GlobalHealth

PROVIDER MANUAL

January 1-December 31, 2025

GlobalHealth Holdings, LLC

www.GlobalHealth.com

1-844-280-5555 (TTY: 711)
8:00 AM - 8:00 PM, 7 days a week (October 1-March 31), and
8:00 AM - 8:00 PM, Monday-Friday (April 1-September 30)

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Contents

Welcome to GlobalHealth

This Provider Manual is a reference tool that describes GlobalHealth policies and procedures and is designed to assist you as a Contracted Provider in the GlobalHealth network. Please read this document carefully as it contains meaningful information that will help us work together more efficiently and effectively. It is important for you to understand GlobalHealth's processes.

GlobalHealth will keep you informed of important changes in our policies, procedures, and benefits. The Provider Manual is accessed via the Providers menu on www.globalhealth.com.

This Provider Manual is intended for use by GlobalHealth Contracted Providers only and is incorporated for reference as a part of your Provider Participation Agreement, Independent Practice Association (IPA) Participation Agreement, or Facility Participation Agreement ("Agreement") with GlobalHealth. Therefore, your reimbursement may be affected by your compliance with the contents herein. The information contained in this Provider Manual is strictly proprietary to GlobalHealth and may not be copied in whole or part without the express, prior written consent of GlobalHealth.

Capitalized words and phrases have the same meaning as in Section 1 Definitions of your Agreement.

Our Mission

We are unique by providing high touch, high value, and a partnership to our members. We work hard to offer affordable health insurance coverage with the benefits people truly want and need. It is our hope to be more than just a health insurance company – we want to be a long-term partner with our members.

New information for 2025

Balance Billing

As a reminder, balance billing is prohibited per the terms of your contract with GlobalHealth. Members may not be billed more than the cost sharing specified by their plan. When reviewing remittance advice to determine Member responsibility, please note that both the "Discount" and "Adjusted Amount" fields are the Provider's responsibility. The Member should never be billed more than the "Patient Liability" amount shown in the lower right-hand corner. See page 42 for a sample remittance advice.

Demographic Verification

CMS requires health plans to validate demographic information on a quarterly basis at a minimum. GlobalHealth requests regular rosters from medical groups in order to ensure we always have the most up-to-date information. As part of this effort, we ask that you only provide addresses where patients can make an appointment to see the provider. Please contact Provider Relations at provider.relations@globalhealth.com with any questions regarding this process.

Digital Health Literacy

Providers are encouraged to use places of service 02 (Telehealth provided other than in patient's home – patient is not located in their home) or 10 (Telehealth provided in patient's home – which is a location other than a hospital or other facility where the patient receives care in a private residence) when applicable to assist with Members accessing medically necessary covered benefits when the Provider and the Member are not in the same location.

Non-Discrimination in Health Programs and Activities

Each provider must adopt and implement a non-discrimination policy, grievance and record-keeping procedures, language access procedures, auxiliary aids and services procedures, and procedures for reasonable modifications for individuals with disabilities. These policies and procedures must be finalized no later than one year from the effective date of the rule, March 31, 2025.

Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus Prevention

GlobalHealth covers PrEP using antiretroviral drugs (including the supplying or dispensing of these drugs and the administration of injectable PrEP), up to eight annual screenings for HIV, one annual screening for hepatitis B, and up to eight counseling sessions with a physician or other health care practitioner per 12 months at no cost to the member. In order to ensure accurate application of benefits, providers must include an appropriate ICD-10 code when billing Part B or submitting prescriptions for Part D. The determination of whether an individual is at increased risk for HIV is made by the physician or health care practitioner who assesses the individual's history.

Provider Data Accuracy and Validation

Providers are encouraged to keep data current in the National Plan & Provider Enumeration System (NPPES). If NPPES is kept up to date by providers, GlobalHealth can download and rely on it as a primary data resource, instead of calling or faxing your office for this information. Visit NPPES help if you have questions: https://nppes.cms.hhs.gov/webhelp/index.html.

Provider Portal

As a reminder, GlobalHealth offers an online portal where Providers can access claim status, referral status, and Member eligibility. Participating Providers are expected to use the Portal rather than calling to create or request status on referrals. If you need assistance navigating the Portal, you may email providerportal@globalhealth.com or attend one of our training sessions. Training information can be found on the Provider Training page at https://www.globalhealth.com/oklahoma/providers/provider-training/.

Provider Quality Portal

The GlobalHealth Quality Portal allows both Providers and Provider Administrators the ability to see real time updates for both Part C and Part D Stars Scores. This portal also allows Providers to access member rosters with open care gaps for ease of coordination of care. The Portal can be accessed at https://qualityportal.globalhealthportals.com. Reporting and User Guides can be accessed at https://www.globalhealth.com/oklahoma/providers/provider-portals.

Provider Training Available

GlobalHealth Provider Relations offers training on Tuesdays at noon central time on a variety of topics. Trainings are conducted via Microsoft Teams at the following times:

- First Tuesday of the month: New Provider Orientation
- Second Tuesday of the month: Provider Portal training
- Third Tuesday of the month: Special Needs Plan (SNP) training
- Fourth Tuesday of the month: Provider Portal training

Additional training may be offered as needed. Visit https://www.globalhealth.com/oklahoma/providers/provider-training/ for more information, including instructions for how to join.

Value-Based Insurance Design (VBID)

GlobalHealth's Dual Special Needs Plans (D-SNP) have VBID benefits. Providers are asked to encourage D-SNP members to utilize the full range of their benefits, including chronic meals, no-copay Part D benefits, and the Smart Wallet Benefit which covers a range of expenses including gasoline, groceries, utilities, and over-the-counter products.

GlobalHealth Products

GlobalHealth is fully licensed in Oklahoma as a Health Maintenance Organization (HMO).

GlobalHealth requires Members to select a Primary Care Provider (PCP) and does not offer out-of-network benefits, except in emergent, urgent, or prior authorized circumstances, except as described below for our Point of Service product.

Products offered by GlobalHealth include Medicare Advantage (MA), Medicare Advantage with Prescription Drug coverage (MAPD), Chronic Special Needs Plans (C-SNP), and Dual Special Needs Plans (D-SNP), as well as products for active and retired State of Oklahoma employees.

MA plans combine the insurance benefits of Medicare Parts A and B with the customer service and care of a consumer-focused HMO. MA plans are sometimes called Part C. MAPD plans combine Medicare Parts A, B, and D. GlobalHealth has received a 4 overall Star Rating out of 5 stars from Medicare for 2025.

GlobalHealth's Generations Valor (HMO-POS) product for 2025 is a Point of Service (POS) product. POS Members are able to access certain services from out-of-network providers with prior authorization. Such services include dialysis services (while still in our service area), inpatient hospital care (acute and psychiatric), opioid dependence treatment services, skilled nursing facility (SNF) care, and certain specialist office visits. Additional information regarding the requirements of these products is included in the PCP Responsibilities, Services That Require Prior Authorization, and Referrals to Non-Contracted Providers sections.

C-SNP products are a type of MAPD product offered to Members with chronic conditions. Qualifying conditions for GlobalHealth C-SNP products include cardiovascular disorders (cardiac arrhythmias, chronic venous thromboembolic disorder, coronary artery disease, and peripheral vascular disease), chronic heart failure, and diabetes. For additional information regarding C-SNP products and your role as a Provider, attend one of our SNP training sessions online. Training information can be found on the Provider Training page at https://www.globalhealth.com/oklahoma/providers/provider-training/. You may also receive this training via mail or email on an annual basis as required by CMS.

D-SNP products are a type of MAPD product offered to Members who are eligible for both Medicare and Medicaid. No specific health conditions are required to qualify for D-SNP. For additional information regarding D-SNP products and your role as a provider, attend one of our SNP training sessions online. Training information can be found on the Provider Training page at https://www.globalhealth.com/oklahoma/providers/provider-training/. You may also receive this training via mail or email on an annual basis as required by CMS.

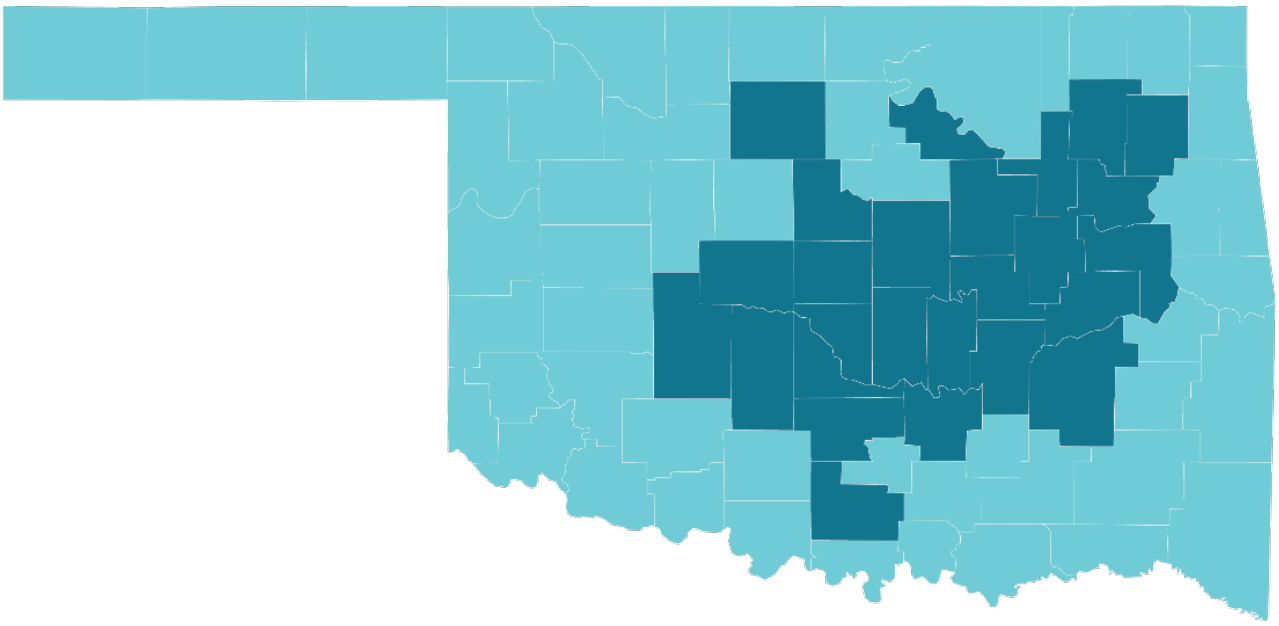
C-SNP and D-SNP products require an evidence-based Model of Care (MOC), which is approved by the National Committee for Quality Assurance and subject to annual review. All providers participating in the care of a SNP member are required to have annual MOC training. SNP products also require an Interdisciplinary Care Team (ICT) and Individualized Care Plan (ICP). The ICT consists of qualified GlobalHealth clinical staff as well as providers participating in the Member's care. The ICP establishes the

Member's health goals and recommended actions, based on the ICT's review of the Member's health risk assessment. Contact Provider Relations with any questions regarding MOC training.

Service Area

GlobalHealth plans are available in 26 Oklahoma counties:

Caddo	Grady	Muskogee	Pottawatomie
Canadian	Hughes	Okfuskee	Rogers
Carter	Lincoln	Oklahoma	Seminole
Cleveland	Logan	Okmulgee	Tulsa
Creek	Mayes	Pawnee	Wagoner
Garfield	McClain	Pittsburg	
Garvin	McIntosh	Pontotoc	



Helpful Numbers and Information

Please refer to exhibit 1 or 2 depending on the Member's plan type for Helpful Numbers and Information.

Provider Portal

Please access the Portal for all Members. The Portal will allow you to:

- Verify eligibility.
- Review Member demographics.
- View benefit information.
- Create Referrals.
- Check Prior Authorization/Referral review status.
- Check claim status.

The Portal is available 24 hours a day, 7 days a week. You may access information about the Portal on the Providers menu at www.globalhealth.com. The Portal is available here: https://ghprovider.prod.healthaxis.net/.

Online Provider Portal Training/New Provider Orientation/C-SNP & D-SNP Training

Training sessions are available online through Microsoft Teams. You may access training information on the Provider Training page at https://www.globalhealth.com/oklahoma/providers/provider-training/.

Provider Responsibilities

GlobalHealth expects all Contracted Providers to adhere to certain guidelines.

- Have the capacity to accept GlobalHealth members.
- Participate in all required training including Provider Orientation, Provider Portal Training, and C-SNP/D-SNP MOC Training within 30 days of the Effective Date of your Agreement.
- Educate Members regarding their healthcare and communicate freely with patients about their treatment, regardless of benefit coverage limitations.
- Provide Medically Necessary healthcare services in accordance with your GlobalHealth Agreement, the applicable benefit plan materials, GlobalHealth policies and procedures, and requirements in the Provider Manual.
- Discuss all treatment alternatives, risks, and benefits with Members, including the risks/benefits of receiving no treatment, recognizing that the Member makes the final decision concerning their preferred treatment option.
- Participate in and cooperate with GlobalHealth's programs including Utilization Management (UM), Care Management (CM), Compliance, and Quality Improvement (QI).
- Participate in the ICT and contribute to the ICP when caring for C-SNP/D-SNP Members.
- Obtain and maintain participation in good standing in the applicable state Medicaid program (when billing state Medicaid programs).
- Provide information to D-SNP Members regarding the availability of Medicaid for needed services that are not covered by Medicare.
- Maintain appropriate medical records to document all services provided to Members.
- Adopt and implement non-discrimination policies, grievance and record-keeping procedures, language access procedures, auxiliary aids and services procedures, and procedures for reasonable modifications for individuals with disabilities. Providers may not discriminate on the basis of race, color, national origin, sex, age, or disability.
- Submit accurate claims to GlobalHealth for services rendered to GlobalHealth Members in accordance with the time frame specified in the Agreement.
- Assist GlobalHealth in resolving Coordination of Benefits (COB) issues with other payers.
- Cooperate with any investigations regarding grievances, quality of care, or other quality assurance measures or fraud, waste, and abuse.
- Verify Member eligibility. Eligibility can be verified by accessing the Portal. The Member ID card does not guarantee coverage or entitlement to benefits. It is essential to verify Member eligibility because:
    - Member benefits may change.
    - Copayments must be determined.
    - Fraudulent use may occur.

Language Assistance

Contracted Providers must provide 24-hour access to interpreter services.

Contracted Providers may request interpreters for Members whose primary language is other than English by calling GlobalHealth's Provider Services using the contact information provided in the Helpful Numbers and Information section of exhibit 1 or 2 depending on the Member's plan type. If the GlobalHealth representative is unable to interpret in the requested language, the representative will immediately connect the Provider and the Member to telephonic interpreter services. Contracted Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Contracted Providers may offer GlobalHealth Members interpreter services if the Members do not request them on their own. It is never permissible to ask a family member, friend, or minor to interpret. If a Member requests someone be allowed to interpret, it must be documented that telephonic interpreter services were offered and declined by the Member.

As a Contracted Provider, you are responsible for documenting the Member's language services/needs in their medical record as follows:

- Record the Member's language preference in a prominent location in the medical record.
- Document all Member requests for interpreter services.
- Document who provided the interpreter service. This includes the name of GlobalHealth's internal staff or someone from a commercial interpreter service vendor. Information should include the interpreter's name, operator code, and vendor.

In addition, different types of Providers have specific responsibilities as outlined below.

Primary Care Provider Responsibilities

All GlobalHealth Members must choose a Primary Care Provider (PCP). The PCP is the Member's first contact for their healthcare needs. The PCP provides a broad range of services and coordinates other care when necessary.

- Manage the Member's total healthcare program, which includes health supervision, basic treatment, initial diagnosis, management of chronic conditions, and preventive health services.
- Provide medical care coverage for assigned patient panel 24 hours a day, 7 days a week within GlobalHealth's established network of Contracted Providers.
- Follow up with the Member within 7 days of an emergency department visit or hospitalization.
- Coordinate healthcare with Specialty Care Providers (SCPs) or healthcare facilities when such care is needed, including submitting Referrals. The PCP should always refer Members to GlobalHealth Contracted Providers and Contracted Facilities unless the services are not available. The most current list of Contracted Providers can be found using the online Provider Directory search tool. Members enrolled in a POS plan may access certain services from out-of-network Providers with prior authorization.
- Provide complete information on authorized care or services to the referred SCP.

Members will usually see their PCP first for most of their routine health care needs. MA/MAPD Members may see any network SCP without a referral, but when the PCP or SCP believes they need specialized diagnostic tests or treatment (such as therapy or outpatient surgery), a referral is required. Commercial Members will need a referral for all services received from SCPs, including office visits.

GlobalHealth requires its PCPs to practice in one of the following fields: Family Medicine, Pediatrics, General Medicine, Geriatrics, or Internal Medicine. Internal Medicine physicians must spend at least 90% of their time practicing primary care to be eligible to contract with GlobalHealth as a PCP. Advanced Practice

Registered Nurses (APRNs) acting as PCPs for MA/MAPD members must follow all requirements set forth for PCPs, practice in a primary care setting with an appropriately certified and contracted supervising physician, and provide care within the scope of their license. The PCP designation may only be applied to the PCP's primary tax identification number (TIN).

PCP Panel Status

GlobalHealth ensures Members have access to Primary Care Services and routinely monitors PCP panel status.

Open

PCP will accept any GlobalHealth Member, whether new or established.

Closed

Providers who have a full practice may close their practice to new GlobalHealth Members. Providers who request to be listed as "not accepting any Members" will not be assigned new GlobalHealth Members. A Provider may close their practice to new Members by providing 30 days' written notice to GlobalHealth Provider Relations. This option allows only patients currently seeing that Provider to select them as a PCP. If a Member incorrectly selects a closed Provider, the PCP must notify GlobalHealth as soon as possible. GlobalHealth will then assist the Member in selecting an available PCP.

Members Changing PCP

Members can change their PCP at any time; however, the effective date will be the first of the following month.

GlobalHealth recommends against Members changing their PCP if the change could have an adverse effect on the quality of their healthcare. For example:

- The Member is an organ transplant candidate.
- The Member has an unstable, acute medical condition for which they are actively receiving medical care.
- The Member is pregnant.

