PROVIDER MANUAL

Serving the elderly through comprehensive community-based care

Center for Elders' Independence Provider Manual

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Claims, Payments, Denials, Disputes, Appeals and Recoupments

What is Center for Elders' Independence?

Center for Elders' Independence (CEI) is a capitated Medicare/Medi-Cal program that provides fully integrated health care and social services to frail seniors. As a Program of All-inclusive Care for the Elderly (PACE), CEI is one of over 138 PACE sites operating across the United States. For more information about PACE, visit www.npaonline.org.

CEI's mission is to provide high quality, affordable, integrated health care services to the elderly, which promote autonomy, quality of life and the ability of individuals to live in their communities.

Once a Participant joins the program, a CEI Interdisciplinary Team develops an ongoing, comprehensive plan of care that is implemented by the Team, in consultation with the Participant and family/caregivers, if applicable. The PACE model emphasizes preventive care to reduce risk for both the Participant and CEI.

The following services are provided directly by CEI staff:

- Primary medical care
- Skilled nursing
- Adult Day Health Care, including meals and personal care while at the Center
- In-home personal care and chore services
- Transportation to the ADHC Center and medical appointments
- All medications
- Medical social services
- Rehabilitation therapies (PT/OT/ST)
- Recreational activities

The following services are provided by CEI through our contracted specialists, ancillary providers, hospitals, and nursing facilities:

- Medical & surgical specialty consults
- Laboratory services
- Imaging services
- Podiatry
- Dentistry
- Audiology
- Optometry
- Psychiatry/Behavioral Health
- DME
- Oxygen
- Ambulance services
- Inpatient and outpatient hospital services
- Skilled Nursing Facility services
- Long-term custodial nursing home services

Key Points

CEI is at risk for all services covered by Medi-Cal and Medicare and frequently provides services which are not traditionally covered by these programs, but which the interdisciplinary team believes are necessary for maintaining function and allowing the Participant to remain safely in the community.

- **CEI's Participants receive services only from CEI staff or from contracted providers who have received prior authorization to provide services. (See page 16 for procedures in emergency situations.)**

- **Medicare and Medi-Cal are never billed for any services provided to CEI participants.**

- **Participants are never billed for services they receive.**

- **All claims and invoices are sent to CEI:**

Center for Elders' Independence
ATTENTION: Claims Dept.
510-17th Street, Suite 400
Oakland, CA 94612
Email:
cei-claims@cei.elders.org

- **Neither CEI nor participant is responsible for payment for any services not authorized by CEI.**

Where to Get Your Questions Answered

Center for Elders' Independence
510-17th Street, Suite 400
Oakland, CA 94612

(510) 433-1150 (24 hours)
FAX: (510) 452-8836

Participant Eligibility/Benefit Verification

Weekdays, 8:30 a.m. to 4:30 p.m.....Membership & Eligibility
Off hours, holidays.....CEI Physician On Call

Prior Authorization/Referrals/Emergencies

Weekdays, 8:00 a.m. to 5:00 p.m.....Primary Care Physician
Off hours, holidays.....CEI Physician On Call

Claims/Billing Questions .....Claims Manager

Concerns/Suggestions/Assistance (Medical issues)

Weekdays, off hours and holidays .....Chief Medical Officer

Problems/Issues (Administrative issues)

Weekdays, 8:00 a.m. to 5:00 p.m.....Chief Medical Officer
Weekdays, 8:00 a.m. to 5:00 p.m.....Chief Financial Officer

Complaints (Quality of Services) .....Quality Director

Responsibilities and Duties of Participating Physicians and Professionals

1. Performs only a consultation and/or treatment to Participant as specified in the referral form for outpatient services.

2. Requests additional authorization from CEI before performing tests, procedures, and/or services not specified in the referral for outpatient services.

3. Make arrangements for Interpreter Services be available for CEI Participants at all services sites and service locations unless CEI notifies the Provider that the Member will be accompanied to the Provider's services location by an interpreter.

4. Accepts CEI payment as payment in full.

5. Avoids duplication of laboratory or X-ray services.

6. Sends written findings and recommendations to Primary Care Physician within thirty (30) days of Participant's visit. Notifies Primary Care Physician in a timely fashion of needs for pharmaceutical and other interventions for outpatient services. (All medications are ordered by Primary Care Physician for outpatient services)

7. Notifies the Primary Care Physician when the need arises for a referral to an additional specialist or for hospital admission.

8. Provider, agrees to hold harmless the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) of the State of California, for charges denied because of lack of compliance with referral policies and procedures.

9. Provider will, in accordance with the Medi-Cal Contract and PACE Agreement, hold harmless Medi-Cal (DHCS), Medicare (CMS) the State of California, Participant, Participant's family and the Participant's estate in the event that CEI cannot or will not pay for services performed by Provider pursuant to the Provider Agreement for any reason, including insolvency of CEI.

10. Provides to Participants the same access to service that non-CEI patients enjoy.

    a. Routine appointment—within thirty (30) days
    b. Problems of "concern" to Primary Care Physician—within five (5) days
    c. Urgent/emergent problem—same day

11. Allows facility inspection by CMS and California DHCS to confirm safe and sanitary environment for CEI Participants.

12. Establishes and maintains appropriate physician/professional coverage for

his/her practice to ensure availability of specialist physician services to Participants 24 hours per day, 7 days per week.

13. Complies with CEI Participant Rights and Grievance and Appeal Procedures.

Credentialing: Physicians and Other Licensed Professionals

1. If Specialist is a Physician or other licensed professional, Specialist shall complete all forms and provide CEI with the information and required for CEI to initially credential and subsequently re-credential Specialist as follows:

   a. If CEI can obtain written verification that Specialist has been credentialed by a CEI Contracted Hospital, Provider shall be deemed to have completed CEI's credentialing process. CEI may request that Provider submit such verification to CEI if CEI is not able to obtain verification from a Contracted Hospital on a timely basis.

   b. If Specialist does not meet the requirements in 1.a., or CEI is unable to verify Provider's status at a Contracted Hospital, then Provider must submit the following:

      - Initial application (California Participating Physicians Agreement – CPPA)
      - Attestations
      - Information Release Authorization
      - Proof of licensure from State of California
      - Copy of DEA certificate or proof of issuance
      - Letter from JCAHO-accredited hospital confirming medical staff membership in good standing
      - Proof of Board Certification, if applicable
      - Malpractice proof of coverage
      - Reference letters
      - Curriculum Vitae
      - Foreign Medical Graduate Proficiency certificate, if applicable

2. CEI shall complete the credentialing process, within ninety (90) days or less, if feasible, in accordance with CEI's Credentialing Policies and Procedures.

3. Specialists, Physicians and other licensed professionals must be fully credentialed by CEI prior to serving as Providers. Any physician or licensed professional who joins a Specialist practice and wishes to serve CEI Participants must be credentialed prior to serving CEI Participants.

