22Health
A Division of Community Care Plan

# PROVIDER MANUAL

*(866) 357-4082 | 22HealthPlan.com*

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## Contents

# Welcome

Dear Valued Provider,

Welcome to the 22 Health Provider Network! We are excited to partner with you in delivering exceptional care to our members. Together, we aim to improve health outcomes, enhance member experiences, and uphold the highest standards of quality and service.

This Provider Manual is your comprehensive guide to 22 Health's policies, procedures, and expectations. It is designed to support you in navigating our processes, meeting regulatory requirements, and providing efficient, patient-centered care. Your expertise and dedication are essential to achieving our shared commitment to quality healthcare.

As a 22 Health provider, you play a key role in:

- Delivering high-quality, evidence-based care;
- Ensuring compliance with State and Federal regulations; and
- Collaborating with 22 Health staff to address community needs and improve access to care.

You can count on 22 Health for:

- **Dedicated Support:** A Provider Relations Representative is always available to assist you.
- **Timely Communication:** Updates on policies, procedures, and regulatory changes Including benefit Changes such as termination or addition of benefits, services, or service delivery
- **Shared Success:** Opportunities to meet goals and celebrate achievements.

Thank you for your commitment to providing **"quality care for every member, every time."** If you have questions or need assistance, please call us at 1-866-357-4082 or email providersupport@22healthplan.com. We look forward to a successful partnership.

# Important Contacts

| Department | Phone | Email/Portal |
|---|---|---|
| Provider Operations | (855) 819-9506 | providersupport@22healthplan.com |
| Member Services | (866) 357-4082 | support@22Healthplan.com |
| Prior Authorization Inquiries | (866) 357-4082 | providerportal.22healthplan.com |
| Claims/Billing | (866) 357-4082 | Claim submission/RA: www.Availity.com<br><br>Claim status, claim appeals, claim status guest, and portal: providerportal.22healthplan.com |
| Fraud and Abuse Hotline | (954) 622-3482 | compliance@22healthplan.com |

## Claim Addresses

| | | |
|---|---|---|
| Electronic Claims | Submit via Availity:<br><br>Payer ID# 22HLT | Contact Availity:<br><br>1-800-282-4548 |
| Paper Claims<br>with attachments | Should be mailed to<br><br>22 Health Claims Department<br>P.O. Box 849029<br>Pembroke Pines, FL 33084 | |

Claims must be submitted within six (6) months after the following have occurred:

1. Discharge from inpatient services or the date of service for outpatient services; and
2. The provider has been furnished with the correct name and address of the patient's HMO.

Claims submitted after six (6) months will be denied as untimely.

For more information on members submitting claims for payment, please refer to the Member Handbook, "Filing Claims for Payment" section.

# Provision of Services

22 Health is committed to delivering high-quality, accessible, and member-centered care through its network of providers. Providers are expected to adhere to the following standards to ensure services meet the needs of our diverse membership:

## Scope of Services

Providers must deliver services in compliance with:

- State and Federal Regulations: Including but not limited to Chapter 627, Part VI and Chapter 641, Parts I and III, Florida Statutes, the Affordable Care Act (ACA), and the Employee Retirement Income Security Act (ERISA).
- Medical Necessity Standards: All services must be medically necessary and within the scope of the provider's licensure and training.
- 22 Health Guidelines: Providers must follow all policies outlined in this manual and their provider agreement.

## Core Service Areas

22 Health offers a comprehensive range of covered services, which providers must deliver or coordinate within the network. These include but are not limited to:

1. Emergency Care: Emergency inpatient, outpatient and physician services must be available on a 24-hour, 7-day a week basis, through 22 Health's arrangements with its providers. Emergency resuscitation supplies must be available. In addition, emergency services, as defined in Florida statutes and rules, are covered by 22 Health.
2. Inpatient Hospital Services. Inpatient hospital services must be available 24 hours a day, 7 days a week through 22 Health's arrangements with hospitals. Inpatient hospital services shall include, for example: room and board, general nursing care, meals and special diets when medically necessary, use of operating room and related facilities, use of intensive care unit and services, x-ray services, laboratory and other diagnostic

tests, drugs, medications, biologicals, anesthesia and oxygen services, radiation therapy, inhalation therapy, and administration of whole blood and blood plasma.

3. Physician Care. Physician care provided or supervised by physicians licensed under chapters 458, 459, 460 or 461, Florida Statutes, include PCPs and specialists to adequately provide for the contracted services. Physician care shall include consultant and referral services by a physician.

4. Ambulatory Diagnostic Treatment. Outpatient diagnostic treatment services with an emphasis directed toward primary care. Ambulatory diagnostic treatment shall include diagnostic laboratory and diagnostic radiological services.

5. Preventive Health Care Services. A program of health evaluation, education and immunizations which is designed to prevent illness and disease and to improve the general health of 22 Health's members. This program shall include at least the following:

    - Well-child care from birth;
    - Periodic health evaluations for adults;
    - Eye and ear screenings by a physician for children through age 21 to determine the need for vision or hearing correction; and,
    - Pediatric and adult immunizations, in accordance with accepted medical practice.