Specialty Care Provider and Other Practitioner Responsibilities

A Specialty Care Provider (SCP) provides certain specialty medical care upon Referral from the PCP. SCPs must:

- Accept and treat GlobalHealth Members referred by their PCP.
- Comply with all GlobalHealth prior authorization requirements.
- Ensure GlobalHealth has authorized services when required.
    - If additional Medically Necessary tests or treatments are needed beyond those initially authorized, the SCP may seek additional authorization from GlobalHealth and will notify the Member's PCP.
- Actively participate in coordination of care activities which may include obtaining the Member's signed authorization to share Protected Health Information (PHI) with other providers involved in their care.

- Always refer Members to GlobalHealth Contracted Providers and Facilities. GlobalHealth regularly monitors the network for access and availability. If you are unable to locate services in-network, please notify Provider Relations.
- Use best efforts to communicate with the Member's PCP within 5 working days.

Hospital/Facility Responsibilities

Provide Covered Health Care Services to GlobalHealth Members 24 hours a day, 365 days a year.

Obtain necessary authorizations from GlobalHealth for non-emergent hospital admissions and continued inpatient stays. Notification is required within 24 hours of admission for all inpatient hospital stays including childbirth or emergencies.

In the event of a transfer, the receiving hospital is required to provide GlobalHealth notification within 24 hours of admission.

Verify hospital/facility and its personnel are duly licensed, certified, Contracted Providers and authorized to provide Covered Health Care Services to GlobalHealth Members. Contracted Providers must be routinely monitored to ensure they are not excluded, precluded, or otherwise ineligible to participate in Medicare.

Provide advance written notice to GlobalHealth of any significant changes in the ability to provide Covered Health Care Services to GlobalHealth Members.

Remain in compliance with applicable State and Federal requirements, Medicare Conditions of Participation, and The Joint Commission (TJC) accreditation standards or equivalent. Provide copies of CMS or State surveys and accreditation status to GlobalHealth when updated.

Medicare Outpatient Observation Notice (MOON)

Hospitals and critical access hospitals (CAH) are required to provide a MOON to Medicare beneficiaries (including MA/MAPD plan enrollees) informing them that they are outpatients receiving observation services and are not inpatients of a hospital or CAH. For additional CMS guidance, visit https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-moon.

Emergency Department Responsibilities

An emergency involves a medical condition, mental or physical, manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that a prudent layperson, who has an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the individual (or an unborn child) in serious jeopardy; (b) serious impairment of bodily functions; or (c) serious dysfunction of any bodily organ or part.

A pregnant woman who is having contractions and (a) there is inadequate time to affect a safe transfer to another hospital before delivery or (b) the transfer may pose a threat to the health or safety of the woman or unborn child may receive care at the nearest Emergency Department (ED).

Referring a Member to the ED should not be used for routine services or non-emergency situations. An urgent care facility or office visit might be an alternate option.

Hospital/facility shall use best efforts to have contracted ED providers on staff.

Provider Accessibility

GlobalHealth is required to notify all Contracted Providers that, under 42 C.F.R. § 422.112, they are required to:

> Provide services, both clinical and nonclinical, that are readily available, accessible, and appropriate, when Medically Necessary to all enrollees, including those with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds. Services must be provided in a culturally competent manner and must give equitable access to all enrollees, including the following: people of ethnic, cultural, racial, or religious minorities; people with disabilities; people who identify as lesbian, gay, bisexual, or other diverse sexual orientation; people who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex; people living in rural areas and other areas with high levels of deprivation; people otherwise adversely affected by persistent poverty or inequality. Services include access to specialty care such as women's health services.

GlobalHealth recommends that Contracted Providers use one of these methods to assist Members after regular business hours:

- A professional answering service that contacts the Contracted Provider or the Covering Provider.
- A high-quality voice mail system that tells Members:
  - How to reach the Contracted Provider or the Covering Provider in an emergency, including phone numbers.
  - What to do in an emergency or urgent situation.

GlobalHealth monitors Contracted Provider accessibility and appointment wait times. GlobalHealth may complete an annual access to care and availability survey for PCPs and high volume and high impact SCPs.

Provider Data Accuracy and Validation

It is important for Contracted Providers to ensure GlobalHealth has accurate practice and business information. Accurate information allows GlobalHealth to better support and serve our provider network and Members.

GlobalHealth Responsibilities

Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement. Invalid information can negatively impact Member access to care. Additionally, current information is critical for timely and accurate claims reimbursement.

GlobalHealth is required to audit and validate the Provider Directory data quarterly at a minimum. As part of our validation efforts, GlobalHealth will reach out through various methods, such as phone campaigns, letters, fax verification, etc. Contracted Providers are required to respond to requests within 30 days of receipt to confirm accuracy of their provider data.

Contracted Provider Responsibilities

The Contracted Provider must validate their information for the Provider Directory at least quarterly for correctness and completeness. Contracted Providers must notify GlobalHealth in writing at least 30 days in advance, when possible, of changes such as:

- Change in office location(s), office hours, phone, fax, e-mail, website, or billing address.

- Addition or closure of office location(s).
- Addition or termination of provider(s).
- Opening or closing of practice to new GlobalHealth Members.
- Verification of specialty status.
- Any additional information that may impact Members' access to care.

Failure to notify GlobalHealth within 30 days of changes may result in removal from the provider directory.

Also, a roster (either provider or facility as appropriate) must be submitted to GlobalHealth at least once per quarter. Rosters should be limited to locations where Members are able to make an appointment to see the Provider.

Providers are encouraged to keep data current in the National Plan & Provider Enumeration System (NPPES). If NPPES is kept up to date by providers, GlobalHealth can download and rely on it as a primary data resource, instead of calling or faxing your office for this information. Visit NPPES help if you have questions: https://nppes.cms.hhs.gov/webhelp/index.html

Access Timeliness Standards

GlobalHealth Contracted Providers are required to provide services per the following standards:

PCP – Scheduling an Appointment

Type	Access Standard	Examples
Emergency	Immediate appointment or Member is directed to nearest emergency department or call 911	Major trauma, laceration, eye injury, musculoskeletal injury, chest pain. Absence of medical attention to result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any body organ or part.
Urgently Needed Services	Immediate	Minor trauma, sprain, high temperature, persistent diarrhea, or vomiting. Unexpected illness or injury that is not an emergency, but severe enough or painful enough to require treatment within 24 hours.
Post-acute (inpatient or emergency department) Discharge	Within 7 calendar days of discharge	Update care plan, coordinate care with any SCPs, obtain labs, and reconcile medications.
Symptomatic, Non-urgent	Within 7 calendar days of request	Flu, cold, headaches, rashes, sore throat.
Routine/Regular Care	Within 30 calendar days of request	Follow-up appointments for asthma, blood pressure checks, diabetes.
Annual Wellness/ Preventive Care	Within 30 calendar days of request	Annual wellness examinations.

High Volume and High Impact SCPs – Scheduling an Appointment

GlobalHealth identifies the following providers as high volume and/or high impact SCPs:

- Cardiologists
- Oncologists
- Ophthalmologists
- Behavioral Health Care Providers

GlobalHealth expects contracted high volume and/or high impact SCPs to provide services per the following standards:

Type	Access Standard
Initial Referral	Within 30 days
Urgently Needed Services	Within 24 hours for sick visits and within 7 days for non-sick visits
Emergent care	Immediate
After-hours	Nurse triage or call coverage with response within 2 hours, or messaging on available services

Specialties considered hospital-based, such as anesthesiology and emergency medicine physicians, will not be considered high volume or high impact specialties.

PCPs and SCPs – Returning Telephone Calls

Contracted Providers are required to provide timely responses to inquiries.

Type	Access Standard	Examples
Return Phone Calls (business hours)	Within 1 calendar day	Schedule appointment and questions related to lab results, prescriptions, or treatment plan.
After-hours	Respond within 2 hours or messaging instructs Members on available services	Call for emergency prescription refill, advise best course of action, which may include Urgently Needed Services or emergent care.

Appointment Wait Times

GlobalHealth expects all non-hospital Contracted Providers to see the Member within 30 minutes of their appointment time, when the Member arrives on time. The office staff will make best efforts to notify Members as early as possible if the wait time is expected to exceed 30 minutes and allow the Member the options of rescheduling the appointment or continuing to wait.

GlobalHealth encourages Contracted Providers to use technology such as texts, email, secure medical record systems, or telephonic systems to remind Members of appointments, notify them of delays, or address health-related questions.

Missed Appointments

If a GlobalHealth MA/MAPD Member is experiencing transportation issues that prevent them from making appointments, their benefits include non-emergency medical transport. All MA/MAPD Members have transportation benefits included in their plans, administered by Roundtrip. Additionally, most MA/MAPD Members have home support benefits administered by Papa Pals, which can be utilized for transportation. Roundtrip can be reached at 877-565-1612 and Papa Pals can be reached at 855-485-9692. GlobalHealth

Customer Care Representatives and Care Managers are also available to assist Members with utilizing these services.

Covering Providers

A Contracted Provider must coordinate coverage by another Contracted Provider when they are on vacation or leave of absence. The Contracted Provider is responsible for ensuring the Covering Provider will:

- Follow the protocols, policies, and rules as stated in this Provider Manual.
- Accept compensation from GlobalHealth as full payment for Covered Health Care Services except for applicable Member Copayments and Coinsurance.
- Obtain Referrals/prior authorizations as stated in this Provider Manual.
- Any Covering Provider should use modifiers Q5 (substitute physician) or Q6 (locum tenens) to help ensure the claim is appropriately recognized.
- Be available 24 hours a day, 7 days a week.

Urgently Needed Services

Type	Access Standard	Examples
During Normal Office Hours	If possible, arrange to see the Member immediately, give them medical advice and direction, or set up an appointment for them. If the Member's assigned PCP is not available, the Member can see another Contracted Provider in the office if they bill under the same tax identification number as the PCP. When appropriate, direct the Member to an urgent care facility if another practitioner is not available.	If a Member has an urgent medical illness or injury that cannot wait for a regular appointment.
After-hours	The Member should call the PCP's contact number on their Member ID card. When a nurse or physician is on call, the Member's call should be returned, and the on-call Contracted Provider should advise them how to proceed. Otherwise, the Member should follow the after-hours voicemail instructions, which may include directing them to a network urgent care facility or network emergency department. The Member may choose to self-refer to a network urgent care facility or, in case of an emergency, call 911 or go to the emergency department.	Call for emergency prescription refill.

Please Note:

An urgent care facility should not be used in place of the PCP for routine services and continuity of care. Use of urgent care facilities is only for an unforeseen illness, injury, or condition that requires immediate, Medically Necessary care.

All follow-up care must be provided or arranged by the PCP. Prior authorization may be necessary, depending on the care needed.

If a Contracted Provider directs a Member to an urgent care facility or ED, the Contracted Provider must use best efforts to notify GlobalHealth within 24 hours of services.

Controlled Substance Restrictions

GlobalHealth may, in rare cases, limit Member access to opioid or benzodiazepine medications such as:

- Requiring a Member to get all prescriptions for opioids or benzodiazepines from one pharmacy.
- Requiring a Member to get all prescriptions for opioids or benzodiazepines from one doctor.
- Limiting the amount of opioids or benzodiazepines that will be covered.

Termination of a Member from Panel

There may be an occasion where a Contracted Provider wishes to terminate a Member from their panel. Reasons for such termination may include non-compliance or threatening or disruptive behavior by the Member. If a Contracted Provider plans to terminate a Member, the Contracted Provider must notify GlobalHealth prior to the termination, when possible. Additionally, the Contracted Provider must notify the Member in writing of the termination and continue to provide coverage for the Member for 30 days or until the Member obtains a new PCP, whichever occurs first.

Exception: A Contracted Provider may not terminate a Member if such termination would be detrimental to the Member's health (e.g., a third trimester or complicated pregnancy, a hospitalized patient, a patient receiving treatment for a degenerative and disabling condition or disease, or life-threatening disease or condition, or terminal illness, etc.) until the Member's condition is stabilized and another Contracted Provider has assumed care or through six weeks of post-delivery care.

Provider Termination from Network

Termination can be initiated for several reasons, either by the provider or by GlobalHealth.

A Contracted Provider may choose to voluntarily discontinue participation in the GlobalHealth network by providing a written notice of the disaffiliation. Providers are expected to notify GlobalHealth in writing as outlined in their Agreement when terminating a contract. When terminating an individual provider, at least 60 calendar days' notice is required. During the termination notification period, GlobalHealth will notify affected Members and transfer their care to another Contracted Provider.

GlobalHealth could initiate termination of a Contracted Provider for reasons that include, but are not limited to:

- Sanctions imposed upon provider by State and Federal regulatory entities.
- Provider misrepresents credentialing or contracting information.
- Provider is noncompliant with credentialing/re-credentialing requirements.
- Provider's certification or license being suspended or revoked.
- Provider opts out of Medicare.
- Safety issues.

GlobalHealth reports practitioner suspension or termination to the appropriate authorities.

Continuity of Care

When a Contracted Provider voluntarily leaves GlobalHealth's network, a Member that is currently in an active course of treatment might be eligible to continue an ongoing course of treatment during the transitional period, up to 90 days or through six weeks of postpartum care. For example, the Member may continue to see a terminating provider for delivery and postpartum care if she is in the second or third trimester of pregnancy at the time the provider notifies GlobalHealth.

When the Agreement is terminated for reasons other than cause, the terminated provider may ask GlobalHealth for permission to continue treating a Member during the transition period if the Member:

- Is receiving ongoing treatment for a Life-threatening Disease or Condition.
- Is receiving ongoing treatment for a Serious Acute Condition.
- Is receiving ongoing institutional or inpatient care from the provider or facility.
- Is receiving an ongoing course of treatment for a pregnancy.
- Is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery.
- Is receiving ongoing treatment after being determined to be terminally ill and is receiving treatment for such illness.
- Is receiving ongoing treatment for which a treating doctor or other Provider attests that changing care to another doctor or Provider would make the condition or expected outcome worse.

If approved for continuity of care, GlobalHealth covers care for up to 90 days while working to transfer the Member's care. If the Member is pregnant, GlobalHealth covers continuity of care through six weeks postpartum, even if it is more than 90 days. If the Member remains enrolled in the same Plan across calendar years, these timeframes apply across calendar years.

The terminating provider would continue to coordinate care and submit claims. Member liability in these cases is limited to only what the Member would have paid if the provider were remaining in the network. The terminating provider will be paid their contracted rate. The terminating provider agrees to comply with utilization management, claims, reconsideration requests, and all other protocols affiliated with a Contracted Provider.

GlobalHealth expects all terminating providers to actively facilitate the Member's transition to the new Contracted Provider(s).

Leave of Absence

GlobalHealth requires a Contracted Provider to notify GlobalHealth when they are going on a leave of absence (LOA) for longer than 60 calendar days. At a minimum, this notification must include the dates and the general reason for the LOA (sabbatical, medical reason, etc.). Contracted Providers must notify GlobalHealth of a pending LOA as soon as possible.

Contracted Providers taking a LOA must arrange for coverage by another Contracted Provider in the GlobalHealth network. All covering arrangements must be acceptable to GlobalHealth.

Arrangements for coverage by a nonparticipating practitioner may be considered. These arrangements must make best efforts to have GlobalHealth's prior authorization and must be consistent with established policies and procedures.

If the LOA is scheduled for six months or less, GlobalHealth will confirm the conclusion of the LOA. If the LOA is concluded within six months, the Contracted Provider's LOA status will be removed and will reflect his or her prior status.

If the LOA is scheduled for longer than six months, GlobalHealth reserves the right to terminate the Contracted Provider from the network based upon continuity of care issues. In addition, if a Contracted Provider's recredentialing is due during the LOA and the Contracted Provider does not complete his/her recredentialing materials, GlobalHealth reserves the right to terminate the provider from the network based on contractual noncompliance. GlobalHealth will process the application upon return to the practice.

Medical Records

Medical Recordkeeping and Documentation Standards

Complete and accurate documentation in medical records is an essential component of quality patient care. GlobalHealth conducts periodic Provider office reviews to assess medical recordkeeping practices and medical record documentation.

Essential medical record components include:

- An organized medical record filing system with patient medical records stored in a systematic, secure, and confidential manner.
- Each page in the record contains the patient's name or identification number – both front and back sides.
- Each record contains appropriate, updated biographical/personal data including language preference.
- All entries are signed by the author and dated. Transcribed notes are initialed or signed by the author. All signatures should include the credentials of the author. Note: an electronic signature is acceptable, provided authorization for its use is included in the signature line. Stamped signatures will not be accepted.
- Physician Assistant's notes are co-signed and dated by physician.
- Personal/biographical data including date of birth, sex, marital status, address, employer, and home and work telephone numbers.
- Family/social history is noted in the record and updated at least annually, initialed and dated.
- Advance Directive documents or a notation that none exist.
- The record is legible to the reviewer or someone other than the writer.
- Medication allergies, adverse reactions, or "no known allergies" is prominently noted in the record. Location is consistent throughout patient charts.
- A current medication list including drug name, dosage, frequency and duration, and initial prescription and refill dates. Medication list is updated each visit.
- Injections are documented and include drug name, dosage, route, and site as well as the NDC number.
- Notation is made in record when sample drugs are provided.
- A current problem list notes significant illnesses and medical conditions, updated at least annually, initialed and dated.
- Immunization records are current, or a note indicates up-to-date immunizations.
- Past medical and social history is present and identifies serious accidents, surgeries, illnesses, and important family information. Personal health history includes complete medical and behavioral health history.
- For Members 20 years old or younger, past medical history includes prenatal care, birth, operations, and childhood illnesses.