4. CEI may, at its sole discretion, grant provisional credentialing to providers if there is an urgent need for services that cannot be met by a credentialed Provider.

5. Specialists and any employees or subcontracted clinicians are, and will remain throughout the term of this Agreement, duly licensed by the applicable state licensing board(s) to perform the services contemplated herein.

6. Specialist will immediately notify CEI if any of the following events occur:

    a. A change in professional liability insurance premiums as a result of malpractice suits;
    b. Any change in hospital privileges (including without limitation, any reduction, suspension or termination of such privileges);
    c. Any cause of action or suspension by a State or the Federal Government from participation in the Medicare and/or, if applicable, the Medicaid program due to fraud and abuse by Provider. Such actions include, but are not limited to, actions by the applicable state regulatory board, professional associations or hospitals;
    d. Any change in business address or change of the address of locations at which services are to be provided to Participants;
    e. Any legal or governmental or other action initiated against Provider, including but not limited to an action: (a) for professional negligence; (b) for violation of the law; or (c) against any license, certification to participate in the Medicare and/or, if applicable, the Medicaid program; or
    f. If any member of Specialist's staff receives a positive test.
    g. Any other problem or situation that will materially impair the ability of Specialist, Provider to carry out his or her duties and obligations under this Agreement.

Quality Management

CEI involves our Participating Physicians and Professionals in its Quality Assessment and Improvement Plan (QAIP) activities as follows:

- On an annual basis, you will receive summary information concerning QAIP activities.

- Participating Physicians and Professionals are part of CEI's QAIP via representation on the Professional Medical Advisory Committee. If you are interested in more information or becoming a member, please forward your resume to the Chief Medical Officer (CMO).

- Specialists are encouraged to call the CMO or Director of Quality Management if you identify any quality issues you would like CEI to investigate. You can also file a formal written Grievance with CEI.

Competency Evaluation

Per 42 CFR §460.71 Competency Evaluations

All contracted staff/providers furnishing care directly to Participants shall comply with CEI's annual competency evaluation program that identifies Provider's skills, knowledge, and abilities necessary for performance of their position. These requirements include the following:

1) Compliance with any State or Federal requirements for direct patient care staff in their respective settings.
2) Comply with the requirements of § 460.68(a) regarding persons with criminal convictions shall not be employed or contracted with PACE organization.
3) Have verified current certifications or licenses for their respective positions.
4) Are free of communicable diseases and are up to date with immunizations before performing direct patient care.
5) Have been oriented to the PACE program.
6) Agree to abide by the philosophy, practices, and protocols of the PACE program.

Verifying Participant Eligibility and Benefits

POLICY

- Specialists agrees to make best efforts to confirm the eligibility of CEI Participants prior to providing non-Emergency Services, except for those Participants and services designated in CEI's referral form.

- Any services prior authorized by CEI shall be considered Covered Services. No confirmation of benefit coverage is required.

- If no authorization for services has been received, either prior to, or at the time of service delivery, Specialist must obtain confirmation of a Participant's eligibility with CEI to assure that CEI has authorized and will pay for services.

- Confirmation of eligibility with CEI and authorization for services may be obtained by calling the Participant's Primary Care Physician, or by calling the main administrative number (510) 433-1150 and asking to be transferred to the appropriate clinic.

- CEI will pay the Specialists for properly authorized services delivered to Participants whose eligibility has been confirmed by CEI even if a Participant's eligibility is retroactively terminated.

PROCEDURES

Identifying a CEI Participant and Confirming Eligibility

Referred Order

- Referral Order. A referral order for an appointment scheduled by CEI on behalf of a Participant in CEI's electronic ordering system, eCW will be considered proof of current eligibility, ***unless the referral has been issued more than 90 days prior to the visit***. In the unlikely event a referral was issued 90 days prior to the visit and the CEI Participant is not accompanied to the visit by a CEI staff member, Provider must call CEI to confirm eligibility.

Urgent or Emergent Services

- Participant Identification Card. Participant will present a CEI ID card or a Medicare Card to which a CEI sticker has been affixed.

- Telephonic Confirmation. CEI can be reached 24-hours per day by telephone at (510) 433-1150 to confirm a Participant's membership status and eligibility for CEI services.

CEI-Initiated Referrals to Contracted Medical Specialists

POLICY

- A CEI Primary Care Physician (Physician, NP or PA) MUST be the one to authorize all outpatient referrals in order for services to be covered by CEI.

- Specialist referrals are usually for either "Consultation" or "Treatment" (although they may be for both). The specialist shall provide only those services that are indicated on the referral form. Additional visits as well as diagnostic tests and treatments not initially authorized must be approved by CEI before being scheduled and delivered.

  EXCEPTION: Dentistry is an exception. For dentistry services, one referral covers the entire process of making and fitting dentures and partial plates. However, oral surgical procedures require prior approval from CEI.

- The specialist may recommend to CEI that a Participant receive care from another specialist/sub-specialist but cannot make such referrals directly.

- In the event a hospital-based out-patient procedure, surgery, or inpatient hospitalization is approved by CEI, a specialist will provide only those services prior authorized by CEI.

PROCEDURES

Initiating a Referral: Consultant's Report Form

A CEI Primary Care Provider (PCP) will refer a Participant to a Specialist by writing an order for referral in CEI's electronic ordering system, eCW. The PCP will indicate what the problem is and what services and advice are being requested (i.e., consultation and/or treatment).

CEI will either send documentation generated from eCW to the specialist in advance of the appointment or a faxed copy of the Referral signed by the PCP's is also acceptable.

Appointment Scheduling

A CEI staff member will call the Specialist's office and schedule an appointment on behalf of the Participant to ensure that CEI's Transportation Department or another responsible party can bring the Participant to the appointment.

Specialist Visit

The person who transports the Participant to the specialist's office will accompany the patient during the visit as needed. Contracted providers are responsible for arranging Interpreter Services for CEI participants in all services sites and locations.

The Specialist will conduct the exam and, if prior authorized, provide specific diagnostic tests and/or treatment. The Specialist will seek prior authorization from the Participant's PCP before providing any services that have not been explicitly prior authorized. **The Specialist may call the Participant's PCP during the visit or the CEI Referral Office to seek authorization additional services, if needed.**

Consultant's Report

The Specialist will complete and fax a Consultant's Report, or the Specialist claims will not be paid until CEI receives a completed Consultant Report from the Specialist. Urgent or critical issues should be highlight, and a telephone call to the referring CEI Clinic is required for urgent issues.

The Consultant Report should include any information that the Specialist believes

is pertinent to the case, and should be communicated to the PCP. A separate written report may be attached if necessary.

The Consultant's Report includes:

a. Findings and/or services rendered: This is a summary of any services that were performed by the Specialist during the visit and the findings of any tests, if appropriate.

b. Recommendations: The Specialist indicates what, in his/her opinion, is the best treatment to produce the most positive outcome for the Participant's functional status, considering quality of life and medical condition.

c. Further Visits: If further visits to the Specialist are recommended, the Specialist must state approximately how many visits s/he feels are appropriate.