# Provider Expectations

Providers are required to:

- Deliver services that are patient-centered, timely, and culturally competent.
- Maintain complete and accurate medical records for all members.
- Participate in health and wellness programs as required by 22 Health, such as Health Risk Assessments (HRAs) and disease management initiatives.
- Follow federal and state regulations regarding billing, coding, and claims submission.
- Keep complete and up-to-date medical records for all members.
- Ensure continuity of care for members transitioning into or out of 22 Health coverage.

## Timeliness of Services

Provider shall ensure that all health care services are delivered within the timeframes established by rule 59A-12.006(3), *Florida Administrative Code*:

- Emergencies will be seen immediately;
- Urgent cases will be seen within 24 hours;
- Routine symptomatic cases will be seen within two weeks; and
- Routine non-symptomatic cases will be seen as soon as possible.

Additionally, 22 Health requires Providers to meet appointment wait time standards established by CMS and AAAHC for the following provider specialty types:

- Behavioral Health: Within 10 business days;
- Primary Care (Routine): Within 15 business days;
- Specialty Care (Non-Urgent): Within 30 business days;
- After-Hours Care: Providers must ensure 24-hour, 7-day access to care for urgent conditions through on-call coverage, answering services, or direct provider contact. Calls must be returned within 30 minutes; and

- Women's Care: Routine/preventive appointments within 15 business days; urgent gynecological issues within 48 hours; and prenatal care initiated within 14 days of a positive pregnancy test or request for care.

Providers are required to report any delays in service delivery to 22 Health by emailing Provider Operations at providersupport@22healthplan.com as soon as the delay is identified and, when possible, prior to the scheduled service date.

This requirement applies to all covered services, including medical, behavioral health, and ancillary services. The reason for the delay must be clearly documented in the member's medical record to support care coordination and compliance.

Your cooperation helps ensure continuity and quality of care for our members.

## Compliance Monitoring

22 Health actively monitors service delivery to ensure compliance with:

- Appointment availability standards;
- Member satisfaction through surveys; and
- Quality and utilization benchmarks.
- Provider Satisfaction Survey

Providers failing to meet these standards may be subject to corrective action plans, up to and including termination from the network.

## Service Limitations

Coverage limitations and exclusions are detailed in the member's benefit plan. Providers must verify member eligibility and coverage before delivering services. Authorization may be required for certain high-cost or specialized procedures, as outlined in Referral and Prior Authorization Processes. Information about member fees, copayments, and payments can be found here: 22healthplan.com/for-members/documents-and-forms/.

For further assistance, please contact **Provider Operations** or use the 22 Health Provider Portal.

## Covered Services

The 22 Health provider network provides comprehensive coverage, including but not limited to:

1. Primary Care Services
   - Preventive health screenings, including immunizations and wellness visits
   - Diagnosis and treatment of acute and chronic conditions
   - Health Risk Assessments (HRAs) for new enrollees
2. Behavioral Health Services
   - Outpatient mental health services, including therapy and counseling
   - Substance use disorder treatment, including detoxification and medication-assisted treatment (MAT)
   - Inpatient psychiatric care for acute mental health crises
3. Specialty Care Services
   - Consultations and treatment for conditions requiring specialized care (e.g., cardiology, endocrinology)
   - Management of complex and high-risk medical conditions
4. Hospital and Emergency Services
   - Emergency room services without prior authorization
   - Inpatient and outpatient hospital care, including surgical procedures
5. Maternity and Newborn Care
   - Prenatal, postnatal, and postpartum care
   - Neonatal care for high-risk infants
   - Breastfeeding support and counseling
6. Pediatric Services
   - Preventive and routine well-child visits
   - Developmental screenings and immunizations
   - Pediatric specialty care (e.g., neonatology, pediatric cardiology)
   - Pediatric Vision care

7. Pharmacy Services
    - Please practice cost-effective prescribing, follow evidence-based prescribing guidelines, submit prior authorization forms promptly, and assist members with understanding the formulary when necessary. Together, we can help members receive the medications they need on time.
    - Prescribers can access the Preferred Drug List (PDL) or Drug Lookup Tool on our website at 22healthplan.com/formulary.
        - The PDL is updated quarterly: January, April, July, and October. Providers are required to check the PDL for updates during these months to ensure prescribing up-to-date, formulary-preferred drugs.
        - Medication Tiers listed on the PDL are as follows:
            - Tier 1 Zero Cost Share/Preventive Drugs/Essential Health Benefit drugs
            - Tier 2 Generics
            - Tier 3 Preferred Brand
            - Tier 4 Non-Preferred Brand
            - Tier 5 Specialty Drugs
    - MedImpact is the pharmacy benefits manager (PBM) that manages the formulary and conducts pharmacy prior authorization (PA) reviews on behalf of 22 Health.
        - MedImpact can be reached at 1-800-788-2949
    - PA forms can be found at: www.medimpact.com/forclients/healthcare-provider-welcome
    - MedImpact provides a provider portal for access to enrollees' claims information and out-of-pocket costs. Please visit www.medimpact.com/forclients/healthcare-provider-welcome for more information on how to view enrollee's benefit information.
    - Benefits such as mail order, and 90-day supply discounts are available to enrollees.

