quality measures for Performance Improvement Projects (PIPs) and operational functions provided by the Plan.

Performance Improvement Projects (PIPs)

FMHP implements the PIPs required by the PRHIA in the administrative and clinical care areas to promote a favorable effect on the health outcomes of the impacted Vital Plan enrollees and their satisfaction. Each PIP includes clear and defined objectives and strategies to achieve the proposed goals. Standard quality indicators are used to monitor performance and improvement over time.

Areas for PIPs are the following

Clinical Care Project to increase fistula use for Enrollees at risk of dialysis - This Project is intended for Enrollees with a kidney condition in early stages who may be candidates for dialysis. The objective of the project is to educate Enrollees of the advantages of having an arteriovenous fistula prior to dialysis process.

Clinical Project to reduce hospital readmissions for behavioral health conditions – This Project is designated to assist Enrollees in the management of their conditions to decrease the possibility of a readmission and provides the delivery of services they need in accordance to the level of care that the Provider determines.

Administrative Project to ensure the availability of providers and health professionals to address physical health and behavioral health (Colocation and Reverse Colocation) - This Project is designated to integrate physical and behavioral health services in the Medical Groups and Behavioral Health facilities.

Administrative Project in the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) – This Project is designated to promote the benefits and the importance of complete health assessments to eligible Enrollees under 21 years of age. These assessments include the areas of prevention, growth and development, vision, hearing, dental, vaccines and laboratory tests.

EPSDT services must comply with the Puerto Rico Health Department guidelines and the Mothers, Children, and Adolescent Program guidelines.

Health Care Improvement Program (HCIP)

As a mechanism to improve the quality of the services provided to the Enrollees, FMHP has established strategies, Programs and Projects to comply with the PRHIA Health Care Improvement Program. The following initiatives are considered in the HCIP Program:

- High Cost and Chronic Conditions Initiatives for enrollees with a High Cost and/or Chronic Conditions to ensure compliance with plans of care and specialized care management services.
- Healthy People Initiative that focuses on preventive screenings for enrollees. HEDIS measures are considered in this HCIP initiative.
- Emergency Room High Utilizers Initiative that is designed to identify high users of emergency services for non-emergency situations and to allow for early interventions to ensure appropriate utilization of services and resources.

Under each initiative, there is a list of conditions, indicators, and performance measures which FMHP must report on a quarterly basis.

Providers and Enrollees Satisfaction Surveys

FMHP identifies quality improvement opportunities through Satisfaction Surveys performed to beneficiaries/enrollees and providers. The surveys for Enrollees correspond to those required by PRHIA: Experience of Care and Health Outcomes (ECHO) and Consumer Assessment of Health Care Providers and System (CAHPS).

FMHP notifies the principal findings to providers and enrollees through the website www.firstmedicalvital.com. The survey findings are available upon request to providers and enrollees.

Additional satisfaction surveys are conducted to identify areas of opportunity in the services offered to FMHP beneficiaries/enrollees. Also, satisfaction surveys are conducted to contracted providers with the objective of improving communication and satisfaction between the Health Services Organization (FMHP) and the health service provider.

Encounters Validation

Procedures to validate the completeness and quality of encounter data were implemented. FMHP has established policies, procedures, and protocols to ensure the accuracy and integrity of the encounter data and claims.

Delegation

FMHP delegates primary activities to contracted entities that comply with the FMHP delegation standards. FMHP performs annual audits and monitoring activities of the delegated entities to ensure compliance with the regulations and FMHP requirements.

FMHP Board of Directors, through the Quality Advisory Board/Quality Committee of FMHP, reserves the right to make final decisions on the recommendations with respect to the participation of the delegated entities in the FMHP System.

QAPI Program Annual Evaluation

FMHP conducts an annual evaluation of the QAPI Program that includes the following:

- Performance against goals/benchmark as well as previous performance;
- Achievements and Barriers for the continuous improvement activities;
- Quality Programs and Projects Effectiveness.

Recommendations are established from the results of the annual evaluation to improve the service quality offered to providers and beneficiaries/enrollees.

Communication with Providers

Providers need to validate the different communications that FMHP delivers to be aligned and in compliance with its Quality Programs, Projects, Initiatives, and requirements. All the communications are published in the First Medical Vital website at www.firstmedicalvital.com.

8 PROVIDER ROLES AND RESPONSIBILITIES

FMHP values the relationship between a patient and their Providers and believes access to health care services is critical for the overall well-being of Vital Plan Enrollees. The Provider plays a critical role in care management and the success of individuals who are encouraged to be engaged in their own health care maintenance and wellness. The Provider will be responsible for providing, managing, and coordinating all medically needed services to Enrollees, including the coordination with Behavioral Health personnel, in a timely manner, and in accordance with the guidelines, protocols, and practices generally accepted in medicine.

In our continuing efforts to offer affordable health care coverage, FMHP guarantees access to an integrated model of physical and behavioral health care services. FMHP will work with our providers and enrollees to avoid uncoordinated, episodic care by encouraging close relationships between them and the PCP and offering readily accessible preventive health care services and treatment.

8.1 COMPLIANCE WITH THE FMHP CONTRACT, REGULATIONS AND PROVIDER GUIDELINES

FMHP is subject to certain requirements as set forth by the PRHIA contract. FMHP requires Providers to comply with important provisions established by FMHP as well as any applicable federal and state laws and regulations. Those requirements are set forth in the FMHP's Provider Contract and these Guidelines. We encourage you to review your contract and let us know if you have any questions about the terms set forth therein. FMHP will keep you informed

about any changes or modifications to the Provider contract regarding Vital Plan's health care services and requirements.

FMHP expects Providers to comply with applicable Federal and Puerto Rico laws, rules, and regulations, and the Puerto Rico policy relative to non-discrimination because of age, race, color, religion, creed, national origin, sex, sexual orientation, physical or mental disability, marital status, political affiliation, socioeconomic status, or status as a recipient of Medicaid benefits. Applicable Federal non-discrimination law includes, but is not limited to, Title VI of the Civil Rights Act of 1964, as amended; Title IX of the Education Amendments of 1972, as amended; the Age Discrimination Act of 1975, as amended; Equal Employment Opportunity and its implementing regulations (45 CFR 74 Appendix A (1), Executive Order 11246 and 11375); the Rehabilitation Act of 1973; and the Americans with Disabilities Act of 1993 and its implementing regulations (including but not limited to 28 CFR § 35.100 et seq.). Also, Providers must obey all provisions of the Puerto Rico Patient's Bill of Rights and the implementing regulation, which prohibits discrimination against any patient. FMHP is responsible for all Vital Plan marketing materials. Any written informational and marketing materials must be developed at a fourth (4th) grade reading level and have prior approval from FMHP's Compliance Department. Providers are not authorized to develop and publicize educational or marketing without FMHP's written consent. If you want to promote any activity or share an educational material with Vital Plan Enrollees, please contact FMHP's Compliance Department at 787-625-9557.

FMHP will not contract or renew contract with any person or entity, or subsidiary companies, or any of its shareholders, partners, officers, principals, managing employees, subsidiaries, parent companies, officers, directors, board members, or ruling bodies that are or have been, under investigation for, accused of, convicted of, or sentenced to imprisonment, in Puerto Rico, the US, or any other jurisdiction, for any crime involving corruption, fraud, embezzlement,

or unlawful appropriation of public funds, pursuant to Act 458, as amended, and Act 84 of 2002.

In some circumstances, a contracted provider may subcontract with another provider to assure the provision of services to FMHP's enrollees. In those cases, the Subcontractor must comply with all the provisions required by FMHP to the Provider. The Provider shall not employ or subcontract individuals included in the Puerto Rico or Federal List of Excluded Individuals and Entities (LEIE), or with any entity that could be excluded from the Medicaid Program under 42 CFR § 1001.1551 - Exclusion of individuals with ownership or control interest in sanctioned entities and 42 CFR § 1001.1901 - Scope and effect of exclusion. Providers must disclose to FMHP whether any staff member or subcontractor has any prior-violation, fine, suspension, termination, or other administrative action taken under Medicare laws or by the federal government.

8.1.1 Cultural Competency Plan

The constant demographic changes produced in recent years in society have a great impact on health services. FMHP has a comprehensive Cultural Competency Plan that describes how we ensure that services are offered to all our Enrollees in a culturally competent manner. Our Cultural Competency Plan describes how providers, employees, and systems will effectively serve people of different cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, gender identity, or religion, in a way that recognizes values, affirms and respects the individual worth of Enrollees, and protects and preserves the dignity of each individual.

Our primary objective is to ensure that our Enrollees have access to health services in a culturally competent environment where associates and providers value diversity within the organization to meet the needs of linguistic services. FMHP's Cultural Competency Plan will assist you in integrating the knowledge, attitudes, and skills that are reflected in a culturally

competent organization to ensure the provision of services to all Enrollees including those with limited Spanish proficiency. FMHP defines limited Spanish proficiency as those Enrollees who have difficulty speaking, reading, writing, or understanding the Spanish language.

FMHP submits a copy of the complete Cultural Competency Plan to providers free of charge during the hiring process and upon request. Additionally, the Cultural Competency Plan training is posted on FMHP's website under the Providers Section, allowing our providers to participate in the training at their own pace. This training addresses the same elements described in the training offered to our employees. Providers will be responsible for providing Cultural Competency Plan training to their office staff. FMHP will provide the training materials at no cost. If you need a copy of FMHP's Cultural Competency Plan, feel free to contact Providers Department at 1-844-347-7802.

8.2 Provider Responsibilities

FMHP has a comprehensive Network of Providers capable of serving all Vital Plan's Enrollees. Our Providers are responsible for evaluating the enrollees periodically and to timely coordinate all the health care needs. The Provider must provide services in a manner consistent with professionally recognized standards of care and in a culturally competent manner.

8.2.1 The Role of a Primary Medical Group (PMG) and Primary Care Physician (PCP)

All Enrollees are required to select a PMG and a PCP. The PMG includes PCPs, Specialists, Subspecialists, laboratories, X-Ray facilities, and hospitals. This group of providers forms the Preferred Provider Network (PPN) of the PMG. Within the PMG, Vital Plan Enrollees have the freedom to visit the PPN physicians and providers without a referral or co-payment.

The PCP serves as the Enrollee's initial and most important contact for receiving medically needed covered services. PCPs will be responsible for providing, managing, and coordinating all medically needed services to Enrollees, including the coordination with Behavioral Health

personnel, in a timely manner, and in accordance with the guidelines, protocols, and practices generally accepted in medicine. The PCP will be responsible for providing referrals and coordinating visits to specialists or subspecialists outside of the PPN (if necessary or when a second opinion is desired) and to provide prescriptions for medications and/or treatments as needed. Prescriptions will not require a co-signature of the PCP if written by a contracted provider within the PPN.

Referrals are made when medically necessary services are beyond the scope of the PCPs practice. Enrollees within a PMG that has its own Preferred Provider Network ("PPN") can access a Specialist of such PPN, without the need of a referral from their PCP as well as acquiring a prescription without the countersignature of their PCP. FMHP expects that Specialists provide support to the PCP in coordinating and managing an Enrollee's health care by providing only those specific services for which the Enrollee has been referred and returning the Enrollee to the PCP as soon as medically appropriate. If a specialist is consulted during an Emergency Room visit or Hospital stay, a referral is not required for providing that care; however, authorization may be required for any follow-up care provided after the Emergency Room visit.

Special Coverage Registration Process

PCPs must notify FMHP's Case Management Department immediately upon identification of an Enrollee diagnosed with a condition that is within the scope of the Special Coverage Benefit. Providers must submit the Special Coverage Registration Form available at: www.firstmedicalvital.com within one (1) working day of the Enrollee having been screened and diagnosed with a qualifying condition. For more information please refer to Section- Special Coverage Benefit for a list of the diagnoses within the scope of the benefit.

8.3 Timely Access to Services

FMHP is committed to providing timely access to health care for Vital Plan Enrollees. We developed access standards to ensure that our Vital Plan Enrollees receive health care services in a timely manner. FMHP will monitor that Providers' office hours for Vital Plan Enrollees' are no less than those offered to commercial members.

Providers are required to comply with the following appointment standards and minimum requirements for access to services:

8.3.1 Non-urgent Conditions

- Routine physical exams shall be provided to Enrollees ages twenty-one (21) and over within thirty (30) calendar days of the Enrollee's request for service, considering both Medical and Behavioral health needs and condition. For minors less than twenty-one (21) years of age, routine physical exams shall be provided within the timeframes of FMHP's EPSDT Program.
- Primary care routine evaluations shall be provided within thirty (30) calendar days, unless the Enrollee requests a later date.
- Covered Services shall be provided within fourteen (14) calendar days following the request for service.
- Specialist Services shall be provided within thirty (30) calendar days of Enrollee's request for service.
- Dental Services shall be provided within sixty (60) calendar days following the request unless the Enrollee requests a later date.
- Behavioral Health Services shall be provided within fourteen (14) calendar days, following the request, unless the Enrollee requests a later date.
- Diagnostic laboratory, diagnostic imaging, and other testing appointments shall be provided consistent with the clinical urgency, but no later than fourteen (14) calendar

days following the request, unless Enrollee requests a later date. If a "walk-in" system is used rather than appointment system, the Enrollee wait time shall be consistent with the severity of the clinical urgency.

- The prescription fill time (ready for pick up) shall be no longer than forty (40) minutes. A prescription phoned in by a practitioner shall be filled within ninety (90) minutes.

Providers shall not establish specific days for the delivery of referrals and requests for Prior-Authorization for Vital Plan Enrollees.

8.3.2 Urgent Conditions

- Emergency Services shall be provided, including the access to an appropriate level of care, within twenty-four (24) hours of the service request.
- Primary medical, dental, and behavioral health care outpatient appointments for urgent conditions shall be available within twenty-four (24) hours.
- Urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability shall be consistent with the clinical urgency, but no later than forty-eight (48) hours.
- Behavioral health crisis services face-to-face appointments shall be available within two (2) hours.
- Detoxification services shall be provided immediately according to the clinical necessity.

Emergency services shall be provided, including access to an appropriate level of care, twenty-four (24) hours a day, seven (7) days a week. The scheduling of follow-up outpatient visits with practitioners shall be consistent with the Enrollee' clinical need.

8.3.3 Behavioral Health Services

- Psychiatric Hospital (or Unit within a General Hospital), Emergency or Stabilization units shall provide services twenty-four (24) hours a day, seven (7) days a week and shall have available at a minimum one (1) nurse, one (1) social worker and one (1) psychologist/psychiatrist.
- Partial Hospitalization Facilities are required to provide services ten (10) hours per day at least five (5) days per week and shall have available one (1) nurse, one (1) social worker and one (1) psychologist/psychiatrist.

8.3.4 Preferential Turns:

FMHP request Providers to establish and publicize a system of Preferential Turns for those Enrollees from the municipalities of Vieques and Culebra, so that they can be seen by the physician within a reasonable time after arriving at the Provider's office. This priority treatment is necessary because of the remote locations of these municipalities, and the greater travel time required for the residents to seek medical attention. This requirement was established in Act No. 86 enacted on August 16, 1997 and Act No. 200 enacted on August 5, 2004.

8.3.5 Extended Schedule of Primary Medical Group (PMG)

PMGs shall be available to provide primary care services or consultations Monday through Saturday, of each week, from 8:00 a.m. to 6:00 p.m. Each Provider that offers these services, as well as any other qualified Provider willing to provide urgent care services, shall have sufficient personnel to offer urgent care services during extended periods Monday through Friday from 6:00 p.m. to 9:00 p.m. (Atlantic Time). To provide Enrollees greater access to their PCP and to urgent care services. PMGs may collaborate with each other to establish extended office hours at one (1) or multiple facilities.

8.3.6 Co-Sharing

Cost Sharing is the co-payment or deductible that Enrollees must pay for Covered Services provided under Vital Plan. The usual processes requiring co-pays and co-signatures for prescriptions will apply for Enrollees that received services from providers in the General Network or Out of Network Providers. It's the provider's responsibility to collect the co-payment and other member Cost Share from the Enrollee. The amount of the co-payment and other cost sharing will be deducted from your payment. Providers may not charge members fees for covered services beyond co-payments or deductible.

No co-pays will apply to the PPN and General Network for Medicaid and CHIP Enrollees when going outside of the PPN. Commonwealth membership will continue to pay applicable co-pays.

8.3.7 Site and Medical Record-Keeping Practice Reviews

Providers are required to comply with certain standards for privacy and confidentiality, and record keeping practices in their practices. Please refer to Section- Commitment to Protect Patient Privacy and Confidentiality for information regarding these requirements.

8.3.8 Panel Closure

Occasionally PCPs will request closure of their panel. This means that they are no longer accepting new patients. FMHP requires the Providers to send a written notice thirty (30) days prior to the proposed effective date of such closure. FMHP will update the Provider Directory to reflect that these providers are "not accepting new Enrollees". If the PCPs determine to reopen their panel to new Enrollees the PCPs will send a written notice to FMHP's Provider Services Department informing the effective date for reopening of the panel.

If Providers relocate or open an additional office, they should notify FMHP's Providers Department sixty (60) days in advance. A site visit of the new office may be conducted after notification.

8.3.9 Ownership

- No PCP may own any financial control or have a direct or indirect economic interest (as defined in Act 101 of July 26, 1965) in any Ancillary Services facility or any other Provider (including clinical laboratories, pharmacies, etc.) under contract with the PMG.

9 CREDENTIALING AND RE-CREDENTIALING

Credentialing refers to the process by which FMHP obtains and evaluates documentation regarding a medical provider's academic qualifications, training, work history, licensure, regulatory compliance record, and malpractice history before allowing the provider to participate in our Network of Providers. Through this process, FMHP guarantees that Providers comply with all the requirements established by the Center for Medicare and Medicaid Services (CMS), PRHIA and FMHP's Policies and Procedures, and assure that Vital Plan Enrollees receive the highest level of care from healthcare professionals who have undergone the most stringent scrutiny regarding their ability to practice medicine. FMHP has contracted International Medical Card, Inc. (IMC) as a delegated entity to conduct the credentialing process.

IMC has established a well-defined credentialing and re-credentialing process that evaluates and selects licensed practitioners to provide care to Vital Plan Enrollees in compliance with FMHP and PRHIA requirements. To be eligible for participation providers must comply with all the credentialing requirements. The Credentialing and Re-credentialing Policy and Procedures defines the criteria (requirements) to participate in FMHP's Providers Network. The credentialing requirements may vary based on the type of provider/facility.

Primary and secondary source verifications of providers' credentials, as a key to ensuring compliance with FMHP's accreditation standards, are conducted within forty-five (45) calendar days from the receipt of a completed application for enrollment on FMHP's Network of Providers. IMC bases the decision to accept or deny an applicant upon primary source validation, the recommendation of peer practitioners/providers members of the Credentialing Committee and the evaluation of additional information if required. Any physician that does not comply with the minimum standards will not be recommended for acceptance to be part of FMHP's Provider Network.

Providers are considered without regard to race, creed, color, gender, age, sexual orientation, national origin, or handicap, unless the latter affects the ability of the practitioner to provide quality healthcare. FMHP and IMC do not discriminate in terms of participation, reimbursement, or indemnification, against any health care professional acting within the scope of his/her license. FMHP and IMC do not discriminate against professionals who serve high-risk populations or who specialize in the treatment of costly conditions. FMHP reserves the right to exercise discretion in applying any criteria and to exclude providers who do not meet the criteria.

Credentialing Requirements to Participate in FMHP's Providers Network

Providers must meet the following criteria to be eligible to participate in FMHP's Providers Network. If the practitioner fails to provide proof of meeting these criteria, the credentialing application will be deemed incomplete and it will result in an administrative denial. Providers who fail to provide proof of meeting these criteria do not have the right to submit an appeal.

