GlobalHealth

2020 Provider Manual

February 2020

GlobalHealth Holdings, LLC
www.GlobalHealth.com

Contents

Welcome to GlobalHealth

This Provider Manual is a reference tool which describes GlobalHealth Holdings, LLC (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 the GlobalHealth processes.

GlobalHealth will keep you informed of important changes in our policies, procedures, and benefits. The Provider Manual is available on the Provider Tab of the GlobalHealth website, www.GlobalHealth.com

This Provider Manual is intended for use by GlobalHealth Contracted Providers only and is incorporated by reference as a part of your Provider 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 confidential and proprietary to GlobalHealth and may not be copied in whole or part or distributed without the express written consent of GlobalHealth.

GlobalHealth does not discriminate provider participation on the basis of race, ethnicity, national origin, religion, gender or gender identity, age, mental or physical disability within the Service Area. No oral statement shall add or take away any terms under the Agreement.

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

Our Mission

- We are driven by our passion to deliver the best healthcare coverage in the industry.
- We are committed to continuous innovation and comprehensive Member engagement to earn the satisfaction and confidence of those we serve.
- We aspire to earn and retain our providers' confidence and trust in us.
- We believe in developing and maintaining valued relationships with our partners.

New information for 2020

New Century Health

GlobalHealth is pleased to announce its partnership with New Century Health (NCH) to manage the complexities related to cancer and cardiovascular care by reducing variability and ensuring the highest quality to our members. New Century Health will be performing utilization management (UM) services for members 18 years of age and older. This program will simplify the administrative process and provide a comprehensive solution through physician collaboration in a true peer-to-peer approach.

NationsHearing

GlobalHealth is pleased to announce its partnership with NationsHearing to administer the hearing aid benefit. In 2020, NationsHearing will provide a comprehensive and cost-effective hearing aid and hearing services solution in the GlobalHealth network. NationsHearing maintains a national network of credentialed hearing healthcare providers, digital hearing centers, hearing aids and related products, and outcomes management to

help GlobalHealth members obtain the best hearing healthcare. Top quality hearing aids from major manufacturers are available at significant savings.

Meal Benefit

GlobalHealth is pleased to announce that Independent Living Systems will coordinate the post discharge meal benefit. If you have a GlobalHealth Medicare Advantage patient with one of the following disease states admitted to the hospital, contact an inpatient discharge case manager to set up meals for your patient following discharge.

- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Diabetes
- Heart disease
- Hypertension
- Blindness

You patient will receive 2 meals per day for 5 days, up to 4 times per year.

GlobalHealth Product Lines

GlobalHealth is fully licensed by the State of Oklahoma as a Health Maintenance Organization (HMO).

GlobalHealth serves two populations, Medicare Advantage and Commercial. Both of these product lines require Members to select a Primary Care Physician (PCP) and do not have out-of-network benefits, except in emergent, urgent, or prior authorized circumstances. You can identify if a Member is enrolled in a commercial or Medicare Advantage plan by looking at their Member ID card.

Commercial

GlobalHealth provides affordable healthcare coverage for federal, State, education, and local government employees, and private companies in the large group market. GlobalHealth commercial plans are available in all 77 counties in Oklahoma. Our commercial line of business is accredited by the National Committee for Quality Assurance (NCQA). We received a Health Insurance Plan Rating of 3.5 for 2019/2020.

Commercial Plan

Federal/FEHB Plan

Medicare Advantage

Medicare Advantage plans combine the insurance benefits of Medicare Parts A, B and D with the customer service and care of a consumer-focused HMO. GlobalHealth has received a 3.5 overall Star Rating out of 5 stars from Medicare since 2016. GlobalHealth Medicare Advantage plans are marketed under the Generations name and are available in 44 counties across Oklahoma.

Sample GlobalHealth Member ID Cards

Medicare Advantage with Drug Plan
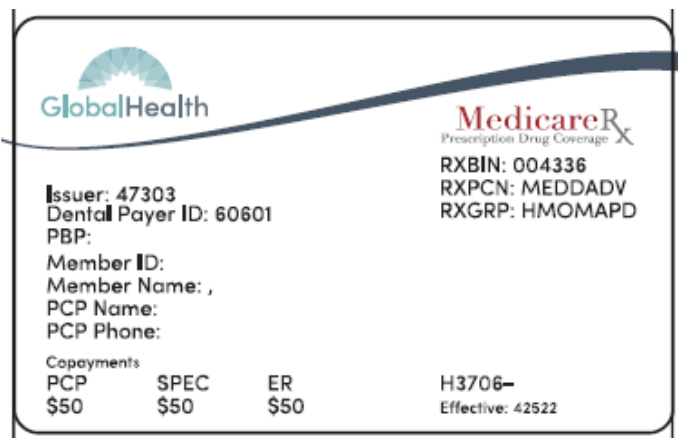
Medicare Advantage without Drug Plan
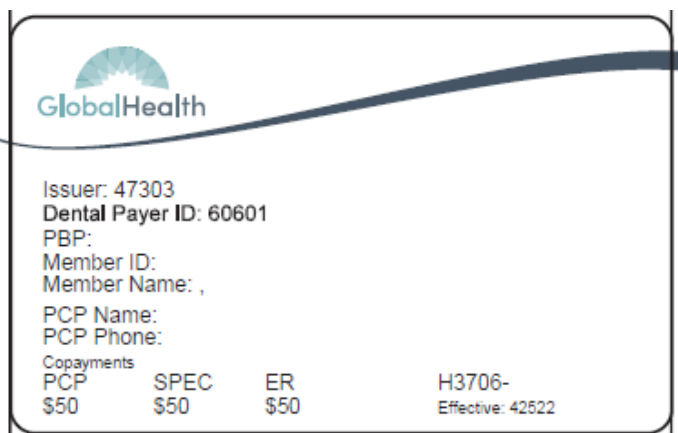
Oklahoma State Retirees (Medicare Advantage)
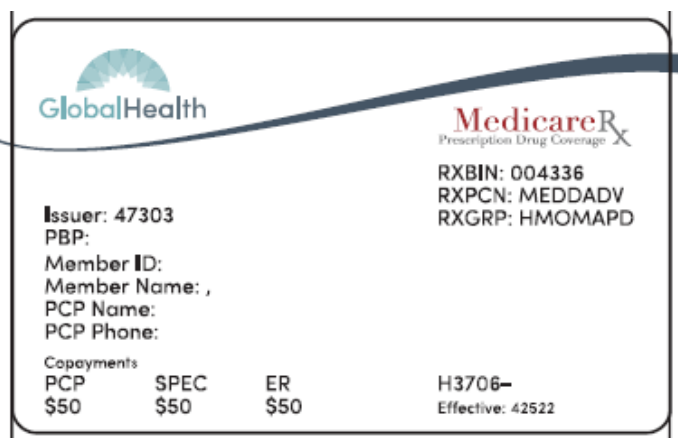
New Provider Orientation

Orientations are offered the second Tuesday of each month. Register online at
https://www.globalhealth.com/providers/provider-training/

Helpful Numbers and Information

Behavioral Health: Beacon Health Options
Federal Plan Options (888) 434-9201
Medicare Advantage (888) 434-9202
Commercial (888) 434-9203
State Plan (888) 434-9204
TTY 1-866-835-2755

Claims Submission Commercial
GlobalHealth, Inc.
Attn: Claims
P.O. Box 2328
Oklahoma City, OK 73101-2383

Claims Submission Medicare Advantage
GlobalHealth, Inc.
Attn: Claims
P.O. Box 1747
Oklahoma City, OK 73101-1747

Claims Status
Contracted Providers should use GlobalLink™ to obtain claim information.
https://globalhealth.com/providers/globallink/
GlobalLink™ provides limited claim information for Non-Contracted Providers. Non-Contracted Providers may contact **Provider Services** for assistance.

Compliance
Phone (405) 280-5852
Toll Free Hotline (877) 280-5852
Email compliance@globalhealth.com

Credentialing
Phone (405) 280-5886
Toll Free (844) 322-5222
Fax (918) 878-7350
Email ghcredentialing@globalhealth.com

EDI set up requests
Email edienrollment@globalhealth.com

Eligibility & Enrollment
Phone (405) 280-5300
Toll Free (866) 277-5300
Fax (405) 280-5881

Medical Management (UM)
Phone (405) 280-5300
After Hours (405) 280-5600
Toll Free (866) 277-5300
Fax (405) 280-5398
Email um@globalhealth.com

Pharmacy Commercial
Phone (918) 878-7361
Fax (405) 280-5613
Email gh.pharmacy@globalhealth.com

Pharmacy Medicare Advantage CVS Caremark
Toll Free (866) 494-3927

Privacy/HIPAA
Phone (405) 280-5824
Toll Free Hotline (877) 280-5852
Email privacy@globalhealth.com

Provider Services
Phone (405) 280-5300
Toll Free (866) 277-5300
Fax (405) 280-5251
Hours 8:00 AM-4:00 PM, Closed 12-1:00 PM, M-F

Provider Relations/Contracting
Phone (405) 280-5300
Toll Free (866) 277-5300
Fax (405) 280-5251
Email ghcontracting@globalhealth.com
Email provider.relations@globalhealth.com

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

Tulsa Office
6120 South Yale Ave, Suite 925
Tulsa, OK 74136-4216

Main Office
210 Park Avenue, Suite 2800
Oklahoma City, OK 73102-5621

GlobalLink™

GlobalLink™ is an online tool available to all Contracted Providers. GlobalLink™ is provided to allow Contracted Providers to:

- Verify eligibility
- Review Member demographics
- View benefit information
- Create Referrals
- Check prior authorization/Referral review status
- Check claim status
- Communicate with GlobalHealth

GlobalLink™ is available 24 hours a day, 7 days a week.