- For Members 11 years and older (or younger if appropriate) the use of cigarettes, alcohol, and any substance use is noted. Documentation of family/household history is also noted.
- Pertinent history and physical exam is documented for visits, including reason for visit, history and description of presenting problems, including precipitating factors, mental status evaluation, physical status evaluation if appropriate, psychosocial history including an appropriate developmental history for children and adolescents, risk assessment of severity and possibility of potential harm to self or others accompanied by a Referral to a level of care which is appropriate to the level of risk, and appropriate diagnostic tests.
- Notes indicate all services provided by practitioner, all Referrals for diagnostic or therapeutic services, services and tests ordered, follow-up care plans including dates of subsequent appointments, and when applicable, a completed discharge plan.
- Lab and other studies ordered as appropriate for diagnosis.
- Preventive and screening services are offered consistent with national and GlobalHealth practice guidelines.
- Diagnosis noted in the medical record is consistent with symptoms and physical exam or other diagnostic findings.
- Evidence of patient teaching as appropriate.
- Treatment plan is consistent with diagnoses and includes measurable objectives, estimated time frames, prevention efforts, community resource utilization, and current caregivers contacted or involved in treatment (if no caregiver is involved, so stated in the record).
- Follow-up plans and dates for return visits are clearly documented.
- Unresolved problems are addressed in subsequent visits.
- Consultations, ancillary services, lab, and imaging study reports are initialed by the practitioner.
- If hospitalized, the record includes an admit report, operative report (if applicable), and discharge summary.
- Working diagnoses are consistent with findings and appropriate diagnoses are documented.
- There is evidence of continuity and coordination of care between primary and specialty practitioners including behavioral health practitioners.
- Phone calls to and from patient are documented, including phone calls notifying the patient of diagnostic test results or related to prescription refills.
- Requests for prescription refills are documented to include the pharmacy name, medication name, dosage, administration directions, and number of refills allowed. Encourage use of technology, like telehealth, as determined appropriate.

Advance Directives

GlobalHealth expects Contracted Providers to give Members the option to complete an Advance Directive if one is not on file. The statutory form of Oklahoma's Advance Directive, also called a Living Will, can be found on GlobalHealth's website on the "Member Materials" page under the Legal Documents heading.

GlobalHealth MA/MAPD Members also have Advance Care Planning Services as a supplemental benefit, administered by Evolent, formerly known as Vital Decisions. This tool can be accessed at https://globalhealth.mylivingvoice.com.

Retention

Medical records shall be retained for 10 years following treatment, 10 years following the patient's age of majority, or 10 years from the final date of GlobalHealth's CMS contract or completion of any audit, whichever time period is longer.

Confidentiality

GlobalHealth expects Contracted Providers to maintain medical records according to HIPAA and other State and Federal privacy laws.

Record Release

Contracted Providers must make medical records available for utilization management, risk management, performance improvement, peer review studies, medical review, fraud, waste, and abuse (FWA), Claims Payment Accuracy, Customer Care inquiries, grievance processing, pre- and post-claim inquiries and disputes, and other GlobalHealth initiatives.

To comply with accreditation and regulatory requirements, GlobalHealth may periodically perform documentation audits.

GlobalHealth may request records be mailed or faxed, accessed via Electronic Medical Records (EMR), or schedule an on-site visit. If GlobalHealth requests duplicate records, the administrative fee specified in the Agreement will be paid.

GlobalHealth is a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HIPAA Privacy Rule permits a provider to disclose PHI to a health plan, provided that the health plan has or had a relationship with the individual who is the subject of the information, and the PHI requested pertains to the relationship. You do not need a separate authorization from the patient to release the medical record information for the purposes listed above. See the Notice of Privacy Practices in the Regulations section in this Provider Manual.

Utilization Management Program

Program Overview

GlobalHealth has a Utilization Management (UM) program to assist in determining:

- The presence of diagnoses or other medical criteria that are the basis for coverage determinations for the specific item or service; or
- To ensure an item or service is medically necessary based on standards specified in §422.101(c)(1).

Prior authorization decisions are made in a timely manner to accommodate the clinical urgency of the Member's situation.

- **Urgent Concurrent:** determination made within 72 hours of receipt of request
- **Urgent Preservice:** determination made within 72 hours of receipt of request
- **Non-urgent Preservice:** determination made within 14 days of receipt of request
- Prior authorization for **Medicare Part B** prescription drugs will be responded to timely and no later than 72 hours after your standard request or 24 hours after your expedited request.

Medical Policies and Criteria Guidelines

GlobalHealth uses plan medical policies and nationally recognized guidelines and resources, such as CMS National and Local Coverage Determinations, MCG™, Hayes, Inc., or National Comprehensive Cancer Network (NCCN) when conducting medical necessity reviews.

GlobalHealth medical policies are developed in coordination with physicians using evidence-based, peer-reviewed literature, criteria developed by specialty societies, and guidelines adopted by other healthcare organizations.

Decisions are supported by current clinical information relevant to each case. Clinical review is based on published standard criteria and/or internal policies that are developed with input from actively participating physicians. Board-certified practitioners or clinical peers from appropriate specialty areas may be consulted in determinations of medical appropriateness of care.

Services That Require Prior Authorization

NOTE: This list is not all-inclusive and may include other outpatient services that are covered only by certain plans. Other infrequently requested or highly specialized services not listed below may require prior authorization. By requesting prior authorization, the Contracted Provider is representing that the proposed Covered Health Care Services are Medically Necessary.

- **Acupuncture**

Chronic lower back pain

- **Ambulance**

Scheduled, non-emergent ambulance transport from one facility to another location

Urgent air ambulance transportation does not require prior authorization but will be subject to a retrospective medical necessity review.

- **Behavioral Health**

GlobalHealth encourages coordination of care with Carelon Behavioral Health. Carelon Behavioral Health handles the prior authorization process if applicable. Refer to the Helpful Numbers and Information section of exhibit 1 or 2 depending on the Member's plan type for the contact information for Carelon Behavioral Health.

- **Continuous Glucose Monitors**
- **Diagnostic Services**
    - Infertility testing and services
    - Cardiac stress tests, nuclear cardiac testing, coronary computed tomography angiography, and other cardiographs
    - Neurology and neuromuscular diagnostic testing, including EMG, NCV, and sleep studies
    - CT scans, nuclear scans/tests, MRI, MRA, PET scan, and gamma camera
    - Non-routine, non-preventive, or high-risk maternity care, maternal support services, fetal monitoring, threatened and premature labor treatment
    - Elective facility-based invasive diagnostic testing
    - Specialty lab (e.g., genetic testing for treatment purposes)
- **Drug Waste**
- **Durable Medical Equipment (DME), Prosthetics, and Orthotics**

Including enhanced or specialty equipment or supplies

- **Home Healthcare**

All home healthcare, including home infusion therapy, requires prior authorization. Hospice care for MA/MAPD Members should be coordinated under Original Medicare benefits.

To qualify for the Medicare home health benefit, under §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act, a Medicare beneficiary must:

- Be confined to the home.
- Be under the care of a physician or allowed practitioner.
- Be receiving services under a plan of care established and periodically reviewed by a physician or allowed practitioner.
- Be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or
- Have a continuing need for occupational therapy.

Refer to §424.22 "Requirements for home health services" for additional information: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-B/section-424.22

- **Hospital Transfers**

All scheduled, non-emergent hospital transfers require prior authorization prior to transfer. All emergent hospital transfers require notification to GlobalHealth the next business day following the date of service. The receiving hospital is required to notify GlobalHealth within 24 hours of the admission.

- **Inpatient Care**

All inpatient elective care or scheduled procedures require prior authorization by the Contracted Facility. GlobalHealth must be notified by the hospital of all admissions within 24 hours of admission, unless otherwise specified in your Agreement. If a service does not require prior authorization (e.g., childbirth, etc.), this does not negate the provider's responsibility to *notify* the plan upon admission.

- **Other Services**
    - Organ transplant services; transplant evaluations, organ donor services, transplant procedures
    - Stereotactic radiosurgery (e.g., gamma-ray radiosurgery, gamma knife, etc.)
    - Dialysis, Epoetin alfa, and laboratory services rendered in conjunction with dialysis
    - Outpatient radiation therapy and chemotherapy
    - Hyperbaric oxygen treatment
    - Non-emergency blood transfusions and all infusion therapies/services
- **Outpatient Hospital/Ambulatory Surgery**

Procedures performed in an outpatient hospital (place of service 22) or ambulatory surgical center (place of service 24) require prior authorization.

- **Outpatient Therapies and Rehabilitation**

All therapies and rehabilitation such as physical, occupational and speech therapy, cardiac rehabilitation, pulmonary rehabilitation services, and supervised exercise therapy require prior authorization.

- **Pharmacy**

Certain injectable medications require prior authorization. Certain formulary drugs may be preferred agents or may require prior authorization.

- **Post-Acute Care**

All Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), and Long-Term Acute Care Hospital (LTACH) care requires prior authorization.

- **Specialty Care Services**

Although prior authorization is not required for in-network SCP office visits for MA/MAPD Members, the SCP may determine the Member needs services other than services routinely rendered during the office visit. It then becomes the responsibility of the referring SCP to submit the authorization for additional services. The SCP is expected to continue to coordinate care with the PCP. All out-of-network specialists require a prior authorization.

Submitting Referrals

The PCP is responsible for submitting a Referral when necessary and for supplying complete clinical information. Referrals are required whether GlobalHealth is the primary or secondary payer. Referrals should be submitted through the Portal.

Referrals to Non-Contracted Providers

Services must generally be referred to a Contracted Provider. Exceptions may be made in certain circumstances such as when a terminating provider is transitioning a Member under current treatment to a Contracted Provider. Contact GlobalHealth for assistance when referring to a non-contracted provider.

Prior Authorizations

Providers are responsible for submitting prior authorization requests through the Portal. Prior authorization notification does not guarantee payment for services rendered. Prior authorization notification will only determine if a service is Medically Necessary.

Prior authorization does **not** determine if your patient is a GlobalHealth Member or if the healthcare service requested is a covered benefit. We recommend that you call to verify the Member's enrollment and benefit coverage. A Contracted Provider may also check eligibility on the Portal. Refer to the authorization for specific approval dates.

Specialty Care Providers

MA/MAPD Members may go to a network SCP without prior authorization for office visits only.

Additional Services

If the SCP decides the Member needs services beyond what is generally handled during an office visit, it becomes the responsibility of the SCP to submit the Referral for additional services. If the Provider does not obtain authorization before providing additional tests, services, or procedures, they may not be payable. GlobalHealth expects the SCP to keep the Member's PCP informed about the ongoing care.

Eligibility must be verified at the time of each visit. Payment will not be made for services rendered to an ineligible Member.

Notify GlobalHealth within one business day regarding any unexpected services that were Medically Necessary but were not included in the original prior authorization.

Facilities

The facility should report the appropriate clinical information to the referring PCP and coordinate any follow-up referrals with the applicable provider.

Eligibility must be verified at the time of each visit. Payment will not be made for services rendered to an ineligible Member.

Notify GlobalHealth within one business day regarding any unexpected services that were Medically Necessary but were not included in the original prior authorization.

How to Obtain a Prior Authorization

Prior authorizations are sent to GlobalHealth's UM department via the Portal: https://ghprovider.prod.healthaxis.net/login

For expedited authorization, a Contracted Provider may submit prior authorizations as specified above or contact GlobalHealth's UM department using the information in the Helpful Numbers and Information section of exhibit 1 or 2 depending on the Member's plan type.

If the Portal is unavailable for any reason, an authorization request may be sent via fax by completing the Physician's Treatment Request Form available on the Providers menu at www.globalhealth.com and faxing it to GlobalHealth's UM Department.

Contracted Providers can check on the status of authorizations and authorization requests in the Portal which is available 24 hours a day, 7 days a week. PCPs can see all the authorizations for each individual Member of their panel.

Non-Approval of Prior Authorizations

If a Pre-service prior authorization is not approved this should not be interpreted as a barrier to patient care or questioning of a physician's judgment. It may indicate the need for additional information, or consideration of alternative treatment plan options, before authorizing the request. GlobalHealth may contact you for additional information prior to issuing an adverse determination.

When an adverse determination is made due to the provider not participating in GlobalHealth's network, GlobalHealth will coordinate care with a Contracted Provider.

Request for More Information

A review may be extended one time by the plan for up to 14 days for healthcare services if:

- You are notified, prior to the expiration of the initial review period, of why it is necessary; and,
- You are notified of the date by which GlobalHealth expects to render a decision.

If such an extension is necessary because GlobalHealth does not have the information necessary to decide the authorization:

- We will tell you specifically what information is needed; and,
- The appropriate timing of receipt.

If the information is not provided in a timely manner, does not support medical necessity, or is not a covered benefit, the requesting provider will be sent a copy of the denial letter with information about the reason as well as the Member's appeal rights and process.

The Member will also receive a letter regarding the denial, with information about the reason and coverage appeal rights and process.

Appeal of Pre-Service Denial

Coverage appeal timelines and processes for both standard and expedited appeals are available on GlobalHealth's website, www.globalhealth.com.

Behavioral Health Authorization

GlobalHealth strongly encourages Contracted Providers to coordinate care with behavioral health providers.

Carelon Behavioral Health is GlobalHealth's delegated behavioral health administrator. For plan-specified mental health and substance use disorder services that require prior authorization, a Carelon Behavioral Health Contracted Provider will assess the Member for medical necessity criteria, and then contact Carelon Behavioral Health for authorization. Refer to the Helpful Numbers and Information section of exhibit 1 or 2 depending on the Member's plan type for the contact information for Carelon Behavioral Health.

Services Not Requiring a Prior Authorization or Referral

The network PCP will coordinate the Covered Health Care Services provided to GlobalHealth Members, but there are a few exceptions. The Member may self-refer to a Contracted Provider for the following services. There may be times a Member needs emergency care or urgently needed services which may be covered at a non-contracted provider without prior authorization. This also applies to plan-directed care. A GlobalHealth Member does not need a Referral from the PCP or authorization from GlobalHealth. However,

GlobalHealth encourages coordination of care between the providers of these services and the Member's PCP, in compliance with State and Federal privacy laws.

- **Anesthesia/Pathology**

Services from a hospital-based anesthesiologist or pathologist (excludes pain management or office-based services).

- **Annual Wellness Exam/Initial Preventive Physical Exam**
- **Chiropractic Care**

Manual manipulation of the spine to correct subluxation.

- **Consulting Physicians**

Services from inpatient consulting physicians and outpatient specialty.

- **Dental**

GlobalHealth strongly encourages Contracted Providers to coordinate care with network dental providers. GlobalHealth administers Medicare-covered dental benefits only. MA/MAPD Members also have supplemental dental benefits through DentaQuest. DentaQuest can be reached at 833-955-3417.

Services from a network dentist when this benefit is part of the Member's plan and not part of a medical procedure.

- **Emergency and Urgent Care**

All services rendered in any ED or emergency ambulance.

All services rendered in an urgent care facility.

- **Hearing/Speech Exam**

Services available without prior authorization are dependent on plan benefits. Hearing benefits are administered through NationsHearing. Refer to the Helpful Numbers and Information section of exhibit 1 or 2 depending on the Member's plan type for the contact information for NationsHearing.

- **Laboratory services**
- **Mammogram**

Routine standard or 3D screening mammogram once every 12 months. (Preventive Services Only)

- **OB/GYN**

Any service from a network health professional that specializes in obstetrics or gynecology within their scope of practice. The OB/GYN is responsible for obtaining prior authorization for services that are not part of a routine office visit.

- **Preventive Services**

All ACA-required or Medicare-covered preventive services

- **Tests**
    - EKG
    - Routine lab work
    - Ultrasound

- X-ray

- **Vision**

GlobalHealth strongly encourages Contracted Providers to coordinate care with network vision providers. GlobalHealth administers Medicare-covered vision benefits only. MA/MAPD Members also have supplemental vision benefits through EyeMed, and they can be reached at 800-884-6321.

- Preventive services during optometrist or ophthalmologist office visits, such as diabetic retinopathy and glaucoma screenings
- Eyewear

Hospital Admissions

All inpatient hospital care **must** be provided at a GlobalHealth network participating hospital, except for emergency admissions or when prior authorized by GlobalHealth under special circumstances. GlobalHealth must be notified by the hospital of all admissions within 24 hours of admission.

GlobalHealth concurrently reviews every Inpatient admission for appropriate level of care beginning on the day of admission through discharge. Discharge planning begins at admission.

Concurrent Review

GlobalHealth performs concurrent review from the day of admission through discharge to ensure the medical necessity of each day, that services are provided at the appropriate level of care, and that necessary discharge arrangements are being/have been made.

If GlobalHealth has approved a course of treatment (to be provided over a period of time or number of treatments), the provider may request to extend the course of treatment. GlobalHealth will notify the provider of the decision. The Member is not entitled to continued coverage pending the outcome of the request.

Contracted Providers should cooperate with GlobalHealth by:

- Providing concurrent review status reports by telephone, fax, or EMR.
- Allowing access to medical records for the Member.
- Providing admission and discharge notifications 24 hours a day, 7 days a week.

Length of Stay

If a preauthorized admission is expected to extend beyond the initially assigned length of stay, the admission is subject to concurrent review.

Admissions From Emergency Department

GlobalHealth must be notified by the hospital of all ED admissions within one business day of the day the Member's status changes to inpatient.

Discharge Planning

Discharge planning starts at the time of hospital admission or when the admission is authorized and continues throughout the discharge process. It includes the coordination of a Member's continued care needs both in and out of the inpatient setting.

The admitting physician should facilitate discharge planning by documenting the anticipated discharge date, disposition (e.g., home, SNF, rehabilitation, etc.), and any post-discharge services the Member may

require. A comprehensive discharge plan is expected to include an assessment of needs, including barriers to successful discharge, plan development, plan implementation, and evaluation of effectiveness. Discharge planning activities include:

- Assessing Member's potential discharge requirements beginning on the day of admission, including behavioral health, psychosocial, and economic needs.
- Completing evaluation of available support and assistance, including:
    - Healthcare services;
    - Financial needs;
    - Safe housing;
    - Food access;
    - Transportation; and
    - Language and cultural needs.
- Arranging ICT meetings as appropriate.
- Involving social services in discharge planning as appropriate.
- Coordinating discharge needs such as DME, home health, SNF, transportation, medications, etc.
- Obtaining authorization from GlobalHealth for necessary post-discharge services.
- Coordinating behavioral health therapy and psychiatric medication management aftercare appointments within 7 days post-discharge with Carelon Behavioral Health. Refer to the Helpful Numbers and Information section of exhibit 1 or 2 depending on the Member's plan type for the contact information for Carelon Behavioral Health.
- Documenting and communicating the discharge plan.
- Ensuring patient understanding of discharge orders and required follow-up care.
- Submitting other authorizations as needed.
- Delivering a written notice of non-coverage, if applicable.
- Communication of discharge plan, including medications and appointments to PCP and any other post-discharge healthcare providers.