- Date of proposed follow-up visit, if appropriate: If the Specialist believes that a follow-up visit is necessary, the proposed date of the first visit is recorded here. If a follow-up visit or visits beyond those already authorized are needed, the PCP will document approval in the eCW Telephone Encounter field, and a new Referral and Authorization will be issued.

Medications

PRESCRIPTION DRUG BENEFITS

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

CEI provides virtually all of the Participant medications to their homes. Rarely, specialized medications may be provided by other pharmacies or medical offices. This requires preauthorization from CEI.

The PCP prescribes and oversees all medications for CEI Participants. Therefore, medications and other therapies recommended by the specialist should be listed on the Consultant's Report and **faxed or phoned** to the CEI clinic. Prescriptions should not be written or sent. CEI's contract pharmacy will provide medications the same day if the request reaches the clinic by 12:30 p.m. or, if the need is urgent, at any time of the day or night. The only exception to the requirement that the PCP prescribe medication is specialized oncologic and other medications after preauthorization.

The specialist **will contact the CEI PCP directly if there is an urgent need for change in medication**. Call (510) 433-1150, give the Participant's name, and the receptionist will connect the specialist with the appropriate clinic.

Request for Additional Visits and/or Services

If follow-up care is required, the Specialist will indicate this on the Consultant report and/or contact CEI. If Additional authorization is required CEI will send another authorization indicating how many visits and which services are authorized, and the referral process proceeds as described above.

If the Specialist wants to know at the time of the initial visit whether such follow-up will be authorized, he or she can call (510) 433-1150 between 8:30am and 5:00pm. The Specialist must provide the Participant's name and the receptionist will connect you with the appropriate clinic. -

Future appointments should never be made directly with CEI Participants or their care-givers when they visit the Specialist since visits must be prior authorized and scheduled in consultation with Transportation personnel. Therefore, it is essential that the specialist wait to hear from CEI before scheduling an appointment.

Referrals for Diagnostic Studies and X-rays

All out-patient diagnostic studies recommended by the Specialist requires prior authorization by CEI must be explicitly authorized by CEI:

X-rays: Include MRI, CT scan, imaging - mammogram, ultrasound, etc.

X Rays - X-rays done in the physician's office will not be reimbursed except under the following circumstances:

- After hours (5:00 p.m. – 8:00 a.m.) and weekends
- Orthopedic surgeon with routine two dimensional X rays.

All other x-rays must be authorized by CEI contracted providers.

Referrals to Other Specialists or Sub-Specialists

A Specialist who recommends that a Participant be referred to another specialist/sub-specialist should indicate so on the Consultant's Report. A discussion with the PCP is preferred. If CEI authorizes the recommended referral, CEI will send a new referral to that Specialist and will follow-up directly with the new provider.

Specialists will make best efforts to recommend referrals to other providers on CEI's panel. CEI Website contains the current list of specialists/sub-specialists under "Contracted Provider Directory":

https://cei.elders.org/contracted-providers/

Referrals to out-of-plan providers are authorized only when there is a compelling medical reason why a provider on the CEI panel cannot perform services.

Elective Procedures, Surgeries and Hospital Admissions

If a Specialist believes a CEI Participant requires inpatient or outpatient services (diagnostic, treatment, or surgical) at an acute-care hospital or surgery center, the Specialist should call the Participant's Primary Care Physician, or state so on the Consultant's Report, if time permits. The CEI Primary Care Physician **MUST** be the one to authorize all hospital-based services and elective inpatient admissions. CEI's staff will make the arrangements for a Participant to receive services from the hospital and will coordinate schedules with the Specialist, as needed.

Except for emergencies, only those tests and procedures that have been authorized prior to or at the time of service/admission will be paid for. The Specialist may request authorization for additional tests and procedures from the Participant's PCP via telephone, and approval can be granted verbally.

Urgent and Emergency Hospital Admissions

If a Specialist believes the Participant should be admitted to an acute-care hospital on an Urgent or Emergency basis **and** the nature of the condition permits, the Specialist should contact PCP or the CEI on-call physician prior to directing the patient to the Emergency Department. A Specialist can speak with a CEI physician by telephone 24 hours a day at (510) 433-1150.

If the CEI physician concurs that it is appropriate that Urgent or Emergency services are provided, he or she where possible, will call the Hospital's Emergency Department to give instructions for treating the patient. The CEI physician will request a call back from the Hospital about the patient's status after the initial treatment. If the physician determines that the situation does not constitute an Emergency, he or she will arrange appropriate follow-up, which might include:

- Meeting the patient at CEI after hours.
- Making time to see the patient in the clinic during business hours.
- Sending a CEI nurse to assess the patient's condition.
- Arranging for a PCP to make a home visit.

CEI Participants must be admitted to Participating Hospitals except in Emergency conditions or when services cannot be provided by a Participating Hospital. The CEI Claims and Provider Services Department can provide an updated list at any time.

Consultant Reports should be faxed to - the referring CEI Clinic at these numbers:

San Leandro	**(510) 746-0977**
Oakland East Bay	**(510) 553-1099**
Berkeley	**(510) 844-0131**

Downtown Oakland (510) 433-1161
Concord (925) 363-2111
El Sobrante (510) 669-1008

REMINDER:
A Consultant Report that requires urgent intervention or medication change must be called to the referring Clinic at these numbers:

San Leandro (510) 746-0500
East Oakland (510) 746-5550
Berkeley (510) 653-1843
DowntownOakland (510) 830-3900
Concord (925) 678-5230
El Sobrante (510) 669-1005

Acute Care
&
Sub-Acute
Hospitals
&
Skilled Nursing Facilities (SNFs)

General Policies

Record Review

CEI reserves the right to conduct concurrent and retrospective medical record review on any and all medical care rendered to a CEI Participant by any medical provider at any time. Medical records should be available to a CEI representative for review on a concurrent basis. Medical records for retrospective review will be requested by a CEI representative routinely twenty-four (24) hours in advance, or shorter t notice if indicated.

Evidence-Based Care

CEI bases its review of appropriateness of care on evidence-based guidelines, such as the Milliman Care Guidelines. Rationale and basis for medical decisions made by CEI physicians and Specialists should be appropriately documented in the medical record.

Emergency Hospital Admissions and Services

POLICY

- **If a Participant present at the Emergency Department (ED), the Hospital will treat the Participant in accordance with, and to the extent required, by State and Federal law.**
- **Whenever feasible, Hospital will determine if CEI Participant has a POLST (Physician Orders for Life Sustaining Procedures) or other similar order and treat accordingly.**
- **All services provided to Participants whose medical condition has been stabilized must be prior authorized by CEI.**

PROCEDURES

Emergency Care: Post-Stabilization

Once a CEI Participant has been stabilized, the Hospital must contact Primary Care Physician or CEI on-call physician or the Coordinated Care Services Center (CCSC) at CEI. CEI is to be notified prior to the time Hospital provides any services beyond those required to stabilize the Participant, including hospitalization. A CEI physician can be reached at (510) 433-115024 hours a day.

