Provider Manual
New Mexico

FRIDAY HEALTH PLANS
PROVIDER MANUAL

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Introduction

Our Mission: Friday Health Plans' mission is to empower more people to choose their own health insurance by offering plans that are affordable, simple and friendly – purpose-built for the modern healthcare consumer.

Our Service Area: Friday is licensed in the following Texas counties: Travis, Tarrant, Dallas, El Paso, Harris, Lubbock and Bexar

Our Products: We are licensed by the Division of Insurance as a commercial carrier and offer Small Group and Individual benefit plans. Qualified Health Plans are offered to individuals both outside and inside of the state health insurance marketplace, Healthcare.gov.

Our Values: Friday is proud of our role as a trusted partner with physicians, hospitals, and other healthcare professionals. We understand the challenges of ensuring access to healthcare, and believe that our Members have the right to quality healthcare services as close to home as possible.

- ☐ **Growing** We are innovative, calculated risk takers who continually strive to learn and improve. We question the status quo as we aim to operate more efficiently and at lower costs.
- ☐ **Trustworthy** We are transparent in our actions and have integrity in all that wedo.
- ☐ **Caring** We are professional, respectful, and appreciate the unique contributions of every team member.
- ☐ **Teamwork** We openly listen and collaborate with others across the organization. We believe good ideas come from everyone.
- ☐ **Productive** We are motivated to achieve the goals of Friday and ourselves. We approach these goals with confidence and help other team members along the way.
- ☐ **Making a difference** We are dedicated to serving our members and providers. We make a positive impact in the communities where we serve.
- ☐ **Flexibility** We are adaptable and considerate in how wework.
- ☐ **Positive** We approach our work with a sense of fulfillment. We foster a culture where every day feels like Friday.

Our Goal: To make healthcare more available and affordable while at the same time providing exceptional service. We achieve this by building strong partners with our providers and in supporting their needs and the needs of our Members.

Provider Manual: This Manual is intended to help you utilize Friday procedures to better benefit you, our Members, other providers, and Friday. The Provider manual is available upon request by mail and at the Friday business office.

How to Reach Us

Provider/Customer Service Telephone:	1-844-805-5000
Fax:	(719) 589-4901
Hours:	Monday-Friday: 7:00 am - 7:00 pm MST
Email:	questions@fridayhealthplans.com
Website:	www.fridayhealthplans.com
TTY Service:	800-659-2656
Translation Services:	Contact Customer Service
Utilization Management:	
Telephone:	1-844-805-5000
Referrals & Prior Auth. Fax:	1-888-610-0019
Hours:	Monday-Friday: 8:00 am – 8:00 pm MST
Pharmacy (Capital Rx) Members:	855-792-2779
Provider/Prior Authorization:	855-792-2779
Claims Address:	Friday Health Plans PO Box 194 Sidney, NE 69162
Mailing Address:	700 Main St. Alamosa, CO 81101
Website:	www.fridayhealthplans.com
Friday Health Plans Portal	www.fridayhealthplans.com

Member Identification & Verification

Member Identification

Each person enrolled in a Friday Health Plans health benefit planis issued an identification card (ID Card). Members can be identified by line of business through the Plan code listed on the identification card.

The front of the Member's ID Card lists basic coverage information. The back of the ID card contains important information about precertification requirements, as well as contact information.

The Friday logo is always printed on the Member's ID card, for easy identification, as follows:

A copy of a Friday ID Card is provided in *ATTACHMENT A*.

Please take a moment to review the card at each visit to be sure that all information is noted correctly in your records. Members should present this ID Card when receiving healthcare services.

If the Member's card is not available, call Customer Service at 1-844-805-5000 to verify eligibility or login to the Friday Health Plans Portal. The Friday Health Plans Portal is available 24 hours a day, 7 days a week.

Note: Possession of the identification card does not guarantee eligibility of coverage. It is the responsibility of the provider to verify the eligibility of the cardholder prior to services being rendered.

Member Identification & Verification

Eligibility Verification

Member eligibility is determined on a month-to-month basis. For your protection it is important to verify eligibility **prior** to rendering **non-urgent, non-emergent** services to our Members. Please contact our Customer Service Team at 1-844-805-5000 or login to the Friday Health Plans Portal to verify Member eligibility and benefits before services are provided. Be prepared to provide the patient's name, identification number, date of birth and insured's name (if different from patient).

Questions you may want to ask us:

- ☐ Is the patient eligible for benefits?
- ☐ What benefits exist for this particular service?
- ☐ Are there any limits, exclusions, or prior authorization requirements?
  - If yes, where can I obtain a "Request for Authorization" referral form?
- ☐ Are there any co-payments that the Member is responsible for at time of service?
- ☐ Are there any deductibles or co-insurance for this service?

Friday may provide verification of your Participating Provider status to ensure the use of in-network providers. Additionally, if you need assistance with locating an in-network provider, including laboratory and radiology services, to whom to refer a Friday Member, please call Customer Service at 1-844-805-5000 or go to https://www.fridayhealthplans.com/member-hub/resources/find-a-doctor/co/ to search for an in-network provider.

Please be aware that you must notify Friday within 48 hours or the first business day following the provision of urgent or emergent services.

If a former Member or other ineligible person attempts to use an ID Card, please notify Friday immediately.

Member Rights and Responsibilities

Friday provides members in all lines of business at the time of enrollment a listing of their member rights and responsibilities. These member rights and responsibilities are designed to help members understand how to access information about and appropriately utilize the programs and services offered through their health benefit plan, and empower them to make informed and responsible choices about their health care. Please refer to *ATTACHMENTS B, C and E* to see the specific member's rights and responsibilities documents.

Cultural Competency

Cultural Competency is defined by the Office of Minority Health, U.S. Department of Health and Human Services (HHS) as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. The components of Cultural Competency include cultural expression and cultural background, language barriers, gender and gender roles, ethnicity, spiritual and religious beliefs, and communication with the elderly.

Friday encourages cultural competency by directing Providers to links and other sources of information designed to assist them in making informed choices in how they understand and serve the diverse needs of our Members. Friday is able to direct Providers to information that health care professionals can use to expand the quality of their interactions with patients whose culture or cultural influences may differ from their own. The information may help Providers improve their communication with patients from diverse cultural backgrounds and provide high-quality health care for all patients.

Health care organizations should provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs and offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them.

Friday has available a TTY system for the hearing-impaired at 800-659-2656, and uses the services of Translation Plus to assist Members who are non-English speakers. If your patients who are Members of Friday need to contact us about programs and services provided by or through Friday, you should inform them that these services are available. The Member can call Customer Service at 1-844-805-5000 and request these services.

The following is a list of resources that you can find on the internet to assist you in obtaining information and training materials, including self-assessment tools, on Cultural Competency:

- ☐ US Department of Health and Human Services:
    - Health Resources and Service Administration –
        - http://www.hrsa.gov/culturalcompetence/age.html
    - Office of Minority Health Knowledge Center Library -
        - http://www.minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=62
- Cross Cultural Healthcare Program –
    - http://xculture.org/cultural-competency-programs/cultural-competency-training/
- ☐ Cultural Competency Program for Oral Health Professionals
    - Cultural and linguistic competency helps oral health professionals deliver care that respects patients' cultural beliefs and language preferences. **By delivering oral health care that respects patients' cultural beliefs and language preferences, oral health professionals can better help patients meet their oral health care goals**.
    - The *CCPOHP* is the first HHS Office of Minority Health e-learningprogram that is based on the enhanced ***National Standards for Culturally and***

Linguistically Appropriate Services (CLAS) in Health and Health Care, published by the HHS Office of Minority Health in 2013. The *National CLAS Standards* help health and health care organizations implement culturally and linguistically appropriate services.

- The *Cultural Competency Program for Oral Health Professionals* is available at https://oralhealth.thinkculturalhealth.hhs.gov/. A flagship initiative fromthe HHS Office of Minority Health, Think Cultural Health offers a suite of freee-learning programs, resources, and other tools to promote cultural and linguistic competency in health care.

Suggestions, Inquiries, Complaints, Appeals and Grievances

Friday meets all federal and state statutes and regulations as well as contractual obligations and internal policies and procedures in processing suggestions, inquiries, complaints, grievances and appeals. Friday maintains procedures to collect, track and report suggestions, inquiries, complaints, grievances and appeals received by regular mail, telephone, hand-delivery, email, website or fax on behalf of Members and Providers. Should you wish to file a suggestion, inquiry, complaint, grievance or appeal on behalf of yourself or a Member, please contact Customer Service or your provider relations representative.

