Provider Manual

Version 1.0
June 2019

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Using This Provider Manual

This Provider Manual is meant to assist you in working with our participants within the framework of Pacific PACE's policies and procedures. Familiarizing yourself with and adhering to the procedures outlined in this manual will help ensure a mutually beneficial, productive relationship in caring for our participants.

The information provided in this manual is intended to be informative and to assist Providers in navigating the various aspects of participation with the Pacific PACE program. Unless otherwise specified in the Provider Agreement, the information contained in this manual is not binding upon Pacific PACE and is subject to change. Pacific PACE will make reasonable efforts to notify Providers of changes to the content of this manual.

This manual may be updated at any time and is subject to change. In the event of an inconsistency between information contained in this manual and the Provider Agreement between you or your facility and Pacific PACE, the Agreement shall govern.

In the event of a material change to the Provider Manual, Pacific PACE will make all reasonable efforts to notify you in advance of such changes through Provider bulletins, Provider newsletters, and other mailings. In such cases, the most recently published information shall supersede all previous information and be considered the current directive. The manual is not intended to be a complete statement of all Pacific PACE Plan policies or procedures. Other policies and procedures not included in this manual may be posted on our website or published in specially-targeted communications.

GENERAL INFORMATION

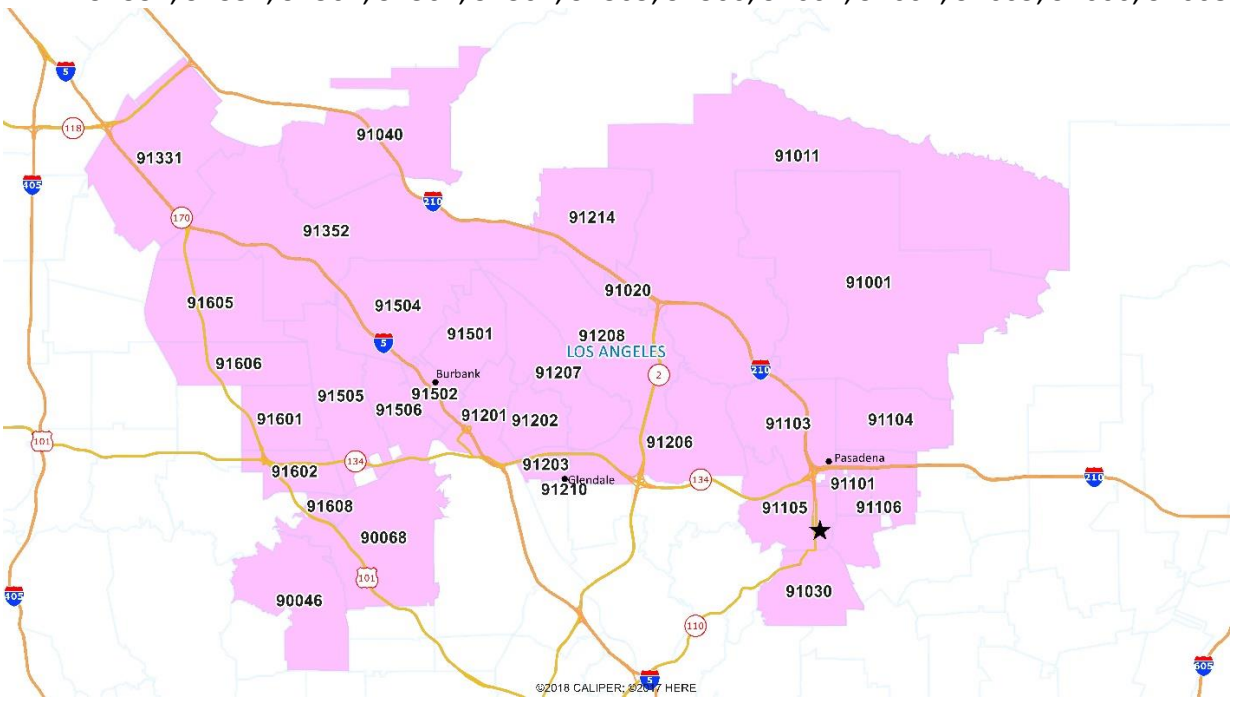
What is Pacific PACE?

WelbeHealth formed Pacific PACE to bring PACE services to the northern Los Angeles area and support our purpose of unlocking the full potential of our most vulnerable seniors. WelbeHealth was founded by mission-driven physicians to bring PACE to underserved communities. Its leadership team includes exemplary PACE operators and seasoned healthcare innovators. Both organizations share top-tier expertise in senior care and a passion for helping seniors reach their full potential.