You may access information about GlobalLink™ on our website on the Provider Tab or at:

www.GlobalHealth.com/globallink.aspxwww.GlobalHealth.com/globallink.aspx

GlobalLink™ Access

Contracted Providers can submit a request for access to GlobalLink™ on our website on the Provider Tab or at:
www.GlobalHealth.com/globallink_access_request.aspxwww.GlobalHealth.com/globallink_access_request.aspx

Each user must submit an email address with a secured domain.

Each user must have a unique username and password. To request multiple users, please submit a separate form for each user. Alternatively you may contact Provider Relations (globallink.access@globalhealth.com) to request a Bulk User Access Request Form.

GlobalLink™ Training

Training sessions are available the first and third Tuesday each month. Register online at https://www.globalhealth.com/providers/globallink-provider-training/

GlobalLink™ Support

For user access questions and/or technical issues with GlobalLink™, such as forgotten passwords or error messages, please contact the GlobalHealth GlobalLink™ Team.

Email globallink.access@globalhealth.com

New Provider Orientation

Orientations are offered the second Tuesday of each month. Register online at
https://www.globalhealth.com/providers/provider-training/.

Cultural Competency Program and Policy Review Guidelines

GlobalHealth routinely monitors to ensure its programs are most effectively meeting the needs of its Members. The provider network is assessed for cultural and linguistic needs. Data is revalidated at least annually.

- Determination of threshold languages and processes in place to provide Members with vital information in threshold languages
- Identification of specific cultural and linguistic disparities found within GlobalHealth's diverse populations
- Analysis for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services

To do this, GlobalHealth collects and analyzes race, ethnicity and language data from:

- Eligible individuals to identify significant culturally and linguistically diverse populations with plan membership
- Local geographic population demographics and trends derived from publicly available sources
- Applicable national and state demographics and trends derived from publicly available sources
- Analysis of HEDIS® and CAHPS® results

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 at 1-866-277-5300 during business hours.
- 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, your responsibilities for documenting Member language services/needs in the Member's medical record are 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.

- Document all counseling and treatment done using interpreter services.

- Document if a Member insists on using a family member, friend or minor as an interpreter, or refuses the use of interpreter services after being notified of his or her right to have a qualified interpreter at no cost.

Provider Responsibilities

GlobalHealth expects all Contracted Providers to adhere to certain guidelines.

1. Educate Members regarding their healthcare needs.

2. Communicate freely with patients about their treatment, regardless of benefit coverage limitations.

3. Provide Medically Necessary healthcare services in accordance with the GlobalHealth contract, the applicable benefit plan materials, GlobalHealth policies and procedures, and requirements in the Provider Manual.

4. 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 his or her preferred treatment option.

5. Participate in and cooperate with GlobalHealth's programs including Utilization Management (UM), Proactive Outreach, Compliance, and Quality Improvement.

6. Allow GlobalHealth to use performance data.

7. Maintain appropriate medical records to document all services provided to Members.

8. Complete the Provider Update Form found at www.GlobalHealth.com Provider Tab within 30 days when any of the following information changes:

   - Tax ID number

   - NPI

   - Address

   - Telephone or fax number

   - Name change

   - New location

   - Limitations/Restrictions to practice

9. Shall not discriminate in the delivery of healthcare services and shall accept for treatment any Member in need of the healthcare services they provide.

10. Submit accurate claims to GlobalHealth for services rendered to GlobalHealth Members in accordance with the time frame specified in the Agreement.

11. Assist GlobalHealth in determining Coordination of Benefits (COB) issues with other payers.

12. Cooperate with any investigations regarding grievances, quality of care, other quality assurance measures or fraud, waste and abuse.

13. Verify Member eligibility. GlobalHealth will provide Member ID cards prior to the start of coverage. It should be presented each time the Member seeks care from a Contracted Provider. If a GlobalHealth Member fails to present a Member ID card, please contact us to verify the Member's eligibility. Eligibility can be verified by accessing GlobalLink™. The Member ID card does not guarantee coverage or entitlement to benefits. It is essential to verify Member eligibility because:

- Employer groups may change benefit plans.

- Member benefits may change.

- Copayments must be determined.

- Fraudulent use may occur.

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

Primary Care Physician

All GlobalHealth Members must choose a PCP. The PCP is the Member's first contact for his or her healthcare needs. The PCP manages the Member's total healthcare program by providing a broad range of services and arranging and coordinating for other care when necessary.

1. Manage the Member's total healthcare program. This includes health supervision, basic treatment, initial diagnosis, management of chronic conditions, and preventive health services.

2. Provide medical care coverage for assigned patient panel 24-hours per day, seven days per week within GlobalHealth's established network of Contracted Providers.

3. Coordinate healthcare with Specialist Physicians or healthcare facilities when such care is needed, including submitting Referrals. (The PCP should always refer Members to GlobalHealth Contracted Physicians and Contracted Facilities, unless the services are not available within the GlobalHealth network.) The most current list of Contracted Providers can be found using the online Provider Directory search tool.

4. Provide complete information on authorized care or services to the referred Specialist Physician.

> **Effective 1/1/2020, GlobalHealth will no longer require prior authorizations for specialist office visits. Members will have direct access to set up an office visit appointment with a Specialist Physician. Services rendered or referred by Specialist Physicians will require prior authorizations. Services include, but are not limited to surgery, physical therapy, cardiac rehabilitation, Part B drugs, and specialized diagnostic tests such as MRIs. These are only examples. Please refer to the plan Evidence of Coverage or call Customer Care if you have any questions about whether a service requires prior authorization. Please note that this only applies to Medicare Advantage plans – Generations Classic (HMO), Generations Select (HMO), Generations Value (HMO), and Generations State of Oklahoma Group Retirees (HMO). All other plans will continue to have the same prior authorization process as is in place today. There are no changes to the specialist authorization requirements for GlobalHealth's commercial products.**

A PCP must 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 family medicine to be eligible to contract with GlobalHealth as a PCP.

PCP Panel Status

GlobalHealth provides a PCP to care for its members. GlobalHealth ensures Members have access to Primary Care Services and routinely monitors PCP panel status.

Open

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

Not Accepting Any Members (Closed)

Physicians who have a full practice may close their practice to all new GlobalHealth Members. Physicians who request to be listed as "not accepting any Members" will not be assigned new GlobalHealth Members.

A physician may close his/her practice to new Members by notifying GlobalHealth. This option allows only patients currently seeing that physician to select him/her as a PCP. If a Member incorrectly selects a closed physician, 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. The change is effective immediately.

We recommend 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 receiving active medical care.

- The Member is pregnant.

> IMPORTANT!
>
> The PCP shown on the card must submit Referrals 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.
>
> Physicians should not see Members for Primary Care Services if they are not listed as the PCP on the Member's card, unless GlobalHealth has authorized the visit or service in advance or they are providing coverage for the listed PCP.

Specialty Care Physician (SCP) and Other Practitioners

An SCP provides certain specialty medical care upon Referral from the PCP.

1. Accept and treat GlobalHealth Members referred by their PCP.
2. Comply with all GlobalHealth prior authorization requirements.
   a) Ensure GlobalHealth has authorized services before treating Members, when required.

b) If additional Medically Necessary tests or treatments are needed beyond those initially authorized, the Specialist Physician may seek additional authorization from GlobalHealth and notify the Member's PCP.

3. Actively participate in coordination of care activities. Encourage Members to sign the authorization to share Protected Health Information (PHI) with other providers involved in their care. Share findings of the Member's physical exam and treatments with the PCP and other authorized providers.

4. Use best efforts to utilize GlobalHealth Contracted Physicians and Contracted Facilities for services for the Member.

5. Use best efforts to provide a written report to the Member's PCP within 5 working days.

Hospital/Facility Responsibilities

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

2. Obtain necessary authorizations from GlobalHealth for hospital admissions and continued inpatient stays. Notification is required within 48 hours of admission for all inpatient hospital stays including childbirth or emergencies.

3. In the event of a transfer, the receiving hospital is required to provide GlobalHealth notification within 48 hours of admission.

4. Verify hospital/facility and its personnel are duly licensed, certified, Contracted Providers and authorized to provide Covered Health Care Services to GlobalHealth Members.

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

6. 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 Medicare Advantage health plan enrollees) informing them that they are outpatients receiving observation services and are not inpatients of a hospital or CAH.
https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MOON

Emergency Room (ER) Care

An emergency involves a medical condition manifesting itself by acute symptoms of 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.

With respect to a pregnant woman who is having contractions and (a) that there is inadequate time to affect a safe transfer to another hospital before delivery or (b) that the transfer may pose a threat to the health or safety of the woman or unborn child.

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

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

Provider Accessibility

GlobalHealth is required to notify all Contracted Physicians 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 (24 hours a day/7 day a week) to all enrollees, including those with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds. 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 Physician.
- A high-quality voice mail system that tells Members:
  - How to reach the Contracted Provider or the covering physician 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 completes an annual access to care and availability survey for PCP and high volume and high impact Specialist Physicians.

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 as well as an NCQA standard. 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 on a routine basis. 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 provide timely responses.

Contracted Provider Responsibilities

The Contracted Provider must validate his/her 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, 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.

Please visit the GlobalHealth online Provider Directory at www.GlobalHealth.com on a quarterly basis to validate your information. Please notify GlobalHealth at epicproviderupdates@globalhealth.com or submit the Provider Update Form, if your information needs to be updated or corrected.