- PBM clinical programs will be provided to enrollees for oncology. More details are available for enrollees at: 22health.nationsbenefits.com/nutrition
- Physician office-administered medications (J-codes) must be requested via the **pharmacy benefit**. Prescribers in the 22 Health network can find information via the ePA tool on the prescriber portal at www.medimpact.com/forclients/healthcare-provider-welcome. The PA submission process for J-codes will follow the same process used to submit PA for a formulary medication from the pharmacy benefit via the ePA tool.

8. Diagnostic and Laboratory Services
   - Laboratory testing for preventive care and disease management
   - Diagnostic imaging services (e.g., X-rays, MRIs, CT scans)
9. Rehabilitative and Habilitative Services
   - Physical therapy, occupational therapy, and speech therapy
   - Acute inpatient rehabilitation for post-injury or post-surgery recovery
   - Durable Medical Equipment
10. Preventive Health and Wellness Services
    - Cancer screenings (e.g., mammograms, colonoscopies)
    - Immunizations for adults, doses, recommended ages, and recommended populations vary
    - Nutritional counseling for eligible members
    - Please see full list of Preventive care benefits www.healthcare.gov/coverage/preventive-care-benefits/
11. Home Health Services
    - Skilled nursing visits for acute and chronic conditions
    - Home health aides for personal care assistance
12. Telemedicine Services
    - Virtual visits for primary and specialty care
    - Behavioral health telehealth consultations

# Provider Responsibilities

Contracted providers and groups should notify 22 Health of material practice changes so we can keep directories accurate, support member access, and meet regulatory requirements. Please report updates such as a provider joining or leaving your group; changes to practice address, telephone or fax numbers; office hours and after-hours coverage; telehealth availability; languages; accepting-new-patients status and panel closures; hospital privileges and supervision relationships; ownership/DBA/name changes; planned relocations/mergers/closures; and any temporary service disruptions exceeding 48 hours.

How to submit: email all updates to providersupport@22healthplan.com with subject line "Provider Change/Update – [Group Name] – [Effective Date]," attach the roster/template or a completed Notice of Change form, include the effective date and supporting documentation, and use your organization's secure email when transmitting PHI (request a secure upload link in your message if needed).

## Primary Care Providers (PCPs)

- Maintain 24/7 availability for member inquiries, including on-call or answering services.
- Complete and submit Health Risk Assessments (HRAs) for new members within 90 days of assignment.
- Develop individualized care plans in collaboration with members.

## Specialist Providers

- Ensure timely access for new and follow-up appointments.
- Collaborate with PCPs for referrals and treatment coordination.
- Submit feedback and progress reports to PCPs within 14 days of a member's visit.

## Behavioral Health Providers

- Post-discharge follow-ups must be scheduled within seven (7) days.
- Offer timely services for urgent and routine behavioral health needs.

# Risk Management Program

Participating providers and groups are responsible for compliance with the 22 Health Risk Management Program and supporting 22 Health's Risk Management obligations under state and federal laws and regulations, including but not limited to Fla. Admin. Code R. 59A-12.012 and Section 641.55, *Florida Statutes*. 22 Health's Risk Management Program and Potential Quality Issue policies and related forms are updated at least annually and available on 22 Health's website.

22 Health's Risk Management Program includes the following components:

- The investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents causing injury to patients;
- The development of appropriate measures to minimize the risk of injuries and adverse incidents to patients, including risk management and risk prevention education and training of al non personnel;
- The analysis of patient grievances which relate to patient care and the quality of medical services; and
- The development and implementation of an incident reporting system based upon the affirmative duty of all providers and all agents and employees of 22 Health to report injuries and adverse incidents to the Risk Manager.

22 Health's Risk Management Program requires the prompt (within 3 days) reporting of adverse incidents to its designated Risk Manager on 22 Health reporting forms, and at a minimum, must include the following information:

- The patient's name, date of birth, sex, physical findings or diagnosis and, if hospitalized; locating information, admission time and date, and the facility's name;
- A clear and concise description of the incident including time, date, exact location, and coding elements as needed for the annual report based on ICD-10-CM;
- Whether or not a physician was called and, if so, a brief statement of said physician's recommendations as to medical treatment, if any;
- A listing of all persons known to be involved directly in the incident, including witnesses, along with locating information for each; and,
- The name, signature and position of the person completing the report, along with date and time that the report was completed.

An adverse incident includes, but may not be limited to the following:

- The unexpected death of a patient;
- Severe brain or spinal damage to a patient;
- Permanent disfigurement;
- Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the case or pre-existing physical condition;
- Any condition requiring transfer of the patient within or outside the facility to a more acute level of care due to an adverse incident;
- A surgical procedure being performed on the wrong patient; or
- A surgical procedure unrelated to the patient's diagnosis or medical needs being performed on any patient.

22 Health engages in regular and systematic review of all incident reports and written patient grievances for the purposes of identifying trends or patterns as to time, place or persons, and upon emergence of any trend or pattern in incident occurrence, will develop recommendations for appropriate corrective action and risk management prevention education and training. All data maintained as a part of the 22 Health Risk Management Program must be maintained for a minimum of three (3) years, or longer where required by federal, state or local law or regulation.