Definitions:

Suggestion: A suggestion is a proposal or recommendation offered by a member, provider, employee, or other for consideration by Friday. The suggestion is a representation of an idea that the suggester believes would improve the customer experience, a function or other aspect of the company. Suggestions may be verbal (e.g., telling a Friday representative or employee an idea) or written (e.g., sending a letter or email, writing a note, or entering a comment on the Friday website). The best suggestions provide useful comments and feedback that contribute to a positive outcome, a better process or improved behaviors.

Inquiry: An inquiry is defined as a contact by anyone, including agency personnel, members, a member's representative, providers, a provider's representative, or others, to give information, request information, or request action. This includes any oral or written request to Friday without an expression of dissatisfaction. Inquiries are routine questions and do not automatically invoke the grievance or organization determination process.

Complaint: A complaint is an oral or written statement of dissatisfaction with Friday or with health services provided through the health plan. Complaints are differentiated from inquiries only to the extent that the contact involves a clearly identifiable allegation of maladministration, misconduct or inefficiency on the part of a staff member, provider, or facility; or fraud or misconduct of any kind. Other complaints may involve benefits, services, payments, or decisions. The words "complaint" and "grievance" are sometimes used interchangeably. A complaint may be resolved without further action or may invoke the organization determination process.

Grievance: A grievance is an oral or written statement of dissatisfaction with the health plan or with health services provided through the health plan. The grievance involves a clearly identifiable allegation of maladministration, misconduct or inefficiency on the part of a staff member, provider, or facility; or fraud or misconduct of any kind. Other grievances may involve benefits, services, payments, or decisions. The words "complaint" and "grievance" are sometimes used interchangeably. A grievance usually invokes the organization determination process through documented action and is generally considered more formal than a complaint. It may require an investigation and response to the party lodging the grievance.

Appeal: An appeal is when a provider or member expresses disagreement with a Friday determination. The appeal may be administrative or medical.

- ☐ **An administrative appeal** is defined as a request to reverse an administrative (non-clinical, non-utilization management) determination including, but not limited to,

payment amount of claims, benefits coverage, member eligibility, credentialing and privileging, or missing referrals or authorizations.

- ☐ **A medical appeal** is defined as a request to reverse a medical (clinical or utilization management) authorization or claims determination including, but not limited to, coverage of health care services or prescription drugs or payment for services or drugs the member already received or for services denied prior to being rendered.

See the section entitled "*Provider Disputes*" later on in this Manual for more information.

Provider Relations Program

Friday is absolutely committed to ensuring that our providers and staff receive the best and latest information and resources available to ensure their success and their ability to provide care to Friday members. Providers and their staff may contact the Provider Relations Team by phone, mail or e-mail to providers@fridayhealthplans.com with questions, to share ideas or provide feedback regarding the performance of Friday.

Friday has a secure portal, the Friday Health Plans Portal, available for providers 24 hours a day, seven days a week. The secure portal requires user IDs and passwords for entry. Providers can locate a participating provider, check eligibility, submit authorizations, review status of claims and referrals, review the formulary and check benefits via the secure provider portal.

The Provider Relations Team is available to our providers and their staff to assist with:

- ☐ New provider orientation/personalized training as needed upon request
- ☐ Handling provider issues re:
  - o Contracting
  - o Fee schedule
  - o Electronic filing
  - o Authorization issues that involve medical management
- ☐ Fee schedule requests
- ☐ Credentialing and recredentialing application questions
- ☐ Member and physician relationships
- ☐ Provider education
- ☐ Provider Manual requests
- ☐ Demographic changes
- ☐ Provider additions/updates
- ☐ National Provider Identifier questions

The Customer Service/Operations Team can assist providers and their staff with the following:

- ☐ Member eligibility
- ☐ Benefit verification
- ☐ Claims issues
  - o Timely filing issues
  - o Adjudication issues
  - o Requests for EOB and RAs
  - o Check, refund and recoupment issues
- ☐ Authorization requirements
- ☐ Benefit and member questions/issues
- ☐ Provider dispute resolution assistance (provider complaints and appeals)
- ☐ Network inquiries
- ☐ Referral and authorization status
- ☐ Provider network
- ☐ Formulary questions

Providers and their staff may contact the Customer Service Team by phone, mail or e-mail to questions@fridayhealthplans.com.

Office Site visit evaluations are performed randomly by Provider Relations Representatives. This provides an opportunity to orient providers and their staff and to perform ongoing staff training.

Quality Management

Quality Assurance

Friday has a quality assurance (QA) program designed to monitor, evaluate, and improve the quality of care provided by participating providers in a continuous, effective, and fair fashion. Per the provider written agreement Friday providers agree to cooperate with Friday quality assurance, peer and utilization review programs.

Physician Advisory Committee (PAC)

The **Friday** committee of providers charged with review and guidance in the areas of quality improvement, utilization management, peer review, and credentialing. The PAC is composed of participating mid-level, primary care, and specialty providers and Friday Medical Director(s).

Quality Assurance Reviews

Peer Review: One aspect of quality assurance consisting of evaluation of a provider's inpatient and outpatient records by providers with similar backgrounds. The primary purpose of peer review is to assess and evaluate coordination of care, documentation issues, quality of care, and appropriateness of treatment.

Quality Assurance (QA): Procedures that monitor the quality of care provided by the plan and its health care providers; identifies problems, chooses and examines solutions to those problems; regularly monitors the solutions implemented; and refines solutions as needed for continued improvement.

Identification of Cases for Review

Cases requiring review by the PAC are identified from several sources including, but not limited to, the following:

- ☐ Scheduled peer review activities;
- ☐ Utilization management activities;
- ☐ Grievances;
- ☐ QI Studies;
- ☐ Member or provider complaints
- ☐ Member satisfaction surveys
- ☐ Office/Facility Site Visits
- ☐ Routine claims, pharmacy, or other data reports;
- ☐ Survey data; or
- ☐ Credentialing information.

Review Methodology

The PAC reviews inpatient and outpatient medical records as indicated, discusses the case, and makes a determination as to whether further review is necessary. If quality of care concerns are identified and substantiated improvement strategies are discussed and agreed upon by the PAC. If corrective action is to be taken, the practitioner is notified, in writing, of the PAC's findings and recommendations. The PAC may refer the case for an independent review by a like specialist or other expert whose recommendations will be presented to the PAC for final recommendation.

Corrective Action Plan

If corrective action is initiated, it may include one or more of the following:

- ☐ Additional monitoring of provider for specifiedperiod;
- ☐ Education of provider;
- ☐ Inquiry about quality concerns;
- ☐ Review of all inpatient admissions related to the practitioner;
- ☐ Review of all procedures performed by the practitioner;
- ☐ An on-site ambulatory medical record review either related to a specific diagnosis or to a randomly selected sample of records;
- ☐ Specific training mandate for the provider;
- ☐ Other action specific to the case is recommended;
- ☐ Warning letter to provider; or
- ☐ Termination of the provider contract per the Professional Quality of Care or Service Concern Review, Suspension or Termination Determinations and Provider Dispute Process Policy and Procedure.

If a response to the action(s) taken is required, the PAC shall review the response from the provider to determine if further corrective action is needed. Such action may include:

- ☐ The PAC may accept the reply and require no further action, closing the case.
- ☐ The PAC may request further data.
- ☐ The PAC may determine that a consistent pattern exists that may constitute a danger to patient care. The PAC then may set a plan to intensify monitoring of the provider(s) care or exercise other actions.
- ☐ The PAC may accept the reply but set specific limitations on provider involvement with Friday patients for a defined probationary period.
- The PAC may not accept the provider's response and explanation and place the provider on probation. The PAC shall notify the provider in writing of thisdecision.
- ☐ Termination of the provider contract per the Professional Quality of Care or Service Concern Review, Suspension or Termination Determinations and Provider Dispute Process.

NOTE: See the section entitled "*Restriction or Termination of Provider*" in this Manual for more information.

The duration of corrective action is determined by the PAC. At the end of the initial corrective action period, the results of the reviews performed while the practitioner was on Corrective Action are presented again to the PAC. The PAC may recommend discontinuing the corrective action, continuing the corrective action, modification of the corrective action to a more intense level, or termination of the provider. The provider is sent written notification of the PAC's findings.

Preauthorization/Referrals

Preauthorization/Referrals

Prior to rendering certain services, providers must submit the Friday "Request for Authorization" referral form located in *ATTACHMENT C*. Forms can be faxed directly to the Medical Department at 1-888-610-0019. Submission of a referral does not mean automatic approval. Utilization Management review which might include Medical Director review is required and additional information or documentation may be requested.

For a list of the most commonly ordered services and tests subject to precertification refer to *ATTACHMENT D.*

Certain requests will require additional information to be submitted along with your referral request, these include:

- ☐ **MRI & CT Scans** requests will always require submission of your notes indicating necessity along with the referral.