Also, a roster (either provider or facility as appropriate) must be submitted to GlobalHealth once a quarter. See Attachment D of the Agreement.

Access Timeliness Standards

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

Primary Care – Scheduling an Appointment

Type	Access Standard	Examples
Emergency	Immediate appointment or Member is directed to nearest emergency room 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	Within 24 hours	Minor trauma, sprain, high temperature, persistent diarrhea, and 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 room) Discharge	Within 14 calendar days of discharge	Update care plan, coordinate care with any Specialist Physician(s), obtain labs, and reconcile medications.
Symptomatic, Non-urgent	Within 7 calendar days of request	Flu, cold, headaches, rashes, sore throat.

Type	Access Standard	Examples
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 Specialist Physicians – Scheduling an Appointment

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

- Cardiology
- PCP's
- OB/GYN
- Oncology

- Ophthalmology
- Pediatricians
- Psychiatrists

GlobalHealth expects contracted high volume Specialist Physicians and high impact Specialist Physicians 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, prescription, or treatment plan.
After-hours	Respond within 2 hour 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

Members should not wait long after their scheduled appointment time to see a practitioner. 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 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.

Covering Physicians

A Contracted Physician must coordinate coverage by another Contracted Provider when he/she is on vacation or leave of absence. The Contracted Provider is responsible for ensuring the Covering physician will:

- Follow the protocols, policies, and rules as stated in this Provider Manual.

- Not bill any Members except for applicable Copayments/Coinsurance.

- 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 Physician should use modifiers Q5 (substitute physician) or Q6 (locum tenens) to help ensure the claim is appropriately recognized.

- Be available 7 days a week, 24 hours a day.

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 a Member has an urgent medical illness or injury that cannot wait for a regular appointment.
	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.	
After-hours	They should call the PCP's contact number on their Member ID card. When a nurse or physician is on call,	Call for emergency prescription refill.

	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 room. 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 room.	

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 emergency room, the Contracted Provider must use best efforts to notify GlobalHealth within 24 hours of services.

Member Lock

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 his or her 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 at least 30 calendar days PRIOR to termination date. During the PCP 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
- Safety issues

GlobalHealth reports practitioner suspension or termination to the appropriate authorities.

Continuity of Care

When a Contracted Provider voluntarily leaves GlobalHealth's network, the Member that is currently in active 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:

- Has a degenerative, disabling, or life-threatening disease or condition.
- Is in the second or third trimester of pregnancy at the time of provider notice to GlobalHealth.
- Is terminally ill.

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 leave of absence 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

Because complete and accurate documentation in medical records is an essential component of quality patient care, GlobalHealth conducts periodic practitioner 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 dated.

- All entries are signed by the author. 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 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.

- 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.

- 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) who have been seen three or more times, the use of cigarettes, alcohol, and any substance use is noted. Documentation of family/household tobacco 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 resources 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. Publications may be ordered from DHS by calling 1-877-283-4113.

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, 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, access via Electronic Medical Records (EMR), or schedule an on-site visit. This is considered part of office overhead and records are to be provided at no cost. 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 healthcare services that are covered and payable under the GlobalHealth plan.

- Healthcare services or supplies Medically Necessary to prevent, diagnose, or treat an illness, injury, disease, or its symptoms. Services must meet generally accepted standards of medicine.

- The appropriate level of care based on evidence-based guidelines.

GlobalHealth's UM employees are properly trained, qualified, and supervised with oversight by a Medical Director. The Medical Director is a licensed physician in good standing.

Medical necessity determinations are made by UM staff, except for adverse determinations which are exclusively made by the GlobalHealth Medical Director. The Medical Director makes all determinations not to authorize treatment that does not meet medical necessity criteria. GlobalHealth maintains a process for providers to appeal UM denials in accordance with GlobalHealth policies and applicable regulatory requirements.

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

1. **Urgent Concurrent:** determination made within 24 hours of receipt of request
2. **Urgent Preservice:** determination made within 72 hours of receipt of request
3. **Non-urgent Preservice:** determination made within 14 days of receipt of request

Policy on Ensuring Appropriate Utilization

All UM 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. GlobalHealth's policy to ensure appropriate utilization is:

- UM decision-making is based on appropriateness of care and service and existence of coverage.

- Practitioners or other individuals are not specifically rewarded for issuing denials of coverage.

- UM decision-makers are not provided financial incentive which would encourage decisions that result in underutilization.

- Incentives are not used to encourage barriers to care and service.

- Decisions regarding hiring, promoting or terminating its practitioners or other individuals are not made based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits.

Medical Policies and Criteria Guidelines

GlobalHealth staff uses plan medical policies and nationally recognized guidelines and resources, such as MCG™ Care Guidelines, Hayes, Inc., or CMS Medicare National and Local Coverage Determinations 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. Medical policies are published in draft form and are available for a 30-day comment period on www.globalhealth.com/providers/medical-policies. At the end of the comment period, the medical policy is posted as pending for an additional 30-day period during which all comments received will be reviewed and taken into consideration for possible changes. After the 30-day period as pending, the medical policy is considered active and will be used to make medical necessity decisions. All active medical policies are available online to view and print as needed. GlobalHealth expects its Contracted Providers to provide services according to published, evidenced-based guidelines and standards of care. GlobalHealth reviews and updates its approved Clinical Guidelines at least every two years or as needed. Our Guidelines are available at www.GlobalHealth.com.

In addition, GlobalHealth reviews and updates its approved clinical practice guidelines at least every two years or as needed. Our guidelines are available at www.GlobalHealth.com on the Providers Tab.

Technology Assessment Process

GlobalHealth has a technology assessment and guideline review process. It is designed to review requests for coverage of newly available devices, procedures, or treatments that are not considered established benefits.

A physician-directed committee reviews requests for approval of new technology. This includes both new technology and new application of existing technology.

The committee reviews medical and behavioral healthcare procedures, drugs, and devices using scientific medical evidence. An appropriate regulatory agency, such as the U.S. Food and Drug Administration (FDA), must have approved the new device, procedure, or treatment before it will be considered.

Before approving coverage, GlobalHealth requires documented evidence to ensure the efficacy and safety of the new technology. The new technology must:

- Improve the net health outcome of the Member;
- Be as beneficial as established alternatives;
- Be available outside the investigational setting;
- Significantly improve the quality of life of the Member; and,
- Clearly demonstrate safe medical care to the Member.

Services That Require Prior Authorization

NOTE: This list is not all-inclusive and may include services that are covered in only 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.

1. **Ambulance:**

   Scheduled ambulance transport from one facility to another location requires prior authorization.

2. **Audiology Services:**

   Audiology services and hearing aids may require prior authorization specific to plan.

3. **Behavioral Health:**

   Outpatient office visits have no prior authorization requirement. GlobalHealth encourages coordination of care with Beacon Health Options. Beacon Health Options handles the prior authorization process for the following behavioral health services:

   - Applied Behavioral Analysis (ABA) autism services

   - Intensive outpatient program (IOP),

   - Partial hospitalization (PHP),

   - Residential and rehabilitation treatment

   - Convulsive therapy treatment transcranial magnetic stimulation therapy,

   - Medical detoxification

   - Inpatient acute admission

4. **Diabetes Prevention Program:**

   A prior authorization is required for commercial plan members. No prior authorization is required for MA Members. The program is only approved for CDC-approved vendors who have contracted with GlobalHealth. Members can contact GlobalHealth Customer Care to select a vendor.

5. **Diagnostic Services:**

   Other procedures and testing that require prior authorization include:

   - Infertility testing and services, if applicable.

   - Cardiac stress tests, nuclear cardiac testing, coronary computed tomography angiography, and other cardiographs.

   - Neurology and neuromuscular diagnostic testing, including EEG, EMG, NCV, and sleep studies.

   - Non-invasive diagnostic testing including vascular, pulmonary, and voiding cysto-urethrogram.

   - 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).

6. **Drug Waste:** Drug waste requires prior authorization.

7. **Durable Medical Equipment (DME), Prosthetics and Orthotics:**

   DME, prosthetic devices, and orthotic devices (Revenue Codes 274 through 278), including enhanced or specialty equipment or supplies, require prior authorization.

8. **Home Healthcare and Hospice Care:**

   All home healthcare, including home infusion therapy, and commercial plan hospice care services require prior authorization. Hospice care for MA Members should be coordinated under Original Medicare benefits.

9. **Hospital Transfers:**

   All scheduled 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 48 hours of the admission.

10. **Inpatient Care:**

    All inpatient care and inpatient rehabilitation require prior authorization by the Contracted Facility. GlobalHealth must be notified by the hospital of all admissions within 48 hours of admission. If a service does not require prior authorization (e.g., childbirth, observation, etc.) this does not negate the provider's responsibility to *notify* the plan upon admission.

11. **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 treatment.

- Non-emergency blood transfusions and all infusion therapies/services.

12. **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.

13. **Pharmacy:**

    Certain injectable medications require prior authorization. Certain formulary drugs may be preferred agents or may require prior authorization. Specific prior authorization criteria are available by contacting the Pharmacy Department or visiting www.globalhealth.com/providers/prior-authorization-forms.

14. **Preventive Services (Commercial Plan Members Only):**

   - Abdominal aortic aneurysm screening

   - BRCA 1 and 2 testing

   - Breast cancer chemoprevention

   - Breastfeeding pumps and supplies

   - Low-dose CT for lung cancer screening

   - Surgical contraception

15. **Skilled Nursing and Long-Term Acute Care:**

   All skilled nursing and long-term acute care hospital (LTACH) care requires prior authorization.

