First MEDICAL
HEALTH PLAN, INC.

IMC
RED DE PROVEEDORES
INTERNATIONAL MEDICAL CARD

PROVIDER MANUAL

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1. INTRODUCTION

Welcome to First Medical Health Plan, Inc., Provider Network.

First Medical Health Plan, Inc., hereinafter First Medical, is a locally owned Puerto Rican Managed Care Organization at the service of the community. For the past forty-seven (47) years, First Medical has dedicated its efforts to improving the quality of life of our members through the planning and implementation of cost-effective and high-quality healthcare coverage. Our primary commitment is to improve their health. First Medical is also committed to work together with our care-provider partners to make a real impact on our members' health. That's why we continue our focus to streamline our processes to help make it easier for care-provider partners to find and use the information they need for their business interactions with us. This collaboration ensures our members have access to high-quality, affordable healthcare.

First Medical has developed a Provider Manual as a guide to be used when implementing in your practice our Managed Care Model. Our goal is to provide integrated care for our enrollees. With a focus on preventive care and continued wellness, our approach is simple: We want to make it easier for our members to get the healthcare they need, when they need it. To that end, this Provider Manual (Manual) contains essential information regarding key requirements, such as:

- Legal and Administrative Requirements
- Eligibility, ID Cards and Covered Services
- Care Management Policies and Procedures
- Credentialing and Recredentialing Processes
- Billing and Claim Submission Procedures
- Complaints and Grievances
- Quality Improvement Programs
- HIPAA Requirements
- Cultural Competency
- Integrity Program: Fraud, Waste and Abuse, among others.

This Manual is intended to support all entities and individuals who have executed a Provider or Facility Agreement with First Medical. However, such agreements and the applicable legal provisions will continue to govern the contractual relationship between Provider or Facility and

First Medical/IMC. To the extent any of the provisions in this Manual conflict with the Provider agreement or applicable legal provisions, the Provider agreement and legal provisions shall control.

The use of the term “Provider” within this Manual refers to entities and individuals contracted with First Medical who submit professional Claims. They may also be referred to as Professional Providers in some instances. The use of “Facility” within this Manual refers to contracted entities, who submit institutional Claims, such as Acute General Hospitals and Skilled Nursing Facilities. General references to “Provider Inquiry”, “Provider Website”, “Provider Network Manager” and similar terms apply to both Providers and Facilities.

As a participant in our diverse Providers Network, the Agreement you have with First Medical requires Providers and Facilities to comply with First Medical policies and procedures including those contained in this Manual. Payment may be denied, in full or part, should Providers or Facilities fail to comply with the Manual. However, in the event of an inconsistency between the Agreement and this Manual, the Agreement will govern. The policies and procedures in this Manual apply unless otherwise required by the Agreement.

This Manual may be updated at any time and is subject to change. If there is a material change to this Manual, First Medical and International Medical Card (IMC) will make reasonable efforts to notify our care provider partners in advance of such change through web-posted newsletters at www.firstmedicalpr,com or www.intermedpr.com, email communications or publications in the IMC Provider Portal. In such cases, the most recently published information will supersede all previous information and be considered the current directive.

Please note that this Manual is not intended to be a complete catalog of all First Medical Policies and Procedures. Other policies and procedures that may apply and are not included in this Manual may be posted on our website or published in specially targeted communications, including but not limited to bulletins and newsletters. First Medical Providers Network shall agree to abide by, and comply with, First Medical’s Provider Manual, Policies, Programs and procedures established and implemented by First Medical.

First Medical retains the right to add to, delete from and otherwise modify this Manual but will make good faith effort to provide notice to Provider or Facility at least sixty (60) days in advance of the effective date of material modifications. Providers and Facilities must acknowledge this Manual and any other written materials provided by First Medical as proprietary and confidential. If there is a conflict between the Manual and the Provider Agreement, the Provider Agreement

supersedes. First Medical encourages Providers to contact a First Medical contracting representative whenever clarification is needed or to share any suggestions for improving the Manual.

Remember, this document does not replace your signed Provider Contract that you currently have with IMC. If you have any questions related to the information provided in the Manual or need additional information, please feel free to contact our Provider Service Center at 787-878-6909. Our office hours are Monday through Friday from 8:00 a.m. to 5:00 p.m. You can also access our webpage at www.intermedpr.com.

FIRST MEDICAL HEALTH PLAN, INC.
QUICK REFERENCE GUIDE

Postal Address	First Medical Health Plan, Inc. PO BOX 71114 San Juan, PR 00936-8014
Phone	787-474-3999
Providers Department	787-878-6909
Credentialing Department	787-878-6909 Ext.7530, 7529
Pre-authorizations	1-866-977-2977
Inhealth Hospital Patient Admission	(InHealth Hospital Reviewers) inpatient@inhealth-pr.com 787-622-3000, Ext. 8334, 8369, 8368, 8372, 8371, 8364, 8374, 8304, 8295, 8367 / Fax: 787-999-1744
Case Management	Fax: 787-993-4916
Pharmacy Benefit Management Program	1-844-550-5540
Claims Submission	International Medical Card, Inc. Claims Department – Original Claims PO Box 144090 Arecibo, PR 00614-4090
Claims Adjustment	International Medical Card, Inc. Claims Department – Claims Adjustment or Resubmission

	PO Box 144095 Arecibo, PR 00614-4090
Complaints and Appeals Department	First Medical Health Plan, Inc. Complaints and Appeals Department PO Box 191580 San Juan, PR 00919-1580 Phone (787) 474-3999 / Fax (787) 625-8765
Compliance Officer	Compliance Officer - First Medical Health Plan, Inc. P.O. Box 191580 San Juan, PR 00919-1580 Phone: (787) 474-3999, Ext 2108 Email: cumplimiento@firstmedicalpr.com
Fraud and Compliance Alert Line	alertafraudeycumplimiento@firstmedicalpr.com 1-800-933-9336 available 24/7
Refunds	You can access the Refund Form through www.firstmedicalpr.com or by visiting a Service Office.
First Health Call (Health Consultations)	1-866-337-3338 / TTY/TDD 1-866-927-0101 It is a free health information service available 24/ 7. It has bilingual nursing professionals. You can get the following services: • Support in unforeseen and urgent situations. • Patient education in health situations.
Persons who may need assistance due to: ☐ ***Spanish is not the primary language*** ☐ ***Special Needs***	The Customer Services Department offers services in alternate formats such as Sign Language, Braille, large print, and translation to other languages, verbally or written, amongst others. If your patient needs plan information in another format or language, please contact our Customer Service Department at 1-888-318-0274. Also, you can contact our Compliance Department at (787) 474-3999, ext. 2108.
Mobile App	Our participants have the option to register on our mobile app, through which they will be able to carry out transactions, such as: • Digital ID Card • Copayment Overview

	• Utilization • Cover Certification • Provider Network • Submission of Pre-authorizations of specialized studies
HIPAA Complaints	787-474-3999, Ext. 2108

First Medical has a Provider Service Center to assist you with questions or concerns you may have. Representatives are available to assist you Monday through Friday from 8:00 a.m. to 5:00 p.m. First Medical has an automated system available during business hours, where you can leave a phone number and a representative will return your call, without losing your turn. During non-business hours you can also leave us a message. We will return your messages on the next business day.

2. ADMINISTRATIVE AND LEGAL REQUIEREMENTS

2.1 IDENTIFICATION CARD

First Medical issues to all members an Identification Card. This ID Card must be presented by the member at the time of service.

Please Note:

- This Member ID Card does not guarantee eligibility. It is for identification purposes only.
- Each Provider has a duty to verify eligibility prior to each visit through the Provider Portal. Failure to verify eligibility may result in non-payment of claims.
- If the Member does not have an ID Card, you must call the Customer Service Department to validate the members eligibility.

2.2 ADDITION OF NEW PROVIDER TO A PROVIDER GROUP AGREEMENT

Providers operating under an existing participation Agreement (individual or group) with First Medical are required to notify First Medical of any new Providers joining or leaving the practice within the term established therein. No Provider subsequently joining a Practitioner shall be

authorized to render services to First Medical members as a participating Provider, until the practice has been notified in writing that First Medical or its designee has completed its credentialing review and system upload of such Provider and approved his or her participation under the executed participation Agreement. If the Provider or Practitioner submits Claims for new Providers prior to First Medical completing its credentialing reviews, the Provider or practitioner will hold First Medical and Member harmless for the charges.

2.3 ADVANCE PATIENT NOTIFICATION FOR THE USE OF A NON-PARTICIPATING PROVIDER

Consistent with the transparency laws and regulations applicable to the healthcare industry, it is important that First Medical members be made fully aware of the financial implications when they are referred by their Physician, on a non-urgent basis, to a non-participating Provider. It is especially critical to notify our members when using a nonparticipating Provider in their Provider's own office for services such as laboratory, anesthesia, specialty drugs, infusion therapy or durable medical equipment. Likewise, members should be made aware if their selected participating surgeon has chosen to use an assistant surgeon or a non-participating ambulatory surgery center in a scheduled surgery. In both cases, the member has no way of knowing that a non-participating Provider was involved in their care unless informed, in advance, by their Physician. While certain members may have out-of-network benefits, it is very disconcerting to them when they are presented with unexpected financial obligations for out-of-network medical services. This requirement is not intended to deter patients from using out-of-network providers. To the contrary, it only pretends to ensure that, in non-emergent situations, when any First Medical member receives services from a non-participating Provider it is because they were involved in the decision-making process and made a conscious election. This procedure does not apply to emergent situations. Likewise, it does not apply when Providers, Facilities or the member have obtained First Medical's prior approval for the referral. When any Provider, Facility or the member have contacted First Medical and received approval in advance to proceed with an out of network service in the Provider office or Facility, First Medical will grant approval for the use of non-participating Facilities, Physicians, or Practitioners.

2.4 CLINICAL DATA SHARING

When requested by First Medical, providers are required to submit clinical data (such as discharge summaries, consult notes, and medication lists) and admission, discharge, and transfer data to

First Medical for certain healthcare operations functions. We collect this data to improve the quality and efficiency of healthcare delivery to our members. Providers may be required to submit:

- Admission, Discharge and Transfer data to First Medical on a near real-time basis (no later than 24 hours) from the time of admission, discharge, or transfer of a member.
- Clinical data for a member on a daily, weekly, or monthly basis, based on the provider's electronic medical record (EMR) or other electronic data sharing capabilities.

First Medical's permitted uses of the data with respect to clinical data requests include: utilization management, case management, identification of gaps in care, conducting clinical quality improvement, risk adjustment, documentation in support of HEDIS® and other regulatory and accrediting reporting requirements, and for any other purpose permitted under HIPAA.

First Medical has determined the data requested is the minimum necessary for First Medical to accomplish its intended purposes. The data will be provided in accordance with data layout and format requirements defined by First Medical.

2.5 COMMITMENT TO PROTECT MEMBERS PRIVACY AND CONFIDENTIALITY

First Medical is committed to protect the Member's privacy and confidentiality of personal and protected health information in compliance with the State and Federal laws and regulations regarding privacy and security, including the Health Insurance Portability and Accountability Act (HIPAA, 1996), Health Information and Technology for Economic and Clinical Health Act (HITECH, 2009), Health Insurance Code of Puerto Rico and the Federal Act of 1974 "Privacy Act" (PL 93579), among others. First Medical has adopted Confidentiality and Privacy Policies and Procedures that requires all Employees, members of all Committees and Board of Directors to sign a Confidentiality Statement and to comply with all applicable federal and state regulations.
Protected Health Information (PHI) is defined as any information that identifies an individual, which is transmitted, maintained, or recorded orally or by any medium or form, including electronic medium, and that:

- It's created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university or healthcare clearinghouse.
- Relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual. (42 C.F.R. § 160.103).

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. Our Providers Network must comply with First Medical contract provisions, which includes HIPAA requirements to protect the confidentiality, integrity, and availability of the First Medical Members' Protected Health Information (PHI). The Privacy Rule requires appropriate safeguards to protect the privacy of the member protected health information (PHI) and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. Federal regulations set a baseline of protection for certain individually identifiable health information ("health information"), but more stringent laws and legal provisions, such as Puerto Rico Mental Health Code and Regulation No. 51 of the Puerto Rico Department of Health, should be followed in certain situations.

First Medical expects that our Provider's Network understand that this core responsibility must be taken seriously and to follow the applicable laws by implementing and maintaining reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of patient protected health information (PHI). In those terms, our Providers shall adopt a confidentiality policy for their office and require that all staff members comply with all applicable privacy and security requirements. First Medical and its Providers Network shall use First Medical Members' PHI for the sole purpose of complying with their roles and responsibilities during the provision of quality and cost-effective health care services. Providers shall treat the Members records and information confidentially and not release such information without the Members written consent, except for treatment, payment, or operations as allowed by state and federal law, including HIPAA regulations.

Providers cannot delegate their responsibility to protect the privacy and security of clinical information of patients receiving treatment at their offices or health facilities. Staff must be trained periodically in confidentiality and privacy requirements to comply with these requirements. Individuals shall be granted access to confidential Information only after complying with the requirements of Puerto Rico and Federal laws pertaining to PHI access.

2.6 ACCESS TO HEALTH RECORDS BY FIRST MEDICAL STAFF OR ITS SUBCONTRACTOR'S

First Medical has the authority to inspect and request copies of a medical records to examine and audit any transaction related to health services provided to First Medical Members to determine quality, adequacy, timeliness, privacy, cost-effectiveness of services, and continuity of care, among others.

2.7 NOTICE OF PRIVACY PRACTICES

Providers that are covered under HIPAA and have a direct treatment relationship with the patient must provide patients with a Notice of Privacy Practices that explains the Members privacy rights and the process that the Member should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices in its first encounter and when changes have been made to the notice. For First Medical's Notice of Privacy Practice please refer to www.firstmedicalpr.com.

2.8 PATIENT RIGHTS

Puerto Rico Patient's Bill of Rights (Article 11) establishes that a patient can have full confidence that their medical and health information will be kept strictly confidential by their health care providers.

First Medical Members have rights and responsibilities under HIPAA. Providers must allow their patients, at a minimum, to exercise any of the below listed rights that apply to the Providers practice, as well as any other required by state or federal laws:

- **Request a copy**. Members have the right to access their own PHI within a provider/practitioner's designated records set. A Personal Representative of a patient has the right to access the PHI of the subject patient. The designated record set includes the patient's medical record, as well as billing and other records used to make decisions about the member's care or payment for care.
- **Request an Amendment**. Members have the right to request that you amend their Protected Health Information, if they understand that it is incorrect or incomplete. Providers/practitioners are not obligated to agree or accept any such request for amendment.
- **Request Restrictions**. Members have the right to request restrictions on certain uses and

disclosures of their Protected Health Information in compliance with Section 164.522 (a) of the Privacy Rule. Providers/practitioners are not obligated to agree or accept any such request for restrictions.

- **Request Confidential Communications**. Members have the right to receive Health Information through reasonable alternative methods or at an alternative location. For example, they can request you to contact them at work or family member address. Providers/practitioners must accommodate reasonable requests by the patient.
- **Inspect and Copy**. Members have the right to inspect and receive an electronic or printed copy of the personal or health information, within the limits and exceptions provided by law. Providers/practitioners may charge a reasonable fee to cover the expenses related to the Members request.
- **Request a Disclosure Report.** Members have the right to obtain a Report of the Disclosures made by you or First Medical of their Protected Health Information in the last six years, except those made for treatment, payment, or health care operations, or those made at their request. First Medical will provide a report of a period of twelve (12) months free of charge; additional reports may have a fee. You may charge a reasonable fee to cover the expenses related to the Member request.
- **File a Complaint.** Members have the right to file a Grievance with First Medical or with the Secretary of the Department of Health and Human Services of the United States of America (DHHS) if they understand that his/her privacy or security rights have been violated. You cannot retaliate against a member in any way for filing a complaint with us or with DHHS.

2.9 SECURITY REQUIREMENTS

First Medical supports the use of electronic transactions to streamline healthcare administrative activities. We encourage you to submit claims and other transactions using electronic formats. Providers Network should implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of First Medical Members PHI. Identity theft occurs when someone uses a person's name (and sometimes other information of their identity) without the person's consent to obtain healthcare services.

First Medical's Members trust on you to keep their most sensitive information private and confidential. Providers shall ensure that the operation of all its systems is performed in

accordance with Puerto Rico and Federal regulations and guidelines related to security and confidentiality of the protected information managed by the Contractor and shall strictly comply with HIPAA Privacy and Security Rules, as amended, and with the Breach Notification Rules under the HITECH Act. Providers shall ensure with special confidentiality provisions in Puerto Rico or Federal law related to people with HIV/AIDS and mental illness.

Providers should report any suspected privacy HIPAA violation or disclosure of Protected Health Information to First Medical's Compliance Department without fear of retaliation to:

Compliance Alert Line	
In writing to: **First Medical Health Plan, Inc.** **PO Box 191580** **San Juan, PR 00918-1580**	**Phone:** **1-866-933-9336**
cumplimiento@firstmedicalpr.com	

First Medical encourages you to comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. You must use your NPI to identify all electronic transactions submitted to First Medical and on all claims and encounters (both electronic and paper formats). Any changes in your NPI or subparts information must be reported to International Medical Card (IMC) Providers Department within 30 days of the change. To report any change in your NPI you should call the Credentialing Department at 787-878-6909.

2.10 MISROUTED PROTECTED HEALTH INFORMATION

Providers and Facilities are required to review all Member information received from First Medical to ensure no misrouted PHI is included. Misrouted PHI includes information about Members that a Provider or Facility is not currently treating. PHI can be misrouted to Providers and Facilities by mail, fax, email, or electronic remittance. Providers and Facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are Providers or Facilities permitted to misuse or re-disclose misrouted PHI. If Providers or Facilities cannot destroy or safeguard misrouted PHI, Providers and Facilities must contact First Medical Compliance Department or IMC Provider Services to report receipt of misrouted PHI.

2.11 COORDINATION OF BENEFITS

If a member or eligible dependent is covered by more than one health benefit plan, the carriers involved shall work together to prevent duplicate payments for any services. This cooperative effort is called Coordination of Benefits ("COB"), a provision in most health benefit plans. If a Plan is other than the primary payor, any further compensation to Provider or Facility from Plan or the member shall be determined in accordance with the Agreement, the applicable Health Benefit Plan and any applicable Plan written policies and procedures for coordinating benefits.

2.12 CO-PAYMENTS AND COST SHARING

Members are responsible for the co-payment amount indicated on their ID cards. Copayments apply to home and office visits but do not apply to in-network Annual Preventative Care visits, and Well-Child Care visits. There may be exceptions depending on the Member's contract. Except for copayments, which may be collected at the time of service or discharge, Providers and Facilities should not bill the Member for any cost-sharing amounts until he/she has received an explanation of benefits (EOB). Per the First Medical Practitioner Agreement, physician or practitioner agrees to only seek payment from a member for a health service that is not covered under the member's benefit plan, whether it is not covered because it is specifically excluded, is not considered medically necessary or is considered investigational, when the physician or practitioner has obtained a signed, First Medical Non-Covered Services Notification Wavier.

All services are subject to all the terms, provisions, limitations, and exclusions of the policies. Members will be entitled to the Medically Necessary Covered Services during the term of their contract.

2.13 BILLING POLICY AND PROCEDURE OVERVIEW

All Claims must be submitted in accordance with the requirements of the Provider contract, applicable Member's contract, and this Provider Manual. Providers and Facilities may not seek payment for covered services from the Member, except for any applicable visit fees, co-payments, deductibles, coinsurance, or penalties as described in the Member's contract. In no event should a Provider or Facility require a deposit from a member prior to providing covered services to the Member. Any Administrative charges applied by physicians must be within First Medical's

contractual and policies guidelines and should be prominently displayed within the office and disclosed to Members prior to any services being rendered.

2.14 CODING REQUIREMENTS

Providers and Facilities will submit Claims in a format consistent with industry standards and acceptable to First Medical.

