CENTERLIGHT Healthcare PACE

A Program of All-Inclusive Care for the Elderly, serving adults 55+

Provider Manual

Updated 11122025

Table of Contents

Welcome to CenterLight Healthcare PACE!

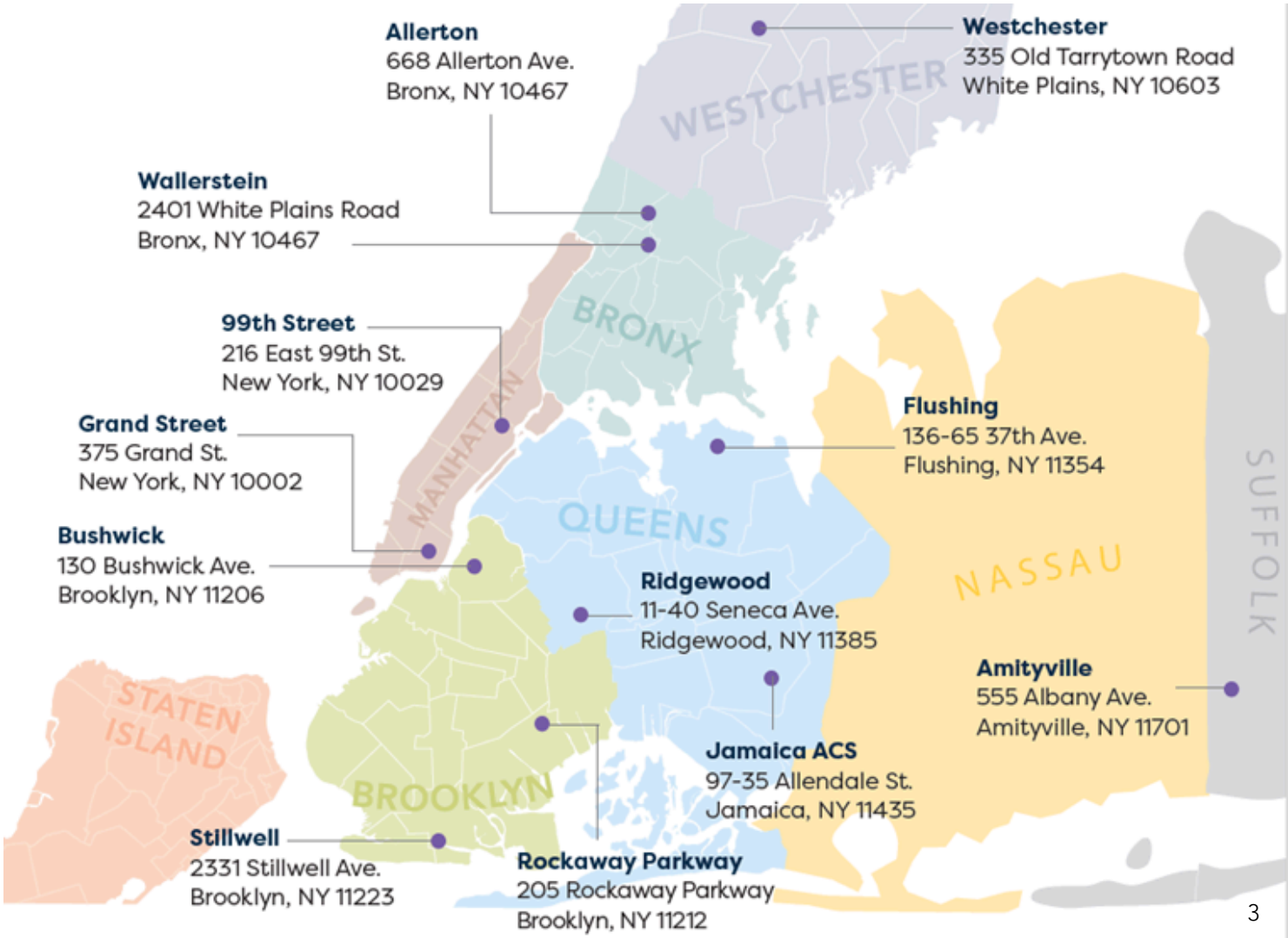
Thank you for being part of the CenterLight Healthcare PACE network. The mission of our Program of All-Inclusive Care for the Elderly (PACE) is to provide individualized care to those we serve while helping them live safely in their own homes.

We recognize the critical role you play in providing our participants with high-quality medical care and service. By working together, we can enhance the participant experience and improve the health outcomes and quality of life for your patients.

This provider manual is a reference tool designed for you. Additional information can be found on our website at CenterLightHealthcare.org which includes a designated provider portal. For more information, contact us at 1-833-252-2737 Mon-Fri, 8AM-8PM or email ProviderRelationsRequest@centerlight.org.

Thank you for participating in our network. We look forward to working with you.

CenterLight is a PACE plan certified under Article 44 of the New York State Public Health Law to operate in all five counties of NYC, Westchester, Nassau, and Western Suffolk.



Provider Quick Reference Guide

CENTERLIGHT Healthcare PACE

Program of All-Inclusive Care for the Elderly, serving adults 55+

CenterLight Healthcare PACE is committed to delivering high quality health and health-related services to our participants. This commitment is only possible through our relationship with you, our network of caring and compassionate providers.

Claims

Electronic Claims:

Smart Data Stream (SDS) Payer ID: 13360

Paper Claims:

CenterLight Healthcare PACE
P.O. Box 21546, Eagan, MN 55121

Claims Status:

General inquiries: **1-800-761-5602**

Provider Portal

Access real-time data about claims, authorization status, member eligibility and patient information.

centerlight.ppi.com/provider/sign_in

Nokomis and DRG Claims Management

CenterLight's partners for payment integrity assist with ensuring accurate claims processing. We appreciate your cooperation in fulfilling requests for medical and billing records.

Nokomis: **1-612-825-2342**

DRG Claims Management: **1-888-406-4711**

Participating providers may have different timeframes and terms for claims submissions and appeal rights. For further information, refer to your contract with CenterLight Healthcare PACE.

Appeals and Disputes

claimsappeals@centerlight.org

Submit appeals or disputes by email within 90 days of receiving the Explanation of Payment or Remittance Advice.

Referrals - Prospective Participants

referrals@centerlight.org

centerlighthealthcare.org/referrals

Follow-up: **cltcintake@centerlight.org**

1-833-252-2737 (TTY 711) M-F, 8AM-8PM

1-877-520-PACE (7223)

Events: **eventscoordination@centerlight.org**

Provider Relations

Contracting, Credentialing and Network Inquiries:

providerrelationsrequest@centerlight.org
Note: the credentialing process can take up to 60 days.

Rosters Submissions

rosters@centerlight.org

ACH Electronic Funds Transfer

centerlightfax@ppi.com

1-608-729-8995

HHAeXchange

hhaexchange.com/info-hub/centerlight

Enrollment form for new providers

cognitoforms.com/HHAeXchange1/centerlighthealthcarePACEproviderportalenrollmentform

Participant Service Coordination

Scheduling Appointments

- clschedulingteam@centerlight.org
- **1-833-252-2737 (TTY 711)** M-F, 8AM-8PM

Visit Documentation

Providers to send medical records, visit documentation and summary notes via email or fax.

- visitdocumentation@centerlight.org
- **1-929-233-7888**

Prior Authorization

- clinicalreview@centerlight.org
- centerlighthealthcare.org/priorauthorization
- **1-718-873-2890**
- Provider Portal (authorization status only) centerlight.ppi.com/provider/sign_in
- PCW/DME related authorization requests/ inquiries: homeservicerequests@centerlight.org

Benefit Partners

Pharmacy

MedImpact Help Desk (duals)

- **1-844-336-2681**

MedImpact Help Desk (Medicaid only)

- **1-888-678-7779**

Pharmacy coverage determination form
Formulary and Pharmacy Directory

- centerlighthealthcare.org/clinical-pharmacy-programs

Dental — LIBERTY Dental Plan

Effective Jan. 1, 2025, Liberty Dental Plan replaced DentaQuest.

- libertydentalplan.com/find-a-dentist
- Participant services: **1-888-352-0215**
- Provider services: **1-833-276-0853**

Vision — National Vision Administrators (NVA)

- **1-800-VISION-1 (1-800-847-4661)**
- e-nva.com

Schedule Transportation

- **1-833-252-2737 (TTY 711)** M-F, 8AM-8PM

Schedule at the time medical appointment is confirmed, or at least 3 business days before the appointment.