16. **Specialty Care Services:**

   - Commercial plans: A Referral is needed for services not performed by the PCP unless the service is specifically listed as not requiring a PCP Referral. See Services Not Requiring a Referral. If additional Medically Necessary tests or treatments are needed beyond those initially authorized, the Specialist Physician may seek additional authorization from GlobalHealth and notify the Member's PCP.

   - Medicare Advantage plans: Although prior authorization is not required for specialist office visits, the Specialist Physician may determine the Member needs services other than services routinely rendered during the office visit. It then becomes the responsibility of the referring Specialist Physician to submit the authorization for additional services. The Specialist Physician is expected to continue to coordinate care with the PCP.

17. **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 follow the requirements outlined in the Physical Therapy Practice Act, 59 O.S. §§ 887.1 - 887.18.

   > 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.

Submitting Referrals

The PCP is responsible for submitting a Referral when necessary and for supplying complete clinical information concerning the Referral to the receiving Specialist Physician or facility. Referrals are required whether GlobalHealth is the primary or secondary payer.

Examples of services that may require a Referral include: Specialist Physician visits, hospitalization, and outpatient surgery. Please see Services That Require Prior Authorization above.

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

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 the Member is enrolled or if the service is a covered benefit for the Member. We recommend that you call to verify the Member's enrollment and benefit coverage.

GlobalHealth may redirect Referrals to low-cost setting Contracted Providers when clinically appropriate. The modification may be made without prior notification to the requesting provider.

Authorizations cover a period of 90 days. There may be exceptions made for specialty care for high risk pregnancy, oncology, rheumatology and renal management.

For Commercial Plans Only

Specialist Physicians: The authorized Specialist Physician may only perform the services specified in the authorization notice. The Specialist Physician 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 GlobalLink™ prior to the office visit.
- The authorization will state "Office Visit" along with the number of office visits that are approved.
- The approved office visit(s) must occur within the authorized approved time frame from the date of the authorization.
- If the authorization covers more than one office visit, the provider must verify eligibility at the time of each visit. Payment will not be made for services rendered to an ineligible Member.

Additional Services: If the Specialist Physician decides the Member needs services beyond what was including in the original prior authorization notice, it becomes the responsibility of the Specialist Physician to submit the Referral for additional services or refer the Member back to his or her PCP.

Other services may include tests, physical, occupational, or speech therapy, cardiac rehabilitation, or surgery for example. If the provider does not obtain authorization before providing additional tests, services, or procedures, they will not be payable.

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

<u>For Medicare Advantage Plans</u>

Specialist Physicians: Members may go to a Specialist Physician without prior authorization for office visits only.

Additional Services: If the Specialist Physician decides the Member needs services beyond what is generally handled during an office visit, it becomes the responsibility of the Specialist Physician to submit the Referral for additional services or refer the Member back to his or her PCP. Other services may include tests, physical, occupational, or speech therapy, cardiac rehabilitation, or surgery for example. If the provider does not obtain authorization before providing additional tests, services, or procedures, they will not be payable. GlobalHealth expects the Specialist Physician to keep the Member's PCP informed about the ongoing care.

- The office should verify eligibility and confirm authorization using GlobalLink™ prior to the visit or service.
- The authorization will state the services that are approved.
- The approved services must occur within the approved time frame from the date of the authorization.
- If the authorization covers more than one visit or service, the provider must verify eligibility at the time of each visit. Payment will not be made for services rendered to an ineligible Member.
- Notify GlobalHealth within 24 hours regarding any unexpected services that were Medically Necessary but were not included in the original prior authorization.

<u>For All Plans</u>

Facilities: The authorized facility may only perform the services specified in the authorization notice. The facility should report the appropriate clinical information to the referring PCP. The PCP or Specialist Physician will need to send a Referral for any additional services.

- The office should verify eligibility and confirm authorization using GlobalLink™ prior to the visit or service.
- The authorization will state the services that are approved.
- The approved services must occur within the approved time frame from the date of the authorization.
- If the authorization covers more than one visit or service, the provider must verify eligibility at the time of each visit. Payment will not be made for services rendered to an ineligible Member.

- Notify GlobalHealth within 24 hours regarding any unexpected services that were Medically Necessary but were not included in the original prior authorization.

How to Obtain a Prior Authorization

Referrals are sent to GlobalHealth's UM department:

GlobalLink™ (preferred method)
Fax (405) 280-5398

For expedited authorization, a Contracted Provider may submit Referrals as specified above or call GlobalHealth at (405) 280-5300.

An authorization request can be sent via fax by downloading the Physician's Treatment Request Form from www.GlobalHealth.com, Provider Tab, completing the form, and faxing it to GlobalHealth's UM Department.

Contracted Providers can check on the status of authorization and authorization requests in GlobalLink™ 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 Referrals

The fact that a Referral is not approved 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. A peer-to-peer discussion is available for non-approval of Referrals (adverse determinations). The referring physician can call the UM department to coordinate the peer-to-peer discussion.

Request for More Information

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

- You are notified, prior to the expiration of the initial 14-day 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 the medical necessity, or is not a covered benefit, the requesting provider will be sent a denial letter with information about the reason, and appeal rights and process. Please see the Provider Appeal of Pre-service Denial section below for additional information.

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

When Services are Not Medically Necessary

A Contracted Provider may not collect payment from a GlobalHealth Member for services that have been determined not Medically Necessary by the GlobalHealth Medical Director unless an Advanced Beneficiary Notice of Non-Coverage or applicable form (1) was signed by the Member, (2) acknowledges the Member's financial responsibility, and (3) was obtained by the provider prior to the service being rendered. (You can get a copy of the criteria used to make the decision by contacting GlobalHealth. The criteria are available via mail, email, or telephone.)

Only the Medical Director (or other physician designee) makes medical necessity denial determinations. The Medical Director is available to discuss denial decisions with a provider.

Non-covered/Excluded Benefits

GlobalHealth details services that are not covered or excluded in Member materials and will notify the provider of its coverage determination for the requested service(s). GlobalHealth will not reimburse providers for services that are not-covered/excluded, even when provided by a Contracted Provider. Payments for services that are not covered/excluded are the responsibility of the Member.

NOTE: A signed Advanced Beneficiary Notice of Non-Coverage or applicable form must be obtained for non-covered services prior to rendering the services to a GlobalHealth Member for a provider to collect from a Member.

Provider Appeal of Pre-service Denial

If you disagree with a coverage determination, you may appeal. Coverage appeal timelines and processes for both standard and expedited appeals depend on the plan in which the Member is enrolled. See GlobalHealth's website, https://www.globalhealth.com/appeals-and-grievances/, for details.

Behavioral Health Authorization

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

Beacon Health Options is GlobalHealth's delegated behavioral health administrator. For plan-specified mental health and substance use disorder services that require prior authorization, a Beacon Health Options Contracted Provider will assess the Member for medical necessity criteria, and then contact Beacon Health Options for authorization.

Services Not Requiring a Referral

As explained elsewhere in this Provider Manual, the PCP will coordinate the Covered Health Care Services a Member gets as a GlobalHealth Member. But there are a few exceptions. The Member may self-refer to a Contracted Provider for the following services. Only emergency care and

urgently needed services may be covered at a non-contracted provider without prior authorization. He/she 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, following State and federal privacy laws.

1. **Anesthesia/pathology:**

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

2. **Behavioral Health:**

   A Member may access behavioral health (mental health and/or substance use disorder) services directly through Beacon Health Options.

3. **Chiropractic Care:**

   - Medicare Advantage: Manual manipulation of the spine to correct subluxation.

   - Commercial: All services within the provider's scope of practice, if it is a Covered Health Care Service, up to the visit limitation specified in plan materials.

4. **Consulting Physicians:**

   Services from inpatient consulting physicians.

5. **Dental:**

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

6. **Emergency and Urgent Care:**

   - All services rendered in any emergency room or emergency ambulance.

   - All services rendered in any urgent care facility:

7. **Hearing/speech exam:**

   Services available without prior authorization are dependent on plan benefits.

8. **Laboratory services.**

9. **Mammogram:**

   Routine standard or 3D screening mammogram once every 12 months.

10. **OB/GYN:**

    Any service from a network health professional that specializes in obstetrics or gynecology within his/her scope of practice. The OB/GYN is responsible for:

    - Obtaining prior authorization for services that are not part of a routine office visit.

    - Following the authorized treatment plan.

    - Following procedures for Referrals.

11. **Preventive Services:**

    - Commercial: All preventive services not specifically listed in Services That Require Prior Authorization.

- All Medicare-covered preventive services.

12. **Specialty Care Services (MA Members Only):**

Office visits do not require prior authorization. However, if additional services are required, such as specialized tests, therapy, rehabilitation, or surgery for example, the Specialist Physician must request prior authorization.

13. **Tests (performed in the doctor's office during the authorized visit):**

- Routine lab work
- Ultrasound
- X-ray
- EKG

14. **Vision:**

o Services during an optometrist or ophthalmologist office visits, including testing that occurs during an office visit.

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

Daily Reporting

In addition to the authorization, GlobalHealth must be notified by the hospital of all admissions within 48 hours of admission. Although prior authorization is not required for some services, *notification is required*.

- GlobalHealth must be notified of admissions from the ER within 48 hours of hospital admission.
- GlobalHealth must be notified of observation stays within 48 hours of admission.
- GlobalHealth must be notified of an admission for childbirth within 48 hours.