22 Health submits at least annual reports to the Agency for Healthcare Administration, as required under Florida law, including all incident reports filed with the organization during the preceding calendar year. All adverse or untoward incidents must be reported to the Agency for Healthcare Administration within three (3) working days after the incident's occurrence, with more detail required in follow up reporting.

## Referral and Authorization Process (Utilization Management)

The Utilization Management (UM) program is designed to promote fair, impartial, and consistent utilization decisions and care coordination for 22 Health members. The UM program aims to:

- Ensure Confidentiality: Safeguard the personal health information of the members.
- Enhance Practices: Initiate process improvement activities to continually refine the utilization management practices.
- Evidence-Based Decisions: Make decisions based on evidence, considering medical necessity, appropriateness, and the availability of benefits.
- Quality and Cost-Efficiency: Objectively monitor and evaluate the delivery of high-quality and cost-effective service.

## Staff Compensation and Incentives

All UM employees must annually sign an affirmative statement regarding compensation. We prohibit compensation or incentives based on:

- The volume of adverse determinations.
- Reductions or limitations on lengths of stay, benefits, or services.
- Frequency of contact with healthcare practitioners or patients.

## Fraud, Waste, and Abuse Prevention

UM policies and processes are integral in preventing, detecting, and responding to reports of fraud, waste, and abuse among practitioners and members. We collaborate closely with the compliance officer, risk manager, and 22 Health's special investigation unit to resolve any identified issues.

## UM Contact Information

For inquiries or to request Utilization Management criteria, providers can contact 22 Health at 1-866-357-4082 Monday through Friday 8am to 5pm. You can also visit our website at 22HealthPlan.com.

## Clinical Practice Guidelines

22 Health UM decisions are guided by various clinical practice guidelines to ensure appropriate care delivery, including but not limited to:

- InterQual (National standardized set of evidence-based criteria): Utilized as a screening to guide and not as a substitute for the practitioner's judgment.
- UpToDate clinical decision support
- Preventive and Practice Guidelines
- The ASAM (American Society of Addiction Medicine) criteria for substance use disorder services.
- Clinical Practice Guidelines from the American Medical Association and the American Psychiatric Association

Utilization review decisions adhere to these guidelines for medical necessity while also considering any special circumstances that may require deviations

from standard criteria. The criteria in the clinical guidelines are used to ensure consistency.

Guidelines are presented to the quality improvement committee for physician review and adoption, as appropriate. These Guidelines are updated at a minimum, every two (2) years or upon significant new scientific evidence or changes in national standards of care.

## Emergency Services and Care

Emergency services are crucial in ensuring that members of 22 Health receive timely and appropriate care during emergency medical conditions.

Emergency medical condition means (a) a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity or severe pain, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to the health of a patient, including a pregnant woman or a fetus.
    - With respect to a pregnant woman:
        - That there is inadequate time to effect safe transfer to another hospital prior to delivery;
        - That a transfer may pose a threat to the health and safety of the patient or fetus; or
        - That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

Emergency Services and Care (also referred to as Emergency Services) means services which are needed immediately because of an injury or unforeseen medical condition which could reasonably be expected to result in disability or death. These must be provided, or arranged to be provided, on a 24-hour basis by 22 Health, but also may be covered inpatient services or outpatient services that are furnished by an appropriate source other than 22 Health

when the time required to reach the 22 Health providers (or alternatives authorized by 22 Health) could mean the risk of permanent damage to the member's health. Notwithstanding the above, these services are considered to be emergency services, in or out of the service area, only as long as transfer of the member to 22 Health's source of health care or designated alternative is precluded because of risk to the member's health or because transfer would be unreasonable, given the distance involved in the transfer and nature of the medical condition. Providers have several key responsibilities in providing these services.

22 Health covers emergency services rendered by a qualified participating or non-participating provider until the member is stabilized. Providers must ensure that emergency services are available 24/7 without requiring prior authorization. In the event of a medical emergency, providers should deliver necessary care immediately. Post-service authorization and review will be conducted retrospectively to ensure coverage and medical necessity. Providers should notify 22 Health as soon as possible after delivering emergency services to facilitate appropriate follow-up care and ensure accurate claims processing.

Providers are responsible for promptly assessing the member's condition and providing stabilizing treatment or arranging for immediate transfer to a facility that can provide the necessary care. An appropriate medical screening examination must be performed to determine if an emergency medical condition exists. If such a condition is identified, the provider is responsible for rendering necessary stabilizing treatment or ensuring the member's safe transfer to an appropriate facility. If 22 Health determines that a medical emergency does not exist, 22 Health will reimburse the provider for any screening, evaluations, and examinations needed to make this determination, as defined by the requirements of the product in which the member is enrolled.

If the provider determines that an emergency medical or behavioral health condition exists, the facility to which the member was admitted is required to notify 22 Health within two (2) business days following the inpatient

admission or after a Baker Act (BA52) psychiatric admission. If the facility is unable to notify 22 Health, it must document its attempts to notify or the circumstances that prevented notification. Importantly, 22 Health does not deny payment for emergency services based on a facility's failure to comply with these notification requirements.