In the event the Hospital has not contacted CEI prior to an Emergency hospital admission (e.g. because the patient was not identified as a CEI Participant), the Hospital must do so within one (1) business day from the time the admission has been made and participation established the Procedures described in the Section

below titled “Non-Emergency Admissions to Acute & Sub-Acute Hospitals” will apply once the Participant has been admitted as an inpatient.

CEI Denial of Request for Authorization

If the Primary Care Physician refuses to authorize the services and the patient still wants to receive them, the CEI Participant (or his/her legal guardian) must sign a release stating that he or she was told in advance the Service might not be Covered. **If CEI denies the claim after reviewing the case retroactively, CEI is not be liable for the claim and the Hospital may bill the Participant directly.**

Late notification of emergency admissions is subject to denial.

Non-Emergency Admissions to Inpatient Facilities

POLICY

- **CEI provides care to Participants in Acute Care Hospitals, Skilled Nursing Facilities (SNFs), Rehabilitation Hospitals, Sub-Acute facilities, and in custodial settings. Prior authorization is required for all non-emergency facility admissions.**

- **A CEI Primary Care Physician or a Contracted Hospitalist will serve as the Participant’s attending physician during any inpatient stay. If a patient is admitted for elective surgery, the Surgeon will serve as the attending physician.**

- **Participants may be admitted directly to any inpatient facility. The Medicare three (3) day acute-care hospitalization rule does not apply to CEI Participants.**

- **All non-custodial care must be reauthorized on a regular basis to assure that the type of facility and assigned Level of Care continue to be appropriate to a Participant’s needs.**

- **Copies of all Treatment Requests, Requests for Authorization or Authorizations for Extended Stay should be faxed to the CEI Coordinated Care Services (CCSC) Department at (510) 433-1160 x7032 at least 24 hours in advance of the date the requested service(s) are to be provided.**

PROCEDURES: Acute, Sub-Acute, Rehab & Psychiatric Hospitals

Authorization of Elective Hospital Admissions

A CEI Primary Care Physician will arrange all elective admissions with the contracted facility.

CEI will indicate how many days are initially authorized. If provider is a Sub-Acute Care Hospital, CEI will indicate the Level of Care that is being authorized and for what period of time. If Hospital is reimbursed on a DRG or other case rate basis, the number of days authorized shall serve as a guideline only for purposes of reimbursement.

Extensions of Stay

If a Hospital believes a Participant should remain in the facility longer than initially authorized, or for Hospitals paid on a DRG or case-rate basis, a period of time that would trigger an outlier payment based on days, the facility's Utilization Review Department must call the Primary Care Provider, or the CCSC no later than the 24 hours before the authorization expires to request an extension of the stay. Primary Care Physician or CCSC will give the Hospital a written authorization or verbal response of approval or denial. CEI will fax to the Hospital a written a confirmation of the verbal approval or denial.

Request to Provide Services Not Included in a Case Rate (DRG, Other)

If a Hospital believes a Participant would benefit from receiving services that were not initially requested and/or authorized or that are outside of the case rate payment for the patient's condition, the Hospital must call Primary Care Physician to request approval of such services. The Primary Care Physician will give the facility a verbal response (approval or denial) and then, if approved, fax a new authorization form to the Hospital.

PROCEDURES: Skilled Nursing Facility (SNF)

Authorization of SNF Admission

The SNF from which a CEI client is being transferred should contact the CCSC at (510) 844-234-7223 as soon it is deemed feasible to begin planning a patient's discharge. CEI will either make arrangements with the SNF for the transfer and admission, including transportation, or will authorize the SNF staff to make the arrangements. (This includes admissions from Long-Term (Custodial) Care settings. Primary Care Physician and Interdisciplinary Team will arrange any direct admissions to a SNF for a client coming from a home setting.

CCSC Department Phone: (510) 433-1160 x7032 or Fax (855) 732-2365.

Open Business hours:

Monday through Friday 8:30am to 5pm

For after hour services Monday through Sunday call (510) 433-1150.

CEI will send a Skilled Nursing Authorization Referral to the SNF Facility via Fax.

The Participant's Primary Care Physician will indicate the beginning and end dates initially authorized and at what level of care. The authorization may be modified by CEI during this initial period based on the Participant's need for additional services or for a reduction in the number and/or type of services the SNF will provide. All Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST) evaluations, and all PT/OT/ST treatments must be explicitly authorized by CEI. All changes in days and/or levels of care shall be prospective in the SNF Referral form confirmed in writing and sent via fax to the SNF.

Extension of Stay

The SNF must call CEI for an extension of stay no later than the 24 hours before the current authorization expires. A Primary Care Physician will verbally respond, or in eCW, a Skilled Nursing Authorization Referral within 24 hours of receipt of the request. In some cases, verbal approval may be granted, but approval is entered in eCW Skilled Authorization Referral, or by fax to the Facility within the required timeframe.

- **Patient Information:** Name, SSN, DOB.
- **Problem/Service Requested:** Indicates the number of additional days, services, or treatments the SNF believes the Participant needs.
- **Indication for Extension:**
  This can be based on medical necessity or on a nursing or psychosocial rationale. If the change will affect the patient's functional status or ability to live independently, this should be documented.

Request to Provide Services Not Initially Authorized

If a SNF believes a Participant would benefit from receiving services that were not initially requested and/or required and that would result in a change in the authorized Level of Care, the SNF will call the Primary Care Physician for prior authorization. The Primary Care Physician will give the facility a verbal response of approval or denial, and fax a new Skilled Nursing Authorization Referral documenting the approval or denial.

CEI reserves the right to deny payment for an increase in a Participant's Level of Care that has not been prior authorized by CEI.

Discharge Planning

POLICY

- CEI will be responsible for developing and/or approving all discharge plans for

Participants. The CEI Interdisciplinary Team will play a major role in managing the Participant's transition out of the Hospital/Rehab facility/SNF and may assist the Hospital's discharge planners in securing admission to a facility providing a lower level of care if requested to do so.

- Whenever feasible, Participants will be discharged to the environment in which they were residing prior to their hospitalization.

- CEI will make all End of Life arrangements for its Participants.

PROCEDURES

Coordination of Care/ Discharge Planning between Skilled Nursing Facility and CEI

The coordination of care/Discharge Planning begins upon admission to the Hospital or SNF's SNF staff should contact the Participant's CEI clinic at 510-433-1150 or CCSC at (510) 433-1160 x7032. CEI will either make arrangements with the SNF for the transfer and admission, including transportation, or will authorize the SNF staff to make the arrangements. If the CEI Participant is being discharged to another inpatient setting, CEI must approve the type of facility and Level of Care to which the patient will be sent. CEI will provide the discharging facility with a list of its Contracted Providers, and Participants will be admitted to these facilities unless otherwise approved by CEI.