Best efforts should be made by the facility to communicate the full discharge plan to the Member's PCP within one business day of discharge.

GlobalHealth's UM staff will work with the hospital case manager to arrange for any needed services. GlobalHealth's participation in the discharge planning process for coordination of care will vary based on the individual Member's circumstances and occurs by telephone.

Care Management Program

GlobalHealth's Care Management Program assists Members in the management of their healthcare and supports the agreed-upon treatment plan. The objective of the program is to decrease inpatient admissions, readmissions, and unnecessary ED visits by helping Members regain optimal health or improve functional capability. GlobalHealth accomplishes this objective by working with identified Members and their PCPs to:

- Evaluate Member health risk.
- Verify or create a practical treatment plan, with Member input.
- Encourage adherence to the treatment plan.
- Provide continuity and coordination of care.

The Care Management Program offers two types of support for GlobalHealth Members: discharge outreach and care management.

Contracted Providers can refer a GlobalHealth Member by contacting Provider Services using the information in the Helpful Numbers section of exhibit 1 or 2 depending on the Member's plan type.

Discharge Outreach

Discharge outreach provides support to Members who have recently experienced a transition of care. The discharge team works with Members to support and reinforce treatment plans to prevent readmission and unnecessary ED visits. Female Members who had a vaginal birth with no complications or conditions (hypertension, depression, etc.) and a healthy newborn are excluded from the program.

Care Management

Members can enter into care management through physician referral, self-referral, or referral from a care team member. Additionally, all C-SNP and D-SNP members will be assigned to care management. Care management assists Members with:

- Development and implementation of a care plan.
- Monitoring and follow-up.
- Access to medical, behavioral health, and social services.
- Access to affordable, long-term supports and services and preventive health.
- Coordination of care across all health care settings.
- Improving health outcomes.

Behavioral Health Benefits

Members can directly access mental health and/or substance use disorder services by calling the Carelon Behavioral Health Customer Care number listed on the back of their Member ID card. Assistance is available for those that need translation or are hearing impaired.

Carelon Behavioral Health can assist Members with:

- Finding a Contracted Provider.
- Crisis intervention.
- Referrals to community resources and self-help groups.

Pharmacy

CVS Caremark is the Pharmacy Benefit Manager (PBM) for both Commercial and MAPD Members

Optimizing Member Benefits

There are several ways you can help your patient save money:

- Prescribe a 90- or 100-day supply where appropriate; lower drug tiers generally have cost-sharing breaks for the Member for extended day supplies.
- Prescribe a generic whenever appropriate.
- MAPD Members may save money by filling prescriptions at a preferred cost-sharing pharmacy rather than a standard cost-sharing pharmacy.

Please refer to the plan-specific documentation on our website for information about drug tiers and cost shares.

Real Time Benefits Tool

Member-specific benefit information is pulled directly from the PBM and delivered to clinicians' EMR. This will allow Providers and Members to make more informed treatment decisions by ensuring they understand exactly what the Member will pay out-of-pocket and being able to see if there are any clinically appropriate lower-cost alternatives covered under the plan. The tool will also communicate which therapy options require prior authorization (PA) or have other restrictions. Providers are able to process a PA in real-time from the EMR. Providers should contact their EMR vendor or EMR system administrator to ensure real-time prescription benefits information is enabled or will be included in the next upgrade.

GlobalHealth's Formulary Drug List

Formularies are specific to the plan benefits. Covered drugs are listed in the Drug Formulary.

The cost share for each prescription drug is based on which tier it is in. The number of tiers may vary based on the plan design. Generally, the lowest tier contains generic or low-cost medications. The next higher tiers contain preferred name brand medications or non-preferred brand name formulary medications and specified high-cost generic drugs. Cost shares typically increase as the tier increases.

Specialty medications are in the highest tier. Specialty medications are limited to no more than a one-month supply and must be pre-approved by CVS Caremark.

Formulary Abbreviations

Type	Description
B vs D (B/D)	Drugs that require review to determine whether the medication will be covered as Part B or Part D. (MAPD only)
Excluded Drug (ED)	Drugs not normally covered by Part D such as erectile dysfunction drugs, vitamins, etc.; however, GlobalHealth covers them as a supplemental benefit. The amount the Member pays to fill a prescription for these drugs does not count towards the Member's total drug costs. In addition, if the Member is

Type	Description
	receiving Extra Help to pay for their prescriptions, they will not get any Extra Help to pay for these drugs. (MAPD only)
Limited Access (LA)	Prescription may only be available at certain pharmacies. Providers will need to consult the Pharmacy Directory or call Customer Care using the contact information in the Helpful Numbers and Information section of exhibit 1 or 2 depending on the Member's plan type.
Not Mail Order (NM)	Drugs that are not available through mail order.
Prior Authorization (PA)	Providers are required to obtain prior authorization for certain medications, including compound drugs. This promotes appropriate, cost-effective use. Any corresponding supplies or equipment also require prior authorization. GlobalHealth may not cover the drug, supply, or equipment without prior authorization.
Quantity Limits (QL)	There are limits to the amount of certain medications that may be filled. These drugs, if taken inappropriately for too long a time, could be unsafe and cause adverse effects.
Step Therapy (ST)	Step therapy requires one or more prerequisite, clinically equivalent drugs to be tried before a step therapy drug will be covered.

Prescription Drug Utilization Management

Some medications have requirements that must be met before they can be filled. These programs are based on current medical findings, FDA-approved manufacturer labeling information, cost, and manufacturer rate agreements. The formulary indicates if the drug has any requirements. CVS Caremark conducts all medication prior authorization reviews.

Medicare beneficiaries who are new to GlobalHealth MAPD can receive a transition supply of medication during the first 90 days of their membership under certain circumstances. The transition supply will be for a maximum of a cumulative 30-day supply (31 days if the Member is in Long-Term Care).

Types of Exceptions Available

Tiering Exceptions

The prescriber must provide a supporting statement indicating that the drug(s) in the applicable lower cost-sharing tier(s) for the treatment of the enrollee's condition would (1) not be as effective as the requested drug, and/or (2) have adverse effects. Tiering exceptions are only considered for MAPD members.

Formulary Exceptions

The prescriber's supporting statement must indicate that the requested drug is medically necessary for one of the following reasons:

1. All covered Part D drugs on any tier of the plan's formulary would not be as effective for the enrollee as the requested non-formulary drug, and/or would have adverse effects; or
2. The number of doses available under a dose restriction for the requested drug:
    a. has been ineffective in the treatment of the enrollee's disease or medical condition; or
    b. based on both sound clinical and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug

regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or

3. The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
    a. has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
    b. has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.

Exception Process

Standard Exception

Members can request that GlobalHealth waive coverage restrictions and limits. Call the Coverage Determinations Department using the contact information in the Helpful Numbers and Information section of exhibit 1 or 2 depending on the Member's plan type to request an exception. A Member may submit their request in writing, electronically, or telephonically. Providers may also call the Coverage Determinations Department or fax completed forms to CVS Caremark at (855) 633-7673. Requests for coverage determinations and redeterminations can be submitted online using the "Request for Medicare Prescription Drug Coverage Determination (or Redetermination) Form." To access these forms, visit https://www.globalhealth.com/oklahoma/providers/prior-authorization-forms/ and scroll down to the section for the Member's plan type. Standard exceptions are reviewed within 72 hours of receiving the prescriber's supporting statement or 14 calendar days after receipt of the request, whichever occurs first.

Expedited Exception

You may request an expedited exception when the Member is suffering from a health condition that may seriously jeopardize their life, health, or ability to regain maximum function.

CVS Caremark will provide a decision to you within 24 hours after receiving the request and sufficient information, such as the prescriber's supporting statement, to begin the review.

- If granted, our approval is usually valid until the end of the plan year, and renewal can be requested as long as the patient continues to be enrolled in a GlobalHealth plan. This is true as long as the physician continues to prescribe the drug for the patient and that drug continues to be safe and effective for treating the condition.
- If your exception request is denied, you may appeal on the Member's behalf using the information provided in the Notice of Medicare Non-Coverage.

Pharmacy Types

Members may fill a prescription at any pharmacy in our network as long as the pharmacy is able to fill it.

Mail Order Pharmacy Service

CVS Caremark offers the convenience of mail order. Providers can contact CVS Caremark at (800) 378-5697 or fax the completed form and prescription to CVS Caremark at (800) 378-0323. Forms are available on our website at https://www.globalhealth.com/oklahoma/pharmacy/mail-order-drugs/. Maintenance medications are mailed to the Member's home in up to a 90-day supply, or up to a 100-day supply for certain plans.

Retail Pharmacy Network

The Member may receive up to a 30-day or up to a 90- or 100-day supply of a maintenance drug at a retail network pharmacy for the applicable Copayment or Coinsurance. Retail network pharmacies can be found in the Pharmacy Directory or by using the Find Care Providers tool on our website at https://gh-findcare.globalhealthportals.com/oklahoma/globalhealth/.

Standard and Preferred Cost-Sharing Pharmacies (MAPD Plans only)

GlobalHealth MAPD Members may choose pharmacies that either offer standard cost-sharing or discounted cost-sharing. Their Evidence of Coverage explains the different Member responsibility amounts. Pharmacy status is indicated on the results of the Find Care Providers tool on our website at https://gh-findcare.globalhealthportals.com/oklahoma/globalhealth/.

Specialty Pharmacies

Contracted specialty pharmacies may fill prescriptions for specialty medications and arrange for delivery to the Member's home or other requested location. Some retail pharmacies can also fill specialty drug prescriptions. Specialty medications sent to and administered by a doctor are covered under the Member's office visit cost share. Specialty medications sent to and administered by the Member are assessed the applicable prescription drug Copayment or Coinsurance. A specialty network pharmacy can be found in the Pharmacy Directory or by using the Find Care Providers tool on our website at https://gh-findcare.globalhealthportals.com/oklahoma/globalhealth/.

Medication Therapy Management Program (MAPD Plans only)

GlobalHealth MAPD Members qualify for our Medication Therapy Management program if at least one of the following criteria are met: 1) have coverage limitation(s) in place for medication(s) with a high risk for dependence and/or abuse, OR 2.a) have three or more targeted chronic conditions, AND 2.b) are likely to incur the minimum annual cost threshold as established by CMS. The goal of this program is to help eliminate duplicate drug therapies, reduce potential for negative drug interactions and/or side effects, and optimize Member benefits by providing information on the lowest cost medication alternatives. Enrollment is automatic for qualified MAPD Members. Member participation is voluntary and does not affect Member's coverage. Benefits include personalized service from registered pharmacists and staff.

ATTENTION: PRESCRIPTION PAIN RELIEVERS CAN BE HIGHLY ADDICTIVE!

Prescription drugs, especially opioid analgesics – a class of prescription drugs used to treat both acute and chronic pain such as hydrocodone, oxycodone, codeine, morphine, and methadone – have increasingly been implicated in drug overdose deaths over the last decade.

Before you prescribe this type of medication for your patient, have a serious discussion regarding the potential for addiction and overdose. Or if you have patients who have been taking this type of medication, consider titrating them off as soon as possible. GlobalHealth urges prescribers to conduct at least annual medication reviews that include over-the-counter products, prescriptions, and supplements with their patients.

If you have a patient who has become addicted to any medication, contact Carelon Behavioral Health immediately for assistance in getting them to treatment and resources to support them through the recovery process. Your patient's GlobalHealth benefits cover outpatient therapies, medication assisted treatment programs, and residential substance abuse treatment as well as assisting Members with locating community resources that will help in their recovery process.

Claims and Payments

Providers must electronically submit Clean Claims to GlobalHealth within the timely filing period specified in the Agreement in order to receive payment. If the provider fails to submit a Clean Claim within the required timeframes, GlobalHealth expressly reserves the right to deny payment for such claim(s). Claim(s) denied for untimely filing **cannot** be billed to a Member.

When GlobalHealth is a secondary payer, the filing period begins on the date shown on the primary carrier's Remittance Advice (RA) reflecting payment or denial.

Claims Reimbursement

GlobalHealth will reimburse for Covered Health Care Services on timely filed Clean Claims in accordance with your Agreement and applicable statutory requirements less any applicable Copayments, Coinsurance, and/or Deductibles owed by the Member. Unless otherwise specified, GlobalHealth follows CMS coding guidelines including ICD-10, CPT-4®, and HCPCS. Should GlobalHealth fail to pay a claim within the required timeframe, GlobalHealth will pay interest in accordance with contractual and State regulatory requirements. Providers will receive a RA Report detailing how each service was processed. This information can be accessed through the online Portal. Electronic RAs can also be accessed online through Zelis. Register online at https://www.zelis.com/providers. Click "Enroll today" to create an account.

Claims Submission

Claims must be submitted electronically. GlobalHealth utilizes a preferred clearinghouse, Change Healthcare (Emdeon), for electronic claims submission. GlobalHealth's electronic data interchange (EDI) number is GHOKC0001. In the unlikely event that electronic filing is not available, refer to the Helpful Numbers section of exhibit 1 or 2 depending on the Member's plan type for our claims mailing address.

Proof of Timely Filing

The clearinghouse vendor can supply a report of accepted electronically filed claims. That report can be used for proof of timely filing for electronic claims. For Providers who submit claims on paper, proof of timely filing would consist of a printout from their billing system showing when the claim was billed.

Claims Adjudication

GlobalHealth reviews and evaluates claims for:

- Correct billing (UB-04 or CMS-1500 format).
- Correct coding (ICD-10, CPT-4®, HCPCS, or other required coding as applicable).
- Coverage criteria.
- Medical necessity.

Approved forms:

- Electronic filing
- CMS-1500
- UB-04

Responsibility for Payment

Members are responsible for payment of:

- Their Deductible, Copayments, or Coinsurance for approved Covered Health Care Services.
- The cost of services not included in their GlobalHealth plan benefits.
- Full Billed Charges when:
  - The services were non-covered services.
  - The services were received out-of-network and were not authorized by GlobalHealth.
  - The services were obtained through fraud.

Copayments/Coinsurance

Members are required to pay a Copayment or Coinsurance for certain benefits. Copayment amounts are generally listed on the Member's GlobalHealth ID card. Coinsurance should be billed when you receive the RA from GlobalHealth.

No Copayment or Coinsurance should be collected from or billed to the Member for preventive care services.

Maximum Out-of-Pocket (MOOP)

For GlobalHealth plans, Member expenses are limited by an annual MOOP amount. If a Member has reached the MOOP, a Contracted Provider should not apply any Member cost share for Covered Health Care Services. Contracted Providers may obtain a Member's MOOP information via the Portal or by contacting GlobalHealth. If the Contracted Provider collected a cost share from the Member, GlobalHealth will notify the Contracted Provider of the amount in excess of the MOOP and the Contracted Provider shall promptly reimburse the Member.

If GlobalHealth determines that the Contracted Provider did not reimburse the Member the amount received in excess of the MOOP, GlobalHealth may reimburse the Member directly and recoup the amount from the Contracted Provider. GlobalHealth will notify the Contracted Provider of any such recoupment 30 days prior to such recoupment.

GlobalHealth may audit the Contracted Provider's compliance with this section and may require the Contracted Provider to submit documentation to GlobalHealth supporting that the Contracted Provider reimbursed Members for amounts in excess of the MOOP.

Members are not responsible for:

Any amounts owed by GlobalHealth to a Contracted Provider for approved Medically Necessary services that are covered by plan benefits.

Any amounts requested as balance billing (after GlobalHealth has paid the contracted allowed amount), provided that:

- The services were preauthorized Covered Health Care Services;
- The services were approved by GlobalHealth;
- The services were provided by a Contracted Provider; and
- The Member has paid the required cost share.

Balance Billing

A Contracted Provider and Facility accepts the GlobalHealth reimbursement as payment in full and may not "balance bill" a GlobalHealth Member. In other words, the Contracted Provider may not seek payment from a GlobalHealth Member for Covered Health Care Services beyond the Member's applicable Deductible, Copayment, and/or Coinsurance amounts. Balance billing is a violation of the Agreement and may result in termination of the Contracted Provider from the GlobalHealth network.

Qualified Medicare Beneficiary

Medicare providers and suppliers may not bill GlobalHealth Members in the Qualified Medicare Beneficiary (QMB), Qualified Medicare Beneficiary Plus (QMB+), Specified Low Income Beneficiary Plus (SLMB+), and Full Benefit Dual Eligible programs for Medicare Part A and B Deductibles, Coinsurance, or Copayments, but state Medicaid programs may pay for those costs. Under some circumstances, Federal law lets states limit how much they pay providers for Medicare cost-sharing. Even when that's the case, people in these programs have no legal obligation to pay Medicare providers for Medicare Part A or Part B cost-sharing. Providers may not refuse to serve members due to assistance with Medicare cost-sharing received from a state Medicaid program. For more information visit www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB.

Remittance Advice (RA)

The RA issued by GlobalHealth summarizes the claim and explains how benefits were applied. Use the RA to determine how a claim was paid including non-allowed amounts and adjustments. The RA will note any non-covered services and cost-sharing amounts that are the responsibility of the Member. The RA lists and explains all codes used in processing each claim. Claim details can also be obtained through the online Portal or through Zelis. If additional details are required, contact Provider Services using the contact information provided in the Helpful Numbers and Information section of exhibit 1 or 2 depending on the Member's plan type.

When reviewing RAs to determine Member responsibility, please note that both the "Discount" and "Adjusted Amount" fields are the Provider's responsibility. The Member should never be billed more than the "Patient Liability" amount shown in the lower right-hand corner. Any bill for more than the patient's responsibility is considered balance billing, which is not allowed.