PACE, or Program of All-Inclusive Care for the Elderly, is a national program sponsored by the Federal government through Medicare and the State governments through Medicaid. A central goal of PACE programs is to enable individuals who are at risk for moving into a nursing home to continue to live safely in their homes and communities. To be eligible to enroll as a Pacific PACE participant, an individual must be:

- 55 years of age or older
- Eligible for nursing home level of care based on criteria established by the State of California
- Eligible for Medicaid or have Medicare and be willing to pay privately
- Able to live safely in the community with the services provided by the PACE program
- A resident of the Pacific PACE service area (the ZIP codes listed below and highlighted in pink in the map below).

  - **Los Angeles County:** 90046, 90068, 91001, 91011, 91020, 91030, 91040, 91046, 91101, 91103, 91104, 91105, 91106, 91201, 91202, 91203, 91206, 91207, 91208, 91210, 91214, 91331, 91352, 91501, 91502, 91504, 91505, 91506, 91601, 91602, 91605, 91606, 91608



The PACE model of care is built around an interdisciplinary team (IDT) which includes a primary care physician, nurse, social worker, physical therapist, occupational therapist, recreational therapist, dietician, center director, transportation coordinator, personal care worker and home care coordinator. Each participant is assessed twice a year by the team. Based on the assessments, participant problems are identified, and the team builds an integrated care plan to resolve them.

When a participant is enrolled in Pacific PACE, we become the sole payer for all the participant's care and services. Services are available 24 hours a day, 7 days a week, and 365 days a year. Many services such as meals, recreational therapy, physical therapy and Adult Day Health Care can be provided in Pacific PACE's PACE centers. Services that are not provided at the centers will be provided in the home or by our network of contracted providers, such as you, in consultation with our interdisciplinary team.

The PACE program provides all the benefits that Medicare and Medicaid provide to its participants at no cost if they have Medicaid or are dual eligible and at the discretion of the IDT can provide additional benefits when deemed necessary for the participant. Core benefits include:

MEDICAL CARE

- Physician Care
- Nursing
- Prescription Medications
- Dentistry
- Podiatry
- Optometry
- Audiology
- All Medical Specialty (cardiology, pulmonology, nephrology, oncology, ophthalmology etc.)
- Labs, X-ray
- Dialysis
- Hospital Care
- Emergency and Urgent Care
- Short-term Rehab and Long-term Care

COMMUNITY- BASED SERVICES

- Rehabilitation Therapies
    - Physical Therapy
    - Occupational Therapy
    - Speech Therapy
- Engagement Programs
    - Socializing with others
    - Music, cultural events and games
    - Stimulating cognitive activities
    - Group exercise activities
- Nutritional Support

    - Nutrition counseling
    - Meals on center days
- Transportation
    - Rides to and from the Pacific PACE Center
- Social Services
    - Connections to community resources
    - Medi-Cal and Medicare benefits support
    - Counseling and psychological services
    - Guidance and support for participants and caregivers
- In-Home Services
    - Skilled Home Health (nursing, wound care, medication administration etc.)
    - Safety Assessment and Equipment
    - Personal care (bathing, dressing, grooming etc.)
    - Chore services (meal preparation, light housekeeping, laundry, etc.)

Pacific PACE Values

Our values serve as the foundation to guide how we behave.

- Courage to Love – We prioritize human connection and value every precious life we touch.
- Pioneering Spirit – We relentlessly pursue resourceful solutions to support participant health and independence.
- Shared Intention – We work as a team with a common purpose. We start by listening, promote and contribute diverse perspectives, and support team decisions.

Contact Information

Pacific PACE
50 Alessandro Place A20, Pasadena, CA 91105
Main phone: (800) 851-0966
Clinic phone: (800) 735-2922
Provider Services phone: (650) 336-0300
Provider Services email: providers@welbehealth.com
Compliance email: PacificPACE.Compliance@welbehealth.com
Clinic fax: (855) 245-2961

NETWORK PARTICIPATION

How to Become a Network Provider

If a potential provider is interested in joining the Pacific PACE Provider Network, email us at providers@welbehealth.com.

Pacific PACE considers requests for contracting based on the following criteria:

- The proposed provider's mission and vision complement the Pacific PACE mission
- The provider is committed to serving participants consistent with the PACE model of care
- The provider meets applicable licensing and/or certification standards applicable to the services to be provided.
- The provider is willing and able to sign and adhere to all components of a contract with Pacific PACE including, but not limited to:
    - Agree to Pacific PACE rate
    - Follow contractual requirements related to authorizations and billing
    - Maintain ongoing communications with Pacific PACE staff
    - Meet or exceed quality assurance expectations set by Pacific PACE

Updating Services or Providers in Existing Network Provider Organizations

If you are a current Pacific PACE contracted provider and you are interested in adding services to your existing contract or otherwise amending or terminating that contract, please email us at providers@welbehealth.com.