List of Credentials and/or Documents Required for Primary Physicians:

General Practitioner, Internal Medicine, Family Medicine, Pediatricians and Obstetric Gynecologists:

- Copy of the License issued by the Medical Board of Puerto Rico (*Junta de Médicos de Puerto Rico*)
- Copy of the Internship
- Copy of the Residence (if applicable)
- Copy of the Fellowship (if applicable)
- Copy of Board Certified (if applicable)
- Current copy of the Federal Narcotics License (DEA)
- Current copy of the State Narcotics License (ASSMCA)
- Current copy of the Medical Malpractice Policy (endorsed by FMHP)
- Current copy of the Registration and Medical Education Certification
- Copy of the NPI Letter
- Current copy of the Professional Association (*Colegiación*)
- Copy of the Medicare Letter (PTAN) (if applicable)
- Work experiences or Curriculum Vitae

List of Credentials and/or Documents Required for Primary Physicians

General Physician, Specialists and Subspecialists:

- Copy of the License issued by the Medical Board of Puerto Rico (*Junta de Médicos de Puerto Rico*)
- Copy of the Internship
- Copy of the Residence (if applicable)
- Copy of the Fellowship (if applicable)

- Copy of Board Certified (if applicable)
- Current copy of the Federal Narcotics License (DEA)
- Current copy of the State Narcotics License (ASSMCA)
- Current copy of the Medical Malpractice Policy (endorsed by FMHP)
- Current copy of the Registration and Medical Education Certification
- Copy of the NPI Letter
- Current copy of the Professional Association (*Colegiación*)
- Copy of the Medicare Letter (PTAN) (if applicable)
- Work experiences or Curriculum Vitae
- Valid copy of the Certificate Triennial Registry of Medicines by office (if applicable)
- Registration of Corporation and Brand (if applicable)
- Copy of the Corporate NPI Letter (if applicable)
- IRS copy (if applicable)

Dentists, Endodontists, Periodontists and Oral and Maxillofacial Surgery:

- Copy of the license issued by the Board of Health Professionals (*Junta de Profesionales de Puerto Rico*)
- Copy of the Diploma
- Copy of the Internship (if applicable)
- Copy of the Residence (if applicable)
- Current copy of the Federal Narcotics License (DEA) (if applicable)
- Current copy of the State Narcotics License (ASSMCA) (if applicable)

- Current copy of the Medical Malpractice Policy (endorsed by FMHP)
- Current copy of the Registration and Medical Education Certification
- Copy of the NPI Letter
- Current copy of the Professional Association
- Summarize with work experiences
- Copy of the Medicare Letter (PTAN) (if applicable)
- List of Faculty by Office (Dental Assistants)
- Current copy of the Continuing Education Record of each Dental Assistant
- Current copy of the X-Ray License by office or Evidence of Recent Payment by office
- Current copy of the Triennial Drug Registry (First aid kit) by office
- Registration of Corporation and Brand (if applicable)
- Copy of the Corporate NPI Letter (if applicable)
- IRS copy (if applicable)

Health Professionals (Physical Therapy, Occupational Therapy, Speech Therapist, Audiology, Nutritionists, among others):

- Copy of the license issued by the Board of Health Professionals (*Junta de Profesionales de Puerto Rico*)
- Copy of the Diploma
- Copy of the Internship (if applicable)
- Current copy of the Medical Malpractice Policy (endorsed by IMC Salud/FMHP)
- Current copy of the Registration and Medical Education Certification

- Copy of the NPI Letter
- Current copy of the Professional Association (if applicable)
- Copy of the Medicare Letter (PTAN) (if applicable)
- Summary of work experiences
- Registration of Corporation and Brand (if applicable)
- Copy of the Corporate NPI Letter (if applicable)
- IRS copy (if applicable)

List of Credentials and/or Documents Required by Facility

Ambulatory Surgery Centers:

- Copy of the Medicare Letter (PTAN) (if applicable)
- Current copy of the Sanitary License
- Copy of the Certificate of Necessity and Convenience
- Copy of the Medical Malpractice Policy (endorsed by IMC SALUD / IMC Salud / FMHP)
- Copy of the Health Department License (SARAF)
- List of updated faculties of doctor
- Copy of the Continuing Education Record of each doctor
- Copy of the FDA License (mammography)
- Copy of the X-Ray License
- Copy of the Accreditation (ADIA)
- Registration of Corporation and Brand (if applicable)
- Copy of the Corporate NPI Letter (if applicable)

- IRS copy (if applicable)

Radiology Center:

- Copy of Medicare (PTAN) (if applicable)
- Current copy of the Sanitary License
- Copy of the Certificate of Necessity and Convenience
- Copy of the Medical Malpractice Policy (endorsed by IMC SALUD / IMC Salud / FMHP)
- Copy of the Health Department License (SARAF)
- List of updated Faculty of Radiologists
- Copy of the License of each Radiologist
- Copy of the Continuing Education Record of each Radiologist
- Copy of the FDA License (Mammography)
- Copy of the X-Ray License
- Copy of the Accreditation (ADIA)
- Registration of Corporation and Brand (if applicable)
- Copy of the Corporate NPI Letter (if applicable)

The Provider Application for Credentials along with the required documents should be sent to IMC's Credentials Department via:

International Medical Card, Inc. Gonzalo Marín Avenue # 51 Arecibo, PR 00612		IMC-Credentials Department PO Box 144090 San Juan, PR 00614-4090
		credenciales@intermedpr.com
		787-300-3920

Note: Incomplete application will not be processed. If you need additional information related to the credentialing requirements, please contact us at 787-878-6909, and press option #3. Our service hours are Monday through Friday from 8:00 a.m. to 5:00 p.m.

9.1 Types of Credentialing process

9.1.1 Provisional Credentialing:

Provisional credentialing is an optional process that IMC incorporated into its credentialing policy to allow FMHP to add practitioners to its network prior to completing the full credentialing process. The intention of provisional credentialing is to meet the Enrollee's needs for continuity or quality of care. IMC Credentialing Committee may provisionally credential a new applicant on a one-time basis. The Credentialing Committee will grant a provisional credentialing based in the evaluation of the following indicators:

- Primary-source verification of a current, valid license to practice;
- Primary-source verification of the past five years of malpractice claims or settlements from the malpractice carrier, or the results of the National Practitioner Data Bank (NPDB) query;
- Current DEA, if applicable;
- Current and signed application

Provisional status cannot last from more than 180 calendar days after the determination of the Credentialing Committee. By that time, IMC must complete the full credentialing process.

9.1.2 Initial Credentialing:

The credentialing process starts when the providers complete a credentialing application designed to provide the information necessary to perform a comprehensive review of the practitioner's credentials. The application must be completed in its entirety. To be eligible to apply practitioners must meet all the criteria outlined above in the section titled "Credentialing Requirements to Participate in FMHP's Providers Network". Credentialing on average takes

approximately six weeks from the time an application is submitted to the IMC Credentialing Department with all required documentation.

All health care providers who request to participate in FMHP's Providers Network must have their credentials verified through State and Federal Agencies, licensing bodies, and hospitals or schools that have supervised the appropriation of such licenses, qualifications, and appointments. This is done through a primary source verification of credentials through the respective primary sources:

1. Current, valid, unrestricted state license to practice the health profession
2. Verification of appropriate education and training
3. Board certified, if applicable, by a recognized certification program
4. Compliance with Federal requirements that prohibit employment or contracting Providers excluded from participation under either Medicare or Medicaid.

FMHP verifies the primary source of all new Providers against the Medicare sanctions list prior to entry into the FMHP provider network. Any Provider violating the existing sanctions will be excluded from participation in the FMHP provider network.

IMC's Credentialing Specialist will conduct a secondary verification to validate the following credentials:

1. Clinical privileges in good standing at the hospital designated by the health care professional as the primary admitting facility if the physician or other health care professional has admitting privileges.
2. Current, adequate malpractice insurance.
3. A valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate.
4. NPI must be active in the NPPES.
5. For physicians, any other information from the National Practitioner Data Bank.

6. Information about sanctions or limitations on licensure from the Medical Board of Puerto Rico (*Junta de Médicos de Puerto Rico*).
7. Eligibility for participation in Medicare Program.

For the application to be deemed complete the provider must produce adequate information to prove that he/she meets all criteria for initial participation in the FMHP's Providers Network. The process is delayed if we need to gather the information or documentation. Your application will be held by the Credentialing Specialist until all the required information is acquired and submitted to the Credentialing Committee. The application may not be more than 180 days before submission to the Credentialing Committee. If the provider does not submit the information necessary to complete the application process in the time requested the application will be deemed incomplete and IMC will discontinue processing of the application. This will result in an administrative denial or administrative termination from the FMHP's Providers Network. The Providers have the right:

- Upon request, to be informed of the status of their application.
- To review their credentials file at any time.
- To correct erroneous information in their credentials file.

The Providers are credentialed upon hire and every three years. IMC will maintain a unique provider file for each Provider. The Provider file shall be updated annually and include at least a minimum of the following documents: updated application, primary source verification, Annual Puerto Rico Review, DEA license, Malpractice Insurance, ASSMCA License, Medical Licensing, and SARAFS.

Providers can access our credentials system to upload and update their credentialing documents into the system. They can access it through the following link: https://firstmedical.rcredentials.com.

On a monthly basis, FMHP will check the List of Excluded Individuals/Entities, maintained by HHS-OIG; and Excluded Parties List System and Puerto Rico List Excluded Provider.

9.1.3 Recredentialing:

Recredentialing is the process of periodically rereviewing and reverifying your professional credentials based on IMC's credentialing criteria. IMC will require to recredential to ensure that we have the most up-to-date and accurate information about your practice. Recredentialing is required every three years. IMC will mail you a Notice of Recredentialing Process with the application and a list of the required documentation on one-hundred and twenty (120), ninety (90), and sixty (60) days before your credentialing appointment expires. Failure to return your application on time would require IMC to terminate your contract with FMHP. The Provider file shall be updated with the following documentation:

- Annual Puerto Rico Review
- DEA License
- Malpractice Insurance
- ASSMCA License

9.2 Credentialing Committee

The Credentialing Committee is responsible for assuring, reviewing, and evaluating the qualifications, conduct, professional character, and competency of each practitioner applying for initial credentialing and Recredentialing, which are necessary to deliver quality care to the members. The Credentialing Committee meets at the end of each month, final approval for credentialing isn't completed until that time.

9.2.1 Notification of Credentialing Committee Decisions

FMHP will send a letter to all providers to inform of the Credentialing Committee decision regarding their participation in FMHP's Providers Network. This notification will be sent within

two weeks of the decision. FMHP will include a copy of the letter in the provider's credentials files.

If a Provider is denied participation in FMHP's Providers Network, the provider has 30 days from receipt of the letter to submit a written request to First Medical Health Plan for a hearing to reconsider the proposed action. The Appeals Committee will render its decision as promptly as possible and will notify the provider of its decision in writing. The panel may decide to reinstate, conditionally reinstate, or terminate the provider. FMHP will include a copy of the letter in the provider's credentials files.

Information submitted, collected, or prepared by any IMC or FMHP's representative for the purpose of evaluating and determining providers participation in FMHP's Providers Network shall, to the fullest extent permitted by law, be confidential and shall only be disseminated to a representative to carry out appropriate activities under these IMC and FMHP's Policies and Procedures.

9.2.2 Ongoing Monitoring

The Credentialing Department shall monitor practitioners' sanctions and/or exclusions monthly through several government reports, including:

- Federal and state/commonwealth lists of excluded individuals and entities.
- List of parties excluded from Federal Procurement and Non-procurement Programs.
- Federal and state/commonwealth Medicaid sanction reports
- Medicaid suspended and ineligible provider list.
- Monthly review of state/commonwealth Medical Board sanctions list.
- Review of license reports from the appropriate specialty board.

If the providers do not comply with the credential's requirements, their contract could be affected.

9.2.3 Provider Orientation

IMC Credentialing Representative will provide orientation to participating providers to ensure full understanding of FMHP's contract dispositions, healthcare applicable laws and regulations, and PRHIA requirements.

9.2.4 Medicare and Medicaid Sanctioned Providers

Providers must voluntarily disclose all Medicare and Medicaid sanctions. Practitioner must disclose all debarments, suspensions, proposals for debarments, exclusions, or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application a detailed response is required from the practitioner.

Practitioner must not be currently sanctioned, excluded, expelled, or suspended from any state/commonwealth or federally funded program including but not limited to the Medicare or Medicaid Programs. IMC will review the list of sanctioned Medicare Providers monthly. Upon identification that a Contracted Provider is included in the Medicare Provider sanction list, the panel will be closed, and the name suppressed from printing in any future directories. Simultaneously, the Credentialing Department may request information from the Provider and reporting agency to determine if there are further details of the sanction. If the information is consistent and the Provider has been barred from participation in Medicare and/or his or her license has been the subject of a disciplinary action, including but not limited to censure, reprimand, loss of license, suspension, etc., termination procedures will follow immediately.

9.3 Terminations

IMC will comply with all Puerto Rico and Federal laws regarding Provider termination. The termination of the provider contract will not be permitted without cause. IMC may terminate or suspend a provider's participation in the network for any of the above reasons.

9.3.1 CREDENTIALING DETERMINATION:

IMC Salud may decide not to contract a Provider if he/she does not meet Recredentialing requirements as established in FMHP's Policies and Procedures and PRHIA contract.

Failure to comply with certain contractual obligations: According to the contract between FMHP and PRHIA "Termination of the Provider Contracts" includes gross negligence in complying with the contractual considerations or obligations; insufficiency of funds, which prevents them from continuing to pay for their obligations; and changes in Federal law.
Quality management requirements: Non-compliance with the Quality Improvement Program (QIP Program).

- A pattern of Quality of Care complaints
- Breach of the following programs:
    - First Medical Quality Management Program,
    - Performance standards, (for example, the score of the review of the medical record, results of HEDIS)

Final disciplinary action taken by a governmental regulatory agency that impairs the provider's ability to practice:

Also, as for criminal cases, for being excluded from some federal program, or not fulfilling the requirements of their credentials. These points can be found in more detail in the contract clauses.

Other issue that could potentially cause imminent harm or danger to the member.

IMC Salud reserves the right to suspend the provider contract and the privileges of a provider to serve a FMHP beneficiaries for the following reasons:

- If the provider has breached the contract or failed to comply with the contract requirements.

- A pattern of Quality of Care complaints or adverse events has been reported
- If the provider has an excessive number of quality issues.
- If a provider's license or credential has been expired more than 90 days and the provider has received three renewal notices from the Credentials Department, and the provider has not submitted the current documents.

9.3.2 Provider Inactivity

Upon notification of FMHP Fraud Waste and Abuse Unit, IMC Salud will terminate inactive providers due to inactivity during the past twelve (12) months. Under no circumstances will IMC Salud initiate termination actions against a provider solely because he or she has:

- Advocated on the behalf of a member
- Filed a complaint against a Local or Federal regulatory body
- Appealed IMC Salud/FMHP decision
- Provided information to an appropriate agency
- Requested a hearing or review.

A Provider may elect to terminate his or her contract with IMC Salud following the provisions specified in the provider's agreement with the plan if:

a. The provider fails to abide by the terms and conditions of the Provider Contracts, as determined by PRHIA, or in the sole discretion of PRHIA, if the provider fails to come into compliance within fifteen (15) Calendar Days after a receipt of notice from IMC Salud or FMHP specifying such failure and requesting such provider to abide by the terms and conditions hereof.

9.3.3 Termination Process

IMC Credentialing Committee may determine that the provider does not meet PHRIA requirements pertaining to quality of care, services, or established performance/professional standards to continue as a participating provider in the FMHP Providers Network. FMHP will

notify to PRHIA at least forty-five (45) Calendar Days prior to the effective date of the suspension, termination, or withdrawal of a provider from participation in the Provider Network.

Process will be as follows:

1. Within ten (10) calendar days of the Committee's decision, the practitioner is sent a written notice of termination via certified mail which includes the following:
    - A description of the action being taken
    - Reason for termination
    - Details regarding the practitioner's right to request a fair hearing within thirty (30) calendar days from receipt of notice, if applicable.
2. If the provider determines to appeal IMC determination, the provider has 30 days from the receipt of the letter to submit a written request to FMHP for a hearing to consider the proposed action.
3. If a request is made IMC will schedule a hearing within the sixty (60) day period after the receipt of the written request. The Appeals Committee will act as the hearing panel. The Appeals Committee must have at least three members, one or more of which must be a clinical peer. A "clinical peer" is defined as a provider having the same or substantially similar specialty as the provider under review. If the panel assembled has more than three members, at least one third of the panel's members must be clinical peers.
4. The Appeals Committee will render its decision as promptly as possible and will notify the provider of its decision in writing. The panel may decide to reinstate, conditionally reinstate, or terminate the provider.

If a provider is terminated or suspended for deficiency in the quality of his or her care, written notice of the action must be given to the licensing or disciplinary bodies or other appropriate authorities.

10 CONTRACTED PROVIDER DISPUTE PROCESS

FMHP has an internal dispute process in which contracted providers have the opportunity to resolve issues related to billing, payment, and other administrative disputes arising under the Provider Contract, included the medical – patient relationship issues. The dispute process for contracted providers addresses two categories of complaints: Payment Disputes and Administrative Disputes. This type of request must be submitted in written with all the necessary evidence for its evaluation.

10.1 ADMINISTRATIVE DISPUTE PROCESS

Under the Administrative Disputes the provider can notify any dissatisfaction related to a contracting, credentialing, or medical-patient relationship issue. The provider has one hundred and twenty (120) calendar days to file a dispute after the incident that generate the dissatisfaction. FMHP will investigate and submitted verbal and written resolution to the provider within fifteen (15) days of the receipt of the request.

10.1.1 PAYMENT DISPUTE PROCESS

If upon submitting an adjustment request to the Claims Department, you receive an adverse determination and do not agree with the resolution you have the right to request a payment dispute. Remember, you must first submit an adjustment process before requesting a dispute.

To request a payment dispute, you must:

Complete the Dispute Form in its entirety or write a request explaining the reason of your disagreement and send it via email, mail, or fax.

Include a copy of the claim and relevant information, necessary to evaluate the case. This includes, but is not limited to, a copy of the Payment Voucher, evidence of claim submission, among others. You will have one hundred and twenty (120) calendar days from the adjustment result notification to request a provider dispute. FMHP will investigate and submitted verbal and written response to the provider within fifteen (15) days from the receipt of the request.

YOU CAN SUBMIT YOUR REQUEST THROUGH THE FOLLOWING:

First Medical Health Plan, Inc. Grievances and Appeals Department PO Box 195079 San Juan, PR 00919-5079		IMC-Credentials Department PO Box 144090 San Juan, PR 00614-4090
		disputas-proveedores@fmsaludpr.com
		787-300-3932

You will be notified in writing of the results of your dispute. Failure to comply with the above process will result in the dismissal of your dispute. You will receive a letter notifying the reason for the dismissal. If you have any questions or require additional information, please feel free to contact the Providers Call Center.

11 COMPLAINT, GRIEVANCE, AND APPEAL PROCESS FOR BENEFICIARIES

In accordance with the applicable laws and contractual requirements FMHP has an internal Grievance System in which Enrollees or Providers on their behalf may report dissatisfaction with the services received or challenge the denial of coverage or payment. The Grievance

System includes the following process: Complaints, Grievances and Appeals; below you will find a short explanation of each process.

A complaint is defined as an expression of dissatisfaction about any matter other than an adverse benefit determination that is resolved at the point of contact rather than through filing a formal grievance. The Enrollee and/or their Authorized Representative can file a complaint either orally or in writing. A complaint should be presented within fifteen (15) calendar days after the date of the occurrence that initiated the dissatisfaction. FMHP shall resolve the complaint within seventy-two (72) hours from the receipt of the complaint. If the complaint is not resolved during that time, the complaint shall be treated as a grievance.

A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination. An Enrollee can file a grievance expressing dissatisfaction with any aspect of the operation, activities, or behavior of a plan sponsor, regardless of whether remedial action is requested. A grievance may also include a complaint that a plan sponsor refused to expedite a coverage determination, a redetermination, an organization determination, or reconsideration, or invoke an extension to an organization determination or reconsideration time frame.

An Enrollee can file a grievance verbally or in writing. It can be sent via fax, email, or regular mail. For standard grievances, FMHP will have to respond to the complaint in writing within ninety (90) calendar days from the date received. FMHP will provide a response to an expedited grievance within twenty-four (24) hours from its receipt.

FMHP may extend the time frame by up to fourteen (14) calendar days if an extension is requested, or if FMHP justifies a need for additional information and the delay is in the Enrollee's best interest.

If FMHP makes an adverse benefit determination and the Enrollee is not satisfied with this decision, he/she can file an appeal. An appeal is a formal way of asking the plan to review and/or change the plan's initial determination.

All appeal requests must be submitted within sixty (60) calendar days from which the initial determination was made. An Enrollee can file the appeal verbally or in writing. Except for expedite requests, if the request is filed verbally, he/she must confirm the appeal request in writing within ten (10) calendar days of the oral request. The Enrollee and/or their Authorized Representative have the opportunity to submit evidence, justifications, or additional supporting documentation related to his/her request.

FMHP has thirty (30) calendar days to respond, to standard requests, in writing and seventy-two (72) hours to respond to expedited requests. FMHP may extend this time frame by up to fourteen (14) calendar days if an extension is requested, or if the plan justifies a need for additional information and the delay is in the Enrollee's best interest.

If FMHP upholds the initial determination in whole or in part, the Enrollee will receive a written notification with the reason for denial. The Enrollee will then have the right to request an Administrative Law Hearing (ALH) from the PRHIA. To request this right, the Enrollee must exhaust FMHP's Complaints, Grievance and Appeal process. PRHIA shall permit the Enrollee to request the ALH within one hundred and twenty (120) calendar days of the Notice of Resolution Appeal receipt.

For any of the above described requests, the Provider can represent the Enrollee with a written authorization from him/her. If the request comes without a written authorization and is not received within thirty (30) days, the request will be dismissed.

11.1 Continuation of Benefit

While the resolution of an appeal or ALH is pending the Enrollee and/or their Authorized Representative can request the continuation or reinstatement of benefits. To request the continuation of benefit, the appeal should:

- Be filed in a timely manner;
- Involve the termination, suspension, or reduction of a previously authorized course of treatment; and
- Be ordered by an authorized provider.

If the final resolution of the appeal or ALH is adverse to the Enrollee, FMHP may recover, from the Enrollee, the cost of services furnished while the appeal or the ALH was pending.

11.2 Appointing a Representative

An Enrollee or someone who he/she appoints as an Authorized Representative may file a complaint, grievance, or appeal. In some PRHIA, an Enrollee may already have someone authorized under the Commonwealth law to act on their behalf. However, if they don't have someone authorized under the Commonwealth law, they can appoint a relative, friend, lawyer, advocate, doctor, or anyone else to act on his/her behalf by completing and returning an Authorization of Representative form. This form must be signed, dated, and must include the name of the person that the Enrollee is authorizing.

The Authorization of Representative form is available in the FMHP website at: www.firstmedicalvital.com.

11.3 Submitting a Complaint, Grievance, or an Appeal

To submit a complaint, grievance or an appeal, the Enrollee may visit one our Service Offices, or send a signed written request by mail or email at:

First Medical Health Plan, Inc. Grievances and Appeals Department PO Box 195079 San Juan, PR 00919-5079		IMC-Credentials Department PO Box 144090 San Juan, PR 00614-4090
		querellas-beneficiarios@fmsaludpr.com
		787-300-3931

The Complaints, Grievances and Appeals Form is available in the FMHP website at: www.firstmedicalvital.com.

12 BILLING AND CLAIMS

Our contract with PRHIA requires to comply with all Federal and State Plan Regulations and requirements; including, but not limited to, CMS instructions applicable to the Medicaid Program, the Puerto Rico Medicaid Management Information System (PRMMIS), and Medicaid Program Integrity measurements, including Fraud, Waste and Abuse, as well as any federal or local requirement as established for the Medicaid Program. Therefore, FMHP's Claim Adjudication System will apply all regulatory payment rules, require by the Medicaid Program. Providers must comply with rules, regulations, and laws as implemented and as amended by PRHIA and CMS related to Puerto Rico Medicaid Program. Also, our Providers must comply with FMHP's Policies and Procedures and all applicable rules and regulations related to claims data submission for purpose of compliance with MMIS (Medicaid Management Information System).