Any hospital observation service that exceeds 23 hours of observation will be deemed an inpatient stay by Friday Health Plans and will be paid accordingly with appropriate authorization as required. This is information is also stated on the Referral/Authorization

Direct Referrals

Members and their enrolled dependents have direct access to in-network specialty providers without a referral from their primary care provider for consultations for covered benefits.

Preauthorization/Referrals

Participating Providers	In order for services to be considered covered, Members must be treated by a provider who is participating (Participating Provider) in the Friday Network. To locate a Friday Participating Provider go to https://www.fridayhealthplans.com/member-hub/resources/find-a-doctor/co/ or call Customer Service at 1-844-805-5000.
Coordination of Care	It is imperative that the Member's care is coordinated. That is why our contracted providers are required to transmit all necessary information to providers to whom they refer patients. Likewise, the provider who receives the referral is required to transmit relevant information back to the referring provider.
Timeframe for Review	Requests for authorizations are approved or denied within 5 business days of request and all information received. In order to facilitate the review process, providers should provide clinical notes and any other pertinent information regarding the request.

Care Management Services

Case Management Referral

Our Case Management Program is free and voluntary. Patient participation in the Program does not replace the care and is intended to support services that a patient receives from you.

Experienced nurses can help your patient understand and get the care they need if he or she is overwhelmed with a new diagnosis or has any special needs such as limited mobility or intellectual struggles.

If you feel your patient would benefit from our Case Management program call us at: 1-844-805-5000.

Disease Management Referral

Our Disease Management program is free and voluntary. Your patient is encouraged to fill out a Health Risk Assessment (HRA). Based on that assessment a Personal Health Summary Report with an action plan is generated. Please encourage your patient to take advantage of this offering.

Select patients with certain chronic conditions are targeted for additional educational materials and/or are contacted to help them learn how to manage their condition and seek out the recommended care guidelines with their providers.

If you feel your patient would benefit from our Disease Management program call us at: 1-844-805-5000.

Clinical Preventive Guidelines

Preventive guidelines for services such as immunizations and chronic disease preventive maintenance are available on the website www.fridayhealthplans.com.

Pharmacy Management Program

Pharmacy Management Program

Friday Health Plans is contracted with Capital Rx as our pharmacy benefit manager. The link below will provide a list of in network pharmacies.

https://www.fridayhealthplans.com/wp-content/uploads/2020/10/In-Network-Pharmacies-TX.pdf

Friday Health Plans uses a four tiered prescription structure. The tiers are as follows:

Tier 1	Generics
Tier 2	Preferred Brand
Tier 3	Non-Preferred Drugs
Tier 4	Specialty Drugs

Excluded drugs are considered non-covered, regardless of whether they are generic or brand name. Excluded drugs may include, but are not limited to:

- OTC medications or their equivalents unless otherwise specified in the Formulary listing.
- Drug products used for cosmetic purposes
- Experimental drug products, or any drug product used in an experimental manner
- Foreign drugs or drugs not approved by the United States Food & Drug Administration

Covered drugs may require prior authorization and must be written by a licensed provider.

The Friday Health Plans formulary can be found on our web-site at www.fridayhealthplans.com or by clicking the link below.

https://caprx.adaptiverx.com/webSearch/index?key=8F02B26A288102C27BAC82D14C006C6FC54D480F80409B6897145FB47DE4F581

Friday Health Plans has multiple pharmacy benefits. Please refer to the specific Pharmacy Benefit Plan purchased by the Member.

Credentialing

Credentialing

All Participating Providers must be credentialed, qualified, properly licensed and maintain appropriate levels of malpractice insurance in accordance with Friday requirements and URAC standards.

Friday maintains current credentialing materials on Friday participating providers in support of application processing for licensed independent practitioners and institutions in a nondiscriminatory manner consistent with state and federal laws and regulations.

Definitions

Physician Advisory Committee (PAC): The Friday committee of providers charged with review and guidance in the areas of quality improvement, utilization management, peer review, and credentialing. The PAC is composed of participating mid-level, primary care, and specialty providers and Friday Medical Director(s). The PAC is charged with reviewing applications for participation with Friday and making decisions regarding approval or denial of participation.

Licensed Independent Practitioner: Any individual permitted by law to provide patient care services without supervision.

Participating Provider: A physician or other clinical provider, institution or vendor who provides medical services or supplies to Friday members and who participates in or contracts with Friday.

Initial Credentialing Application

Application to become a Friday participating provider includes, but is not limited to, CAQH Application Form and supporting documentation.
Applicants must also agree to abide by the provisions of Friday policies and procedures, and contractual agreements; consent directed to third parties authorizing them to release information to one of the Medical Directors of Friday; agree to exhaust internal administrative remedies before litigating in the event of any adverse ruling; and release from civil liability for Fridayincluding any individuals participating in the application and review process.

Recredentialing Application

Within three (3) years of the last credentialing, the provider will be asked to complete the recredentialing cycle. The information will be pulled from CAQH o and submit supporting documentation in order that Friday can maintain an updated file on each provider and review any judgments, professional liability, or quality issues.

Completion, Verification and Decision

Once an application is received, a confidential file is made or updated for the applicant. If the application is incomplete, it will be returned to the provider requesting missing information. If the

application is complete, verification of the applicant's credentials will take place in accordance with URAC standards. Once the application and verification processes are complete, the file will be forwarded to the PAC. For recredentialing, the committee shall also be sent any Peer Review or other chart audits; internal or PAC reviews for the past three (3) years; and previous credentialing documents.

The PAC will make the decision about acceptance or denial of the provider as a participating Friday provider. Providers being recredentialed may consider themselves approved unless otherwise notified. Therefore, recredentialed providers will only be notified of adverse decisions or concerns from the PAC. This decision must be made within 180 calendar days from the date of the original application and verification of information.

Criteria for Participating Provider with Friday

In order for a provider's application to be approved by the PAC, the applicant must:

- ☐ be a provider in good standing in the state of Texas with an unrestricted Texas license;
- ☐ have in effect and continuously maintain professional liability insurance coverage;
- ☐ have completed the application form and submitted all appropriate documents;
- ☐ agree to abide by the provisions of Friday policies and procedures and contractual agreement.

In addition to the mandatory criteria set forth above, the PAC may give consideration to other factors in reaching a decision upon an application for membership. Such factors for consideration may include, but not be limited to:

- ☐ The general fitness, skill, and competence of the applicant to provide the level of medical care which the applicant proposes to provide to Friday members;
- The applicant's ability to work with others including professional peer and administrative personnel to such extent that it would not be disruptive of the quality, availability, and accessibility of medical care to Friday members;
- ☐ The needs of Friday for available, accessible, and cost-effective delivery of medical care, giving consideration to the professional qualifications and the location for delivery of care proposed by the applicant.

No credentialing or recredentialing decision will be based solely on an applicant's race, ethnicity, national origin, religion, gender, age, or sexual orientation; or by type of procedure or patient in which the practitioner specializes.

Credentialing

Notification of Discrepancies and Credentialing Decisions

Providers will be notified of major discrepancies between information they have submitted on their application and information gathered during the credentialing or recredentialing process. A discrepancy is considered "major" at the discretion of the Medical Director and is dependent upon the nature of the item in question and the possible effect it may have on the credentialing decision. Notification will include the provider's rights to supply additional information regarding the discrepancy.

If initial credentialing is approved the provider will receive a contract to become a participating provider and recredentialing occurs at least every three (3) years. If credentialing is denied, the Medical Director sends a letter to the provider indicating the reason for denial. If there are issues or questions regarding the application that preclude a final decision by the PAC at the initial review, Friday will send a letter to the provider explaining the issues or questions and outlining steps necessary to allow a final decision.

Right to Review or Correct Credentials Information

Providers applying for participation with Friday have the right to obtain information about the status of their credentialing application and be provided the opportunity to correct incomplete, inaccurate or conflicting information. Providers must submit a letter to the Credentialing Department to view or correct any information they consider to be incorrect in their record.

Obligation of Applicant

Each applicant for participation shall have the burden of proofto satisfy all requirements for participation at each stage of the application process. Friday participating providers have a continuing obligation to notify Friday in writing of any material change in the information provided during the application process. A material change shall include, but not be limited to:

- Suspension, voluntary relinquishment, or termination of medical licensure;
- Disciplinary action imposed by the Texas Board of Medical Examiners or equivalent body in any otherstate;
- Reduction in the amount or types of professional liability insurance coverage;
- Loss or relinquishment of board certification or hospital staff privileges.

Contract components

All providers must be credentialed to receive a written agreement from Friday and must have a signed agreement to be a participating provider and listed in the Friday Provider Directory.

Restriction or Termination of Provider

Restriction or Termination of Provider

Friday maintains the quality of network services through compliance audits and through professional review and evaluation of its network practitioners.