Member:
Member ID:
Provider/Practioner:
Provider NPI:
Paid Date:

Birthdate:
Patient Acct #:
Claim #:

Provider Network: **In-Network**
Group Name: **GlobalHealth of Oklahoma**
Global Payment#:

Dates of Service	Procedure	Modifier	Units	Remark Codes	Billed Amount	Allowed Amount	Discount	Adjusted Amount	CoPay	Co-Insurance	WithHold	Incentive Paid	Paid Amount	COB Amount
		PO	1		$4,194.45	$1,267.60	$2,926.85	$0.00	$250.00	$0.00	$10.18	$0.00	$1,007.42	$0.00
		PO	2		$1,449.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
		PO	1		$537.71	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
		PO	4		$615.24	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
				Column Totals:	$6,796.40	$1,267.60	$2,926.85	$0.00	$250.00	$0.00	$10.18	$0.00	$1,007.42	$0.00

Patient Liability:	**$250.00**
Prior Payment Paid:	**$0.00**
Paid on this Claim:	**$1,007.42**

Reasons for Payment Delays

GlobalHealth will process claims as expeditiously as possible. In order to do so, it is essential that complete and accurate claims are submitted. Common mistakes that delay payment include:

- Missing Provider Group NPI or Place of Service.
- Missing employer or group number or Member number.
- Missing authorization numbers.
- Failure to submit claims electronically.
- Failure to submit required additional documentation.
- Inaccurate or questionable diagnosis or procedure coding.
- Missing or wrong Tax ID Number.
- Missing provider name and/or NPI.

Claims Status

Contracted Providers must use the Portal to obtain claims status. The Portal is available here: https://ghprovider.prod.healthaxis.net/.

Circumstances That May Affect Hospital Reimbursement

Reimbursement for inpatient services may be affected in certain circumstances described below:

- Pended for Case Review
- Hospital Acquired Conditions/Not Present on Admission
    - GlobalHealth does not provide additional reimbursement for complications related to procedures and co-morbidities related to hospital-acquired conditions not present upon admission as defined by the CMS.
- Hospital Readmissions
    - GlobalHealth does not make additional, separate DRG payments for readmissions that are reasonably avoidable and at the same Contracted Facility for same, similar, or related conditions or the result of a premature discharge or inadequate discharge planning and that were avoidable. GlobalHealth applies standardized evidence-based criteria such as CMS guidelines, MCG™, NCCN, and other applicable industry guidance in determinations not to reimburse for a subsequent hospitalization.
- Never Events
    - GlobalHealth does not reimburse for charges that are related to “Never Events” (NE) or “Serious Reportable Events” (SRE) as defined by the CMS and National Quality Forum (NQF).
- Healthcare services or diagnosis not supported due to inadequate documentation in the requested medical record.

Coding and Billing, Industry Standards, and Best Practices

GlobalHealth does not reimburse for charges that are not in adherence with coding and billing best practices and standards or supported by documentation. GlobalHealth utilizes but is not limited to the following resources:

- CMS Guidelines as stated in CMS' Medicare Managed Care Manual
- Medicare Local and National Coverage Determinations
- GlobalHealth Provider Manual, claims payment and UM policies, and Member materials
- National Uniform Billing Code Guidelines from National Uniform Billing Committee
- American Medical Association Current Procedural Terminology System (CPT) guidelines
- Healthcare Common Procedure Coding System (HCPCS) rules
- ICD-10 Official Guidelines for Coding and Reporting
- American Association of Medical Audit Specialists National Health Care Billing Audit Guidelines
- National Correct Coding Initiative (NCCI) and Medically Unlikely Edits (MUE)
- Medicare Code Editor (MCE)
- Integrated Outpatient Code Editor (I/OCE)
- American Hospital Association Coding Clinic Guidelines
- UB-40 Data Specifications Manual

GlobalHealth does not reimburse for charges that do not adhere to industry standards of care. GlobalHealth utilizes but is not limited to the following resources:

- Industry standard UM criteria and/or care guidelines, including MCG™, Hayes, Inc., NCCN, CALOCUS or LOCAT (current edition on date of service)
- Social Security Act
- U.S. Food and Drug Administration Guidance
- National professional medical societies' guidelines and consensus statements
- Publications from specialty societies such as the American Society for Parenteral and Enteral Nutrition, American Thoracic Society, Infectious Diseases Society of America, etc.
- Department of Health and Human Services final rules, regulations, and instructions published in the Federal Register
- Nationally recognized, evidenced-based published literature from such sources as: World Health Organization, Medscape, American College of Cardiology Foundation/American Heart Association Task Force, American Diabetes Association, and American Psychiatric Association

Claim Denial

GlobalHealth will notify the provider of a denial or partial denial as outlined in the Agreement. This period may be extended one time by GlobalHealth, provided that GlobalHealth determines:

- An extension is necessary due to matters beyond its control;
- GlobalHealth notifies the provider and the Member, prior to the end of the initial review period, of why the extension is needed; and,
- The date by which GlobalHealth expects to render a decision.

If an extension is necessary because GlobalHealth does not have the information to decide the claim, the notice will specifically describe the required information. A response is required within the timeframe outlined in the Agreement.

If the claim was denied due to missing or incomplete information, the provider may resubmit the claim with the necessary information to complete the claim processing.

Provider Payment Disputes/Claim Reviews

A provider may request a claim review if any part of a claim submitted for payment is either fully or partially denied. The appropriate claim review form can be found on the All Forms & Resources page, https://www.globalhealth.com/oklahoma/providers/forms-and-resources/. Claim reviews may be resolved by attaching any pertinent documents to support the claim (e.g., sending proof of timely filing, sending a copy of the authorizations for claims denied for no authorization). The request for claim review must be submitted in writing and include the following:

- Member's name and address;
- GlobalHealth Member ID;
- Date of service if appealing a denied claim;
- Description of the denied service and why the claim review is being requested; and
- Copies of documentation to support the claim review request (e.g., claims, medical records, physician statements, and any other relevant information).

The time frame for submitting a claim review is located in your Agreement with GlobalHealth.

Claims Payment Recovery

If GlobalHealth overpays a claim for healthcare services, GlobalHealth may request a refund. When this occurs, the provider will be notified of any overpayment amount with a request for a refund. In the notification, GlobalHealth will provide the name of the Member for whom an overpayment was made, and the relevant date or dates of service. This notification process occurs within the timeframe specified in the Agreement. GlobalHealth may recoup overpayment amounts by subtracting such amounts from future payments. You can locate identifying information on the RA.

Laboratory Testing

If the Contracted Provider has a CLIA-approved lab on site, they may provide and bill for those tests if approved and contracted to perform them. All other test(s) must be performed at a laboratory facility that is contracted with GlobalHealth. If the Contracted Provider does not have a lab onsite, either refer the Member to a GlobalHealth contracted laboratory or draw and send the specimen to a GlobalHealth contracted laboratory.

Compliance Program

GlobalHealth has a written Compliance Program that incorporates the following elements:

- A designated Compliance Officer
- Written Code of Conduct
- Auditing and monitoring, including methods for detecting Fraud, Waste, and Abuse (FWA)
- Education and training
- Hotline for reporting compliance concerns
- Policies and procedures
- Remediation/corrective action when problems are identified

All Contracted Providers are expected to adhere to the GlobalHealth Compliance Program.

Compliance Officer

The Compliance Officer oversees the Compliance Program. Contracted Providers are encouraged to speak directly with the GlobalHealth Compliance Officer regarding any compliance matters, policy questions, or other concerns using the contact information provided in the Helpful Numbers and Information section of exhibit 1 or 2 depending on the Member's plan type.

Code of Conduct

All participating Providers are expected to adhere to the GlobalHealth Compliance Program, including the Code of Conduct. A link to the Code of Conduct can be found on the Compliance page of our website at https://www.globalhealth.com/oklahoma/compliance.

Auditing and Monitoring

FWA

GlobalHealth is committed to an effective FWA Program to detect, correct, and prevent FWA. Our FWA program is designed to uphold the highest standards of integrity in medical, pharmacy, and equipment/supply services by ensuring that services are reasonably protected from FWA, and/or non-compliant use, delivery, and billing of services.

The FWA program is part of the Compliance Department through its Special Investigations Unit (SIU) and has initiatives in place to detect, prevent, and control FWA.

Examples of potential FWA include, but are not limited to:

- Submission of false or fraudulent claims by a Provider
- Submission of claims for services that are not Medically Necessary
- Submission of claims for services that are not properly documented
- Failure to provide Medically Necessary services to a Member which adversely affects the Member
- Payments made for excluded drugs or drugs that were not for medically accepted indications
- Multiple billings for the same services

- Altered or forged documentation
- Billing or charging for services that GlobalHealth covers (other than Member cost share)
- Offering gifts or money for treatment or services that are not needed
- Offering free services, equipment, or supplies in exchange for using a GlobalHealth Member ID number
- A Member selling or lending their Member ID card to someone else
- Members lying to a Healthcare Provider to receive goods or services that are not Medically Necessary

FWA Program Components

Prevention

Ongoing education to Providers, Beneficiaries, Employees, and Contractors is performed throughout the year. System edits are also in place to prevent inappropriate payments.

Monitoring and Detection

The SIU performs periodic reviews of reports to detect potentially fraudulent claims. The SIU also performs evaluations of alerts received from any regulatory agency, Beneficiary, and/or Provider.

Auditing and Investigating

Outliers are carefully reviewed to determine if an investigation is necessary. If warranted, investigations are carried out by the SIU to identify instances of potential FWA, or non-compliance.

Action Plan Development and Execution

When findings during audits and/or investigations are identified, corrective actions are developed and applied to handle these issues and to prevent, stop, and report any potential FWA pattern.

Activity/Results Reporting

When potential FWA is identified, the situation is reported to our Providers and operational areas to ensure the implementation of applicable actions to stop and prevent the recurrence of any FWA pattern. Also, if potential fraud or abuse is detected, the issues are reported to regulatory and/or law enforcement agencies for further action, in accordance with our Compliance Program.

These components work collaboratively, allowing us to offer solutions for preventing, detecting, correcting, reporting and reducing FWA in a way that is comprehensive, timely and within CMS and business standards.

Current FWA alerts can be found on our website at https://www.globalhealth.com/oklahoma/fwa-alerts.

Audit

GlobalHealth reserves the right to audit claims and make or request adjustments. These decisions are made based on comparison of medical records to claim payments as well as determination of appropriateness of covered healthcare services. GlobalHealth reserves the right to perform on-site audits. Such audits may be conducted at random or selected based on data analysis. Certain claims present higher risk for payment errors and may be subject to pre- or post-payment audits.

Education and Training

FWA education and training is available on our website at https://www.globalhealth.com/oklahoma/compliance. Additionally, the GlobalHealth Compliance department will provide FWA and other compliance-related training to Contracted Providers upon request.

Hotline

Contracted Providers are expected to report known or suspected compliance violations. For any question about the Compliance Program or to report a concern, call our reporting line and leave a message. Please provide as much detailed information as possible. You may remain anonymous if you choose. You may email Compliance if you prefer. GlobalHealth will promptly investigate any reported potential violations of Federal or State laws, regulations, or other policies. Contact information is available in the Helpful Numbers and Information section of exhibit 1 or 2 depending on the Member's plan type.

All questions and concerns are thoroughly investigated by the Compliance Officer in a timely manner. GlobalHealth will not retaliate against anyone who, in good faith, reports an actual or potential violation of any Federal or State law or regulation or GlobalHealth policy.

Policies and Procedures

GlobalHealth maintains written policies and procedures to address compliance, ethical, and legal concerns. For questions, contact our Compliance Officer.

Remediation and Corrective Action

Compliance remediation is the process of recognizing problems, creating a plan to correct and prevent them from occurring in the future, and executing that plan. Follow-up auditing and monitoring is conducted to ensure the corrective action plan is being followed and is effective.

Quality Improvement Program (QIP)

GlobalHealth is committed to supporting quality healthcare and the preservation of good health. The QIP provides the framework to assess and improve the quality of care and services provided by Contracted Providers. It is based on a model that stresses a systematic, integrated approach to quality. The QIP is designed to meet statutory requirements. It adheres to standards, guidelines, and contractual requirements for health plans, including those published by CMS.

The program identifies issues and opportunities for improvement. The program consists of multi-disciplinary work groups, including GlobalHealth employees and Contracted Providers who:

- Monitor performance indicators.
- Analyze data.
- Implement changes to improve performance.

With a focus on providing high-quality, cost-effective healthcare, the use of the QIP will positively impact the:

- Improvement in processes and outcomes of care.
- Satisfaction of Members and Contracted Providers.
- Cost of healthcare services.

Quality Improvement Work Plan

GlobalHealth develops and implements a Quality Improvement Work Plan each year. The Work Plan monitors and evaluates healthcare delivery systems and health plan management activities. Its purpose is to ensure quality care and service.

Quality improvement activities are evaluated annually. GlobalHealth will implement changes to address identified opportunities and follow up in areas that need improvement.

Medicare Advantage Plan Ratings (Star Ratings)

Every year, CMS evaluates MA/MAPD plans based on a 5-star rating system. CMS scores how well plans perform in certain categories, including quality of care and customer service. Ratings range from 1 to 5 stars, with 5 being the highest and 1 being the lowest.

The **Overall Star Rating** combines scores for the types of services each health plan offers. For health plans covering health and drug services, the overall score for quality of those services covers many different topics that fall into the following categories:

- **Staying healthy:** screenings, tests, and vaccines. Includes whether Members got various screening tests, vaccines, and other check-ups that help them stay healthy.
- **Managing chronic (long-term) conditions:** Includes how often Members with different conditions got certain tests and treatments that help them manage their condition.
- **Member experience with the health plan:** Includes ratings of Member experience with the health plan.

- **Member complaints and changes in the health plan's performance:** Includes how often Medicare found problems with the health plan and how often Members had problems with the health plan. Includes how much the health plan's performance has improved (if at all) over time.
- **Health plan customer service:** Includes how well the health plan handles Member appeals.
- **Drug plan customer service:** Includes how well the health plan handles Member appeals.
- **Member complaints and changes in the drug plan's performance:** Includes how often Medicare found problems with the health plan and how often Members had problems with the plan. Includes how much the health plan's performance has improved (if at all) over time.
- **Member experience with plan's drug services:** Includes ratings of Member experience with the health plan.
- **Drug safety and accuracy of drug pricing:** Includes how accurate the health plan's pricing information is and how often Members with certain medical conditions are prescribed drugs in a way that is safer and clinically recommended for their condition.

Medicare Advantage Quality Portal

GlobalHealth offers a Quality Portal. This Portal allows both Providers and Provider Administrators the ability to see real time updates for both Part C and Part D Stars Scores. The Portal can be accessed at https://qualityportal.globalhealthportals.com/. Reporting and User Guides can be accessed at https://www.globalhealth.com/oklahoma/providers/provider-portals/.

Preventive Care and Clinical Practice Guidelines

GlobalHealth adheres to all applicable preventive care guidelines. Not everyone needs every preventive service. You should determine which services are right for each individual Member. Refer to the Centers for Disease Control and Prevention for additional guidance.

CMS requires coverage at no cost share to MA/MAPD Members for the following services:

Alcohol Misuse Screening & Counseling

Annual Wellness Visit

Bone Mass Measurements

Cardiovascular Disease Screening Tests

Colorectal Cancer Screening

Counseling to Prevent Tobacco Use

Depression Screening

Diabetes Screening

Diabetes Self-Management Training

Glaucoma Screening

Hepatitis B Vaccine & Administration for high or intermediate risk Members

Hepatitis B Virus Screening

Hepatitis C Virus Screening

HIV Screening

IBT for Cardiovascular Disease

IBT for Obesity

Influenza Virus Vaccine & Administration

Initial Preventive Physical Examination

Lung Cancer Screening

Medical Nutrition Therapy

Medicare Diabetes Prevention Program

Pneumococcal Vaccine & Administration

Pre-Exposure Prophylaxis (PrEP)

Prostate Cancer Screening

Screening for Cervical Cancer

Screening for STIs and HIBC to Prevent STIs

Screening Mammography	Screening Pelvic Examinations
Screening Pap Tests	Ultrasound Screening for AAA

Medical Review Program

As part of our quality improvement efforts, GlobalHealth recognizes the CMS Hospital Readmissions Reduction Program (HRRP) and Hospital-Acquired Conditions Reduction Program (HACRP). GlobalHealth expects its Contracted Providers to follow established evidence-based standards of care.

Contracted Providers are expected to make medical records and other requested information available to support the review of services rendered. EMR access will be utilized when possible to complete the reviews. GlobalHealth encourages providers to allow EMR access to facilitate coordination of care and support plan operations in a timely, cost-efficient manner.

Cases that may be subject to review include, but are not limited to, reasonably avoidable readmissions, potential coding discrepancies, and clinical concerns such as preventable complications, Never Events (NE) or Serious Reportable Events (SRE) as defined by the National Quality Forum (NQF) and CMS, quality of care provided, and associated prepayment and post-payment facility and professional claims. Cases may be referred from, but are not limited to, Utilization Management (UM), Claims, Customer Care, Claims Payment Accuracy, or Compliance Departments, and Members.

Never Events include:

- Surgery or invasive procedure events
- Product or device events
- Patient protection events
- Care management events
- Environmental events
- Radiologic events
- Potential criminal events

Examples of NE include wrong patient, wrong surgical site, procedure errors, medication errors, inappropriate restraint usage, delayed treatment, incompatible blood group hemolytic transfusion reactions, stage III and stage IV pressure ulcers, and falls or trauma resulting in death or serious disability.

GlobalHealth does not reimburse for additional costs associated with these types of concerns or events.

A reasonably avoidable readmission (as defined by CMS) is a readmission to the same acute care hospital within 30 days of hospital discharge for the same, similar, or related conditions.