2.15 COSMETIC AND RECONSTRUCTIVE SURGERY

Cosmetic surgery is not a covered service because it is performed to reshape the structure of the body to alter the appearance or to alter the manifestation of the aging process. Reconstructive surgery is covered when it is performed to improve or restore bodily function or to correct a functional defect resulting from disease, trauma, or congenital or developmental anomalies. When surgery is done for both cosmetic and reconstructive purposes, the allowed amount will be prorated based on the percentage of the surgery that was reconstructive in nature. However, breast reconstruction following mastectomy for cancer is not considered cosmetic. This includes surgery on the contra lateral breast for symmetry.

2.16. DISPUTE RESOLUTION AND MEDIATION

The rights and obligations of First Medical, Providers and Facilities with respect to resolving disputes are set forth in the First Medical Provider Agreement or the First Medical Facility Agreement. All administrative remedies set forth above shall be exhausted prior to filing an arbitration demand.

2.17 DOMESTIC VIOLENCE – ALTERNATE CONTACT INFORMATION

Members who are victims of domestic violence may ask you (and First Medical) to send mail with personal information to an alternate address. First Medical will honor any reasonable request to use an alternative address or alternative means of communication if a Member tells First Medical that directing coverage or claims-related information to the policyholder address poses a threat to the covered person or a child covered under the policy. Be sure to share this information with Members. A Member can call First Medical at the Customer Services phone number on their First Medical ID card or write to First Medical to make a request.

2.18 INSURANCE REQUIREMENTS

Providers and Facilities shall self-insure or maintain insurance in types and amounts reasonably determined by Providers and Facilities, or as required under applicable licensing or regulatory requirements. Please refer to you contract for First Medical's Insurance Requirements or contact your Provider Service Representative.

2.19 ANNUAL DEDUCTIBLE

An annual deductible is a specified dollar amount that the member must pay for covered expenses, except for any deductible designated for prescriptions or specialty drugs from a pharmacy or specialty pharmacy, per year before most benefits will be paid under the policy. There are individual and family network provider and non-network provider deductibles. The deductible amount(s) for each covered person and each covered family must be satisfied each year, either individually or combined as a covered family. Once the deductible requirement is met, any remaining deductible for a covered person will be waived for that year. Copayments do not apply towards the annual deductible.

2.20 MAXIMUM OUT OF POCKET

The Maximum Out of Pocket (MOOP) applies to all essential health benefits if covered by First Medical. The following services and their cost-sharing are not contemplated for the calculation of the MOOP:

- Nonessential health benefits
- Services provided by an out-of-network Provider

The applicable MOOP will be the one established by the Office of the Commissioner of Insurance of Puerto Rico for the year in which the member contract is in effect and represents the sum of out-of-pocket expenses of the covered person, meaning: the initial deductible, co-payments, or coinsurance established for medical coverage and prescription drugs (combined). For the 2024 coverage period, it will be $6,350.00 for individuals and $12,700.00 for families. This amount may be modified annually by Office of the Commissioner of Insurance of Puerto Rico.

2.21 NETWORK PARTICIPATION, TERMINATION AND APPEALS

First Medical may evaluate certain managed healthcare practitioners participating in the network for possible termination or other actions, as necessary. First Medical contracts with various practitioners so that it can offer quality, accessible, cost-efficient healthcare to its managed care network Members. First Medical monitors the care provided by the practitioners participating in network and re-credentials them every three years to ensure that such healthcare is being rendered. Certain circumstances, including but not limited to, professional misconduct of a participating practitioner within the managed care network may require First Medical to take certain actions with respect to the practitioner's participation in the network. Actions may include termination of the practitioner's network participation privileges, as set forth below.

Any Provider who wishes to terminate its contractual relationship with First Medical must abide by the terms of the Provider Agreement, including but not limited provisions concerning notice and continuation of care. First Medical may elect to non-renew a Provider's Agreement and will provide notice of nonrenewal in accordance with the terms of the Provider Agreement. Immediate Terminations can occur in the following instances:

- Sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or Federal Employee Health Benefit Plan.
- A determination that the conduct of a participating practitioner in First Medical 's managed care network poses the threat of imminent harm to the health of network Members; or
- A finding that a participating practitioner in First Medical 's managed care network has perpetrated an act of fraud; or
- A final disciplinary action by a state licensing board or other governmental agency that impairs the ability of a participating practitioner in First Medical's managed care network to practice.

In the above cases, the participating practitioner in First Medical 's managed care network will be immediately terminated from all managed care networks and will not be eligible for hearing.

First Medical has established policies for monitoring and re-credentialing participating Providers, who seek continued participation in one or more of First Medical 's networks. Administrative Terminations can occur when an administrative issue arises with respect to a participating practitioner in First Medical's managed care network and may include, but is not limited to, noncompliance with First Medical 's Provider Agreement or First Medical Policies and Procedures.

Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and First Medical may wish to terminate Providers.

First Medical also seeks to treat participating and applying Providers fairly, and thus provides participating Providers with a process to appeal determinations terminating participation in First Medical ’s networks for professional competence and conduct reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB). Additionally, First Medical will permit Providers who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (Informal/ Reconsideration only).

It is the intent of First Medical to give practitioners the opportunity to contest a termination of the practitioner’s participation in one or more of First Medical ’s networks or programs and those denials of request for initial participation which are reported to the NPDB that were based on professional competence and conduct considerations. Immediate terminations may be imposed due to the practitioner’s suspension or loss of licensure, criminal conviction, or First Medical’s determination that the practitioner’s continued participation poses an imminent risk of harm to First Medical’s Members. A practitioner whose license has been suspended or revoked has no right to Informal Review/Reconsideration or Formal Appeal.

2.22 OPEN DIALOGUE

First Medical places no restrictions of any kind on open dialogue between Providers and their patients. Providers are encouraged to discuss all treatment options, regardless of costs or coverage. Providers may also advocate on a member’s behalf, or file complaints with First Medical or government agencies about First Medical ’s practices that the Provider or Facility may believe affect quality or access of care.

2.23 PROVIDER AND FACILITY DIGITAL ENGAGEMENT

First Medical expects Providers and Facilities will utilize digital tools unless otherwise mandated by law or other legal requirements for transactions such as filing Claims, verifying eligibility and benefits, etc. Providers and Facilities should refer to the guidance included throughout the Provider Manual where digital tools are available.

2.24 TRANSITIONAL CARE OF MEMBER

If a member has a life-threatening disease or condition or a degenerative and disabling disease or condition and the provider has been offering medical treatment related to that condition prior to the plan's termination date, then the transition period will be extended for the remainder of the patient's life.

If the member has entered the second trimester of pregnancy at the plan's termination date, the transition period for pregnancy-related services shall extend until the date of discharge from the mother's hospitalization due to childbirth or the date of discharge of the newborn, whichever is later. Failure to pay any required premium to First Medical when due may result in the termination of the member benefit coverage.

2.25 SITE AND MEDICAL RECORD-KEEPING PRACTICE REVIEWS

Providers are required to comply with certain standards for privacy and confidentiality, and record keeping practices in their practices. Please refer to Section- Commitment to Protect Patient Privacy and Confidentiality for information regarding these requirements.

2.26 PANEL CLOSURE

Occasionally, Physicians may request closure of their panel. This means that they are no longer accepting new patients. First Medical requires the Providers to send a written notice thirty (30) days prior to the proposed effective date of such closure. First Medical will update the Provider Directory to reflect that these providers are "not accepting new members". If the Physician determines to reopen their panel to new members, the Physician will send a written notice to First Medical's Provider Services Department informing the effective date for reopening of the panel.

If Providers relocate or open an additional office, they should notify First Medical's Providers Department sixty (60) days in advance. A site visit of the new office may be conducted after notification.

3. DIGITAL TOOLS

First Medical promotes the technology transformation in healthcare. One of the key aspects of this transformation is the implementation of electronic health information management systems. This has allowed First Medical to speed up the members and providers digital health processes. The following tools, available to First Medical in-network providers, shall help you to manage your medical processes:

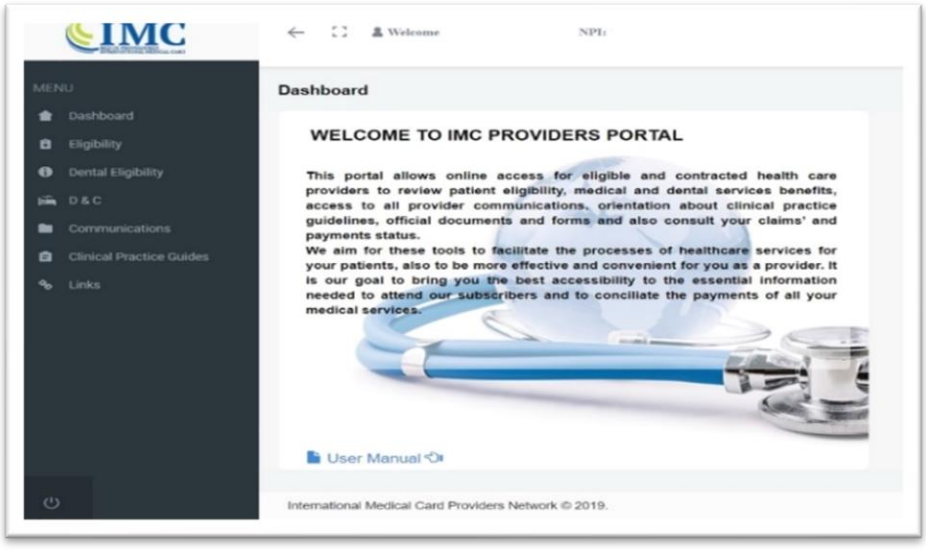
3.1 FIRST MEDICAL WEBSITE

First Medical's Website **(www.firstmedicalpr.com)** is a public website. The webpage was designed to make navigation easy and more useful for members and Providers. The website holds timely and important information to assist you when working with First Medical.

3.2 IMC PROVIDER PORTAL

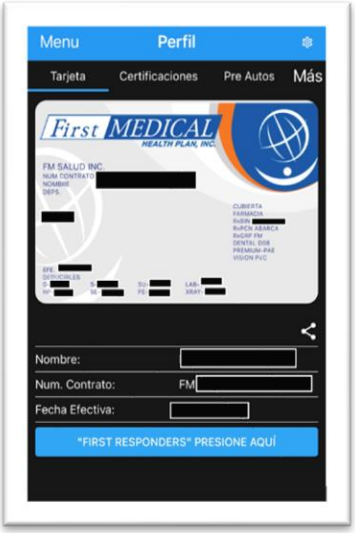
The International Medical Card (IMC) Provider Portal holds timely and valuable information to assist Providers when working with First Medical. Health care professionals like you can access patient- and practice-specific information 24/7, complete tasks online, get updates on benefits, copayment, clinical practice guidelines, submit prior authorization requests and check eligibility — all at no cost without calling. Sign up to get the content available, such as Network eUpdates, newsletters designed to educate Providers, Facilities and their staff on updates and notification of changes, Provider Policies, Guidelines & Regulatory Communications.

As a member of the First Medical provider network, don't miss out on the opportunity to register on IMC's Provider Web Portal at http://portal.intermedpr.com.



3.3 ON-LINE PROVIDER DIRECTORY AND DEMOGRAPHICS DATA INTEGRITY

Providers and Facilities can confirm their Network participation status by navigating in www.firstmedicalpr,com. A search can be done on a specific Provider name or by viewing a list of in network Providers and Facilities using search features such as Provider name, specialty or municipality. It is critical that Members receive accurate and current data related to Provider availability. You must notify IMC of any changes on your demographic data. All requests must be received 30 days prior to change/update. Any requests received within less than 30 days' notice may be assigned a future effective date. Contractual terms may supersede effective date request. Types of demographic data updates can include, but not limited to:



- Name change (Provider/Organization or Practice)
- National Provider Identifier (NPI)
- Office Hours/Days of Operation
- Phone/Fax Number/Web Address
- Provider Termination, Leaving Group, Retiring, or Joining another Practice
- Specialty, Tax ID, License Number and Board Certifications
- Accepting New Patients
- Address – Additions, Terminations, Updates (including physical and billing locations)
- Handicapped Accessibility
- Hospital Affiliation, Restrictions or Admitting Privileges

3.4 ACCEPTANCE OF DIGITAL ID CARDS

As our members transition to electronic member ID cards, providers may need to implement changes in their processes to accept this new format. First Medical expects that providers will accept the electronic version of the member identification card in lieu of a physical member identification card when presented by members who are transitioning to digital cards. If providers require a copy of a physical member identification card, members can email a copy of the electronic member ID card from their phone application.

4. PROVIDERS ROLES AND RESPONSABILITIES

First Medical values the relationship between a patient and their Providers and believes access to health care services is critical for the overall well-being of First Medical Members. The Provider plays a critical role in care management and the success of individuals who are encouraged to be engaged in their own health care maintenance and wellness. The Provider will be responsible for providing, managing, and coordinating all medically needed services to Members, including the coordination with Behavioral Health personnel, in a timely manner, and in accordance with the guidelines, protocols, and practices generally accepted in medicine.

In our continuing efforts to offer a quality health care coverage, First Medical guarantees access to an integrated model of physical and behavioral health care services. First Medical will work with our providers and Members to avoid uncoordinated, episodic care by encouraging close relationships between them and the Physicians offering readily accessible preventive health care services and treatment.

4.1 COMPLIANCE WITH THE FIRST MEDICAL CONTRACT, REGULATIONS AND PROVIDER GUIDELINES

First Medical requires Providers to comply with important provisions established by First Medical as well as any applicable federal and state laws and regulations. Those requirements are set forth in the First Medical's provider contract and these Manual. We encourage you to review your contract and let us know if you have any questions about the terms set forth therein. First Medical will keep you informed about any changes or modifications to the provider contract regarding First Medical's health care services and requirements.

First Medical expects Providers to comply with applicable Federal and Puerto Rico laws, rules, and regulations, and the Puerto Rico policy relative to non-discrimination because of age, race, color, religion, belief, national origin, sex, sexual orientation, physical or mental disability, marital status, political affiliation, socioeconomic status. Applicable Federal non-discrimination law includes, but is not limited to, Title VI of the Civil Rights Act of 1964, as amended; Title IX of the Education Amendments of 1972, as amended; the Age Discrimination Act of 1975, as amended; Equal Employment Opportunity and its implementing regulations (45 CFR 74 Appendix A (1), Executive Order 11246 and 11375); the Rehabilitation Act of 1973; and the Americans with Disabilities Act of 1993 and its implementing regulations (including but not limited to 28 CFR §

35.100 et seq.). Also, Providers must obey all provisions of the Puerto Rico Patient's Bill of Rights and the implementing regulation, which prohibits discrimination against any patient. First Medical is responsible for all First Medical marketing materials. Any written informational and marketing materials must be developed at a fourth (4th) grade reading level and have prior approval from First Medical's Compliance Department. Providers are not authorized to develop and publicize educational or marketing without First Medical's written consent. If you want to promote any activity or share an educational material with First Medical Members, please contact First Medical's Compliance Department at 787-625-9557.

First Medical will not contract or renew contract with any person or entity, or subsidiary companies, or any of its shareholders, partners, officers, principals, managing employees, subsidiaries, parent companies, officers, directors, board members, or ruling bodies that are or have been, under investigation for, accused of, convicted of, or sentenced to imprisonment, in Puerto Rico, the US, or any other jurisdiction, for any crime involving corruption, fraud, embezzlement, or unlawful appropriation of public funds, pursuant to Act 458, as amended, and Act 84 of 2002.

In some circumstances, a contracted provider may subcontract with another provider to assure the provision of services to First Medical's Members. In those cases, the Subcontractor must comply with all the provisions required by First Medical to the Provider. The Provider shall not employ, or subcontract individuals included in the Puerto Rico or Federal List of Excluded Individuals and Entities (LEIE), or with any entity that could be excluded from the Medicare Program under 42 CFR § 1001.1551 - Exclusion of individuals with ownership or control interest in sanctioned entities and 42 CFR § 1001.1901 - Scope and effect of exclusion. Providers must disclose to First Medical whether any staff member or subcontractor has any prior-violation, fine, suspension, termination, or other administrative action taken under Medicare laws or by the federal government.

4.2 PROVIDER RESPONSIBILITIES

First Medical has a comprehensive Network of Providers capable of serving all First Medical's Members. Our Providers are responsible for evaluating the Members periodically and to timely coordinate all the health care needs. The Provider must provide services in a manner consistent with professionally recognized standards of care and in a culturally competent manner.

5. CREDENTIALS AND RE-CREDENTIALING PROCESS

5.1 CREDENTIALING REQUIREMENTS TO PARTICIPATE IN FIRST MEDICAL'S PROVIDER NETWORK

Credentialing is the process of obtaining and verifying information about a health professional or entities and evaluate said health professional or entities when he/she applies to become a participating provider of a health insurance organization or insurer.

To ensure that First Medical's members receive the highest level of care from healthcare professionals who have undergone rigorous scrutiny regarding their ability to practice medicine, First Medical has contracted International Medical Card, Inc. (IMC), currently certified as a Credentialing Verification Organization (CVO), as a delegated entity to conduct the credentialing process.

IMC has established a well-defined credentialing and re-credentialing process that evaluates and selects licensed practitioners to provide care to First Medical members in compliance with First Medical and OCS requirements. To be eligible for participation providers must comply with all the credentialing requirements. The Credentialing and Re-credentialing Policy and Procedures defines the criteria (requirements) to participate in First Medical's Providers Network. The credentialing requirements may vary based on the type of provider/facility.

Verifications of providers' credentials, as a key to ensuring compliance with First Medical's accreditation standards, are conducted within thirty (30) calendar days from the receipt of a completed application for enrollment on First Medical's Network of Providers. IMC bases the decision to accept or deny an applicant in compliance with the requirements established in the Health Insurance Code, as well as any other applicable provisions. Any Physician that does not comply with the minimum standards will not be recommended for acceptance to be part of First Medical's Provider Network.

Providers are considered without regard to race, belief, color, gender, age, sexual orientation, national origin, or handicap, unless the latter affects the ability of the practitioner to provide quality healthcare. First Medical and IMC do not discriminate in terms of participation, reimbursement, or indemnification, against any health care professional acting within the scope of his/her license. First Medical and IMC do not discriminate against professionals who serve high-risk populations or who specialize in the treatment of costly conditions. First Medical reserves the right to exercise

discretion in applying any criteria and to exclude providers who do not meet the criteria. Providers must meet the criteria to be eligible to participate in First Medical's Providers Network. If the practitioner fails to provide proof of meeting these criteria, the credentialing application will be deemed incomplete, and it will result in an administrative denial. Providers who fail to provide proof of meeting these criteria do not have the right to submit an appeal.

5.2 TYPES OF CREDENTIALING PROCESS

5.2.1 INITIAL CREDENTIALING

Credentialing and re-credentialing processes shall comply with the Law 73 of July 17th of 2023, the Puerto Rico Health Insurance Code, as well as any other applicable provisions. The credentialing process starts when the providers complete a credentialing application and required documents at the Credentialing Digital Platform of the Insurance Commissioner Office.
Article 18.052 of the Law 73 provides the following:

(a) Every insurer or health insurance organization or health services organization must complete the credential verification or re-credentialing process of the applicant health care professional or institution, within thirty (30) days from the date of receipt duly completed in all its parts with the information and documents required in the Uniform Application Form.
(b) Within the first fifteen (15) days of the date of receipt, the application, the insurer or health insurance organization or health services organization will notify the requesting health care professional or institution of any defect, in if it is considered that the application is not submitted correctly and completely; specifying what defects were found in your application so that it can be processed. The health care professional or institution will have the right to supplement or correct the application or request reconsideration to dispute any objection within a period of no more than thirty (30) days from notification to the applicant of the defect found.
(c) Upon receipt of the application, with due corrections of the objections found by the insurer or health insurance organization or health services organization; They will have a period of no more than thirty (30) days to corroborate the request and documents submitted and will notify the requesting health care professional or institution within said period of the decision on their request for credentialing or re-credentialing.

(d) After thirty (30) days have elapsed from the date of receipt of the application without having been objected to, the accreditation or reaccreditation of the applicant health professional or institution will be considered approved.

Important: Once the completed application with all documents is received through the Digital Platform, the Credentials Department will proceed with the required validations and present your case to the Credentials Committee for evaluation and final determination. During this process you have the right to know the status of your application. IMC will notify you if your application is received, if it is in the process of evaluation and the final determination of the Credentials Committee. It is important to mention that incomplete or incorrect documents will not be accepted. If you do not receive the requested documents by the stipulated delivery deadline, your contract to provide the service could be affected, and your contract will be terminated.