The following reports are required to be provided daily to GlobalHealth's UM Department:

- Census report for all GlobalHealth Members
- Discharge report
- Inpatient and outpatient surgeries, observation stays, and Skilled Nursing Facility (SNF) admissions, if applicable

The following information must be included on the report:

- Member name

- Member ID number

- Date of birth

- Admitting and/or attending physician

- Facility

- Admit date

- Admit type

- Bed type

- Diagnosis (ICD-10)

- Procedures

- Extraordinary items and services requiring authorization

- Anticipated discharge date

- Actual discharge date

- Discharge disposition

Outpatient Observations

Although prior authorization is not required, notification is required on the day the Member is transferred/admitted to observation. GlobalHealth reviews every outpatient observation stay to determine appropriate level of care and utilization of services. See Concurrent Review below.

Concurrent Review

GlobalHealth performs concurrent review from the day of admission through discharge to assure 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. GlobalHealth's concurrent review process assesses:

- The necessity for continued treatment;

- Level of care; and

- Quality of care for Members receiving inpatient services.

- Active discharge planning

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 entitled to continued coverage pending the outcome of the request.

Contracted Providers should cooperate with GlobalHealth by:

- Providing concurrent review status reports by telephone.

- Allowing GlobalHealth's UM staff to conduct on-site concurrent reviews.

- Allowing access to medical records for the Member.

- Providing admission and discharge notifications 24 hours/day, 7 days/week.

Re-authorization

If a preauthorized admission is expected to extend beyond the initially assigned length of stay, the admission is subject to concurrent review and must be re-authorized. Re-authorization must be completed on or before the last day of the approved hospital stay. The re-authorization process is the same as the prior authorization process.

Admissions From ER

GlobalHealth must be notified by the hospital of all emergency admissions on the day the Member's status changes to inpatient. GlobalHealth will obtain clinical information from the hospital on the first business day following admission. Subsequent reviews are performed following the concurrent review process above.

Discharge Planning

Transition of care management/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 patient'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 assessment of needs, including barriers to successful discharge, plan development, plan implementation, and evaluation of effectiveness. Discharge planning activities include:

- Assessing patient'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 multidisciplinary meetings to include patient and family members, 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 Beacon Health Options at

- Documenting and communicating the discharge plan.

- Ensuring patient understanding of discharge orders and follow-up care required.

- Submitting other Referrals 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

The full discharge plan should make best effort to communicate 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 will vary based on the individual patient's circumstances and may occur by telephone or through on-site reviews.

Proactive Outreach Program

GlobalHealth's Proactive Outreach 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 emergency room visits through helping Members regain optimum 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 Proactive Outreach Program offers two types of support for GlobalHealth Members: discharge outreach and case management.

Contracted Providers can refer a GlobalHealth Member by either calling Provider Services or completing the online enrollment for at https://www.globalhealth.com/case-management/enroll-in-case-management/.

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 ER visits.

Exclusion from program includes:

- Female Members who had a vaginal birth with no complications or conditions (hypertension, depression, etc.) and a healthy newborn.

- Any Member being discharged to a hospice or nursing home facility.

Case Management

Members can enter into case management through predictive modeling, self-referral or Referral from a care team member. Case management assists Members with:

- Removal of social, cultural and economic barriers

- Internal and external coordination of care

- Disease state education

- Development and implementation of a health management plan

- Monitoring and follow-up

Global Health Proactive Outreach is an opt-out program; all eligible Members are enrolled, but may decline to participate at any time. To opt-out of case management please notify GlobalHealth customer care or case management team.

Cases that May Require Special Care

Conditions that may benefit from case management intervention include, but are not limited to:

- Amputations
- Anxiety
- Asthma
- Burns (severe)
- COPD
- CHF
- Cystic Fibrosis
- Depression/Suicidality
- Diabetes
- Eating disorders
- Hospital admission greater than the expected length of stay (LOS)
- Head injuries
- Hemophilia
- IV therapy (long-term)
- Muscular/neurological disorders (traumatic and degenerative such as ALS, MS, MD, or paralysis)
- Neonates with high risk complications or congenital anomalies
- Pre-term labor/high-risk pregnancies
- Rehabilitation (long-term)
- Rheumatoid arthritis (severe)
- Spinal cord injury
- Substance use disorder (alcohol, illegal and/or prescription drugs not being used as prescribed)
- Transplant candidates
- Trauma (Major)
- Ulcerative colitis

Behavioral Health Benefits

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

Beacon Health Options can assist Members with:

- Finding a Contracted Provider.

- Crisis intervention.

- Referrals to community resources and self-help groups.

Pharmacy

There are two Pharmacy Benefit Managers (PBM):

Magellan Rx Management for GlobalHealth Commercial Members

CVS Caremark for GlobalHealth Medicare Advantage Members

Optimizing Member Benefits

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

- Many drug tiers have cost-sharing breaks for the Member in 90-day supplies versus 30-day supplies.

- Prescribe a generic whenever appropriate.

- MA 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 formularies for information about drug tiers and cost shares at www.GlobalHealth.com/pharmacy/drug-pricing/.

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, as applicable per benefit design, by either GlobalHealth Pharmacy Department (commercial plans) or CVS Caremark (Medicare Advantage plans).

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.

The prior authorization process and point of contact is different for Medicare Advantage and commercial plans. The GlobalHealth Pharmacy Department performs prior authorization reviews for the commercial plans. CVS Caremark provides prior authorization reviews for Medicare Advantage plans.

Type	Description
Prior Authorization (PA):	Physicians 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.
Medicare Advantage Formularies - Limited Access (LA):	Prescription may only be available at certain pharmacies. Physicians will need to consult the Pharmacy Directory or call Customer Care at 1-866-494-3927 (toll-free) 24 hours a day, seven days a week.
Step Therapy (ST):	Step therapy requires one or more prerequisite, clinically equivalent drugs to be tried before a step therapy drug will be covered.
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.
Medicare Advantage Formularies - Not Mail Order (NM):	Drugs that are not available through mail-order.
Medicare Advantage Formularies - (B/D):	Drugs that require coverage determination for Medicare Part B or Part D are designated with the abbreviation B/D.

Exception Process

Commercial Plan Standard Exception:

You can request GlobalHealth to waive coverage restrictions and limits. Call (918) 878-7361 to request an exception. You may submit your request in writing, electronically, or telephonically. Requests may be faxed to (405) 280-5613.

This exception process also applies to new Members who are taking drugs that require coverage determination or taking non-formulary drugs. GlobalHealth could 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 exceptions process when:

- The Member is suffering from a health condition that may seriously jeopardize his/her 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 the duration of the prescription, including refills.
- If GlobalHealth denies your exception request, you may request an external review.

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

Medicare Advantage Plan Standard Exception:

You can request GlobalHealth to waive coverage restrictions and limits. Call (866) 494-3927 to request an exception. You may submit your request in writing, electronically, or telephonically. Providers can contact CVS Caremark at (866) 494-3927 (toll free) or fax completed forms to CVS Caremark at (855) 633-7673. Forms for a Medicare Coverage Determination are available at www.GlobalHealth.com under the Pharmacy & RX Tab.

Medicare beneficiaries who are new to GlobalHealth Medicare Advantage can receive a "transition supply" of medication for the first 90 days of their membership under certain circumstances. The temporary supply will be for a maximum of a 30-day supply. If the Member is in Long-term Care, the supply is for up to 31 days, during the first 90 days of enrollment.

Medicare Advantage Plan Expedited Exception:

You may request an expedited exceptions process when:

- The Member is suffering from a health condition that may seriously jeopardize his/her 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 to begin the review.

- If granted, we approve the request for an exception, our approval usually is valid until the end of the plan year. 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.

Pharmacy Types

Mail Order Pharmacy Service

Both Magellan Rx Management and CVS Caremark offer the convenience of mail order.

> For commercial plan Members, Contracted Providers can submit the prescription and completed fax form to Magellan Rx Management at 888-282-1349. Forms are available at https://www.GlobalHealth.com/prescriptions.aspx. Maintenance medications are mailed to the Member's home in a 90-day supply.

- For MA Members, providers can contact CVS Caremark at 800-378-5697 (toll free) or fax completed form and prescription to CVS Caremark at 800-378-0323. Forms are available at www.GlobalHealth.com under Pharmacy & RX. Maintenance medications are mailed to the Member's home in either a 30-day or 90-day supply.

Retail Pharmacy Network

The Member may receive up to a 30-day or up to a 90-day supply of a maintenance drug at a retail network pharmacy for the applicable supply Copayment or Coinsurance. Retail network pharmacies can be found on www.GlobalHealth.com.

Medicare Advantage Standard and Preferred Cost Sharing Pharmacies

GlobalHealth MA 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 designated in the Pharmacy Directory on the GlobalHealth website, https://www.globalhealth.com/pharmacy-directories/.

Chickasaw Nation Refill Center Medications by Mail

Chickasaw Nation Refill Center is a Native American-owned retail pharmacy located in Oklahoma. It provides prescription medications to Native Americans. The Member must complete the Native American Prescription Benefit Program Patient Enrollment form available on www.GlobalHealth.com and submit to Chickasaw Nations Refill Center. Proof of Native American status in one of the federally recognized tribes is required. Once Native American heritage is established with Chickasaw Nation Refill Center, the Member may receive cost-share discounts. Medications are mailed directly to the Member's home or designated location. Non-Native American spouses are also covered. Prescriptions may be a 30- or 90-day supply. Online prescription services available at www.cnrefillcenter.net.

Specialty Pharmacies

Contracted specialty pharmacies may fill prescriptions for specialty medications and mail them to the Member's home. 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-sharing responsibility. 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 on in the Pharmacy Directory or by provider search at www.GlobalHealth.com.