Credentialing

Pacific PACE's credentialing process enables us to contract with qualified health care providers and to meet the requirements of our contracts with the Centers for Medicare & Medicaid Services (CMS) and the California Departments of Health Care Services (DHCS). The credentialing process ensures that providers are properly educated, trained, and accessible to Pacific PACE's participants.

Although Pacific PACE delegates some credentialing activities to recognized credentialing programs, Pacific PACE always retains the right and the obligation to accept or reject the recommendations of our credentialing delegates. Pacific PACE reviews these credentialing programs on an annual basis.

Information acquired through the credentialing and re-credentialing processes is considered confidential, and Pacific PACE staff and credentialing delegates who have access to the files are responsible for ensuring the information remains confidential, except as otherwise provided by law. Pacific PACE may deny or restrict participation, terminate participation, or take other action in accordance with the provider's written agreement with Pacific PACE and our credentialing policies and procedures.

Initial Credentialing

Each practitioner, facility or ancillary Provider must complete a standard application form when applying for initial participation in the Pacific PACE Network. This application may be a state-mandated form or a standard form created by or deemed acceptable by Pacific PACE for practitioners, facilities and ancillary practitioners. The Council for Affordable Quality Healthcare ("CAQH"), a universal credentialing data source is utilized. CAQH is building the first national provider credentialing database system, which is designed to eliminate the duplicate collection and updating of provider information for health plans, hospitals and practitioners. To learn more about CAQH, visit their web site at www.CAQH.org.

Pacific PACE will verify those elements related to an applicant's legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the

credentialing process. All verifications must be current and verified within the one hundred and eighty (180) calendar-day period prior to the Credentialing Committee making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Pacific PACE will review verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These lists represent minimum verification requirements.

Practitioners (Providers)

- National Provider Identification number
- License to practice in the state(s) in which the practitioner will be treating Covered Individuals
- Current DEA registration
- Proof of education (evidence of graduation from applicable professional school and completion of residency or other post-graduate training as applicable)
- Malpractice claims history
- Malpractice insurance
- Board certification (for relevant practitioners)
- Clinical history
- Work history
- Exclusions and sanctions
- Medicare Opt Out

Facility and Ancillary (Health Delivery Organizations)

- Good standing with State and Federal government
- CMS Certification (if applicable)
- Proof of Accreditation (if applicable)

Re-credentialing

The re-credentialing process incorporates re-verification and the identification of changes in the practitioner's or facility and ancillary practitioner's licensure, sanctions, certification, and/or performance information (including, but not limited to, malpractice experience) that may reflect on the practitioner's, facility or ancillary professional's conduct and competence. This information is reviewed to assess whether practitioners, facility and ancillary providers continue to meet Pacific PACE's credentialing standards.

During the re-credentialing process, Pacific PACE will review verification of the credentialing data as described in the tables under Initial Credentialing unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements. All applicable practitioners and HDOs in the network within the scope of Pacific PACE's Credentialing Program are required to be re-credentialed every three (3) years unless otherwise required by contract or state regulations.

To support certain credentialing standards between the re-credentialing cycles, Pacific PACE has established an ongoing monitoring program. Credentialing performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listings/reports within thirty (30) calendar days of the

time they are made available from the various sources including, but not limited to, the following:

- Office of the Inspector General (OIG)
- System for Award Management (SAM)
- National Practitioner Data Bank (NPDB)

Professional Medical Advisory Committee

The Professional Medical Advisory Committee consists of providers representing a variety of service categories throughout Pacific PACE service area. The purpose of the group is to:

- Provide guidance to the Pacific PACE Medical Director, Quality Improvement Committee, and the Board of Directors on the Quality Improvement (QI) Plan and results,
- Review and advise Pacific PACE Board on medical and dental policies and procedures,
- Evaluate QI medical and dental data, and
- Review provider credentialing packets for approval (or withholding).

PARTICIPANT SCHEDULING AND TRANSPORTATION

Scheduling

Pacific PACE is responsible for scheduling and arranging transportation to and from all provider encounters for Pacific PACE participants. Please refrain from scheduling appointments directly with participants or their family members. If you need to schedule an appointment or other service, please contact Pacific PACE at (800) 851-0966.

Transportation

In order to ensure access to care and safety for our participants, Pacific PACE provides non-emergency medical transportation. These services include not only transportation to and from Pacific PACE, but also to doctor's appointments and other healthcare facilities in the community. The transportation program is designed to accommodate both ambulatory and non-ambulatory participants in a safe manner.