IMC shall:

(a) Obtain primary verification of at least the following information about the applicant:
(1) Current license, certificate of authority or registration to practice his/her profession in Puerto Rico;
(2) meets financial responsibility requirements;
(3) status of hospital privileges (if applicable);
(4) specialty board certification status (if applicable);
(5) current Drug Enforcement Agency (DEA) registration certificate (if applicable);
(6) graduation from an accredited professional school, and
(7) completion of post graduate training (if applicable).

(b) Obtain, subject to either primary or secondary verification at the health insurance organization or issuer's discretion:
(1) The healthcare professional's license history in Puerto Rico and all other states;
(2) the healthcare professional's malpractice history, and
(3) the healthcare professional's practice history.

(c) At least every three (3) years, obtain primary verification of a participating healthcare professional's:

(1) Current license, certificate of authority or registration to practice his/her profession in Puerto Rico;
(2) meets financial responsibility requirements;
(3) status of hospital privileges (if applicable);
(4) current DEA registration certificate (if applicable), and
(5) specialty board certification status (if applicable).

(d) Require all participating providers to notify the health insurance organization or issuer of changes in the status of any of the items listed in this section and indicate to the participating providers the contact information to report such changes.

In compliance with the Puerto Rico Health Insurance Code, IMC shall provide a healthcare professional or entity the opportunity to review and correct information submitted in support of his/her credentialing verification application as set forth below.

(a) Each health care professional or entity that is subject to the credentialing verification process shall have the right to review all information, including the source of that information, obtained by the health insurance organization or issuer during the credentialing process.

(b) A health insurance organization or issuer shall notify a healthcare professional of any information obtained that does not meet its credentialing verification standards or that varies substantially from the information provided by the healthcare professional or entity. Notwithstanding the foregoing, the health insurance organization or issuer shall not be required to reveal the source of information, if such disclosure is prohibited by law.

(c) A healthcare professional or entity shall have the right to correct any erroneous information. A health insurance organization or issuer shall have a formal process whereby a healthcare professional or entity may submit supplemental or corrected information to the credentialing verification committee and request reconsideration, if the healthcare professional or entity believes that the committee has received information that is incorrect, misleading or erroneous. Supplemental information shall be subject to confirmation by the health insurance organization or issuer.

The Providers are credentialed upon hire and every three years. IMC will maintain a unique provider file for each Provider. The Provider file shall be updated annually and include at least a

minimum of the following documents: updated application, primary source verification, Annual Puerto Rico Review, DEA license, Malpractice Insurance, ASSMCA License, Medical Licensing, and SARAFS. Providers can access our credentials system to upload and update their credentialing documents into the system. They can access it through the following link: https://firstmedical.rcredentials.com.

On a monthly basis, First Medical will check the List of Excluded Individuals/Entities, maintained by HHS-OIG; and Excluded Parties List System and Puerto Rico List Excluded Provider. If any provider is identified at these sanctions list, the provider will be excluded from participation in the First Medical provider network.

5.2.2 RECREDENTIALING

Recredentialing is the process of periodically rereviewing and reverifying your professional credentials based on IMC's credentialing criteria. IMC will require to recredential to ensure that we have the most up-to-date and accurate information about your practice. Recredentialing is required every three years. IMC will mail you a Notice of Recredentialing, ninety (90), sixty (60) and thirty (30) days before your credentialing appointment expires. Failure to complete and update your application at the OCS Credentialing Digital Platform on time would require IMC to terminate your contract with First Medical. The Provider file shall be updated with the following documentation:

- Medical License Registry
- DEA License
- Malpractice Insurance
- ASSMCA License

5.3 CREDENTIALING COMMITTEE

The Credentialing Committee is responsible for assuring, reviewing, and evaluating the qualifications, conduct, professional character, and competency of each practitioner applying for initial credentialing and Recredentialing, which are necessary to deliver quality care to the members. The Credentialing Committee meets every three weeks, therefore the final approval for credentialing isn't completed until that time.

5.3.1 NOTIFICATION OF CREDENTIALING COMMITTEE DECISIONS

First Medical will send a letter to all providers to inform them of the Credentialing Committee decision regarding their participation in First Medical's Providers Network. This notification will be sent the 15th day of the next month. If a Provider is denied participation in First Medical's Providers Network, the provider has 30 days from receipt of the letter to submit a written request to First Medical Health Plan, Inc., for a hearing to reconsider the proposed action. The Appeals Committee will render its decision as promptly as possible and will notify the provider of its decision in writing. The panel may decide to reinstate, conditionally reinstate, or terminate the provider. First Medical will include a copy of the letter in the provider's credentials files.

All the information submitted, collected, or prepared by any IMC or First Medical's representative for the purpose of evaluating and determining providers participation in First Medical's Providers Network shall, to the fullest extent permitted by law, be confidential and shall only be disseminated to a representative to carry out appropriate activities under these IMC and First Medical's Policies and Procedures.

5.3.2 ONGOING MONITORING

The Credentialing Department shall monitor practitioners' sanctions and/or exclusions monthly through several government reports, including:

- Federal and state/commonwealth lists of excluded individuals and entities.
- List of parties excluded from Federal Procurement and Non-procurement Programs.
- Federal and state/commonwealth Medicare sanction reports
- Medicare suspended and ineligible provider list.
- Monthly review of state/commonwealth Medical Board sanctions list.
- Review of license reports from the appropriate specialty board.

If the providers do not comply with the credential's requirements, their contract could be affected.

5.3.3 PROVIDER ORIENTATION

IMC Credentialing Representative will provide orientation to participating providers to ensure full understanding of First Medical's contract dispositions, healthcare applicable laws and regulations, and OCS requirements.

5.3.4 MEDICARE AND MEDICAID SANCTIONED PROVIDERS

Providers must voluntarily disclose all Medicare and Medicaid sanctions. Practitioner must disclose all debarments, suspensions, proposals for debarments, exclusions, or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.

Practitioners must not be currently sanctioned, excluded, expelled, or suspended from any state/commonwealth or federally funded program including but not limited to the Medicare or Medicaid Programs. IMC will review the list of sanctioned Medicare Providers monthly. Upon identification that a Contracted Provider is included in the Medicare Provider sanction list, the panel will be closed, and the name suppressed from printing in any future directories. Simultaneously, the Credentialing Department may request information from the Provider and reporting agency to determine if there are further details of the sanction. If the information is consistent and the Provider has been barred from participation in Medicare and/or his or her license has been the subject of a disciplinary action, including but not limited to censure, reprimand, loss of license, suspension, etc., termination procedures will follow immediately.

5.3.5 TERMINATIONS

IMC will comply with all Puerto Rico and Federal laws regarding Provider termination. The termination of the provider contract will not be permitted without cause. IMC may terminate or suspend a provider's participation in the network for any of the reasons detailed in the provider contract.

5.3.6 CREDENTIALING DETERMINATION

IMC may decide not to contract a Provider if he/she does not meet Recredentialing requirements, as established in First Medical's Policies, Procedures and applicable provisions, which may include:

- Failure to comply with certain contractual obligations**.**

"Termination of the Provider Contracts" includes gross negligence in complying with the contractual considerations or obligations; insufficiency of funds, which prevents them from continuing to pay for their obligations; and changes in Federal law.

- Quality management requirements: Non-compliance with the Quality Improvement Program (QIP Program).
    - A pattern of Quality-of-Care complaints
    - Breach of the following programs:
        - First Medical Quality Management Program,
        - Performance standards, (for example, the score of the review of the medical record,)
        - Another issue that could potentially cause imminent harm or danger to the member.

Final disciplinary action taken by a governmental regulatory agency impairs the provider's ability to practice. Also, as for criminal cases, for being excluded from some federal program, or not fulfilling the requirements of their credentials. These points can be found in more detail in the contract clauses.

IMC reserves the right to suspend the provider contract and the privileges of a provider to serve a First Medical Member for the following reasons:

- If the provider has breached the contract or failed to comply with the contract requirements.
- A pattern of Quality-of-Care complaints or adverse events has been reported.
- If the provider has an excessive number of quality issues.
- If a provider's license or credential has expired more than 90 days and the provider has received three renewal notices from the Credentials Department, and the provider has not submitted the current documents.

5.3.7 PROVIDER INACTIVITY

Upon notification of First Medical' Special Investigation Unit, IMC will terminate inactive providers due to inactivity during the past twelve (12) months. Under no circumstances will IMC initiate termination actions against a provider solely because he or she has:

- Advocated on behalf of a member.
- Filed a complaint against a Local or Federal regulatory body.
- Appealed IMC /First Medical decision
- Provided information to an appropriate agency.
- Request a hearing or review.

A Provider may elect to terminate his or her contract with IMC following the provisions specified in the provider's agreement with the plan if the provider fails to abide by the terms and conditions of the Provider Contracts, as determined by OCS, or in the sole discretion of OCS, or if the provider fails to come into compliance within fifteen (15) Calendar Days after a receipt of notice from IMC or First Medical specifying such failure and requesting such provider to abide by the terms and conditions hereof.

5.3.8 TERMINATION PROCESS

IMC Credentialing Committee may determine that the provider does not meet First Medical requirements pertaining to quality of care, services, or established performance/professional standards to continue as a participating provider in the Providers Network.

Process will be as follows:

1. A notice with the Committee's decision, is sent via certified mail to the practitioner which includes the following:
    - A description of the action being taken
    - Reason for the decision
    - Details regarding the practitioner's right to request a fair hearing within thirty (30) calendar days from receipt of notice, if applicable.
2. If the provider determines to appeal the Committee decision, the provider has 30 days from the receipt of the letter to submit a written request to First Medical for a hearing to consider the proposed action.
3. If a request is made, a hearing will schedule within the sixty (60) day period after the receipt of the written request. The Appeals Committee will act as the hearing panel. The Appeals Committee must have at least three members, one or more of which must be a clinical peer. A "clinical peer" is defined as a provider having the same or substantially similar

specialty as the provider under review. If the panel assembled has more than three members, at least one third of the panel's members must be clinical peers.

4. The Appeals Committee will render its decision as promptly as possible and will notify the provider of its decision in writing. The panel may decide to reinstate, conditionally reinstate, or terminate the provider.

If a provider is terminated or suspended for deficiency in the quality of his or her care, written notice of the action must be given to the licensing or disciplinary bodies or other appropriate authorities.

6. CLAIMS, DISPUTE PROCESS AND CLINICAL APPEALS

6.1 CLAIMS AND BILLING

The submission of claims shall be governed by Chapter 30 of the Puerto Rico Insurance Code, applicable rules and regulations, as well as the provisions of the Provider contract. Moreover, First Medical shall comply with all Federal and State Plan Regulations and requirements; including, but not limited to, Insurance Commissioners Officer, Center of Medicare Program, Fraud, Waste and Abuse, as well as any federal or local requirement as established for the Puerto Rico Health Insurance Agency. Therefore, First Medical's Claim adjudication system will apply all regulatory payment rules. Providers must comply with rules, regulations, and laws as implemented and as amended by regulatory agencies. Also, our providers must comply with First Medical's Policies and Procedures, and all applicable rules and regulations related to claims data submission. Regulators, such as CMS and AMA, implemented several initiatives to prevent improper payment before a claim is processed, and to identify and recoup improper payments after the claim has been processed. These initiatives have the purpose of reducing payment errors by identifying and addressing billing errors related to coverage and coding made by providers. The National Correct Coding Initiatives (NCCI) Edits and the MUEs (Medically Unlikely Edits) are programs that apply the coding policies as defined by the American Medical Association (AMA) Current Procedural Terminology (CPT) Manual, HealthCare Common Procedure Coding System (HCPCS) Manual, National and local Medicare Policies and edits, coding guidelines developed by national societies, standard medical and surgical practices, and current coding practice. CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment of claims.

It is important to understand, however, that the NCCI does not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination. If a Provider identifies that a claim has been coded incorrectly, he/she must submit a correct bill for the corresponding adjustment.

First Medical's Providers agree to safeguard Members privacy and confidentiality and assure accuracy of Member health records and encounter data. Submission of electronic claims/encounter data must be done through the standard HIPAA formats 837P, 837I, and 837D as applicable, with the new 5010 HIPAA compliance layout. Those Providers that submit paper claims must use the standard format CMS-1500 for professional services, UB-04 for Institutional claims and J-400 ADA for dental services. This Manual will provide you with the billing instructions for each form type (CMS-1450-UB-04/CMS-1500/ADA).

Providers must comply with requirements for timely claims submissions as specified on the Provider Participation Agreement. All required fields on the 837 fields as well as paper claims must be included in the claims transaction to avoid rejects due to incomplete, missing, and incorrect data elements. The required supporting documentation must also be submitted with a claim to process the same accordingly. Also, claims must be submitted within ninety (90) days from the service/discharged date. Providers are required by law to submit the required data on claims, related but not limited to, POA (Present on Admission Indicator) for Principal, external cause of injury and other diagnosis for inpatient services, Combination of CPT and/or HCPCS codes and revenue codes when required must be submitted on the claim transaction. Also, information such as Discharge hour, Admission type, Admission Source, Discharge Status, Admitting Diagnosis codes, modifiers when required, diagnosis pointer, billing address (must be a street address), among other fields, must be completed and submitted to First Medical. Please refer to the detailed requirements specified further on section: FIELD SPECIFIC INSTRUCTIONS.

Since each form type has its own required fields, depending on provider type, First Medical has developed a billing guide for claim form completion and submission. The provider must follow the instructions for each form type. These instructions could change from time to time depending on CMS' regulations as well as any business rules based on Program specifics. The required fields must be completed on all form types, for First Medical to evaluate and process your claim.

To process a claim adequately and promptly, the Provider must submit a clean claim to First Medical. A clean claim is defined as a claim received by First Medical for adjudication, which can be processed without obtaining additional information from the Provider of the service or from a Third Party. Claims returned to providers as unclean must be resubmitted with all corrections and/or required supporting documentation within twenty days (20) from the letterhead date indicated on the letter.

Any request for an adjustment to a claim previously paid and/or denied must comply with submission timeframe of twenty (20) days from the EOP (Explanation of Payment) /835 transaction date. There are other payment rules which may be applicable to the different methodologies according to the provider type and contract that the Provider might have with First Medical. It is important that the Provider takes into consideration the importance of submitting a clean claim with the correct coding information in all the required and correspondent fields. You can obtain more information visiting the following Web Pages:
https://www.cms.gov/medicare/coding-billing/ncci-medicare
https://www.cms.gov/files/document/mln901346-how-use-medicare-ncci-tools.pdf
Remember that it is important to submit a timely and complete claim to expedite the processing of your claim.

6.1.1 CODING

The use of correct coding is key to submitting valid claims. To ensure claims are as accurate as possible, **use current valid diagnosis and procedure codes and codes them to the highest level of specificity (maximum number of digits available)**. You can find additional information on coding requirements, diagnosis coding and procedure coding, as well as instructions for codes with modifiers on Chapter 23 of the Medicare Claims Processing Manual.

6.1.2 DIAGNOSIS CODING

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), is currently used to code diagnostic information on claims. You can access ICD-10-CM codes electronically on the National Center for Health Statistics (NCHS), the Centers for Disease Control and Prevention website or you may purchase hard copy code books from code book publishers. Procedure Coding uses Healthcare Common Procedure Coding System (HCPCS) Level I and II codes to code procedures on all claims. Level I Current Procedural Terminology (CPT-4) codes

describe medical procedures and professional services. CPT is a numeric coding system maintained by the American Medical Association (AMA). Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and DMEPOS when used outside a Physician's office or injections administered within a Physician's office or clinic. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the Level II HCPCS codes, or alphanumeric codes as they may be referred to, were established for submitting claims for these items. These codes are found in the HCPCS code book or by visiting the Alphanumeric HCPCS webpage.

The CPT code book is available from the AMA Bookstore on the Internet at www.medicalcodingbooks.com. You can also obtain additional information from "The Medicare Learning Network® (MLN)" who offers a downloadable guide about Evaluation and Management (E/M) codes which are a subset of HCPCS Level I codes. The Evaluation and Management Services Guide is available at the Medicare Claims Processing Manual, chapter 12.

6.1.3 MODIFIERS

The use of an appropriate modifier with procedure codes is essential to submitting correct claims. CMS established on the *Modifier 59 Article* that Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when two Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes should not be reported together either in all situations or in most situations.

Note: The AMA's CPT code book includes HCPCS Level I code and modifiers, while the HCPCS code book includes HCPCS Level II codes and related modifiers.

6.1.4 SUBMITTING ACCURATE CLAIMS

Health care professionals and providers play a vital role in protecting the integrity services rendered by submitting accurate claims, maintaining current knowledge of billing policies, and ensuring that all the documentation required to support the medical need for the service rendered is submitted. In addition to correct claims completion, First Medical requires that an item or service:

- Meets a benefit category

- Is not specifically excluded from coverage
- Is reasonable and necessary

In general terms, fraud is defined as making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist. Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Plan. It is a crime to defraud a Plan. Punishment may involve imprisonment, significant fines, or both when noncompliance with several laws including, the False Claims Act, the Anti-Kickback Statute, the Physician Self- Referral Law (Stark Law), and the Criminal Health Care Fraud Statute, among others.

Below you will find detailed instructions on how to fill in the claims forms for First Medical. Also, information related to transactions 837P, 837 I, and 837D is included. Reference materials used to develop this guide are:

1. **National Uniform Claim Committee (NUCC) 1500 Health Insurance Claim Form**- Reference Instruction Manual for Form Version 02/12- Version 8.0 7/2020, or the most recent version.
2. **Optum**- Uniform Claim Editor for Professional Services-A guide to accurate 1500 Professional Claim Submission 837 refer to: http://www.x12.org for details and requirements for submission of 837 P= Professional.
3. **OPTUM 360**- Uniform Billing Editor-The ultimate guide to accurate facility claim submission.

6.1.5 CMS FIELD SPECIFIC INSTRUCTIONS

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes* complete items 9, 9a, and 9c.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CMS FIELD SPECIFIC INSTRUCTIONS

NOTE: **All fields of form CMS 1500 are required.**

Claims that do not meet the federal requirements will be rejected for resubmission with the requested data elements.

FIELD	INSTRUCTIONS
1	Title: Medicare, Medicaid, Tricare, Champva, Group Health Plan, FECA, Black Lung, Other: Indicate the type of health insurance coverage applicable to this claim by placing an X in the appropriate box. Only one box can be marked.
837P	Loop 2000B, 2320 Item or data element number and name: SUBR05 insurance type code Length insurance type code: 3AN Repeatable: Once per claim. Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
1a	Title: Insured's ID Number: The Member to payer to which claim is being submitted.
837P	Item or data element number and name: NM 108 Identification Code Qualifier NM 109 Identification Number Length identification Number: 80 Repeatable: Once per claim. Refer to: http://www.x12.org for details and requirements for submission of 837P. P= Professional.
2	Title: Patient's name: Enter the patient's full last name, first name, and middle initial. The patient's name is the name of the person who received the treatment or supplies. You should enter the information as it appears on the Member's card.
837P	Loop (2000B, 2000C) Item or data element number and name: NM 101 =QC Patient NM 102= 2 person (entity type qualifier) Patient Last Name: NM 103 Patient First Name: NM 104 Patient Middle Name NM 105

	Patient Name Suffix NM 107 Refer to: http://www.x12.org for details and requirements for submission of 837P. P= Professional.
3	Title: Patient's Birth Date, Sex Enter the patient's 8-digit birth date (MM | DD | CCYY). Enter an X in the correct box to indicate sex of the patient. The "Patient's Birth Date, Sex" (gender) is information that identifies the patient, and it distinguishes persons with similar names.
837P	Loop 2010CA Item or data element number: DMG01=D8 DMG02 PATIENT'S DATE OF BIRTH DMG03 PATIENT'S GENDER Length qualifier: 2AN Length date of birthday: 8N Format birthdate: CCYYMMDD Length patient sex: 1 AN Repeatable: Once per claim Valid entries for Patient sex are: M - Male F - Female U- Unknown Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
4	Title: Insured's Name: Enter the Member's full last name, first name, and middle initial. The "Member Name" identifies the person who holds the policy. If there is a primary insured to the First Medical, indicate the name of the primary insurer.
837P	Loop 2000B,2000C Item or data element Number and name: Member name NM 101=IL insured or member NM 102= 1 person Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
5	Title: Patient's Address (multiple fields) Enter the patient's mailing address and telephone number. The first line is for the street address; the second line, the city and state; the third line, the ZIP code and phone number. Do not use punctuation (e.g., commas, periods) or other symbols in the address. When entering a 9-digit ZIP code, include the hyphen.
837P	Loop 2010CA

	Item or data element number and name: Patient Address N301: Address line 1 N302: Address line 2 N401: City N402: State N403: Zip Code Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
6	Title: Patient Relationship to Insured: This field contains the code that indicates the relationship of the patient to the insured individual identified in item 4. Enter an X in the correct box to indicate the patient's relationship with the Member when Item Number 4 is completed. Only one box can be marked.
837P	Loop 2000BA, 2000c Item or data element number and name: SBR02 OR PAT01 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
7	Title: Insured's Address (multiple fields) SITUATIONAL FIELD, REQUIRED IF APPLICABLE. Enter the Member's address and telephone number. If Item Number 4 is completed, then this field should be completed. The first line is for the street address; the second line, the city and state; the third line, the ZIP code and phone number.
837P	Loop 2000B, 2000C Item or data element number and name: Patient's/ Member's Address N301: Address line 1 N302: Address line 2 N401: City N402: State N403: Zip Code Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
8	Title: Reserved for NUCC Use.
9	Title: Other Insured's Name: SITUATIONAL FIELD, REQUIRED IF APPLICABLE FIELD.