Medication Therapy Management Program

GlobalHealth MA Members taking multiple medications for chronic conditions can receive support from our medication therapy management program. 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 MA Members. Benefits include personalized service from registered pharmacists and staff.

GlobalHealth commercial plan Members can be referred for a similar pharmaceutical review at the request of the PCP.

Refer a Member:

Contact the Provider Services Department:
        1-866-277-5300 (toll-free)
        711 (TTY)

Prescription Drug Addiction

ATTENTION: PRESCRIPTION PAIN RELIEVERS CAN BE HIGHLY ADDICTIVE AND DANGEROUS!

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 Beacon Health Options 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, residential substance abuse treatment as well as assisting Members with gaining community resources that will help in their recovery process.

Claims, Payment, and Time Limits for Filing Claims

Providers must 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 the date of the primary carrier's Remittance Advice (RA) showing their payment or denial.

Claims Reimbursement

GlobalHealth will reimburse for Covered Health Care Services on timely filed claims in accordance with contractual agreements and applicable statutory requirements less any applicable Copayments, Coinsurance, and/or Deductibles owed by the Member. Unless otherwise specified, GlobalHealth follows Centers for Medicare and Medicaid Services (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 Remittance Advice (RA) detailing how each service was processed.

Claims Submission

Claims must be submitted electronically or mailed to the applicable address. GlobalHealth utilizes the following clearing houses for electronic claims submission:

- Change Healthcare (Emdeon)
- Gateway EDI**
- ClaimLogic**
- Optum
- The SSI Group
- TK Software
- InfinEDI
- G4 Health
- HMS
- Magellan (PBM for Comm)

GlobalHealth's electronic data interchange (EDI) number is GHOKC. The EDI Claims Submitter Request Form can be found at http://www.GlobalHealth.com/providers_edi.aspx.

Please use the appropriate mailing address.

Medicare Advantage: Commercial:

GlobalHealth, Inc.   GlobalHealth, Inc.
ATTN: Claims   ATTN: Claims
P.O. Box 1747   P.O. Box 2328
Oklahoma City, OK 73101-1747   Oklahoma City, OK 73101-2328

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. Providers who submit claims on paper, proof of timely would consist of a printout from their billing system showing when the claim was billed.

Claims Adjudication

GlobalHealth reviews and evaluates claims for:

- Correct coding (ICD-10, CPT-4®, or other required coding as applicable).
- Correct billing (UB-04 or CMS-1500 format).
- Coverage criteria.
- Medical necessity.
- Approved Forms:
    o CMS 1500
    o UB-04
    o Electronic Filing

Responsibility for Payment

The Members Are Responsible for Payment of:

- Their Deductible, Copayments, or Coinsurance for approved Covered Health Care Services.
- The charges for services provided by a provider without an authorized Referral, when prior authorization is required.
- The cost of services not included in their GlobalHealth plan benefits.
- Full billed charges when:
    o The services were non-covered services.
    o The services were received out-of-network and were not authorized by GlobalHealth.
    o 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.

Some commercial plans have a Deductible for some services. ER, hospital, some diagnostic tests, and outpatient surgery all are subject to a Deductible if a plan has one. Preventive services are not subject to any Deductible.

Maximum Out-of-Pocket (MOOP):

For GlobalHealth plans, Member expenses are limited by a maximum out-of-pocket (MOOP) amount. If a Member has reached the MOOP, a Contracted Provider should not apply any Member cost-share for the Covered Health Care Services. Contracted Providers may obtain a Member's MOOP information via GlobalLink™ 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.

The 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 accepts the GlobalHealth reimbursement as payment in full and may NOT "balance bill" a GlobalHealth Member. In other words, the Contracted Provider may not look to a GlobalHealth Member for payment 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) program for Medicare 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 the QMB program have no legal obligation to pay Medicare providers for Medicare Part A or Part B cost-sharing.

https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB

Remittance Advice (RA)

The RA GlobalHealth issues 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 GlobalLink™.

Reasons for Payment Delays

It is GlobalHealth's goal to 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:

- No employer or group number or Member number
- No authorization numbers
- 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 GlobalLink™ to obtain claims status.

Situations That May Affect Hospital Reimbursement

Reimbursement for inpatient services may be affected in certain situations described below.

1. Pended for Quality Medical Record 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 on admission as defined by the Centers of Medicare and Medicaid Services (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™ Care Guidelines, 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" or "Serious Reportable Events" (SRE) as defined by the CMS and National Quality Forum (NQF).

2. Healthcare services or diagnosis not supported due to inadequate documentation in the requested medical record.

3. 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:

  o Industry standard UM criteria and/or care guidelines, including MCG™ Care Guidelines, Hayes, Inc., CALOCUS or LOCAT (current edition on date of service)

  o Social Security Act

  o U.S. Food and Drug Administration Guidance

  o National professional medical societies' guidelines and consensus statements

  o Publications from specialty societies such as the American Society for Parenteral and Enteral Nutrition, American Thoracic Society, Infectious Diseases Society of America, etc.

  o Department of Health and Human Services final rules, regulations and instructions published in the Federal Register

  o 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
    ➢ American Psychiatric Association

Claim Denial

GlobalHealth will notify the provider of a denial or partial denial within 30 calendar days after receipt of the claim. This period may be extended one time by GlobalHealth for up to 15 days, 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 30-day 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 45 days from receipt of the notice to provide the specified information.

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 at www.GlobalHealth.com, Provider tab. 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. The request should 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 claim review requests equals the claims timely filing limit stated in your contract. Example: if your timely filing is 60 days, you have 60 days from the date of denial to submit a claim review request. This time frame applies only to claims denied for notes, medical records, or request for missing information and non-clean claims.

For review requests arising out of claims denied for no authorization or disagreement with the payment amount, a request must be submitted within the specified time frames outlined in the Agreement.

Claims Payment Recovery

If GlobalHealth overpays a claim for services or pays for services where the Member was not eligible for coverage at the time services were rendered, GlobalHealth may request a refund. This allows GlobalHealth to recoup overpayment amounts by subtracting such amounts from future payments. The provider will be notified of any offset amount, the name of the Member for whom an overpayment was made, and the relevant dates of service 30 days before the recoupment. Identifying information will be noted on the Remittance Advice.

Laboratory Testing

If the Contracted Provider has a CLIA-approved lab on site, he/she 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 patient to a GlobalHealth contracted laboratory facility or draw and send the lab specimen to a GlobalHealth contracted laboratory.

Drug Testing Limitations

The test may be limited to the detection of specific drugs. The frequency of the testing is limited to the lowest level to detect the presence of drugs. Drug confirmation is limited to:

- When the result of the screen is positive, or

- The result is negative and negative finding is inconsistent with the medical history.

Confirmatory testing must be necessary for treatment planning and appropriate referral.

Drug Testing Exclusions

- Testing ordered by third parties, such as school, courts, or employers or requested by a provider for the sole purpose of meeting the requirements of a third party.

- Testing for residential monitoring.

- Routine urinalysis for confirmation of specimen integrity.

Compliance Program

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

- A designated Chief Compliance Officer
- Written Code of Conduct
- Auditing and monitoring, including methods for detecting fraud, waste, and abuse
- 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.

Chief Compliance Officer

The Chief 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 at 1-877-280-5852 (toll-free).

You may also contact our Compliance Officer in writing at:

> GlobalHealth, Inc.
> ATTN: Compliance Officer
> 210 Park Avenue
> Suite 2800
> Oklahoma City, OK 73102-5621

Code of Conduct

All participating Providers are expected to adhere to the GlobalHealth Compliance Program, including the Code of Conduct. A current copy of the Code of Conduct is available on the GlobalHealth website.

Auditing and Monitoring

Fraud, Waste and Abuse

GlobalHealth is committed to an effective Fraud, Waste, and Abuse (FWA) Program to detect, correct, and prevent 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.

Fraud alerts are posted on the GlobalHealth website.

Audit

GlobalHealth reserves the right to audit paid claims in order to determine payment accuracy and as part of its program to detect FWA. 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.

Such claims include, but are not limited to:

- Inpatient short stays

- Outpatient observation greater than 24 hours

- Inpatient high-severity DRG

- Readmissions within 30 days

- High dollar claims

- Multiple units billed

- Targeted areas identified by the Office of the Inspector General (OIG), CMS or other entity as being high risk for error

Education and Training

Education on FWA is available on the GlobalHealth website. Additionally, the GlobalHealth Compliance Officer will provide FWA and other compliance-related training to Contracted Providers upon request.

Hotline

Contracted Providers are expected to report known or suspected compliance violation. 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.

Call and leave message 24 hours a day

   405-280-5852 (local)
   1-877-280-5852 (toll-free)

Email

   compliance@globalhealth.com

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 helps GlobalHealth improve health plan functions and services from Contracted Providers. It provides the framework to assess and improve the quality of care and services. 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:

- The National Committee for Quality Assurance (NCQA).

- The Centers for Medicare and Medicaid Services (CMS).

The program identifies issues and opportunities for improvement. Multi-disciplinary work groups, comprised of 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. We implement changes to address identified opportunities. We follow up in areas that need improvement.