At Pacific PACE, these services are provided through contracted third parties. In order to contract with Pacific PACE, each partner must go through an extensive review process to ensure that its safety and quality standards meet or exceed our quality standards as well as all relevant federal and state regulations.

All drivers are trained and credentialed per federal and state guidelines, and also receive PACE-specific training on the provision of safe and high-quality care to our population. As the staff-member who is the first and last person to see a participant, drivers are a critical part of the interdisciplinary team and proactively provide input into care plans.

We use a combination of sedans and wheelchair-ready shuttles to ensure that all participants have an appropriate mode of transportation. All vehicles are inspected and maintained according to the manufacturer's recommendations, and all incidents are tracked in a quality assurance database.

Transports are scheduled at the request of designated Pacific PACE employees (or other duly

appointed designees) based on a participant's unique needs.

PROVIDER RESPONSIBILITIES

The government expects Pacific PACE and all our contractors and providers to follow all laws, rules, regulations, and contract requirements and conduct business in an ethical manner. This means:

- Providers will always act in the best interests of our program participants, including the protection of participants' rights.
- Providers will avoid conflicts of interest. Where potential conflicts exist, providers are expected to disclose the conflict to Pacific PACE and work with us to successfully resolve it.
- Providers will treat participants with dignity, respect and fairness. Participants will not be discriminated against based on race, color, religion, gender, sexual orientation, age, disability, or any other protected characteristic.
- Providers will protect the confidentiality of participant information and any confidential information of Pacific PACE.
- Providers will obey all laws, rules, regulations, and contract requirements.
- Providers will report any known or suspected instances of unethical or illegal behavior and will not retaliate against any staff participant who in good faith reports any such concern.

Providers are expected to have written policies and procedures that guide staff in complying with regulatory and contractual requirements. Staff should also be trained annually on compliance and fraud, waste and abuse. Pacific PACE may ask for copies of these training records.

Providers are expected to check the government sanction and exclusion databases monthly to ensure that they, their employees, and their subcontractors are not excluded from participating in government programs. There are companies that provide monitoring service or you can monitor by going to the government sites (www.sam.gov and http://exclusions.oig.hhs.gov/). Providers need to keep documentation of this monthly monitoring activity. Pacific PACE may ask for this documentation as proof the monitoring is being performed.

- Provider is expected to understand and adhere to the contract provisions at all times.
- Provider is required to provide compliance and fraud, waste and abuse training for all staff and annually document training in staff files.
- Validate monthly that employees have not been listed on the Office of Inspector General exclusion list. http://oig.hhs.gov/fraud/exclusions.asp Provider shall immediately notify Pacific PACE if they as a provider or any of their employees appear on the exclusion list.
- Prior to rendering any services to Pacific PACE program participants, a service authorization is needed to specify the authorized services in accordance with the participant's service plan. If an authorization has not been received, the provider is expected to contact the participant's Care Team to obtain a copy.
- Written notice of any change in the type, scope or location of delivery of services shall be provided to Pacific PACE at least ninety (90) days prior to the effective date of the change.
- Provider must only bill for services actually provided. Submitting claims for services that were not provided – even if authorized – is illegal (fraud).

- Provider shall send written notice to Pacific PACE within five (5) days of any legal, governmental or other action initiated against Provider.
- Provider shall notify Pacific PACE's Provider Management Department at providers@welbehealth.com of any changes in address, telephone number, or other contact information, such as email address or contract administrator name.
- Pacific PACE expects providers to demonstrate sensitivity to cultural diversity and to honor participants' beliefs. Providers are expected to foster staff attitudes and interpersonal communication styles that respect participants' cultural backgrounds.

Record Keeping, Record Submission, and Records Inspection

All Network Providers must maintain and upon request furnish to Pacific PACE all information requested by Pacific PACE related to the quality and quantity of services provided through their contract. This includes written documentation of care and services provided, including dates of services, time records, invoices, contracts, vouchers or other official documentation evidencing in proper detail the nature and propriety of the services provided. Network providers should submit progress notes to Pacific PACE within 72 hours of care delivery and same day if the provider is recommending any changes to a patient's treatment regimen.

Provider shall maintain books and records, including Participant medical records, pertaining to actions performed pursuant to this Contract by the Provider in a form consistent with and in compliance with provisions of all applicable state and federal laws. For Family Care-funded services, records must be retained for a minimum of six (6) years after termination of services as specified in this Contract or from the date of completion of any audit, whichever is later. For Family Care Partnership and PACE-funded services, records must be retained for a minimum of ten (10) years after termination of services as specified in this Contract or from the date of completion of any audit, whichever is later.