	If Item Number 11d is marked, complete fields 9, 9a and 9d, otherwise leave blank. When additional group health coverage exists, enter other Member's full last name, first name, and middle initial of the Member in another health plan if it is different from that shown in Item Number 2. Use commas to separate the last name, first name, and middle initial. The "Other Insured's Name" indicates that there is a holder of another policy that may cover the patient.
837P	Loop 2000B, 2000C Item or data element number and name: Member Name NM101: IL= Insured or member NM102: 1 person NM103: Insured's Last Name NM104: Insured's First Name NM105: Insured's Middle Name NM107: Insured's Suffix Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
9a	Title: Other Member Policy or Group Number- SITUATIONAL FIELD, REQUIRED IF APPLICABLE. The "Other Beneficiary Policy or Group Number" identifies the policy or group number for coverage of the Beneficiary as indicated in Item Number 9.
837P	Loop 2320 Item or data element number and name: SBR03 – Member group or policy number Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
9b	Reserved for NUCC Use.
9c	Reserved for NUCC Use.
837P	This field does not exist in 5010A1 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
9d	Title: Insurance Plan Name or Program-SITUATIONAL FIELD, REQUIRED IF APPLICABLE FIELD.

	This field identifies the name of the name of the plan or program of the other insured as indicated in item Number 9
837P	Loop 2010BB, 2330B Item or data element number and name: Payer Name Current Payer: NM101:PR NM 102=2 NM 103 = Payer Name Payer ID qualifier: NM108 Payer ID: NM 109 Payer secondary ID qualifier: REF01 Payer secondary ID: REF02 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
10a-10c	Title: Is Patient's Condition Related to: Employment, Auto Accident, or Other Accident-SITUATIONAL FIELD, REQUIRED IF APPLICABLE First Medical does not duplicate coverage provided by other third-party healthcare insurance. When a Member has coverage, other than with First Medical, which requires or permits coordination of benefits from a third-party payer, First Medical will process the claim according with applicable laws and regulations and in accordance with the terms of its health benefits contracts. Providers must submit the data related to other insurance in the correspondent fields of the CMS 1500 or 837P transaction. When appropriate, enter an X in the correct box to indicate whether one or more of the services described in item Number 24 are for a condition or injury occurred on the job, or because of an automobile or other accident. The state postal code where the accident occurred must be reported, if "YES" is marked in 10b for "Auto Accident." Any item marked "YES" indicates there may be other applicable insurance coverage that would be primary, such as automobile liability insurance. Primary insurance information must then be shown in Item Number 11.
837P	Loop 2000B, 2300 Item or data element number and name CLM11 Related causes information SBR01, SBR05, SBR09 Member Information Date of Accident Qualifier: DTP01=439 Date of Accident format: DTP02=D8 Date of Accident: DTP03

	State where auto accident Occurred: CLM11 Payer responsibility sequence number: SBR01 Insurance Type Code: SBR05 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
10d	Claim Codes- This is a variable field that may be used to report condition codes. Only those codes designated by NUCC are used. This is a SITUATIONAL FIELD, REQUIRED IF APPLICABLE. Coding structure: Valid codes for CMS 1500 and 837P: Condition Codes Related to Abortions: AA: Abortion performed due to rape AB: Abortion performed due to incest AC: Abortion performed due to serious fetal genetic defect, deformity, or abnormality AD: Abortion performed due to a life endangering physical condition AE: Abortion performed due to physical health of mother that is not life endangering AF: Abortion performed due to emotional/psychological health of the mother AG: Abortion performed due to social or economic reasons AH: Elective abortion Al: Sterilization Condition Codes for Workers Compensation Claims: W2: Duplicate or original bill W3: Level 1 appeal W4: Level 2 appeal W5: Level 3 appeal Note: Do not use Condition Codes when submitting a revised or corrected bill. Please refer to NUCC Website: http://www.nucc.org/index.php?option=com_content&view=article&id=20&Itemid=118 with the permission of the National Uniform Billing Committee (NUBC)]
837P	Loop 2300 Item or data element number and name: (Qualifier) • HI01-1: BG • HI01-2: Condition Code Refer to: http://www.x12.org for details and requirements for submission of 837P.

	P= Professional.
11	Title: Insured's Policy, Group, or FECA number - SITUATIONAL FIELD, REQUIRED IF APPLICABLE. Enter the Member policy or group number as it appears on the Member health care identification card. If Item Number 4 is completed, then this field must be completed. Do not use a hyphen or space as a separator within the policy or group number. For Workers Compensation and Other Property & Casualty Claims: First Medical does not duplicate coverage provided by other third-party healthcare insurance. When a Member has coverage, other than with First Medical, which requires or permits coordination of benefits from a third-party payer, First Medical will process the claim according with applicable laws and regulations and in accordance with the terms of its health benefits contracts. Providers must submit the data related to other insurance in the correspondent fields of the CMS 1500 or 837P transaction. Enter Workers' Compensation or Property & Casualty Claim Number assigned by the payer.
837P	Loop 2000B, 2320 Item or data element number and name: SBR03 Member Group or Policy Number Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
11a	Title: Insured's Date of Birth, Sex This field contains the birth date and gender of the insured as indicated in item 1a. Enter the 8-digit date of birth (MM | DD | YYYY) of the Member and an X to indicate the sex of the Member. Only one box can be marked. If gender is unknown, leave blank.
837P	Loop 2010BA, 2010CA Item or data element number and name: DMG01 - Date format DMG02 - Member Birth date DMG03 - Gender Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
11b	Title: Other Claim ID (Designated by NUCC) SITUATIONAL FIELD, REQUIRED IF APPLICABLE

	When submitting to Property and Casualty payers, for example Automobile, Homeowners, or Workers' Compensation insurers and related entities, the following qualifier and accompanying identifier has been designated for use: Y4 Agency Claim Number (Property Casualty Claim Number)
837P	Loop 2010BA Qualifier: REF01 - Reference ID qualifier Other Claim ID: REF02 - Property Casualty Claim Number Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
11c	Title: Insurance Plan Name or Program Name- SITUATIONAL FIELD, REQUIRED IF APPLICABLE Enter the name of the "Insurance Plan or Program Name" of the Member. Some payers require an identification number of the primary insurer rather than the name in this field.
837P	Loop 2000B, 2320 Item or data element number and name SBR04: Group Name Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
11d	Title: Is there another Health Benefit Plan? SITUATIONAL FIELD, REQUIRED IF APPLICABLE When appropriate, enter an X in the correct box. If marked "YES", complete 9, 9a, and 9d. Only one box can be marked. "Is there another health benefit plan" indicates that the patient has insurance coverage other than the plan indicated in item Number 1.
837P	This field does not exist on 5010A1 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
12	Title: Patient's or Authorized Person's Signature – Enter "Signature on File," "SOF," or legal signature. When legal signature, enter date signed in 6-digit format (MMDDYY) or 8-digit format (MMDDCCYY). The "Patient's or Authorized Person's Signature" indicates there is an authorization on file for the release of any medical or other information necessary to process and/or adjudicate the claim.

837P	Loop 2300 Item or data element number and name: CLM09 Release of information Code Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
13	Titled: Insured's or Authorized Person's Signature Payment Authorization This field indicates there is a signature on the file authorizing payment of medical benefits. Enter "Signature on File," "SOF," or legal signature.
837P	Loop 2300 Item or data element number and name: CLM08 Benefits assignment certification indicator. Refer to: http://www.x12.org for details and requirements for submission of 837 P= Professional.
14	Title: Date of Current Illness, Injury, Pregnancy (LMP- Last menstrual period)- SITUATIONAL FIELD, REQUIRED IF APPLICABLE Enter the 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431: Onset of Current Symptoms or illness 484: Last Menstrual Period Enter the qualifier to the right of the vertical, dotted line.
837P	Loop 2300 Item or data elements number and name: Claim dates Date: DTP03 Date Qualifier: DTP01 - Date/time qualifier. Format Qualifier: DTP02 D8 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
15	Title: Other date- SITUATIONAL FIELD, REQUIRED IF APPLICABLE Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit format (MM | DD | YY) or 8-digit format (MM | DD | CCYY). Enter the applicable qualifier to identify which date is being reported

	454: Initial Treatment 304: Latest Visit or Consultation 453: Acute Manifestation of a Chronic Condition 439: Accident 455: Last X-ray 471: Prescription 090: Report Start (Assumed Care Date) 091: Report End (Relinquished Care Date) 444: First Visit or Consultation
837P	Loop 2300, 2400 Item or data element number and name: other Claim dates Qualifier: DTP01 Date/time qualifier Format Qualifier: DTP02 D8 Date: DTP03 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
16	Title: Dates Patient Unable to Work in Current Occupation - SITUATIONAL FIELD, REQUIRED IF APPLICABLE FIELD, REQUIRED IF APPLICABLE If the patient is employed and is unable to work in current occupation, a 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) date must be shown for the "from–to" dates that the patient is unable to work. An entry in this field may indicate employment-related insurance coverage
837P	Loop 2300 Item or data element number and name: Disability dates Date qualifier: DTP01 Format qualifier: DTP02 Actual dates: DTP03 837P version 5010 Enter the applicable qualifier in DTP 01 to identify which disability date(s) is being reported. Coding Structure: 314: Disability (use code 314 when both disabilities start, and end dates are being reported. 360: Initial Disability Period Start (use code 360 if the patient is currently disabled and the disability end date is unknown). 361: Initial Disability Period end (use code 361 if the patient is no longer disabled and the disability start date is unknown).

	837P, version 5010. Enter the applicable qualifier in DTP02 to identify which date format is being reported. Coding structure: D8: Date expressed in format CCYYMMDD RD8: Range of dates expressed in format CCYYMMDDCCYYMMDD Use code RD8 when DTP01 is 314. Use code D8 when DTP01 is 360 or 361 Enter the actual date(s) that corresponds to the qualifier in DTP01. Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
17	Title: Name of Referring Provider or Other Source Enter the name (First Name, Middle Initial, and Last Name) and credentials of the professional who referred, ordered, or supervised the service(s) or supply(ies) on the claim. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider Do not use periods or commas within the name. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported. Enter one of the following qualifiers to the left of the vertical, dotted line: DN: Referring Provider, DK: Ordering Provider, DQ: Supervising Provider
837P	Loop 2310D, 2420E, 2420F Item or data element number and name: other supervising/rendering/referring provider name and ID Physician Qualifier: NM101 Entity Type Qualifier: NM102 Physician Last Name: NM103 Physician First Name: NM104 Physician Middle Name: NM105 Physician Name Suffix: NM107 Provider Primary ID Qualifier: NM108 Provider NPI: NM109 Secondary ID Qualifier: REF01 Secondary ID Number: REF02 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
17a	Title: Other ID# SITUATIONAL FIELD, REQUIRED IF APPLICABLE

	The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. The NUCC defines the following qualifiers used in 5010A1: 0B: State License Number 1G: Provider UPIN Number G2: Provider Commercial Number LU: Location Number (This qualifier is used for Supervising Provider only)
837P	Loop 2310D, 2420E, 2420F Item or data element number and name: Another rendering/referring provider name & ID Provider primary ID qualifier: NM108 Provider NPI: NM 109 Provider secondary qualifier: REF01 Provider other ID number: REF02 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
17b	Title: NPI # Enter the NPI number of the referring, ordering, or supervising provider.
837P	Loop 2310D, 2420E,2420F Provider NPI: NM109 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
18	Title: Hospitalization Dates Related to Current Services - SITUATIONAL FIELD, REQUIRED IF APPLICABLE Enter the inpatient 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave discharge date blank. This date is when a medical service is furnished because of, or subsequent to, a related hospitalization.
837P	Loop 2300 Item or data element number and name: Hospitalization dates related to current services Date qualifier: DTP01

	Date format qualifier: DTP02 Actual dates: DTP03 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
19	Title: Additional Claim Information – SITUATIONAL FIELD, REQUIRED IF APPLICABLE First Medical Health Plan –First Medical has determined to use this field for the provider to report the REFERRAL NUMBER.
837P	Loop 2300 Item or data element number and name: Paperwork-claim supplemental information Attachment type: PWK01 Transmission Code: PWK02 Identification Qualifier: PWK 05 Attachment control number: PWK06 For the Claim Information (NTE), the following are the qualifiers in 5010A1. Enter the qualifier "NTE" followed by the appropriate qualifier, then the information. Do not enter spaces between the qualifier and the first word of the information. After the qualifier, use spaces to separate any words. ADD: Additional Information CER: Certification Narrative DCP: Goals, Rehabilitation Potential, or Discharge Plans DGN: Diagnosis description TPO: Third Party Organization Notes Example: NTEADD Surgery was unusually long due to scarring. Please refer to: NUCC 1500 HEALTH INSURANCE CLAIM FORM, REFERENCE INSTRUCTION MANUAL FOR FORM VERSION 02/12 July 2018 or most current version of the manual – Item number 19. Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
20	Title: Outside Lab? Charges? SITUATIONAL FIELD, REQUIRED IF APPLICABLE Complete this field when billing for purchased services by entering an X in "YES." A "YES" mark indicates that the reported service was provided by an entity other than the billing provider (for example, services subject to Medicare's anti-markup rule). A "NO" mark or blank indicates that no purchased services are included on the claim.

	If "Yes" is annotated, enter the purchase price under "Charges" and complete Item Number 32. Each purchased service must be reported on a separate claim form as only one charge can be entered. When entering the charge amount, enter the amount in the field to the left of the vertical line. Enter number right justified to the left of the vertical line. Enter 00 for cents if the amount is a whole number. Do not use dollar signs, commas, or a decimal point when reporting amounts. Negative dollar amounts are not allowed. Leave the right-hand field blank.
837P	Loop 2400, 2420B Item or data element number and name: PS1 Purchased service information Outside Lab?: PS101 Qualifier $Charge: PS102 Purchased service amount Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
21	Title: Diagnosis or Nature of Illness or Injury This field contains the International Classification of Disease (ICD) Indicator, which identifies the version of the ICD code set being reported. In Puerto Rico, for services rendered prior to 10-1-2015, the provider used 9 for ICD-9-CM. All services render on 10/1/2015 and thereafter, the provider must indicate a 0 for ICD-10-CM. Enter the diagnosis code left justified on each line to identify the patient's diagnosis or condition. Do not include the decimal point, because it is implied. List no more than 12 ICD-10-CM diagnosis Codes. The maximum length of characters is 7. The provider must use the greatest level of specificity. Do not provide narrative description in this field. Do not repeat diagnosis codes. The diagnosis or nature of illness or injury is the sign, symptom, complaint, or condition of the patient relating to the service(s) on the claim. At least one (1) principal diagnosis must be reported on this field on item 21. A.
837P	Loop 2300 ICD indicator: HI01-1 Diagnosis Code: H101-2 The diagnosis codes can be repeated up to eleven times (11) in addition to the principal diagnosis.

22	Title: Resubmission and/or Original Reference Number -SITUATIONAL FIELD, REQUIRED IF APPLICABLE List the original reference number (Payer assigned Claim number) for resubmitted claims and/or Adjustments. The claim number will appear on the Explanation of Payment (EOP) or the 835 transactions. In situations where the provider is submitting a replacement of a prior claim and/or Void/Cancel of prior claim, the provider must use the following coding structure: 7 Replacement of prior claim 8 Void/Cancel of prior claim
837P	Loop 2300 Item or data element number and name: CLM05-3 claim frequency code/REF02 Reference number Resubmission Indicator: CLM05-3 Original claim reference qualifier: REF01 Original claim reference number: REF02 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
23	Title: Prior Authorization Number SITUATIONAL FIELD, REQUIRED IF APPLICABLE If service requires an authorization the number must be included with the claim. Enter the prior authorization number assigned by First Medical. The prior authorization number is the payer assigned number authorizing the service.
837P	Loop 2300, 2400 Item or data element number and name: Prior authorization/CLIA mammography cert number Prior authorization number qualifier: REF01 Prior Authorization Number: REF02 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
24	Title: Supplemental Information – SHADOW FIELD across the top of each service line (1-6)

	On the 1500 form contains supplemental information that relates to the line immediately beneath the shaded area. Supplemental information can only be entered with a corresponding, completed service line. The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and another/proprietary identifier and to accommodate the submission of supplemental information to support the billed service. The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service. Providers are required by CMS to report NDC whenever drugs or biologicals are administered. This information must be reported on the shaded area of the CMS 1500.
837P	For the submission of supplemental information on the 5010 electronic transactions: Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
24a	Title: Date (s) of Service (lines 1-6) Enter date(s) of service, both the "From" and "To" dates. If there is only one date of service, enter that date under "From" and also on the "To" field.
837P	Loop 2300,2400 Item or data element number and name: Service date Date qualifier: DTP01 Date format qualifier: DTP02 Date of Service "from date": DTP03 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
24b	Title: Place of Service (lines 1-6) In 24B, enter the appropriate two-digit Place of Service Code for each item used or service performed. The Place of Service Codes are available at: Centers for Medicare and Medicaid Service site. Refer to: www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html
837P	Loop 2300,2400 Item or data element number and name: Place of Service Qualifier claim place of service: CLM05-2 Claim place of service: CLM05-1

	Service line place of service: SV105 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
24c	Title: EMG – Emergency Indicator -SITUATIONAL FIELD, REQUIRED IF APPLICABLE This field is required when the service is the result of an emergency.
837P	Loop 2400 Item or data element number and name: Emergency Indicator Emergency: SV109 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
24d	Title: Procedures, Services, or Supplies Enter the CPT or HCPCS code(s) and applicable modifier(s) from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four two-character modifiers. The specific procedure code(s) must be shown without a narrative description. The provider must submit valid codes for the date of service, in order for the payer to process the claim. NCCI rules, MUE edits, and other regulatory validation are applied to procedure codes, services, or supplies.
837P	Loop 2400 Item or data element number and name: SV101 Composite professional Service Identifier Product or service qualifier: SV101-1 CPT/HCPCS code: SV101-2 Modifiers: SV101-3 thru SV101-6 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
24e	Title: Diagnosis Pointer (lines 1-6) In 24E, enter the diagnosis code reference number (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple diagnoses are related to one service, the reference number for the primary diagnosis should be listed first, other applicable diagnosis reference numbers should follow. The reference number(s) should be A- L. Enter letters left justified in the field. Do not use commas between the letters.