Regulators such as CMS and PRHIA implemented several initiatives to prevent improper payment before a claim is processed and to identify and recoup improper payments after the claim has been processed. These initiatives have the purpose of reducing payment error by identifying and addressing billing errors related to coverage and coding made by providers. The

Medicaid National Correct Coding Initiatives (NCCI) Edits and the MUEs (Medically Unlikely Edits) are programs that apply the coding policies as defined by the American Medical Association (AMA) Current Procedural Terminology (CPT) Manual, HealthCare Common Procedure Coding System (HCPCS) Manual, National and local Medicare Policies and edits, coding guidelines developed by national societies, standard medical and surgical practices and current coding practice. CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment of claims.

However, it is important to understand that the NCCI does not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination. If a Provider identifies that a claim has been coded incorrectly, he/she must submit a correct bill for the corresponding adjustment.

FMHP's Providers agree to safeguard beneficiary privacy and confidentiality and assure accuracy of beneficiary health records and encounter data. Submission of electronic claims/encounter data must be done through the standard HIPAA formats 837P, 837I, and 837D as applicable, with the new 5010 HIPAA compliance layout. Those Providers that submit paper claims must use the standard format CMS-1500 for professional services, UB-04 for Institutional claims and J-400 ADA for dental services. This Manual will provide you the billing instructions for each form type (CMS-1450-UB-04/CMS-1500/ADA).

Providers must comply with requirements for timely claims submissions as specified on the Provider Participation Agreement. All required fields on the 837 fields as well as paper claims must be included on the claims transaction to avoid rejects due to incomplete, missing, and incorrect data elements. The required supporting documentation must also be submitted with

a claim to process the same accordingly. Also, claims must be submitted within ninety (90) days from service/discharged date.

Providers are required by law to submit the required data on claims, related but not limited to, POA (Present on Admission Indicator) for Principal, external cause of injury and other diagnosis for inpatient services, Combination of CPT and/or HCPCS codes and revenue codes when required must be submitted on the claim transaction. Also, information such as Discharge hour, Admission type, Admission Source, Discharge Status, Admitting Diagnosis codes, modifiers when required, diagnosis pointer, billing address (must be a street address), among other fields, must be completed and submitted to FMHP. Please refer to the detail requirements specified further on section: FIELD SPECIFIC INSTRUCTIONS.

Since each form type has its own required fields, depending on provider type, FMHP has developed a billing guide for claim form completion and submission. Provider must follow the instructions for each form type. These instructions could change from time to time depending on PRHIA and CMS' regulations as well as any business rules based on Program specifics. The required fields must be completed on all form types, for FMHP to evaluate and process your claim.

To process a claim adequately and promptly, the Provider must submit a clean claim to FMHP. A clean claim is defined as a claim received by FMHP for adjudication, which can be processed without obtaining additional information from the Provider of the service or from a Third Party. Claims returned to providers as unclean must be resubmitted with all corrections and/or required supporting documentation within twenty days (20) from the letterhead date indicated on the letter. Any request of an adjustment to a claim previously paid and/or denied must comply with submission timeframe of twenty (20) days from the EOP (Explanation of Payment)/835 transaction date. There are other payment rules which may be applicable to the

different methodologies according to the provider type and contract that the Provider might have with FMHP.

It is important that the Provider takes into consideration the importance of submitting a clean claim with the correct coding information in all the required and correspondent fields. You can obtain more information visiting the following Web Pages:
http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd

MLN/MLNProducts/Downloads/How-To-Use-NCCI-Tools.pdf

Additional information regarding Medicaid NCCI edits can be find in the following link:
https://www.medicaid.gov/medicaid/program-integrity/ncci/edit-files/index.html

Remember that it is important to submit a timely and complete claim to expedite the processing of your claim.

IMPORTANT INFORMATION:

12.1 CODING

The use of correct coding is key to submitting valid claims. To ensure claims are as accurate as possible, **use current valid diagnosis and procedure codes and code them to the highest level of specificity (maximum number of digits available)**. You can find additional information on coding requirements, diagnosis coding and procedure coding, as well as instructions for codes with modifiers on Chapter 23 of the Medicare Claims Processing Manual.

12.1.1 DIAGNOSIS CODING

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), is currently used to code diagnostic information on claims. You can access ICD-10-CM codes

electronically on the National Center for Health Statistics (NCHS), the Centers for Disease Control and Prevention website or you may purchase hard copy code books from code book publishers. Procedure Coding uses Healthcare Common Procedure Coding System (HCPCS) Level I and II codes to code procedures on all claims. Level I Current Procedural Terminology (CPT-4) codes describe medical procedures and professional services. CPT is a numeric coding system maintained by the American Medical Association (AMA). Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and DMEPOS when used outside a physician's office or injections administered within a physician's office or clinic. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the Level II HCPCS codes, or alphanumeric codes as they may be referred to, were established for submitting claims for these items. These codes are found in the HCPCS code book or by visiting the Alphanumeric HCPCS webpage.

The CPT code book is available from the AMA Bookstore on the Internet at www.medicalcodingbooks.com. You can also obtain additional information from "The Medicare Learning Network® (MLN)" who offers a downloadable guide about Evaluation and Management (E/M) codes which are a subset of HCPCS Level I codes. The Evaluation and Management Services Guide is available at the Medicare Claims Processing Manual, chapter 12.

12.1.2 Modifiers

The use of an appropriate modifier with procedure codes is essential to submitting correct claims. CMS established on the *Modifier 59 Article* that Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when two Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes should not be reported together either in all situations or in most situations.

Note: The AMA's CPT code book includes HCPCS Level I codes and modifiers, while the HCPCS code book includes HCPCS Level II codes and related modifiers.

12.1.3 Submitting Accurate Claims

Health care professionals and suppliers play a vital role in protecting the integrity of the Medicaid Program by submitting accurate claims, maintaining current knowledge of Medicare/Medicaid billing policies, and ensuring that all the documentation required to support the medical need for the service rendered is submitted. In addition to correct claims completion, Medicaid payment requires that an item or service:

- Meets a benefit category
- Is not specifically excluded from coverage
- Is reasonable and necessary

In general terms, a fraud is defined as making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist. Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicaid Program. It is a crime to defraud the Federal Government and its Programs. Punishment may involve imprisonment, significant fines, or both when noncompliance with several laws including, the False Claims Act, the Anti-Kickback Statute, the Physician Self-Referral Law (Stark Law), and the Criminal Health Care Fraud Statute, among others.

Below you will find detailed instructions on how to fill the claims forms for FMHP. Also, information related to the transaction 837P, 837 I, and 837D is included. Referral materials used to develop this guide are:

1. National Uniform Claim Committee (NUCC) 1500 Health Insurance Claim Form-Reference Instruction Manual for Form Version 02/12- Version 8.0 7/2020, or the most recent version.

2. Optum- Uniform Claim Editor for Professional Services-A guide to accurate 1500 Professional Claim Submission 837 refer to: http://www.x12.org for details and requirements for submission of 837 P= Professional.
3. OPTUM 360- Uniform Billing Editor-The ultimate guide to accurate facility claim submission.

12.2 CMS -1500- For Professional Services

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA ☐ PICA ☐

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		ZIP CODE / TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES ☐ NO ☐	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. / 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.		

NUCC Instruction Manual available at: www.nucc.org

12.2.1 CMS 1500 Field Specific Instructions

NOTE: All fields of form CMS 1500, are required. Remember that the new statues regarding the Puerto Rico Medicaid Management Information System (PRMMIS) requires compliance with the submission of all required data on the claim forms (CMS 1500/UB-04- J430-ADA Dental Claim Form) and, 837P/837I/837D electronic formats submitted for payment.

Claims that do not meet the federal requirements will be rejected for resubmission with the requested data elements.

FIELD	INSTRUCTIONS
1	Title: Medicare, Medicaid, Tricare, Champva, Group Health Plan, FECA, Black Lung, Other: Indicate the type of health insurance coverage applicable to this claim by placing an X in the appropriate box. Only one box can be marked.
837P	Loop 2000B, 2320 Item or data element number and name: SUBR05 insurance type code Length insurance type code: 3AN Repeatable: Once per claim. Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
1a	Title: Insured's ID Number: Enter "Beneficiary MPI Number" as shown on Beneficiary ID card from FMHP Vital. This information identifies the Beneficiary to the Payer to which claim is being submitted.
837P	Item or data element number and name: NM 108 Identification Code Qualifier NM 109 Identification Number Length identification Number: 80 AN Repeatable: Once per claim. Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.

2	Title: Patient's name: Enter the patient's full last name, first name, and middle initial. The patient's name is the name of the person who received the treatment or supplies. You should enter the information as it appears on the Beneficiary's card.
837P	Loop (2000B, 2000C) Item or data element number and name: NM 101 =QC Patient NM 102= 2 person (entity type qualifier) Patient Last Name: NM 103 Patient First Name: NM 104 Patient Middle Name NM 105 Patient Name Suffix NM 107 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
3	Title: Patient's Birth Date, Sex Enter the patient's 8-digit birth date (MM | DD | CCYY). Enter an X in the correct box to indicate sex of the patient. The "Patient's Birth Date, Sex" (gender) is information that identifies the patient and it distinguishes persons with similar names.
837P	Loop 2010CA Item or data element number: DMG01=D8 DMG02 PATIENT'S DATE OF BIRTH DMG03 PATIENT'S GENDER Length qualifier: 2AN Length date of birthday: 8N Format birthdate: CCYYMMDD Length patient sex: 1 AN Repeatable: Once per claim Valid entries for Patient sex are: M - Male F - Female U- Unknown Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
4	Title: Insured's Name:

	Enter the Beneficiary's full last name, first name, and middle initial. The "Beneficiary Name" identifies the person who holds the policy. If there is a primary insured to the Vital Plan, indicate the name of the primary Beneficiary person.
837P	Loop 2000B,2000C Item or data element Number and name: Subscriber name NM 101=IL insured or subscriber NM 102= 1 person Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
5	Title: Patient's Address (multiple fields) Enter the patient's mailing address and telephone number. The first line is for the street address; the second line, the city and state; the third line, the ZIP code and phone number. Do not use punctuation (e.g. commas, periods) or other symbols in the address. When entering a 9-digit ZIP code, include the hyphen.
837P	Loop 2010CA Item or data element number and name: Patient Address N301: Address line 1 N302: Address line 2 N401: City N402: State N403: Zip Code Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
6	Title: Patient Relationship to Insured: This field contains the code that indicates the relationship of the patient to the insured individual identified in item 4. Enter an X in the correct box to indicate the patient's relationship to Beneficiary when Item Number 4 is completed. Only one box can be marked.

837P	Loop 2000BA, 2000c Item or data element number and name: SBR02 OR PAT01 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
7	Title: Insured's Address (multiple fields) SITUATIONAL FIELD, REQUIRED IF APPLICABLE. Enter the Beneficiary address and telephone number. If Item Number 4 is completed, then this field should be completed. The first line is for the street address; the second line, the city and state; the third line, the ZIP code and phone number.
837P	Loop 2000B, 2000C Item or data element number and name: Patient's/Subscriber's Address N301: Address line 1 N302: Address line 2 N401: City N402: State N403: Zip Code Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
8	Title: Reserved for NUCC Use.
9	Title: Other Insured's Name: SITUATIONAL FIELD, REQUIRED IF APPLICABLE FIELD. If Item Number 11d is marked, complete fields 9, 9a and 9d, otherwise leave blank. When additional group health coverage exists, enter other Beneficiary's full last name, first name, and middle initial of the Beneficiary in another health plan if it is different from that shown in Item Number 2. Use commas to separate the last name, first name, and middle initial. The "Other Insured's Name" indicates that there is a holder of another policy that may cover the patient.
837P	Loop 2000B, 2000C Item or data element number and name: Subscriber Name

	NM101: IL= Insured or subscriber NM102: 1 person NM103: Insured's Last Name NM104: Insured's First Name NM105: Insured's Middle Name NM107: Insured's Suffix Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
9a	Title: Other Beneficiary Policy or Group Number- SITUATIONAL FIELD, REQUIRED IF APPLICABLE. The "Other Beneficiary Policy or Group Number" identifies the policy or group number for coverage of the Beneficiary as indicated in Item Number 9.
837P	Loop 2320 Item or data element number and name: SBR03 –Subscriber group or policy number Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
9b	Reserved for NUCC Use.
9c	Reserved for NUCC Use.
837P	This field does not exist in 5010A1 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
9d	Title: Insurance Plan Name or Program-SITUATIONAL FIELD, REQUIRED IF APPLICABLE FIELD. This field identifies the name of the name of the plan or program of the other insured as indicated in item Number 9
837P	Loop 2010BB, 2330B Item or data element number and name: Payer Name Current Payer: NM101:PR

	NM 102=2 NM 103 = Payer Name Payer ID qualifier: NM108 Payer ID: NM 109 Payer secondary ID qualifier: REF01 Payer secondary ID: REF02 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
10a-10c	Title: Is Patient's Condition Related to: Employment, Auto Accident, or Other Accident-SITUATIONAL FIELD, REQUIRED IF APPLICABLE The Vital Plan does not duplicate coverage provided by other third-party healthcare insurance. When a Member has coverage, other than with FMHP, which requires or permits coordination of benefits from a third-party payer, FMHP will process the claim according with applicable laws and regulations and in accordance with the terms of its health benefits contracts. It is required from Providers to submit the data related to other insurance in the correspondent fields of the CMS 1500 or 837P transaction. When appropriate, enter an X in the correct box to indicate whether one or more of the services described in item Number 24 are for a condition or injury occurred on the job, or because of an automobile or other accident. The state postal code where the accident occurred must be reported, if "YES" is marked in 10b for "Auto Accident." Any item marked "YES" indicates there may be other applicable insurance coverage that would be primary, such as automobile liability insurance. Primary insurance information must then be shown in Item Number 11.
837P	Loop 2000B, 2300 Item or data element number and name CLM11 Related causes information SBR01, SBR05, SBR09 Subscriber Information Date of Accident Qualifier: DTP01=439 Date of Accident format: DTP02=D8

	Date of Accident: DTP03 State where auto accident Occurred: CLM11 Payer responsibility sequence number: SBR01 Insurance Type Code: SBR05 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
10d	Claim Codes- This is a variable field that may be used to report condition codes. Only those codes designated by NUCC are used. This is a SITUATIONAL FIELD, REQUIRED IF APPLICABLE. Coding structure: Valid codes for CMS 1500 and 837P: Condition Codes Related to Abortions: AA: Abortion performed due to rape AB: Abortion performed due to incest AC: Abortion performed due to serious fetal genetic defect, deformity, or abnormality AD: Abortion performed due to a life endangering physical condition AE: Abortion performed due to physical health of mother that is not life endangering AF: Abortion performed due to emotional/psychological health of the mother AG: Abortion performed due to social or economic reasons AH: Elective abortion Al: Sterilization Condition Codes for Workers Compensation Claims: W2: Duplicate or original bill W3: Level 1 appeal W4: Level 2 appeal W5: Level 3 appeal Note: Do not used Condition Codes when submitting a revised or corrected bill. Please refer to NUCC Website:

	http://www.nucc.org/index.php?option=com_content&view=article&id=20&Itemid=118 with the permission of the National Uniform Billing Committee (NUBC)]
837P	Loop 2300 Item or data element number and name: (Qualifier) • HI01-1: BG • HI01-2: Condition Code Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
11	Title: Insured's Policy, Group, or FECA number - SITUATIONAL FIELD, REQUIRED IF APPLICABLE. Enter the Beneficiary policy or group number as it appears on the Beneficiary health care identification card. If Item Number 4 is completed, then this field must be completed. Do not use a hyphen or space as a separator within the policy or group number. For Workers Compensation and Other Property & Casualty Claims: The Vital Plan does not duplicate coverage provided by other third-party healthcare insurance. When a Member has coverage, other than with FMHP, which requires or permits coordination of benefits from a third-party payer, FMHP will process the claim according with applicable laws and regulations and in accordance with the terms of its health benefits contracts. It is required from Providers to submit the data related to other insurance in the correspondent fields of the CMS 1500 or 837P transaction. Enter Workers' Compensation or Property & Casualty Claim Number assigned by the payer.
837P	Loop 2000B, 2320 Item or data element number and name: SBR03 Subscriber Group or Policy Number Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
11a	Title: Insured's Date of Birth, Sex

	This field contains the birth date and gender of the insured as indicated in item 1a. Enter the 8-digit date of birth (MM | DD | YYYY) of the Beneficiary and an X to indicate the sex of the Beneficiary. Only one box can be marked. If gender is unknown, leave blank.
837P	Loop 2010BA, 2010CA Item or data element number and name: DMG01 - Date format DMG02 - Subscriber Birth date DMG03 - Gender Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
11b	Title: Other Claim ID (Designated by NUCC) SITUATIONAL FIELD, REQUIRED IF APPLICABLE When submitting to Property and Casualty payers, for example Automobile, Homeowners, or Workers' Compensation insurers and related entities, the following qualifier and accompanying identifier has been designated for use: Y4 Agency Claim Number (Property Casualty Claim Number)
837P	Loop 2010BA Qualifier: REF01 - Reference ID qualifier Other Claim ID: REF02 - Property Casualty Claim Number Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
11c	Title: Insurance Plan Name or Program Name- SITUATIONAL FIELD, REQUIRED IF APPLICABLE Enter the name of the "Insurance Plan or Program Name" of the Beneficiary. Some payers require an identification number of the primary insurer rather than the name in this field.
837P	Loop 2000B, 2320 Item or data element number and name SBR04: Group Name

	Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
11d	Title: Is there another Health Benefit Plan? SITUATIONAL FIELD, REQUIRED IF APPLICABLE When appropriate, enter an X in the correct box. If marked "YES", complete 9, 9a, and 9d. Only one box can be marked. "Is there another health benefit plan" indicates that the patient has insurance coverage other than the plan indicated in item Number 1.
837P	This field does not exist on 5010A1 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
12	Title: Patient's or Authorized Person's Signature – Enter "Signature on File," "SOF," or legal signature. When legal signature, enter date signed in 6-digit format (MMDDYY) or 8-digit format (MMDDCCYY). The "Patient's or Authorized Person's Signature" indicates there is an authorization on file for the release of any medical or other information necessary to process and/or adjudicate the claim.
837P	Loop 2300 Item or data element number and name: CLM09 Release of information Code Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
13	Titled: Insured's or Authorized Person's Signature Payment Authorization This field indicates there is a signature on the file authorizing payment of medical benefits. Enter "Signature on File," "SOF," or legal signature.
837P	Loop 2300 Item or data element number and name: CLM08 Benefits assignment certification indicator.

	Refer to: http://www.x12.org for details and requirements for submission of 837 P= Professional.
14	Title: Date of Current Illness, Injury, Pregnancy (LMP- Last menstrual period)- SITUATIONAL FIELD, REQUIRED IF APPLICABLE Enter the 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported 431: Onset of Current Symptoms or illness 484: Last Menstrual Period Enter the qualifier to the right of the vertical, dotted line.
837P	Loop 2300 Item or data elements number and name: Claim dates Date: DTP03 Date Qualifier: DTP01 - Date/time qualifier Format Qualifier: DTP02 D8 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
15	Title: Other date- SITUATIONAL FIELD, REQUIRED IF APPLICABLE Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit format (MM | DD | YY) or 8-digit format (MM | DD | CCYY). Enter the applicable qualifier to identify which date is being reported 454: Initial Treatment 304: Latest Visit or Consultation 453: Acute Manifestation of a Chronic Condition 439: Accident 455: Last X-ray 471: Prescription

	090: Report Start (Assumed Care Date) 091: Report End (Relinquished Care Date) 444: First Visit or Consultation
837P	Loop 2300, 2400 Item or data element number and name: other Claim dates Qualifier: DTP01 Date/time qualifier Format Qualifier: DTP02 D8 Date: DTP03 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
16	Title: Dates Patient Unable to Work in Current Occupation - SITUATIONAL FIELD, REQUIRED IF APPLICABLE FIELD, REQUIRED IF APPLICABLE If the patient is employed and is unable to work in current occupation, a 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) date must be shown for the "from–to" dates that the patient is unable to work. An entry in this field may indicate employment-related insurance coverage
837P	Loop 2300 Item or data element number and name: Disability dates Date qualifier: DTP01 Format qualifier: DTP02 Actual dates: DTP03 837P version 5010 Enter the applicable qualifier in DTP 01 to identify which disability date(s) is being reported. Coding Structure: 314: Disability (use code 314 when both disabilities start, and end dates are being reported. 360: Initial Disability Period Start (use code 360 if the patient is currently disabled and the disability end date is unknown). 361: Initial Disability Period end (use code 361 if the patient is no longer disabled and the disability start date is unknown).

	837P, version 5010. Enter the applicable qualifier in DTP02 to identify which date format is being reported. Coding structure: D8: Date expressed in format CCYYMMDD RD8: Range of dates expressed in format CCYYMMDDCCYYMMDD Use code RD8 when DTP01 is 314. Use code D8 when DTP01 is 360 or 361 Enter the actual date(s) that corresponds to the qualifier in DTP01. Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
17	Title: Name of Referring Provider or Other Source Enter the name (First Name, Middle Initial, and Last Name) and credentials of the professional who referred, ordered, or supervised the service(s) or supply(ies) on the claim. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider Do not use periods or commas within the name. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported. Enter one of the following qualifiers to the left of the vertical, dotted line: DN: Referring Provider, DK: Ordering Provider, DQ: Supervising Provider
837P	Loop 2310D, 2420E, 2420F Item or data element number and name: other supervising/rendering/referring provider name and ID Physician Qualifier: NM101 Entity Type Qualifier: NM102 Physician Last Name: NM103 Physician First Name: NM104 Physician Middle Name: NM105 Physician Name Suffix: NM107 Provider Primary ID Qualifier: NM108

	Provider NPI: NM109 Secondary ID Qualifier: REF01 Secondary ID Number: REF02 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
17a	Title: Other ID# SITUATIONAL FIELD, REQUIRED IF APPLICABLE The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. The NUCC defines the following qualifiers used in 5010A1: 0B: State License Number 1G: Provider UPIN Number G2: Provider Commercial Number LU: Location Number (This qualifier is used for Supervising Provider only)
837P	Loop 2310D, 2420E, 2420F Item or data element number and name: Another rendering/referring provider name & ID Provider primary ID qualifier: NM108 Provider NPI: NM 109 Provider secondary qualifier: REF01 Provider other ID number: REF02 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
17b	Title: NPI # Enter the NPI number of the referring, ordering, or supervising provider.
837P	Loop 2310D, 2420E,2420F Provider NPI: NM109 Refer to: http://www.x12.org for details and requirements for submission of 837P

	P= Professional.
18	Title: Hospitalization Dates Related to Current Services - SITUATIONAL FIELD, REQUIRED IF APPLICABLE Enter the inpatient 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave discharge date blank. This date is when a medical service is furnished because of, or subsequent to, a related hospitalization.
837P	Loop 2300 Item or data element number and name: Hospitalization dates related to current services Date qualifier: DTP01 Date format qualifier: DTP02 Actual dates: DTP03 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
19	Title: Additional Claim Information – SITUATIONAL FIELD, REQUIRED IF APPLICABLE First Medical Health Plan –Vital Plan has determined to use this field for the provider to report the REFERRAL NUMBER.
837P	Loop 2300 Item or data element number and name: Paperwork-claim supplemental information Attachment type: PWK01 Transmission Code: PWK02 Identification Qualifier: PWK 05 Attachment control number: PWK06 For the Claim Information (NTE), the following are the qualifiers in 5010A1. Enter the qualifier "NTE" followed by the appropriate qualifier, then the information. Do not enter spaces between the qualifier and the first word of the information. After the qualifier, use spaces to separate any words.