Proof of Insurance

Pacific PACE requires all Network Providers to procure and maintain comprehensive policies of property and casualty insurance including general and professional liability insurance, and workers compensation, if the Provider is acting as an employer. Provider will provide certificates of insurance within thirty (30) calendar days of a renewal of any property or casualty policy annually. Provider will list Pacific PACE as a certificate holder on the Certificate of Insurance.

Participant rights

When enrolled in a PACE program, participants have certain rights and protections. The PACE program must fully explain these rights to all participants or someone acting on their behalf in a way that they can understand at the time they join. As a Provider, you have the responsibility to respect every participant's rights. Please see https://pacificpace.welbehealth.com/participant-rights/ for an overview of the PACE participants' rights.

HIPAA

Based on the services you provide on behalf of Pacific PACE you may be provided with protected

health information (PHI). This information includes all medical and care-related services you provide. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) you are responsible to keep this information secure. Information must not be left out where anyone can read it, including paper records and emails, and should be protected against theft.

The law also requires you to only share PHI with the participant's consent in all but a limited number of situations. Any loss, theft, misuse, or accidental disclosure of PHI must be reported to Pacific PACE's Compliance Department and may also need to be reported to the government under the breach notification requirements.

There are government resources available to assist you to understand your obligations. These include:

- http://www.hhs.gov/ocr/privacy/index.html
- http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/index.html

Please contact our Provider Management Department or Compliance Department if you have questions or concerns about HIPAA.

Pacific PACE is concerned with protecting participant privacy and is committed to complying with the Health Insurance and Portability Act (HIPAA) privacy regulations. Generally, covered health plans and covered Providers are not required to obtain individual participant consent or authorization for use and disclosure of Protected Health Information (PHI) for treatment, payment and health care operations. Activities such as: care coordination, reviewing the competence of health care professionals, billing/claims management, and quality improvement fall into this category. If you have further concerns, please contact Provider Services at (650) 336-0300.

Individuals should be notified in writing or e-mail if that is their preferred method of contact, and be provided with basic information about the breach, such as:

- When the breach happened, when the event was discovered, and a brief statement about what happened
- What type of PHI was breached
- Things that the individual can do in order "to protect themselves from potential harm resulting from the breach"
- What corrective actions and investigation the covered entity is doing to prevent future breaches and mitigate losses; and contact information for the individual to use in case of any questions.

In addition to disclosure accounting, the individual is also entitled to receive a copy of his or her electronic health record, if they request; this information may be sent to the individual, or another person designated by individual.

Fraud, Waste, and Abuse

Pacific PACE operates a comprehensive compliance program that actively investigates allegations of fraud, waste and abuse on the part of Providers and participants. Pacific PACE is required to report to DHCS all suspected fraud, waste or abuse (FWA).

- Fraud – is defined as an intentional deception, false statement or misrepresentation made by an individual with knowledge that the deception could result in unauthorized benefit to that individual or another person. Claims submitted for services not provided are considered fraudulent.
- Waste – is defined as failing to control costs or using Medicare or Medicaid funds to pay for services that are not determined to be necessary.
- Abuse – is defined as practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business or medical practices. The primary difference between fraud and abuse is "intent". Poor recordkeeping, lack of understanding of care responsibilities or reporting obligations may result in an investigation for abuse.

The following are some examples of fraudulent, abusive, and unacceptable practices that are prohibited by Pacific PACE:

- Submission of false information for the purpose of obtaining greater compensation than that to which the Provider is legally entitled (i.e. up coding or unbundling of charges)
- Billing for services not rendered or billing in advance of care
- Knowingly demanding or collecting any compensation in addition to claims submitted for covered services (except where permitted by law)
- Ordering or furnishing inappropriate, improper, unnecessary or excessive care services or supplies
- Failing to maintain or furnish, for audit and investigative purposes, sufficient documentation on the extent of care and services rendered to participants
- Offering or accepting inducements to influence participants to join the plan or to use or avoid using a particular service
- Submitting bills or accepting payment for care, services or supplies rendered by a Provider who has been disqualified from participation in the Medicare or Medicaid programs

Providers must comply with federal laws and regulations designed to prevent fraud, waste and abuse, but not limited to, applicable provisions of federal criminal law, the False Claims Act, the anti-kickback statute, and the Health Insurance Portability and Accountability Act administrative simplification rules, applicable state and federal law, including, but not limited to, Title VI of The Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act and all other laws applicable to recipients of federal funds from which payments to Providers under this Agreement are made in whole or in part, and all applicable Medicare laws, regulations, reporting requirements, and CMS instructions.