837P	Loop 2400 Item or data element number and name: SV107 Composite diagnosis code pointer Diagnosis Pointer: SV107-1 thru SV107-4 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
24f	Title: Charges (lines 1-6) Enter the charge amount for each listed service. Enter the number right justified in the left-hand area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in right hand area of the field if the amount is a whole number. Charges are the total billed amount for each service line.
837P	Loop 2400 Item or data element number and name: Line-item charge amount Charges: SV102 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
24g	Title: Days or Units (lines 1-6) Enter the number of days or units. This field is most used for multiple visits, units of supplies, or oxygen volume. If only one service is performed, the numeral 1 must be entered. Enter numbers right justified in the field. No leading zeros are required. NOTE: Please refer to NCCI MUE Edits.
837P	Loop 2400 Item or data element number and name: Unit or basis for measurement code and quantity. Unit or basis for measure: SV103 Unit amount: SV104 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
24h	Title: EPSDT/Family Plan (lines 1-6) SITUATIONAL FIELD, REQUIRED IF APPLICABLE For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows:

	If there is no requirement (for example, state requirement) to report a reason code for EPDST, enter Y for "YES" or N for "NO" only.
837P	Item or data element number and name: • CRC EPSDT Referral • CRC EPSDT Indicator • SV Family Planning Indicator • Referral Code Qualifier: CRC01 • Certification condition code applies indicator: CRC02 • Condition Code: CRC03-CRC05 • EPSDT Response: SV111 • Family Planning response: SV112 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
24i	Title: ID Qualifier SITUATIONAL FIELD, REQUIRED IF APPLICABLE Enter in the shaded area of 24I the qualifier identifying if the number is a non-NPI. The Other ID# of the rendering provider is reported in 24 in the shaded area.
837P	Loop2420A Item or data element number and name: Rendering provider secondary identification NPI: N109, Non-NPI number: REF02
25	Title: Federal Tax ID Number Enter the "Federal Tax ID Number" (employer identification number or Social Security number) of the Billing Provider identified in Item Number 33/33a. This is the tax ID number intended to be used for 1099 reporting purposes. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked. Description: The "Federal Tax ID Number" refers to the unique identifier assigned by a federal or state agency.
837P	Loop 2010AA Item or data element number and name: Billing provider federal tax ID number EIN or SSN: REF01 ID Number: REF02 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
26	Title: Patient's Account No.

	Enter the patient's account number assigned by the provider of service or supplier's accounting system. We encourage providers to comply with the submission of this information on the CMS 1500 claim form as well as electronic transactions. The regulations require that the patient control number be reported on the 835 HIPAA transaction to the provider.
837P	Loop 2300 Item or data element number and name: Patient control number Account Number: CLM01 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
27	Title: Accept Assignment? The Accept Assignment indicates that the provider agrees to accept assignment under the terms of the payer's program. Therefore, all providers must complete this field.
837P	Loop 2400 Item or data element number and name: Assignment or plan participation code Response Yes or No: CLM07 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
28	Title: Total Charge. Enter total charges for the services (i.e., total of all charges in 24F). Enter the number right justified in the dollar area of the field. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.
837P	Item or data element number and name: Total claim charge amount Charge: CLM02 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
29	Title: Amount Paid. Enter total amount the patient and/or other payers paid on the covered services only. Enter number right justified in the dollar area of the field. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.
837P	Loop 2300

	Item or data element number and name: AMT Amount patient paid AMT Coordination of Benefits (COB) payer paid amount Amount qualifier: AMT01 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
30	Title: Reserved for NUCC Use
31	Title: Signature of Physician or Supplier including Degrees or Credentials. Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, "Signature on File," or "SOF." Enter either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD |CCYY), or alphanumeric date (for example, July 1, 2019) when the form was signed.
837P	Loop 2400 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
32	Title: Service Facility Location Information Enter the name, address, city, state, and zip code of the location where the services were rendered and identifies the site where service(s) were provided. Providers of service (namely Physicians) must identify the supplier's name, physical address, zip code, and NPI number when billing for purchased diagnostic tests. When more than one supplier is used, a separate 1500 Claim Form should be used to bill for each supplier. Enter the name and physical address information in the following format: 1st Line – Name 2nd Line – Physical Address 3rd Line – City State and ZIP Code
837P	Loop 2310C, 2420 For instructions on completing this field please refer to: http://www.x12.org for details and requirements for submission of 837P. P= Professional.
32 a	Title: NPI# Enter the NPI number of the service facility location in 32a.
837P	Billing Provider NPI: NM109 Refer to: http://www.x12.org for details and requirements for submission of 837P

	P= Professional.
32b	Title: Service Other ID SITUATIONAL FIELD, REQUIRED IF APPLICABLE Enter the two-digit qualifier identifying the non-NPI number
837P	Service Other ID - REF 02 REFER TO: http://www.x12.org for details and requirements for submission of 837P P= Professional
33	Title: Billing Provider Info & PH# This field identifies the provider that is requesting to be paid for the services rendered. Enter the provider or supplier's billing name, physical address, zip code, and telephone number. Enter the name and physical address in the following format: 1st Line- Name 2nd Line- Physical Address 3rd Line- City, State and ZIP Code
837P	Loop 2010AA, 2010BB Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
33a	Title: NPI # - Enter the NPI number of the billing provider in 33a. The NPI number refers to the HIPAA National Provider Identifier number.
837P	Billing Provider NPI: NM109 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.
33b	Title: Other ID# SITUATIONAL FIELD, REQUIRED IF APPLICABLE Enter the NON- NPI number of the billing provider indicated on item 33a.
837P	Billing Provider Other ID: REF02 Refer to: http://www.x12.org for details and requirements for submission of 837P P= Professional.

Note: All CMS FORMS MUST BE LEGIBLE AND CONTAIN ALL REQUIRED FIELDS.

6.1.6 UB-04 CMS-1450- FIELD SPECIFIC INSTRUCTIONS

Reference: OPTUM 360- UNIFORM BILLING EDITOR (The ultimate guide to accurate facility claims submission)

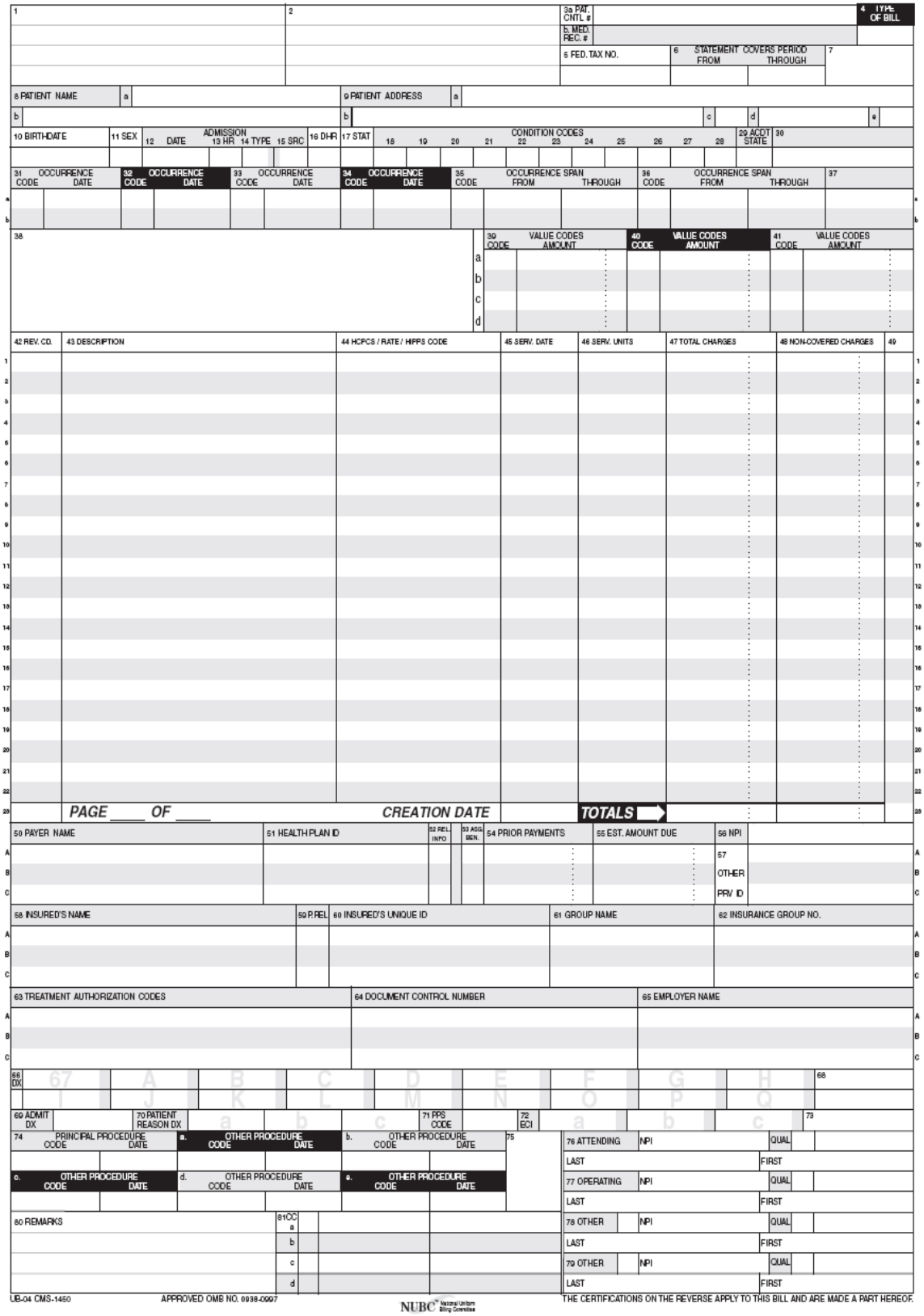
The CMS-1450- (UB-04) is used for the submission of institutional services such as:

- Hospital Inpatient Services
- Hospital Outpatient Services
- Home Health Services
- Skilled Nursing Services
- Ambulatory Surgical Centers among others

The National Uniform Billing Committee (NUBC, nubc.org) was appointed by HIPAA as Designated Standards Maintenance Organization (DSMO) for the Uniform Bill. The NUBC is responsible for the maintenance of the Official UB-04 Data Specifications Manual.

The Uniform Billing was developed with the purpose of assisting the Providers on preparing a clean, accurate, and complete claim. Please refer to the next page for UB-O4 Field Description.

6.1.7 UB-04 FIELDS DESCRIPTION



UB-04 (CMS-1450) FIELD SPECIFIC INSTRUCTIONS	
FIELD	**INSTRUCTIONS**
FL 1	Billing Provider Name, Address and Telephone Number REQUIRED – The Billing Provider Address field requires a physical location address. A postal address (P.O. Box) cannot be reported as a billing provider either. Claims submitted with other than a physical address will be returned to the provider as unclean claims.
FL-2	Billing Provider's Designated Pay-to-Name, Address, and Secondary SITUATIONALFIELD, REQUIRED IF APPLICABLE- It should be completed if the Provider designated to receive the payment is different than the Provider specified on FL 1.
FL-3[a]	Patient Control Number REQUIRED-- The patient's unique alphanumeric number assigned by the Provider to facilitate retrieval of individual financial records and posting of payments. Patient control enables providers to reconcile payments against the account receivable for the patient. Payers are required to return the patient control number on the payment check, remittance advice, voucher or 835 Transaction. Claims not submitted with the patient control number will be returned to the provider as unclean claims.
FL-3b	Medical/Health Record Number REQUIRED –This field contains the number assigned by the provider to the patient's Medical or health record. The purpose of the medical record is to provide an audit trail of the patient's treatment history. Claims not submitted with the Medical/Health Record Number will be returned to provider as unclean claims.
FL-4	Type of Bill (TOB) REQUIRED – The TOB provides specific information about the bill for billing purposes. Only on UB-04 there is a leading 0 which precedes the facility code number. The second digit of the four-digit number identifies the type of facility, the third digit classifies the type of care being bill (bill classification), and the fourth digit indicates the sequence of the bill for a specific episode

	of care. Claims not submitted with the correspondent Type of Bill will be returned to provider as unclean claims. Code Structure: First Digit- - Leading Zero (only used on UB-04 paper claim) Second Digit - Type of facility Third Digit - Bill Classification Fourth Digit - Bill Frequency Codes are available from the NUBC (National Uniform Billing Committee) at www.nucc.org via the NUBC's Official UB-04 Data.
FL- 5	*Federal Tax Number:* REQUIRED- The format is XX-XXXXXXX.
FL-6	*Statement Covers Period From/Through*: REQUIRED- This field is used for reporting the beginning and ending dates of service for the entire period reflected on the bill.
FL-7	Reserved by the NUBC
FL-8	Patient's Name/Identifier: REQUIRED- The patient's last name, middle initial is reported in FL8b. Form Locator 8a contains the patient identifier as assigned by the payer.
FL-9	Patient's Address: REQUIRED- This field contains the full mailing address of the patient. Enter the complete mailing address including the street number and name or post office box or RFD: city name, state name, and zip code.
FL-10	Patient's Birth Date: REQUIRED- This field contains the patient's date of birth.
FL-11	Patient's Sex: REQUIRED- This field contains the sex of the patient as recorded at the date of admission, outpatient service or at the start of care.
FL-12	Admission/Start of Care Date: REQUIRED- The Admission or Start of Care Date field contains the start date for this episode of care. It is the date of admission for inpatient care. For home health claims, it is the date that the episode of care began.
FL-13	Admission Hour

	REQUIRED- This field contains the hour during which the patient was admitted for inpatient care. The hour is entered in military time using two numeric characters.
FL-14	Priority (Type) of Admission/Visit REQUIRED- This field contains a code that indicates the priority of the admission/visit. Code Structure: 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma 6-8 Reserved for Assignment by the NUBC 9 Information Not Available
FL-15	Point of Origin for Admission or Visit REQUIRED- This field contains a code that identifies the point of patient origin for this admission or visit. This field locator is required on all TOB's except 014X. Code Structure: 1 Non-healthcare Facility Point of Origin 2 Clinic or Physician's Office 3 Reserved for assignment by the NUBC 4 Transfer form a Hospital (Different facility) 5 Transfer from a Skilled Nursing Facility, ICF, Assisted Living Facility (ALF), or other Nursing Facility (NF) 6 Transfer from another Healthcare Facility 7 Reserved for Assignment by the NUBC 8 Court/La Enforcement 9 Information not Available A-C Reserved for assignment by the NUBC D Transfer from another Distinct Unit of the Hospital to Another Distinct Unit of the same Hospital resulting in a separate claim to the Payer E Transfer from Ambulatory Surgery Center

	F Transfer from Hospice Facility G-Z Reserved for Assignment by the NUBC Coding structure for Newborn: 5 Born inside this hospital 6 Born outside of this hospital 7-9 Reserved for Assignment by the NUBC
FL-16	Discharge Hour SITUATIONAL FIELD REQUIRED IF APPLICABLE- This field contains the hour during which the patient was discharged from inpatient care. This field is REQUIRED for inpatient services.
FL-17	Patient Discharge Status REQUIRED- This field contains a code indicating the patient's disposition or discharge status at the ending date of service for the period of care on the Claim Form Locator 6. This field is required for all claims.
FL-18 through FL-28	Condition Codes SITUATIONAL FIELD REQUIRED IF APPLICABLE BUT REQUIRED if any condition code is applicable to a claim. These fields contain codes identifying conditions that may affect payer processing of this bill.
FL-29	Accident State SITUATIONAL FIELD REQUIRED IF APPLICABLE- This field contains the two-character abbreviation of the state where the accident occurred. This information is required when the claim is related to an auto accident.
FL-30	Reserved for assignment by the NUBC
FL-31 through FL-34	Occurrence Codes and Dates SITUATIONAL FIELD REQUIRED IF APPLICABLE- The occurrence code and associated date fields define a significant event relating to this bill that may affect payer processing. These fields are required if any occurrence code is applicable to a Claim. Report in alphanumeric sequence. Report occurrence codes in the following order: 31ª, 32ª, 33ª, 34ª, 31b, 32b, 33b, and 34b.

	If additional codes need to be reported and there are no occurrence span codes to report, then the additional codes may be reported in 35ª, 36ª, 35b, 36b, with the date in the "from" date.
FL-35 through FL-36	Occurrence Span Codes and Dates SITUATIONAL FIELD REQUIRED IF APPLICABLE - Occurrence span codes and dates identify an event that relates to payment of the claim. These codes identify occurrences that happened over a span of time. Report the code, the beginning (from) date and the ending (through) date associated with the reported occurrence span code.
FL-37	Reserved for assignment by the NUBC
FL-38	Responsible Party Name and Address REQUIRED FIELD - The name and address of the party responsible for the bill are entered in this field.
FL-39 through FL-41	Value Codes and Amounts SITUATIONAL FIELD REQUIRED IF APPLICABLE - These fields contain codes, and the related dollar amounts or values that identify data elements that are necessary to process this claim as qualified by the payer organization. These fields are required if any value span code is applicable to a claim. Each code must be accompanied by an amount. Report codes in alphanumeric sequence.
FL-42	Revenue Code REQUIRED- use this field to report the appropriate numeric code corresponding to each narrative description or standard abbreviation that identifies a specific accommodation, and/or ancillary services. There are 22 lines available on a single UB-04 claim form to list revenue codes and charges. The revenue code must be valid for the type of claim being billed. HCPCS procedure codes must be billed on outpatient claims when required for specific revenue codes. Also, you should refer to your contracted fee schedule attachments with First Medical to report the corresponding revenue codes contracted with your facility.
FL-43	Revenue Descriptions

	REQUIRED- This field contains a narrative description or standard abbreviation for each revenue code.
FL-44	HCPCS/CPT/RATES/HIPPS Codes SITUATIONAL, REQUIRED IF APPLICABLE- The provider must submit the corresponding RATE, HCPCS, CPT, or HIPPS codes that are associated to the Revenue Code on FL-42. HCPCS procedure codes must be billed on outpatient claims when required for specific revenue codes. For inpatient, the provider must submit the daily accommodation rate on the corresponding revenue codes.
FL-45	Service Date/Assessment Date REQUIRED - This field contains the date in which the indicated service was provided.
FL-46	Units of Service REQUIRED -This field contains a quantitative measure of services rendered, by revenue, category, to or for the patient, including items such as the number of accommodation days, visits, and miles, pints of blood, units, or treatments. Zero or negative values are not allowed for inpatient or outpatient claims.
FL- 47	Total Charges REQUIRED - This field contains the total charges pertaining to the related revenue code for the current billing period as entered in the Statement Covers Period field (FL-6).
FL-48	Non-covered Charges SITUATIONAL FIELD REQUIRED IF APPLICABLE- this field contains the total non-covered charges for the destination payer pertaining to a revenue code.
FL-49	Reserved This field is reserved for Assignment by the NUBC.
FL-50 (A-C)	Payer Name REQUIRED- This field contains the name of the health plan from which the provider might expect some payment for the bill. (Primary Payer, Secondary Payer. Tertiary Payer)
FL-51	Payer ID Health Plan ID

	REQUIRED- Report the HIPAA National Plan Identifier when it is mandated for use. First Medical has determined that until this field becomes HIPAA Mandatory the provider must leave this field blank for UB-04 paper claims.
FL-52 (A-C)	Release of Information Certification Indicator REQUIRED- This field indicates whether the provider has on file a signed statement from the patient or the patient's legal representative permitting the provider to release data to other organization to adjudicate the claim. This indicator applies to the payers listed in FL 50 on lines A, B and C. The provider must indicate a Y (yes) in this field. A "Y" indicates that the provider has a signed statement permitting release of medical billing data related to a claim.
FL-53 A, B and C	Assignment of Benefits Certification Indicator REQUIRED FIELD - This field shows whether the provider has a signed form authorizing the third-party insurer to pay the provider directly for the services. This indicator applies to the payers listed in FL-50 lines A, B, and C. This field is related to the fact that the provider accepts assignment and/or has a participation agreement with the destination Payer.
FL-54 (A-C)	Prior Payments -Payers SITUATIONAL FIELD, REQUIRED IF APPLICABLE- The amount in this field represents the amount the hospital has received to date toward payment of this bill for the payer indicated in FL-50 on lines A, B, and C.
FL-55 A, B and C	Estimated amount Due-Payer SITUATIONAL FIELD, REQUIRED IF APPLICABLE- The amount in this field represents an estimate by the hospital of the amount due from the indicated payer in FL-50 on lines A, B, and C.
FL-56	National Provider Identifier-Billing Provider (NPI) REQUIRED- This field contains the unique identification number assigned to the provider submitting the bill.
FL-57	Other (Billing) Provider Identifier SITUATIONAL FIELD, REQUIRED IF APPLICABLE FIELD, REQUIRED IF APPLICABLE