Quality Improvement Program Goals:

- Improve Member health by increasing utilization of preventive health, behavioral health, and chronic care services as evidenced by improved HEDIS®/CAHPS® and HOS scores and reduced inpatient admissions

- Improve transitions in care for high-risk Members with chronic conditions

- Improve Member education of chronic disease states and engage the Member in care management plans

- Reduce all-cause readmission rates

- Improve Member adherence to medications for treatment of diabetes, cholesterol, and blood pressure

- Maintain a high-level of Member and Contracted Provider satisfaction, based on survey scores
- Medicare Advantage plan with 4 out of 5 Star Rating
- Meet or exceed external regulatory and accreditation standards (CMS, NCQA, OPM)
- Improve member satisfaction and exceed industry quality measure benchmarks: HEDIS® /CAHPS®/HOS

Ratings and Accreditation

GlobalHealth continually strives to improve health plan performance of the measures for Medicare Star Ratings and NCQA accreditation.

Medicare Advantage Plan Ratings (Star Ratings)

Every year, CMS evaluates Medicare Advantage 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 satisfaction 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 satisfaction 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.

Commercial Plan Accreditation

GlobalHealth demonstrates its commitment to high quality value-based services by undergoing a standardized, comprehensive evaluation of clinical measures and consumer experience conducted by the National Committee for Quality Assurance (NCQA) every three years. GlobalHealth was last accredited in 2019. The accreditation covers all non-Medicare Advantage Plans, including State and Federal employee plans. The assessment measures several areas of performance:

- **Staying healthy:** Health plan activities that help Members maintain good health and avoid illness. Did the health plan provide doctors with guidelines about appropriate preventive services and did Members receive appropriate tests and screenings?

- **Getting Better:** Health plan activities that help people recover from illness. How does the health plan evaluate new medical procedures, drugs and devices to ensure that patients have access to the most up-to-date care?

- **Living with Illness:** Health plan activities that help people manage chronic illness. Does the health plan have programs in place to help patients manage chronic conditions?

- **Qualified Providers:** Health plan efforts to ensure that each doctor is licensed and trained to practice medicine and that health plan Members are happy with their doctors.

- The accreditation standards look at the health plan's:
  - Quality Improvement Management
  - Population Health Management
  - Network Management
  - Utilization Management
  - Credentialing and Recredentialing
  - Member Experience
  - HEDIS® and CAHPS® survey results

Federal Employees Health Benefit (FEHB) Plan Performance Assessment

In addition to the NCQA accreditation, the U.S. Office of Personnel Management (OPM) performs an annual assessment of the FEHB carriers, which evaluates the following areas:

- Clinical Quality
  - Members' use of preventive care and behavioral health services (HEDIS®)
  - Members' adherence to medications (HEDIS®)
  - Chronic disease management services
- Customer Services
  - Communication with Members (materials, etc.)
  - Access to services
  - Members' experience and engagement (CAHPS® Surveys)
- Resource use

- o How well we manage utilization of services (over and underutilization, medical necessity)
- Contract Oversight
  - o Compliance with Contract
  - o Responsiveness to OPM
  - o Technology Management and Data Security

Preventive Care and Clinical Practice Guidelines

Preventive Care Guidelines

GlobalHealth adheres to the preventive care guidelines for each product line. Not everyone needs every preventive service. You should determine which services are right for each individual Member.

Commercial:

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

Medicare Advantage:

CMS requires coverage at no cost share to MA 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 C Virus Screening
- HIV Screening

- Influenza Virus Vaccine & Administration
- Initial Preventive Physical Examination
- IBT for Cardiovascular Disease
- Hepatitis B Vaccine & Administration for high or intermediate risk members
- IBT for Obesity
- Lung Cancer Screening
- Medical Nutrition Therapy
- Medicare Diabetes Prevention Program
- Pneumococcal Vaccine & Administration
- Prostate Cancer Screening
- Screening for Cervical Cancer

- Screening for STIs and HIBC to Prevent STIs
- Screening Mammography

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

Clinical Practice Guidelines

The evidence-based clinical practice guidelines on care that we recommend for the following Member subgroups are posted on our website. Additional reference sources for preventive guidelines are the American Academy of Pediatrics, Centers for Disease Control and Prevention and Life Stages: Centers for Disease Control and Prevention. Disease Control and Prevention. Guidelines for preventive care are available for:

- Perinatal
- Children up to 24 months old
- Children 2-19 years old
- Adults 20-64 years old
- Adults 65 years and older

Preventive health guidelines can be found on the GlobalHealth website at https://www.globalhealth.com/healthy-living-tips/maintain-your-health/preventive-care/. The Clinical Practice guidelines are located at here.

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) for all lines of business. GlobalHealth expects its Contracted Providers to follow established evidenced-based standards of care.

Contracted Providers are expected to make medical records and other requested information available to support the review of services rendered. The Quality Department will utilize electronic medical record review (EMR) access when possible to complete the reviews.

Cases that may be subject to review by the Quality Medical Review Committee 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 Foundation (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. The Committee is comprised of physicians, nurses, pharmacists, and behavioral health clinicians.

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

The Quality Department medical reviewer will notify the Claims Department of the potential coding discrepancy but will not issue a notice to the Contracted Provider unless other quality issues were identified. The Claims Department may take additional action on the identified coding discrepancy.

Never Events (NE) are also known as Serious Reportable Events (SRE) or Sentinel Events (SE) (The Joint Commission). They include medical errors that are preventable, of a serious nature (i.e., resulting in death or serious physiological or psychological injury or risk thereof) and were clearly identifiable and measurable. The NE apply to hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, and long-term care/skilled nursing facilities.

Never Events (NE) 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. A complete list is available at https://www.qualityforum.org/Topics/SREs/List_of_SREs.aspx.

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

Medical Review Process

GlobalHealth reserves the right to audit claims and make or request adjustments based on comparison of medical records to claims payment, determinations of 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 request.

When a case is referred for medical review, the licensed reviewer conducts an initial review of the available and relevant medical records and may research related conditions and standards of care as indicated. The licensed reviewer summarizes the case and presents it to the Medical Review Team for discussion. If the Medical Director determines 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, we 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 Quality Department 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 Quality Department 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 the Agreement and will be referred to the Provider Relations Department for follow-up.

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

Please note: The Quality Department medical review appeal process and the Claims Department payment appeal process are separate and distinct appeal processes. Even if a case is closed to the Quality Department, you may still have Claims appeal rights available as outlined in the 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 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.

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. Providers must respond to requests within 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.

Pharmacy complaints and grievances will be reviewed by the PBMs.

Resources

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

Hospital-Acquired Condition Reduction Program: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html

HEDIS®

The Healthcare Effectiveness Data and Information Set ([1]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.

To ensure that HEDIS® stays current, NCQA has established a process to evolve the measurement set each year. NCQA's Committee on Performance Measurement, a broad-based group representing employers, consumers, health plans and others, debates and decides collectively on the content of HEDIS®. This group determines what HEDIS® measures are included and field tests determine how it gets measured.

HEDIS® is used by the Centers for Medicare & Medicaid Services (CMS) and NCQA for monitoring the performance of managed care organizations. Data is collected for measures related to preventive care. NCQA has expanded the size and scope for HEDIS® and includes 91 measures across 7 domains of care. As a health plan, GlobalHealth 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 are randomly selected for review to ensure quality care is being provided to GlobalHealth Members. PCPs and OB/GYNs are the primary participants. However, if the data is 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 electronic medical record (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. For individual or very small amounts of records, compliant 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. On-site visits are designed to take the burden of complicated record review away from provider office staff. Any questions about HEDIS® record review should be directed to the contact information that is provided in the request.

[1]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. HEDIS® results are included in Quality Compass, an interactive, web-based comparison tool that allows users to view plan results and benchmark information. Quality Compass users benefit from the largest database of comparative health plan performance information to conduct competitor analysis, examine quality improvement and benchmark plan performance.

CAHPS®

GlobalHealth participates in the CAHPS® 5.0 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. There are two versions of the CAHPS® survey that we participate in: Adult Commercial and the Medicare Advantage and Prescription Drug. These surveys are distributed annually to a random sample of GlobalHealth Members.

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 spent enough time with Member
- Follow-up of test results with Member
- Medication review with Member
- Ease of access to Specialist Physicians
- Smoking cessation discussion/counseling
- Annual flu vaccine

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

Provider Satisfaction

Member satisfaction is only part of the quality improvement picture. To continually improve upon health plan services, GlobalHealth may conduct Provider Satisfaction Surveys. The survey identifies the providers' level of satisfaction including, but not limited to:

- GlobalHealth overall
- UM/Referral Department
- Complex Case Management Department
- Provider Relations Department
- Claims Department

Member Rights and Responsibilities

As a partner with GlobalHealth, you should be aware of our Member Rights and Responsibilities.

Our Members have the right to:
- Receive information about GlobalHealth, its services, practitioners and providers, and Member rights and responsibilities.
- Be treated with respect and recognition of his/her dignity and right to privacy.
- Ask questions about any medical advice or prescribed treatment in order to make an informed consent or refuse a course of treatment.
- A candid discussion of all appropriate, Medically Necessary treatment options that are recommended, regardless of the cost or benefit coverage.
- To participate in decisions regarding medical care, to completely understand his/her medical condition, health status, and the medications prescribed (including why the medication is being prescribed, how to take it properly, and possible side effects).
- Voice complaints or grievances about GlobalHealth or the care the Member received without discrimination, retaliation, or adverse effect.
- Appeal any unfavorable medical or administrative decisions by following GlobalHealth's established appeals and grievances procedures. Members have the right to an external or expedited review of an adverse determination when applicable.
- Timely access to his/her PCP and Referrals to Specialist Physicians when Medically Necessary or urgent.
- Use emergency services when the Member, acting as a prudent layperson, has a reasonable belief that an Emergency Medical Condition exists.
- Confidential treatment of individual identifiable or protected health information as required by federal and State laws.
- Receive explanations of benefits and claims processing determinations.
- Expect problems to be fairly examined and appropriately addressed.