1-833-252-2737
Monday - Friday, 8AM-8PM
CenterLightHealthcare.org

Overview of the CenterLight Healthcare PACE Model

CenterLight Healthcare is a unique program authorized by New York State as a managed long-term care plan and by the federal Centers for Medicare & Medicaid Services (CMS) as a Program of All-Inclusive Care for the Elderly (PACE).

Who we serve

Adults 55 years and older

Those living in our service area including the Bronx, Kings, New York, Queens, Richmond, Nassau, Western Suffolk and Westchester counties

Must be Medicaid eligible and/or entitled to Medicare Part A and/or enrolled in Medicare Part B or able to pay privately

In need of nursing home level of care and eligible for more than 120 days of community based long-term care services, but able to remain living safely at home

Keeping Up with the PACE of Aging

About CenterLight PACE

What we do

CenterLight Healthcare PACE is a fully integrated Medicaid/Medicare program providing comprehensive medical, long-term care, nursing, and ancillary health-related services coordinated by the Interdisciplinary Team (IDT).

The cornerstone of the PACE model is the PACE Center, where participants receive primary care at the diagnostic and treatment center, rehabilitation, and recreation.

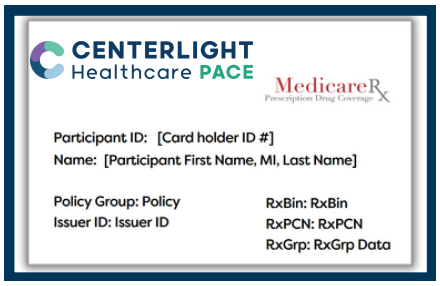
Our goal is to improve the health and quality of life for participants with complex medical and social needs. The participant's care is planned and provided by a team of skilled health professionals who work with the Primary Care Provider (PCP) and the participant to coordinate services across a continuum of health care settings. The IDT monitors care, reviews medical documentation, consults with the PCP and other team members, and refers the participant for medically necessary services.

ONE Plan for all Medicare and Medicaid covered services and prescription drugs:

- Medical Care
- Visiting Nurses
- Dental, Vision, Hearing
- Prescription Drugs
- Over-the-Counter (OTC)
- Physical and Occupational Therapy
- Home Health Aides
- Adult Day Centers
- Recreation and Meals
- Transporation and more!

Identification of CenterLight Participants and Eligibility

As a provider, you are responsible for verifying the eligibility of each participant before providing any non-emergency services. Each participant is sent an ID card for verification. You can confirm eligibility by visiting the Provider Portal.



Eligible enrollees who choose to enroll in CenterLight must agree to forgo their usual sources of care and receive all services through the PACE organization. They are not permitted to enroll in other Medicare/Medicaid programs concurrently. PACE provides all services covered by Medicare and Medicaid. Participants may also self-pay, provided they meet all other program eligibility requirements.

Covered Services

The services provided or arranged by CenterLight Healthcare are fully covered when approved by the Interdisciplinary Team (IDT). They will determine and arrange the care and services that the participants need.

A. Outpatient Health Services

- Primary medical and specialist care, including consultation, routine care, and periodic physical examinations
- Nursing care
- Medical social services
- Physical, occupational, speech and respiratory therapies
- Nutrition counseling and education
- Laboratory tests, x-rays and other diagnostic procedures
- Drugs, biological and medical supplies
- Prosthetics, orthotics, and durable medical equipment
- Podiatry, including routine foot care
- Vision care/optometry services, including period examinations, treatment and corrective devices, such as eyeglasses
- Psychiatry and psychology, including evaluation, consultation, diagnostic and treatment services
- Audiology, including evaluation, hearing aids and repairs
- Dental care
- Alcohol and substance abuse services
- PACE Center services, including recreational therapy, meals, transportation to and from the center, personal care and supportive services

B. Inpatient Hospital Services

- Semi-private room and board
- General medical and nursing services
- Medical, surgical, intensive care and coronary care unit services
- Laboratory tests, x-rays and other diagnostic procedures
- Drugs and biologicals
- Blood and blood derivatives
- Surgical care, including the use of anesthesia
- Use of oxygen
- Physical, speech, occupational and respiratory therapies
- Medical social services and discharge planning
- Ambulance and emergency room services
- Alcohol, substance abuse and psychiatric services

Inpatient hospital services do not include: private room, private duty nursing or non-medical items primarily for personal convenience (such as telephone, radio or television rental), unless the IDT determines the service is medically necessary.

C. Home Health Care

- Nursing services
- Physical, speech, occupational and respiratory therapies
- Medical social services
- Personal care and home health aide services
- Nutritional services and home-delivered meals as prescribed by the IDT
- Physician visits
- Temporary relief for caregivers (respite)

D. Other Health-Related Services

- Transportation and escort to health appointments
- Health-related translation services and services for speech impairments
- Personal emergency response systems
- Health-related moving assistance and minor home modification for medical reasons
- Palliative and end-of-life care including medication management, nutritional care, family counseling and quality of life determination
- Other services determined necessary by the IDT

A participant who elects to receive medical care for services not included in the contract or services determined by their IDT not to be medically necessary may be responsible for payment.

Participant Rights and Responsibilities

When a participant joins the PACE program, they are entitled to specific rights, protections, and responsibilities. A complete list of these rights and responsibilities can be found at CenterLightHealthcare.org. To fully comply with PACE requirements, we ensure that participants — or their representatives — are informed of their rights in a clear and understandable manner.

Advance Directives

If a participant becomes incapacitated or unable to communicate their needs, we follow the instructions as outlined in their advance directive, if one is in place. Examples of an advance directive include a living will, durable power of attorney for healthcare, healthcare proxy, or do-not-resuscitate (DNR) request.

Under advance directive guidelines, we look to you to assist your patients in developing advance directives. We recommend discussing advance directives with your patients (as appropriate) and filing a copy of any advance directive document in the medical record. Each medical record that contains an advance directive should indicate that such document is included.

You can find more information on advance directives at the New York State Department of Health (DOH) website.

The Medical Management Approach

The CenterLight Medical Management approach includes:

- Integration of medical, social, and supportive services
- Care Management and delivery via an Interdisciplinary Team (IDT) consisting of Primary Care Physicians, Nurse Practitioners, Registered Nurses, Social Workers, Dieticians, and others
- Primary Care management of specialty and institutional services
- Continuous monitoring of medical conditions and supervision of health and safety

Interdisciplinary Team Care Planning

Each PACE program has an Interdisciplinary Team (IDT) of healthcare professionals responsible for assessing and treating each participant and meeting their needs. The assessment and documentation process are known as "care planning."

At enrollment (within the first 30 days) and every six months after that, the IDT must complete the participant's care plan. The members of the IDT will meet with the participant and family member(s) to assess the participant's needs and create a care plan that works in conjunction with each of the other disciplines.

The care plan is integral to the PACE model and guides the IDT to manage the participant's needs.

As a contracted provider, your input in the participant's care is essential. Your referral notes will be documented within the participant's medical record to adjust the care plan as necessary.

A **Nurse Practitioner**, easily reachable by phone or email, who will ensure that my care plan will be followed and completed with the full cooperation of the participant and their family.

A **Home Care Nurse** that can set up any medications, monitor changes, as well as compliance and proper intake.

A **Rehab Team** with facilities able to provide Occupational, Physical and Speech Therapy to patient as needed and also in the home.

Social Work services readily available for any need the patient may have.

Registered Dietitians who are available to evaluate the patients with issues like weight loss, poorly controlled diabetes, and others.

A **Recreational Therapist** for patients whose quality of life may benefit from continued engagement and learning.




Provider Responsibilities

Transparent communication is vital to the success of our partnership. We will strive to clearly communicate our provider expectations and share how we can be a valuable resource for you.

Appointment & Access Standards

Providers must schedule appointments according to minimum availability standards, taking into account the member's past and present medical history and the presenting condition's severity and acuity. Participating providers in the CenterLight Healthcare PACE network use the following appointment goals to ensure timely access to medical care and behavioral health care to ensure that you are providing appropriate and timely care for all members in the network.

Standard	Goal
Routine Physicals	Within 30 days of enrollment.
Routine preventative care	As soon as possible, no longer than one month. Emergency care — immediately upon presentation.
Urgently Needed Services	Within 24 hours.
Non-urgent "sick" visit	Within 48-72 hours of the request, as clinically indicated specialist referrals (non-urgent) — within 4-6 weeks of request.
Non-urgent mental health or substance abuse visits	Within two weeks of request. Follow-up visits related to an emergency of hospital discharge, mental health or behavioral health — within five days of the request, or as clinically indicated.