Friday provides a fair process for imposing participation restrictions or contract termination on network practitioners who are not meeting network or contract standards or requirements.

See Professional Quality of Care or Service Concern Review, Suspension or Termination Determinations and Provider Dispute Process.

Definitions

Quality of care concerns: concerns that relate to care that does not meet accepted standards of practice, is inappropriate or for which the practitioner lacks sufficient qualifications, or unprofessional conduct by the practitioner.

Quality of service concerns: concerns that relate to the failure of the practitioner to comply with Friday administrative requirements or to provide services in accordance with contract requirements.

Physician Advisory Committee (PAC): The Friday committee of providers charged with review and guidance in the areas of quality improvement, utilization management, peer review, and credentialing. The PAC is composed of participating mid-level, primary care, and specialty providers and Friday Medical Director(s).

Quality of Care and Quality of Service Concerns

Receipt of Concerns

Quality of care concerns may arise from member or provider complaints, results of QA activities, member satisfaction surveys, claim reviews and other sources.

Imminent Threat to Safety

The Medical Director may summarily suspend the authority of any practitioner to participate in the care of Friday members when, in the judgment of the Medical Directors, the immediate health and safety of any member is in imminent danger, pending an investigation. Grounds for a summary suspension include, but are not limited to, voluntary relinquishment, suspension, expiration, or termination of the practitioner's license to practice, termination or cancellation of malpractice insurance or professional care or behavior that might imminently threaten the life or safety of a member.

In such cases, the Medical Director notifies the practitioner by telephone of the summary suspension with written notice by certified mail to be sent on the same day. The written notice informs the practitioner that an investigation will be conducted

to determine whether the suspension will remain in place beyond 14 days.

The PAC will appoint an ad hoc committee of one or more persons to investigate the circumstances involved in the suspension and to report back to the PAC within 7 days. The PAC will meet within 10 days of the suspension to determine whether the suspension will be continued.

If the suspension is lifted because the suspension was unfounded or because the concern can be handled in the normal QI process, the Medical Director notifies the practitioner by telephone and in writing of this decision. If the suspension will continue, the Medical Director notifies the practitioner in writing including notice of the right to a hearing on the suspension.

All Other Concerns

If the concern is not of a nature to cause imminent threat to the health or safety of a member, the Medical Director brings the concern before the next meeting of the PAC. The PAC will investigate the concern and upon completion of the investigation, will determine whether further actions or explanations are needed.

If further information is needed, the Medical Director will send a letter to the practitioner to explain the issue in question and requests the practitioner to provide, within 15 days, a written explanation of or rationale for the care at issue and answer any specific questions posed by the Committee. If a written response is not received from the practitioner in the requested time, the Medical Director may make one follow-up request for information.

At the next meeting of the PAC, the PAC deliberates the need for and the type of further action, which may include, but is not limited to the following:

- Further investigation, including independent review of the care involved
- Meeting with the practitioner
- Corrective action plan which may include requirements to participate in CPHP or CPEP, proctoring, or ongoing retrospective case review
- Denial of appointment or reappointment
- Restriction on participation rights (e.g., limits on procedures that may be performed on members)
- Termination of professional services agreement

The Friday Medical Directors will notify the contracted provider in writing with a description of and the reasons for the recommendation and if the provider is entitled to a first- level

panel hearing.

Reporting Requirement
If the final action of the Plan will restrict, suspend over 30 days, or terminate the practitioner's participation in the Plan, the Medical Director will report the final action to the National Practitioner Data Bank (NPDB) and the Texas Medical Board.

Confidentiality
All parties and all participants in the professional review of quality of care concerns will maintain the confidentiality of the investigation, findings, recommendations and proceeding. All reports, correspondence and records are confidential. All participants in a professional review, including staff, witnesses and anyone filing a complaint, are immune from suit in any civil or criminal action, including antitrust actions, brought by the subject practitioner, provided they have acted in good faith and in accordance with the standards for professional review. No participant will be liable for damages in any civil or criminal suit brought as a result of the professional review, provided that he/she has acted in good faith and in accordance with the standards for professional review.

Friday shall suspend payments to any participating provider against whom there is a credible allegation of fraud or that is actively under investigation for a credible allegation of fraud.

Provider Dispute Resolution Process for Professional Quality of Care or Service Concern Review, Suspension or Termination Determinations

Friday provides a fair process to address significant disputes or problems regarding a participating provider's professional competence or conduct that could result in a change in provider status such as restrictions or contract termination. The dispute resolution process is determined based on if it is a quality of care concern or a quality of service concern.

The dispute process applies to contracted providers only and does not apply for termination of a provider who no longer meets Friday credentialing criteria requirements including but not limited to voluntary relinquishment, suspension, expiration, or termination of the practitioner's license to practice, termination or cancellation of malpractice insurance or exclusion or other restriction of participation in either the Medicare or Medicaid program.

Quality of Care Concerns

The practitioner must submit a timely written request for a hearing. A Medical Director will select a panel of three qualified individuals, including two physicians of which at least one who must be a participating provider who is not otherwise involved in day to day operations of Friday and who is in the

same specialty (clinical peer) as the practitioner filing the dispute but who is not in direct competition with the practitioner; the panel may not include any person who has previously been involved with the investigation.

The hearing is conducted outside the formal rules of evidence, with the panel allowing into evidence any evidence that reasonable persons would rely on in serious affairs. However, both sides may examine and cross-examine witnesses; the panel may ask questions of any witness as well. The burden of proof is on Friday. That is, Friday must show that the facts justify its recommendation by a preponderance of the evidence. In the case of a summary suspension, the burden is on Friday to show that the suspension was necessary and that investigation could not have been done in the normal course. If the recommendation involves an initial application to Friday, the applicant practitioner has the burden to show that he/she meets the credentialing standards of Friday. The hearing will be recorded if feasible. Only individuals presenting relevant information may attend the hearing. The hearing panel deliberates privately. The hearing panel can accept, reject or modify the recommendation of the PAC. The hearing panel forwards the findings and recommendations of the hearing panel to the Medical Director.

Within fifteen (15) business days after the completion of the hearing the Medical Director notifies the practitioner in writing, by certified mail, of the findings and recommendation of the first level panel.

If the provider is dissatisfied with the decision of the first hearing panel, the practitioner must submit a written request for a second-level panel hearing, the Medical Director will select a panel of three qualified individuals, including two physicians of which at least one of whom is not otherwise involved in day to day operations of Friday and who is in the same specialty (clinical peer) as the practitioner filing the dispute but who is not in direct competition with the practitioner; the panel may not include any person who has previously been involved with the investigation or the first-level panel.

The second-level panel will establish a deadline for written position statements from each party, based on the record from the hearing. No new evidence may be introduced on second level appeal. Within fifteen (15) business days of receipt of the position statements, the second level panel will report its recommendations back to the Friday COO, based on its review of the position statements, and the COO of Friday will make a final determination of action against the practitioner. The

Medical Director notifies the practitioner in writing, by certified mail, of the final decision of the panel within fifteen (15) business days and reports the final action to the appropriate authorities including the NPDB and the BME as required.

Quality of Service Concerns

The practitioner must submit a timely written request for reconsideration. The Medical Director will bring the concern before the PAC. The PAC, as the authorized agent of Friday, investigates the concern.

Upon completion of the investigation, the PAC determines whether further actions or explanations are needed. The PAC discusses the written response received from the practitioner and deliberates the need for and the type of further action.

The Medical Director notifies the practitioner in writing within fifteen (15) business days, by certified mail, of the final determination and action of the PAC. The decision of the PAC will be final.

Medical Records & HIPAA

Medical Records

An individual record must be maintained for each Member, regardless of the number of treating providers at that location. Each record must contain a section for Member identification that includes name, age, employer, occupation, work and home telephone numbers, address, insurance information, marital status and emergency contact person information.
Requirements for charting include:

- Progress Notes
- Identifying Information
- Problem List
- Medication List including initial and refill dates
- Additionally, there must be documentation in the medical record demonstrating whether or not a Member has executed an Advance Directive

HIPAA Information & Disclosure

Participating providers are contractually bound to comply with HIPAA privacy and all applicable state and federal privacy laws and regulations.

Request for Medical Records

Friday Health Plans may request records for utilization review, claims processing or audit requirements. Friday Health Plans does not pay for medical records.

Benefit Plans and Summary of Benefits

Friday offers health insurance to small employer groups (1-50 employees) and individuals.

Services and benefits provided vary by type of coverage, and benefit plan selected by the employer group or individual. Upon enrollment, all members are provided with a summary of benefits and an evidence of coverage related to the health benefit plan they are enrolled in. To verify benefits, contact Friday at 1-844-805-5000 or go to www.fridayhealthplans.com and login to the Friday Health Plans Provider Portal.