The Hospital or SNF will forward all compulsory documentation (Participant's medical records, notes, etc.) to the new facility prior to or concurrent with the Participant's discharge.

For weekday discharges to a patient's home/apartment or Board and Care facility, the Hospital will notify CEI as soon as there is a potential for discharge to assure that CEI staff or another designated party(s) is are present to assist the patient CEI patients will not be discharged if proper arrangements cannot be made.

CEI may withhold payment for claims submitted by Hospitals or SNFs that have not submitted a copy of a Discharge Summary to CEI.

Transportation

CEI will either make the make arrangements for the patient to be transported to a new facility or to the Participant's home, or will authorize the Hospital or SNF to make the arrangements. CEI will provide the Hospital or SNF with a list of those Contracted Transportation Vendors that are to be used in the event CEI's own Transportation Department is unable to transport the patient. Hospital will utilize CEI's Contracted Transportation Vendors unless otherwise approved by CEI.

End-of-Life Arrangements

In addition to completed advance directives and POLST relating to end of life treatment preferences, CEI is often aware of the burial and other end of life care preferences of its participants. It should be notified immediately upon the death of any participant or any time a Participant me require such care.

Billing, Claims Payment, and Provider Disputes and Appeals

How to Complete and File Claims

POLICY

CEI abides by Medicare and Administrative Simplification Compliance Act (ASCA) standards and requirements for submission of claims. Unless exceptions are met, provider must submit claims electronically to CEI. Those eligible for an exception may send a claim on paper claim form.

Providers sending professional and supplier claims on paper must use Form CMS-1500 in the latest version.

The required format for submitting institutional claims on paper is the CMS1450 a.k.a UB-04 form.

A “complete claim” consists of:

- All required data elements to pass electronic submission edits; Appropriate HIPAA standard codes have been used; and supplemental information or documentation necessary for CEI to determine payer liability.

PROCEDURES

Completion of Claim Forms

Claims must be completed according to the national standard formats for electronic and/or paper submission.

Required Data Elements

1. Insured’s type of coverage (check Group Health Plan)
2. Insured’s (i.e., Participant’s) CEI Plan ID number (either the unique number assigned by CEI) or Medicare Beneficiary Identifier (MBI). If the insured is covered under Medi-Cal only, provider may also use the Client Index Number (CIN).
3. Patient’s name (last name, first, middle initial)
4. Patient’s date of birth gender
5. Patient’s address (street, city, state, and ZIP code)
6. Patient relationship to insured
7. Name of referring or ordering physician and NPI
8. Hospitalization dates related to current services
9. Diagnosis code(s) (ICD-10-CM)
10. Date of service
11. Place of service code
12. CPT/HCPCS code and applicable modifier
13. Diagnosis code pointer

14. Billed charge (for each service)
15. Days or units
16. Rendering Provider NPI
17. Provider's Tax Identification Number (TIN)
18. Provider's Patient account number
19. Claim Total charge amount
20. Signature of physician or supplier
21. Name and address of facility where services were rendered (if other than home or office)
22. Physician's/Supplier's billing name, address, zip code and phone number

Acceptable Coding Structures

The diagnosis and procedure codes utilized by CMS (ICD-10-CM diagnosis codes, CPT-4 procedure codes, HCPCS Level II codes, ICD-10-PCS inpatient procedure codes, National Drug Code (NDC), and other applicable Medicare coding schemes) that were current as of the date services were rendered.

Authorization Number

(Note: does not apply to Emergency Services.)

- Authorization # on Medical Consultation Request/Report Form (MCRR) issued by the Plan, if available; or
- The name of the Primary Care Physician who issued prior approval for the service(s).

Other Information

CEI may request additional information to process and pay a claim. Although a claim contains all required data elements, it may be necessary for CEI to review other information reasonably required to verify and substantiate the provision of Covered Services and the charges for such services. CEI shall send a written request specifying the necessary additional information.

Claims Submission

I. Claims Submission, Adjudication, and Payment.

CEI abides by Medicare and Administrative Simplification Compliance Act (ASCA) standards and requirements for submission of claims. Unless exceptions are met, provider must submit claims electronically to CEI.

Providers sending professional and supplier claims must be Medicare eligible to submit paper claims, by providing CEI with a copy of the Medicare Exhibit F – Notice that waives electronic claims submission. Paper claims must use Form CMS-1500 in the latest version.

Electronic Claims Submission. Claims will be submitted through electronic data interchange (EDI) to CEI under Payer ID 94312 within one-hundred and twenty (120) days from the date of service.

Electronic claims submission are sent to: cei-claims@cei.elders.org
CEI Payer ID 94312.

Attention: Claims Department
510-17th Street, Suite 300
Oakland, CA 94612
Email: cei-claims@cei.elders.org

Filing Deadline

Claims must be received within one hundred eighty (180) days from:

- the date of discharge from Contractor for inpatients;
- the date of service for Participants treated as outpatients, or
- the date Contractor determines the Plan's liability for payment.

Payment will be denied for claims received more than 180 days from the applicable date.

Claims, Payments, Denials, Disputes, Appeals and Recoupments

POLICY

- CEI abides by Medicare's standards (as modified from time to time) for reviewing, paying, and when appropriate, denying claims.
- CEI may pay claims for non-Emergency Covered Services that were not prior authorized if CEI determines them to have been Medically Necessary.
- A Contracted Provider has the right to inquire about and appeal the denial of a claim or the amount of any payment made by CEI.

PROCEDURES

Provider Payments

Timeliness of Payments

CEI follows Medicare rules for payment of claims to fee-for-service providers. Medicare requires that 95% of claims be paid within thirty (30) days of receipt.

Contracted providers agree to accept CEI claim payment as payment in full and will not seek additional payment or "balance-bill" participants after CEI has paid the claim.

Explanation of Payment

All payments to CEI Contracted Providers will be sent along with a Remittance Advice that includes the following information:

a. Provider's practice name and Tax ID
b. Participant's name
c. Date of service
d. Claim ID (assigned by Plan)
e. Code/Description – CPT code, HCPCS code and description of service
f. Patient account – this number reflects the number supplied by the provider on the claim form
g. Billed amount
h. Reimbursement – the actual amount paid for each participant's charges
i. Claim adjustment reason code(s) for provider

Claims Denials

If CEI denies payment for all or a part of a claim, CEI will:

- Notify the CEI Contracted Providers in writing
- Communicate the reason for the denial ("Explanation of Benefits")
- Specify additional information required for Plan to pay the amount due with respect to the applicable claim, to the extent feasible; and
- Notify the provider of his or her appeal rights.

Claims for non-Emergency Services that have not been prior authorized will be automatically denied. The Provider may submit documentation to CEI showing that services rendered were medically necessary and would have been authorized by CEI. If CEI agrees with the Contracted Provider's assessment, CEI will pay the Contracted Provider within sixty (60) days. If the Plan denies the claim, the Contracted Provider may submit an appeal. Note: If documentation is provided along with the original claim, the claim may not be automatically denied.