Confirmed cases of fraud and abuse are reported to the appropriate state agency. Providers who suspect fraud, waste and abuse on the part of another Provider or a participant should contact the Pacific PACE Compliance Hotline at PacificPACE.Compliance@welbehealth.com. Remember, you may report anonymously as Pacific PACE abides by a zero-tolerance against non-compliance. All contacts will be treated confidentially.

Quality Management

Pacific PACE strives to deliver outstanding services so participants can achieve their goals and desired

outcomes. Delivering quality care is a strategic objective and is driven each year by the Annual Quality Plan.

- Pacific PACE conducts formal QI projects as defined and approved by state and federal agencies.
    - Required projects to meet CMS and DHCS contract requirements
    - Pacific PACE strategically selects meaningful projects that will benefit the participants
- Measures and evaluates the quality of the Care Management activities to improve the participants' experience.
    - Participant Satisfaction Survey
    - Care Management process monitoring
    - Regulatory audit readiness/corrective action planning
    - Practice Guidelines
    - Consumer and Provider input to Quality Plan
- Integrate other organizational plans with the Quality Program

Pacific PACE encourages its network providers to communicate feedback on how we can continue with our strong tradition of delivering quality care.

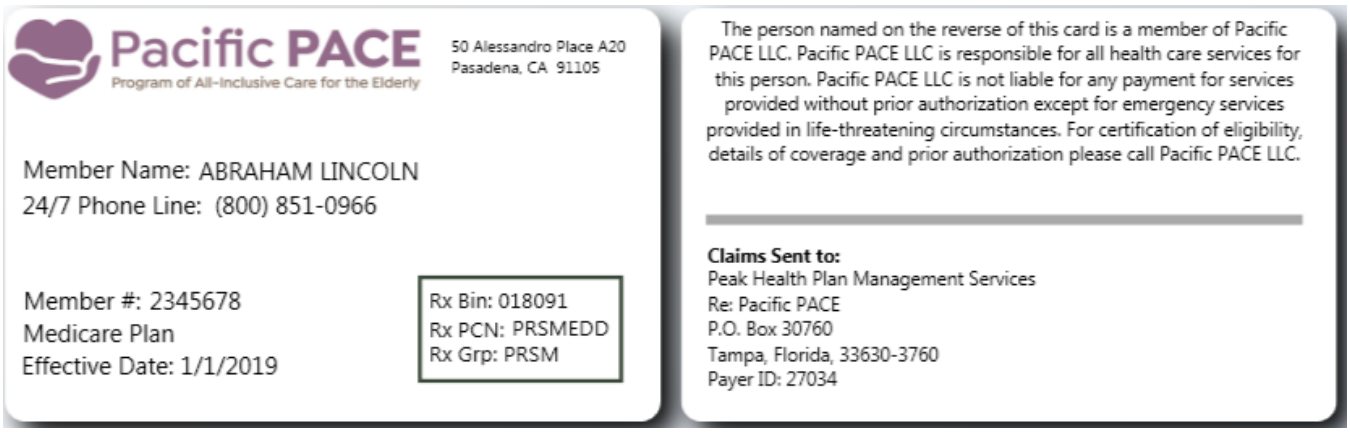
Gifts and Entertainment

As we operate a federally-funded program and in order to avoid even the appearance of improper conduct, Pacific PACE discourages providers and vendors from offering gifts to our staff and participants. Pacific PACE limits vendor gifts to staff to $20 per employee per year and $100 across all employees per year. Gifts include business meetings over meals or coffee, physical gifts, gift certificates, and tickets to sporting and other entertainment events. Financial support to attend conferences or seminars would be a legitimate business expense and would not be considered a gift. It is our hope that this policy will eliminate real or imagined bias by regarding selection of providers for participant services. Providers who may be in doubt of what is considered an acceptable or unacceptable item should ask Provider Relations for clarification and assistance.

PAYMENT

Eligibility for Payment

Every Pacific PACE participant receives an identification card that will detail the participant's name and identification number. This card identifies them as a Pacific PACE participant and should be presented to physicians and other Providers when seeking healthcare services. If a Pacific PACE participant is requesting service and is unable to present an identification card, please contact Pacific PACE Provider Services at (650) 336-0300.



Regardless of whether a participant has an identification card, Providers should verify participant eligibility at the time of service to ensure s/he is enrolled in Pacific PACE. Failure to do so may affect claims payment.

Payment terms are defined in provider contracts with Pacific PACE. The amount of payment for services provided is affected not only by the terms in the contract, but also by the following:

- Participant's eligibility at the time of service
- Whether services provided are covered services
- Whether services provided are medically necessary
- Whether services were without the prior approval of Pacific PACE, if prior approval is required
- Amount of the Provider's billed charges
- Adjustments of payments based on coding edits described below

A Provider who receives reimbursement for services rendered to Pacific PACE Participants must comply with all federal laws, rules, and regulations applicable to individuals and entities receiving federal funds, including without limitation Title VI of the Civil Rights act of 1964, Age Discrimination Act of 1975, Americans with Disability Act, and Rehabilitation Act of 1973.