Panel closures

If you decide not to accept additional participants, please give us 60 days' notice and keep the panel open for participants who were patients before the panel closure.

Hospital Privileges

Physicians must maintain admitting privileges at contracted hospitals. If a physician does not have admitting privileges, CenterLight must be notified, and the provider must obtain prior approval by the medical director before entering into the contract.

Non-Adherent Participants

We recognize that you may need help in managing non-adherent participants. If you have an issue regarding behavior or treatment cooperation or completion, or if you have a participant who cancels or does not appear for necessary appointments and fails to reschedule, even after follow-up attempts by you or your office, contact Provider Services at 1-833-252-2737.

Participant Referrals

If you are responsible for providing or arranging a covered service, you agree to direct the participant to an in-network provider. Network providers can be found in our Provider Directory. You may refer a participant to a non-participating provider only when:

(a) there is no participating provider available to perform the necessary services;
(b) a participant requires emergency services and directing such participant to a non-participating provider would expedite diagnosis or treatment;
(c) CenterLight agrees that the participant may be referred to a non-participating provider;
(d) the provider reasonably determines referral to a non-participating provider to be in the participant's best interest.

Access to Medical Records

CenterLight will evaluate medical records and clinical documentation based on the standards for medical records listed below. A representative or designee may visit a provider's office to review the medical records of CenterLight participants to obtain information regarding medical necessity and quality of care. Whenever possible, CenterLight will give reasonable notice to the provider. Clinical staff will review the medical record audits quarterly.

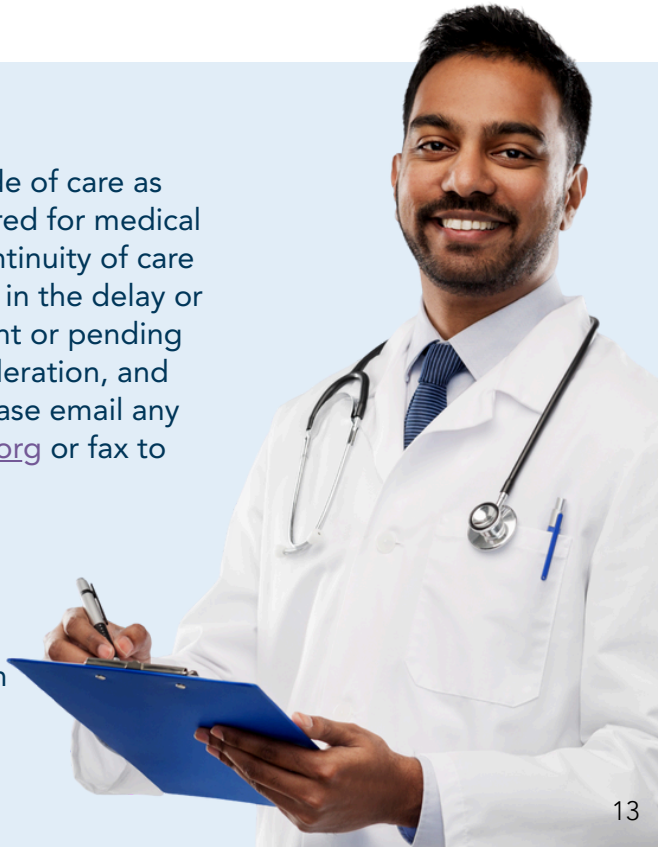
Medical Record Standards

Participating physicians must have a system to maintain medical records that conform to regulatory standards as prescribed in The Medicare Program Integrity Manual. Each medical encounter must be comprehensively documented in the participant's medical record.

Required Progress Notes

Progress notes must be submitted following each visit or episode of care as stated in the providers' contractual agreement. These are required for medical record accuracy, compliance purposes and are critical to the continuity of care for our participants. Failure to submit progress notes may result in the delay or denial of future service approvals, administrative holds on current or pending referrals, and due to its regulatory implications, review, reconsideration, and potential removal of network status with CenterLight PACE. Please email any outstanding progress notes to Visitdocumentation@centerlight.org or fax to our dedicated line at 1-929-233-7888.

Patient medical records must show medical necessity. This may include records for services before the date of services listed on the medical record request. The Centers for Medicare and Medicaid Services have resources available for more information on complying with medical record documentation requirements and complying with Medicare signature requirements.



Medical Record Documentation

Medical information must be legible and follow a logical and consistent format, with page numbers indicated if an encounter spans multiple pages.

- The record must contain complete information for each encounter in the chart. This includes:
  - Participant's full name and date of birth
  - Provider's full name, title and facility name
  - Date(s) of service
  - Documentation of all services provided by the physician as well as other non-physician services (e.g., physical therapy, diagnostic or laboratory services, home healthcare)
- The record must indicate:
  - All illnesses and medical conditions
  - Medications list
  - Consultations/referrals
  - Present issue
  - Treatment plan
  - Follow-up plan
  - Preventive screenings and health education offered
  - Documentation on advance directives

- Information should be stored within a secure folder in a safe place.
- No record should be altered, falsified, or destroyed. If a correction is introduced, the individual correcting the record should draw a single line through the item to be updated and date and initial the correction. All telephone messages and consult discussions must be identified and recorded.
- The medical record system should provide a mechanism to ensure participant confidentiality.

Provider Data Collection

Initial roster and facility data collection

A CenterLight Healthcare Provider Roster must be submitted with all current practitioners, groups and facilities. The roster must be fully populated to load into the internal claim system and the provider directory.

Additions, changes, and terminations should be reported promptly, groups must submit at least monthly, so our claims system and provider directory remain current. Inaccurate provider data may result in denial of claims and false representation in the provider directory.

Providers are responsible for the accuracy of the information sent. CenterLight Healthcare will communicate any verification or corrections needed based on errors identified during the load process. Updates to provider information can be sent to rosters@centerlight.org.

Service Determination Requests (SDR)

As a participating provider of CenterLight Healthcare and an integral part of maintaining the care of our participants/your patients, we feel it is essential to establish a close, collaborative partnership. Together, we can share beneficial health information about patients. We then have the potential to identify concerns earlier to improve patient experience and health outcomes.

Our goal is to keep you informed and share relevant information that will assist you in caring for your patients. A Service Determination Request (SDR) is a regulation that affects the care delivery of our participants. We have created a brief guide to what an SDR is, how to identify one, and how they can be communicated to CenterLight Healthcare. We encourage you to review this guide and become familiar with the SDR process. We appreciate your taking the time to review this critical information.

After reviewing this guide, please complete the Service Determination Request Training Attestation confirming you have reviewed the material. Only one attestation form needs to be completed for your organization. If you have multiple providers under one Tax Identification Number (TIN), please complete one attestation for the TIN, and a member of our team will be happy to assist you.

Contact ProviderRelationsRequest@centerlight.org if you have any questions and a member of our team will assist you.

Service Determination Requests

When a PCP is referring the participant to a specialist, or the participant self-refers, the PCP should check the CenterLight Healthcare Provider Directory to ensure the specialist is a participating provider. The directory is available on our website. The PCP should provide the specialist with the following clinical information:

- Participant's name;
- Pertinent past medical history;
- Reason for the consultation;
- History of the present illness;
- Diagnostic procedures and results;
- Current medications and treatments;
- Problem list and diagnosis; and
- The specific request of the specialist
- Referring PCP

Specialist Responsibilities

After the initial evaluation, specialists must send the PCP the consultation report of the participant's condition. The report must include medical findings, test results, assessment, treatment plan, and any other pertinent information.

Claims and Billing

We know that you prefer to spend your time with patients, so we do what we can to make it easier to manage billing and paperwork. This section describes our claims process and how we can work together to ensure you're paid accurately and on time.

Claims Submission

Electronic Submission

Participating providers should submit claims electronically to streamline administrative processes, protect participant information and receive faster claims processing and payment. Submit claims to Smart Data Systems (SDS) with CenterLight Healthcare's Payer ID #13360. After submission, your claims clearing house will generate an EDI 277 Healthcare Claim Status Notification indicating if the claims have been accepted or rejected.

Paper Submission

CenterLight Healthcare also accepts the CMS-1500 and the UB04 paper claim forms. We encourage our participating providers to submit claims electronically whenever possible.