Disputed Claims and Provider Appeals

A Contracted Provider has the right to file an appeal disputing the denial of a claim, or the amount of any payment made by CEI.

Prior to submitting an appeal, a provider may call CEI Clams and Provider Relations during normal business hours to discuss the reasons for denial or payment adjustment. CEI's goal is to resolve most issues on the telephone and avoid the need for the provider to file a formal appeal.

> A Contracted Provider has 365 calendar days from the date on which CEI has paid or denied a claim(s) to submit a payment dispute to CEI. The Plan will not be consider disputes filed more than 365 working days from date of payment by the Plan. The Plan will issue a formal denial of such requests within thirty (30) days from the date the Plan receives the dispute, and the original payment will be considered payment in full.

The appeal must be in writing on the Contracted Provider's letterhead and contain the following information to identify the claim:

- Member name.
- Member CEI ID.
- Provider name.
- Provider Contact person name.
- Provider contact address and telephone number.
- Provider Tax ID number.
- Date of service.
- Charges denied/underpaid.
- Clear explanation of the basis for provider's dispute.
- Supporting documentation for the grounds on which the provider is appealing.

The Plan will send a written request if additional information is needed from the Contracted Provider. The Provider will have thirty (30) days to respond. If the Contracted Provider doesn't respond within thirty (30) days, the appeal will be considered closed and the original claim decision is upheld.

ATTN: Claims Dispute
Center for Elders' Independence
510 17th Street Oakland, CA
94612

Processing of Provider Dispute

CEI Claims Staff shall send a written acknowledgement of receipt of the dispute to the Provider within fifteen (15) working days of its receipt.

If CEI determines that additional information is needed in order to review and make a determination, a written request will be sent to provider specifying the information required. Provider must respond within 30 days from receipt of the letter, either sending the requested information or explaining why provider disagrees with the request.

CEI will review and send a written determination within sixty (60) calendar days from the date it receives a Contracted Provider's written dispute.

Recoupment of Overpayment

If CEI determines that it has overpaid a claim, it will send the provider a written notice of overpayment with request to refund the amount over paid. Provider must respond within thirty (30) days from receipt of written notice of overpayment and either:

a. issue a check to CEI; or
b. approve permission for recoupment; or

file a dispute with the Plan explaining why the refund request is incorrect.

Participant Appeals and Grievances

Participant Grievances

A key Compliance Management function is the processing of Participant-initiated grievances or complaints. This may include a Participant's interactions with CEI or a Contracted Provider, a Provider's staff, the perceived quality of care received, wait times for appointments or other similar issues. The grievance process provides feedback from a patient's perspective that can be useful to CEI and its Contracted Providers in improving the way we work together.

In the event a Participant files a formal grievance with CEI that involves a Contracted Provider, the Compliance Manager will review the merits of the grievance or complaint. **Contracted Providers must respond to any telephonic or written inquiries made by CEI within fifteen (15) calendar days of receiving the inquiry.** CEI is required by its regulators to respond in writing to the Participant within thirty (30) calendar days of receiving the grievance or complaint.

CEI's Provider Agreements state that Providers will make best efforts to implement changes recommended by CEI when dealing with Participants. In rare cases, where CEI concludes that there is a serious issue regarding quality of care that cannot be resolved, CEI may elect to terminate its contract with the Provider as described in the Provider Agreement.

Participant Appeals

Participants may also file an appeal challenging CEI's decision not to authorize the provision of services recommended by a Provider or provided without authorization.

Providers are required to provide information requested by CEI for purposes of processing a Participant's appeal within fifteen (15) calendar days of receiving the inquiry. CEI is required by its regulators to respond in writing to the Participant within thirty (30) calendar days of receiving the appeal. CEI's decision will be final unless a Participant whose appeal is denied exercises his or her right to seek a second level appeal with either the Department of Health Care Services or the Centers for Medicare and Medicaid.

CHAPTER 12

YOUR RIGHTS & RESPONSIBILITIES as a MEMBER

As a member of CEI, you have certain rights and responsibilities.

Your Rights as a Member of CEI

You are entitled to the rights listed below. You may designate a family member, caregiver, or other representative to exercise any or all of the rights to which you are entitled. If you feel that your rights have been violated, please follow the grievance procedures described in Chapter 13, "Member Grievance & Appeal Process."

1. To be treated with dignity and respect.
2. To be afforded privacy and confidentiality in all aspects of care.
3. To receive humane care from all CEI employees and contractors at all times and under all circumstances.
4. To have your property treated with respect.
5. To receive comprehensive health care in a safe and clean environment and in an accessible manner.
6. Not to be required to perform services for CEI.
7. To have reasonable access to a telephone while at the Center, both to make and receive confidential calls, or to have such calls made for you, if necessary.
8. To be free from hazardous procedures.
9. To be free from harm, including physical or mental abuse, neglect, corporal punishment, involuntary seclusion, excessive medication, and any physical or chemical restraint imposed for purposes of discipline or convenience and not required to treat your medical symptoms.

10. To be encouraged and assisted to exercise your rights as a participant, including the Medicare and Medi-Cal appeals processes, as well as civil and other legal rights.
11. To be encouraged and assisted to recommend changes in policies and services to staff.
12. To be fully informed in writing of the services available from CEI, including identification of all services that are delivered through contracts, rather than furnished directly by CEI, at the following times: before enrollment, at enrollment, and when there is a change in services.
13. To have the Member Enrollment Agreement Terms and Conditions, including your rights and any premiums, fully explained in a manner and in a language you understand.
14. To examine, or upon reasonable request to be assisted to examine, the result of the most recent review of CEI conducted by the Centers for Medicare and Medicaid Services, the California Department of Health Care Services or the California Department of Public Health and any plan of correction in effect.
15. To choose your primary care physician and specialists from within the CEI network.
16. To request that a qualified specialist for women's health services furnish routine or preventive women's health services.
17. To disenroll from the program at any time without cause. (A 30-day notice is requested.)
18. To access certain services when and where the need arises without prior authorization from the Interdisciplinary Team. These are: 1) Emergency care; 2) Sensitive services (such as those related to sexually transmitted diseases and HIV testing).
19. To participate fully in all decisions related to your treatment. If you are unable to participate fully in treatment decisions, you have the right to designate a representative.
20. To have all treatment options explained in a manner and in a language you understand; and to make health care decisions, including the right to refuse treatment, and be informed of the consequences of your decisions.
21. To have CEI staff explain advance directives and to establish them, if you wish.