Please see *ATTACHMENT E* for a listing of some of the most common non-covered services under the Friday health benefit plans.

MENTAL HEALTH PARITY ACT NOTICE OF RIGHTS AND SERVICES

Friday Health Plans provides coverage for medically necessary mental health and substance abuse treatment according to federal and state mental health parity laws. The financial requirements and treatment limits for mental health or substance abuse can be NO MORE restrictive than those for medical/surgical benefits and coverage. This means the cost share (i.e., copayments, coinsurance or deductible) for services to treat mental health and substance abuse will be the same as those for comparable medical/surgical services.

Also, the review and authorization of services to treat mental health and substance abuse will be handled in a way that is comparable to the review and authorization of medical and surgical services. If there are any pre-authorization requirements, mental health and substance abuse services will not have any greater restrictions than medical and surgical services. If Friday Health Plans makes a decision to deny or reduce authorization of a service, you will receive a letter explaining the reason for the denial or reduction.

Billing & Payment

Claims Submission Process

Provider claims can be submitted to Friday either using standard paper forms or electronically.

Submitting Claims by Mail or Fax

Claims should be submitted on a standard HCFA1500 form or UB-04 form. These forms can be ordered from the CMS web page at www.cms.hhs.gov.

Paper claims should be mailed to:

Friday Health Plans
PO Box 194
Sidney, NE 69162

Submitting Claims Electronically

To submit electronic claims directly to Friday, please contact us at 1-844-805-5000. Our electronic payer ID is H0657

Required Information

The information listed below is ***required*** on all claims submissions. Omission of any of these items may delay claims processing.

- Patient's full name

☐ Member identification number (from ID card)

☐ Date of birth

☐ Date of service

☐ Valid ICD-10 diagnosis code(s)

☐ Place of service

☐ Type of service

☐ Valid Procedure code(s) (i.e. HCPCS, CPT, Revenue codes) **must use CPT4 procedure coding with 2-digit modifier as applicable*

☐ Units of service(Quantity)

*Anesthesia claims require start and stop times in addition to units.

☐ Amount charged for each service (usual & customary)

☐ Name of Referring Physician authorization or referral number

- Rendering Provider's name, address and authorized signature
- Rendering Provider's federal tax identification number
- Rendering Provider's NPI

Please note: Any claims for unlisted procedures must be accompanied by the appropriate documentation to allow for pricing consideration.

Billing & Payment

Quick Processing Tips

In order to ensure your claims are processed quickly please follow these tips:

- ☐ ensure all the above information is complete &valid
- ☐ complete the claim form using **black** ink
- ☐ ensure the writing or typing is legible
- ☐ do not submit negativecharges
- ☐ no manual alterations (for example white-outs, cross-outs, etc.)
- any required supporting documentation must have the patient's name and date of birth clearly marked
- ☐ Utilize correct coding resources to ensure you claim does not require code editing and bill review

Claims Payment

Friday pays providers within thirty (30) days for all Clean Claims submitted electronically for Health Care Services delivered to Members and within forty-five (45) days all Clean Claims submitted by othermeans.

If a claim requires additional information, Friday has 30 days after receipt of the claim to request such information. Provider must submit requested information within 30 days after receipt of request or Friday may deny the claim.

Reimbursement

Provider shall accept payment from Friday for health care services in accordance with the reimbursement terms outlined in their contract. Provider shall accept such reimbursement as payment in full for those health care services provided toMembers.

Amounts Collectible from The Member

Providers should collect the Member's co-pay amount at the time of service. If the services being rendered have been verified as not covered under the Member's plan, these fees may also be collected at the time of service as long as the Member has been advised of his/her financial responsibility and signs a written waiver for these non-covered services.

For any applicable co-insurance and/or deductibles, Friday recommends either waiting for availability of the Provider Reimbursement Voucher/Hospital Reimbursement Voucher or Explanation of Payment (See ATTACHMENT F for a copy of the Voucher and EOP) that indicates the Member's amount owed, OR collecting a portion of the co-insurance/deductible at the time of service in order to avoid refunds to Members.

Billing & Payment

Remittance Advice

To obtain a remittance advice (EOP) for claims **Zelis Payments**:

https://provider.zelispayments.com/registration

For issues with login or to set up a new login:

Zelis Provider Service Line: 877-828-8770

payerservice@zelispayments.com

The Member ***may not*** be billed for the difference between the provider's charged amounts and the contracted reimbursement amount.

Balance Billing

Coordination of Benefits

In order to receive reimbursement from Friday on claims that require coordination of benefits, please submit a copy of the primary carrier/ insurance company's explanation of benefits (EOB) with the claim to Friday for payment.

In no event will payment exceed more than 100% of billed charges after the primary carrier and Friday have reached final claim disposition.

Third Party Liability

Friday reserves the right to subrogate where another third party is liable for payment. Claims are identified by triggering diagnoses and procedures as well as information from the provider's office, the Member or other source.

Appeals Process

Contact Friday Customer Service at 1-844-805-5000 if you disagree with the manner in which Friday has processed your claim. See the section entitled "Provider Disputes" in this Manual for more information.

Provider Disputes

Provider Disputes for Administrative issues

Friday provides a mechanism for fair and prompt resolution of participating provider disputes (appeals) regarding administrative, payment or other dispute matters that are neither utilization review, disputes concerning professional competence or conduct nor routine provider inquiries

Process for Dispute Resolution

Requests for resolutions of provider-carrier disputes must be submitted in writing. All requests must include the necessary information: (1) each applicable date of service; (2) subscriber and member name; (3) subscriber and member number; (4) provider name; (5) provider tax identification number; (6) dollar amount in dispute, if applicable; (7) provider position statement regarding the nature of the dispute; and (8) supporting documentation where necessary.

An authorized representative of Friday who was not involved in the initial decision of the subject in dispute shall review the dispute and make a determination within sixty (60) calendar days of receipt of all necessary information.

Notification of Determination

Friday shall provide written notification of the determination to the provider within sixty (60) calendar days of receipt of all necessary information. The notification shall include:

1. The reviewers' decision in clear terms;
2. The rationale for the decision; and

If the determination is not in favor of the provider, the notification shall also include the principal reasons for the determination.

Provider's Right to Present Rationale for Request

The provider or the provider's representative may present the rationale for the dispute resolution request in person. If a face-to-face meeting is not practical, Friday shall offer the opportunity to use alternative methods such as teleconference to present the rationale for the dispute resolution request. Friday may require appropriate confidentiality agreements from representatives as a condition to participating in the dispute resolution process.

Provider Changes

Notification

Friday requires written notification thirty (30) days prior to changes in Provider's demographic information that includes changes in practice location, phone numbers, fax numbers, physician additions/terminations, and other changes in the practice or facility including notification if a provider is no longer accepting new patients.

Please submit a roster to provide notification of any changes.

ATTACHMENTS

ATTACHMENT A – Sample ID Card

ATTACHMENT B – Commercial Member Rights and Responsibilities

ATTACHMENT C – Request for Authorization/Referral

ATTACHMENT D- Notification & Preauthorization List

ATTACHMENT E – Non-covered Services List

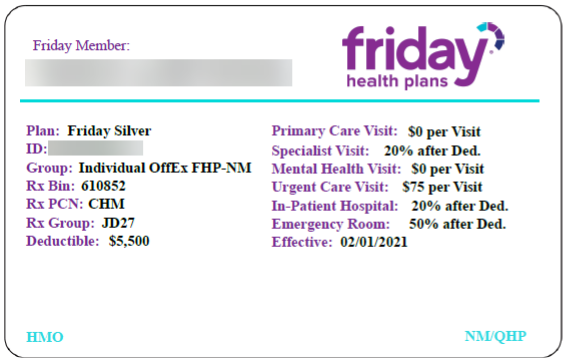
ATTACHMENT F – Payment Voucher

ATTACHMENT G – Provider Dispute Resolution

ATTACHMENT A

SAMPLE ID CARD

2021 New Mexico ID Cards



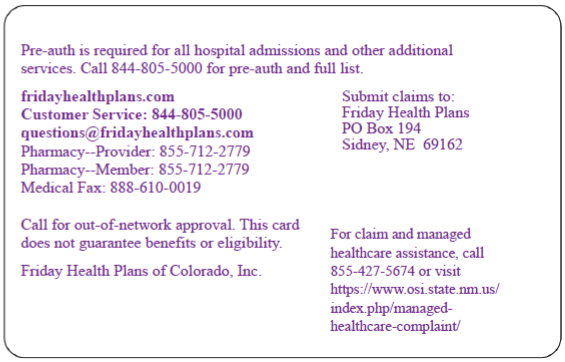
Friday Member:

friday health plans

Plan: Friday Silver
ID:
Group: Individual OffEx FHP-NM
Rx Bin: 610852
Rx PCN: CHM
Rx Group: JD27
Deductible: $5,500

Primary Care Visit: $0 per Visit
Specialist Visit: 20% after Ded.
Mental Health Visit: $0 per Visit
Urgent Care Visit: $75 per Visit
In-Patient Hospital: 20% after Ded.
Emergency Room: 50% after Ded.
Effective: 02/01/2021

HMO NM/QHP



Pre-auth is required for all hospital admissions and other additional services. Call 844-805-5000 for pre-auth and full list.

fridayhealthplans.com
Customer Service: 844-805-5000
questions@fridayhealthplans.com
Pharmacy--Provider: 855-712-2779
Pharmacy--Member: 855-712-2779
Medical Fax: 888-610-0019

Submit claims to:
Friday Health Plans
PO Box 194
Sidney, NE 69162

Call for out-of-network approval. This card does not guarantee benefits or eligibility.