Paper claims must be submitted to:
CenterLight Healthcare
PO Box 21546
Eagan, MN 55121

Encounter Data

CMS, New York State, and other governmental and regulatory agencies require CenterLight Healthcare to report encounter data for claims processing and utilization reporting. Claims must be submitted for services provided under a capitated arrangement as well as services provided on a fee-for-service basis. The claims provide the encounter data required to meet regulatory requirements.

Quality incentive payment bonuses and capitation payments may be impacted, especially for capitated providers, if claims are not submitted for all services rendered.

Timely Filing of Claims

CenterLight Healthcare requires claims to be submitted within 90 days from the date of service for in-network providers. Corrected claims are also required to be resubmitted within 90 days from the claim date of service. These timely filing rules apply unless otherwise specified in your Provider Agreement. Claims submitted beyond the timely filing limit will not be paid.

At no time should participants be billed for services provided, as outlined in your Provider Agreement.

Claims Processing

CenterLight Healthcare processes all claims in accordance with New York State Prompt Pay Law, a combination of guidelines established by New York State, CMS, and internal claims processing policies are used to determine proper coding. These guidelines and policies dictate claims edits, adjustments to payment, or requests to review medical records related to the claim. You can check the status of claims you have submitted by logging into the Provider Portal at www.centerlight.ppi.com or call 1-800-761-5602.

At no time should participants be billed for services provided, as outlined in your Provider Agreement.

Clean Claims

Claims that include all required data elements are adjudicated daily. Failure to submit a clean claim may result in delayed payment or possible claim rejection.

Common submission errors include incomplete fields, invalid codes, lack of supporting medical records, provider data mismatches and use of the wrong claim form(s).

Claim Corrections

Claims with incorrect or incomplete information will be denied. A corrected claim can be resubmitted within the timely filing period. CenterLight Healthcare's standard timely filing limit is 90 days from the date of service for in-network providers, unless otherwise specified in your Provider Agreement. Claims that were previously denied must be submitted as a corrected claim. Any claims that are resubmitted as a new claim may be denied as a duplicate.

Correcting or Voiding Electronic Claims

Use the following codes to correct or void a claim submitted electronically:

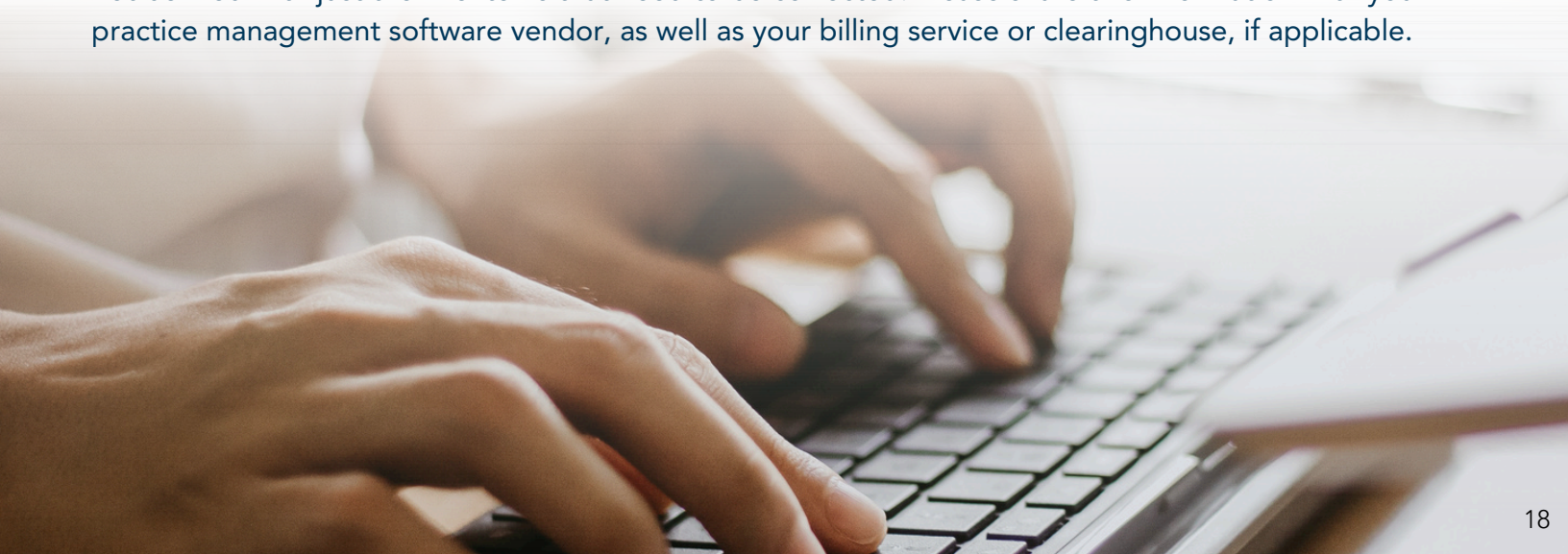
- Professional claims (837p): Enter Frequency Code 7 for corrections, or Frequency code 8 to void, in Loop 2300 Segment CLM05-3. Enter the original claim number on the 2300 loop in the REF*F8*.
- Institutional claims (837i): Submit with the last character of the Type of Bill as 7, to indicate Frequency Code 7 for corrections, or Type of Bill as 8, to indicate Frequency Code 8 to void.

Correcting or Voiding Paper Claims

Use the following codes to correct or void a paper claim:

- Professional claims CMS-1500: Stamp "Corrected Billing" on the CMS 1500 form. Complete box 22 when resubmitting a claim. Enter the appropriate bill frequency code left-justified on the left-hand side of the field:
  - 06 - Corrected Claim
  - 07 - Replacement of prior claim
  - 08 - Void/Cancel prior claim
- Institutional claims UB-04: Submit with the last digit of 7 in the Type of Bill for corrections, or last digit of 8 for void claims.

Corrected claims should be submitted with all line items completed for that specific claim and should not be filed with just the line items that need to be corrected. Please share this information with your practice management software vendor, as well as your billing service or clearinghouse, if applicable.



Claim Payment Integrity

Payment accuracy is important to us. We aim to ensure that the care you provide to our participants is delivered effectively, reimbursed accurately and in accordance with the contract — while avoiding errors, duplicates and any wasteful or abusive practices. All claims can be subject to review for both billing and payment accuracy.

Readmissions Review Program

As part of the Readmissions Review Program, CenterLight reviews:

- Same-day readmission for a related condition
- Same-day readmission for an unrelated condition
- Planned readmission/leave of absence
- Unplanned readmission less than 30 days after the prior discharge

If a patient is readmitted to a facility on the same day as a prior discharge for the same or a related condition, CenterLight requires the facility to combine the two admissions on one claim. We will deny both the initial and subsequent admissions for payment as separate DRGs. The facility must submit both admissions combined on a single claim to receive reimbursement. For a same-day readmission to qualify for separate reimbursement, the medical record must support that the conditions are clinically unrelated.

Consistent with CMS billing requirements, if a patient is readmitted the same day for an unrelated condition, two properly coded claims must be submitted.

If a patient is readmitted to a facility as part of a planned readmission or leave of absence, the admissions are not considered two separate admissions. We require the facility to submit one claim and receive one combined DRG payment for both admissions because they are for the treatment of the same episode.

Reimbursement for readmissions may be denied (see Medicare QIO Manual, Chapter 4, Section 4240) if the readmission:

- Was medically unnecessary
- Resulted from a premature discharge from the same hospital
- Was a result of circumvention of the PPS by the same hospital

Claim Payment Review

CenterLight Healthcare uses the following vendors to complete utilization and code edit reviews. The response to the Medical Record Request Letter must be received within 45 days from the date of the letter. Failure to respond may result in a claim denial or adjustment. Medical records should be sent to:

- **Nokomis — for Non-Inpatient Claims:**
  - Records@nokomishealth.com
  - Nokomis Health, 206 N 1st Street, Minneapolis MN 55401
  - Fax 612-825-2344

Claim Payment Review, continued

- **DRG Claim Management — for Inpatient Claims:**
  - (For immediate delivery) Upload records online: centerlight.recordsupload.com/claim/insert claim number
  - Medical Records Intake Department
    600 E Crescent Avenue Suite 305, Upper Saddle River, NJ 07458
  - Fax: 718-840-3712
  - Support contact: 888-406-4711

Overpayment Recovery

If CenterLight Healthcare determines that an overpayment occurred, a written Overpayment Notice will be generated. Providers must respond to the Overpayment Notice within 30 days to prevent any overpayment recovery efforts. The Overpayment Notice includes the participant's name, dates of service, payment amount(s) for the proposed adjustment and an explanation for the overpayment. The provider may dispute the finding or remit payment to CenterLight Healthcare as outlined below.