22 Health covers any medically necessary stay in a non-participating facility resulting from a medical emergency until the member can safely be transported to a participating facility. The attending emergency physician or treating provider is responsible for determining when the member is stabilized for transfer. Providers must continue rendering medically necessary care until the member is safely transferred or discharged, regardless of the authorization status.

Coordination of care is essential following the provision of emergency services. Providers should work with the members' Primary Care Provider (PCP) and other relevant healthcare providers to ensure continuity of care, sharing relevant medical records and information to facilitate appropriate follow-up care. Emergency services must be billed in compliance with 22 Health's billing guidelines, with detailed documentation of the services provided, including the medical screening examination, treatment, and any transfer or discharge details.

Providers must also inform members of their rights and responsibilities regarding emergency services, including their right to access emergency care without prior authorization. It is important to educate members on when and how to seek emergency services and the importance of notifying their PCP following an emergency event. 22 Health will monitor the provision of emergency services to ensure compliance with federal and state regulations, as well as 22 Health's policies. Providers are expected to cooperate with 22 Health in this monitoring process, including providing access to relevant records and documentation. Non-compliance with emergency services responsibilities may result in corrective action, including reimbursement

adjustments, contract termination, or other actions as deemed necessary by 22 Health.

## Services Requiring Prior Authorization

Providers should refer to the Services Requiring Prior Authorization (PA) list to determine if prior authorization is needed for a specific service code. Providers may request authorization through the 22 Health secure provider portal, PlanLink. The specific service requirements are integrated into many of these forms.

- Services Requiring Prior Authorization: 22healthplan.com/for-providers/priorauth
- Provider Portal

Prior authorization requires the provider to make a formal medical necessity determination request to 22 Health before the service may be rendered. Services that are not on the PA list may not require prior authorization or may not be covered as a benefit for 22 Health. It is essential to review the PA list prior to providing preadmission services, pretreatment services, and utilization management services to ensure the services are covered.

Most Behavioral Health Outpatient Services do not require prior authorization. Providers should use the Prior Auth list to determine if prior authorization is needed for a specific service code. To view these codes, review the PA list on our website.

## Medical Necessity Definition

Medically Necessary or Medical Necessity - Services provided that include medical, allied or long-term care, goods and services furnished or ordered which meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain.
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the enrollee's needs.
- Be consistent with the generally accepted professional medical standards and not be experimental or investigational in nature.
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available.
- Be furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee's caretaker or the provider.

Medical necessity for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provision of appropriate medical care be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type. The fact that a provider has prescribed, recommended, or approved medical or allied goods, or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service benefit.

Upon receiving a request for service authorization from a practitioner or provider, a thorough review of the member’s clinical information is conducted by a utilization management nurse or licensed clinician. This assessment encompasses various factors, including co-existing health conditions, psychosocial considerations, home environment, and support systems. The evaluation also incorporates criteria for medical necessity from InterQual criteria, American Society of Addiction Medicine (ASAM) guidelines for substance use admissions, and other relevant adopted guidelines.

Should the provided information not align with the applicable criteria, further review is undertaken by a medical director or qualified healthcare practitioner. In instances where a service is denied or restricted, the requesting provider retains the option to request a peer-to-peer review by contacting customer service.

Prior authorization requires the provider or practitioner to make a formal medical necessity determination request to 22 Health prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health services proposed, including the setting in which the proposed care will take place.

Decision-making at 22 Health is based *ONLY* on the appropriateness of care and service and the existence of coverage.

- Practitioners, or other individuals, are not rewarded for issuing denials of coverage.
- Decisions are not connected to any financial incentive, and staff are not encouraged to make decisions that result in underutilization.

## Submitting Prior Authorization Requests

Providers must submit authorization requests through the Secure Provider Portal, PlanLink: providerportal.22healthplan.com. Requests for authorization must include all necessary clinical information to ensure timely processing, included but not limited to:

- Current information
- Patient history
- Progress notes (Specialist notes)
- Lab results
- Imaging results
- Progress to treatment
- Doctor's order

*Prior Authorization Information and Request Form is available on 22 Health's website: 22HealthPlan.com. For information on obtaining access to the PlanLink provider portal to submit electronic prior authorization requests, please contact PlanLink@22healthplan.com.*

## Timeline for Utilization Review Decisions

Practitioners, providers, and facilities must submit prior authorization requests for services within the following timeframes:

### *Standard Preauthorization Review*

If all the information necessary to make a medical necessity determination regarding a Preauthorization request received, the determination will be made and notice will be provided to the member and to the requesting provider in writing, within fifteen (15) calendar days of receipt of the request.

The time frame for authorization decisions can be extended up to fifteen (15) calendar days for a standard request and three (3) calendar days for an expedited request if the member or provider requests an extension or the Plan justifies the need for additional information and how the extension is in the member's interest. For these cases, an extension letter request will be mailed to the member and the requesting provider. If all necessary information is not received within the allowed days for the extensions, a decision will be made utilizing the available clinical information.

### *Urgent Preauthorization Review*

With respect to urgent Preauthorization requests, if all information necessary to make a medical necessity determination is received, a determination will be made within 72 hours of receipt of the request. Written notice of the determination will be provided within three (3) business days. If additional information is required, a request for additional information will be requested within 24 hours. The member or the provider will then have 48 hours to submit the information. A determination and notice will be provided to the member and the

provider within 48 hours. Written notification will be provided within three (3) business days of receipt of the additional requested information.