Clinical concerns include, but may not be limited to, preventable hospital-acquired or associated conditions (HAC) as defined by CMS, surgical complications including accidental lacerations and punctures, preventable perioperative or postoperative conditions (as defined by CMS), development of infections during hospitalization, premature discharge, inadequate discharge planning and/or failure to identify or treat HAC prior to discharge.

Presumption of “preventable” complications includes consideration if the condition contributed to the need for:

- Additional procedures or surgery
- Higher inpatient level of care

- Extended hospitalization
- Placed the Member at risk for or subjected to serious harm or death

Potential coding discrepancies include but may not be limited to:

- Hospital-assigned diagnosis code(s) unsupported in the medical record
- Hospital failure to assign primary/secondary diagnosis code
- Invalid/incorrect hospital-assigned primary or secondary diagnosis code(s)
- Incorrect hospital assignment of present/not present on admission (POA) status

GlobalHealth reserves the right to audit claims and make or request adjustments based on comparison of medical records to claims payment, as well as determine the appropriateness of covered health services furnished by provider. GlobalHealth reserves the right to perform onsite audits. Provider agrees to cooperate with such reasonable audit requests.

Member Complaints and Grievances

If a Member files a complaint against a provider, GlobalHealth will contact the provider for additional information, which may include a request for an explanation or medical records, to ensure all the facts are obtained before responding to the grievance. GlobalHealth requests that Providers respond to requests as soon as possible and no later than 15 days so the response can be included in the investigation. GlobalHealth is subject to timeliness standards that require a response within a specific period. A quick response to the inquiry will ensure compliance with State, Federal, and CMS regulations.

Complaints and grievances related to prescription benefits covered by the PBM will be reviewed by the PBM. Complaints and grievances related to mental health services covered by Carelon Behavioral Health will be reviewed by Carelon Behavioral Health.

Resources

Hospital Readmission Reduction Program: www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html

Hospital-Acquired Condition Reduction Program: www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/HAC-Reduction-Program.html

HEDIS®

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. HEDIS® is part of a nationally recognized quality improvement initiative. Because so many health plans collect HEDIS® data, and because the measures are so specifically defined, HEDIS® makes it possible to compare the performance of health plans on an "apples-to-apples" basis. Health plans also use HEDIS® results themselves to see where they need to focus their improvement efforts.

HEDIS® is used by CMS to monitor the performance of managed care organizations. Data are collected for measures related to preventive care. As a health plan, GlobalHealth is responsible for collecting data on these performance measures and one of the ways to do that is through medical record review. Each year, a sample of medical records is randomly selected for review to ensure quality care is being provided to GlobalHealth Members. If the data are not found in these medical records, additional medical record reviews may be required.

GlobalHealth requests HEDIS® records all year and during a HEDIS® reporting drive each spring. Contracted Provider office assistance throughout the year minimizes the number of records needed in the HEDIS® season. GlobalHealth will use EMR access when possible to conduct the reviews or provider will permit on-site access to review patient medical records or other documentation.

There are several ways GlobalHealth may send record requests for HEDIS® purposes. Frequently fax requests are sent with detailed instructions on how to return the request. GlobalHealth also employs auditors that may call to schedule an on-site visit to review appropriate medical records. They will provide a detailed list of information to prepare for the visit. We ask that Contracted Provider offices schedule these visits quickly on a day that is convenient. These visits are not a "pass or fail" situation. GlobalHealth is simply reviewing records to determine if they meet HEDIS® measure compliance. In some cases, the auditor may make recommendations on changes to improve your overall compliance. Any questions about HEDIS® record review should be directed to the contact information that is provided in the request.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS® is designed to provide purchasers and consumers with the information they need to reliably compare the performance of healthcare plans.

CAHPS®

GlobalHealth participates in the CAHPS® survey, which asks Members about their experience with their care in areas such as provider communication, access to care, getting care quickly, claims processing, and customer service. These surveys are distributed annually to a random sample of GlobalHealth Members. These questions are affected by provider intervention and should be reviewed annually with your assigned membership.

Survey questions include:

- Access to timely care
- Preventive care counseling
- Discussion of treatment options – including pros and cons
- Understandability of physician explanations
- Physician listened, showed respect, and quality time with Member
- Follow-up of test results with Member
- Medication review with Member
- Ease of access to Specialist Physicians
- Care Coordination
- Annual flu vaccine

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Patient Rights and Protections

As a partner with GlobalHealth, you should be aware of Medicare's patient rights and protections. Please visit the Medicare website for more information: https://www.medicare.gov/basics/your-medicare-rights

Rights for everyone with Medicare:

- Be treated with courtesy, dignity, and respect at all times

- Be protected from discrimination. Every company or agency that works with Medicare must obey the law. Patients can't be treated differently because of their race, color, national origin, disability, age, religion, or sex.
- Have their personal and health information kept private
- Have access to doctors, specialists, and hospitals for medically necessary services
- Get Medicare-covered services in an emergency
- Get information in a way they understand from Medicare, health care providers, and, under certain circumstances, contractors.
- Learn about their treatment choices in clear language that they can understand and participate in treatment decisions.
- Get Medicare information and health care services in a language they understand.
- Get their Medicare information in an accessible format, like braille or large print.
- Get answers to their Medicare questions.
- Get a decision about health care payment, coverage of items and services, or drug coverage. When they or their provider file a claim, they'll get a notice letting them know what will and won't be covered. This notice comes from one of these:
    - Medicare
    - Medicare Advantage Plan (Part C) or other Medicare health plan
    - Medicare drug plan for Medicare drug coverage (Part D)

If they disagree with the decision of their claim, they have the right to file an appeal. They may:

- Request a review (appeal) of certain decisions about health care payment, coverage of items and services, or drug coverage.
- Be able to file complaints (sometimes called "grievances"), including complaints about the quality of their care. They can file a complaint if they have concerns about the quality of care and other services they get from a Medicare provider.
- In addition to the rights and protections listed above, patients in an MA plan also have the right to:
- Choose health care providers within the plan.
- Get a treatment plan from their doctor.
    - If they have a complex or serious medical condition, a treatment plan lets them directly see a specialist within the plan as many times as they and their doctor think they need.
    - Women have the right to go directly to a women's health care specialist without a referral within the plan for routine and preventive health care services.
- Know how their doctors are paid.
    - When they ask their plan how it pays its doctors, the plan must tell them.
    - Medicare doesn't allow a plan to pay doctors in a way that could interfere with them getting the care they need.

- Request an appeal to resolve differences with their plan.
- File a complaint (grievance) about other concerns or problems with their plan.
- Get a coverage decision or coverage information from their plan before getting services.

In addition to the rights and protections listed above, patients in an MAPD plan also have the right to:

- Get a written explanation for drug coverage decisions (coverage determinations) from their Medicare drug plan
    - A coverage determination is the first decision the Medicare drug plan (not the pharmacy) makes about their benefits. This can be a decision about if their drug is covered, if they met the plan's requirements to cover the drug, or how much they pay for the drug.
    - They'll also get a coverage determination decision if they ask their plan to make an exception to its rules to cover their drug.
- File a complaint (grievance) with the plan.
- Have the privacy of their Medicare health and drug information protected.

Risk Adjustment Program

Risk adjustment is required by the U.S. Department of Health and Human Services (HHS) by utilizing Hierarchical Conditional Categories (HCC) to calculate a patient risk score that annually represents the burden of each individual Member's disease. In order to achieve the calculation, CMS and HHS require us to annually provide demographic and health status of our MA/MAPD Members. All existing and chronic conditions must be evaluated and documented each calendar year as the patient diagnoses do not carry forward from year to year. The diagnosis codes and risk adjustment date you submit must be complete and accurate.

GlobalHealth and providers have a mutual interest in ensuring (1) the provision of quality care to Members including the assessment and treatment of existing medical conditions, that is supported by appropriate medical record documentation; (2) the correct assignment of diagnosis and/or procedure coding for services rendered to Members; and (3) the submission of accurate claims to GlobalHealth. Contracted Providers are expected to participate in the diagnosis coding review process, which includes the use of an individual Member Condition Report that contains all Risk Adjustment related conditions for a given member, OR an Open Gaps Report which contains all Risk Adjustment related conditions for a Provider and/or Provider Group that remain open for the current year. These conditions may be either historically captured for the member or suspected conditions. GlobalHealth conducts HCC reviews all year. In order to provide the required documentation, GlobalHealth requests records from Contracted Providers.

- Provider will evaluate, treat, and appropriately document and code all conditions identified during office visits.
- Provider will review the Member Condition Report and/or the Open Gaps Report for accuracy and completeness when applicable. Completed Member Condition Reports may be returned to GlobalHealth Medicare Risk Adjustment Department.
- Provider will use best efforts to coordinate with SCPs to ensure accuracy and completeness of the medical record.
- GlobalHealth will use EMR access, when possible, to conduct the reviews.
- Provider will be reasonably available for risk adjustment meetings.
- Risk Adjustment meetings may address, but are not limited to, the following:
    - Specific coding and documentation concerns and/or questions
    - Unaddressed diagnosis coding gaps

Credentialing and Re-Credentialing

GlobalHealth (including its delegated entity/entities, if applicable) does not discriminate in the selection of Providers based on race, religion, age, ethnicity, or gender factors.

Council for Affordable Quality Healthcare (CAQH) is our preferred credentialing application source. This application is free to providers. Access CAQH at https://proview.caqh.org. If a Provider does not have a CAQH number, please contact the Credentialing Department for a standardized application.

You have the right to request the status of your credentialing application, correct erroneous information, and to review the information we obtained that pertains to our credentialing decision.

Provider Credentialing Requirements

The following requirements must be met to become a credentialed Provider:

- Current unrestricted State license
- Graduation from an appropriately accredited medical or professional school
- Completion of a formal accredited training program
- Current and unrestricted DEA certificate and Controlled Dangerous Substance certificate, if applicable
- Board certification or Board eligibility, if applicable
- Enrolled for Medicare participation
- Not on the Medicare Preclusion or Exclusion List
- Current and unrestricted admitting privileges in good standing at a GlobalHealth contracted hospital, if applicable
- Demonstration of current professional liability insurance minimum requirements
- Absence of history of involvement in malpractice suit, arbitration, or settlement; or in the case of an applicant with such history, evidence that the history does not demonstrate probable future substandard professional performance
- Absence of history of denial, suspension, restriction, or termination of hospital privileges; or in the case of an applicant with such history, evidence that this history does not currently affect applicant's ability to perform professional duties for which the applicant contracted or does not demonstrate probable future substandard performance
- Absence of a history of disciplinary actions affecting applicant's professional license, DEA, or other required certifications; or, for applicants with such history, evidence that this history does not currently affect applicant's ability to perform professional duties for which the applicant contracted or does not demonstrate probable future substandard performance
- Absence of history of felony convictions; or for an applicant with such history, evidence that the nature of the conviction does not affect applicant's current ability to perform the professional duties for which applicant contracted or does not demonstrate probable future substandard care

- Absence of history of exclusions or sanctions by regulatory agencies, including Medicare/Medicaid sanctions; or for an applicant with such history, evidence that applicant is not currently sanctioned or prevented by a regulatory agency from participating in any Federal or State sponsored programs
- Absence of chemical dependency/substance misuse; or for those applicants who have such history, evidence that the applicant is participating in, or has completed, a prescribed, monitored treatment program and that no current chemical dependency or substance misuse exists that would affect applicant's ability to adequately perform the professional duties for which applicant is contracted
- Absence of physical or mental condition that would impair the ability to competently and safely perform the professional duties for which the applicant is seeking
- Evidence of the capability to provide 24 hours a day, 7 days a week coverage, if applicable
- Work history for at least the past five years
- Cooperation with office surveys, which may include a structured review of the office site and evaluation of the medical recordkeeping system and practices, if applicable

Advanced Practice Registered Nurse (APRN) Credentialing Requirements

In addition to the Provider Credentialing Requirements above, APRNs must have a board certificate from an accredited nursing board, as well as a supervising physician as required by the state nursing board. If acting as a PCP, at least one supervising physician must be a Contracted Provider with GlobalHealth.

Physician Assistant (PA) Credentialing Requirements

In addition to the Provider Credentialing Requirements above, PAs must have a supervising physician as required by the state physician assistant board.

Hospital and Facility Credentialing Criteria

To be credentialed as a hospital or facility within the GlobalHealth network, the entity must be licensed in good standing with State and Federal regulatory bodies. Additionally, the entity must be accredited by an approved accrediting body such as The Joint Commission (TJC) or equivalent. If the entity is not accredited, GlobalHealth may require an on-site review to ensure the entity meets quality standards established by TJC and GlobalHealth and/or a current (within the past 36 months) copy of a state licensing agency Site Visit Report. Any deficiencies identified during the on-site visit are communicated to the entity with a request for a corrective action plan within GlobalHealth's requested timeframe. Failure to correct deficiencies in a timely manner may result in a determination not to credential the organization. GlobalHealth will confirm the entity continues to be licensed and in good standing with State and Federal bodies at least once every 36 months.

Hospital and/or Contracted Facility must provide the following:

- Submit a completed GlobalHealth "Ancillary & Facility Application" along with the necessary attachments:
    - Evidence of Medicare certification
    - Copy of current accreditation approval letter (e.g., TJC) and state licensure or waiver upon renewal with issuing body

- A current and unrestricted DEA certificate, Controlled Dangerous Substance certificate, CLIA/CAP certification if applicable, and any other relevant certifications
- W-9
- Current unrestricted state license
- Demonstration of current professional liability insurance minimum requirements

Entities must also have an acceptable malpractice claims history as approved by GlobalHealth.

Re-credentialing

To remain in the GlobalHealth network, all Contracted Providers must be re-credentialed, at a minimum, every 36 months. Providers are expected to submit all appropriate documentation to ensure reappointment is timely. Information and status inquiries can be submitted to the Credentialing department using the contact information in the Helpful Numbers and Information section of exhibit 1 or 2 depending on the Member's plan type.

Credentialing/Re-credentialing Appeal Process

GlobalHealth will:

- Provide written notification within ten (10) days when a provider has been denied participation in the GlobalHealth network which will include reasons for the denial and what corrective actions the applicant may consider regarding the denied application.
- Allow practitioners to request a hearing and provide the specific time period for submitting the request.
- Allow up to 30 calendar days after the notification for practitioners to request a hearing.
- Allow practitioners to be represented by a legal representative or another entity of their choice.
- Appoint a hearing officer or a panel of individuals to review the appeal. This panel will include, at a minimum, the GlobalHealth Medical Director, or designated MD or equivalent practitioners, GlobalHealth Compliance Officer, GlobalHealth Vice President of Provider Relations, and one network practitioner to participate in the appeal. Designees may be included as needed.
- Provide written notification of the appeal decision within 10 business days. When applicable, notification will contain the specific reason for the decision.
- Follow all applicable State law requirements.
- There are no appeal rights and processes when a practitioner is terminated or denied for administrative reasons, including but not limited to the following:
  - Network need
  - Failure to comply with credentialing or recredentialing process
  - Failure to meet the terms of minimum licensure
  - Failure to comply with the Agreement

Regulations

GlobalHealth takes all reasonable steps and uses best efforts to comply with applicable laws and regulations. The regulations include, but are not limited to:

- The Health Information Technology for Economic and Clinical Health (HITECH)
- The False Claims Act (FCA) and Fraud Enforcement Recovery Act (FERA)
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- The Physician Self-Referral Law (Stark Law)
- The Medicare Improvements for Patients and Providers Act (MIPPA)
- The Anti-Kickback Statute
- The Americans with Disabilities Act (ADA)

As a Contracted Provider in the GlobalHealth network, you are also expected to comply with these laws and regulations.

The Health Information Technology for Economic and Clinical Health (HITECH)

The Health Information Technology for Economic and Clinical Health (HITECH) Act was signed into law to promote the adoption and meaningful use of health information technology.

The False Claims Act (FCA) and Fraud Enforcement Recovery Act (FERA)

The Federal False Claims Act (FCA) was enacted by Congress as an effective tool in combating fraud against the Federal government. It prohibits any person from knowingly making a false statement or claim for payment from the Federal government. It also allows a private individual or “whistleblower”, who has knowledge of fraud of the Federal government, to file a lawsuit on behalf of the government resulting in stiff penalties and damages. The Fraud Enforcement and Recovery Act (FERA), enacted in 2009, implemented significant changes to the FCA, including the expansion of prohibited conduct under the FCA to include not just the improper filing to collect monies, but also the known retention of overpayments by healthcare providers (also known as “Reverse False Claims”).

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The HIPAA Privacy Rule provides protections for individually identifiable health information held by covered entities and their business associates and gives patients an array of rights with respect to that information. The Privacy Rule is balanced as it permits the disclosure of health information needed for patient care and other important purposes.

Members’ identifiable health information is protected by Federal and State laws. Members have the right to access or restrict the release of their protected health information (PHI) in accordance with Federal and State laws. They may also request an accounting of disclosures of your PHI.

Medical records and/or information may be disclosed and used between GlobalHealth and Providers, without the Member’s written authorization, for purposes related to treatment, payment, and plan operations.

To report a possible privacy violation or breach, please contact the GlobalHealth Compliance and Privacy Officer using the contact information on the Helpful Numbers page of exhibit 1 or 2 depending on the Member's plan type.

The HIPAA Security Rule establishes national standards to protect individuals' electronic PHI that is created, received, used, or maintained by a covered entity, like a provider or health plan. The Security Rule requires appropriate administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and security of electronic PHI.

Notice of Privacy Practices (NPP)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

GlobalHealth is committed to and required to protect the privacy and confidentiality of our Members' Protected Health Information ("PHI") in compliance with applicable federal and state laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act. This HIPAA Notice of Privacy Practices (the "Notice") contains important information regarding the member's PHI. Our current Notice is posted at www.globalhealth.com.

How GlobalHealth May Use or Disclose Your Health Information

For Treatment. We may use and/or disclose your PHI to a healthcare provider, hospital, or other healthcare facility in order to arrange for or facilitate treatment for you.

For Payment. We may use and/or disclose your PHI for purposes of paying claims from physicians, hospitals, and other healthcare providers for services delivered to you that are covered by your health plan; to determine your eligibility for benefits; to coordinate benefits; to review for medical necessity; to obtain premiums; to issue explanations of benefits to the individual who subscribes to the health plan in which you participate; and other payment related functions.