- Exercise Member rights regardless of race, national origin, gender, sexual orientation, marital status, or cultural, economic, educational, or religious background.

Our Members have the responsibility to:
- Identify himself/herself as a GlobalHealth Member by presenting a Member ID card to the provider of services.

- Provide, to the extent possible, information and medical records needed by the provider in order to render appropriate care.

- Do their part to improve their own health condition by following treatment plans and instructions.

- Be on time for appointments and notify the provider in advance as possible if the Member needs to cancel or reschedule an appointment.

- Notify their PCP as soon as possible, if hospitalized or if emergency or out-of-network Urgently Needed Services were received.

- Pay all required Copayments.

Risk Adjustment Program

As of January 2014, 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 patient's disease. In order to achieve the calculation, CMS and HHS require us to annually provide demographic and health status of our Medicare Advantage 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 to use must be complete and accurate.

GlobalHealth and providers have a mutual interest in ensuring the provision of quality care to Members including the assessment and treatment of existing medical conditions that are supported by appropriate medical record documentation. Providers are expected to participate in the diagnosis coding review process. 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 code all conditions identified during office visits. Provider uses best efforts to coordinate with specialty providers to ensure accuracy and completeness of the medical record. HCC coding auditors also arrange on-site reviews of medical records for the supporting documentation and help train clinic staff on what is needed to document the health conditions appropriately. Contracted Providers are expected to cooperate in providing records and to be available for HCC training. GlobalHealth will use electronic medical record (EMR) access when possible to conduct the reviews.

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.

Primary Care and Specialist Physician Credentialing Requirements:

- Submit a complete standardized application or a completed Council for Affordable Quality Healthcare (CAQH) with original signature (no signature stamps).

- Current unrestricted State license.

- Graduation from a school of medicine or osteopathy that is accredited by the Liaison Committee on Medical Education and completion of residency. Graduates of foreign medical schools must be certified by the Educational Commission for Foreign Medical Graduates (ECFMG certificate). For other practitioners, graduation from an appropriate accredited professional school and/or completion of a formal training program.

- A current and unrestricted DEA certificate and Controlled Dangerous Substance certificate, if applicable.

- Board certification or Board eligibility.

- Evidence of Medicare certification.

- Current and unrestricted admitting privileges in good standing at a GlobalHealth contracted hospital.

- Demonstration of current professional liability insurance minimum requirements, unless otherwise agreed to.

- 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 hour, seven days per week coverage.

- 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.

Non-Physician Practitioner Criteria

To be credentialed as a non-physician practitioner, the applicant must be licensed as a Nurse Practitioner (NP), Clinical Nurse Specialist (CNS) or Physician's Assistant (PA) and provide the following:

1. Submit a complete standardized application or a completed Council for Affordable Quality Healthcare (CAQH) with original signature (no signature stamps).

2. Current unrestricted State license.

3. Graduation from an appropriate accredited professional school and/or completion of a formal training program.

4. Evidence of Medicare certification.

5. Demonstration of current professional liability insurance minimum requirements, unless otherwise agreed to.

6. 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.

7. Absence of a history of disciplinary actions affecting applicant's professional license, 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 sub-standard performance.

8. 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.

9. 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.

10. 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 abuse exists that would affect applicant's ability to adequately perform the professional duties for which applicant is contracted.

11. Absence of physical or mental condition that would impair the ability to competently and safely perform the professional duties for which an applicant is seeking.

12. Evidence of the capability to provide twenty-four (24) hour, seven (7) days per week coverage, if applicable.

13. Work history for at least the past five years.

Hospitals 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 will conduct an on-site review to ensure the entity meets quality standards established by TJC and GlobalHealth. GlobalHealth will confirm the entity continues to be licensed and in good standing with State and federal bodies at least once every thirty-six (36) months.

Hospital and facility Contracted Providers must provide the following:

1. Submit a completed GlobalHealth "Ancillary & Facility Application" along with the necessary attachments.

2. Evidence of Medicare certification.

3. Copy of current accreditation approval letter (e.g., TJC) and state licensure or waiver upon renewal with issuing body.

4. If an organization is not accredited, the entity must provide current copies of its DEA certification, CLIA/CAP certification, and any other relevant certifications held by the organization.

5. If an organization is not accredited, GlobalHealth will conduct an on-site review. Any deficiencies identified during the on-site visit are communicated to the entity with a request for corrective action plan within GlobalHealth's requested timeframe. Failure to timely correct deficiencies may result in a determination not to credential the organization. (Survey results provided by a regulatory agency may be accepted in place of a site visit at GlobalHealth's sole discretion.)

6. Entities that are not accredited must also have an acceptable malpractice claims history as approved by GlobalHealth. The entity must provide the number and facts of each legal action brought against it in the three (3) years prior to the application and the resolution of

such action (e.g., withdrawn, dismissed, judgment, or settlement), including the amounts of settlements and judgments.

7. The entity must submit a copy of its Quality Assurance/Quality Improvement (QA/QI) and Risk Management Plans and a copy of its medical staff roster.

Re-credentialing

To remain in the GlobalHealth network, all Contracted Providers must be re-credentialed, at a minimum, every 36 months. Provider are expected to submit all appropriate documentation to ensure reappointment is timely. The information can be submitted to ghcredentialing@globalhealth.com.

Credentialing/Re-credentialing Appeal Process

GlobalHealth will:

- Provide written notification when a professional review action has been brought against a practitioner, reasons for the action, and a summary of the appeal rights and process.

- Allow practitioners to request a hearing and provide the specific time period for submitting the request.

- Allow at least 30 calendar days after the notification for practitioners to request a hearing.

- Allow practitioners to be represented by an attorney or another person of their choice.

- Appoint a hearing officer or a panel of individuals appointed by GlobalHealth to review the appeal. This panel will include, at a minimum, the GlobalHealth Medical Director, or designated MD or equal practitioners, and one network practitioner to participate in the appeal.

- Provide written notification of the appeal decision that contains the specific reason for the decision within 10 business days.

- Follow all applicable State law requirements.

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 and Fraud Enforcement Recovery Act
- 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)
- 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 and Fraud Enforcement Recovery Act

The Federal False Claims Act was enacted by Congress as an effective tool in combating fraud against the federal government. It 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.

HIPAA/Protected Health Information (PHI)

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 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 collected and used for:

- Clinical review.
- Satisfaction and quality studies.
- Complaint and/or appeal investigation.
- Fraud detection.

- State, federal, or accreditation reviews.

- Other matters as required by law.

To report a possible privacy violation or breach, please contact the GlobalHealth Compliance and Privacy Officer at (405) 280-5524 (direct phone) or 1-877-280-5852 (recorded hotline), email privacy@globalhealth.com, or write to:

>ATTN: Privacy Officer
>GlobalHealth, Inc.
>210 Park Avenue, Suite 2800
>Oklahoma City, OK   73102-5621

Notice of Privacy Practices (NPP)

THIS NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION (PHI) MAY BE USED AND/OR DISCLOSED. PLEASE REVIEW IT CAREFULLY.

GlobalHealth, Inc. (GlobalHealth) is committed to protecting 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.

How GlobalHealth May Use or Disclose Your Health Information:

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

For Payment. We may use and/or disclose member PHI for purposes of paying claims from physicians, hospitals, and other healthcare providers for services delivered to member that are covered by health plan; to determine member 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 member participates; and other payment related functions.

For Health Care Operations. We may use and/or disclose PHI about members 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.

Health-Related Business and Services. We may use and disclose member PHI to inform of health-related products, benefits, or services related to member 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 members 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); and

- In the course of any administrative or judicial proceeding, where required by law.

Business Associates. We may use and/or disclose member 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 authorized representative.

Family, Friends, Caregivers. We may disclose member PHI to a family member, caregiver, or friend who accompanies member or is involved in member's medical care or treatment, or who helps pay for member's medical care or treatment. If member is unable or unavailable to agree or object, we will use our best judgment in communicating with member's family and others.

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

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

Inmates. If member is an inmate of a correctional institute or under the custody of law enforcement officer, we may disclosure member's PHI to the correctional institute or law enforcement official.

Appointment Reminders. We may use and/or disclosure member PHI to contact member as a reminder that member has an appointment for treatment or medical care. This may be done through direct mail, email, or telephone call. If member is 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 member PHI to remind member to refill their prescriptions, to communicate about the generic equivalent of a drug, or to encourage member to take prescribed medications.

Limited Data Set. If we use member 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 member information.

Any Other Uses. We will disclose member PHI for purposes not described in this notice only with member's 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 member's written authorization.

NOTE: 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.

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)

Physician self-referral is the practice of a physician referring a patient to a medical facility in which he has a financial interest either directly or indirectly. CMS published the self-referral disclosure protocol (SRDP) that sets forth a process to enable providers of services and suppliers to self-disclose actual or potential violations of the physician self-referral statute.

The Medicare Improvements for Patients and Providers Act (MIPPA)

Legislation enacted to expand access to care, enhance the quality of healthcare, and provide coverage for certain preventive services.

Anti-Kickback Statute

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

American with Disabilities Act

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. See the Cultural Competence section in this Provider Manual.

Non-Discrimination Notice

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.

If you believe that GlobalHealth has discriminated in any way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: **ATTN: Executive Director, Compliance & Legal Services, 210 Park Avenue, Suite 2800, Oklahoma City, OK 73102, or Email: Compliance@globalhealth.com.** You can file a grievance in person or by mail or email. 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.

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Issued February 2020