### *Retrospective Review*

After a service has been performed, 22 Health may use retrospective (post-service) review to determine if an admission or service was Medically Necessary. In the event the services are determined to be Medically Necessary, benefits will be provided as described in this Plan. If it is determined that a service was not Medically Necessary, the member may be responsible for payment of the charges for those services.

## Provider Compliance and Monitoring

Providers are monitored to ensure adherence to:

- Appointment access standards
- Member satisfaction benchmarks
- Timely and accurate claims submissions

Corrective action plans may be required for non-compliance, up to and including termination of network participation.

### Network Adequacy and Access Standards

| Practitioner Type | Standard | Measurement Method | Frequency |
|---|---|---|---|
| PCP | 99% of members within 5 miles | GeoAccess Analysis | Annual |
| OB/GYN | 95% of members within 20 miles | GeoAccess Analysis | Annual |
| Oncology | 95% of members within 20 miles | GeoAccess Analysis | Annual |

## Language Access Services and Non-Discrimination

- Providers must ensure language access services are available, including interpreters and translated materials.
- Multilingual signage should be displayed prominently in all offices.

## Member Grace Period

Providers should be aware that members who purchase coverage through the Health Insurance Marketplace may have a grace period if they miss a premium payment.

- Non-Subsidized Members (No APTC): These members have a 31-day grace period after the premium due date. If payment is not received by the end of that period, coverage terminates at the end of the grace period.
- Subsidized Members (Receiving Advance Premium Tax Credit – APTC): These members are entitled to a three-month grace period, provided they have already paid at least one month's premium in full.
    - During the first month, coverage remains active, and claims are paid as usual.
    - During the second and third months, coverage remains in effect, but claims and authorizations may be suspended or pended until the member pays all past-due premiums.
    - If the member fails to pay by the end of the third month, coverage terminates retroactive to the end of the first month of the grace period, and any pended claims for Months 2–3 will be denied.

Providers are encouraged to verify eligibility and claim status before rendering non-emergency services, especially if notified that a member is in a grace period.

## Member Information and Rights

A full list of member rights and responsibilities can be found in the member handbook under “Member Rights and Responsibilities”.

Members have the right to:

1. Access to Quality Care
    - Receive medically necessary services promptly and without discrimination based on race, ethnicity, age, gender, religion, disability, sexual orientation, or socioeconomic status.
    - Be treated with respect and due consideration for their privacy and cultural beliefs.
2. Informed Decision-Making
    - Obtain information about their diagnosis, treatment options, and potential risks and benefits in a language or format they understand.
    - Obtain information about their provider, including information obtained during the provider credentialing contract, and including but not limited to all information a member may request about Provider’s qualification to participate in the plan network, perform a particular service, or treat a particular condition.
    - Participate in decisions about their healthcare, including the right to:
        1. refuse treatment, except as otherwise provided by law, and to be informed of the consequences of such refusal;
        2. formulate advance directives in accordance with the Patient Self-Determination Act and Florida Statute Chapter 765; and/or
        3. appoint a personal representative either by Power of Attorney or by designation of a Health Care Surrogate to

make health care decisions for the patient where the patient is incapable of doing so.

3. Continuity of Care
    - Transition seamlessly between providers, even when moving to a different plan or location.
    - Continue receiving care from non-participating providers during a transition period, as specified in 22 Health policies.
4. Privacy and Confidentiality
    - Expect their medical records and personal information to remain confidential and secure, except as required by law.
    - Access and request changes to their medical records in accordance with federal and state regulations.
5. Support and Advocacy
    - File complaints, grievances, and appeals regarding the services provided by 22 Health or its network providers.
    - Request and receive a second opinion for any medical diagnosis or treatment plan. Members are entitled to obtain a second opinion regarding their care. A second opinion involves consultation with another qualified healthcare provider to obtain an independent assessment of the member's diagnosis, treatment plan, or recommended services. The intent is to support informed decision-making and ensure that the proposed care is appropriate. There is no cost to the member for obtaining a second opinion.
    - Providers, case managers, or Member Services representatives should assist members in identifying an appropriate provider to perform the second opinion. Members may select any in-network provider for this purpose. If an in-network provider is not available, the plan will assist in locating a qualified out-of-network provider. Authorization is required before the member

receives services from an out-of-network provider for a second opinion.

- Be free from retaliation when exercising these rights.

## Complaint, Grievance, and Appeals Processes

22 Health ensures a transparent process for filing complaints, grievances and appeals to address member and provider concerns effectively.

You can submit a Complaint by:

Calling Member Services at 866-357-4082,
Monday through Friday, 8 am - 5 pm.

**Complaints include a**ny expression of dissatisfaction by a Member, including dissatisfaction with the administration, claims practices, or provision of services, which relates to the quality of care provided by a provider pursuant to our contract and which is submitted to us or the Agency for Health Care Administration or the Department of Insurance, a state agency.

Complaints submitted to Member Services will be addressed promptly, with a response provided by telephone by the end of the next business day.