22. To be fully informed of your health and functional status by the interdisciplinary team.
23. To participate in the development and implementation of your plan of care, and be fully informed of the services to be provided, including frequency and treatment objectives.
24. To request a reassessment by the interdisciplinary team.
25. To be given reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer (that is, due to medical reasons or for your welfare, or that of other participants).
26. To review and/or receive a copy of your own medical records and request amendments to those records.
27. To be assured of confidential treatment of all information contained in your health record, including information contained in an automated data bank.
28. To be assured that your written consent will be obtained for the release of information, documents or photographs to persons not otherwise authorized under law to receive them.
29. To provide written consent that limits the degree of information and the persons to whom information may be given.
30. To be encouraged and assisted to voice complaints about CEI or the care received, to staff and outside representatives of your choice, free of any restraint, interference, coercion, discrimination, or reprisal by the staff.
31. To appeal any treatment decision of CEI, its employees, or contractors through the process provided (see Chapter 13, "Member Grievance & Appeal Process").
32. To have a fair hearing through the California Department of Social Services when issues remain unresolved (see Chapter 13, "Member Grievance & Appeal Process").
33. To be free from discrimination in the delivery of CEI services based on race, ethnicity, national origin, religion, sex, age, sexual orientation, mental or physical disability, or source of payment.

Your Responsibilities as a Member of CEI

To be effective, we at CEI depend on you and your family to be involved in your care. The interdisciplinary team will work closely with you to be sure that your health care needs are met. To help us accomplish this goal, you and your caregivers have the following responsibilities:

1. To be involved in the planning of your care.
2. To follow the plan of care especially developed for you.
3. To treat CEI staff with respect and dignity.
4. To take your medications as directed.
5. To use only the services authorized by CEI.
6. To use the hospitals and specialists that have contracts with CEI.
7. If you have an emergency, to follow the CEI emergency plan developed for you.
8. To notify CEI if you plan to travel outside of our service area.
9. If you are away from home and an emergency arises, to notify CEI within 24 hours, or as soon as you possibly can.
10. To notify CEI if you are injured by someone else's actions, such as being in an automobile accident.
11. To provide accurate medical and financial information to CEI.
12. To pay any monthly premiums on time.
13. To let CEI know as soon as possible if you are not satisfied with care or services.
14. If you wish to disenroll from CEI, to provide a written or verbal notice of your wish to leave the program.
15. To provide and maintain a safe work environment for CEI staff that is free of violence, illegal substances, criminal activity and environmental hazards.

CHAPTER 13

MEMBER GRIEVANCE & APPEAL PROCESS

All of us at CEI share the responsibility for ensuring your satisfaction with the care you receive. We encourage you and your family, caregiver(s) or designated legal representative to express any concerns or dissatisfaction with CEI services, including any violation of your rights as a member. If you wish to file either a grievance or an appeal, please follow the procedures described below.

CEI will not discriminate against a participant because a grievance or appeal has been filed. We will continue to provide you with all services at the frequency designated in your current plan of care, as well as maintain confidentiality, throughout the grievance or appeal process. In this chapter, we explain how to file a grievance or an appeal, the timeframe for resolution, and the forms used to document. We will review this process with you at enrollment, each year thereafter, and whenever a grievance has been filed or CEI denies a request you have made for service or payment.

If you do not speak English, a bilingual staff member or volunteer will be made available to help you in filing a grievance or appeal.

I. Grievance Procedure

Definition: A grievance is an oral or written expression of dissatisfaction with service delivery or the quality of care furnished by CEI and/or contracted specialists.

Steps for using the grievance process:

A. You or your designated legal representative may express your dissatisfaction with services or quality of care by speaking or writing to your Social Worker, Homecare RN or Center Director.

   If you wish to file a written grievance, please send it to:

Center for Elders' Independence
510 - 17th Street, Suite 400
Oakland, CA 94612

Or, you may call or fax:
Telephone: (510) 433-1150 (M-F, 8 a.m.-5 p.m.)
Facsimile: (510) 452-8836
TDD (for the hearing impaired): (510) 433-1165 (M-F, 8 a.m.-5 p.m.)

1. The staff member taking your grievance will summarize the grievance on CEI's Grievance Form.

2. The Compliance Officer will send you or your designated legal representative written acknowledgement of receipt of your grievance within five (5) calendar days of the initial staff member receiving your grievance.

3. An investigation of your grievance will be performed by one of the following staff members identified below, with involvment from appropriate staff as necessary:

    a) Center Director if the grievance is related to a non-medical issue at the site where you receive services;
    b) Chief Medical Officer if the grievance is related to your medical care;
    c) Director of Services if the grievance is related to general program services;
    d) Chief Operating Officer if the grievance involves a violation of your participant's rights.

4. Within 30 calendar days of receipt of the grievance, you or your designated legal representative will be notified in writing about the findings of the investigation and action, if any, that will be taken. The letter will include the grievance review options available if you or your designated legal representative are still dissatisfied.

5. If your grievance is pending and cannot be resolved within 30 calendar days from the date it was filed, the Chief Operating Officer shall be involved in the process and the Compliance Officer will notify you of the following in writing:
    - The status of the grievance
    - Estimated resolution date

- Your right to request a Fair Hearing (see Grievance Review Options below)

A copy of this letter will also be sent to the CA Department of Health Care Services, Long Term Care Division.

Note: If the grievance involves serious or imminent threat to your health or safety, you may request that an expedited (fast) process be used. The Compliance Officer will immediately turn over an expedited grievance to the appropriate staff person (Center Director, Chief Medical Officer or Director of Services) who will respond with a decision within 72 hours of receiving your written or verbal grievance and request to expedite the process.

In this case, you will be informed within one working day of: (a) the receipt of your request for expedited review and (b) your right to notify the State Department of Health Care Services and the State Department of Social Services of the grievance (see "Grievance Review Options" below for more information.)

B. Grievance Review Options:

If after completing the CEI grievance process or participating in the process for at least thirty (30) calendar days, you are still dissatisfied, you or your legal representative have the option to pursue the steps described below. (Note: If the grievance involves an imminent and serious threat to your health or safety, you do not need to complete the entire grievance process nor wait 30 calendar days.) Your grievance review options are:

If you are covered by Medi-Cal only or Medi-Cal and Medicare, you are entitled to pursue your grievance with the California Department of Health Services by contacting:

Ombudsman Unit
Medi-Cal Managed Care Division
California Department of Health Care Services

P.O. Box 997413, Mail Station 4412
Sacramento, CA 95899-7413
1 (888) 452-8609

At any time during the grievance process, you may request a Fair Hearing from the California Department of Social Services by contacting:

California Department of Social Services
State Hearings Division
744 P Street, Mail Station 19-37
P.O. Box 944243
Sacramento, CA 94244-2430

Telephone: 1 (800) 952-5253
Facsimile: 1 (916) 229-4410
(Attention: State Hearing Support)
TDD (for the hearing impaired): 1 (800) 952-8349

II. Appeal Process

Definition: An appeal is action taken by a participant (or designated legal representative) with respect to CEI's decision not to cover, or not to pay for, a service. There are two types of appeals:

Standard Appeal: If you or your designated legal representative requests a standard appeal, your appeal must be filed within 60 calendar days of when your request for service or payment of service was denied. (The 60-day limit may be extended for good cause.) We will respond to your appeal as quickly as your health requires, but no later than 30 calendar days after receipt of your appeal.