If You Agree That We Have Overpaid You

If a provider agrees with the overpayment determination, they may voluntarily submit a refund check payable to CenterLight Healthcare within 30 days from the date the Overpayment Notice.

Providers should include a statement in writing, regarding the purpose of the refund check (i.e., payment of identified overpayment), the claim ID number, date of service, provider NPI and a copy of the Overpayment Notice to ensure the proper recording and timely processing of the refund. Refund checks should be mailed to:

CenterLight Healthcare
136-65 37th Avenue
Flushing, NY 11354

If You Disagree That We Overpaid You

If a provider disagrees with the overpayment determination they must respond in writing within 30 days from the date of the Overpayment Notice. The response must include all supporting documentation. CenterLight Healthcare will provide a written notice of the appeal determination after reviewing the provider's request and supporting documentation. If the overpayment determination is upheld, providers may submit a second appeal with additional support or may initiate arbitration, pursuant to their provider agreement. CenterLight Healthcare will proceed to offset the amount of the overpayment prior to any final determination made.

If You Fail to Respond to an Overpayment Notice

The provider has 30 days from the date of the Overpayment Notice to respond or dispute an overpayment. If a response is not received within 30 days it will be deemed that the provider has acknowledged and accepted the overpayment amount demanded. After the 30-day period CenterLight Healthcare will off set the overpayment amount against current and future claims until the full overpayment amount is recovered.

If an Offset Results in a Negative Balance

When an offset results in a negative balance, the provider will receive an EOP once the negative balance has been resolved.

If you have any questions about Overpayment Recoveries, please contact Provider Services at 1-800-761-5602, available 9:00 am–5:00 pm, Monday–Friday, to assist you.

Claims Appeals

Providers may dispute a claim payment decision by submitting an appeal to initiate the claim review. Disputes may include, but are not limited to, medical necessity, administrative determinations or payment variances.

All disputes must be submitted in writing, via email, fax or USPS, with appropriate supporting documentation, within 90 days from the date of the explanation of payment (EOP) or according to the contracted timeframes.

Appeal request shall include:

- Claim ID Number
- Date of Service
- Authorization Number
- Participant ID Number
- Provider ID Number and NPI
- Reason for dispute

Appeal requests can be submitted electronically via email to claimsappeals@centerlight.org, fax to 718-888-5972 or mail to the following address:

CenterLight Healthcare
136-65 37th Avenue
Flushing, NY 11354

CenterLight Healthcare should respond to a dispute within 60 days of receiving the written appeal and all supporting documentation. If there is a favorable outcome the claim will be reprocessed and the provider will be notified via the Explanation of Payment (EOP). If the outcome was unfavorable and no additional payment will be made, the provider will be sent a Letter of Determination. A second level appeal with additional supporting documentation may be submitted or the provider may initiate arbitration pursuant to their Provider Agreement.

Clinical Review

Our goal at CenterLight is to provide the right care to our participants at the right time. Our clinical review (CR) program was designed to apply CMS and evidence-based criteria, to our clinical decision making to ensure participants have access to quality care that is medically necessary.

Prior Authorization Review

Prior Authorization is required to assess the need for a participant to receive inpatient or outpatient treatment at a hospital, ambulatory care facility, physician's office, or other healthcare setting for a range of procedures determined by CenterLight. CenterLight uses its own Clinical Review policies, CMS National and Local Coverage Determinations, and MCG Criteria.

Your claim and payment may be denied if you do not obtain required prior authorization before providing the service.

CenterLight's approval of a prior authorization does not guarantee payment for all procedure codes included in your claim submission.

The participating PCP or specialist responsible for providing the service must submit requests for services requiring prior authorization

Requests may be submitted to the CenterLight Clinical Review Department by:

- Calling our Clinical Review department at 1-833-252-2737 (TTY 711), 8AM-8PM, M-F.
- Faxed requests should be sent on a completed Prior Authorization Request Form, located on our website at centerlighthealthcare.org/priorauthorization to 1-718-873-2890.

Additional CenterLight PACE contact information can be found in our Provider Quick Reference Guide on pages 4 and 5.

Coverage determinations are based on Medicare coverage guidelines, nationally recognized evidence-based guidelines, or by CenterLight clinical coverage policies. A coverage determination requires the provision of information regarding the clinical condition and treatment or services proposed for the participants. Components of coverage determination are based on whether the patient is an eligible participant and if the service is medically necessary.

Prior authorizations are issued within 72 hours for an expedited request and 14 days for a standard request. Providers will be notified of the determination by phone or in writing in the case of urgent or expedited requests. If a phone call or fax notification is unsuccessful or a phone number or fax number was not provided, the provider will be contacted for the correct information.

Standard Prior Authorization Requests

Determinations are communicated to providers within a time frame appropriate to the medical needs of the case, but not more than 14 calendar days after the request for prior authorization was received. You are notified by fax in the case of standard requests. If a fax notification is unsuccessful or a fax number is not provided, notifications will be made by phone.

Written notification of adverse determinations includes instructions regarding reconsideration options, an explanation of the reason for the determination, and other rights and information.

Request for Information

If CenterLight requires additional information, you will be notified by phone, fax, email or written communications within the time frames for issuing a determination and the specific information required to make a decision will be requested.

If you fail to respond to our request for additional information necessary to render a determination, the authorization request may be denied.

Concurrent Review

Concurrent review is conducted on hospitalizations and other services that require consideration for continued care, specifically SNFs, acute rehab and inpatient psychiatric services. Concurrent review includes Clinical Review activities that take place during the inpatient level care or an ongoing outpatient course of treatment. The CenterLight Clinical Review Registered Nurse will review all participant hospitalizations within five business days for medical necessity, provided all clinical documentation is received. If services do not meet the medical necessity criteria, the Clinical Review Medical Director/IDT will make the final determination.

The concurrent review process includes:

- Obtaining necessary information from providers and facilities concerning the care provided to the participants
- Assessing the participant's clinical condition and ongoing medical services and treatments to determine medical necessity
- Collaborating with the PACE IDT / Clinical Care Supervisor / Transitions of Care Team to ensure safe discharge
- Notifying providers of coverage determinations in the appropriate manner and within the appropriate time frame
- Identifying continuing care needs early in the inpatient stay to facilitate discharge to the appropriate setting

Notifications

When an adverse determination is issued, the IDT will notify the participant, and the clinical review team will notify the provider with the results. Notices made in writing meet applicable language and format requirements and are written to ensure understanding.

The Denial Notice is used for denials of pre-service authorization requests and indicates the following for the provider:

- The effective date of the denial, reduction, stoppage, termination of service, or other medical coverage determination
- The action taken by CenterLight on the request for prior authorization and the reason for such action, including the clinical review criteria relied upon to make the determination and a clinical rationale

Quality Improvement Program

We design our Quality Improvement Program to hold ourselves to the highest standards in quality of care and are driven to providing a best-in-class experience for our providers and participants.

Goals and Objectives

We strive to continually improve the quality of care and service our participants in an efficient manner. We accomplish this by maintaining the focus of all levels of the organization on the assessment and improvement of all aspects of care. The overarching principle of CenterLight PACE Quality Improvement Program (QIP) is to develop an integrated and comprehensive approach to continuously improve care and service to meet or exceed our Participants' expectations.

The QI Program is a data-driven framework to develop, implement, maintain, and evaluate the full range of services furnished by CenterLight PACE, incorporating specific measures in accordance with regulatory standards and evidence-based practices aligning strategic priorities focused on: service, quality, people (participants/providers), financial efficiency, and community.

To accomplish these goals, CenterLight PACE employs various health promotion, disease prevention, disease management, and self-management techniques. CenterLight PACE Quality Improvement Program (QIP) sets guidelines for the evaluation of all aspects of program operations, incorporating structure, process, and outcome criteria to meet appropriately and efficiently, the goals of the program.