Friday Health Plans of Colorado, Inc.

For claim and managed healthcare assistance, call 855-427-5674 or visit https://www.osi.state.nm.us/index.php/managed-healthcare-complaint/

ATTACHMENT B

NEW MEXICO MEMBER RIGHTS AND RESPONSIBILITIES

FRIDAY HEALTH PLANS
Member Rights & Responsibilities
(For New Mexico Members)

Member Rights

Each Member Has The Right To:

- To be treated with respect and with due consideration for his or her dignity and privacy;
- To receive information on available treatment options and alternatives, presented in a manner appropriate to his or her condition and ability to understand such information;
- To make and have honored his her advance directive that is consistent with state and federal laws;
- To receive covered services in a nondiscriminatory manner;
- To participate in decisions regarding his or her health care, including the right to refuse treatment;
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion;
- To request and receive a copy of his or her medical records and to request that they be amended or corrected as specified in 45 CFR 164.524 and 526;
- To choose an authorized representative to be involved, as appropriate, in making his or her health care decisions;
- To provide informed consent;
- To voice grievances concerning the care provided by the MCO;
- To appeal any action regarding services that the member or his or her authorized representative or authorized provider believes is erroneous;
- To protect the member, his or her authorized representative or authorized provider who uses the grievance, appeal, and HSD administrative hearing processes from fear of retaliation;
- To choose from among contracted providers in accordance with his or her MCO's prior authorization requirements;
- To receive information about covered services and how to access these covered services, and providers;
- To be free from harassment by FHP or its contracted providers in regard to contractual disputes between FHP and the provider;
- To participate in understanding physical and behavioral health problems and developing mutually agreed-upon treatment goals;

- To be assured that FHP complies with any other applicable federal and state laws including: Title VI of the Civil Rights Act of 1964 as implemented by regulations in 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.
- To be ensured that each member or the member's authorized representative or authorized provider is free to exercise his or her rights, and the exercise of those rights does not adversely affect the way that FHP or provider treats the member or member's authorized representative or authorized provider.
- To be provided to member or his or her authorized representative with written information on advance directives that include a description of applicable state and federal law and regulation, FHP's policy respecting the implementation of the right to have an advance directive, and that complaints concerning noncompliance with advance directive requirements may be filed with HSD; the information must reflect changes in federal and state statute, regulation or rule as soon as possible, but no later than 90 calendar days after the effective date of such a change;
- To have honored advance directives within UM protocols; and
- To ensure that a member is offered the opportunity to prepare an advance directive and that, upon request, FHP provides assistance in the process.
- To seek a second opinion from a qualified health care professional within his or her FHP's network, or FHP shall arrange for the member to obtain a second opinion outside the network, at no cost to the member. A second opinion may be requested when the member or his or her authorized representative needs additional information regarding recommended treatment or believes the provider is not authorizing requested care.
- To access services in a timely and confidential manner; and
- To choose a qualified family planning provider who participates in the FHP network or from a provider who does not participate in the member's FHP network;

Member Responsibilities

Each Member or his or her authorized representative or authorized provider, to the extent possible, has a responsibility to:

- To provide information that the MCO and providers need in order to care for the member, such information includes, but is not limited to the member's:
    - Most current mailing address;
    - Most current email address, if one is available;
    - Most current phone number, including any land line and cell phone, if available; and
    - Most current emergency contact information;

- To follow the care plans and instructions from his or her provider that have been agreed upon;
- To keep a scheduled appointment;
- To reschedule or cancel a scheduled appointment rather than simply fail to keep it.

ATTACHMENT C

REQUEST FOR AUTHORIZATION/REFERRAL

New Mexico Uniform Prior Authorization Form

To file electronically, send to: NM-medical@fridayhealthplans.com	**To file via facsimile, send to: 1-888-610-0019**

To contact the coverage review team for **New Mexico Health Connections**, please call 1-844-805-5000 between the hours of 8:00 a.m. and 5:00 p.m. (Mon-Fri).

[1] Priority and Frequency

a. Standard [ ] Services scheduled for this date:	**b. Urgent/Expedited** [ ] Provider certifies that applying the standard review timeline may seriously jeopardize the life or health of the enrollee.

c. Frequency Initial [ ] Extension [ ] Previous Authorization #:

[2] Enrollee Information

a. Enrollee name:	b. Enrollee date of birth:	c. Subscriber/Member ID #:
d. Enrollee street address:		
e. City:	f. State:	g. Zip code:

[3] Provider Information: Ordering Provider [ ] Rendering Provider [ ] Both [ ]
Please note: processing delays may occur if rendering provider does not have appropriate documentation of medical necessity. Ordering provider may need to initiate prior authorization.

a. Provider name:	b. Provider type/specialty:	c. Administrative contact:
d. NPI #:		e. DEA # if applicable:
f. Servicing Clinic/facility name:		g. Clinic/pharmacy/facility street address:
h. City, State, Zip code	i. Phone number and ext.:	j. Facsimile/Email:

[4] Requested medical or behavioral health course of treatment/procedure/device information (skip to Section 8 if drug requested)

a. Service description:

b. Setting/CMS POS Code Outpatient [ ] Inpatient [ ] Home [ ] Office [ ] Other* [ ]

c. *Please specify if other:

[5] HCPCS/CPT/CDT/ICD-10 CODES

a. Latest ICD-10 Code	b. HCPCS/CPT/CDT Code	c. Medical Reason

[6] Frequency/Quantity/Repetition Request

a. Does this service involve multiple treatments? Yes [ ] No [ ] If "No," skip to Section 7.

b. Type of service:	c. Name of therapy/agency:
d. Units/Volume/Visits requested:	e. Frequency/length of time needed:

[7] Prescription Drug

a. Diagnosis name and code:

b. Patient Height (if required):	c. Patient Weight (if required):

d. Route of administration Oral/SL [ ] Topical [ ] Injection [ ] IV [ ] Other* [ ]

*Explain if "Other:"

e. Administered: Doctor's office [ ] Dialysis Center [ ] Home Health/Hospice [ ] By patient [ ]

f. Medication Requested	g. Strength (include both loading and maintenance dosage)	h. Dosing Schedule (including length of therapy)	i. Quantity per month or Quantity Limits

j. Is the patient currently treated with the requested medication[s]? Yes* [ ] No [ ]

*If "Yes," when was the treatment with the requested medication started? Date:

k. Anticipated medication start date (MM/DD/YY):

l. General prior authorization request. Explain the clinical reason(s) for the requested medications, including an explanation for selecting these medications over alternatives:

l. Rationale for drug formulary or step-therapy exception request:

□ **Alternate drug(s) contraindicated or previously tried, but with adverse outcome**, e.g., toxicity, allergy, or therapeutic failure, Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s).

□ **Patient is stable on current drug(s)**, high risk of significant adverse clinical outcome with medication change. Specify anticipated significant adverse clinical outcome below.

□ **Medical need for different dosage and/or higher dosage**, Specify below: (1) Dosage(s) tried; (2) explain medical reason.

□ **Request for formulary exception**, Specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome

□ **Other** (explain below)

Required explanation(s):

m. List any other medications patient will use in combination with requested medication:

n. List any known drug allergies:

[8] Previous services/therapy (including drug, dose, duration, and reason for discontinuing each previous service/therapy)	
a.	Date Discontinued:
b.	Date Discontinued:
c.	Date Discontinued:

[9] Attestation

I hereby certify and attest that all information provided as part of this prior authorization request is true and accurate.

Requester Signature_____ Date _____

DO NOT WRITE BELOW THIS LINE. FIELDS TO BE COMPLETED BY PLAN.

Authorization #_____Contact name _____

Contact's credentials/designation _____

ATTACHMENT D

NOTIFICATION AND PREAUTHORIZATION LIST

Friday Health Plans
NOTIFICATION & PREAUTHORIZATION LIST
New Mexico

It is important to verify Benefits and Eligibility with Friday Health Plans for *all* services. The Services listed below may be governed by Friday Health Plans Medical Policies, which may impact coverage decisions. **All admissions and any procedure or service costing $500 or more require preauthorization** unless otherwise specified below.