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| Email | Grievances may be submitted via email to GAdepartment@22healthplan.com<br><br>They can be submitted with or without the grievance and appeals form available on our website: 22healthplan.com/for-members/documents-and-forms |
| Fax | Complaints or grievances may be submitted via fax to 1-954-251-4848<br><br>They can be submitted with or without the grievance and appeals form available on our website: 22healthplan.com/for-members/documents-and-forms |

Mail 22 Health
Attn: Grievances and Appeals
1643 N Harrison Parkway
Sunrise, Florida 33323

## Complaint

- Definition: Is any expression of dissatisfaction by a Member, including dissatisfaction with the administration, claims practices, or provision of services, which relates to the quality of care provided by a provider pursuant to our contract and which is submitted to us or the Agency for Health Care Administration or the Department of Insurance, a state agency.

## Grievance

- Definition: Is a formal written Complaint submitted by or on behalf of an enrollee regarding:
  - The Availability, delivery or quality of Health Care Services, including a Complaint regarding an Adverse Determination made pursuant to Utilization Review;
  - A claims payment, handling or reimbursement for Health Care Services; or
  - Matters pertaining to the contractual relationship between an enrollee and a health carrier.
- Submission: Members or authorized representatives can choose to submit a grievance with or without the Grievance and Appeal Form available at 22healthplan.com/for-members/documents-and-forms and submit it via:
  - Fax: 954-251-4848
  - Email: GAdepartment@22Health.com

- Timeline: Grievances will be acknowledged in writing within 5 business days and Resolutions are provided within 30 calendar days for non-urgent issues, in accordance with federal and state regulations.

## Appeals

- Definition: A formal request to reverse a decision related to service denials, reductions, or terminations. To initiate a non-urgent clinical appeal, the members or authorized representatives must submit a request for an appeal within 180 days of receipt of a denial notice. The person requesting the appeal should state the reason why they feel their appeal should be approved in writing and include any clinical records, or additional information to support their appeal. All non-urgent appeals will be acknowledged within 5 business days, and written notification of the resolution or decision will be provided within 30 calendar days, in accordance with federal and state regulations.
- Submission: There are three types of appeals providers can submit to the plan.
    1. Pre-service appeals, which are handled by the Grievances and Appeals department.
        - Pre-service appeals can be submitted by the member or by the provider on behalf of a member with supporting documentation and written consent from the member within 180 days of the decision, unless the request is for an expedited appeal.
        - The appeal can be submitted by completing the G&A Form available online, or by submitting it on signed letterhead and faxing or mailing it to the address provided on the prior authorization denial letter.
    2. Post-service appeals, which are handled by the Claims department.
        - Post-service provider claim appeals can be submitted electronically via the provider portal, PlanLink or submitted via fax to 954-417-7187 with the provider claim reconsideration form.

3. Expedited appeals, which are also handled by the Grievances and Appeals department.

   - The member or authorized representative may request an expedited appeal if the member's life, health, or ability to regain maximum function would be placed in jeopardy by delay due to a non-urgent appeal review.
   - Expedited appeals may be requested orally through the Member Services department, or in writing directed to GAdepartment@22Health.com. An expedited external appeal may be requested at the same time that as an expedited internal appeal.
   - 22 Health's Physician reviewer will decide if the expedited appeal criteria apply, and the person filing the appeal will be notified if the appeal will be handled as an expedited request within 72 hours, or if it will be downgraded to a standard appeal review and resolved within 30 calendar days.
   - For any concurrent review of an urgent care request, coverage for the treatment shall be continued without additional liability to You until You are notified of the review decision.

- Resolution: The Grievances and Appeals department will provide written notification of 22 Health's decision regarding the expedited appeal within 72 hours of receiving the request.

## Request an External Review of our Appeal Decision

If we deny Your appeal and our decision involves a medical judgment, including, but not limited to, a decision based on Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the Health Care Service or treatment You requested or a determination that the treatment is Experimental or Investigational, You are entitled to request an independent, external review of our decision. Your request will be reviewed by an Independent Review Organization (IRO) with clinical and legal expertise that has no association with us.

You or an individual acting on your behalf or Your Provider has the right to request an immediate review of our appeal decision by an IRO by submitting a request to the HHS-administered external review contractor, MAXIMUS Federal Services, Inc., within 4 months after receipt of the notice of the determination of your appeal. There is no cost to you for the independent review.

You will not be required to exhaust Our Appeal process before requesting an IRO if:

- The Appeal process timelines are not met; or
- In an urgent care situation.

Under non-urgent circumstances, you may request a standard external review. For urgent care, you may request an expedited external review.

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| Mail | MAXIMUS Federal Services<br>3750 Monroe Avenue, Suite 708<br>Pittsford, NY 14534 |
| Fax | (888) 866-6190 |
| Online | Standard external reviews:<br>maximusferp.my.site.com/FERP |
| Phone | Expedited external reviews:<br>888-975-1080 |
| Email | Expedited external reviews:<br>FERP@maximus.com |

The MAXIMUS Federal Services examiner will contact us upon receipt of the request for external review. For a standard external review, we will provide the examiner all documents and information used to make the final internal adverse benefit determination within five (5) business days. For an expedited external review, we will provide the examiner all documents and information used to make the final internal adverse benefit determination as soon as

possible. If You have not completed Our expedited internal appeal process, the IRO will determine immediately whether You will be required to complete the expedited internal appeal before proceeding to the expedited external review.