CenterLight PACE considers our participating providers essential to our efforts to deliver high-quality, cost-effective care to participants. We encourage your participation in our quality improvement efforts and welcome your feedback on any aspect of the program. The goals of our Quality Improvement Program support CenterLight's vision and values and promote continuous improvement in quality of care/service and safety for our participants and providers:

- Utilize clinically driven data insights through standardized and collaborative activities that work to identify opportunities for improvement on the health status of members. (This enables us to develop and implement thoughtful health promotion, preventive health education, and disease and case management programs to maximize safety and quality of healthcare delivered to members through the continuous quality improvement process.)
- Maintain a high-quality provider network through a formalized credentialing and recredentialing process.
- Ensure that adequate resources are arranged to provide available, appropriate, accessible, and timely healthcare services to all participants according to evidence-based guidelines.
- Ensure easy and timely access to accurate information through the IDT, written materials, and our website.
- Attend to the needs and expectations of our customers by resolving inquiries, complaints, grievances, and appeals in a timely manner, evaluating performance and acting to meet those needs and expectations.
- Maintain compliance with local, state, and federal regulatory requirements.

As part of the QI Program, initiatives in key areas include, but are not limited to:

Participant Experience:

We are committed to delivering a best-in-class experience for our participants by listening to their concerns and preferences. Our goal is to make it easier for them to access care and services, while supporting cultural competency and health literacy.

CenterLight uses internal and external data to measure participant's satisfaction with their health plan and healthcare services (including their providers). We also use data from the HOS-M (Health Outcome Survey-Modified), which measures a participant's frailty.

The QI Program Description defines the quality infrastructure that supports our QI strategies:

- The QI Program Description establishes QI Program governance, scope, goals, measurable objectives, structure, and responsibilities, which encompass the quality of medical and behavioral health care and services providers to participants.
- Annually, a QI Work Plan is developed and implemented which reflects ongoing progress made on QI activities during the year. The QI work plan includes our approach to member safety and improving medical/behavioral health care: quality of clinical care, safety of clinical care, and quality of service.
- Annually, the QI Evaluation assesses outcomes of our clinical quality programs, processes, and activities. This evaluation also assesses whether the QI Program goals and objectives were met.

Performance Improvement Projects

CenterLight PACE conducts yearly Performance Improvement Projects (PIPs) that focus on both clinical and non-clinical services which are likely to have beneficial effects on health outcomes and participant satisfaction. The design of these projects consists of setting goals for achieving demonstrable and sustained improvement.

Our community providers are encouraged to participate in these projects. Results, progress, and final outcomes are shared with our provider Network.

Satisfaction Survey

As part of our commitment to providing our participants with the best quality of life, we ask our participants, caregivers and families how satisfied they are with the services we provide, including our provider network.

Questions include home care services, communication, access to care, problem resolution, and overall satisfaction.

Results of the satisfaction surveys are disseminated to our providers via provider newsletter or provider portal. We appreciate your feedback to make our services better and improve our participants' experience.

HOS-M

The Health Outcomes Survey-Modified (HOS-M) is administered by the Centers for Medicare & Medicaid Services (CMS) to vulnerable PACE beneficiaries at greatest risk for poor health outcomes.

HOS-M design is based on a randomly selected sample of individuals from each participating PACE organization. The HOS-M is a cross-sectional survey, measuring the physical and mental health functioning of beneficiaries at a single point in time. Based on results, CMS adds a separate frailty score onto member risk scores when paying PACE organizations.

The HOS-M is a brief survey that can be found at hosonline.org/en/survey-instrument. The survey is conducted via mail to eligible PACE enrollees (age 55+, community-residing Medicare beneficiaries, no ESRD) or their designated proxy, with telephone follow-up. DataStat, is the solely approved vendor to administer the survey on behalf of CMS.

Survey completion should take 10 minutes or less. Providers and caregivers can participate as Proxy assisting participants completing the HOS-M. When serving as a proxy, make sure to answer ADL items and questions specifically for the enrollee at the end of the survey.

If you have questions, you can contact Provider Services at 1-877-853-8019, 8 AM to 5:30 PM EST.

Provider Requirements

As a contracted provider, you will collaborate with CenterLight PACE to engage participants and maintain a regular schedule of visits with them. Share your latest encounter notes with CenterLight PACE to ensure compliance with the CMS requirement that the PACE organization maintains a single record for each participant.

As a valued member of the interdisciplinary team (IDT), you will communicate with your CenterLight IDT representative about the medical management of participants, ensuring you provide high-quality care. Occasionally, you may be asked to participate in quality assurance and performance review activities as needed.

Incentive Payment Program

You may qualify for the CenterLight incentive payment program, administered through Stellar Health, a third-party vendor. You earn incentives by completing specific tasks in the Stellar Health platform that close value-based care gaps. Your overall success in the program depends on meeting goals related to quality, cost, and utilization outcomes. These goals typically fall into the following categories:

- Participant engagement with you, the primary care physician
- Sharing primary care records and notes
- Completing recommended vaccinations and other preventive measures
- Following evidence-based safe transitions of care interventions
- Providing higher-intensity care for high-need participants
- Supporting medication adherence
- Ensuring continuity of care
- Improving clinical documentation

Credentialing

To ensure that everyone we partner with meets the industry regulatory requirements, all network providers, physicians, non-physician healthcare professionals, and ancillary providers must get credentialed. This section will show you how.

Credentialing Process

CenterLight Healthcare completes the credentialing process in accordance with the National Committee for Quality Assurance (NCQA) standards prior to executing a contract with physicians, healthcare professionals and facilities. The credentialing process is performed to ensure that patients receive the best possible care and provide assurance that the healthcare professionals meet necessary requirements to practice medicine under NYS law. CenterLight Healthcare processes non-delegated credentialing applications within 90 days of initial application. CenterLight Healthcare does not discriminate in terms of participation or reimbursement against any physician or healthcare professional acting within the scope of their license. The Credentialing Committee reviews all credentialing applications. A welcome and recredentialing approval letter is sent to approved providers. A denial letter is sent if the application is not approved. An appeal of the determination can be submitted, within 15 days of the denial letter to credentialing@centerlight.org or mailed:

CenterLight Healthcare
136-65 37th Avenue
Flushing, NY 11354

The recredentialing process is performed every three years, except for facilities and practitioners covered under NYS Public Health Law Article 28 that must be recredentialed every two years. A delegated entity may perform the credentialing and recredentialing process on CenterLight Healthcare's behalf. CenterLight Healthcare completes annual audit of the delegated entity's credentialing process to monitor compliance with NCQA standards and CenterLight Healthcare's policies and procedures.

Initial Credentialing and Application Submission

Licensed Independent Practitioners

CenterLight Healthcare uses Council for Affordable Quality Healthcare (CAQH) credentialing application to complete the primary source verification for physician and non-physician healthcare professionals. Practitioners should maintain a current CAQH attestation. Primary source verification includes, but is not limited to:

- Validation of current professional medical license for New York State.
- Current Drug Enforcement Administration (DEA) and Controlled Dangerous Substance (CDS) certificates for the practicing state, required for physicians and, if applicable. An explanation must be submitted for physicians unable to meet this requirement and how prescriptions will be covered.
- Current Board Certification, if applicable.
- Proof of current professional malpractice insurance with a minimum coverage as indicated in the provider agreement.
- Summary of professional work history for the last 5 years, with an explanation for any gaps of 6 months or more.
- Documentation of education, training and or certificates.
- Review of regulatory websites to ensure practitioners are eligible to participate in the network that include National Practitioner Data Bank (NPDB), licensure agencies for information on sanctions or limitations on licensure, Office of Inspector General (OIG) and Department of Health and Human Services, for the List of Excluded Individuals/Entities.

Ancillary Providers

CenterLight Healthcare begins the facility/ancillary provider credentialing upon receipt of a signed application, which includes an attestation. The facility must submit a W9 form, a Wage Parity Form, a Fraud Waste Abuse (FWA) Attestation Form and a current liability insurance certificate. A Complete ADA, DBA Certificate, CLIA Certificate, State Operating Certificate and Facility Roster must be submitted, if applicable.

Review of regulatory websites to verify practitioners are eligible to participate in the network include NPI Verification, Office of Foreign Assets Control (OFAC), Medicaid Enrollment Check, Office of Inspector General (OIG) Exclusion Search and SAM/EPLS Sanction Search. The Accreditation Certification – Joint Commission and the License Homecare Agency Certification are verified if applicable. Upon completion of the credentialing process the results are summarized and submitted to the Credentialing Committee for review and approval. A welcome or recredentialing approval letter is sent to approved providers. A denial letter is sent if the application is not approved. An appeal of the determination can be submitted, within 15 days of notification, to:

CenterLight Healthcare
136-65 37th Avenue
Flushing, NY 11354

The recredentialing review process is performed every three years, except for facilities and practitioners covered under NYS Public Health Law Article 28 that must be recredentialed every two years. The same procedures as the initial credentialing process are followed.