Nothing contained in a provider contract or this Manual is intended by Pacific PACE to be a financial incentive or payment which directly or indirectly acts as an inducement for Providers to limit medically necessary services.

Pacific PACE applies the CMS site-of-service payment differentials in its fee schedules for CPT codes based on the place of treatment (physician office services versus other places of treatment).

Coding Edits: Pacific PACE will process Provider claims that are accurate and complete in accordance with Pacific PACE's 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 Participants. 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 Pacific PACE (please see the Provider Claims Reconsideration section of this Manual for more information). A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a noncovered service.

Pass-Through Billing: Pacific PACE prohibits pass-through billing. Pass through billing occurs when the ordering Provider requests and bills for a service, but the service is not performed by the ordering Provider or those under their direct employ. Provider agrees that services related to pass-through billing will not be eligible for reimbursement from Pacific PACE and Provider shall not bill, charge, seek payment or have any recourse against Pacific PACE or Participants for any amounts related to the provision of pass-through billing.

Claims Submission

Providers are responsible for submitting a clean claim for each participant served in order to receive payment. A clean claim is free from errors and contains all of the following:

Participant Information:

- Participant full name
- Participant ID number
- Date of birth

Service Information:

- Authorization number (each claim form must contain ONLY ONE authorization number)
- Date(s) of service (date range or individual days)
- Service/HCPCS/Revenue code/Modifier (if applicable)
- Diagnosis code (if applicable)
- Number of units (number of days in service period or units of provided service)
- Unit rate/Billed amount

Provider Information:

- Provider name
- Provider address
- Provider Tax Identification Number (TIN)
- National Provider Identifier (NPI)

All providers are required to bill encounters thirty days after the service date, but no later than one hundred and eighty days after the service date as prescribed in the provider contract.

Electronic Claims

All encounters when possible should be submitted electronically. Our payer ID is 27034. Pacific PACE accepts electronic claim submissions for professional (837P), institutional (837I) and (837D) dental. Contact your clearinghouse to initiate the process to forward Pacific PACE claims to Change Healthcare and RelayHealth.

Paper Claims

Your paper claims must be submitted on typed, redlined CMS-1500 or UB-04 claim forms and mailed to:

Peak
Re: Pacific PACE
P.O. Box 30760
Tampa, Florida, 33630-3760

Failure to send claims to this address, may result in delayed claims processing and/or rejected claims. Please ensure that all your claims are submitted timely, are complete and all required data elements are present, are correct, and valid for the service date to avoid delays in claims processing or denial of your claims.

Claim Submission Tips

- Use the Participant ID or MBI number for the Insured ID Number. (Use the entire number including any zeroes or letters)
- Ensure the correct date of birth is on the claim.
- Ensure both first and last names are spelled correctly.
- When submitting a corrected or voided claim please reference the ORIGINAL claim number (ICN/DCN) Failure to reference original claim will cause delays in claims processing.
- All ICD-10 diagnosis codes must be reported on the claim, as applicable, and must be submitted with the required level of specificity.
- All DME Claims must include the referring Physician NPI and the applicable ICD-10 code.

First time billing Pacific PACE?

Please contact Pacific PACE at providers@welbehealth.com.

Payment of Claims

Pacific PACE shall process all Clean Claims within thirty (30) calendar days of receipt. A Clean Claim means one which can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is known to be under investigation for fraud or abuse, a claim under review for medical necessity or a claim for which there is no authorization or the claim does not match the services authorized via the authorization.

Payment for services rendered is subject to verification that:

- The participant was enrolled in Pacific PACE at the time the service was provided;
- The service was delivered to the patient (cancelled services are not eligible for payment); and,
- The Provider was compliant with Pacific PACE Prior Authorization policies at the time of service.

Claims that are not clean may be denied. Provider agrees that in the event of a denial of payment for services rendered to Participants, that Provider shall not bill, charge, seek payment or have any recourse against Participant, Medicare, or Medicaid for such services. Medicare and Medicaid will not be responsible for claims for the participant while they are enrolled as a participant of Pacific PACE. All claims for services provided to Pacific PACE participants must be submitted to Pacific PACE.

If you have questions concerning claim status, adjustment or requests for claim review please contact Provider Services at (650) 336-0300.