	ADD: Additional Information CER: Certification Narrative DCP: Goals, Rehabilitation Potential, or Discharge Plans DGN: Diagnosis description TPO: Third Party Organization Notes Example: **NTEADD Surgery was unusually long due to scarring.** Please refer to: NUCC 1500 HEALTH INSURANCE CLAIM FORM, REFERENCE INSTRUCTION MANUAL FOR FORM VERSION 02/12 July 2018 or most current version of the manual – Item number 19. Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
20	Title: Outside Lab? Charges? SITUATIONAL FIELD, REQUIRED IF APPLICABLE Complete this field when billing for purchased services by entering an X in "YES." A "YES" mark indicates that the reported service was provided by an entity other than the billing provider (for example, services subject to Medicare's anti-markup rule). A "NO" mark or blank indicates that no purchased services are included on the claim. If "Yes" is annotated, enter the purchase price under "Charges" and complete Item Number 32. Each purchased service must be reported on a separate claim form as only one charge can be entered. When entering the charge amount, enter the amount in the field to the left of the vertical line. Enter number right justified to the left of the vertical line. Enter 00 for cents if the amount is a whole number. Do not use dollar signs, commas, or a decimal point when reporting amounts. Negative dollar amounts are not allowed. Leave the right-hand field blank.
837P	Loop 2400, 2420B Item or data element number and name: PS1 Purchased service information Outside Lab?: PS101 Qualifier $Charge: PS102 Purchased service amount Refer to: http://www.x12.org for details and requirements for submission of 837P

	P= Professional.
21	Title: Diagnosis or Nature of Illness or Injury This field contains the International Classification of Disease (ICD) Indicator, which identifies the version of the ICD code set being reported. In Puerto Rico, for services rendered prior to 10-1-2015, the provider used 9 for ICD-9-CM. All services render on 10/1/2015 and thereafter, the provider must indicate a 0 for ICD-10-CM. Enter the diagnosis code left justified on each line to identify the patient's diagnosis or condition. Do not include the decimal point, because it is implied. List no more than 12 ICD-10-CM diagnosis Codes. The maximum length of characters is 7. The provider must use the greatest level of specificity. Do not provide narrative description in this field. Do not repeat diagnosis codes. The diagnosis or nature of illness or injury is the sign, symptom, complaint, or condition of the patient relating to the service(s) on the claim. At least one (1) principal diagnosis must be reported on this field on item 21. A.
837P	Loop 2300 ICD indicator: HI01-1 Diagnosis Code: H101-2 The diagnosis codes can be repeated up to eleven times (11) in addition to the principal diagnosis.
22	Title: Resubmission and/or Original Reference Number -SITUATIONAL FIELD, REQUIRED IF APPLICABLE List the original reference number (Payer assigned Claim number) for resubmitted claims and/or Adjustments. The claim number will appear on the Explanation of Payment (EOP) or the 835 transactions. In situations where the provider is submitting a replacement of a prior claim and/or Void/Cancel of prior claim, the provider must use the following coding structure: 7 Replacement of prior claim

	8 Void/Cancel of prior claim
837P	Loop 2300 Item or data element number and name: CLM05-3 claim frequency code/REF02 Reference number Resubmission Indicator: CLM05-3 Original claim reference qualifier: REF01 Original claim reference number: REF02 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
23	Title: Prior Authorization Number SITUATIONAL FIELD, REQUIRED IF APPLICABLE If service requires an authorization the number must be included with the claim. Enter the prior authorization number assigned by FMHP. The prior authorization number is the payer assigned number authorizing the service.
837P	Loop 2300, 2400 Item or data element number and name: Prior authorization/CLIA mammography cert number Prior authorization number qualifier: REF01 Prior Authorization Number: REF02 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
24	Title: Supplemental Information – SHADOW FIELD across the top of each service line (1-6) On the 1500 form contains supplemental information that relates to the line immediately beneath the shaded area. Supplemental information can only be entered with a corresponding, completed service line. The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and another/proprietary identifier and to accommodate the submission of supplemental information to support the billed service.

	The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service. Providers are required by PRHIA and CMS to report NDC whenever drugs or biologicals are administered. This information must be reported on the shaded area of the CMS 1500.
837P	For the submission of supplemental information on the 5010 electronic transaction: Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
24a	Title: Date (s) of Service (lines 1-6) Enter date(s) of service, both the "From" and "To" dates. If there is only one date of service, enter that date under "From" and also on the "To" field.
837P	Loop 2300,2400 Item or data element number and name: Service date Date qualifier: DTP01 Date format qualifier: DTP02 Date of Service "from date": DTP03 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
24b	Title: Place of Service (lines 1-6) In 24B, enter the appropriate two-digit Place of Service Code for each item used or service performed. The Place of Service Codes are available at: Centers for Medicare and Medicaid Service site. Refer to: www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html
837P	Loop 2300,2400 Item or data element number and name: Place of Service Qualifier claim place of service: CLM05-2 Claim place of service: CLM05-1

	Service line place of service: SV105 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
24c	Title: EMG – Emergency Indicator -SITUATIONAL FIELD, REQUIRED IF APPLICABLE This field is required when the service is the result of an emergency.
837P	Loop 2400 Item or data element number and name: Emergency Indicator Emergency: SV109 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
24d	Title: Procedures, Services, or Supplies Enter the CPT or HCPCS code(s) and applicable modifier(s) from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four two-character modifiers. The specific procedure code(s) must be shown without a narrative description. Provider must submit valid codes for the date of service, in order for the payer to process the claim. Medicaid NCCI rules, MUE edits and other regulatory validation are applied to procedure codes, services or supplies.
837P	Loop 2400 Item or data element number and name: SV101 Composite professional Service Identifier Product or service qualifier: SV101-1 CPT/HCPCS code: SV101-2 Modifiers: SV101-3 thru SV101-6 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
24e	Title: Diagnosis Pointer (lines 1-6)

	In 24E, enter the diagnosis code reference number (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple diagnoses are related to one service, the reference number for the primary diagnosis should be listed first, other applicable diagnosis reference numbers should follow. The reference number(s) should be A- L. Enter letters left justified in the field. Do not use commas between the letters.
837P	Loop 2400 Item or data element number and name: SV107 Composite diagnosis code pointer Diagnosis Pointer: SV107-1 thru SV107-4 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
24f	Title: Charges (lines 1-6) Enter the charge amount for each listed service. Enter the number right justified in the left-hand area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in right hand area of the field if the amount is a whole number. Charges are the total billed amount for each service line. Providers must comply with PRHIA regulations to complete this field.
837P	Loop 2400 Item or data element number and name: Line item charge amount Charges: SV102 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
24g	Title: Days or Units (lines 1-6) Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, or oxygen volume. If only one service is performed, the numeral 1 must be entered. Enter numbers right justified in the field. No leading zeros are required.

	NOTE: Please refer to Medicaid NCCI MUE Edits.
837P	Loop 2400 Item or data element number and name: Unit or basis for measurement code and quantity. Unit or basis for measure: SV103 Unit amount: SV104 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
24h	Title: EPSDT/Family Plan (lines 1-6) SITUATIONAL FIELD, REQUIRED IF APPLICABLE For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows: If there is no requirement (for example, state requirement) to report a reason code for EPDST, enter Y for "YES" or N for "NO" only.
837P	Item or data element number and name: • CRC EPSDT Referral • CRC EPSDT Indicator • SV Family Planning Indicator • Referral Code Qualifier: CRC01 • Certification condition code applies indicator: CRC02 • Condition Code: CRC03-CRC05 • EPSDT Response: SV111 • Family Planning response: SV112 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
24i	Title: ID Qualifier SITUATIONAL FIELD, REQUIRED IF APPLICABLE Enter in the shaded area of 24I the qualifier identifying if the number is a non-NPI. The Other ID# of the rendering provider is reported in 24 in the shaded area.
837P	Loop 2310B,2420A

	Item or data element number and name: Rendering provider NPI and secondary identification NPI qualifier: NM108 Secondary ID Qualifier: REF01 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
24j	Title: Rendering Provider ID # (Lines 1-6) SITUATIONAL FIELD, REQUIRED IF APPLICABLE The individual rendering the service is reported in 24J. The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. Report the rendering provider NPI Identification Number in Item 24J only when different from data recorded in items 33a. Enter numbers left justified in the field.
837P	Loop2420A Item or data element number and name: Rendering provider secondary identification NPI: N109, Non-NPI number: REF02
25	Title: Federal Tax ID Number Enter the "Federal Tax ID Number" (employer identification number or Social Security number) of the **Billing Provider** identified in Item Number 33/33a. This is the tax ID number intended to be used for 1099 reporting purposes. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked. Description: The "Federal Tax ID Number" refers to the unique identifier assigned by a federal or state agency.
837P	Loop 2010AA Item or data element number and name: Billing provider federal tax ID number EIN or SSN: REF01 ID Number: REF02 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.

26	Title: Patient's Account No. Enter the patient's account number assigned by the provider of service or supplier's accounting system. We encourage providers to comply with the submission of this information on the CMS 1500 claim form as well as electronic transactions. The regulations require that the patient control number be reported on the 835 HIPAA transaction to the provider.
837P	Loop 2300 Item or data element number and name: Patient control number Account Number: CLM01 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
27	Title: Accept Assignment? The Accept Assignment indicates that the provider agrees to accept assignment under the terms of the payer's program. Therefore, all providers must complete this field.
837P	Loop 2400 Item or data element number and name: Assignment or plan participation code Response Yes or No: CLM07 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
28	Title: Total Charge. Enter total charges for the services (i.e., total of all charges in 24F). Enter the number right justified in the dollar area of the field. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.
837P	Item or data element number and name: Total claim charge amount Charge: CLM02 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.

29	Title: Amount Paid. Enter total amount the patient and/or other payers paid on the covered services only. Enter number right justified in the dollar area of the field. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.
837P	Loop 2300 Item or data element number and name: AMT Amount patient paid AMT Coordination of Benefits (COB) payer paid amount Amount qualifier: AMT01 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
30	Title: Reserved for NUCC Use
31	Title: Signature of Physician or Supplier including Degrees or Credentials. Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, "Signature on File," or "SOF." Enter either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD |CCYY), or alphanumeric date (for example, July 1, 2019) when the form was signed.
837P	Loop 2400 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
32	Title: Service Facility Location Information Enter the name, address, city, state, and zip code of the location where the services were rendered and identifies the site where service(s) were provided. Providers of service (namely physicians) must identify the supplier's name, physical address, zip code, and NPI number when billing for purchased diagnostic tests. When more than one supplier is used, a separate 1500 Claim Form should be used to bill for each supplier.

	Enter the name and physical address information in the following format: 1st Line – Name 2nd Line – Physical Address 3rd Line – City State and ZIP Code
837P	Loop 2310C, 2420 For instructions on completing this field please refer to: http://www.x12.org for details and requirements for submission of 837P. P= Professional.
32 a	Title: NPI# Enter the NPI number of the service facility location in 32a.
837P	Billing Provider NPI: NM109 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
32b	Title: Service Other ID SITUATIONAL FIELD, REQUIRED IF APPLICABLE Enter the two-digit qualifier identifying the non-NPI number
837P	Service Other ID - REF 02 REFER TO: http://www.x12.org for details and requirements for submission of 837P P= Professional
33	Title: Billing Provider Info & PH# This field identifies the provider that is requesting to be paid for the services rendered. Enter the provider or supplier's billing name, physical address, zip code, and telephone number. Enter the name and physical address in the following format: 1st Line- Name 2nd Line- Physical Address 3rd Line- City, State and ZIP Code
837P	Loop 2010AA, 2010BB Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
33a	Title: NPI #

	Enter the NPI number of the billing provider in 33a. The NPI number refers to the HIPAA National Provider Identifier number.
837P	Billing Provider NPI: NM109 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
33b	Title: Other ID# SITUATIONAL FIELD, REQUIRED IF APPLICABLE Enter the NON- NPI number of the billing provider indicated on item 33a.
837P	Billing Provider Other ID: REF02 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.

Note: All CMS FORMS MUST BE LEGIBLE AND CONTAIN ALL REQUIRED FIELDS.

12.3 UB-04 (CMS-1450)-FIELD SPECIFIC INSTRUCTIONS

Reference: OPTUM 360- UNIFORM BILLING EDITOR (The ultimate guide to accurate facility claim submission)

The CMS-1450- (UB-04) is used for the submission of institutional services such as:

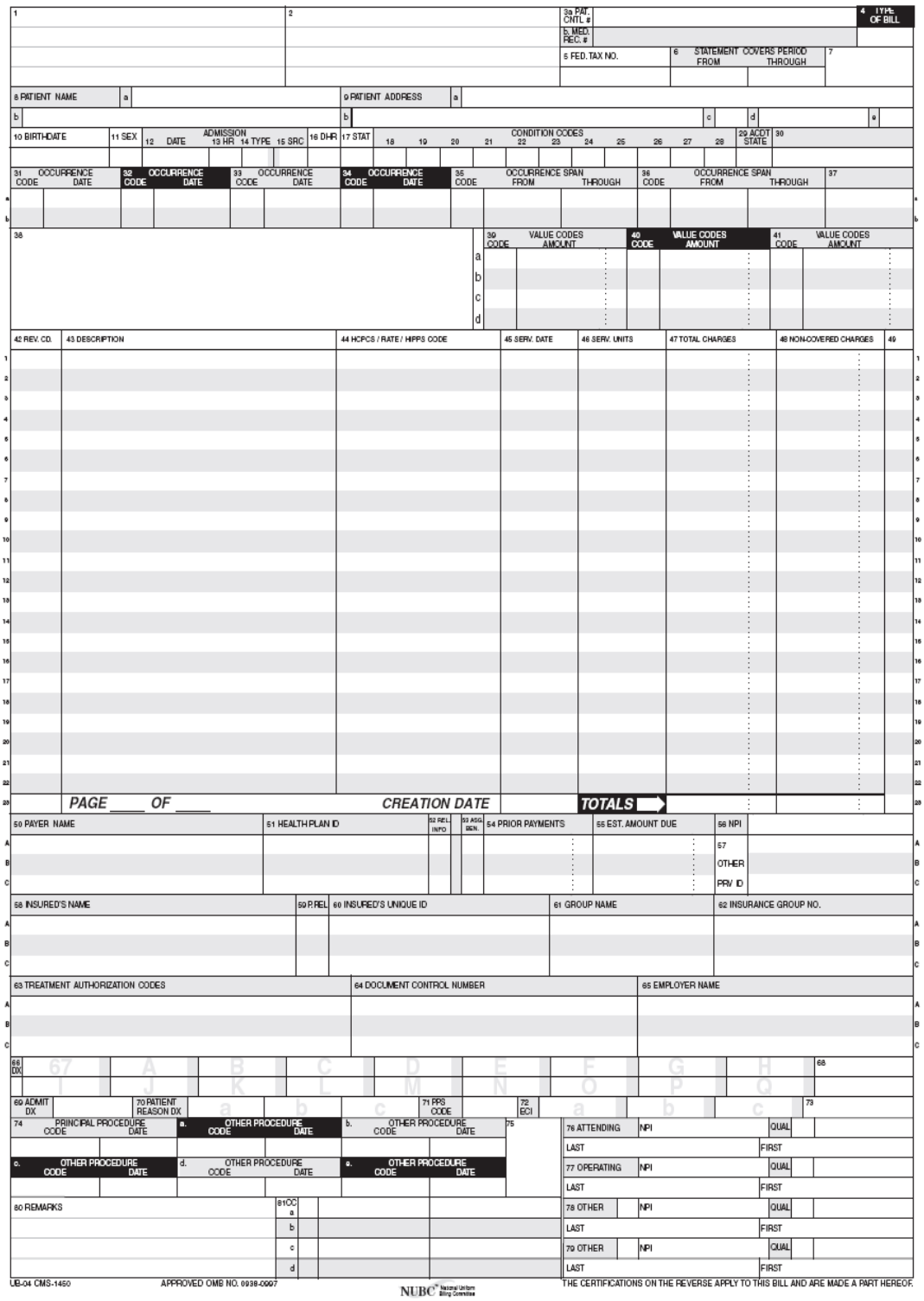
- Hospital Inpatient Services
- Hospital Outpatient Services
- Home Health Services
- Skilled Nursing Services
- Ambulatory Surgical Centers among others

The National Uniform Billing Committee (NUBC, nubc.org) was appointed by HIPAA as Designated Standards Maintenance Organization (DSMO) for the Uniform Bill. The NUBC is responsible for the maintenance of the Official UB-04 Data Specifications Manual. The Uniform

Billing was developed with the purpose of assisting the Providers on preparing a clean, accurate, and complete claim.

Please refer to the next page for UB-O4 Field Description.

12.3.1 UB-04 FIELDS DESCRIPTION



UB-04 (CMS-1450)-FIELD SPECIFIC INSTRUCTIONS	
FIELD	INSTRUCTIONS
FL 1	Billing Provider Name, Address and Telephone Number REQUIRED – The Billing Provider Address field requires a physical location address. A postal address (P.O. Box) cannot be reported as a billing provider either. Claims submitted with other than a physical address will be returned to the provider as unclean claims.
FL-2	Billing Provider's Designated Pay-to-Name, Address, and Secondary SITUATIONALFIELD, REQUIRED IF APPLICABLE- It should be completed if the Provider designated to receive the payment is different than the Provider specified on FL 1.
FL-3ª	Patient Control Number REQUIRED-- The patient's unique alphanumeric number assigned by the Provider to facilitate retrieval of individual financial records and posting of payments. The patient control enables providers to reconcile payments against the account receivable for the patient. Payers are required to return the patient control number on the payment check, remittance advice, voucher or 835 Transaction. Claims not submitted with the patient control number will be returned to the provider as unclean claims.
FL-3b	Medical/Health Record Number REQUIRED –This field contains the number assigned by the provider to the patient's Medical or health record. The purpose of the medical record is to provide an audit trail of the patient's treatment history. Claims not submitted with the Medical/Health Record Number will be returned to provider as unclean claims.

FL-4	Type of Bill (TOB) REQUIRED – The TOB provides specific information about the bill for billing purposes. Only on UB-04 there is a leading 0 which precede the facility code number. The second digit of the four-digit number identifies the type of facility, the third digit classifies the type of care being bill (bill classification), and the fourth digit indicates the sequence of the bill for a specific episode of care. Claims not submitted with the correspondent Type of Bill will be returned to provider as unclean claims. Code Structure: First Digit- - Leading Zero (only used on UB-04 paper claim) Second Digit - Type of facility Third Digit - Bill Classification Fourth Digit - Bill Frequency Codes are available from the NUBC (National Uniform Billing Committee) at www.nucc.org via the NUBC's Official UB-04 Data.
FL- 5	*Federal Tax Number:* REQUIRED- The format is XX-XXXXXXX.
FL-6	*Statement Covers Period From/Through*: REQUIRED- This field is used for reporting the beginning and ending dates of service for the entire period reflected on the bill.
FL-7	Reserved by the NUBC
FL-8	Patient's Name/Identifier: REQUIRED- The patient's last name, middle initial is reported in FL8b. Form Locator 8a contains the patient identifier as assigned by the payer.