Preauthorization is required ***before*** the service is provided in non-emergent situations. Retroactive requests will be denied unless there are extenuating circumstances. All pre-authorizations should be requested using Friday Health Plans request form. **Supporting documentation (e.g., notes and lab or radiology findings) should be sent with all preauthorization requests**.

For notification or preauthorization:
Phone: 1-844-805-5000 option 4 **Medical Fax: 1-888-610-0019** **Online: fridayhealthplans.com**

SERVICES REQUIRING NOTIFICATION	
SERVICE	**COMMENTS**
Admissions – **all** unplanned medical and surgical inpatient admissions	Notification is the responsibility of the contracting facility providing the service
Observation Stays resulting from ER visit over 23 hours	Notification is the responsibility of the contracting facility providing the service.
Observations Stays, unanticipated after surgery or other procedure over 23 hours	Notification is the responsibility of the contracting facility providing the service.
Obstetric care, routine	In normal, uncomplicated pregnancy, one ultrasound is considered routine.
OON Network Observation stays or admissions	Notification is the responsibility of the contracting facility providing the service. And will be subject to emergent criteria review.

SERVICES REQUIRING PREAUTHORIZATION

Any procedure or service costing $500 or more requires preauthorization unless otherwise specified below. This list may not be all-inclusive. Services **must be provided by participating providers**. **Please call** if you are uncertain whether a referral is necessary, or a provider is participating.

CATEGORY	SERVICE	COMMENT
Applied Behavioral Analysis	All Services	Covered children under 18 or 21 if still enrolled in high school
Admissions	**All** planned or scheduled inpatient medical and surgical admissions including acute, rehab, and skilled nursing facility.	
Ambulance or Air Transport	**Non-emergent** transport or transfer	Generally, not covered
Breast reconstruction	Post- mastectomy for breast cancer and revisions.	Breast reductions also covered with authorization.
Cardiac Procedures	EP studies, ablations cardiac catheterizations.	Diagnostic testing covered another section
Dental	All dental related services	Generally, not covered without a dental rider
DME/ Devices Replacement of devices every 36 months	Durable medical equipment over $500	Authorization not needed for bilirubin bed for a newborn, cpap supplies, diabetic supplies, oxygen and supplies.
	Hearing aids/Cochlear Implants	Hearing aids covered for children under 18 or 21 if still enrolled in high school. Max benefit of $2200 each set. Replacement for device needed for growth also covered.

SERVICES REQUIRING PREAUTHORIZATION

Any procedure or service costing $500 or more requires preauthorization unless otherwise specified below. This list may not be all-inclusive. Services **must be provided by participating providers**. **Please call** if you are uncertain whether a referral is necessary, or a provider is participating.

CATEGORY	SERVICE	COMMENT
Diagnostic Procedures (cont'd)	Arteriogram	
	CT scans	
	Upper Endoscopy	
	MRIs, MRA's	
	Myelogram	
	PET or SPECT scans other than Cardiac	
	Sleep studies except home sleep studies	
	MCOT	
	Transesophageal Echocardiogram	
Dialysis	All services	
Genetic testing	All services	Generally non-covered service except prenatal testing and BRCA
Habilitative Therapies	Acupuncture	Must submit auth after 20 visits.
	Physical Therapy	Must submit auth after 20 visits.
	Occupational Therapy	Must submit auth after 20 visits.
	Speech Therapy	Must submit auth after 20 visits.
Hematology and Oncology	Cancer treatment including chemo, radiation, and surgery	Submit treatment plan as soon as known to facilitate rapid approval of necessary services.
Home Services	Home care	Max benefit 100 4 hour visits/per plan year combined modalities.
	Home infusion services	
	Medical foods or enteral nutrition	Oral foods generally not a covered benefit
	Total parenteral nutrition	
Injections and Infusions	Back injections	ESI, RFA, MBB, Facet
	Medical injectables >$1000	
	Infusion pumps	
	All infusions	
Mental Health/Substance Abuse	Electroconvulsive therapy	
	Transcranial Magnetic Stimulation (TMS)	
	Partial Hospitalization	
Ophthalmology	Medical eye condition treatments	Cataracts and Yag laser covered without auth
Out-of-Network Services	Any service	Generally, not a covered benefit. Only approved if medically necessary **AND** not available in-network.
Outpatient Services	Any in-office procedure costing >$1000	Call Friday Health Plans for details
	Hyperbaric oxygen therapy	
	Infertility services	Diagnostic and treatment of involuntary infertility
	Photodynamic therapy	
Breast reconstruction	Post- mastectomy for breast cancer and revisions.	Breast reductions also covered with authorization.
Podiatry	All procedures	Routine foot care is generally not covered.
Rehabilitation	Cardiac and Pulmonary	Limited benefit.
Rehabilitation therapies	Acupuncture	Must submit auth after 20 visits.
	Chiropractic care	Must submit auth after 20 visits.
	Physical Therapy	Must submit auth after 20 visits.
	Occupational Therapy	Must submit auth after 20 visits.
	Speech Therapy	Must submit auth after 20 visits.
Transgendered services	All services that require authorization in the other categories	Some services are not covered. Call Friday Health Plans to check.
Transplants	All services	Transportation benefits covered up $150/day if transplant is out of state

ATTACHMENT E

NON-COVERED SERVICES LIST

fridayhealthplans.com
1-844-805-5000

700 Main Street
Alamosa, CO 81101

New Mexico

NON-COVERED SERVICES LIST

The Services listed below contains some of the most common non-covered services but is **not all inclusive. Please call Customer Services 1-844-805-5000** if there is any question about what services are covered.

Remember it is important to verify Benefits and Eligibility with Friday Health Plans for all services.

SERVICES THAT ARE NOT COVERED		
CATEGORY	**SERVICES NOT COVERED**	**Comment**
Complementary and Alternative Medicine	Massage, etc.	
Dental	All dental-related services including most oral surgery	TMJ treatment, anesthesia and facility charges may be covered in some situations.
Devices and DME	Deluxe items, comfort items disposable items and items available over the counter.	
Education	Education services other than diabetic education, nutrition therapy and tobacco cessation.	
Experimental or Investigational	All experimental or investigative services	
Genetic counseling	Genetic counseling related to genetic testing not covered by the plan.	
Genetic testing	Only BRCA1 and BRCA2 and testing for prenatal diagnosis of congenital disorders are covered	
Hearing Aids	Any services related to hearing aids unless for a child under age of 18 or 21 if still enrolled in high school.	
Immunizations	Immunizations that are required for travel.	
Long Term Care	Nursing homes, custodial care	
Mental Health	All services for sexual, marital, or occupational counseling; and court-ordered care	.
Nutritional supplementation	Oral supplements not covered. Enteral and tube feeding supplements that are available over the counter.	Enteral and tube feeding supplies
Obesity Treatment	Cosmetic procedures such as liposuction, surgery, except for bariatric surgery. Diet supplements, weight loss	
Ophthalmology	Vision testing or other vision services for non-medical conditions	Medical ophthalmology services are covered
Plastic or Cosmetic	Cosmetic services or surgery of any kind unless part of reconstruction following medical illness or trauma with authorization or breast reconstruction post-mastectomy for breast cancer	Some transgendered services are covered with auth. Call for details.
Podiatry	Routine podiatric care including treatment of flat feet, nail trimming, corns, and calluses.	

Reproductive Services	Reversal of any voluntary infertility causes, any procedures related to conception by artificial means (other than artificial insemination) and medications. Services and treatments related to impotency.	Only diagnostic services, treatment for involuntary infertility and artificial insemination are covered.
Residential Treatment	Treatment that is residential in nature and lasting longer than 30 day programs, or does not have 24 hour nursing/physician care.	
Surrogate Pregnancy	Any services related to a pregnancy where the pregnant women enters into a contract prior to getting pregnant to surrender the newborn child at time of birth.	