Utilization Management and Prior Authorization

Pacific PACE maintains a "Right Care, Right Place, Right Time" Program to evaluate medical necessity and manage the quality and cost of health care services delivered to participants. All services are evaluated either prospectively, concurrently, or retrospectively to determine medical necessity based on standard criteria. This program is designed to ensure that:

- Services are medically necessary, consistent with the assigned participant's diagnoses, and are delivered at appropriate levels of care.
- Services are provided by Pacific PACE contracted Providers and that the utilization review staff is notified immediately to discuss the use of non-contracted Providers based on services that are not available through contracted Providers.
- Hospital admissions and length of stay are justified.
- Services are not over-utilized or under-utilized.
- Continuity and coordination of care is monitored.
- Guidelines, standards, and criteria set by governmental and other regulatory agencies are adhered to as appropriate. Pacific PACE utilizes standard criteria, such as InterQual Criteria, National Coverage Decisions, the Medicare Benefit Policy Manual, Local Coverage Determinations and current literature to assess all requests for determination of medical necessity. All criteria are reviewed by the Quality Improvement Committee on an annual basis.
- New technology is evaluated based on Medicare and Medicaid reviews and review of studies that determine its application and effectiveness.
- There is coordination of thorough and timely investigations and responses to Provider Appeals (see Provider Appeals section).

All non-emergency services provided to Pacific PACE participants require prior authorization from Pacific PACE. With that said, any service ordered by Pacific PACE employed providers is automatically authorized – the order number is the authorization number. If you need to request prior authorization for a service, please use the Prior Authorization Request Form, which can be downloaded from our web site at https://pacificpace.welbehealth.com/network/. All information on the service authorization must be accurate before performing services, especially:

- Dates of Service: Provider must verify that the service authorization covers the date span of the expected service period.
- Units of Service: Provider must verify that the number of units authorized is equal to the number of units expected during the service period.
- Service Code/HCPCS/Revenue Code: Provider must verify that the service code authorized is the same as the expected service to be provided.

Prior authorization is based upon the clinical documentation that supports medical necessity for the requested item. If you have questions concerning prior authorizations, please contact Provider Services at (650) 336-0300.

Urgent and Emergency Care

Pacific PACE provides coverage for the treatment of an emergency medical condition, which is defined by CMS as a condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

Inpatient and outpatient emergency health services are covered both inside and outside of the Pacific PACE service area. Prior authorization is not required for emergency care. In the event of an emergency, Pacific PACE instructs its participants to seek immediate care, or call 911 for assistance. Pacific PACE will not deny payment if an Pacific PACE contracted health care Provider instructs a participant to seek emergency services.

Enrollment in Pacific PACE includes coverage for post-stabilization care, defined as non-emergency services needed to ensure the participant remains stabilized after an emergency. In the post-stabilization period, providers should only provide services authorized by Pacific PACE. Unauthorized services will not be paid by Pacific PACE unless it is an emergency or Pacific PACE fails to respond to an authorization request within one hour of being contacted for urgently needed or post-stabilization services.

Urgently needed services are defined as those conditions which require immediate medical attention due to unexpected illness or injury. Fevers, abdominal pain, nausea and vomiting and difficulty urinating are some examples of situations requiring urgently needed services.

Urgent care services are covered for participants. Providers must notify Pacific PACE within 24 hours or the next business day of providing emergency or urgent services to an Pacific PACE participant, or if the participant is admitted to a hospital.

Participants are encouraged to carry their Pacific PACE identification card at all times and to notify Pacific PACE should they need urgent or emergency care.

Provider Appeals Process

For appeals regarding authorization or payment of a claim for services rendered to Pacific PACE participants, providers are directed as follows:

1. Within 30 calendar days of the denial, the provider may initiate an appeal by providing Pacific PACE with written information identifying the claim and specifically describing the disputed action. Written appeals, along with any pertinent documentation, must be submitted electronically to providers@welbehealth.com. The appeal must be on the contracted provider's letterhead and contain the following information to identify the claim:
    i. Participant name
    ii. Provider name
    iii. Dates of service

iv. Charges denied/underpaid
v. Grounds for appeal
vi. Supporting documentation for the grounds on which the provider is appealing

2. The appeal should be submitted to the Pacific PACE Medical Director at:

   Pacific PACE
   50 Alessandro Place A20
   Pasadena, CA 91105
   Attn: QI Coordinator

3. The Pacific PACE QI Coordinator or designee will acknowledge receipt of the appeal within 5 calendar days of receipt.

4. The Pacific PACE Medical Director will:

   i. Determine if the appeal relates to a medical decision.

   ii. Review the appeal and sends a written report of its conclusions and reasons to the provider within 30 calendar days from the acknowledged receipt of the appeal.