For Health Plan Operations. We may use and/or disclose PHI about you for health plan operational purposes. Some examples include: risk management, patient safety, quality improvement, internal auditing, utilization review, medical or peer review, certification, regulatory compliance, internal training, accreditation, licensing, credentialing, investigation of complaints, performance improvement, etc. We will not use or disclose your genetic information for underwriting purposes.

Health-Related Business and Services. We may use and disclose your PHI to tell you of health-related products, benefits, or services related to your treatment, care management, or alternate treatments, therapies, providers, or care settings.

Where Permitted or Required by Law. We may use and/or disclose information about you as permitted or required by law. For example, we may disclose information:

- To a regulatory agency for activities including, but not limited to, licensure, certification, accreditation, audits, investigations, inspections, and medical device reporting;
- To law enforcement upon receipt of a court order, warrant, summons, or other similar process;
- In response to a valid court order, subpoena, discovery request, or administrative order related to a lawsuit, dispute, or other lawful process;
- To public health agencies or legal authorities charged with preventing or controlling disease, injury, or disability;

- For health oversight activities conducted by agencies such as the Centers for Medicare and Medicaid Services ("CMS"), State Department of Health, Insurance Department, etc.;
- For national security purposes, such as protecting the President of the United States or the conducting of intelligence operations;
- In order to comply with laws and regulations related to Workers' Compensation;
- For coordination of insurance or Medicare benefits, if applicable;
- When necessary to prevent or lessen a serious and imminent threat to a person or the public and such disclosure is made to someone that can prevent or lessen the threat (including the target of the threat);
- In the course of any administrative or judicial proceeding, where required by law.

Business Associates. We may use and/or disclose your PHI to business associates that we contract with to provide services on our behalf. Examples include consultants, accountants, lawyers, auditors, health information organizations, data storage and electronic health record vendors, etc. We will only make these disclosures if we have received satisfactory assurance that the business associate will properly safeguard your PHI.

Personal/Authorized Representative. We may use and/or disclose PHI to your authorized representative. Family, Friends, Caregivers. We may disclose your PHI to a family member, caregiver, or friend who accompanies you or is involved in your medical care or treatment, or who helps pay for your medical care or treatment. If you are unable or unavailable to agree or object, we will use our best judgment in communicating with your family and others.

Emergencies. We may use and/or disclose your PHI if necessary in an emergency if the use or disclosure is necessary for your emergency treatment.

Military/Veterans. If you are a member or veteran of the armed forces, we may disclose your PHI as required by military command authorities.

Inmates. If you are an inmate of a correctional institute or under the custody of law enforcement officer, we may disclose your PHI to the correctional institute or law enforcement official.

Appointment Reminders. We may use and/or disclose your PHI to contact you as a reminder that you have an appointment for treatment or medical care. This may be done through direct mail, email, or telephone call. If you are not home, we may leave a message on an answering machine or with the person answering the telephone.

Medication and Refill Reminders. We may use and/or disclose your PHI to remind you to refill your prescriptions, to communicate about the generic equivalent of a drug, or to encourage you to take your prescribed medications.

Limited Data Set. If we use your PHI to make a "limited data set", we may give that information to others for purposes of research, public health action or health care operations. The individuals/entities that receive the limited data set are required to take reasonable steps to protect the privacy of your information.

Other Uses. If you are an organ donor, we may release your medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation or transplantation. We may release your medical information to a coroner or medical examiner.

NOTE: We will disclose your PHI for purposes not described in this notice only with your written authorization. Most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of PHI for marketing or fundraising purposes, and disclosures that constitute a sale of PHI require your written authorization. The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease required to be reported pursuant to State law.

Your Health Information Rights

Right to Inspect and Copy

You have the right to inspect and copy your PHI as provided by law. This right does not apply to psychotherapy notes. Your request must be made in writing. We have the right to charge you the amounts allowed by State and Federal law for such copies. We may deny your request to inspect and copy your records in certain circumstances. If you are denied access, you may appeal to our Privacy Officer.

Right to Confidential Communication

You have the right to receive confidential communication of your PHI by alternate means or at alternative locations. For example, you may request to receive communication from us at an alternate address or telephone number. Your request must be in writing and identify how or where you wish to be contacted. We reserve the right to refuse to honor your request if it is unreasonable or not possible to comply with.

Right to Accounting of Disclosures

You have the right to request an accounting of certain disclosures of your PHI to third parties, except those disclosures made for treatment, payment, or health care or health plan operations and disclosures made to you, authorized by you, or pursuant to this Notice. To receive an accounting, you must submit your request in writing and provide the specific time period requested. You may request an accounting for up to six (6) years prior to the date of your request (three years if PHI is an electronic health record). If you request more than one (1) accounting in a 12-month period, we may charge you for the costs of providing the list. We will notify you of the cost and you may withdraw your request before any costs are incurred.

Right to Request Restrictions on Uses or Disclosures

You have the right to request restrictions or limitations on certain uses and disclosures of your PHI to third parties unless the disclosure is required or permitted by law. Your request must be made in writing and specify (1) what information you want to limit; (2) whether you want to limit use, disclosure, or both; and (3) to whom you want the limits to apply. We are not required to honor your request. If we do agree, we will make all reasonable efforts to comply with your request unless the information is needed to provide emergency treatment to you or the disclosure has already occurred or the disclosure is required by law. Any agreement to restrictions must be signed by a person authorized to make such an agreement on our behalf.

Right to Request Amendment of PHI

You have the right to request an amendment of your PHI if you believe the record is incorrect or incomplete. You must submit your request in writing and state the reason(s) for the amendment. We will deny your request if: (1) it is not in writing or does not include a reason to support the request; (2) the information was not created by us or is not part of the medical record that we maintain; (3) the information is not a part of the record that you would be permitted to inspect and copy, or (4) the information in the record is accurate and complete. If we deny your amendment request, you have a right to file a statement of disagreement with our Privacy Officer.

Right to Be Notified of a Breach

You have the right to receive notification of any breaches of your unsecured PHI.

Right to Revoke Authorization

You may revoke an authorization at any time, in writing, but only as to future uses or disclosures and not disclosures that we have made already, acting on reliance on the authorization you have given us or where authorization was not required.

Right to Receive a Copy of this Notice

You have the right to receive a paper copy of this Notice upon request.

Changes to this Notice

GlobalHealth is required to comply with the requirements of this Notice currently in effect. We reserve the right to change this Notice and make the new provisions effective for all PHI that we maintain. The revised Notice will be made available to you on our website at www.globalhealth.com.

To Report a Privacy Violation

If you have a question concerning your privacy rights or believe your rights have been violated, please contact our Privacy Officer at:

GlobalHealth
ATTN: Privacy Officer
210 Park Avenue
Suite 2900
Oklahoma City, OK 73102

Toll-free 1-877-627-0004

Email privacy@globalhealth.com

GlobalHealth, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. GlobalHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

GlobalHealth:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact GlobalHealth's Customer Care at 1 (844) 280-5555 (toll-free) (TTY:711).

If you believe that GlobalHealth has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

ATTN: Medicare Compliance Officer
210 Park Ave
Suite 2900
Oklahoma City, OK 73102-5621

Email: compliance@globalhealth.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Customer Care is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Please be advised that most Third-Party Apps will not be covered by HIPAA. Most apps will instead fall under the jurisdiction of the Federal Trade Commission (FTC) and the protections provided by the FTC Act. The FTC Act, among other things, protects against deceptive acts (e.g., if an app shares personal data without permission, despite having a privacy policy that says it will not do so). If you have any concerns regarding the use of Third-Party App's and your information you may contact the Federal Trade Commission (FTC) and file a complaint at https://reportfraud.ftc.gov/#/.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-280-5555 (TTY: 711)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-280-5555 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-280-5555 (TTY: 711).**Effective Date: 10/01/2023**

Original Notice: 04/01/2003

Revised: 04/01/2011
04/01/2013
08/01/2021
10/01/2023

Personally Identifiable Information (PII)

PII is information that can be used to distinguish or trace an individual's identity. It may be information used alone. It may be combined with other information that may be linked to a specific individual. It is protected by Federal and State laws.

As a GlobalHealth provider, anyone who receives information that you are required to provide may use the information only for the purposes of, and to the extent necessary in, ensuring the efficient operation of the Member's health coverage. GlobalHealth may receive the information directly, from another person, or from a Federal agency. GlobalHealth will not share PII with anyone else except to carry out the functions of providing a Member's health coverage and for which the Member has provided consent for the information to be used or disclosed.

Physician Self-Referral Law (Stark Law)

The Physician Self-Referral Law prohibits a physician from referring a patient for designated health services (DHS) to an entity in which he or she (or their immediate family member) has a financial interest, either directly or indirectly, unless an exception applies. CMS published the self-referral disclosure protocol (SRDP) that sets forth a process to enable healthcare providers to self-disclose actual or potential violations of the physician self-referral statute.

The Medicare Improvements for Patients and Providers Act (MIPPA)

The Medicare Improvements for Patients and Providers Act (MIPPA) supports states and tribes through grants to provide outreach and assistance to eligible Medicare beneficiaries to apply for benefit programs that help to lower the costs of their Medicare premiums and deductibles. Grantees help educate beneficiaries about the Low-Income Subsidy (LIS) program for Medicare Part D, Medicare Savings Programs (MSPs), and Medicare Preventive Services. This initiative includes special efforts to target rural areas and Native American elders.

The Anti-Kickback Statute

The Federal Anti-Kickback Statute prohibits the willful and knowing acceptance of solicitations or offers of any remuneration, directly or indirectly, overtly or covertly, in cash or in kind regarding influencing referrals for the Federal healthcare program business. Violators may face charges and/or penalties including being debarred from participation in federal programs.

The Americans with Disabilities Act

The Americans with Disabilities Act (ADA) prohibits discrimination against people with disabilities in several areas, including employment, transportation, public accommodations, communications, and access to state and local government programs and services. Provider's offices are required to adhere to ADA guidelines and any other applicable Federal or State laws.

Special Needs

Limited English Proficiency, Vision, Hearing, or Physically Challenged: Contact Customer Care if you have a Member who requires the services of an interpreter or who has special language needs (e.g., is visually and hearing impaired or who is physically disabled). GlobalHealth offers professionally certified medical interpreters. Please have Members call the Customer Care Number on the back of their ID card.

Non-Discrimination Notice

GlobalHealth, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), sex (consistent with the scope of sex discrimination described at § 92.101(a)(2)), age, or disability.

GlobalHealth, Inc.:

- Provides reasonable modifications for individuals with disabilities and appropriate auxiliary aids and services, including:
    - Qualified interpreters for individuals with disabilities
    - Information in alternate formats, such as braille or large print, free of charge and in a timely manner, when such modifications, aids, and services are necessary to ensure accessibility and an equal opportunity to participate to individuals with disabilities
    - Provides language assistance services, including electronic and written translated documents and oral interpretation, free of charge and in a timely manner, when such services are a reasonable step to provide meaningful access to an individual with limited English proficiency

If you need reasonable modifications, appropriate auxiliary aids and services, or language services, contact GlobalHealth's Customer Care at 1 (844) 280-5555 (toll-free). Our hours of operations are Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31. From April 1 to September 30 are Monday through Friday 8:00 a.m. to 8:00 p.m. TTY users should call 711.

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, sex, age, or disability, our Section 1557 Coordinator is available to help you. You can file a grievance in person, or by mail, fax, or email:

Mailing address:	GlobalHealth Section 1557 Coordinator P.O. Box 2658 Oklahoma City, OK 73101-2658
Telephone number:	1-844-280-5555 8:00 a.m. to 8:00 p.m., seven days a week, from October 1 through March 31. 8:00 a.m. to 8:00 p.m., Monday to Friday, from April 1 through September 30.
TTY number:	711
Fax number:	405-280-5294
Email:	section1557coordinator@globalhealth.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.

This notice is available at our website: www.globalhealth.com.

Frequently Asked Questions

How can I learn more about using the Portal?

Attend a training session: https://www.globalhealth.com/oklahoma/providers/provider-training/

How do I inform GlobalHealth of changes to my practice demographics?

Use the Provider Update Form: https://www.globalhealth.com/oklahoma/providers/provider-update-form/

How can I verify a member's eligibility?

Use the Provider Portal: https://ghprovider.prod.healthaxis.net/

How can I request a referral/prior authorization?

For Part C/medical issues, use the Provider Portal: https://ghprovider.prod.healthaxis.net/

For Part D, contact CVS Caremark: (866) 494-3927

For pharmacy authorizations for commercial members, contact CVS Caremark: (800) 424-1789

How can I file a claim?

GlobalHealth's preferred clearinghouse is Change Healthcare (Emdeon), and our EDI number is GHOKC0001

How can I check claim status?

Use the Provider Portal: https://ghprovider.prod.healthaxis.net/

How can I check payment status?

Use Zelis: https://www.zelis.com/providers/

How can I file a claim reconsideration?

Use the form in the Claims section of the Provider Forms & Resources page: https://www.globalhealth.com/oklahoma/providers/forms-and-resources/

Where can I find RAs/Explanation of Payment?

Use Zelis: https://www.zelis.com/providers/

Who can I contact with questions about claims/payments?

For individual issues, call Provider Services at (844) 280-5555 (MA/MAPD) or (877) 280-5600 (Commercial). For multiple issues, send an email to providerservices@globalhealth.com.

Who can I contact with questions about my contract?

Email Provider Relations at provider.relations@globalhealth.com

Where can I find forms?

https://www.globalhealth.com/oklahoma/providers/forms-and-resources/

Exhibit 1: Oklahoma Generations MA/MAPD Plans

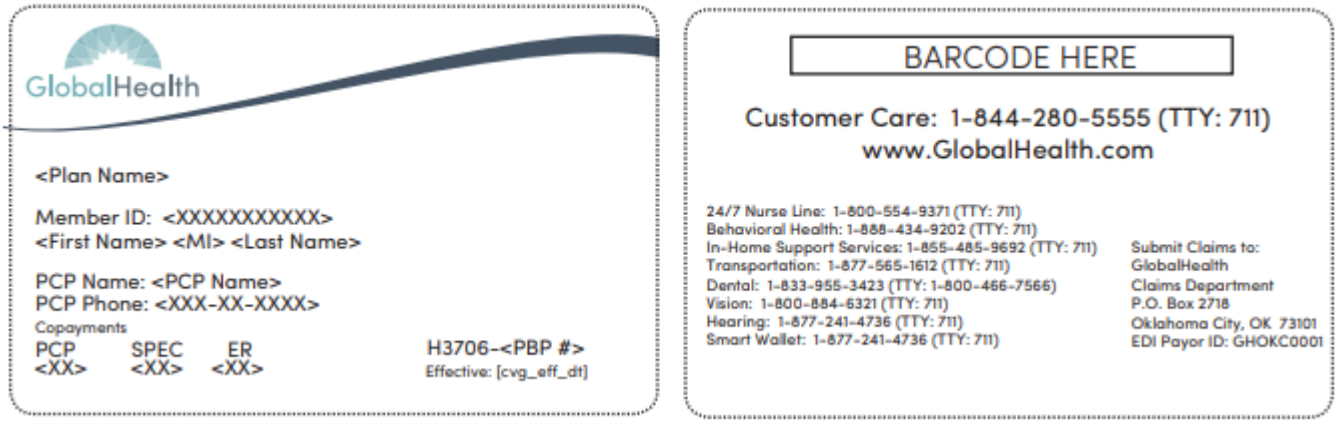
This Exhibit contains information specific to GlobalHealth's Oklahoma MA/MAPD Plans.

Page 8: GlobalHealth Products

Sample GlobalHealth Member ID Cards

Medicare Advantage with Drug Plan

Medicare Advantage without Drug Plan



If you have issues retrieving a member with a legacy ID number (11 digits beginning with 370), drop the 01 from the end and try again.

Page 9: Helpful Numbers and Information

Claims Submission

Change Healthcare: Payor ID GHOKC0001
GlobalHealth
Attn: Claims
P.O. Box 2718
Oklahoma City, OK 73101-2718

Compliance & FWA
Email compliance@globalhealth.com

Compliance & FWA Confidential Hotline
Phone (877) 627-0004
https://secure.ethicspoint.com/domain/media/en/gui/28052/index.html

Contracting
https://www.globalhealth.com/oklahoma/providers/how-to-become-a-globalhealth-provider/

Credentialing
Fax (405) 552-3003
Email ghcredentialing@globalhealth.com

Customer Care
Phone (844) 280-5555

EDI
Change Healthcare: Payor ID GHOKC0001

EDI set up requests
Email edienrollment@globalhealth.com

Part D Coverage Determinations
Phone (855) 344-0930
Fax (855) 633-7673

Privacy/HIPAA
Toll Free Hotline (877) 627-0004
Email privacy@globalhealth.com

Provider Portal
https://ghprovider.prod.healthaxis.net/

Provider Relations
Fax (405) 280-5251
Email provider.relations@globalhealth.com

Provider Services
Phone (844) 280-5555
Email providerservices@globalhealth.com

Quality Improvement
Email quality@globalhealth.com

Utilization Management (Health Services)
Phone (844) 280-5555
Fax (405) 280-5398

Helpful Numbers and Information – Supplemental Plan Benefits

Advance Care Planning Services: Evolent, formerly known as Vital Decisions
https://globalhealth.mylivingvoice.com

Behavioral Health: Carelon Behavioral Health
Phone (888) 434-9202

Dental: DentaQuest
Phone (833) 955-3417

Hearing: NationsHearing
Phone (877) 241-4736

Home Health Support Benefits: Papa Pals
Phone (855) 485-9692

Over-the-Counter (OTC) Products: NationsBenefits
Phone (877) 241-4736

Personal Emergency Response System (PERS): NationsBenefits
Phone (877) 241-4736

Smart Wallet Benefit: NationsBenefits
Phone (877) 241-4736

Transportation: Roundtrip
Phone (877) 565-1612

Vision: EyeMed
Phone (800) 884-6321

Various forms and resources can be found on our website at:
www.globalhealth.com/oklahoma/providers/forms-and-resources/

Member benefit information can be found on our website at:
www.globalhealth.com/oklahoma/medicare-advantage/member-materials

Page 25: Services That Require Prior Authorization

More information regarding prescription prior authorizations is available on our website: www.globalhealth.com/oklahoma/medicare-advantage/utilization-management-program.