FL-9	Patient's Address: REQUIRED- This field contains the full mailing address of the patient. Enter the complete mailing address including the street number and name or post office box or RFD: city name, state name, and zip code.
FL-10	Patient's Birth Date: REQUIRED- This field contains the patient's date of birth.
FL-11	Patient's Sex: REQUIRED- This field contains the sex of the patient as recorded at the date of admission, outpatient service or at the start of care.
FL-12	Admission/Start of Care Date: REQUIRED- The Admission or Start of Care Date field contains the start date for this episode of care. It is the date of admission for inpatient care. For home health claims, it is the date that the episode of care began.
FL-13	Admission Hour REQUIRED- This field contains the hour during which the patient was admitted for inpatient care. The hour is entered in military time using two numeric characters.
FL-14	Priority (Type) of Admission/Visit REQUIRED- This field contains a code that indicates the priority of the admission/visit. Code Structure: 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma 6-8 Reserved for Assignment by the NUBC

	9 Information Not Available
FL-15	Point of Origin for Admission or Visit REQUIRED- This field contains a code that identifies the point of patient origin for this admission or visit. This field locator is required on all TOB's except 014X. Code Structure: 1 Non-healthcare Facility Point of Origin 2 Clinic or Physician's Office 3 Reserved for assignment by the NUBC 4 Transfer form a Hospital (Different facility) 5 Transfer from a Skilled Nursing Facility, ICF, Assisted Living Facility (ALF), or other Nursing Facility (NF) 6 Transfer from another Healthcare Facility 7 Reserved for Assignment by the NUBC 8 Court/La Enforcement 9 Information not Available A-C Reserved for assignment by the NUBC D Transfer from another Distinct Unit of the Hospital to Another Distinct Unit of the same Hospital resulting in a separate claim to the Payer E Transfer from Ambulatory Surgery Center F Transfer from Hospice Facility G-Z Reserved for Assignment by the NUBC Coding structure for Newborn: 5 Born inside this hospital 6 Born outside of this hospital 7-9 Reserved for Assignment by the NUBC

FL-16	Discharge Hour SITUATIONAL FIELD REQUIRED IF APPLICABLE- This field contains the hour during which the patient was discharged from inpatient care. This field is REQUIRED for inpatient services.
FL-17	Patient Discharge Status REQUIRED- This field contains a code indicating the patient's disposition or discharge status at the ending date of service for the period of care on the Claim Form Locator 6. This field is required for all claims.
FL-18 through FL-28	Condition Codes SITUATIONAL FIELD REQUIRED IF APPLICABLE BUT REQUIRED if any condition code is applicable to a claim. These fields contain codes identifying conditions that may affect payer processing of this bill.
FL-29	Accident State SITUATIONAL FIELD REQUIRED IF APPLICABLE- This field contains the two-character abbreviation of the state where the accident occurred. This information is required when the claim is related to an auto accident.
FL-30	Reserved for assignment by the NUBC
FL-31 through FL-34	Occurrence Codes and Dates SITUATIONAL FIELD REQUIRED IF APPLICABLE- The occurrence code and associated date fields define a significant event relating to this bill that may affect payer processing. These fields are required if any occurrence code is applicable to a Claim. Report in alphanumeric sequence. Report occurrence codes in the following order: 31ª, 32ª, 33ª, 34ª, 31b, 32b, 33b, and 34b.

	If additional codes need to be reported and there are no occurrence span codes to report, then the additional codes may be reported in 35ª, 36ª, 35b, 36b, with the date in the "from" date.
FL-35 through FL-36	Occurrence Span Codes and Dates SITUATIONAL FIELD REQUIRED IF APPLICABLE - Occurrence span codes and dates identify an event that relates to payment of the claim. These codes identify occurrences that happened over a span of time. Report the code, the beginning (from) date and the ending (through) date associated with the reported occurrence span code.
FL-37	Reserved for assignment by the NUBC
FL-38	Responsible Party Name and Address REQUIRED FIELD - The name and address of the party responsible for the bill are entered in this field.
FL-39 through FL-41	Value Codes and Amounts SITUATIONAL FIELD REQUIRED IF APPLICABLE - These fields contain codes and the related dollar amounts or values that identify data elements that are necessary to process this claim as qualified by the payer organization. These fields are required if any value span code is applicable to a claim. Each code must be accompanied by an amount. Report codes in alphanumeric sequence.

FL-42	Revenue Code REQUIRED- use this field to report the appropriate numeric code corresponding to each narrative description or standard abbreviation that identifies a specific accommodation, and/or ancillary services. There are 22 lines available on a single UB-04 claim form to list revenue codes and charges. The revenue code must be valid for the type of claim being billed. As required by PRHIA, and the MMIS (Medicaid Management Information System) layout, HCPCS procedure codes must be billed on outpatient claims when required for specific revenue codes. Also, you should refer to your contracted fee schedule attachments with FMHP to report the corresponding revenue codes contracted with your facility.
FL-43	Revenue Descriptions REQUIRED- This field contains a narrative description or standard abbreviation for each revenue code.
FL-44	HCPCS/CPT/RATES/HIPPS Codes SITUATIONAL, REQUIRED IF APPLICABLE- The provider must submit the corresponding RATE, HCPCS, CPT, or HIPPS codes that are associated to the Revenue Code on FL-42. As required by PRHIA, and the MMIS (Medicaid Management Information System) layout, HCPCS procedure codes must be billed on outpatient claims when required for specific revenue codes. For inpatient the provider must submit the daily accommodation rate on the corresponding revenue codes.
FL-45	Service Date/Assessment Date REQUIRED - This field contains the date in which the indicated service was provided.

FL-46	Units of Service REQUIRED -This field contains a quantitative measure of services rendered, by revenue, category, to or for the patient, including items such as the number of accommodation days, visits, and miles, pints of blood, units, or treatments. Zero or negative values are not allowed for inpatient or outpatient claims.
FL- 47	Total Charges REQUIRED - This field contains the total charges pertaining to the related revenue code for the current billing period as entered in the Statement Covers Period field (FL-6).
FL-48	Non-covered Charges SITUATIONAL FIELD REQUIRED IF APPLICABLE- this field contains the total non-covered charges for the destination payer pertaining to a revenue code.
FL-49	Reserved This field is reserved for Assignment by the NUBC.
FL-50 (A-C)	Payer Name REQUIRED- This field contains the name of the health plan from which the provider might expect some payment for the bill. (Primary Payer, Secondary Payer. Tertiary Payer)
FL-51	Payer ID Health Plan ID REQUIRED- Report the HIPAA National Plan Identifier when it is mandated for use. FMHP has determined that until this field becomes HIPAA Mandatory the provider must leave this field blank for UB-04 paper claims.

FL-52 (A-C)	Release of Information Certification Indicator REQUIRED- This field indicates whether the provider has on file a signed statement from the patient or the patient's legal representative permitting the provider to release data to other organization to adjudicate the claim. This indicator applies to the payers listed in FL 50 on lines A, B and C. The provider must indicate a Y (yes) in this field. A "Y" indicates that the provider has a signed statement permitting release of medical billing data related to a claim.
FL-53 A, B and C	Assignment of Benefits Certification Indicator REQUIRED FIELD - This field shows whether the provider has a signed form authorizing the third-party insurer to pay the provider directly for the services. This indicator applies to the payers listed in FL-50 lines A, B, and C. This field is related to the fact that the provider accepts assignment and/or has a participation agreement with the destination Payer.
FL-54 (A-C)	Prior Payments -Payers SITUATIONAL FIELD, REQUIRED IF APPLICABLE- The amount in this field represents the amount the hospital has received to date toward payment of this bill for the payer indicated in FL-50 on lines A, B, and C.
FL-55 A, B and C	Estimated amount Due-Payer SITUATIONAL FIELD, REQUIRED IF APPLICABLE- The amount in this field represents an estimate by the hospital of the amount due from the indicated payer in FL-50 on lines A, B, and C.
FL-56	National Provider Identifier-Billing Provider (NPI) REQUIRED- This field contains the unique identification number assigned to the provider submitting the bill.

FL-57	Other (Billing) Provider Identifier SITUATIONAL FIELD, REQUIRED IF APPLICABLE FIELD, REQUIRED IF APPLICABLE
FL-58 (A- C)	Insured's Name REQUIRED FIELD. This field contains the name of the patient or insured individual in whose name the insurance is issued as qualified by the payer organization listed in FL-50 on lines A, B, and C.
FL-59 (A-C)	Patient's relationship to Insured REQUIRED- This field contains the code that indicates the relationship of the patient to the Insured individuals identified in FL-58 on lines (A-C.)
FL-60 A, B and C	Beneficiary's Unique Identifier REQUIRED- This field contains the insured's unique identification number assigned by the payer organization.
FL-61 (A- C)	Insured Group Name SITUATIONAL FIELD REQUIRED IF APPLICABLE -This field contains the identification number, the control number or the code that is assigned by the insurance company or claims administrator to identify the group under which the individual is covered.
FL-62 A, B and C	Insurance Group Number SITUATIONAL FIELD REQUIRED IF APPLICABLE- This field contains the identification number, the control number or the code that is assigned by the insurance company or claims administrator to identify the group under which the individual is covered. Required, if the Beneficiary's identification card shows a group number.

FL- 63	Authorization Code/Referral Number SITUATIONAL FIELD REQUIRED IF APPLICABLE -This field is an identifier that designates that the services on this bill have been authorized by the payer or indicates that a referral is involved. The provider must complete the field when applicable (when an authorization or referral number is assigned by the payer). For inpatient services a contracted provider billing an 837 electronic transaction must indicate the authorization number. 837I, version 5010: Enter one of the following in REF01: • 9F Referral Number • G1 Prior Authorization number Enter the correspondent number in REF02. For paper claims submit the authorization code as follows: UB-04 LINE A= AUTHORIZATION CODE UB-04 LINE B= REFERRAL NUMBER UB-04 LINE C= SECONDARY PAYER AUTHORIZATION CODE Provider must ensure that the authorization code and referral number are indicated on the correct field as instructed above. Failure to do so might result on a denial due to lack of authorization and/or referral number.
FL- 64	Document Control Number (DCN) SITUATIONAL FIELD REQUIRED IF APPLICABLE- This is the internal control number (ICN) or document control number (DCN) assigned to the original bill by the health plan. This number appears on the Explanation of Payment to the provider (EOP-paper /835-electronic-refer to ICN #).

FL- 65	Employer Name (of the Insured) SITUATIONAL FIELD REQUIRED IF APPLICABLE -This field contains the name of the employer that provides (or may provide) health care coverage for the insured individual identified in FL-58 (A-C). Applies when there is a WC (Workers Compensation) or an EGHP (Employer Group Health Plan). The provider enters the name of the employer that provides the health coverage for the individual identified on the same lines in FL-58. This information is required when the payer is either primary or secondary and Medicare is the secondary or tertiary insurer.
FL-66	Diagnosis and Procedure Code Qualifier (ICD version) REQUIRED- This code identifies the version of the International Classification of Diseases (ICD) being reported. Code Structure: 9-Ninth Edition (ICD-9-CM) 10-Tenth Edition – (ICD-10-CM) for service dates of 10/1/2015 and after.
FL-67	Principal Diagnosis Code: REQUIRED - This field contains the full ICD-10-CM diagnosis code, including the fourth and fifth digits, which describes the principal diagnosis (the condition established after study, to be chiefly responsible for causing the hospitalization or use of other hospital services). All diagnosis codes must be a valid code for the date of service. To prevent claim errors, ICD-10-CM codes should be used at the highest level of specificity. You are required to assign the most precise ICD-10-CM code that most fully explains the narrative description in the chart of symptoms or diagnoses. Vague or nonspecific diagnosis codes may

cause your claim to edit for medical necessity. Also, claims submitted with three- or four-digit codes, where four- or five- digit codes are available, will be rejected.

PRHIA contract requires that the providers comply with mandated instructions to report the Present on Admission Indicator (POA) in all inpatient claims. Inpatient claims received without the POA indicator will be rejected and sent to the provider for completion. As required by Medicaid and enforced by PRHIA, all Principal, external cause of injury and other diagnosis codes must include Present on Admission (POA) indicator.

CMS- POA Indicator Options and Definitions

The POA indicator is used to denote not only conditions known at the time of admission, but also those conditions that were clearly present, but not diagnosed until after the admission took place.

Code	Reason for Code
Y	Diagnosis was present at time of inpatient admission.
N	Diagnosis was not present at time of inpatient admission.
U	Documentation insufficient to determine if the condition was present at the time of inpatient admission.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.

Note: Please refer to Centers for Medicare and Medicaid Services for a complete list of diagnosis excluded from (HAC- Hospital Acquired

	Conditions): www.cms.gov/Medicare/Coding/ICD10/Downloads/2018-ICD-10-CM-Coding-Guidelines.pdf
FL-67A through FL-67Q	Other Diagnosis Codes REQUIRED - This field contains the full ICD-10-CM diagnosis codes corresponding to all conditions that coexist at the time of admission, which develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode, which have no bearing on the current hospital stay, should be excluded. This is a required field when there are conditions that result as secondary diagnosis. NOTE: Present on Admission Indicator (POA) must be reported on all secondary (other) diagnosis field. (Position-8 of the ICD-10 FIELD). The present on admission indicator (POA) applies to diagnosis codes (i.e., principal, secondary and E codes) for inpatient claims to general acute-care hospitals or other facilities as required by law or regulation for public health reporting. It is the eighth (8) digit related to the corresponding diagnosis code. Any hospital that is currently contracted under FHMP is required to submit the POA indicator. As a rule, all hospital inpatient admission to general acute care hospitals must report the POA indicator on their claims. Additional information related to POA guidelines can be obtained from ICD-10-CM Official Guidelines for Coding and Reporting that are available in the Centers for Medicare and Medicaid Services site at: http://www.cms.gov
FL-68	Reserved- This field is reserved for Assignment by the NUBC.

FL-69	Admitting Diagnosis REQUIRED- This field is for reporting the complete ICD-10-CM code describing the patient's diagnosis at the time of admission, including fourth and fifth digits when appropriate. Also, is a required field for inpatient admission claims and encounters, and Part B only claims (TOB's 012X, and 022X in FL 4). POA indicator must be reported with the admitting diagnosis code. Enter the patient's admitting diagnosis using a complete and accurate ICD-10-CM code. The ICD-10-CM admitting diagnosis code describes a significant finding presenting patient distress, an abnormal finding on an examination, a possible diagnosis base on significant findings, a diagnosis established from a previous encounter or admission, an injury, a poisoning, or a reason or condition (not an illness or injury) such as follow-up or pregnancy in labor.
FL-70 A-C	Patient's reason for visit SITUATIONAL FIELD REQUIRED IF APPLICABLE- This field is for reporting the complete ICD-10-CM code describing the patient's reason for the visit at the time of admission or outpatient registration. Patient's Reason for Visit is required for all unscheduled outpatient visits. The patient reason for visit code is required on claims for TOB 013x and 085X when the priority (type) of visit (FL 14) IS 1, 2, or 5 and one of the following revenue codes is present: 045X, 0516, 0526, 0762.
FL-71	Prospective Payment System (PPS) code Not used at this moment. FMHP will notify providers when this field should be completed on the future.

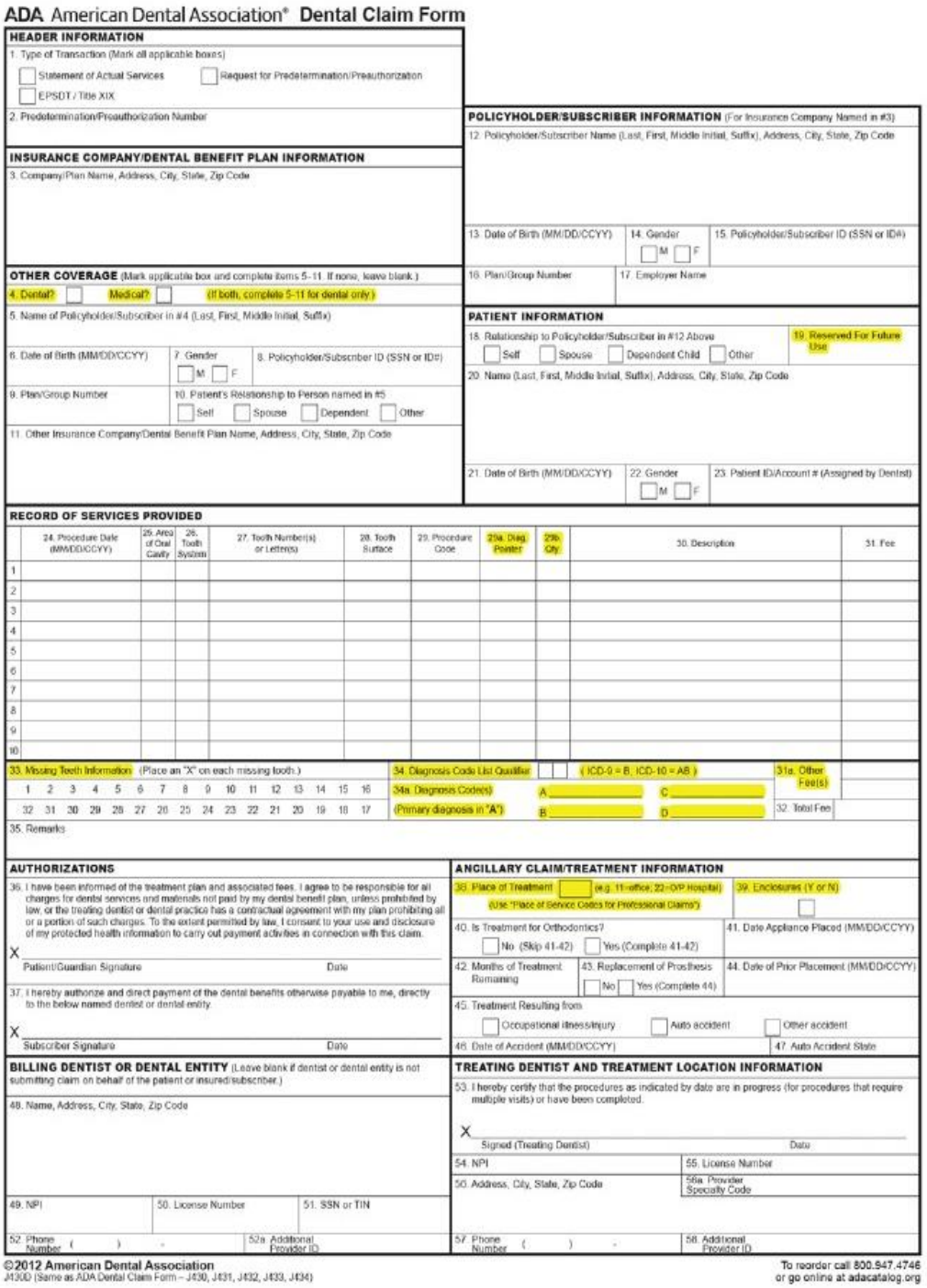
FL-72 (A-C)	External Cause of Injury (ECI Code) SITUATIONAL FIELD REQUIRED IF APPLICABLE- This field contains up to three full ICD-10-CM codes, including all digits if applicable, pertaining to the external cause of injury, poisoning, or adverse effect. Health Care facilities are encouraged to report an E code whenever there is a diagnosis of an injury, poisoning, or other adverse effect. The Coding guidelines for prioritizing the assignment of an ECI code are as follows: • Principal diagnosis of an injury or poisoning • Other diagnosis of an injury, poisoning, or adverse effect directly related to the principal diagnosis • Other diagnosis with an external cause
FL-73	Reserved for NUBC Assignment
FL-74	Principal Procedure Code and Date SITUATIONAL FIELD REQUIRED IF APPLICABLE- This field contains the ICD-10 PCS code for the inpatient principal procedure performed at the claim level during the period covered by this bill and the corresponding date on which the principal procedure was performed. HIPAA code set requirements do not allow the use of ICD-10-PCS procedure codes on outpatient claims. Report the ICD-10-PCS procedure code only for inpatient claims.

74 (A-E)	Other Procedure Codes and Dates SITUATIONAL FIELD REQUIRED IF APPLICABLE- This field allows reporting of up to five ICD-10-CM codes to identify the significant procedures performed during the billing period, other than the principal procedure, and the corresponding dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis. HIPAA code set requirements do not allow the use of ICD-10- PCS procedure codes on outpatient claims. Completion of this field is required for inpatient claims only. Enter the full ICD-10-PCS code, including the seventh digit, if applicable and the dates for as many as six surgical procedures
FL- 75	Reserved for assignment by the NUBC
FL-76	Attending Provider Name and Identifiers (including NPI) REQUIRED- This field identifies the name and identifying number of the attending provider. The attending provider is the individual who has overall responsibility for the patient's medical care and treatment. Provider NPI must be reported, Last and First Name.
FL-77	Operating Physician Name and Identifiers SITUATIONAL FIELD REQUIRED IF APPLICABLE - This field identifies the name and identification number of the individual with the primary responsibility for performing the surgical procedure(s).
FL-78 and 79	Other Provider Names and Identifiers SITUATIONAL FIELD REQUIRED IF APPLICABLE- These fields contain the name and identification number of the provider that corresponds to the indicated provider type on this claim.

FL-80	Remarks SITUATIONAL FIELD REQUIRED IF APPLICABLE- This field is used to capture additional information necessary to adjudicate. Provide any additional information that is necessary to adjudicate the claim or otherwise fulfill the payer's reporting requirements. Enter any information that is not reported elsewhere on the bill but that may be necessary for reimbursement.
FL-81	Code-Code field SITUATIONAL FIELD REQUIRED IF APPLICABLE- This field is used to report overflow or additional codes related to field locators or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

12.4 AMERICAN DENTAL ASSOCIATION (ADA- 2012)

The ADA Dental Claim Form has been revised to incorporate key changes to the HIPAA standard



ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B, ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A")
A _____ C _____
B _____ D _____

31a. Other Fee(s)
32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=OP Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

©2012 American Dental Association
J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

To reorder call 800.947.4746 or go online at adacatalog.org

12.4.1 ADA - Data Element Specific Instructions

Header Information	
Field	Instruction
1.	Type of Transaction: There are three boxes that may apply to this submission. If services have been performed, mark the "Statement of Actual Services" box. If there are no dates of service, mark the box marked "Request for Predetermination/ Preauthorization". If the claim is through the Early and Periodic Screening, Diagnosis and Treatment Program, mark the box marked 'EPSDT/Title XIX'.
2.	Predetermination/Preauthorization Number: If you are submitting a claim for a procedure that has been preauthorized by a third-party payer, enter the preauthorization or predetermination number provided by the insurance company.
Insurance Company/Dental Benefit Plan Information	
Field	Instruction
3.	Company/Plan Name, Address, City, State, and Zip Code: This Item is always completed. Enter the information for the insurance company or dental benefit plan that is the third-party payer receiving the claim. • If the patient is covered by more than one plan, enter the primary insurance company information here for the initial claim submission. • When submitting a separate claim to the secondary carrier, place the secondary carrier's company/plan name and address information here.
Other Coverage This area of the claim form provides information on the existence of additional dental or medical insurance policies. This is necessary to determine if multiple coverages are in effect, and the possibility of coordination of benefits.	
Field	Instruction
4.	Other Dental or Medical Coverage: Mark the box after "Dental?" or "Medical?" whenever a patient has coverage under any other dental or medical plan, without

	regard to whether the dentist or the patient will be submitting a claim to collect benefits under the other coverage. • Leave blank when the dentist is not aware of any other coverage(s). • When either box is marked, complete Items 5 through 11 in the "Other Coverage" section for the applicable benefit plan. • If both Dental and Medical are marked, enter information about the dental benefit plan in Items 5 through 11.
5.	Name of Policyholder/Subscriber with Other Coverage Indicated in #4 (Last, First, Middle Initial, Suffix): If the patient has other coverage through a spouse, domestic partner or, if a child, through both parents, the name of the person who has the other coverage is reported here.
6.	Date of Birth (MM/DD/CCYY): Enter the date of birth of the person listed in Item #5. The date must be entered with two digits each for the month and day, and four digits for the year of birth.
7.	Gender: Mark the gender of the person who is listed in Item #5. Mark "M" for Male or "F" for Female as applicable.
8.	Policyholder/Subscriber Identifier (SSN or ID#): Enter the social security number or the identifier number of the person who is listed in Item #5. The identifier number is a number assigned by the payer/insurance company to this individual.
9.	Plan/Group Number: Enter the group plan or policy number of the person identified in Item #5.
10.	Patient's Relationship to Person Named in Item #5: Mark the patient's relationship to the other Beneficiary named in Item #5.
11.	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, and Zip Code: Enter the complete information of the additional payer, benefit plan or entity for the Beneficiary named in Item #5.