The MAXIMUS examiner will give you and 22 Health written notice of the final external review decision as soon as possible, but no later than 45 days after the examiner receives the request for a standard external review. For an expedited external review, the examiner will give You and Us the external review decision as quickly as medical circumstances require, but no later than within 72 hours of receiving the request.

## Assistance From the Florida Office of Insurance Regulation

If you have any questions regarding a Complaint, Grievance, or appeal concerning the health care services you have been provided, which have not been satisfactorily addressed by Your Plan, you may contact the Florida Office of Insurance Regulation at any time. Information regarding the Florida Office of Insurance Regulation can be found online at floir.com. No insured who exercises the right to file a complaint or an appeal shall be subject to disenrollment or otherwise penalized due to the filing of a complaint or appeal.

The Florida Office of Insurance Regulation may be contacted as follows:

Florida Office of Insurance Regulation
Division of Consumer Services
200 East Gaines Street
Tallahassee, FL 32399-0322

## Provider Support

Providers should assist members with completing the Grievance and Appeal Form, gathering documentation, and submitting appeals.

### Access to the Grievance and Appeal Form

The required Grievance and Appeal Form is available on the 22 Health website. Submissions must be completed per the form's instructions.

This process ensures grievances and appeals are addressed fairly and promptly, supporting quality care for all members.

## Billing and Payment Processes

Providers must submit clean claims within 180 days.

For reimbursement, payment is based on the agreed-upon rates and timelines.

Co-payments must be collected at the time of service.

## Credentialing and Recredentialing

Credentialing is mandatory before participating in the network.

Recredentialing occurs every three years and includes performance evaluations.

# Quality and Utilization Management

Providers play a critical role in ensuring members receive high-quality care. 22 Health employs a comprehensive Quality and Utilization Management program to monitor and improve care delivery and ensure compliance with state, federal, and accreditation standards.

Key Components of the Program:

1. Clinical Guidelines and Standards
   Providers must adhere to evidence-based clinical guidelines and best practices, including standards established by national organizations such as NCQA, AAAHC, or relevant state-specific requirements.
2. Utilization Review Process
   - All prior authorizations and service approvals are reviewed for medical necessity using InterQual® criteria or other nationally recognized guidelines.
   - Denials for medical necessity are reviewed by 22 Health's Medical Director or qualified peer reviewers.
3. Timely Access Monitoring
   22 Health conducts regular surveys or audits to ensure providers meet access-to-care standards:
   - Routine primary care visits: Within 30 days.
   - Specialty care visits: Within 60 days.
   - Urgent care: Within 48 hours.
   - Behavioral health post-discharge follow-ups: Within seven (7) days.

4. Provider Performance and Outcome Monitoring
   Providers are assessed on:
   - Appointment availability and compliance with access standards.
   - Accuracy and timeliness of documentation and claims submission.
   - Clinical outcomes, including HEDIS and other performance measures as applicable.
   - Adherence to preventive care schedules, including immunizations, well-child visits, and chronic disease management.
5. Member Experience
   22 Health evaluates member feedback on access and satisfaction with care through member surveys, grievance data, complaint logs, and appeals tracking. This information is used to identify trends and opportunities for improvement.
6. Corrective Action Plans (CAPs)
   Providers failing to meet performance benchmarks will be placed on a CAP, which may include:
   - Mandatory training sessions
   - Increased monitoring frequency
   - Implementation of specific process improvements
7. Overutilization and Underutilization Monitoring
   Providers are monitored to identify:
   - Overutilization of high-cost or unnecessary services
   - Underutilization of recommended preventive or follow-up care
8. Peer Review
   A peer review process is in place to evaluate adverse events, quality concerns, and compliance with standards. Peer reviews may include provider-specific remediation plans.

9. Case Management and Disease Management Programs
   Providers are expected to collaborate with 22 Health's case management and disease management teams to support members with complex health conditions, including:
   - Asthma
   - Diabetes
   - Hypertension
   - Maternity Management
10. Provider Compliance Reporting
    Providers must submit requested data, including encounter reports, medical records, and other documentation, within the specified timeframes to support quality audits and regulatory reporting.

## Preventive Care Programs

22 Health encourages preventive care through programs like:

- Smoking Cessation
- Substance Abuse Recovery
- Weight Loss

## Fraud, Waste, and Abuse Prevention

Providers must report suspected fraud via the 22 Health compliance hotline or online portal. Fraud prevention training is required annually.

If you suspect fraud, please report your concern to 22 Health's Special Investigative Unit (SIU) using our 24/7 toll-free fraud hotline at 954-622-3482 or our online portal at lighthouse-services.com/22healthplan.

# Provider Education and Resources

22 Health offers regular training sessions and updates on policy changes. In addition, providers can electronically confirm PCP assignment and member eligibility, submit authorizations, and check auth and claim status via the PlanLink provider portal.

For information on the PlanLink provider portal, please send an email to PlanLink@22healthplan.com.