Step therapy protocols apply to Part B prescription drugs. A list of Part B drugs that may be subject to Step Therapy is available on our website at www.globalhealth.com/oklahoma/pharmacy/drug-formularies/. Under this policy, step therapy will only be applied to new prescriptions or administrations of Part B drugs for Members that are not actively receiving the affected medication. This means that no Member currently receiving drugs under Part B will have to change their medication.

Page 27: Referrals to Non-Contracted Providers

GlobalHealth Members covered by Generations Valor (HMO-POS) may seek care out of the network. Please submit a Referral to GlobalHealth for all out-of-network services.

Exhibit 2: Oklahoma GlobalHealth State & Education Commercial Plan

This Exhibit contains information specific to GlobalHealth's State & Education Commercial plan, available to active State and education employees in designated Oklahoma counties.

Page 6: New information for 2025

Oklahoma House Bill 1712

Effective May 30, 2024, Oklahoma House Bill 1712 requires coverage for durable medical equipment (DME) through an out-of-network provider in the event that a) a member needs such equipment or supplies within 24 hours and b) no in-network provider is available within a 15-mile radius of the member's home address. Members may not be subjected to drop-shipped orders under these circumstances.

Oklahoma House Bill 1739

Effective November 1, 2024, Oklahoma House Bill 1739 requires coverage for post-partum home care following a vaginal delivery, when childbirth occurs at home or in a birthing center that is accredited as a freestanding birth center by the Commission for the Accreditation of Birth Centers. Services may be performed by an APRN, certified professional midwife, or a licensed physician. Licensure is not required for birthing centers unless the birthing center is in a hospital, in which case the hospital must be licensed pursuant to 63 O.S. 1-701.

Oklahoma House Bill 1979

Effective May 30, 2024, Oklahoma House Bill 1979 defines a vision care provider as a licensed doctor of optometry, medical, or osteopathic doctor.

Oklahoma House Bill 3199

Effective November 1, 2024, Oklahoma House Bill 3199 includes physician assistants (PAs) and advanced practice registered nurses (APRNs) in Oklahoma's statutory definition of "health care professional."

Oklahoma Senate Bill 442

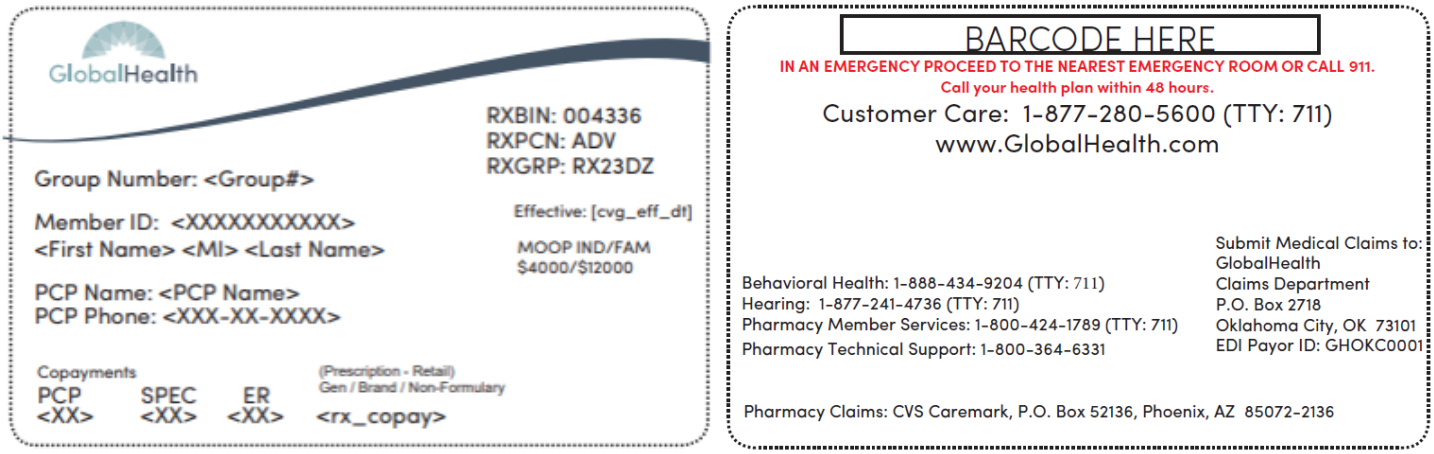
As a reminder, Oklahoma Senate Bill 442 was effective November 1, 2023. This bill set new rules for how insurers must manage their networks and provider directories. The bill requires additions to the information displayed, monitoring of providers who have not submitted a claim, and regular audits. In order to comply with this law, you may be contacted by Provider Relations or Credentialing staff to obtain or validate various demographic information, or to confirm your intent to continue participating in GlobalHealth's network. Failure to respond to this communication within thirty (30) days may result in your termination from the Commercial network. Your assistance with keeping our records current is appreciated.

Page 8: GlobalHealth Products

GlobalHealth provides affordable healthcare coverage for State, education, and local government employees. GlobalHealth commercial plans are available in the same 26 counties as our MA/MAPD plans.

Sample GlobalHealth Member ID Cards

State Plan



Page 9: Helpful Numbers and Information

Behavioral Health: Carelon Behavioral Health
State Plan (888) 434-9204

Hearing: NationsHearing
Phone (800) 921-4559

Claims Submission
Change Healthcare: Payor ID GHOKC0001
GlobalHealth
Attn: Claims
P.O. Box 2328
Oklahoma City, OK 73101-2383

Compliance & FWA
Email compliance@globalhealth.com

Compliance & FWA Confidential Hotline
Phone (877) 627-0004
https://secure.ethicspoint.com/domain/media/en/gui/28052/index.html

Credentialing
Fax (405) 552-3003
Email ghcredentialing@globalhealth.com

Customer Care
Phone (877) 280-5600

EDI
Change Healthcare: Payor ID GHOKC0001

EDI set up requests
Email edienrollment@globalhealth.com

Pharmacy Prior Authorizations
Phone (800) 424-1789
Fax (888) 836-0730

Privacy/HIPAA
Toll Free Hotline (877) 627-0004
Email privacy@globalhealth.com

Provider Relations
Fax (405) 280-5251
Email provider.relations@globalhealth.com

Provider Services
Phone (877) 280-5600
Email providerservices@globalhealth.com

Quality Improvement
Phone (405) 280-5600
Fax (405) 280-5641
Email quality@globalhealth.com

Utilization Management
Phone (877) 280-5600
Fax (405) 280-5398

Various forms and resources can be found on our website at:
www.globalhealth.com/oklahoma/providers/forms-and-resources/

Member benefit information can be found on our website at:
www.globalhealth.com/oklahoma/state/member-materials-search

Page 11: Provider Responsibilities

GlobalHealth must comply with the No Surprises Act, which sets forth rules for when and how the Provider Directory is updated. In order to fulfill these responsibilities, GlobalHealth requires Contracted Providers to notify us whenever information supplied in the Provider Directory has changed. Changes must be supplied by Contracted Providers to GlobalHealth within 30 days of the effective date of the change, or the Provider may be removed from the Provider Directory.

Page 12: PCP Responsibilities

Authorization is required for most services when a member is referred to a Specialty Care Physician (SCP). The PCP shown on the card must submit Referrals/Prior Authorizations for non-emergency medical services provided to the Member, except for the services the Member can obtain by self-referral. See section on Services Not Requiring Prior Authorization.

Page 17: High Volume and High Impact SCPs – Scheduling an Appointment

In addition to the list provided, OB/GYNs and Pediatricians are considered high volume and/or high impact for Commercial Members.

Page 20: Continuity of Care

If a Commercial Member is receiving care from a provider who leaves the network, they may keep getting care from that provider in certain cases while GlobalHealth transfers their care to a participating provider. Members must be in active treatment. “Active treatment” means:

- Ongoing treatment for a serious and complex condition from the provider or facility:

    - In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
    - In the case of a chronic illness or condition, a condition that is:
        - Life-threatening, degenerative, potentially disabling, or congenital; and
        - Requires specialized medical care over a prolonged period of time.
- Ongoing course of institutional or inpatient care from the provider or facility;
- Ongoing course of treatment for a pregnancy from the provider or facility;
- Scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- Ongoing treatment for an individual determined to be terminally ill and is receiving treatment for such an illness from such provider or facility; or
- Ongoing treatment for which a treating doctor or other provider attests that changing care to another doctor or provider would make the condition or expected outcome worse

If approved for transition care, GlobalHealth covers care until the earlier of 90 days or the date on which the Member is no longer a continuing care patient with respect to such provider or facility. If the Member is pregnant, GlobalHealth covers transition care through six weeks postpartum, even if it is more than 90 days. If the Member remains enrolled in the same plan across calendar years, these timeframes apply across calendar years.

Authorization is required to continue care. GlobalHealth will not cover continuing care when:

- The provider's contract ended due to quality-of-care issues.
- The provider did not comply with regulatory or other contract requirements.

If the Member is new to GlobalHealth, GlobalHealth will honor a prior authorization from the previous health insurance carrier for 60 days. During that time, GlobalHealth will perform its own review and either issue a new prior authorization or make an adverse determination.

Page 25: Utilization Management Program Overview

- **Non-urgent Preservice:** determination made within 7 days of receipt of all necessary information to make the determination

Page 25: Services That Require Prior Authorization

Acupuncture
Not covered

Ambulance

Pre-hospital transportation, for the provision of emergency health care services, or for transfers between facilities do not require prior authorization.

Audiology Services

Hearing aids may require prior authorization. Providers should coordinate benefits with NationsHearing using the contact information in the Helpful Numbers and Information section above.

Diabetes Prevention Program

The program is only approved for CDC-approved vendors who have contracted with GlobalHealth. Members can contact GlobalHealth Customer Care to select a vendor. For more information about GlobalHealth's Diabetes Prevention Program, visit www.globalhealth.com/oklahoma/healthy-living-tips/diabetes-prevention-program.

Diagnostic Services – Infertility Testing and Services

Effective January 1, 2025, Oklahoma Senate Bill 1334 requires coverage for standard fertility preservation services, only for individuals diagnosed with cancer and who are within reproductive age, when a medically necessary treatment may directly or iatrogenic infertility. Prior authorization is not required for these services.

Home Healthcare and Hospice Care

All home healthcare, including home infusion therapy and hospice care, requires prior authorization.

Inpatient Care

For continuation of inpatient care, submit a request at least seventy-two (72) hours prior to the termination of the previously approved prior authorization and include all necessary information for GlobalHealth to make a determination.

Outpatient Therapies and Rehabilitation

All therapies and rehabilitation such as occupational and speech therapy, cardiac rehabilitation, pulmonary rehabilitation services, and supervised exercise therapy require prior authorization. Referrals for physical therapy in commercial plans follow the requirements outlined in the Physical Therapy Practice Act, 59 O.S. §§ 887.1 - 887.19.

> Except for worker's compensation claims, any person licensed under the Physical Therapy Practice Act as a physical therapist shall be able to evaluate human ailments by physical therapy on a patient without a Referral from a licensed healthcare practitioner for a period not to exceed 30 days. An authorization must be submitted for treatment. Treatment may be provided by a physical therapist assistant under the supervision of a physical therapist. Any treatment provided shall be only under the Referral of a person licensed as a physician or surgeon with unlimited license, or the physician assistant of the person so licensed, with those Referrals being limited to their respective areas of training and practice. All subsequent treatments, up to any plan limitation, must follow normal Referral/prior authorization processes.

Pharmacy

Certain drugs may be subject to prior authorization as indicated in the formulary. Specific prior authorization criteria are available by visiting https://www.globalhealth.com/oklahoma/pharmacy/drug-formularies or contacting CVS Caremark's Pharmacy Helpdesk.

Preventive Services

- Abdominal aortic aneurysm screening
- BRCA1 and 2 testing
- Breast feeding pumps and supplies
- Low-dose CT for lung cancer screening
- Surgical contraception

Specialty Care Services

A Referral is needed for services not performed by the PCP unless the service is specifically listed as not requiring a PCP Referral. If additional Medically Necessary tests or treatments are needed beyond those initially authorized, the SCP may seek additional authorization from GlobalHealth and notify the Member's PCP.

Page 28: Prior Authorizations

GlobalHealth may offer a low-cost setting option when available for its Members.

SCPs

Commercial Members must obtain prior authorization for all SCP services, including office visits. The authorized SCP may only perform the services specified in the authorization notice. The SCP providing the referred service should report the appropriate clinical information to the referring PCP within 5 days of seeing the Member.

- The office should verify eligibility and confirm authorization using the Provider Portal prior to each office visit.
- The authorization will list the type and number of approved services.
- The approved service(s) must occur within the authorized time frame.
- Eligibility must be verified at the time of each visit. Payment will not be made for services rendered to an ineligible Member.

Additional Services

If the SCP decides the Member needs services beyond what was included in the original prior authorization notice, it becomes the responsibility of the SCP to submit the Referral for additional services. If the provider does not obtain authorization before providing additional tests, services, or procedures, they may not be payable. Submit a new authorization online or via fax within one business day regarding any unexpected services that were Medically Necessary but were not included in the original prior authorization. New referrals must reference the existing referral number and indicate that it is a re-opening request.

The SCP is responsible for coordinating care with the Member's PCP. At a minimum of every six months, the SCP refers the Member back to his or her PCP.

GlobalHealth will honor a prior authorization granted to an enrollee from a previous utilization review entity for at least the initial sixty (60) days of an enrollee's coverage under a new health plan. During this time period GlobalHealth may perform our own review to grant a prior authorization or make an adverse determination.

Page 29: Services Not Requiring a Prior Authorization or Referral

Chiropractic Care
All services within the provider's scope of practice, up to the visit limitation specified in plan materials.

Preventive Services
All preventive services not specifically listed in Services That Require Prior Authorization.

Page 35: Pharmacy

Commercial Member benefits are limited to 90-day supplies.

Preferred/standard cost-sharing does not apply to Commercial Member benefits.

Exception Process

Commercial Plan Standard Exception

You can request that GlobalHealth waive coverage restrictions and limits. You may submit your request via fax to (888) 836-0730. Forms can be found on our website at www.globalhealth.com/oklahoma/providers/prior-authorization-forms.

This exception process also applies to new Members who are taking drugs that require coverage determination or taking non-formulary drugs. GlobalHealth may grant a temporary supply during the Member's first 90 days of membership while transitioning to the GlobalHealth formulary.

Commercial Plan Expedited Exception

You may request an expedited exception when:

- The Member is suffering from a health condition that may seriously jeopardize their life, health, or ability to regain maximum function, or
- The Member is undergoing a current course of treatment using a non-formulary drug.

We will provide a decision to you within 24 hours after receiving the request and sufficient information to begin the review.

If granted, the exception will be for up to 12 months, depending on clinical criteria.

If GlobalHealth denies your exception request, you may request an appeal or an external review per the instructions included in the denial letter.

The Member's medication will be covered during the time GlobalHealth is reviewing, and if applicable, during the external review.

Medication Therapy Management Program

The Medication Therapy Management Program is not available to Commercial Members. However, physicians may request a medication review by a licensed pharmacist by contacting Provider Services using the contact information in the Helpful Numbers section.

Page 50: Preventive Care and Clinical Practice Guidelines

Preventive service guidelines are issued by the U.S. Preventive Services Task Force, the Centers for Disease Control and Prevention, and the Health Resources & Services Administration.

If the primary purpose of the service is for treatment rather than preventive screening, the Member may be required to pay their normal cost share. Services are preventive when there are no prior symptoms. Services are for treatment purposes when the Member is having symptoms, or they have been diagnosed with a condition. Please refer to Member materials for additional information and exceptions.

Page 51: Medical Review Program

When a case is referred for medical review, the reviewer conducts an initial review of the available and relevant medical records and may research related conditions and standards of care as indicated. The reviewer summarizes the case and may present it to the Medical Director for further determination. If the issue is a reasonably avoidable readmission or of significant clinical concern, an initial notice is sent to the Contracted Provider, usually by fax or secure email.

As indicated in the notice, the Contracted Provider has 30 calendar days from the date of the notice to submit a medical review appeal with additional information to address the identified issue. In some cases, the reviewer may also request a response to the situation or summary of internal activities conducted to address the issue under review.

If a medical review appeal is received within the 30 calendar days, the case and associated medical records will be reviewed by a Medical Director not previously involved in the initial review and a final determination will be made. The Medical Director may agree with the medical review appeal and overturn the initial decision, or determine the original finding is correct and uphold the decision. This determination is a final determination. The Contracted Provider will be notified of the outcome, typically within 30 days of the medical review appeal receipt date.

If the initial medical review notice is not appealed within the 30 calendar days, it is considered final. A final notice will be sent to the Contracted Provider and the case is considered closed with no further appeals. Failure to provide any requested response to the situation or summary of internal activities conducted to address the issue under review will be considered a failure to support Quality Improvement (QI) activities outlined in your Participation Agreement and will be referred to the Provider Relations Department for follow-up.

The Claims Department will be notified of the final determination and may take additional action on the claim.

Please note: This medical review appeal process and the Claims Department payment appeal process are separate and distinct appeal processes. Even if a case is closed for quality review, you may still have Claims appeal rights available as outlined in your Participation Agreement.

Peer-to-Peer Requests

The GlobalHealth Medical Director may grant a peer-to-peer discussion during the 30-calendar day window in lieu of a written post-service quality review appeal. The request should be made in writing to the Quality Department contact in the notice and include the physician’s name and contact telephone number. The Medical Director will attempt to conduct the peer-to-peer within the 30-day window. The Medical Director’s determination is final with no further Quality Department appeals.

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Oklahoma City, OK 73102

www.globalhealth.com

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