Policyholder/Subscriber Information (For Insurance Company Named in Item #3) This section documents information about the Beneficiary who may or may not be the patient. • When the claim form is being prepared for submission to the primary carrier the information supplied applies to the Beneficiary by the primary carrier. • When the claim form is being prepared for submission to the secondary carrier the information entered applies to the Beneficiary by the secondary carrier.	
Field	Instruction
12.	Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, and Zip Code: Enter the complete name, address, and zip code of the policyholder/Subscriber with coverage from the company/plan named in #3.
13.	Date of Birth (MM/DD/CCYY): A total of eight digits are required in this field; two for the month, two for the day of the month, and four for the year.
14.	Gender: This applies to the primary Beneficiary, who may or may not be the patient. Mark "M" for male or "F" for female.
15.	Policyholder/Subscriber Identifier (SSN or ID#): Enter the unique identifying number assigned by the insurance company to the person named in Item #12, which is on their identification card.
16.	Plan/Group Number: Enter the policyholder/subscriber's group plan/policy number.
17.	Employer Name: If applicable, enter the name of the policyholder/subscriber's employer.
Patient Information The information in this section of the claim form pertains to the patient.	
Field	Instruction
18.	Relationship to Policyholder/Subscriber in #12 Above: Mark the relationship of the patient to the person identified in Item #12 who has the primary insurance coverage. The relationship between the Beneficiary and the patient may affect the

	patient's eligibility or benefits available. If the patient is also the primary Beneficiary, mark the box titled 'Self' and skip to item #23.
19.	Reserved for Future Use: Leave blank and skip to Item #20. (#19 was previously used to report "Student Status.")
20.	Name (Last, First, Middle Initial, Suffix), Address, City, State, and Zip Code: Enter the complete name, address, and zip code of the patient.
21.	Date of Birth (MM/DD/CCYY): A total of eight digits are required in this field; two for the month, two for the day of the month, and four for the year of birth of the patient.
22.	Gender: This applies to the patient. Mark "M" for male or "F" for female.
23.	Patient ID/Account # (Assigned by Dentist): Enter if the dentist's office has assigned a number to identify the patient. This is not required to process claim; however, this information might serve to identify the records for reconciliation of payment purposes.
Record of Services Provided The 'Record of Services Provided' contains information regarding the proposed treatment (predetermination/preauthorization), or treatment performed (actual services). NOTE: Items 24 through 31, apply to each of the 10 available lines on the claim form for reporting dental procedures provided to the patient. The remaining Items in this section of the form (33-35) do not repeat.	
Field	Instruction
24.	Procedure Date (MM/DD/CCYY): Enter procedure date for actual services performed. The date must have two digits for the month, two for the day, and four for the year.
25.	Area of Oral Cavity: The use of this field is conditional. Always report the area of the oral cavity when the procedure reported in Item #29 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the

	procedure's nomenclature. The Area of the oral cavity is designated by a two-digit code.
26.	Tooth System: Enter "JP" when designating teeth using the ADA's Universal/National Tooth Designation System (1-32 for permanent dentition and A-T for primary dentition).
27.	Tooth Number(s) or Letter(s): Enter the appropriate tooth number or letter when the procedure directly involves a tooth or range of teeth. Otherwise, leave blank. If the same procedure is performed on more than a single tooth on the same date of service, report each procedure and tooth involved on separate lines on the claim form. When a procedure involves a range of teeth, the range is reported in this field. This is done either with a hyphen "-" to separate the first and last tooth in the range (for example, 1-4; 7-10; 22-27), or using commas to separate individual tooth numbers or ranges (for example, 1, 2, 4, 7-10; 3-5, 22-27). Supernumerary teeth in the permanent dentition are identified in the ADA's Universal/ National Tooth Designation System ("JP") by the numbers 51 through 82, beginning with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar (for example, supernumerary number 51 is adjacent to the upper right molar number 1; supernumerary number 82 is adjacent to the lower right third molar number 32). Supernumerary teeth in the primary dentition are identified by the placement of the letter "S" following the letter identifying the adjacent primary tooth (for example, supernumerary "AS" is adjacent to "A"; supernumerary "TS" is adjacent to "T").
28.	Tooth Surface: This Item is necessary when the procedure performed by tooth involves one or more tooth surfaces. Otherwise leave blank.
29.	Procedure Code: Enter the appropriate procedure code found in the version of the Code on Dental Procedures and Nomenclature in effect on the "Procedure Date" (Item #24).

29a.	Diagnosis Code Pointer: Enter the letter(s) from Item 34 that identifies the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first.
29b.	Quantity: Enter the number of times (01-99) the procedure identified in Item 29 is delivered to the patient on the date of service shown in Item 24. The default value is "01."
30.	Description: Provide a brief description of the service provided (for example, abbreviation of the procedure code's nomenclature).
31.	Fee: Report the dentist's full fee for the procedure. Resolution 44-2009 Statement on Reporting Fees on Dental Claims adopted by the ADA House of Delegates, which provides guidance on the appropriate entry for this item.
31a.	Other Fee(s): When other charges applicable to dental services provided must be reported, enter the amount here. Charges may include state tax and other charges imposed by regulatory bodies.
32.	Total Fee: The sum of all fees from lines in Item #31, plus any fee(s) entered in Item #31a.
33.	Missing Teeth Information: Mark an "X" on the number of the missing tooth – for identifying missing permanent dentition only. Report missing teeth when pertinent to Periodontal, Prosthodontics (fixed and removable), or Implant Services procedures on a claim.
34.	Diagnosis Code List Qualifier: Enter the appropriate code to identify the diagnosis code source: B = ICD-9-CM AB = ICD-10-CM (as of October 1, 2015) This information is required when the diagnosis may have an impact on the adjudication of the claim in PRHIA where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions.
34a.	Diagnosis Code(s): Enter up to four applicable diagnosis codes after each letter (A. – D.). The primary diagnosis code is entered adjacent to the letter "A."

	This information is required when the diagnosis may have an impact on the adjudication of the claim in PRHIA where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions.
35.	Remarks: This space may be used to convey additional information for a procedure code that requires a report, or for multiple supernumerary teeth. It can also be used to convey additional information you believe is necessary for the payer to process the claim (for example, for a secondary claim, the amount the primary carrier paid). Remarks should be concise and pertinent to the claim submission. Claimants should note that an entry in "Remarks" might prompt review by a person as part of claim adjudication, which may affect the overall time required to process the claims.
Authorizations This section provides consent for treatment as well as permission for the payer to send any patient benefit available for procedures performed directly to the dentist or the dental business entity.	
Field	Instruction
36.	Patient Consent: The patient is defined as an individual who has established a professional relationship with the dentist for the delivery of dental health care. For matters relating to communication of information and consent, the term includes the patient's parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case. By signing (or "Signature on File" notice) in this location of the claim form, the patient or patient's representative has agreed that he/she has been informed of the treatment plan, the costs of treatment and the release of any information necessary to carry out payment activities related to the claim. Claim forms prepared by the dentist's practice management software may insert "Signature on File" when applicable in this Item.

37.	Authorize Direct Payment: The signature and date (or "Signature on File" notice) are required when the Policyholder/Subscriber named in Item #12 wishes to have benefits paid directly to the dentist/provider. This is an authorization of payment. It does not create a contractual relationship between the dentist or dental entity and the insurance company. Claim forms prepared by the dentist's practice management software may insert "Signature on File" when applicable in this Item.
Ancillary Claim/Treatment Information	
Field	Instruction
38.	Place of Treatment: Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard. Frequently used codes are: 11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 =Skilled Nursing Facility; 32 = Nursing Facility
39.	Number of Enclosures (00 to 99): Enter a "Y" or "N" to indicate whether there are enclosures of any type included with the claim submission (for example, X-rays, oral images, models).
40.	Is Treatment for Orthodontics: If no, skip to Item #43. If yes, answer Items 41 and 42.
41.	Date Appliance Placed (MM/DD/CCYY): Indicate the date an orthodontic appliance was placed. This information should also be reported in this section for subsequent orthodontic visits.
42.	Months of Treatment: Enter the total number of months required to complete the orthodontic treatment. (**Note:** This is the total number of months from the beginning to the end of the treatment plan. Some versions of the paper claim form incorrectly include the word "Remaining" at the end of this data elements name).
43.	Replacement of Prosthesis: This Item applies to Crowns and all Fixed or Removable Prostheses (for example, bridges and dentures).

	Please review the following three situations to determine how to complete this Item. a) If the claim does not involve a prosthetic restoration mark "NO" and proceed to Item 45. b) If the claim is for the initial placement of a crown, or a fixed or removable prosthesis, mark "NO" and proceed to Item 45. c) If the patient previously had these teeth replaced by a crown, or a fixed or removable prosthesis, or the claim is to replace an existing crown, mark the "YES" field and complete section 44.
44.	Date of Prior Placement (MM/DD/CCYY): Complete if the answer to Item #43 was "YES."
45.	Treatment resulting from: If the dental treatment listed on the claim was provided because of an accident or injury, mark the appropriate box in this item, and proceed to Items #46 and #47. If the services you are providing are not the result of an accident, this Item does not apply; skip to Item #48.
46.	Date of Accident (MM/DD/CCYY): Enter the date on which the accident noted in Item #45 occurred. Otherwise, leave blank.
47.	Auto Accident State: Enter the state in which the auto accident noted in Item #45 occurred. Otherwise, leave blank.
Billing Dentist or Dental Entity The 'Billing Dentist' or 'Dental Entity' section provides information on the individual dentist's name, the name of the practitioner providing care within the scope of their state licensure, or the name of the group practice/corporation that is responsible for billing and other pertinent information. Depending on the business relationship of the practice and the treating dentist, the information provided in this section may not be the treating dentist. If the patient is submitting the claim directly, do not complete Items 48-52A.	
Field	Instruction

48.	Name, Address, City, State, and Zip Code: Enter the name and complete address of a dentist or the dental entity (corporation, group, etc.).
49.	NPI (National Provider Identifier): Enter the appropriate NPI type for the billing entity. A Type 2 NPI is entered when the claim is being submitted by an incorporated individual, group practice or similar legally recognized entity. Unincorporated practices may enter the individual practitioners Type 1 NPI.
50.	License Number: If the billing dentist is an individual, enter the dentist's license number. If a billing entity (for example, corporation) is submitting the claim, leave blank.
51.	SSN or TIN: Report the: 1) SSN or TIN if the billing dentist is unincorporated; 2) corporation TIN of the billing dentist or dental entity if the practice is incorporated; or 3) entity TIN when the billing entity is a group practice or clinic.
52.	Phone Number: Enter the business phone number of the billing dentist or dental entity.
52a.	Additional Provider ID: This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI. The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (for example, third-party payer; federal government). Some Legacy IDs have an intrinsic meaning.
Treating Dentist and Treatment Location Information This section must be completed for all claims. Information that is specific to the dentist or practitioner acting within the scope of their state licensure that has provided treatment is entered in this section.	
Field	Instruction
53.	Certification: Signature of the treating or rendering dentist and the date the form is signed. This is the dentist who performed, or is in the process of performing, procedures, indicated by date, for the patient. If the claim form is being used to

	obtain a pre-estimate or pre-authorization, it is not necessary for the dentist to sign the form. Claim forms prepared by the dentist's practice management software may insert the treating dentist's printed name in this Item.
54.	NPI (National Provider Identifier): Enter the treating dentist's Type 1- Individual Provider NPI in Item # 54. (See Item #49 for more NPI information.)
55.	License Number: Enter the license number of the treating dentist. This may vary from the billing dentist.
56.	Address, City, State, and Zip Code: Enter the physical location where the treatment was rendered. Must be a street address, not a Post Office Box.
56a.	Provider Specialty Code: Enter the code that indicates the type of dental professional who delivered the treatment.
57.	Phone Number: Enter the business telephone number of the treating dentist.
58.	Additional Provider ID: This is an identifier assigned to the treating dentist other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI. The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (for example, third-party payer; Federal government). Some Legacy IDs have an intrinsic meaning.

12.5 ADJUDICATION RULES/REQUIRED DATA ON CLAIMS TRANSACTIONS

FMHP adjudication System processes claims through a series of edits and validations related to accuracy, completeness, providers and diagnosis and procedure codes to ensure the validity of the assigned plan benefits, within the Plan Coverage. The FMHP Claims System includes edits and validations related to eligibility, duplicate claims, referral and authorization requirements, codes and diagnosis validation, provider configuration, timely filing, benefits configuration, adjudication rules, and other type of edits configured to manage the processing of claims. Detail instructions on filling a claim is included on section 15 of this manual. It is a PRHIA requirement that the providers comply with the submission of the required data on their claims

transactions, either paper or electronic, in compliance with HIPAA and the Medicaid Management Information System requirements.

Key edits as well as key elements to consider when billing a service are included but are not limited to in the following list:

1. Members' eligibility validation
2. Duplicate claims validation
3. Referral Requirements
4. Authorized amount to be paid
5. Approved Units validation
6. Diagnosis effective date validation against service dates
7. Service Code validation
8. Provider Contracting status validation and services contracted
9. Benefits validation (covered services, limitations, etc.)
10. Authorization Requirements Validation
11. Modifiers validation
12. CARC's and RARC's Validation
13. Condition Codes validation
14. Service Area validation
15. PCP Assignment and referral validation
16. Fee assignment according to provider contracting arrangement
17. Sex vs service type validation
18. Age and service type validation according to benefits requirements, if applicable
19. Authorized level of accommodation for inpatient services (Currently-InHealth MSO)
20. Service Date is outside of benefit matrix
21. Provider does not participate in this Health Plan line of business
22. Vendor is terminated on the service date from
23. Benefit type year to date limit exceeded
24. Bundled Services

25. Global Period
26. Mutually Exclusive Procedure
27. Multiple (One) day Visits
28. Invalid Place of Service
29. Multiple and Bilateral Payment
30. Terminated Code
31. Medicaid MUE Edits
32. Medicaid NCCI Edits
33. Primary Diagnosis
34. Coordination of Benefits
35. Laboratory Panels
36. New Patient Visit Validation
37. Add-on Codes
38. Incidental Procedures
39. Separate Procedures
40. POA indicator validation in Inpatient claims
41. ICD-10-code must be coded to the highest specificity
42. Bill type must be a valid code
43. Admission date is required
44. Admission source (Point of Origin) is a required field for inpatient and outpatient services
45. Diagnosis Pointer is required for professional services (CMS-1500/837P)
46. Discharge hour for inpatient claims
47. Ambulance service must include the correspondent pick up/drop off modifier
48. Attending provider is a requirement for inpatient services
49. Patient's reason of visit is required on all unscheduled outpatient visits
50. Billing provider address on UB-04/837I must be a street (physical) address
51. ICD-10-PCS must be reported only on inpatient claims.

13 TIMELY SUBMISSION OF CLAIMS

13.1 SUBMISSION OF CLAIMS

Provider shall submit all claims and encounters to First Medical or its designee, as applicable, using the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") compliant 837 electronic formats, or the applicable CMS 1500 and/or UB-04 paper format or their successors. For dental services claims must be submitted on the applicable ADA J430D- 2012 form or its successor. Claims and encounters will utilize HIPAA compliant code sets for all coded values. Claims shall include the provider's NPI and the valid taxonomy code that most accurately describes the services reported on the claim.

Provider shall, within ninety (90) days after (a) discharge for inpatient services or (b) the date of service for outpatient services ("claims submission period"), submit a claim and/or encounters to First Medical or its designee along with any applicable authorization/referral documentation or other applicable documentary support for all services rendered in a manner consistent with the terms of the agreement. First Medical or its designee may, in its sole discretion, deny payment for any claim(s) received after the ninety (90) days mentioned in this section. Provider acknowledges and agrees that at no time shall enrollees be responsible for any payments to provider except for applicable co-payments and non-covered services provided to such enrollees. FMHP will process provider claims that are accurate and complete in accordance with FMHP normal claims processing procedures and applicable state and/or federal laws, rules, and regulations with respect to the timeliness of claims processing. Such claims processing procedures and edits may include, without limitation, automated systems applications which identify, analyze, and compare the amounts claimed for payment with the diagnosis codes and which analyze the relationships among the billing codes used to represent the services provided to beneficiaries. These automated systems may result in an adjustment of the payment to the provider for the services or in a request, prior to payment, for the submission for review of medical records that relate to the claim. Providers may request reconsideration of any adjustments produced by these automated systems by submitting a

timely request for reconsideration to FMHP. A reduction in payment because of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service. In no event may the provider bill a beneficiary for any amount adjusted in payment. Provider shall use best efforts to submit all claims and clinical data to FMHP by electronic means available and accepted as industry standards that are mutually agreeable, and which may include claims clearinghouses or electronic data interface companies used by FMHP. The provider acknowledges that FMHP may market certain products that will require electronic submission of claims and clinical data for the provider to participate. Providers shall notify FMHP when they have completed their transition to electronic medical records and agree to provide information on the status to FMHP upon request. FMHP reserves the right to perform post-payment, electronic claims audits on regular basis as indicated in the provider guidelines.

Providers agree not to bill FMHP or its beneficiaries for unusual inpatient days. Irregular inpatient days means those inpatient days incurred by FMHP beneficiaries as a direct result of provider staff and/or facility delays, unavailability of services or diagnostic tests and/or other provider operational deficiencies. Providers understand that FMHP shall make no payment for inpatient days, which are, in the opinion of FMHP, or its delegated party determined to be atypical. Providers shall have the right to appeal atypical inpatient days to FMHP or its delegated party following FMHP's clinical appeal process. The decision of FMHP medical director shall be final.

13.2 Coordination of Benefits

Vital Plan does not duplicate coverage provided by other third-party healthcare insurance. When an Enrollee has coverage, other than with First Medical, which requires or permits coordination of benefits from a third-party payer, First Medical or its designee will process the claim according with applicable laws and regulations and in accordance with the terms of its health benefits contracts. When permitted to do so by such laws and regulations and by its health benefits contracts, First Medical or its designee will pay the lesser of the amount due under the Agreement or the amount of the primary payer Enrollee's responsibility (deductible,

coinsurance, co-payment). It's the responsibility of the provider to make all efforts in the collection of the amount.

13.3 Rules Applicable to Coordination of Benefits Under Vital Plan

13.3.1 Vital Plan as Secondary Payer to Medicare:

A. For Medicare Dual Eligible Beneficiaries First Medical shall not be a secondary payer for services for which Medicare is liable. However, in situation in which a covered service is covered in whole or part by both Medicare and Vital Plan (for example, hospitalization services for a Dual Eligible Beneficiary who is enrolled in Medicare Part A only and whose hospitalization costs exceed the Medicare Limit), First Medical shall determine liability as a secondary payer as follows:

1. If the total amount of Medicare's established liability for the services (Medicare paid amount) is equal to or greater than the negotiated contract rate between First Medical and the Provider for the services, minus any Vital Plan cost sharing requirements, then the Provider is not entitled to, and First Medical shall not pay, any additional amounts for the services.

2. If the total amount of Medicare's established liability (Medicare paid amount) is less than the negotiated contract rate between First Medical and the Provider for the services, minus any Vital Plan cost sharing requirements, the Provider is entitled to, and First Medical shall pay, the lesser of:

    a. The Medicaid cost sharing (deductibles and coinsurance) payment amount for which the Dual Eligible Beneficiary is responsible under Medicare; and
    b. An amount which represents the difference between (1) the negotiated contract rate between First Medical and the Provider for the service minus any Vital Plan cost sharing requirements, and (2) the established Medicare liability for the services.

B. Dual Eligible Beneficiaries who receive Medicare Part A only: First Medical shall provide regular Vital Plan coverage, excluding services covered under Medicare Part A (hospitalization). However, the Vital Plan shall cover hospitalization services after the Medicare Part A coverage limit has been reached. First Medical shall not cover the Medicare Part A premium or deductible.

C. Dual Eligible Beneficiaries who receive Medicare Part A and Part B: First Medical shall provide regular Vital Plan coverage, excluding services covered under Medicare Part A or Part B. However, the Vital Plan shall cover hospitalization services after the Medicare Part A coverage limit has been reached. First Medical shall not cover the Medicare Part A premium or deductible. First Medical shall cover Medicare Part B deductibles and coinsurance according to the Coordination of Benefits Rules described on section 16.1.1 above. Dual Eligible Beneficiaries Enrolled in a Medicare Part C and/or Platino Plan are not eligible under Vital Plan contract.

D. Third Party Liability and Cost Avoidance: The Vital Plan shall be the payer of last resort for all Covered Services rendered on behalf of Medicaid and CHIP Enrollees in accordance with Federal regulations at 42 CFR 433 Subpart D. First Medical and PRHIA will enforce this rule with respect to all Vital Plan Enrollees. First Medical shall exercise full assignment rights as applicable and shall be responsible for making every reasonable effort to determine the legal liability of Third Parties to pay for services rendered to Enrollees under this Contract and to cost avoid or recover any such liability from the Third Party.