Expedited or "Fast" Appeal: If you or your designated legal representative believes that your life or health could be seriously harmed without the requested services, you may request an expedited (fast) appeal. An expedited appeal is resolved as expeditiously as your health condition requires but no later than 72 hours after receipt of the appeal. This may be extended for up to 14 calendar days if you or your designated legal representative request an extension and/or if CEI is able to justify to the California Department of Health Services that additional time is needed to gather information and the delay is in your best interest.

As a member of CEI, you have the right to appeal any treatment decision made by CEI or our contracted specialists, including decisions not to authorize or pay for services and equipment. You will receive written information about appeals when

you enroll, annually thereafter, and whenever CEI denies a request for service or payment.

If you are a Medi-Cal eligible member, CEI will not discontinue providing a service for which an appeal has been filed until the appeal process has concluded. However, if CEI's initial decision to discontinue or reduce a service is upheld, you will be financially responsible for the cost of disputed service provided during the appeals process.

Steps to initiating an appeal:

A. You can request a standard appeal by speaking or writing to a CEI Social Worker, Center Director, Home Care Nurse, Nurse Practitioner or Physician.

Center for Elders' Independence
510 - 17th Street, Suite 400
Oakland, CA 94612

Or, you may call or fax:
Telephone: (510) 433-1150 (M-F,8 a.m.-5 p.m.)
Facsimile: (510) 452-8836 Fax
TDD (for the hearing impaired): (510) 433-1165 (M-F, 8 a.m.-5 p.m.)

1. The staff member will summarize the appeal on a CEI Appeal Form.
2. The Compliance Officer will send you written acknowledgement of receipt of your appeal within five (5) calendar days of the initial staff member receiving your appeal.

B. The Chief Executive Officer (CEO) will immediately forward the appeal form and all relevant information to an appropriately credentialed and impartial third party who was not involved in the original decision-making process.

1. The assigned third party will investigate the unresolved appeal with involvement from appropriate individuals as necessary.
2. The assigned third party will make a decision regarding the necessity of the service(s) or payment at issue.

C. If it is a "Standard Appeal" as defined above, you or your designated legal representative will be notified of our decision regarding your appeal no later than 30 calendar days from the initial receipt of the appeal.

D. If it is an "Expedited (Fast) Appeal" as defined above, you or your designated legal representative will be notified of our decision regarding your appeal within 72 hours from the initial receipt of the appeal, unless the timeframe is extended for reasons described above.

CEI's Decision on Your Appeal

If CEI decides fully in your favor on a standard appeal of a request for service, we must either provide the service or arrange for you to get the service as quickly as your health condition requires, but no later than 30 calendar days from the date we received your request for an appeal.

If CEI decides fully in your favor on a request for payment, CEI must make the requested payment within 60 calendar days after receiving your request for an appeal.

If CEI does not decide fully in your favor on a **standard appeal**, either in whole or in part, or if CEI fails to provide you with a decision within the proper timeframe, you have the right to pursue an external appeal through either the Medicare or Medi-Cal program (see Additional Appeal Rights below). CEI will inform you or your designated legal representative in writing of your appeal rights under either Medicare or Medi-Cal and also notify the federal Centers for Medicare and Medicaid Services and the California Department of Health Care Services. CEI will assist you to determine which appeal route to pursue if both are applicable and will forward your appeal to the appropriate external entity.

If CEI decides fully in your favor on an **expedited** appeal, we must either provide the service or arrange for you to get the service as quickly as your health condition requires, but no later than 72 hours after receiving your request for an appeal.

If CEI does not decide fully in your favor on an expedited appeal, either in whole or in part, or if CEI fails to provide you with a decision within the appropriate 72 hour timeframe, you have the right to pursue an external appeal process under either Medicare or Medi-Cal (see Additional Appeal Rights below). CEI will inform you or your designated legal representative in writing of your appeal rights under either Medicare or Medi-Cal and also notify the federal Centers for

Medicare and Medicaid Services and the California Department of Health Care Services. CEI will assist you to determine which appeal route to pursue if both are applicable and will forward your appeal to the appropriate external entity.

Additional Appeal Rights under Medicare and Medi-Cal

If you are denied your request for a service or payment of service, you have additional appeal rights. This is referred to as the right to an "external appeal." Your request to file an external appeal can be made either verbally or in writing. The external appeal involves a new and impartial review of your case through either the Medicare or Medi-Cal program. If you are enrolled in both Medicare and Medi-Cal, you can choose to use either the Medicare or Medi-Cal external appeal process. Both are described below. CEI will help you choose which external appeal process you should follow if both are applicable and will forward your appeal to the appropriate external entity.

Medi-Cal External Appeals Process:

Medi-Cal conducts its next level of appeal through the State's Fair Hearing process.

If you are enrolled in both Medi-Cal and Medicare, or Medi-Cal only, and choose to appeal CEI's decision using the Medi-Cal appeals process, CEI will send the appeal to the California Department of Social Services, or you may request a fair hearing from:

California Department of Social Services
State Hearings Division
744 P Street, Mail Station 19-37
P.O. Box 944243
Sacramento, CA 94244-2430

Telephone: 1(800) 952-5253
Facsimile: 1(916) 229-4410
(Attention: State Hearing Support)
TDD (for the hearing impaired): 1(800) 952-8349

Medicare External Appeals Process:

Medicare contracts with an "independent review organization" to provide external review of appeals.

If you are enrolled in both Medicare and Medi-Cal, or Medicare only, you may appeal using Medicare's appeal process. After completing the CEI appeal process, we will send your case file to Medicare's independent review organization for you. Medicare currently contracts with the Center for Health Dispute Resolution (CHDR) to impartially review appeals involving PACE programs like CEI. CHDR will contact us with the results of their review. CHDR will either maintain CEI's original decision or change CEI's decision and rule in your favor. (If CHDR's decision is not in your favor, there are further levels of appeal, which we will assist you in pursuing if you choose to do so.)

There is a standard and an expedited Medicare external appeal process:

- You can request a standard external appeal if we deny your request for non-urgent services or for nonpayment of a claim. For a standard appeal, you will get a decision no later than thirty (30) calendar days after you request the appeal. If CHDR's decision is in your favor and you have requested a service that you have not received, we must give you the service you asked for as quickly as your health condition requires. If you have requested payment for a service that you have already received, we must pay for the service.

- You can request an expedited appeal if you believe your health would be jeopardized by not receiving a specific service. In an expedited appeal, we will send your case file to CHDR as quickly as your health requires. CHDR must give us a decision within 72 hours after they receive the appeal from us. If CHDR asks for more time to review the appeal, they must give us their decision within fourteen (14) calendar days. If CHDR's decision is in your favor, we must give permission for you to get the service or give you the service as quickly as your health condition requires.