CenterLight Healthcare sends the recredentialing notification three months in advance of the recredentialing due date. A follow-up reminder is sent, if necessary. A lack of response from the provider or facility may result in termination from the network.

Confidentiality

The Credentialing Department is responsible for ensuring the confidentiality of all information received and maintained in the credentialing and recredentialing processes. This includes proceedings, reports, and records of a peer review specialty committee. Information derived from peer-review functions is protected from subpoena and discovery by state immunity laws, except as otherwise provided by law.

Nondiscrimination

CenterLight Healthcare does not discriminate in the credentialing or recredentialing process based on religion, race, color, national origin, age, gender, sexual orientation, familial status, marital status, disability, or any other basis prohibited by law. Additionally, CenterLight Healthcare does not discriminate in credentialing and recredentialing based upon the types of procedures or the risks of the population that you serve.

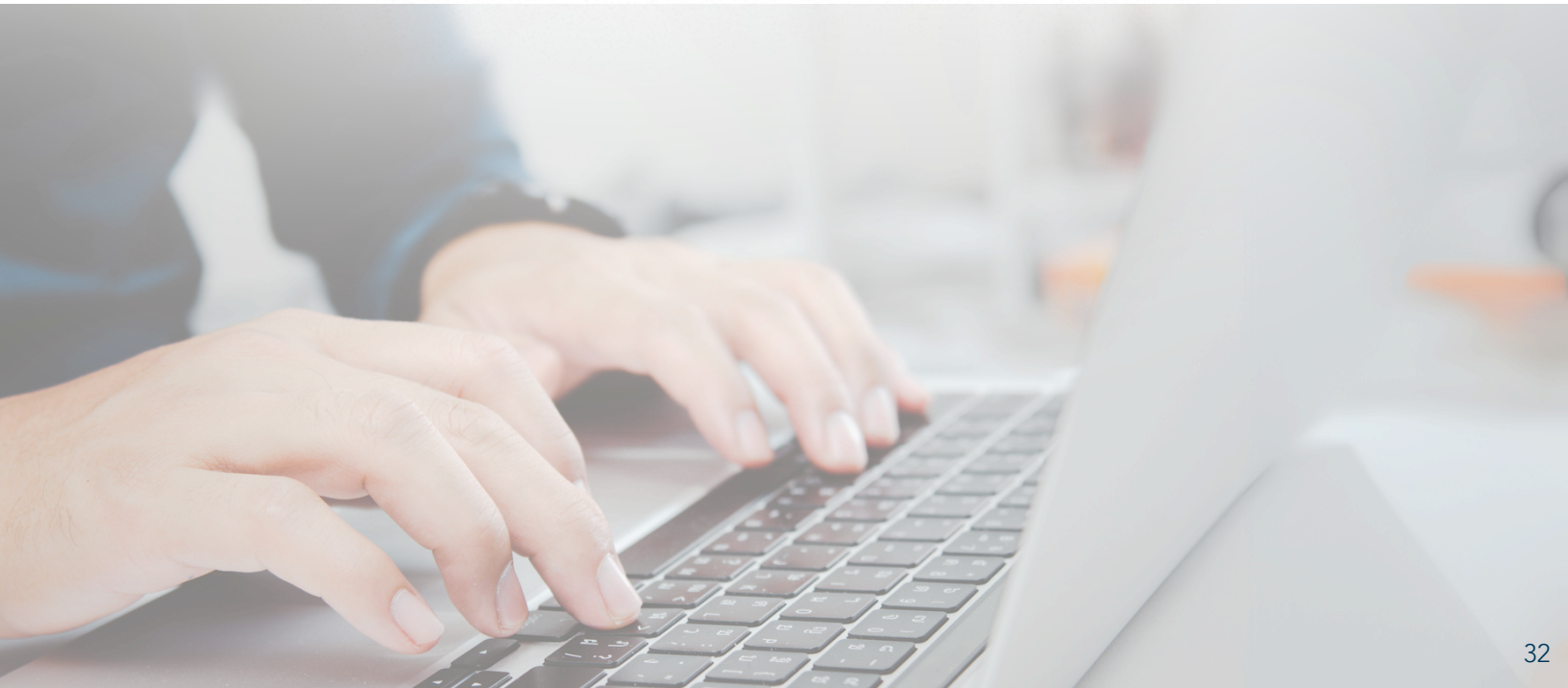
Ongoing Monitoring

CenterLight Healthcare is responsible for ensuring its participants have access to qualified and competent providers who will be accountable for delivering appropriate and medically necessary care and services. Because of this, CenterLight monitors provider sanctions and limitations. CenterLight is responsible for regularly informing you of any findings related to performance or practice of care.

The Credentialing Department is responsible for the management of ongoing (monthly) monitoring of:

- Medicare-Medicaid sanctions, which can lead to termination/suspension of Provider Agreement
- State licensure/disciplinary actions, which can lead to termination/suspension of Provider Agreement
- Quality-of-care issues, which can lead to a corrective action plan or termination

Any findings are discussed during the monthly Credentialing Committee meeting. If the Credentialing Committee denies you inclusion into the provider network, you are notified in writing within ten business days of the committee decision. The letter includes reasons for denial and indicates your rights to appeal the committee's decision. The actual termination date is not effective until the appeal process is completed and the original decision upheld. Exceptions to this rule are terminations related to quality-of-care issues that have caused or can cause harm to participants.



Provider Termination

While we do everything we can to ensure a successful partnership with you, there can be times when the only reasonable resolution is to discontinue working together. This section describes what is involved when a partnership is not serving the best interests of either party.

Circumstances for Termination

There can be certain circumstances in which CenterLight decides to terminate its relationship with a provider. Depending on the cause, CenterLight can work with you to address the problem, initiate a termination per the terms of the provider agreement, or initiate a termination to take effect immediately.

An immediate termination can be initiated for the following reasons:

- Suspension, revocation, condition, expiration, or other restriction of your licensure, certification, or accreditation to perform services contemplated under the provider agreement.
- Suspension or bar from participation in federal healthcare programs.
- Determination that you engaged in or are engaging in fraud.
- Noncompliance with the general and professional liability insurance requirements set forth in your Provider Agreement.
- State sanctions, indictment, arrest, or conviction, or a felony or any criminal charge.
- CenterLight's reasonable determination that your immediate termination is necessary for the health and safety of participants.

Certain terminations initiated can also not take effect immediately (terminations for cause, terminations without cause). Refer to your Provider Agreement for details around terminations that cannot take effect immediately and the effective time frames.

In the event of a termination, CenterLight will send a termination notice to you. We can require you to provide continuity of care until a safe transition to another provider has been made.

Your Provider Agreement will not be terminated or refused renewal solely because you have:

- Advocated on behalf of a participant
- Filed a complaint against CenterLight
- Appealed a decision made by CenterLight

Additionally, you can have termination rights of your own. For details about provider termination rights, refer to your Provider Agreement.

Appeal Hearing Process

When you request an appeal of a termination decision, a committee will form to review your appeal. This committee will consist of at least three participants and will adhere to the following guidelines:

- Peers can be providers or healthcare professionals outside of the CenterLight network of providers
- No individuals involved in the investigation of an appeals case can be part of the appeals hearing committee
- The appeals hearing committee voting can be made in person, via phone, or via email
- The medical director appoints a hearing officer who serves as the presiding officer over the hearing

- The presiding officer should:
  - Determine the order of the hearing and deliberations
  - Assure that all participants have opportunity to present oral and documented evidence
  - Provide guidance to the appeals hearing committee during the hearing and deliberations
- The hearing officer does not have voting privileges

The notice of the final decision of the appeals hearing committee is delivered by certified mail to you, your ancillary, or your hospital 30 days after close of the hearing. The notice includes the final decision, the basis for that decision(affirm, modify, or withdraw the original proposed action), and the Provider Agreement provisions and facts relied upon by CenterLight during the hearing.

Continuity of Care

In the event of a termination, whether initiated by you or by us, our goal is to ensure that your patients, our participants, continue to receive the care they require until they no longer require it or until a safe transition can be made (unless otherwise specified).