13.4 CLAIMS PAYMENT

First Medical requires from the Provider to comply with the clean claim requirements as defined above. All claims must include acceptable billing and coding requirements including but not limited to, valid ICD-10 codes and CPT/HCPCS codes. First Medical agrees to pay 95% of all submitted clean claims within a thirty (30) calendar day's period. First Medical agrees to

pay 100% of all clean claims no later than fifty (50) calendar days from the date of receipt of the claim.

Any Clean Claim not paid within thirty (30) calendar days shall bear interest in favor of Provider, according to the prevailing legal interest rate established by the Puerto Rico Commissioner of Financial Institutions. Such interest shall be paid together with the Claim.

13.5 Industry Standard Codes for Claims Processing and Claims Status

FMHP will use Standard Claims Adjustment Reason Codes (CARCS) and Standard Remittance Advice Remark Codes (RARCs) as mandated by Federal Regulations. These codes describe the reason of the action taken on a claim line, or entire claim during the adjudication process. This allows the Provider to review the payment or denial of a service for the required corrective action, if needed.

13.6 Electronic Data Interchange (EDI)

FMHP will accept electronic claims in the Standard ANSI X12 HIPAA transactions. FMHP accepts electronics claims (837P, 837I and 837D) from all active Clearinghouses' in Puerto Rico, therefore Providers should coordinate with their respective contracted Clearinghouse to submit electronic claims to FMHP.

Contracted Providers could also submit electronic claims directly to FMHP but before submitting them, the Provider must complete the configuration process. We encourage Providers to submit their claims electronically for a more efficient and effective payment process.

If the provider changes clearinghouse, it must be notified by writing to FMHP thus the ERA (Electronic Remittance or 835) is routed to the new clearinghouse. Otherwise the ERA report (835) will be sent to the registered clearinghouse in our system.

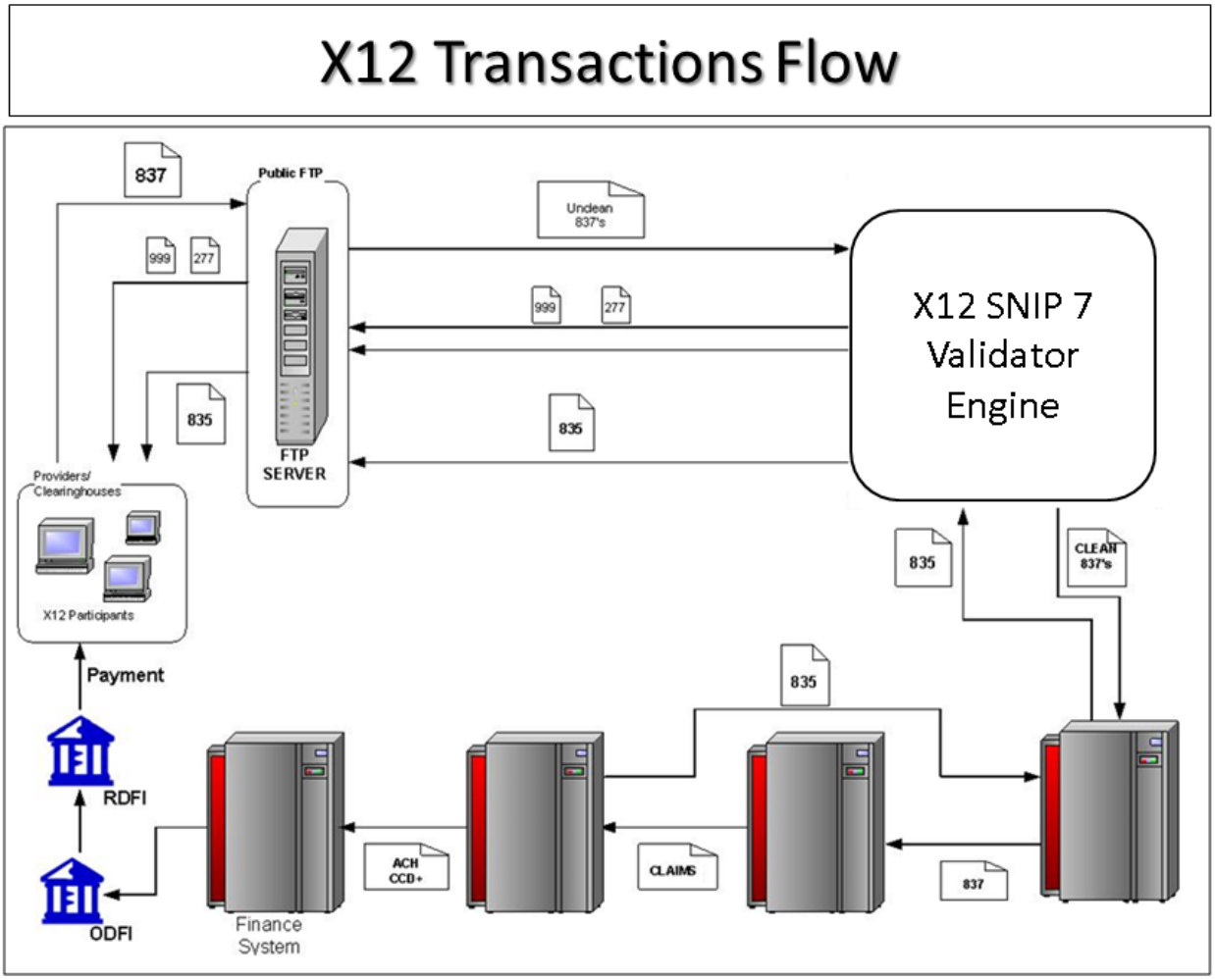
FMHP also offers Electronic Fund Transfer for the providers that request this service. The form to request this service can be downloaded from this web site:

http://www.intermedpr.com/wp-content/uploads/2014/06/2-Electronic-Fund-Transfer-Authorization-Agreement-Form-word-version-10-6.pdf

13.7 ANSI X12 AND HIPAA COMPLIANCE CHECKING, AND BUSINESS EDITS

FMHP returns a 999 Functional Acknowledgment to the submitter for every inbound 837 transaction received. Each transaction passes through edits to ensure that it is X12 compliant. If it successfully passes X12 syntax edits, a 999 Functional Acknowledgement is returned indicating acceptance of the transaction.

If the transaction fails X12 syntax compliance, the 999 Functional Acknowledgement will also report the Level 1 errors in the AK segments and, depending on where the error occurred, will indicate that the entire interchange, functional group, or transaction set has been rejected.



13.8 Interchange Control Structures

Typically, the term "interchange" connotes the ISA/IEA envelope that is transmitted between trading/business partners. Interchange control is achieved through several "control" components. The interchange control number is contained in data element ISA13 of the ISA segment. The identical control number must also occur in data element 02 of the IEA segment. Acknowledgment can be requested through data element ISA14. The interchange acknowledgment is the TA1 segment. Data element ISA15, Test Indicator, is used between trading partners to indicate that the transmission is in a "test" or "production" mode. Data element ISA16, Sub-element Separator, is used by the translator for interpretation of

composite data elements. FMHP generates a TA1 transaction when a file is completely rejected.

13.9 Claim Status Report (277CA Transaction)

FMHP returns a Claim Status Report (277CA - Unsolicited) for each received file detailing the acceptance or rejection of each claim within the transaction. This report is sent to the transmitter of the X12 file. For example, if FMHP receives a file from a Clearinghouse, the claim status report is sent to the Clearinghouse. It is the Provider's responsibility to request that report from its Clearinghouse. In the Claim Status Report the claim status category code A1 means claim acceptance and A3 means claim rejection by FMHP. Usually the claim status category code is followed by the claim status code that describes the error. These codes are standardized through the industry and your system should interpret them. A complete list of the claim status codes as well as Claim Adjustment Reason Codes (CARC), and Remittance Advice Remark Codes (RARC) can be found at: http://www.wpc-edi.com/reference/.

13.10 Claim Status Report (CAQH CORE 276-277 Transaction)

Transaction 276 allows the provider to request the status of a claim. Transaction 277 will provide the status of claim for a beneficiary in real time.

13.11 Claim Eligibility Status (CAQH CORE 270-271 Transaction)

In this option the provider may validate the status of a Vital Plan beneficiary benefit verification of professional services.

Additional information regarding Business Rules and Companion Guides for Electronic Claims Submission is available at our Provider Portal at www.firstmedicalvital.com.

14 Commitment to Protect Patient Privacy and Confidentiality

FMHP is committed to protect the privacy and confidentiality of Vital Plan Enrollees' personal and protected health information in compliance with the State and Federal laws and

regulations regarding privacy and security, including the Health Insurance Portability and Accountability Act (HIPAA, 1996), Health Information and Technology for Economic and Clinical Health Act (HITECH, 2009), Health Insurance Code of Puerto Rico and the Federal Act of 1974 "Privacy Act" (PL 93579), among others.

FMHP has adopted Confidentiality and Privacy Policies and Procedures that requires all Employees, members of all Committees and Board of Directors to sign a Confidentiality Statement and to comply with all applicable federal and state regulations. Our Providers Network must comply with FMHP contract provisions, which includes HIPAA requirements to protect the confidentiality, integrity, and availability of the Vital Plan Enrollees' Protected Health Information (PHI).

14.1 Compliance with the federal Health Insurance Portability and Accountability Act (HIPAA)

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of the member protected health information (PHI) and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization.

Protected Health Information (PHI) is defined as any information that identifies an individual, which is transmitted, maintained, or recorded orally or by any medium or form, including electronic medium, and that:

- It's created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university or healthcare clearinghouse.
- Relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual. (42 C.F.R. § 160.103).

Federal regulations set a baseline of protection for certain individually identifiable health information ("health information"), but more stringent laws, such as PR Mental Health Code and Regulation No. 51 of the Department of Health, should be followed in certain situations. FMHP expects that our Provider's Network understand that this core responsibility must be taken seriously and to follow the applicable laws by implementing and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of patient protected health information (PHI).

In those terms, our Providers shall adopt a confidentiality policy for their office and require that all staff members comply with all applicable privacy and security requirements. FMHP and its Providers Network shall use Vital Enrollees' PHI for the sole purpose of complying their roles and responsibilities during the provision of quality and cost-effective health care services. Providers shall treat the Enrollee's records and information confidentially and not release such information without the Enrollee's written consent, except for treatment, payment, or operations as allowed by state and federal law, including HIPAA regulations.

Providers cannot delegate their responsibility to protect the privacy and security of clinical information of patients receiving treatment at their offices or health facilities. Staff must be trained periodically on confidentiality and privacy requirements to comply with these requirements. Individuals shall be granted access to confidential Information only after complying with the requirements of Puerto Rico and Federal laws pertaining to PHI access.

14.2 Access to Health Records by FMHP Staff or its Subcontractors

FMHP has the authority to inspect and request copies of a medical records to examine and audit any transaction related to health services provided to Vital Plan Enrollees. to determine quality, adequacy, timeliness, privacy, cost-effectiveness of services, and continuity of care, among others.

14.3 Notice of Privacy Practices

Providers that are covered under HIPAA and have a direct treatment relationship with the patient must provide patients with a Notice of Privacy Practices that explains the Enrollee's privacy rights and the process that the Enrollee should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices in its first encounter and when changes have been made to the notice. For FMHP's Notice of Privacy Practice please refer to www.firstmedicalvital.com.

14.4 Patient Rights

Puerto Rico Patient's Bill of Rights (Article 11) establishes that a patient can have full confidence that their medical and health information will be kept strictly confidential by their health care providers.

FMHP Enrollees have rights and responsibilities with HIPAA law. Providers must allow Enrollees, at minimum, to exercise any of the below listed rights that apply to the Providers practice, as well as any other required by state or federal laws:

- **Request a copy**. Enrollees have the right to access their own PHI within a provider/practitioner's designated records set. A Personal Representative of a patient has the right to access the PHI of the subject patient. The designated record set includes the patient's medical record, as well as billing and other records used to make decisions about the member's care or payment for care.
- **Request an Amendment**. Enrollees have the right to request that you amend their Protected Health Information, if they understand that it is incorrect or incomplete. Providers/practitioners are not obligated to agree or accept any such request for amendment.
- **Request Restrictions**. Enrollees have the right to request restrictions on certain uses and disclosures of their Protected Health Information in compliance with Section 164.522 (a) of the Privacy Rule. Providers/practitioners are not obligated to agree or accept any such request for restrictions.

- Request Confidential Communications. Enrollees have the right to receive Health Information through reasonable alternative methods or at an alternative location. For example, they can request you to contact them at work or family member address. Providers/practitioners must accommodate reasonable requests by the patient.
- Inspect and Copy. Enrollees have the right to inspect and receive an electronic or printed copy of the personal or health information, within the limits and exceptions provided by law. Providers/practitioners may charge a reasonable fee to cover the expenses related to the Enrollee's request.
- Request a Disclosure Report. Enrollees have the right to obtain a Report of the Disclosures made by you or First Medical of their Protected Health Information in the last six years, except those made for treatment, payment, or health care operations, or those made at their request. First Medical, will provide a report of a period of twelve (12) months free of charge; additional reports may have a fee. You may charge a reasonable fee to cover the expenses related to the Enrollee request.
- File a Complaint. Enrollees have the right to file a Grievance with First Medical or with the Secretary of the Department of Health and Human Services of the United States of America (DHHS) if they understand that his/her privacy or security rights have been violated. You cannot retaliate against an Enrollee in any way for filing a complaint with us or with DHHS.

14.5 Security Requirements

FMHP supports the use of electronic transactions to streamline healthcare administrative activities. We encouraged you to submit claims and other transactions using electronic formats. Providers Network should implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of Vital Plan Enrollees PHI. Identity theft occurs when someone uses a person's name (and sometimes other information of their identity) without the person's consent to obtain healthcare services.

FMHP's Enrollees trust on you to keep their most sensitive information private and confidential. Providers shall ensure that the operation of all of its systems is performed in

accordance with Puerto Rico and Federal regulations and guidelines related to security and confidentiality of the protected information managed by the Contractor, and shall strictly comply with HIPAA Privacy and Security Rules, as amended, and with the Breach Notification Rules under the HITECH Act. Providers shall ensure with special confidentiality provisions in Puerto Rico or Federal law related to people with HIV/AIDS and mental illness.

Providers should report any suspected privacy HIPAA violation or disclosure of Protected Health Information to FMHP's Compliance Department without fear of retaliation to:

Fraud and Compliance Alert Line	
In writing to: First Medical Health Plan, Inc. PO Box 191580 San Juan, PR 00918-1580	1-866-933-9336 
alertacumplimiento@firstmedicalpr.com	

FMHP encourages you to comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. You must use your NPI to identify all electronic transactions submitted to FMHP and on all claims and encounters (both electronic and paper formats). Any changes in your NPI or subparts information must be reported to FMHP's Providers Department within 30 days of the change. To report any change in your NPI you should call the Credentialing Department at 787-878-6909.

14.6 Business Associates

You can disclose protected health information to FMHP's Business Associates. FMHP Business Associates provide satisfactory assurances that the members information will be used only for the purposes for which it was engaged by FMHP, will safeguard the information from misuse, and will help you to comply with some contractual requirements under the Privacy Rule.

15 INTEGRITY PROGRAM

The Puerto Rico Health Insurance Administration (PRHIA) will establish a program with the objective to evaluate compliance with the requirements of the Government Health Plan. As part of the program, the PRHIA will review the following areas:

- Enrollees and Provider Services
- Reporting
- Financial requirements
- Guidance
- Quality, adequacy, timeliness, and costs of services
- Quality Clinical Indicators
- Fraud, Waste, and Abuse (Program Integrity)
- Accessibility
- Grievances and Appeals Process

Providers will provide to the PRHIA, the Department of Health and Human Services ("DHHS"), the Center for Medicare and Medicaid Services ("CMS"), FMHP and the Comptroller of Puerto Rico and/or their authorized representatives, access to all books, documents, and records relating to provider services rendered under this Agreement for purposes of examination, audit or copying of such records.

PRHIA, DHHS, FMHP and CMS, and their authorized agents, including external independent review organizations, shall have the right to inspect, evaluate, copy and audit any pertinent books, documents, papers and records of Providers to evaluate the services performed, determine the costs of services rendered, amounts paid and amounts payable, reconcile benefits, determine liabilities and review and monitor compliance with their agreement. Providers shall allow the PRHIA and FMHP to review, by random sampling, written complaints, filed by Enrollees or their representatives relating to the quality of services provided and the results.

Providers further acknowledge and agree that FMHP, PRHIA, DHHS, CMS and their authorized agents, may conduct inspections and evaluations, at all reasonable times, through on-site audits, system tests, assessments, performance review, and regular reports, to assure the quality, appropriateness, timeliness, and cost of services furnished to Enrollees. The Provider agrees that FMHP, PRHIA, DHHS and CMS have the right to inspect, evaluate, copy, and audit the Provider records during a six (6) year period after the termination of an agreement.

15.1 Fraud, Waste and Abuse

Health care fraud and abuse is a federal offense. FMHP has a strict zero tolerance policy toward fraud, waste, and abuse. The purpose of investigating these activities is to protect the Enrollees, government, and/or FMHP from paying more for a service than it is obligated to pay.

However, FMHP *zero tolerance* policy is not limited to cases of fraud or abuse. FMHP also investigates instances of waste as well as any inappropriate activities.

Our policies in this area reflect that FMHP, its Providers, their staff and agents are subject to federal and state laws designed to prevent fraud and abuse in government programs (for example, Medicare and Medicaid), federally funded contracts and private insurance. FMHP complies with all applicable laws, including the Federal False Claims Act, applicable whistleblower protection laws, the Deficit Reduction Act of 2005, the American Recovery and Reinvestment Act of 2009, the Patient Protection and Affordable Care Act of 2010 and applicable state and federal billing requirements for state-funded programs, federally funded health care programs (for example, SCHIP and Medicaid) and other payers. It's FMHPs expectation that you fully cooperate and participate in its fraud, waste, and abuse programs.

This includes, but is not limited to, permitting FMHP access to Enrollee records and allowing on-site audits or reviews. Also, FMHP may interview Enrollees as part of an investigation, without Provider interference.

15.2 What is Fraud?

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself for some other person. It includes any act that constitutes fraud under applicable federal or state law. (42 CFR § 455.2)

15.3 What is Abuse?

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to federally and/or state-funded health care programs, and other payers. (42 CFR § 455.2)

15.4 What is Waste?

Health care spending that can be eliminated without reducing the quality of care. Quality Waste includes overuse, underuse, and ineffective use. Inefficient Waste includes redundancy, delays, and unnecessary process complexity. For example, the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent; however, the outcome of poor or inefficient billing methods (for example coding) causes unnecessary costs to the Medicaid program.

Examples of Fraud, Waste and Abuse include, but are not limited to:

- Billing more than once for the same service.
- Billing for services never performed or provided.
- Performing inappropriate or unnecessary services.
- Balance billing a Medicaid Enrollee for Medicaid covered services.

Intentional misrepresentation or manipulating the benefits payable for services procedures and or supplies, dates on which services and/or treatments were rendered, medical record of

service, condition treated or diagnosed, charges or reimbursement, identity of Provider/Practitioner or the recipient of services, “unbundling” of procedures, non-covered treatments to receive payment, “upcoding”.

- Concealing patients misuse of Enrollees identification card
- Routinely waiving patient deductibles or co-payments.
- Knowingly and willfully soliciting/receiving payment of kickbacks or bribes in exchange for the referral of Medicaid patients.
- A physician knowingly and willfully referring Medicaid patients to health care facilities in which or with which the physician has a financial relationship. (The Stark Law)
- Altering or falsifying pharmacy prescriptions
- Providing services in a method that conflicts with regulatory requirements
- Prescribing a medication for thirty (30) days with a refill when it is not known if the medication will be needed.

15.5 Sanctioned Providers

Pursuant to Section 1128 and Section 1902(a) (39) of the Social Security Act, Medicaid does not reimburse providers for any services/items that were ordered, prescribed, referred, or rendered by sanctioned (suspended, terminated, or excluded) providers. If a provider is presented with an order, prescription, or referral from a sanctioned provider, that provider should inform the Enrollee that the service/item cannot be provided because the provider has been excluded from Medicaid participation. Any payments that may be unintentionally made to a sanctioned provider or a provider acting on an order, prescription or referral from a sanctioned provider must be refunded to Medicaid.

15.6 FWA Training

FMHP providers are responsible for administering the necessary training on Fraud, Waste and Abuse to its new employees within the first ninety (90) days of employment, including managers, directors, contractors, subcontractors, and board members and annually thereafter. The provider must keep a copy of this training and proof of its delivery in case FMHP

and/or any government agency requests it and must acknowledge, annually, that it has complied with this requirement.

It is important that you keep training logs, demonstrating who was trained, including training dates and certificates of completion. For your convenience, a certificate of completion, which can be filled out by the person completing the FWA training, is included as the last slide of CMS' FWA training and education module.

15.7 Reporting Fraud, Waste and Abuse

FMHP expects providers, their staff, and agents to report any suspected case of fraud, waste, or abuse. FMHP will not retaliate against you if you inform us, the federal government, state government or any other regulatory agency with oversight authority, of any suspected cases of fraud, waste, or abuse.

If a violation of federal law has taken place the case will be referred to the PRHIA, the Centers of Medicare and Medicaid Services (CMS), Department of Health and Human Services (DHHS), Office of Inspector General (OIG), Medicaid Fraud Control Unit (MFCU) and/or other law enforcement agencies, as appropriate.
Overpayments for prescription drugs require immediate corrective action in the form of repayment.

All employees, Enrollees, and providers shall report all alleged Fraud, Misuse, and Abuse cases and other inappropriate activities to the Special Investigations Unit (SIU). All such activities will be subject to investigation and forwarded to the applicable government agency for further investigation, if warranted.

An individual who engages in any fraud, waste, and abuse activity, alone or in collaboration with other employees, patients, or providers, is subject to immediate disciplinary action up to and including termination of contract or employment.

The provider or their employees must report any alleged inappropriate activity. Providers may do so confidentially without disclosing his/her name and information.

FMHP will not tolerate retaliation in any form, toward any reporter of potential fraud, waste, or abuse.