FL-58 (A-C)	Insured's Name REQUIRED FIELD. This field contains the name of the patient or insured individual in whose name the insurance is issued as qualified by the payer organization listed in FL-50 on lines A, B, and C.
FL-59 (A-C)	Patient's relationship to Insured REQUIRED- This field contains the code that indicates the relationship of the patient to the Insured individuals identified in FL-58 on lines (A-C.)
FL-60 A, B and C	Member's Unique Identifier REQUIRED- This field contains the insured's unique identification number assigned by the payer organization.
FL-61 (A-C)	Insured Group Name SITUATIONAL FIELD REQUIRED IF APPLICABLE -This field contains the identification number, the control number or the code that is assigned by the insurance company or claims administrator to identify the group under which the individual is covered.
FL-62 A, B and C	Insurance Group Number SITUATIONAL FIELD REQUIRED IF APPLICABLE- This field contains the identification number, the control number or the code that is assigned by the insurance company or claims administrator to identify the group under which the individual is covered. Required, if the Member's identification card shows a group number.
FL- 63	Authorization Code/Referral Number SITUATIONAL FIELD REQUIRED IF APPLICABLE -This field is an identifier that designates that the services on this bill have been authorized by the payer or indicates that a referral is involved. The provider must complete the field when applicable (when an authorization or referral number is assigned by the payer). For inpatient services, a contracted provider billing an 837 electronic transaction must indicate the authorization number. 837I, version 5010: Enter one of the following in REF01: • 9F Referral Number • G1 Prior Authorization number

	Enter the correspondent number in REF02. For paper claims submit the authorization code as follows: UB-04 LINE A= AUTHORIZATION CODE UB-04 LINE B= REFERRAL NUMBER UB-04 LINE C= SECONDARY PAYER AUTHORIZATION CODE Provider must ensure that the authorization code and referral number are indicated on the correct field as instructed above. Failure to do so might result on a denial due to lack of authorization and/or referral number.
FL- 64	Document Control Number (DCN) SITUATIONAL FIELD REQUIRED IF APPLICABLE- This is the internal control number (ICN) or document control number (DCN) assigned to the original bill by the health plan. This number appears on the Explanation of Payment to the provider (EOP-paper /835-electronic-refer to ICN #).
FL- 65	Employer Name (of the Insured) SITUATIONAL FIELD REQUIRED IF APPLICABLE -This field contains the name of the employer that provides (or may provide) health care coverage for the insured individual identified in FL-58 (A-C). Applies when there is a WC (Workers Compensation) or an EGHP (Employer Group Health Plan). The provider enters the name of the employer that provides the health coverage for the individual identified on the same lines in FL-58. This information is required when the payer is either primary or secondary and Medicare is the secondary or tertiary insurer.
FL-66	Diagnosis and Procedure Code Qualifier (ICD version) REQUIRED- This code identifies the version of the International Classification of Diseases (ICD) being reported. Code Structure: 9-Ninth Edition (ICD-9-CM) 10-Tenth Edition – (ICD-10-CM) for service dates of 10/1/2015 and after.
FL-67	Principal Diagnosis Code: REQUIRED - This field contains the full ICD-10-CM diagnosis code, including the fourth and fifth digits, which describes the principal diagnosis

<table>
<tr><td></td><td>(the condition established after study, to be chiefly responsible for causing the hospitalization or use of other hospital services). All diagnosis codes must be a valid code for the date of service.
To prevent claim errors, ICD-10-CM codes should be used at the highest level of specificity. You are required to assign the most precise ICD-10-CM code that most fully explains the narrative description in the chart of symptoms or diagnoses. Vague or nonspecific diagnosis codes may cause your claim to edit for medical necessity. Also, claims submitted with three- or four-digit codes, where four- or five- digit codes are available, will be rejected.</td></tr>
<tr><td></td><td>All Principal, external cause of injury and other diagnosis codes must include Present on Admission (POA) indicator.
CMS- POA Indicator Options and Definitions
The POA indicator is used to denote not only conditions known at the time of admission, but also those conditions that were clearly present, but not diagnosed until after the admission took place.
<table>
<tr><th>Code</th><th>Reason for Code</th></tr>
<tr><td>Y</td><td>Diagnosis was present at time of inpatient admission.</td></tr>
<tr><td>N</td><td>Diagnosis was not present at time of inpatient admission.</td></tr>
<tr><td>U</td><td>Documentation insufficient to determine if the condition was present at the time of inpatient admission.</td></tr>
<tr><td>W</td><td>Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.</td></tr>
</table>

Note: Please refer to Centers for Medicare and Medicaid Services for a complete list of diagnosis excluded from (HAC- Hospital Acquired Conditions): www.cms.gov/Medicare/Coding/ICD10/Downloads/2018-ICD-10-CM-Coding-Guidelines.pdf</td></tr>
<tr><td>FL-67A through FL-67Q</td><td>Other Diagnosis Codes
REQUIRED - This field contains the full ICD-10-CM diagnosis codes corresponding to all conditions that coexist at the time of admission, which develop subsequently, or that affect the treatment received and/or the</td></tr>
</table>

	length of stay. Diagnoses that relate to an earlier episode, which have no bearing on the current hospital stay, should be excluded. This is a required field when there are conditions that result as secondary diagnosis. Note: Present on Admission Indicator (POA) must be reported on all secondary (other) diagnosis field. (Position-8 of the ICD-10 FIELD). The present on admission indicator (POA) applies to diagnosis codes (i.e., principal, secondary and E codes) for inpatient claims to general acute-care hospitals or other facilities as required by law or regulation for public health reporting. It is the eighth (8) digit related to the corresponding diagnosis code. Any hospital that is currently contracted under FHMP is required to submit the POA indicator. As a rule, all hospital inpatient admission to general acute care hospitals must report the POA indicator on their claims. Additional information related to POA guidelines can be obtained from ICD-10-CM Official Guidelines for Coding and Reporting that are available in the Centers for Medicare and Medicaid Services site at: http://www.cms.gov
FL-68	Reserved- This field is reserved for Assignment by the NUBC.
FL-69	Admitting Diagnosis REQUIRED- This field is for reporting the complete ICD-10-CM code describing the patient's diagnosis at the time of admission, including fourth and fifth digits when appropriate. Also, is a required field for inpatient admission claims and encounters, and Part B only claims (TOB's 012X, and 022X in FL 4). POA indicator must be reported with the admitting diagnosis code. Enter the patient's admitting diagnosis using a complete and accurate ICD-10-CM code. The ICD-10-CM admitting diagnosis code describes a significant finding presenting patient distress, an abnormal finding on an examination, a possible diagnosis base on significant findings, a diagnosis established from a previous encounter or admission, an injury, a poisoning, or a reason or condition (not an illness or injury) such as follow-up or pregnancy in labor.
FL-70 A-C	Patient's reason for visit

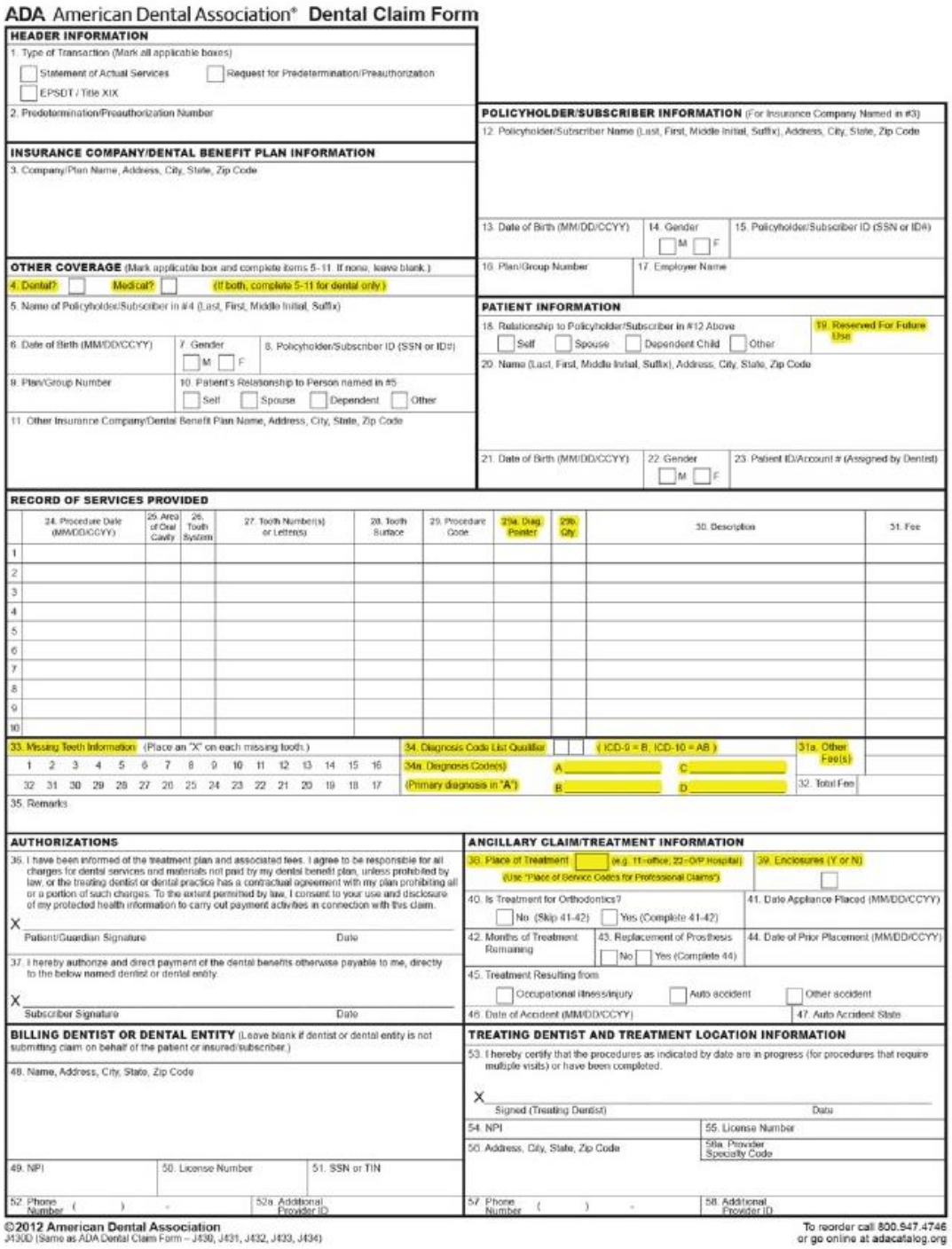
	SITUATIONAL FIELD REQUIRED IF APPLICABLE- This field is for reporting the complete ICD-10-CM code describing the patient's reason for the visit at the time of admission or outpatient registration. Patient's Reason for Visit is required for all unscheduled outpatient visits. The patient reason for visit code is required on claims for TOB 013x and 085X when the priority (type) of visit (FL 14) IS 1, 2, or 5 and one of the following revenue codes is present: 045X, 0516, 0526, 0762.
FL-71	Prospective Payment System (PPS) code Not used at this moment. First Medical will notify providers when this field should be completed on the future.
FL-72 (A-C)	External Cause of Injury (ECI Code) SITUATIONAL FIELD REQUIRED IF APPLICABLE- This field contains up to three full ICD-10-CM codes, including all digits if applicable, pertaining to the external cause of injury, poisoning, or adverse effect. Health Care facilities are encouraged to report an E code whenever there is a diagnosis of an injury, poisoning, or other adverse effect. The Coding guidelines for prioritizing the assignment of an ECI code are as follows: • Principal diagnosis of an injury or poisoning • Other diagnosis of an injury, poisoning, or adverse effect directly related to the principal diagnosis. Other diagnosis with an external cause
FL-73	Reserved for NUBC Assignment
FL-74	Principal Procedure Code and Date SITUATIONAL FIELD REQUIRED IF APPLICABLE- This field contains the ICD-10 PCS code for the inpatient principal procedure performed at the claim level during the period covered by this bill and the corresponding date on which the principal procedure was performed. HIPAA code set requirements do not allow the use of ICD-10-PCS procedure codes on outpatient claims. Report the ICD-10-PCS procedure code only for inpatient claims.
74 (A-E)	Other Procedure Codes and Dates SITUATIONAL FIELD REQUIRED IF APPLICABLE- This field allows reporting of up to five ICD-10-CM codes to identify the significant

	procedures performed during the billing period, other than the principal procedure, and the corresponding dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis. HIPAA code set requirements do not allow the use of ICD-10- PCS procedure codes on outpatient claims. Completion of this field is required for inpatient claims only. Enter the full ICD-10-PCS code, including the seventh digit, if applicable and the dates for as many as six surgical procedures
FL- 75	Reserved for assignment by the NUBC
FL-76	Attending Provider Name and Identifiers (including NPI) REQUIRED- This field identifies the name and identifying number of the attending provider. The attending provider is the individual who has overall responsibility for the patient's medical care and treatment. Provider NPI must be reported, Last and First Name.
FL-77	Operating Physician Name and Identifiers SITUATIONAL FIELD REQUIRED IF APPLICABLE - This field identifies the name and identification number of the individual with the primary responsibility for performing the surgical procedure(s).
FL-78 and 79	Other Provider Names and Identifiers SITUATIONAL FIELD REQUIRED IF APPLICABLE- These fields contain the name and identification number of the provider that corresponds to the indicated provider type on this claim.
FL-80	Remarks SITUATIONAL FIELD REQUIRED IF APPLICABLE- This field is used to capture additional information necessary to adjudicate. Provide any additional information that is necessary to adjudicate the claim or otherwise fulfill the payer's reporting requirements. Enter any information that is not reported elsewhere on the bill but that may be necessary for reimbursement.
FL-81	Code-Code field

	SITUATIONAL FIELD REQUIRED IF APPLICABLE- This field is used to report overflow or additional codes related to field locators or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

6.1.8 AMERICAN DENTAL ASSOCIATION (ADA-2012)

The ADA Dental Claim Form has been revised to incorporate key changes to the HIPAA standard.



ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A B C D
31a. Other Fee(s)
32. Total Fee
35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
X _____ Patient/Guardian Signature _____ Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
X _____ Subscriber Signature _____ Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=OP Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
49. NPI | 50. License Number | 51. SSN or TIN
52. Phone Number ( ) - | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X _____ Signed (Treating Dentist) _____ Date
54. NPI | 55. License Number
56. Address, City, State, Zip Code | 56a. Provider Specialty Code
57. Phone Number ( ) - | 58. Additional Provider ID

6.1.9 ADA-DATA ELEMENT SPECIFIC INSTRUCTIONS

HEADER INFORMATION	
FIELD	**INSTRUCTIONS**
1.	Type of Transaction: There are three boxes that may apply to this submission. If services have been performed, mark the "Statement of Actual Services" box. If there are no dates of service, mark the box marked "Request for Predetermination/ Preauthorization". If the claim is through the Early and Periodic Screening, Diagnosis and Treatment Program, mark the box marked 'EPSDT/Title XIX'.
2.	Predetermination/Preauthorization Number: If you are submitting a claim for a procedure that has been preauthorized by a third-party payer, enter the preauthorization or predetermination number provided by the insurance company.
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	
FIELD	**INSTRUCTION**
3.	Company/Plan Name, Address, City, State, and Zip Code: This Item is always completed. Enter the information for the insurance company or dental benefit plan that is the third-party payer receiving the claim. • If the patient is covered by more than one plan, enter the primary insurance company information here for the initial claim submission. When submitting a separate claim to the secondary carrier, place the secondary carrier's company/plan name and address information here.
Other Coverage This area of the claim form provides information on the existence of additional dental or medical insurance policies. This is necessary to determine if multiple coverages are in effect, and the possibility of coordination of benefits.	
FIELD	**INSTRUCTION**
4.	Other Dental or Medical Coverage: Mark the box after "Dental?" or "Medical?" whenever a patient has coverage under any other dental or medical plan, without regard to whether the dentist or the patient

	will be submitting a claim to collect benefits under the other coverage. • Leave blank when the dentist is not aware of any other coverage(s). • When either box is marked, complete Items 5 through 11 in the "Other Coverage" section for the applicable benefit plan. • If both Dental and Medical are marked, enter information about the dental benefit plan in Items 5 through 11.
5.	Name of Policyholder/ Member with Other Coverage Indicated in #4 (Last, First, Middle Initial, Suffix): If the patient has other coverage through a spouse, domestic partner or, if a child, through both parents, the name of the person who has the other coverage is reported here.
6.	Date of Birth (MM/DD/CCYY): Enter the date of birth of the person listed in Item #5. The date must be entered with two digits each for the month and day, and four digits for the year of birth.
7.	Gender: Mark the gender of the person who is listed in Item #5. Mark "M" for Male or "F" for Female as applicable.
8.	Policyholder/ Member Identifier (SSN or ID#): Enter the social security number or the identifier number of the person who is listed in Item #5. The identifier number is a number assigned by the payer/insurance company to this individual.
9.	Plan/Group Number: Enter the group plan or policy number of the person identified in Item #5.
10.	Patient's Relationship to Person Named in Item #5: Mark the patient's relationship to the other Member named in Item #5.
11.	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, and Zip Code: Enter the complete information of the additional payer, benefit plan or entity for the Member named in Item #5.
Policyholder/ Member Information (For Insurance Company Named in Item #3) This section documents information about the Member who may or may not be the patient.	

• When the claim form is being prepared for submission to the primary carrier the information supplied applies to the Member by the primary carrier. • When the claim form is being prepared for submission to the secondary carrier the information entered applies to the Member by the secondary carrier.	
FIELD	**INSTRUCTION**
12.	Policyholder/ Member Name (Last, First, Middle Initial, Suffix), Address, City, State, and Zip Code: Enter the complete name, address, and zip code of the policyholder/ Member with coverage from the company/plan named in #3.
13.	Date of Birth (MM/DD/CCYY): A total of eight digits are required in this field; two for the month, two for the day of the month, and four for the year.
14.	Gender: This applies to the primary Member, who may or may not be the patient. Mark “M” for male or “F” for female.
15.	Policyholder/ Member Identifier (SSN or ID#): Enter the unique identifying number assigned by the insurance company to the person named in Item #12, which is on their identification card.
16.	Plan/Group Number: Enter the policyholder/ Member’s group plan/policy number.
17.	Employer Name: If applicable, enter the name of the policyholder/ member’s employer.
Patient Information The information in this section of the claim form pertains to the patient.	
FIELD	**INSTRUCTION**
18.	Relationship to Policyholder/ Member in #12 Above: Mark the relationship of the patient to the person identified in Item #12 who has the primary insurance coverage. The relationship between the Member and the patient may affect the patient’s eligibility or benefits available. If the patient is also the primary Member’s, mark the box titled ‘Self’ and skip to item #23.
19.	Reserved for Future Use: Leave blank and skip to Item #20. (#19 was previously used to report “Student Status.”)