ATTACHMENT F

PAYMENT VOUCHER

ePayment Transmittal

MATCH TO PAYMENT ID: [redacted]

zelis payments

18167 US Hwy 19 N, Ste 300
Clearwater, FL 33764

Payment Date: 07/01/2019

Claim Payor:
Friday Health Plans
700 Main Street #100
Alamosa, CO 81101
Customer Service: 1-844-805-5000

Electronic Claims:
H0657

[redacted]

Claim Questions ? **Please refer to the Payor's Customer Service Phone Number as noted ABOVE.**

Provider's TIN: [redacted]

PT: [redacted]
MBR: [redacted] **PLAN ID:** [redacted] **PT. ACCT:** **CLAIM #:** [redacted]

Date of Service	Procedure	Billed Amount	PPO Discount	Non Covered	Other Coverage	Deductible Co-Pays	Patient Resp.	Paid	Ref.
03/11/19-03/11/19	[redacted]	$160.00	$20.77	$0.00	$0.00	$0.00	$0.00	$139.23	*
	Totals:	**$160.00**	**$20.77**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$139.23**	

Reference: * Interest Amount:$0.08
1:* PPO Discount Amount

PT: [redacted]
MBR: [redacted] **PLAN ID:** [redacted] **PT. ACCT:** [redacted] **CLAIM #:** [redacted]

Date of Service	Procedure	Billed Amount	PPO Discount	Non Covered	Other Coverage	Deductible Co-Pays	Patient Resp.	Paid	Ref.
03/21/19-03/21/19	:	$25.00	$4.31	$0.00	$0.00	$20.69	$20.69	$0.00	*,25
03/21/19-03/21/19	[redacted] :	$25.00	$4.31	$0.00	$0.00	$20.69	$20.69	$0.00	*,25
	Totals:	**$50.00**	**$8.62**	**$0.00**	**$0.00**	**$41.38**	**$41.38**	**$0.00**	

Reference: 1:* PPO Discount Amount
1:25 Deductible Amount
2:* PPO Discount Amount
2:25 Deductible Amount

Total Paid By Payor

Total: $139.31

For questions regarding the claim or benefit determination, please contact the Payor indicated in the box at the upper right hand corner of thisEOP.

This ePayment was issued as Print Check.

Friday Health Plans of Texas
700 Main Street, Suite 100
Alamosa, CO 81101
1-844-805-5000

PROVIDER REIMBURSEMENT VOUCHER(AC150R2A)
Friday Health Plans of Texas (A8)
Payment Date: 12/04/2017

Payee ID:
NPI:

Provider:

CLAIMS PAID

11/10/2017	87804	33.00	19.62	0.00	0.00	0.00	0.00	3.92	3.92	15.70
11/10/2017										
11/10/2017-	81003	7.00	3.67	0.00	0.00	0.00	0.00	0.73	0.73	2.94
11/10/2017										
TOTALS:		$266.00	$125.62	$0.00	$0.00	$0.00	$20.00	$4.65	$24.65	--$100.97

AB

SUBSCRIBER:

D.O.S.	CPT	BILLED	ALLOWED	COB	WTHLD	DEDUCT	COPAY	COINS	PAT RESP	PAID	CODES	CAP
11/10/2017	99213	149.00	67.99	0.00	0.00	0.00	20.00	0.00	20.00	47.99		
11/10/2017												
11/10/2017	81003	7.00	3.67	0.00	0.00	0.00	0.00	0.73	0.73	2.94		
11/10/2017												
TOTALS:		$156.00	$71.66	$0.00	$0.00	$0.00	$20.00	$0.73	$20.73	---$50.9		

Attachment G
Provider Dispute Resolution for Administrative Issues Policy

Friday Health Plans
A&G #7002-Provider Dispute Resolution- Admin

Title: Provider Dispute Resolution-Administrative Issues	**No. A&G#7002**
Friday Health Plans Management Services Company, Inc. **Adopted By:** Colorado, New Mexico, Texas **LOB:** Commercial CHP+ Medicare Self-Funded (if applicable)	**Effective Date:** 11/2013
Distribution: Admin/Medical Management/Provider Relations	**Review Date**: 05/2020
Policy Owner: Provider Relations Manager	**Revision Date:** 05/2020 **Next Annual Review:** 03/2021

PURPOSE

Friday Health Plans has processes in place that assure provider disputes are resolved in a consistent, impartial, and timely manner and in accordance with accreditation agency standards, state regulations and statutes.

Procedure

For the purpose of this policy, all written notification required may be met by electronic means, including e-mail or facsimile, as long as confirmation of the transmission can be shown.

Receipt/Handling of Requests for Resolution of Provider Disputes

Requests for resolutions of provider disputes must be submitted in writing.

- All requests must include the necessary information:
    1. applicable date of service;
    2. subscriber and member name;
    3. subscriber and member number;
    4. provider name;
    5. provider tax identification number;
    6. dollar amount in dispute, if applicable;
    7. provider position statement regarding the nature of the dispute; and
    8. supporting documentation where necessary

- All written requests will be entered into the Provider Dispute Log (Attachment A) by Customer Services upon receipt.
- The request will be forwarded to the Senior Director of Operations within two working days of receipt.
- The Senior Director of Operations will determine which department should handle the dispute and forward the request to that department within two (2) working days.
- An authorized representative of Friday Health Plans who was not involved in the initial decision of the subject in dispute shall review the dispute and make a determination within sixty (60) calendar days of receipt of all necessary information.[1]
- If all necessary information is not included in the request, Friday Health Plans shall request in writing, within thirty (30) calendar days of initial receipt of the request, the additional information that is needed.
- The provider has thirty (30) calendar days from the date of the request for additional information to provide that information.

[1] NM14e.16

- If the provider does not respond within thirty (30) calendar days, Friday Health Plans shall close the request without further review. Further consideration of the closed dispute resolution request must begin with a new request by the provider.
- The parties may mutually agree in writing to extend the timeframe beyond the sixty (60) calendar days from receipt of all necessary information.

Notification Requirements

Receipt of Request

If all necessary information is provided, Friday Health Plans shall send written confirmation within thirty (30) calendar days of receipt of the dispute resolution request. The confirmation must include:

1. A description of Friday Health Plans' dispute resolution procedures and timeframes;[2]
2. Procedures and time frames for the provider or the provider's representative to present the rationale for the dispute resolution request; and
3. The date by which Friday Health Plans must resolve the dispute resolution request.

If the provider dispute resolution request is resolved within thirty (30) calendar days, the notice of the resolution shall constitute this notice. If all necessary information is not received, Friday Health Plans shall send, within thirty (30) calendar days of receipt of the provider dispute resolution request, a written notice to the provider that contains:

1. A description of the additional necessary information required to process the request;
2. The date that additional information must be provided to Friday Health Plans; and
3. A statement that failure to provide the requested information within thirty (30) calendar days from the Friday Health Plans' request for additional information will result in closure of the request with no further review unless a new request is submitted.

If the provider does not submit the additional necessary information required by Friday Health Plans and Friday Health Plans closes the request, Friday Health Plans shall notify the provider that the case is closed and that further consideration of the closed dispute resolution request must begin with a new written request from the provider.

Notification of Determination[3]

Friday Health Plans shall provide written notification of the determination to the provider within sixty (60) calendar days of receipt of all necessary information. The notification shall include:

1. The name an title of the authorized representative of Friday Health Plans who reviewed the request and made the determination;[4]
2. The qualifying credentials of the authorized representative of Friday Health Plans who reviewed the request where the decision was based on a review of medical documentation;
3. A statement of the reviewer's understanding of the reason for the provider's dispute;
4. The reviewer's decision in clear terms;
5. The rationale for the decision; and
6. A reference to evidence or documentation used as the basis for the decision.

If the determination is not in favor of the provider, the notification shall also include the principal reasons for the determination. Copies of all notifications shall be returned to Customer Services for completion of the Dispute Log and filing of the documents.

[2] NM14d
[3] NM14e,g
[4] NM16

Provider's Right to Present Rationale for Request[5]

The provider may designate a provider representative in the dispute resolution process. The provider or the provider's representative may present the rationale for the dispute resolution request in person. If a face-to-face meeting is not practical, Friday Health Plans shall offer the opportunity to use alternative methods such as teleconference to present the rationale for the dispute resolution request. Friday Health Plans may require appropriate confidentiality agreements from representatives as a condition to participating in the dispute resolution process.

Requests from the Commissioner

The provider dispute resolution log shall be made available to the Commissioner within a reasonable time, upon request. All Provider Dispute Logs shall be given confidential or privileged treatment by the Commissioner to the extent provided by law to protect the privacy of the patient and provider.

References

URAC

DEFINITION(S)

Administrative Provider Disputes: Disputes that may include any of the following: claims payment, timeliness of payment, enrollment verification, etc.
Participating provider: any provider that enters into an agreement with Friday Health Plans for the provision of health care services to members.
Provider Dispute Resolution Log: a record of provider dispute resolution requests received by Friday Health Plans and maintained on a calendar year basis. At a minimum, the log shall include: (1) date of receipt of the dispute; (2) date the request was closed; (3) whether the request was pended for additional information; and (4) outcome of the request.
Provider representative: a person designated by a provider in writing, including other providers or an association of providers, to represent the provider's interest during the dispute resolution process.
Utilization review: A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. This includes the standard referral process.

Related Documents

Complaint Log
Provider Handbook

[5] NM14c