Any questions involving inappropriate activities or clarification should be forwarded to the SIU. Reports to the Fraud, Waste and Abuse Hotline may be made twenty-four (24) hours a day/seven (7) days a week. Callers may choose to remain anonymous. All calls will be investigated and will remain confidential.

Fraud, Waste and Abuse reports may be made through one of the following:

<table>
<tr><th colspan="2">Fraud and Compliance Alert Line</th></tr>
<tr><td>In writing to:
First Medical Health Plan, Inc.
Special Investigations Unit
PO Box 191580
San Juan, PR 00918-1580</td><td>1-866-933-9336
  </td></tr>
<tr><td colspan="2">alertafraude@firstmedicalpr.com
alertacumplimiento@firstmedicalpr.com</td></tr>
</table>

The informant needs to provide the SIU with as much detail as possible on the incident. If available, provide:

- Description of the incident
- When informant became aware of the incident

- Date(s) the incident occurred
- Specific individuals involved in the incident
- If available, provide documentation/evidence.
- If not anonymous, the informant should be prepared to provide his/her name and contact phone number in the event additional information and/or follow up is required.
- The SIU creates a file and begins the investigation. Please note, the SIU will not update the informant of the status or results of the investigation as such information is confidential.

You may also contact the following:

Center for Medicare and Medicaid Services (CMS) 1-800-633-4227 www.cms.gov	Patient Procurement Office 787-977-0909	PRHIA 1-800-921-2731

15.8 IMPORTANT LAWS AGAINST HEALTH CARE FRAUD THAT YOU MUST KNOW

There are several laws that address health care fraud. These laws define fraud and establish the framework for the prosecution of criminal acts and the initiation of civil suits by injured parties. Listed below are a few of the laws that address health care fraud.

Federal False Claims Act (FCA) – 31 U.S.C. Titles 1347

The False Claims Act addresses any person or entity that does any of the following:

- Knowingly presents, or causes to be presented, to an employee of the United States government a false or fraudulent claim for payment or approval.

- Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the government.
- Conspires to defraud the government by getting a false or fraudulent claim allowed or paid.
- Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money to the government.
- Has actual knowledge of the information.
- Acts in deliberate ignorance of the truth or falsity of the information.
- Acts in reckless disregard of the truth or falsity of the information; no proof of specific intent to defraud is required.

The False Claims Act imposes two sorts of liability:

- The submitter of the false claim or statement is liable for a civil penalty, regardless of whether the submission of a claim causes the government any damages and even if the claim is rejected.
- The submitter of the claim is liable for damages that the government sustains because of the submission of the false claim.

Under the False Claims Act, those who knowingly submit or cause another person to submit false claims for payment by the government, are liable for three times the government's damages plus civil penalties of $5,500 to $11,000 per false claim.

Note: The federal government does not consider an innocent mistake as a legitimate defense for submitting a false claim and the violation could result in a multitude of penalties.

15.9 Whistleblower (Qui Tam) Protection- 31 United States Code Section (USC) 3730 (h)

The whistleblower provision protects employees who assist the federal government in investigation and prosecution of violations of the False Claims Act. Whistleblower protections apply only to actions taken in furtherance of a viable False Claims Act case, which has been, or

is about to be, filed. The provision prevents retaliation against employees such as firing them for assisting in the investigation and prosecution. If any retaliation does occur, the employee has a right to obtain legal counsel to defend the actions taken.

Note: A whistleblower (Qui Tam) is someone, such as an employee, who reports suspected misconduct that would be considered an action against company policy or federal laws or regulations. In 1994 alone, false claims act litigation resulted in payment to people/plaintiffs of $379 million.

15.10 Physician Self-Referral Prohibition Statute Commonly Referred to as the "Stark Law" 1877 of the Social Security Act (42 USC 1395)

This statute prohibits physicians from referring Medicare and Medicaid patients for certain designated health services (DHS) to an entity with which the physician or an enrollee of the physician's immediate family has a financial relationship unless an exception applies. It also prohibits an entity from presenting or causing to be presented a bill or claim to anyone for a DHS furnished because of a prohibited referral.

15.11 Anti-Kickback Statute Section 1128(b) of the Social Security Act (42 USC 1320a-7b [b])

The federal anti-kickback laws that apply to Medicare and Medicaid prohibit health care professionals, entities, and vendors from knowingly offering, paying, soliciting, or receiving remuneration of any kind to induce the referral of business under a federal program. In addition, most states have laws that prohibit kickbacks and rebates. Remuneration under the federal anti-kickback statute includes the transfer of anything of value, directly or indirectly, overtly, or covertly, in cash or in kind.

Violators are subject to criminal sanctions such as imprisonment as well as high fines, exclusion from Medicare and Medicaid, very costly civil penalties, and possible prosecution under many similar state laws.

The anti-kickback law is extremely broad and covers a wider range of activities than just traditional kickbacks. Federal regulations include safe harbors that protect certain technically prohibited activities from prosecution. If you are unsure whether an activity violates the anti-kickback law, you should seek the advice of a legal professional.

15.12 Fraud and Abuse, Privacy and Security Provisions of the Health Insurance Portability and Accountability Act, as modified by HITECH Act

This act could be considered an extension of HIPAA, as it enabled the U.S. Department of Health and Human Services to promote and expand the adoption of health information technology. It addresses:

• Use of electronic health records, including incentives for adopting them and requirements around their disclosure

• How to secure protected health information appropriately

• When and to whom notifications should made regarding data breaches of unsecured protected health information (PHI)

15.13 Antitrust Laws

State and federal antitrust laws prohibit monopolistic conduct and agreements that restrain trade. FMHP Vital Plan is committed to competition and consumer choice in the marketplace. All health care professionals, entities and vendors must adhere to the antitrust laws and must avoid any agreements or understandings with competitors on price, customers, markets, or other terms of dealing and avoid trade practices that unfairly or unreasonably restrain competition in dealings with providers or customers.

15.14 Civil Monetary Penalties Law

The OIG may seek civil penalties and sometimes exclusion for a wide variety of conducts and is authorized to seek different amounts of penalties and assessments based on type of violation at issue.

Penalties range from $10,000 to $50,000 per violation and include:

- Presenting a claim that the person knows or should know is for an item or
- Service that was not provided or is false or fraudulent or for which payment may not be made.
- Violating Medicare and/or Medicaid assignment provisions.
- Violating the Medicare and/or Medicaid physician agreement.
- Providing false or misleading information expected to influence a decision or discharge.
- Making false statements or misrepresentations on application or contracts to participate in Federal Health Care programs.
- Violations of the Anti-Kickback statute and/or Stark Law.

15.15 The Enrollee Anti-Inducement Statute (42 U.S.C. § 1320a-7a (a) (5)

This federal statute declares that any person who gives or offers to give anything of value* to a Medicare or Medicaid Enrollee that the person knows or should know is likely to influence a Enrollee's choice of a particular health care provider, practitioner, or supplier to buy or rent a Medicare or Medicaid covered item from the provider, practitioner, or supplier may be liable for civil money penalties of up to $10,000 for each wrongful act.
http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap7-subchapXI-partAsec1320a-7a.pdf

* The OIG stated in guidance that there is a "nominal value" exception that allows a health care provider to give:

- A gift to an Enrollee if the gift has a retail value of $10 or less.
- Multiple gifts of $10 or less over a 12-month period if the total retail value of the gifts does not exceed $50.

Any such gift must not be in cash or cash equivalents, so it should not be a gift card or gift certificate.

The types of gifts and their value(s) are detailed in a Special Advisory Bulletin from the OIG.

16 RISK ADJUSTMENT

16.1 HEALTH ASSESSMENT

Obtaining periodic health assessments on patients provides an opportunity for PCP's to get a snapshot on the health status and the health risks of Vital Plan Enrollees. FMHP developed a Comprehensive Health Risk Assessment (CHRA) as a reference and compliance tool for the documentation of the health conditions and needs. CHRA for Pediatric population includes developmental milestone: use to identify level of functionality and skills in the patient's growth, as well as lags in areas such as speech, height, growth of their intimate areas, fine motor skills, among others. Adults CHRA emphasizes in health assessment that includes an evaluation of social and cultural needs, preferences, strengths and limitations, pain assessment and Special Needs/DME. Health assessments shall provide important health-related information on Vital Enrollees for use by FMHP's Medical Affairs Division and PCPs to identify needs. Through the information provided in the CHRA Form, FMHP may:

- Get updated information on the conditions presented by Vital Enrollees.
- Develop clinical profiles of our population and improve Care Management Programs.
- Promote compliance with the Quality Preventive Measures.
- Identify high risk populations.
- Ensure reporting of timely and accurate data.

FMHP recommends that you complete an individual CHRA during the first ninety (90) days of the beneficiary's enrollment. PCPs must perform the CHRA during a face-to-face intervention and request the enrollee signature as evidence of the encounter. The CHRA Form must not be submitted to FMHP. Instead, you must send a paper or electronic claim on or before ninety (90) days from the date of service just as you do with any other claims for professional services offered.

FMHP may develop other initiatives to assure all Vital Enrollees have at least a CHRA, once a year. It is important to emphasize that FMHP will be evaluating monthly the PMG compliance with CHRA submission.

17 DEFINITIONS

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and that result in unnecessary costs to the Vital Plan Program or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for the provision of health care. It also includes Enrollee practices that result in unnecessary costs to the Vital Plan. **Access**: Adequate availability of Benefits to fulfill the needs of Enrollees.

Act 72: Puerto Rico law adopted on September 7, 1993, as subsequently amended, which created PRHIA and empowered PRHIA to administer certain government health programs.

Act 408: The Puerto Rico Mental Health Code (Act No. 408 of October 2, 2000, as amended), which established the public policy and procedures regarding the delivery of Behavioral Health services in Puerto Rico.

Adult: An individual age twenty-one (21) or older unless otherwise specified.

ADFAN: Administration for Children and Families of Puerto Rico (*Administración de Familias y Niños*), which is responsible for foster care children in the custody of the Government.

Appeal: An Enrollee request for a review of an Adverse Benefit Determination. It is a formal petition by an Enrollee, an Enrollee's Authorized Representative, or the Enrollee's Provider, acting on behalf of the Enrollee with the Enrollee's written consent, to reconsider a decision in the case that the Enrollee or Provider does not agree with an Adverse Benefit Determination taken.

PRHIA: Puerto Rico Health Insurance Administration (*Administración de Seguros de Salud de Puerto Rico*), the Government entity responsible for oversight and administration of the Vital Plan Program, or its Agent.

Basic Coverage: The physical and Behavioral Health Services available to all Vital Plan Enrollees (different from Special Coverage, which is available only to Enrollees with certain diagnoses after a registration process).

Behavioral Health: The umbrella term for mental health conditions (including psychiatric illnesses and emotional disorders) and substance use disorders (involving addictive and chemical dependency disorders). The term also refers to preventing and treating co-occurring mental health conditions and substance use disorders ("SUDs").

Benefits: The services set forth in this Contract, for which the Contractor has agreed to provide, arrange, and be held fiscally responsible, including Basic Coverage, dental services, Special Coverage, High Cost/High Needs Program, and Administrative Functions.

Breach: As defined in 45 CFR 164.402, the acquisition, access, use, or disclosure of Protected Health Information in a manner not permitted under 45 CFR 164, subpart E which compromises the security or privacy of such Information.

Claim: Whether submitted manually or electronically, a bill for services, a line item of services, or a bill detailing all services for one (1) Enrollee.

Clean Claim: A Claim received by the Contractor for adjudication, which can be processed without obtaining additional information from the Provider of the service or from a Third Party. It includes a Claim with errors originating in the Contractor's Claims system. It does not include a Claim from a Provider who is under investigation for Fraud, Waste, or Abuse, or a Claim under review to determine Medical Necessity.

Complaint: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination that is resolved at the point of contact rather than through filing a formal Grievance.

Covered Services: Those Medically Necessary health care services provided to Enrollees by Providers, the payment or indemnification of which is covered under this Contract.

Credentialing: The Contractor's determination as to the qualification of a specific Provider to render specific health care services.

Credible Allegation of Fraud: Any allegation of Fraud that has been verified by another State, the Government, or PRHIA, or otherwise has been preliminary investigated by the Contractor, as the case may be, and that has evidence of reliability that comes from any source.

Cultural Competency: A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among, and between groups and the sensitivity to know how these differences influence relationships with the Enrollees. This requires a willingness and ability to draw on community-based values, traditions, and customs, to devise strategies to better meet culturally diverse Enrollee needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports.

Domestic Violence Population: Certain survivors of domestic violence referred by the Office of the Women's Advocate (OPM).

Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") Program: A Medicaid-mandated program that covers screening and diagnostic services to determine physical and mental deficiencies in Enrollees less than twenty-one (21) years of age, and health care, prevention, treatment, and other measures to correct or ameliorate any deficiencies and Chronic Conditions discovered.

Eligible Person: A person eligible to enroll in Vital Plan by virtue of being Medicaid Eligible, CHIP Eligible, or another Eligible Person.

Encounter: A distinct set of services provided to an Enrollee in a face-to-face setting on the dates that the services were delivered, regardless of whether the Provider is paid on a Fee-for-Service, Capitated, salary, or alternative payment methodology basis. Encounters with more than one (1) Provider, and multiple Encounters with the same Provider, that take place on the same day in the same location will constitute a single Encounter, except when the Enrollee, after the first Encounter, suffers an illness or injury requiring an additional diagnosis or treatment.

Encounter Data: (i) All Data captured during the course of a single Encounter that specify the diagnoses, comorbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices, and equipment associated with the Enrollee receiving

services during the Encounter; (ii) The identification of the Enrollee receiving and the Provider(s) delivering the health care services during the single Encounter; and (iii) A unique (i.e., unduplicated) identifier for the single Encounter.

Enrollee: A person who is currently enrolled in Vital Plan.

Formulary of Medications Covered ("FMC"): A published subset of pharmaceutical products used for the treatment of physical and Behavioral Health conditions.

Foster Care Population: Children who are in the custody of the Family Department ADFAN Program and enrolled in the Vital Plan.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit or financial gain to him/herself or some other person. It includes any act that constitutes Fraud under applicable Federal or Puerto Rico law.

General Network: The entire group of Providers with Provider Contracts with the Contractor, including those that are and those that are not members of the Contractor's Preferred Provider Network.

Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination.

Health Care Provider: An individual engaged in the delivery of health care services as licensed or certified by Puerto Rico in which he or she is providing services, (including but not limited to physicians, podiatrists, optometrists, chiropractors, psychologists, psychiatrists, licensed Behavioral Health practitioners, dentists, physician's assistants, physical or occupational therapists and therapists assistants, speech-language pathologists, audiologists, registered or licensed practical nurses (including nurse practitioners, clinical nurse specialist, certified registered nurse anesthetists, and certified nurse midwives), licensed certified social workers, registered respiratory therapists, and certified respiratory therapy technicians).

Health Information Technology for Economic and Clinical Health ("HITECH") Act: Public Law 111-5 (2009). When referenced in this Guidelines, it includes all related rules, regulations, and procedures.

Health Care Effectiveness Data and Information Set ("HEDIS"): A set of standardized performance measures developed by the National Committee for Quality Assurance ("NCQA") to measure and compare MCO performance.

Health Insurance Portability and Accountability Act ("HIPAA"): A law enacted in 1996 by the US Congress. When referenced in this Guidelines, it includes all related rules, regulations, and procedures.

List of Medications by Exception ("LME"): List of medications that are not included in the FMC, but that have been evaluated and approved by PRHIA' Pharmacy and Therapeutics (P&T) Committee to be covered only through an exception process if certain clinical criteria are met.

MA-10: Form issued by the Puerto Rico Medicaid Program, entitled "Notice of Action Taken on Application and/or Recertification," containing the Certification decision (whether a person was determined eligible or ineligible for Medicaid, CHIP, or the State Population).

Medicaid: The joint Federal/state program of medical assistance established by Title XIX of the Social Security Act.

Medicaid Eligible: An individual eligible to receive services under Medicaid, who is eligible, on this basis, to enroll in the Vital Plan.

Medicaid Fraud Control Unit ("MFCU"): The Unit created by the Puerto Rico Department of Justice under Administrative Order 2018-002 to investigate and prosecute Medicaid Provider Fraud as well as patient abuse and neglect in health care facilities, as defined in Section 1903(q) of the Social Security Act, found at 42 USC 1396b(q).

National Provider Identifier ("NPI"): The 10-digit unique-identifier numbering system for Providers created by the Centers for Medicare and Medicaid Services (CMS), through the National Plan and Provider Enumeration System.

Network Provider- A Medicaid-enrolled Provider that has a contract with FMHP under Vital Plan Program. This term includes both Providers in the General Network and Providers in the Preferred Provider Network.

Office of the Women's Advocate: An office of the Government created by Act 20 of April 11, 2001, as amended, which is tasked, among other responsibilities, with protecting victims of domestic violence.

Out-of-network Provider: A Provider that does not have a Provider Contract with FMHP under Vital Plan.

Overpayment: Any funds that a person or entity receives which that person or entity is not entitled to under Title XIX of the Social Security Act as defined in 42 CFR 438.2. Overpayments shall not include funds that have been subject to a payment suspension or that have been identified as a Third-Party Liability as set forth in Section 23.4.

Pediatric Enrollee: An Enrollee aged zero (0) through twenty (20) (inclusive) unless otherwise specified.

Performance Improvement Projects ("PIPs"): Projects consistent with 42 CFR 438.330.

Per Member Per Month ("PMPM") Payment: The fixed monthly amount, developed in accordance with actuarially sound principles and practices as specified in 42 CFR 438.4, that the Contractor is paid by PRHIA for each Enrollee to ensure that Benefits under this Contract are provided.

Protected Health Information ("PHI"): As defined in 45 CFR 160.103, individually identifiable health Information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.

Physician Incentive Plan: Any compensation arrangement between a Contractor and a physician or PMG that is intended to advance Utilization Management and is governed by 42 CFR 438.3(i).

Preferential Turns: The policy of requiring Network Providers to give priority in treating Enrollees from the island municipalities of Vieques and Culebra, so that they may be seen by a Provider within a reasonable time after arriving at the Provider's office. This priority treatment is necessary because of the remote locations of these municipalities, and the greater travel time required for their residents to seek medical attention.

Preferred Provider Network ("PPN"): A group of Network Providers that Vital Plan Enrollees (i) may access without any requirement of a Referral or Prior Authorization; (ii) provides services to Vital Plan Enrollees without imposing any Co-Payments on Medicaid or CHIP-Eligible populations; and (iii) meets the Network requirements as described in both federal and state regulations.

Prevalent Non-English Language: A non-English language spoken by a significant number or percentage of Potential Enrollees and current Enrollees in Puerto Rico, as determined by the Government.

Preventive Services: Health care services provided by a physician or other Provider within the scope of his or her practice under Puerto Rico law to detect or prevent disease, disability, Behavioral Health conditions, or other health conditions; and to promote physical and Behavioral Health and efficiency.

Primary Care: All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by PRHIA, to the extent the furnishing of those services is legally authorized where the practitioner furnishes them.

Primary Care Physician: A Licensed Medical Doctor (MD) who is a Provider and who, within the scope of practice and in accordance with Puerto Rico Certification and licensure requirements, is responsible for providing all the required Primary Care to Enrollees. The PCP is responsible for determining services required by the Enrollees, provides continuity of care, and provides Referrals for Enrollees, when medically necessary. A PCP may be a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.

Primary Medical Group ("PMG"): A grouping of associated Primary Care Physicians and other Providers for the delivery of services to Vital Plan Enrollees using a coordinated care model.

Prior Authorization: Authorization granted by the Contractor to determine whether the service is Medically Necessary. In some instances, this process is a condition for receiving the Covered Service.

Provider: Any physician, hospital, facility, or other Health Care Provider who is licensed or otherwise authorized to provide physical or Behavioral Health Services in the jurisdiction in which they are furnished.

Provider Contract: Any written contract between the Contractor and a Provider that requires the Provider to order, refer, provide, or render Covered Services under this Contract. The execution of a Provider Contract makes the Provider a Network Provider.

Puerto Rico Medicaid Program: The subdivision of the Health Department that conducts eligibility determinations under Vital Plan for Medicaid, CHIP, and the State Population.

Quality Assessment and Performance Improvement Program ("QAPI"): A set of programs aimed at increasing the likelihood of desired health outcomes of Enrollees through the provision of health care services that are consistent with current professional knowledge; the QAPI Program includes incentives to comply with HEDIS standards, to provide adequate Preventive Services, and to reduce the unnecessary use of Emergency Services.

Quality Management/Quality Improvement ("QM/QI"): The process of developing and implementing strategies to ensure the delivery of available, accessible, timely, and Medically Necessary Services that meet optimal clinical standards. This includes the identification of key measures of performance, discovery and Data collection processes, identification and remediation of issues, and systems improvement activities.

Recertification: A determination by the Puerto Rico Medicaid Program that a person is again eligible for services under the Vital Plan.

Referral: A request by a PCP, Psychiatrist, Psychologist, or any other type of Provider in the PMG for an Enrollee to be evaluated and/or treated by a different Provider. Usually a specialist. Referrals shall be required only for services outside the Contractor's PPN.

Special Coverage: A component of Covered Services provided by the Contractor which are more extensive than the Basic Coverage services, and for which Enrollees are eligible only by "registering." Registration for Special Coverage is based on intensive medical needs occasioned by serious illness.

Specialist- A doctor who provides health care services for a specific disease or part of the body, or certain age groups. Examples includes oncologists (who care for patients with cancer), or cardiologists (who care for patients with heart conditions).

Utilization: The rate patterns of service usage or types of service occurring within a specified time frame.

Utilization Management ("UM"): A service performed by FMHP which seeks to ensure that Covered Services provided to Enrollees are in accordance with, and appropriate under, the

standards and requirements established by FMHP, or a similar program developed, established, or administered by PRHIA.

Vital Plan (or "Vital, Government Health Plan"): The health services program offered by the Government of Puerto Rico, and administered by PRHIA, which serves a mixed population of Medicaid Eligible, CHIP Eligible, and Other Eligible Persons, and emphasizes integrated delivery of physical and Behavioral Health services.

Waste: Health care spending that can be eliminated without reducing quality of care.