20.	Name (Last, First, Middle Initial, Suffix), Address, City, State, and Zip Code: Enter the complete name, address, and zip code of the patient.
21.	Date of Birth (MM/DD/CCYY): A total of eight digits are required in this field; two for the month, two for the day of the month, and four for the year of birth of the patient.
22.	Gender: This applies to the patient. Mark "M" for male or "F" for female.
23.	Patient ID/Account # (Assigned by Dentist): Enter if the dentist's office has assigned a number to identify the patient. This is not required to process claim; however, this information might serve to identify the records for reconciliation of payment purposes.
FIELD	**INSTRUCTION**
24.	Procedure Date (MM/DD/CCYY): Enter procedure date for actual services performed. The date must have two digits for the month, two for the day, and four for the year.
25.	Area of Oral Cavity: The use of this field is conditional. Always report the area of the oral cavity when the procedure reported in Item #29 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature. The Area of the oral cavity is designated by a two-digit code.
26.	Tooth System: Enter "JP" when designating teeth using the ADA's Universal/National Tooth Designation System (1-32 for permanent dentition and A-T for primary dentition).
27.	Tooth Number(s) or Letter(s): Enter the appropriate tooth number or letter when the procedure directly involves a tooth or range of teeth. Otherwise, leave blank. If the same procedure is performed on more than a single tooth on the same date of service, report each procedure and tooth involved on separate lines on the claim form. When a procedure involves a range of teeth, the range is reported in this field. This is done either with a hyphen "-" to separate the first and last tooth in the range (for

	example, 1-4; 7-10; 22-27), or using commas to separate individual tooth numbers or ranges (for example, 1, 2, 4, 7-10; 3-5, 22-27). Supernumerary teeth in the permanent dentition are identified in the ADA's Universal/ National Tooth Designation System ("JP") by the numbers 51 through 82, beginning with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar (for example, supernumerary number 51 is adjacent to the upper right molar number 1; supernumerary number 82 is adjacent to the lower right third molar number 32). Supernumerary teeth in the primary dentition are identified by the placement of the letter "S" following the letter identifying the adjacent primary tooth (for example, supernumerary "AS" is adjacent to "A"; supernumerary "TS" is adjacent to "T").
28.	Tooth Surface: This Item is necessary when the procedure performed by tooth involves one or more tooth surfaces. Otherwise leave blank.
29.	Procedure Code: Enter the appropriate procedure code found in the version of the Code on Dental Procedures and Nomenclature in effect on the "Procedure Date" (Item #24).
29a.	Diagnosis Code Pointer: Enter the letter(s) from Item 34 that identifies the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first.
29b.	Quantity: Enter the number of times (01-99) the procedure identified in Item 29 is delivered to the patient on the date of service shown in Item 24. The default value is "01."
30.	Description: Provide a brief description of the service provided (for example, abbreviation of the procedure code's nomenclature).
31.	Fee: Report the dentist's full fee for the procedure. Resolution 44-2009 Statement on Reporting Fees on Dental Claims adopted by the ADA House of Delegates, which provides guidance on the appropriate entry for this item.

31a.	Other Fee(s): When other charges applicable to dental services provided must be reported, enter the amount here. Charges may include state tax and other charges imposed by regulatory bodies.
32.	Total Fee: The sum of all fees from lines in Item #31, plus any fee(s) entered in Item #31a.
33.	Missing Teeth Information: Mark an "X" on the number of the missing tooth – for identifying missing permanent dentition only. Report missing teeth when pertinent to Periodontal, Prosthodontics (fixed and removable), or Implant Services procedures on a claim.
34.	Diagnosis Code List Qualifier: Enter the appropriate code to identify the diagnosis code source: B = ICD-9-CM AB = ICD-10-CM (as of October 1, 2015)
34a.	Diagnosis Code(s): Enter up to four applicable diagnosis codes after each letter (A. – D.). The primary diagnosis code is entered adjacent to the letter "A."
35.	Remarks: This space may be used to convey additional information for a procedure code that requires a report, or for multiple supernumerary teeth. It can also be used to convey additional information you believe is necessary for the payer to process the claim (for example, for a secondary claim, the amount the primary carrier paid). Remarks should be concise and pertinent to the claim submission. Claimants should note that an entry in "Remarks" might prompt review by a person as part of claim adjudication, which may affect the overall time required to process the claims.
Authorizations This section provides consent for treatment as well as permission for the payer to send any patient benefit available for procedures performed directly to the dentist or the dental business entity.	
FIELD	**INSTRUCTION**
36.	Patient Consent: The patient is defined as an individual who has established a professional relationship with the dentist for the delivery of dental health care. For matters relating to communication of information and consent, the term includes the patient's parent,

	caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case. By signing (or "Signature on File" notice) in this location of the claim form, the patient or patient's representative has agreed that he/she has been informed of the treatment plan, the costs of treatment and the release of any information necessary to carry out payment activities related to the claim. Claim forms prepared by the dentist's practice management software may insert "Signature on File" when applicable in this Item.
37.	Authorize Direct Payment: The signature and date (or "Signature on File" notice) are required when the Policyholder/ Member named in Item #12 wishes to have benefits paid directly to the dentist/provider. This is an authorization of payment. It does not create a contractual relationship between the dentist or dental entity and the insurance company. Claim forms prepared by the dentist's practice management software may insert "Signature on File" when applicable in this Item.
Ancillary Claim/Treatment Information	
FIELD	**INSTRUCTION**
38.	Place of Treatment: Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard. Frequently used codes are: 11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 =Skilled Nursing Facility; 32 = Nursing Facility
39.	Number of Enclosures (00 to 99): Enter a "Y" or "N" to indicate whether there are enclosures of any type included with the claim submission (for example, X-rays, oral images, models).
40.	Is Treatment for Orthodontics: If no, skip to Item #43. If yes, answer Items 41 and 42.
41.	Date Appliance Placed (MM/DD/CCYY): Indicate the date an orthodontic appliance was placed. This information should also be reported in this section for subsequent orthodontic visits.
42.	Months of Treatment: Enter the total number of months required to complete the orthodontic treatment. (Note**:** This is the total number

	of months from the beginning to the end of the treatment plan. Some versions of the paper claim form incorrectly include the word "Remaining" at the end of this data elements name).
43.	Replacement of Prosthesis: This Item applies to Crowns and all Fixed or Removable Prostheses (for example, bridges and dentures). Please review the following three situations to determine how to complete this Item. a) If the claim does not involve a prosthetic restoration mark "NO" and proceed to Item 45. b) If the claim is for the initial placement of a crown, or a fixed or removable prosthesis, mark "NO" and proceed to Item 45. If the patient previously had these teeth replaced by a crown, or a fixed or removable prosthesis, or the claim is to replace an existing crown, mark the "YES" field and complete section 44.
44.	Date of Prior Placement (MM/DD/CCYY): Complete if the answer to Item #43 was "YES."
45.	Treatment resulting from: If the dental treatment listed on the claim was provided because of an accident or injury, mark the appropriate box in this item, and proceed to Items #46 and #47. If the services you are providing are not the result of an accident, this Item does not apply; skip to Item #48.
46.	Date of Accident (MM/DD/CCYY): Enter the date on which the accident noted in Item #45 occurred. Otherwise, leave blank.
47.	Auto Accident State: Enter the state in which the auto accident noted in Item #45 occurred. Otherwise, leave blank.
Billing Dentist or Dental Entity The 'Billing Dentist' or 'Dental Entity' section provides information on the individual dentist's name, the name of the practitioner providing care within the scope of their state licensure, or the name of the group practice/corporation that is responsible for billing and other pertinent information. Depending on the business relationship of the practice and the treating dentist, the information provided in this section may not be the treating dentist. If the patient is submitting the claim directly, do not complete Items 48-52A.	
FIELD	**INSTRUCTION**

48.	Name, Address, City, State, and Zip Code: Enter the name and complete address of a dentist or the dental entity (corporation, group, etc.).
49.	NPI (National Provider Identifier): Enter the appropriate NPI type for the billing entity. A Type 2 NPI is entered when the claim is being submitted by an incorporated individual, group practice or similar legally recognized entity. Unincorporated practices may enter the individual practitioners Type 1 NPI.
50.	License Number: If the billing dentist is an individual, enter the dentist's license number. If a billing entity (for example, corporation) is submitting the claim, leave blank.
51.	SSN or TIN: Report the: 1) SSN or TIN if the billing dentist is unincorporated; 2) corporation TIN of the billing dentist or dental entity if the practice is incorporated; or 3) entity TIN when the billing entity is a group practice or clinic.
52.	Phone Number: Enter the business phone number of the billing dentist or dental entity.
52a.	Additional Provider ID: This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI. The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (for example, third-party payer; federal government). Some Legacy IDs have an intrinsic meaning.
Treating Dentist and Treatment Location Information This section must be completed for all claims. Information that is specific to the dentist or practitioner acting within the scope of their state licensure that has provided treatment is entered in this section.	
FIELD	**INSTRUCTION**
53.	Certification: Signature of the treating or rendering dentist and the date the form is signed. This is the dentist who performed, or is in the process of performing, procedures, indicated by date, for the patient. If the claim form is being used to obtain a pre-estimate or

	pre-authorization, it is not necessary for the dentist to sign the form. Claim forms prepared by the dentist's practice management software may insert the treating dentist's printed name in this Item.
54.	NPI (National Provider Identifier): Enter the treating dentist's Type 1- Individual Provider NPI in Item # 54. (See Item #49 for more NPI information.)
55.	License Number: Enter the license number of the treating dentist. This may vary from the billing dentist.
56.	Address, City, State, and Zip Code: Enter the physical location where the treatment was rendered. Must be a street address, not a Post Office Box.
56a.	Provider Specialty Code: Enter the code that indicates the type of dental professional who delivered the treatment.
57.	Phone Number: Enter the business telephone number of the treating dentist.
58.	Additional Provider ID: This is an identifier assigned to the treating dentist other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI. The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (for example, third-party payer; Federal government). Some Legacy IDs have an intrinsic meaning.

6.1.10 ADJUDICATION RULES / REQUIRED DATA ON CLAIMS TRANSACTIONS

First Medical adjudication system processes claims through a series of edits and validations related to accuracy, completeness, providers and diagnosis and procedure codes to ensure the validity of the assigned plan benefits, within the Plan Coverage. The First Medical Claims System includes edits and validations related to eligibility, duplicate claims, referral and authorization requirements, codes and diagnosis validation, provider configuration, timely filing, benefits configuration, adjudication rules, and other type of edits configured to manage the processing of claims. Detailed instructions on filling a claim is included on section 6 of this manual. It is a requirement that the providers comply with the submission of the required data on their claims

transactions, either paper or electronic, in compliance with HIPAA and the Medicare Management Information System requirements.

Key edits as well as key elements to consider when billing a service are included but are not limited to in the following list:

1. Members' eligibility validation
2. Duplicate claims validation
3. Referral Requirements
4. Authorized amount to be paid
5. Approved Units validation
6. Diagnosis effective date validation against service dates
7. Service Code validation
8. Provider Contracting status validation and services contracted
9. Benefits validation (covered services, limitations, etc.)
10. Authorization Requirements Validation
11. Modifiers validation
12. CARC's and RARC's Validation
13. Condition Codes validation
14. Service Area validation
15. Physician Assignment and referral validation
16. Fee assignment according to provider contracting arrangement
17. Sex vs service type validation
18. Age and service type validation according to benefits requirements, if applicable
19. Authorized level of accommodation for inpatient services (Currently-InHealth MSO)
20. Service Date is outside of benefit matrix
21. Provider does not participate in this Health Plan line of business
22. Vendor is terminated on the service date from
23. Benefit type year to date limit exceeded
24. Bundled Services
25. Global Period
26. Mutually Exclusive Procedure
27. Multiple (One) day Visits
28. Invalid Place of Service
29. Multiple and Bilateral Payment

30. Terminated Code
31. Medicare MUE Edits
32. NCCI Edits
33. Primary Diagnosis
34. Coordination of Benefits
35. Laboratory Panels
36. New Patient Visit Validation
37. Add-on Codes
38. Incidental Procedures
39. Separate Procedures
40. POA indicator validation in Inpatient claims
41. ICD-10-code must be coded to the highest specificity
42. Bill type must be a valid code
43. Admission date is required
44. Admission source (Point of Origin) is a required field for inpatient and outpatient services
45. Diagnosis Pointer is required for professional services (CMS-1500/837P)
46. Discharge hour for inpatient claims
47. Ambulance service must include the correspondent pick up/drop off modifier
48. Attending provider is a requirement for inpatient services
49. Patient's reason of visit is required on all unscheduled outpatient visits
50. Billing provider address on UB-04/837I must be a street (physical) address
51. ICD-10-PCS must be reported only on inpatient claims.

6.1.11 TIMELY SUBMISSION OF CLAIMS

Provider shall submit all claims and encounters to First Medical or its designee, as applicable, using the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") compliant 837 electronic formats, or the applicable CMS 1500 and/or UB-04 paper format or their successors. For dental services, claims must be submitted on the applicable ADA J430D- 2012 form or its successor. Claims and encounters will utilize HIPAA compliant code sets for all coded values. Claims shall include the provider's NPI and the valid taxonomy code that most accurately describes the services reported on the claim.

Provider shall, within ninety (90) days after (a) discharge for inpatient services or (b) the date of service for outpatient services, (“claims submission period”), submit a claim and/or encounters to First Medical or its designee along with any applicable authorization/referral documentation or other applicable documentary support, for all services rendered in a manner consistent with the terms of the agreement. First Medical or its designee may, in its sole discretion, deny payment for any claim(s) received after the ninety (90) days mentioned in this section, or the time specified by applicable state law. Provider acknowledges and agrees that at no time shall Members be responsible for any payments to provider except for applicable co-payments and non-covered services provided to such Members. First Medical will process provider claims that are accurate and complete in accordance with First Medical normal claims processing procedures and applicable state and/or federal laws, rules, and regulations with respect to the timeliness of claims processing. Such claims processing procedures and edits may include, without limitation, automated systems applications which identify, analyze, and compare the amounts claimed for payment with the diagnosis codes and which analyze the relationships among the billing codes used to represent the services provided to Members. These automated systems may result in an adjustment of the payment to the provider for the services or in a request, prior to payment, for the submission for review of medical records that relate to the claim. Providers may request reconsideration of any adjustments produced by these automated systems by submitting a timely request for reconsideration to First Medical. A reduction in payment because of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service. In no event may the provider bill a Member for any amount adjusted in payment. Provider shall use best efforts to submit all claims and clinical data to First Medical by electronic means available and accepted as industry standards that are mutually agreeable, and which may include claims clearinghouses or electronic data interface companies used by First Medical. The provider acknowledges that First Medical may market certain products that will require electronic submission of claims and clinical data for the provider to participate. Providers shall notify First Medical when they have completed their transition to electronic medical records and agree to provide information on the status to First Medical upon request. First Medical reserves the right to perform post-payment, electronic claims audits on regular basis as indicated in the provider guidelines.

6.1.12 COORDINATION OF BENEFITS

First Medical does not duplicate coverage provided by other third-party healthcare insurance. When a Member has coverage, other than First Medical, which requires or permits coordination of benefits from a third-party payer, First Medical or its designee will process the claim according to the applicable laws and regulations and in accordance with the terms of its health benefits contracts. When permitted to do so by such laws and regulations and by its health benefits contracts, First Medical or its designee will pay the lesser of the amount due under the Agreement or the amount of the primary payer Members responsibility (deductible, coinsurance, co-payment). It is the responsibility of the provider to make all efforts in the collection of the amount. If you need to contact the Coordination of Benefit Unit (COB) please do not hesitate to contact us at 1-888-318-0274, you can also contact us through the portal at firstmedicalpr.com or you can send us an email to cob_referidos@firstmedicalpr.com

6.1.13 RULES APPLICABLE TO COORDINATION OF BENEFITS UNDER FIRST MEDICAL CLAIMS PAYMENTS

First Medical requires the Provider to comply with the clean claim requirements as defined above. All claims must include acceptable billing and coding requirements including but not limited to, valid ICD-10 codes and CPT/HCPCS codes.

If First Medical fails to meet the time schedule for payment of clean claims, it shall pay to Provider interest from the day after the expiration of said term through the date of issuance of such payment by First Medical (or until the date of receipt of payment by Provider, if the date of receipt of payment is more than three (3) working days after First Medical issuance of payment) at the prevailing interest rate at the time of payment set by the Commissioner of Financial Institutions of Puerto Rico for this purpose.

6.1.14 INDUSTRY STANDARD CODES CLAIMS PROCESSING AND CLAIMS STATUS

First Medical will use Standard Claims Adjustment Reason Codes (CARCS) and Standard Remittance Advice Remark Codes (RARCs) as mandated by Federal Regulations. These codes describe the reason of the action taken on a claim line, or entire claim during the adjudication process. This allows the Provider to review the payment or denial of a service for the required corrective action, if needed.

6.1.15 ELECTRONIC DATA INTERCHANGE (EDI)

First Medical will accept electronic claims in the Standard ANSI X12 HIPAA transactions. First Medical accepts electronics claims (837P, 837I and 837D) from all active Clearinghouses in Puerto Rico, therefore Providers should coordinate with their respective contracted Clearinghouse to submit electronic claims to First Medical.

Contracted Providers could also submit electronic claims directly to First Medical but before submitting them, the Provider must complete the configuration process. We encourage Providers to submit their claims electronically for a more efficient and effective payment process. If the provider changes clearinghouse, it must be notified by writing to First Medical thus the ERA (Electronic Remittance or 835) is routed to the new clearinghouse. Otherwise, the ERA report (835) will be sent to the registered clearinghouse in our system.

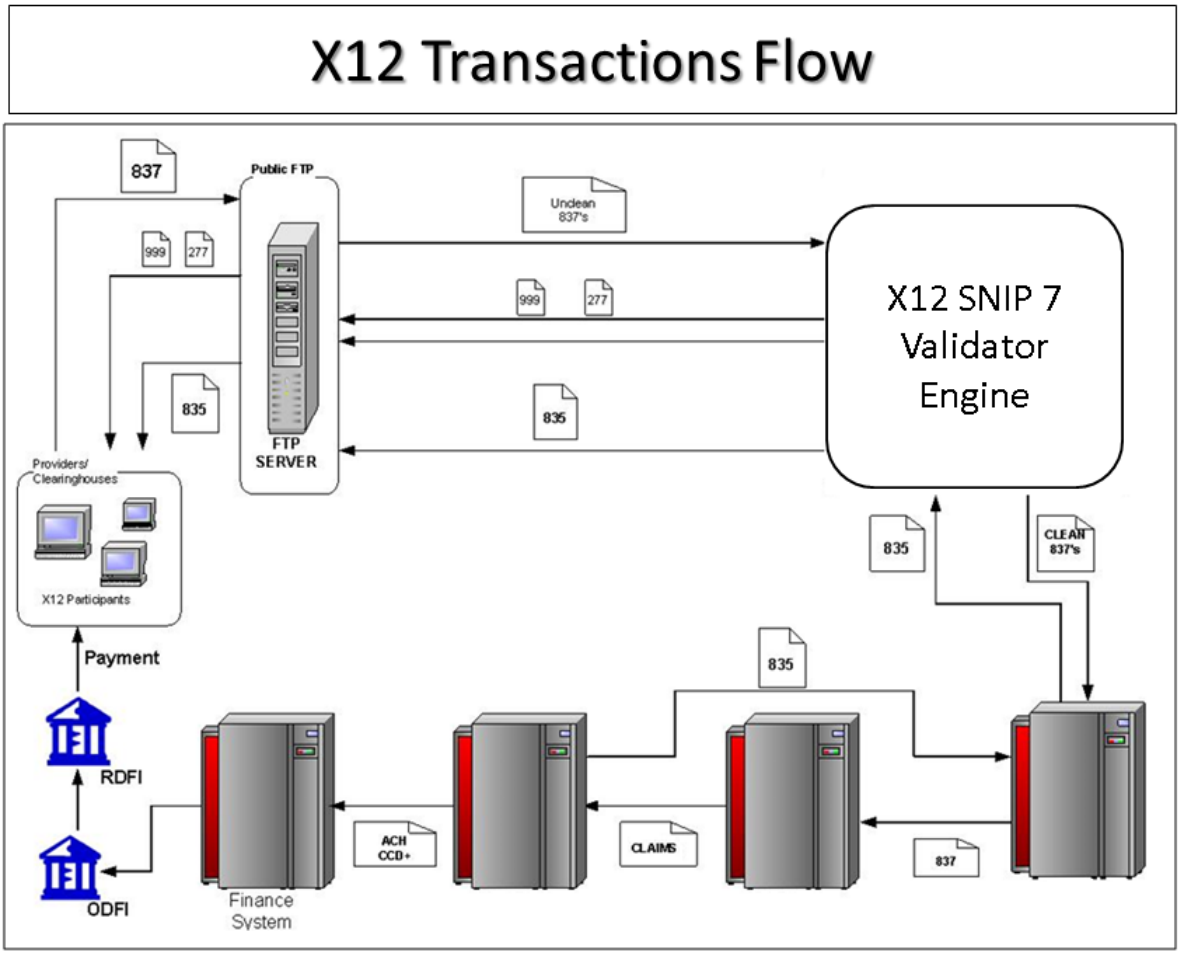
First Medical also offers Electronic Fund Transfer for the providers that request this service. The form to request this service can be downloaded from this web site:

http://www.intermedpr.com/wp-content/uploads/2014/06/2-Electronic-Fund-Transfer-Authorization-Agreement-Form-word-version-10-6.pdf

6.1.16 ANSI X12 AND HIPAA COMPLIANCE CHECKING, AND BUSINESS EDITS

First Medical returns a 999 Functional Acknowledgment to the submitter for every inbound 837 transaction received. Each transaction passes through edits to ensure that it is X12 compliant. If it successfully passes X12 syntax edits, a 999 Functional Acknowledgement is returned indicating acceptance of the transaction.