In the event that you voluntarily decide to leave the network, or are terminated by CenterLight, you must agree to continue to provide covered services until it is safe to discontinue, or safe alternatives have been confirmed.

During this continuity-of-care period, you agree to:

1. Accept the established reimbursement rates as payment in full
2. Adhere to our quality improvement requirements
3. Provide medical information related to the care
4. Adhere to our policies and procedures

Prior authorization for all services is required during this time period.

CenterLight maintains discretion to select the providers with whom it decides to contract. CenterLight may make changes to its network.

Administrative Procedures and Compliance

We are here to ensure your practice stays aligned with compliance guidelines, our marketing policies, and other industry-standard regulations. In the following section, we provide some helpful links and overviews to make it easy for you or your staff to reference or access them.

CMS Guidelines

You and any persons involved in the administration or delivery of Medicare and Medicaid program benefits must complete the following training requirements within upon initial contracting and annually thereafter:

- CMS Medicare Parts C and D Compliance training
- CMS Medicare Parts C and D Fraud, Waste, and Abuse (FWA) training

CMS has developed a web-based training module that can be used to satisfy these training requirements. It is available on the CMS Medicare Learning Network (MED Learn) website.

CenterLight recommends that you read and understand the guidelines set forth by the Centers for Medicare and Medicaid Services. For additional information, visit cms.gov.

Marketing Plans

You cannot develop materials that market CenterLight without prior written approval, but you can use approved materials supplied directly by CenterLight. Under Medicare Advantage program rules, CenterLight must follow CMS marketing guidelines and obtain CMS review and approval for all marketing materials before making such materials available for distribution to eligible individuals.

You can have our marketing materials, including brochures, posters, or notifications, available in your office as long as we are not exclusively represented. Materials for other plans in which you are a participant must be available as well and in the same location. Marketing materials can only be displayed in common areas and not in private patient exam rooms.

If you are interested in receiving our marketing materials to share with participants, contact us at providerrelationsrequest@centerlight.org.

Audit

Providers must ensure compliance with all applicable laws, regulations, and CMS instructions; agree to audits and inspections by CenterLight, New York State DOH, CMS, or its designees; cooperate, assist, and provide information as requested; and maintain records for a minimum of 10 years.

Conflict of Interest Policy

Conflicts of interest are created when an activity or relationship renders you unable or potentially unable to provide impartial assistance or advice, impairs your objectivity, or provides you with an unfair competitive or monetary advantage. Many of the relationships discussed in this document are subject to conflict-of-interest disclosure policies. Even if the relationships are legal, you can have an obligation to disclose their existence.

Compliance with Federal Laws and Nondiscrimination

The Code of Federal Regulations (42 CFR 422.504) requires that we have oversight for contractors, subcontractors, and other entities. The intent of these regulations is to ensure services provided by these parties meet contractual obligations, laws, regulations, and CMS instructions. CenterLight is held responsible for the compliance of its providers and subcontractors with all contractual, legal, regulatory, and operational obligations.

The contracted provider represents and warrants to CenterLight that he or she will not discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, HIV status, source of payment, veteran status, or geographic location. Payments received by contracted providers from Medicare Advantage plans for services rendered to participants include federal funds; therefore you, as a contracted provider, are subject to all laws applicable to recipients of federal funds, including but not limited to: Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, and all other laws that apply to organizations that receive federal funding. In addition, as a contracted provider, you must not discriminate against our participants based on their payment status.

Compliance with Federal Laws and Nondiscrimination

CenterLight Healthcare is committed to preventing and detecting fraud, waste, and abuse as part of its Compliance Program. CenterLight Health uses the service of a third-party Special Investigation Unit to assist in investigating complaints about potential fraud, waste, and abuse. All substantiated complaints are referred to the appropriate regulatory agencies, as required. As a CenterLight Healthcare contracted provider, you have specific responsibilities related to reporting activity which may be deemed fraud, waste, and abuse.
You are required to report any suspected non-compliance and/or potential fraud, waste or abuse of any rules and regulations as soon as you become aware of it. You may use any of the following methods to report:

- **CenterLight Healthcare's Compliance Hotline at (855) 231-0616***
  **The compliance hotline is available 24 hours a day, 7 days a week and is both anonymous and confidential.*
- **Online at www.CenterLight.alertline.com**
- **CenterLight Healthcare Compliance Department: compliancedepartment@centerlight.org**
- **Or in writing to:**

Chief Compliance Officer
CenterLight HealthCare, Inc.
136-65 37th Avenue
Flushing, NY 11354

When calling the CenterLight Healthcare Compliance Hotline or emailing the CenterLight Healthcare Compliance department email address:

- You have an assurance of anonymity and non-retaliation in the reporting process, and confidentiality to the extent reasonably possible.
- You have an obligation to disclose any action or situation that is, or may appear to be, a conflict of interest that would make it difficult for you to perform your work objectively or effectively.

Training

Compliance and Fraud, Waste and Abuse training is a Centers for Medicare and Medicaid Services (CMS) and New York State Department of Health (NYSDoH) requirement for direct care provider/staff who are involved with the administration or delivery of Medicaid benefits. Providers/staff must complete this training within 90 days of hire, and on an annual basis.

Proof of your completion of this training must be made available to the CenterLight Healthcare Compliance Department, upon request.

Advize

Advize Health is contracted with CenterLight Healthcare to provide Special Investigation Unit services. Advize Health is made up of Accredited Healthcare Fraud Investigators (AHFIs), Certified Fraud Examiners (CFEs), retired law enforcement officials and staff with decades of experience working in the healthcare fraud arena. Advize Health is tasked with mining claims data submitted to CenterLight Healthcare by providers (Physicians, DME, Home Health Agencies, Adult Social Day Care, Transportation vendors, and other practitioners) in order to identify any aberrant patterns of possible upcoding, unbundling, misuse of modifiers or egregious issues such as services billed not rendered. If allegations of waste or abuse are substantiated by Advize Health, they make all attempts to recover the identified overpayments and make the proper referral to regulatory agencies and/or law enforcement, if necessary.

The request letter will include the email address to submit records to.

Advize Health, 4550 N. Palmetto Ave, Unit 102 Winter Park Florida 32792
Fax: 610-871-0003
Support contact: 888-722-6059

Refund checks can be sent directly to:
CenterLight Healthcare Inc., 205 Rockaway Parkway
Brooklyn, NY 11212
Attention: Corporate Compliance

Glossary

Abuse:
Actions that can, directly or indirectly, result in unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has knowingly and intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Appeal:
Any of the procedures that deal with the review of adverse organization determinations on the healthcare services the participant believes he or she is entitled to receive, including delay in providing, arranging for, or approving the healthcare services.

Covered services:
Medically necessary healthcare services to which the participant is entitled under the terms of the plan of care.

Fraud:
Knowingly and willfully executing or attempting to execute a scheme or artifice to defraud any healthcare benefit program, or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any healthcare benefit program.
18 USC § 1347.

First-tier, downstream, and related entities:
Includes contracted physicians, healthcare professionals, facilities and ancillary providers, as well as delegates, contractors, and related parties of the plan.

Grievance:
Any complaint or dispute expressing dissatisfaction with the way CenterLight or one of its delegated entities provides healthcare services, regardless of whether any remedial action can be taken.

Group/group provider:
Employees, affiliates, or any individuals contracted with a group to provide covered services to a participant.

Healthcare provider:
Physicians, healthcare professionals, or other providers licensed and authorized under the laws of the state in which services are provided who are employed by or contracted by CenterLight.

Medically necessary services:
Services that are necessary for the diagnosis or treatment of disease, illness, or injury, and without which the participant can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort.

Participating Provider:
A healthcare provider, hospital, healthcare facility, ancillary provider, or any other person or entity who has contracted with CenterLight to provide covered services to participants.

Provider Agreement:
A signed agreement between CenterLight and a provider outlining the obligations of both parties in the delivery of quality care and covered services to participants, and the compensation for those services.

Provider Manual:
A document that explains CenterLight's operating policies, standards, and procedures for participating providers including, but not limited to, requirements for claims submission and payment, credentialing, utilization review, care management, quality improvement, advance directives, participants' rights, grievances, and appeals.

Representative:
An individual appointed by a participant or other party, or authorized under state or other applicable law, to act on behalf of an enrollee or other party involved in an appeal or grievance.

Waste:
Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.