If the transaction fails X12 syntax compliance, the 999 Functional Acknowledgement will also report the Level 1 errors in the AK segments and, depending on where the error occurred, will indicate that the entire interchange, functional group, or transaction set has been rejected.



6.1.17 INTERCHANGE CONTROL STRUCTURES

Typically, the term "interchange" connotes the ISA/IEA envelope that is transmitted between trading/business partners. Interchange control is achieved through several "control" components. The interchange control number is contained in data element ISA13 of the ISA segment. The identical control number must also occur in data element 02 of the IEA segment. Acknowledgment can be requested through data element ISA14. The interchange acknowledgment is the TA1 segment. Data element ISA15, Test Indicator, is used between trading partners to indicate that the transmission is in a "test" or "production" mode. Data element ISA16, Sub-element Separator, is used by the translator for interpretation of composite data elements. First Medical generates a TA1 transaction when a file is completely rejected.

6.1.18 CLAIMS STATUS REPORT (277 CA TRANSACTION)

First Medical returns a Claim Status Report (277CA - Unsolicited) for each received file detailing the acceptance or rejection of each claim within the transaction. This report is sent to the transmitter of the X12 file. For example, if First Medical receives a file from a Clearinghouse, the claim status report is sent to the Clearinghouse. It is the Provider's responsibility to request that report from its Clearinghouse. In the Claim Status Report the claim status category code A1 means claim acceptance and A3 means claim rejection by First Medical. Usually, the claim status category code is followed by the claim status code that describes the error. These codes are standardized through the industry and your system should interpret them. A complete list of the claim status codes as well as Claim Adjustment Reason Codes (CARC), and Remittance Advice Remark Codes (RARC) can be found at: http://www.wpc-edi.com/reference/.

6.1.19 CLAIMS STATUS REPORT (CAQH CORE 276-277 TRANSACTION)

Transaction 276 allows the provider to request the status of a claim. Transaction 277 will provide the status of claim for a Member in real time.

6.1.20 CLAIMS ELIGIBILITY STATUS (CAQH CORE 270-271 TRANSACTION)

In this option the provider may validate the status of a First Medical Member benefit verification of professional services. Additional information regarding Business Rules and Companion Guides for Electronic Claims Submission is available at our Provider Portal at www.firstmedicalpr.com.

6.2 SUBMITTING A COMPLAINT, GRIEVANCE OR AN APPEAL

To submit a complaint, grievance or an appeal, the Member may visit one our Service Offices, or send a signed written request by mail or fax at:

Information	
In writing to: **First Medical Health Plan, Inc.** **Complaints and Appeals Department** **PO Box 191580** **San Juan, PR 00918-1580**	**Phone: 787-474-3999** **Fax: 787-625-8765**
cumplimiento@firstmedicalpr.com	

The Complaints, Grievances and Appeals Form is available in the First Medical website at: www.firstmedicalpr.com

6.3 DISPUTE PROCESS

The Provider contract describes First Medical internal dispute process, in which contracted Providers have the opportunity to resolve the issues detailed therein. Specifically, a Provider may challenge in writing any notice, payment or claim (denied or paid) by First Medical within twenty (20) days of receipt. In such event, First Medical will review the challenge and will render a final decision with respect thereto within thirty (30) days of receipt thereof.

Notwithstanding the aforementioned, if Provider wishes for any additional information to be considered by First Medical in the Provider Dispute process, it shall include such information in its notice of intent to challenge the First Medical claim, payment or notice. In such case, the thirty (30) day term for First Medical to render a final determination will commence on the date in which all such additional information is received by First Medical, but no later than thirty (30) days after the Provider notice to First Medical of its intent to challenge a claim, payment or notice.

The internal Provider Dispute resolution process shall be handled by a reviewing committee comprised of at least three (3) members designated by First Medical, which shall also be responsible for making any final determinations. If Provider wishes to object to any final determination issued by the reviewing committee, it may do so by filing an objection or requesting an investigation from the Puerto Rico Office of the Commissioner of Insurance, following the procedures and requirements of the Act for Prompt Payment of Health Services Providers' Claims.

- You can submit your request through the Following:

Information	
In writing to: **First Medical Health Plan, Inc.** **Complaints and Appeals Department** **PO Box 191580** **San Juan, PR 00918-1580**	**Phone: 787-474-3999** **Fax: 787-625-8765**
cumplimiento@firstmedicalpr.com	

You will be notified in writing of the results of your dispute. Failure to comply with the above process will result in the dismissal of your dispute. You will receive a letter notifying the reason for the dismissal. If you have any questions or require additional information, please feel free to contact the Providers Call Center.

6.4 CLINICAL APPEALS

GRIEVANCE AND APPEALS PROCESS FOR MEMBERS

1. Review of Grievances Related to an Adverse Determination

Receive from First Medical, upon request and free of charge, access to, and obtain copies thereof, as well as information relevant to the grievance.

(1)(b) Documents, records, or any information will be deemed to be relevant to the filing of the covered person's grievance if:

i. They were used in the determination of benefits;
ii. They were submitted, considered, or generated in relation to the adverse determination, even if the benefit determination did not depend on said documents, records, or other information;
iii. They show that, in making the decision, First Medical, consistently followed the same administrative procedures and safeguards that are followed with other covered persons in similar circumstances; or
iv. They constitute health plan policy statements or guidelines related to the health care service or treatment denied and the diagnosis of the covered person, regardless of whether they were taken into consideration at the time of making the initial adverse determination.

(1) First Medical., will send the covered person or the personal representative a notification of their rights no later than three (3) business days after receiving the notification.

e. The deadline for responding to the grievance will begin upon receipt of the grievance by First Medical, regardless of whether all information necessary to decide is included with the grievance. If the organization believes that the complaint does not contain all the information necessary to decide, it will clearly indicate to the covered person or his/her

personal representative, the reasons why it considers that it cannot process the complaint, indicating the additional documents or information that must be submitted.

f. First Medical, will issue their decision and notify it in writing, or by electronic means if the covered or insured person or, if applicable, the personal representative, has agreed to receive notification by this means, within the deadline set out in subparagraphs (2) or (3).

   i. In cases where the grievance is because of an adverse determination and is related to a **prospective** review (before the service is submitted) the organization will issue its decision in a reasonable time but no later than fifteen (15) days after the grievance is received.

   ii. In cases involving a **retrospective** review (after the service has been provided), the organization will issue a decision in a reasonable time but no later than thirty (30) days after the grievance is received.

g. The determination issued under section F shall express in a manner understandable to the covered person or insured or, if applicable, to his or her personal representative:

   i. The titles and credentials of the persons who participated in the first-tier review process (the reviewers);

   ii. A statement of the reviewers' interpretation of the grievance;

   iii. The decision of the reviewers in clear terms and the contractual basis or medical justification, so that the covered person or the personal representative can respond to the organization's decision;

   iv. Evidence or documentation used as the basis of the decision;

   v. If the decision of the organization is adverse, after a first-tier review, the following shall also be included:

      (a) The specific reasons for the adverse determination;

(b) Reference to the specific provisions of the health plan on which the decision is based;

(c) A statement that mentions the right of the covered person to receive free of charge, at his or her request, reasonable access and copies of all documents, records, and other relevant information;

(d) If the organization made the adverse determination based on an internal rule, guideline, or protocol or other similar criterion, a copy of the specific rule, guideline, or protocol or other similar criterion on which the adverse determination was based will be provided, free of charge, upon request by the covered person or by the personal representative;

(e) If the adverse determination is based on the medical necessity or experimental or investigational nature of the treatment, or a similar exclusion or limitation, a written explanation of the scientific or clinical reasoning followed in making the decision, or a statement that an explanation will be provided to the covered person or his or her personal representative, free of charge, upon request; and

(f) If applicable, the instructions for making a request:

(g) A copy of the rule, guideline, internal protocol, or other similar criterion on which the decision was based. An explanation of the scientific or clinical reasoning followed in making the decision.

vi. If applicable, a statement stating:

(a) A description of the process to obtain an additional voluntary review, if the covered or insured person wishes to request a voluntary review, under Article 22.090;

(b) The written procedures governing the voluntary review, including the deadline required for review;

(c) A description of the procedures to obtain an independent external review, under the provisions of the Chapter on “External Review of Health Insurance Organizations or Insurers” of this Code, if the covered or insured person decides that he or she will not request a voluntary review; and

(d) A notification of the right of the covered or insured person to contact the Office of the Commissioner or the Patient’s Advocate Office to request

assistance at any time, with the telephone number and address of the Office of the Commissioner and the Patient's Advocate Office.

First Medical., and its members may have other options for voluntarily resolving disputes, such as mediation, or arbitration. To determine the available options, members may contact the Commissioner of Insurance. Members have the right to contact the Office of the Commissioner of Insurance or the Patient's Advocate Office at the telephone numbers and addresses provided in the members' contracts.

2. Ordinary Review of Grievances Not Related to an Adverse Determination

Any covered person or personal representative will have the right to submit written documentation for consideration by the Health Services Organization for a regular review. This grievance is presented because of the payment or handling of claims or reimbursement for health care services, matters related to the contractual relationship between the covered person and the health services organization, or the availability, presentation, or quality of the health care services.

The organization will inform the covered person, if applicable, the personal representative, within 3 business days of the grievance's receipt and their rights. In addition, the organization will issue an acknowledgement of receipt classifying the grievance as an ordinary one and stating that it will be evaluated and answered no later than thirty (30) calendar days after the submission of the grievance. This acknowledgement of receipt will inform the covered person, or the personal representative of the name, address, and telephone number of the person assigned by the organization to review the grievance.

The written decision issued will express in a clear manner to the covered person or to the personal representative:

a. The titles and credentials of the persons who participated in the ordinary review process (the reviewers);

b. A statement of the reviewers' interpretation of the grievance; and

c. The decision of the reviewers in clear terms and the contractual basis or medical justification, so that the covered or insured person can respond to the guidelines of the health insurance organization or insurer;

d. Reference to the evidence or documentation used as the basis for the decision;
If applicable, a written statement that includes:

i. A description of the process for obtaining an additional voluntary review, if the covered or insured person wants to request a voluntary review under Article 22.090;

ii. Written procedures governing voluntary review, which includes the deadline required for revision; and

e. A notification of the covered person's or insured person's right to contact the Office of the Commissioner or the Patient's Advocate Office for assistance at any time, through the following telephone number and addresses:

OFFICE OF THE COMMISSIONER OF INSURANCE OF PUERTO RICO
268 Ave. Muñoz Rivera San Juan, PR 00918
Physical Address: World Plaza Building 9th Floor
Mailing Address: PO Box 195415, San Juan, PR 00919-5415
Tel: 787-304-8686
Fax: 787-273-6082

PATIENT'S ADVOCATE OFFICE
Physical Address: 1501 Ave. Ponce de León Mercantil Plaza Building, 9th Floor
Hato Rey, PR 00908
Mailing Address: PO Box 11247 San Juan, PR 00910-2347
Tel: 787-977-0909
Tel: 787-977-0915

3. Expedited Review - Expedited Review of Grievances Related to an Adverse Determination

a. First Medical Health Plan, Inc., will establish in writing the procedures for the expedited review of urgent care requests related to an adverse determination.

b. The procedures will allow the covered or insured person, or their personal representative, to request an expedited review from First Medical Health Plan, Inc., as provided for in this Article, verbally or in writing.

c. First Medical, will designate for the Expedited Review clinical peers of the same specialty or similar specialties like that of the person that would normally handle the case under review. The peers must not have participated in the initial adverse determination.

d. In an expedited review, all the necessary information, including the decision of First Medical, will be shared between First Medical Health Plan, Inc., and the covered or insured person or, if applicable, the personal representative, by telephone, fax, or the most expeditious way available.

e. The decision of the expedited review will be made and notified to the covered or insured person or, if applicable, to the personal representative, per section G, as expeditiously as required for the medical condition of the covered or insured person, but no later than forty-eight (48) hours after the request for an expedited review is received.

f. To calculate the deadlines for the decision to be made and notified under Section E, the deadline will begin on the date on which the request for an Expedited Review is submitted to the First Medical Health Plan, Inc., independently of whether the filing includes all the information required to carry out the decision.

g. The notification of the decision will detail the following, in a clear manner to the covered or insured person or, if applicable, to the personal representative:

i. The titles and credentials of the persons who participated in the expedited review process (the reviewers);

ii. A statement of the reviewers' interpretation of the request for an expedited review;

iii. The decision of the reviewers in clear terms and the contractual basis or medical justification, so that the covered person can respond to First Medical Health Plan, Inc.;

iv. A reference to the evidence or documentation used as the basis for the decision; and

v. If the decision results in an adverse determination, it will provide:

(a) The specific reasons for the adverse determination;

(b) A reference to the specific health plan provisions on which the decision is based;

(c) If First Medical Health Plan, Inc., relied on an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, a copy of the rule, guideline, protocol, or other similar criterion on which the adverse determination was based, will be provided free of charge upon request by the covered or insured person;

(d) If the adverse determination is based on medical necessity or the experimental or investigational nature of the treatment, or a similar exclusion or limitation, a written explanation of the scientific or clinical reasoning followed in making the decision;

(e) If applicable, instructions on how to make a request:

- A copy of the rule, guideline, internal protocol, or other similar criterion on which the adverse determination was based, as provided in subparagraph (v) (c) or

- An explanation of the scientific or clinical reasoning followed in making the decision, as provided in subparagraph (v) (d);

(f) A description of the procedures for obtaining an independent external review under the provisions of the Chapter on “External Review of Health Insurance Organizations or Insurers” of this Code;

(g) A statement indicating the right of the covered or insured person to initiate an action in the appropriate court;

(h) The following statement, emphasizing the voluntary nature of the proceedings: “The health plan and you may have other voluntary dispute resolution options, such as mediation or arbitration. To determine the options available, contact the Commissioner of Insurance”; and

(i) A notification of the covered or insured person’s right to contact the Office of the Commissioner or the Patient’s Advocate Office for assistance at any time, with the telephone number and address of the Office of the Commissioner and the Patient’s Advocate Office. First Medical, may provide the notification required in this article either verbally, in writing, or electronically. If the notification of the adverse determination is provided verbally, First Medical Health Plan, Inc., will provide a written or electronic notification no later than three (3) days after the verbal notification. Nothing here will be construed to limit the right of First Medical Health Plan, Inc., to repeal an adverse determination without observing the procedure prescribed here.

4. Right to Request an Independent External Review

The covered person or subscriber may request an external review of an adverse determination or final adverse determination, according to Article 28.050 of the Health Insurance Code.

6.5 DESIGNATE A REPRESENTATIVE

A Member or someone who he/she appoints or designate as an Authorized Representative may file a complaint, grievance, or appeal**.** In some cases, a Member may already have someone authorized under the HIPAA law to act on their behalf. However, if they do not have someone authorized under the HIPAA law, they can appoint a relative, friend, lawyer, advocate, doctor, or anyone else to act on his/her behalf by completing and returning an Authorization of

Representative form. This form must be signed, dated, and must include the name of the person that the Member is authorizing.

The Authorization of Representative form is available in the First Medical website at: www.firstmedicalpr.com.

7. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

First Medical has a Quality Assessment Performance Improvement Program in compliance with applicable regulations and regulatory agencies. The program's mission is to promote and continuously improve the quality of clinical care (physical and behavioral) and the quality of services offered to Members from health service providers and First Medical.

The members of the First Medical Board of Directors are responsible for the administration of the Program, delegating the responsibility of the implementation to the First Medical Regulatory Affairs Vice President. The Corporate Quality Director is responsible for the daily operations of the Quality Department and the operational components of the First Medical QAPI Program. All First Medical employees are responsible for offering quality service to the Members.

7.1 QUALITY COMMITEES STRUCTURE

The Quality Committee of First Medical is responsible for the development, implementation, and general surveillance of the First Medical's Operational Programs. Oversight areas include the services offered (physical or behavioral health services) and their quality, rights, and responsibilities with the Member, patient safety, medical policies and guidelines, credentialing and recredentialing of any provider, services satisfaction, Members and suppliers, and the quality execution of the operational areas. The Quality Committee of First Medical evaluates the results of quality improvement activities, utilization results, health outcomes and the actions that have been carried out to provide recommendations based on the reports of the various subcommittees and the results of the Quality Work Plans.

7.2 FIRST MEDICAL QAPI MONITORING TOOLS

The First Medical QAPI Monitoring Tools are designed to track the performance of quality measures for Performance Measures and operational functions provided by the Plan.

7.3 CARE GAPS- PREVENTIVE SERVICES

First Medical analyzes quarterly the First Medical members Claims Profile to assess compliance with the following Quality Indicators: breast cancer screening, cervical cancer screening, colorectal cancer screening, diabetes management, access to preventive care visits, asthma management, follow-up after hospitalization for mental health reasons. Educational materials are sent to the enrollees identified in "no compliance with the measure" and/or telephone counseling calls/ educational sessions were performed.

7.4 PROVIDERS AND MEMBER'S SATISFACTION SURVEYS

First Medical identifies quality improvement opportunities through Satisfaction Surveys performed to Members and providers. Satisfaction surveys are conducted to identify areas of opportunity in the services offered to First Medical Members. Also, satisfaction surveys are conducted to contracted providers with the objective of improving communication and satisfaction between the Health Services Organization (First Medical) and the health service provider.

7.5 DELEGATION

First Medical delegates primary activities to contracted entities that comply with the First Medical delegation standards. First Medical performs annual audits and monitoring activities of the delegated entities to ensure compliance with the regulations and First Medical requirements.
First Medical Board of Directors, through the Quality Committee of First Medical, reserves the right to make final decisions on the recommendations with respect to the participation of the delegated entities in the First Medical System.

7.6 QAPI PROGRAM ANNUAL EVALUATION

First Medical conducts an annual evaluation of the QAPI Program that includes the following:

- Performance against goals/benchmark as well as previous performance;
- Achievements and Barriers for the continuous improvement activities;
- Quality Programs and Projects Effectiveness.

Recommendations are established from the results of the annual evaluation to improve the service quality offered to providers and members.

7.7 COMMUNICATION WITH PROVIDERS

Providers need to validate the different communications that First Medical delivers to be aligned and in compliance with its Quality Programs, Projects, Initiatives, and requirements. All the communications are published in IMC's Provider Web Portal at http://portal.intermedpr.com

7.8 PROVIDERS RESPONSIBILITIES IN RELATION TO QUALITY COMPLAINTS PROCEEDINGS

Please be reminded that the provider is responsible for providing all information requested by First Medical in order to conduct any investigation or resolution of a quality of care complaint. This includes providing timely copies of the file or any other information that First Medical request from the provider.

8. CLINICAL PRACTICE GUIDELINES

For your knowledge, annually the Clinical Practice Review Committee approves and adopts CPG's for prevention, diagnostic and management of physical and mental health.

These national and international Guidelines correspond to standards of care and clinical treatments for specific conditions. We encourage you to use these Guidelines, in order to collaborate with the quality and consistency of health care management.

Clinical Practice Guidelines	
Adult, Children and Adolescent Preventive Health	The Guidelines for Clinical Preventive Services from the U.S. Preventive Services Task Force (USPSTF) includes recommendations on screening, counseling, and preventive treatments with clinical considerations for each topic.
Asthma	The Guidelines Implementation Panel (GIP) Report presents recommendations and strategies for overcoming barriers to the acceptance and utilization of the updated National Heart, Lung, and Blood Institute (NHLBI) Clinical Practice Guidelines for asthma.

Attention Deficit Hyperactivity Disorder (ADHD)	The American Academy of Pediatrics provides the ADHD link: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder (ADHD) in children and adolescents.
Autism Spectrum Disorder	The best practices organizations for Autism Spectrum Disorder: National Professional Development Center on Autism Spectrum Disorders (ASD), Frank Porter Graham Child Development Institute of the University of North Carolina at Chapel Hill, which published in 2014 the Evidence-Based Practices for Children, Youth, and Young Adults with Autism Spectrum Disorder. This article provides information focused on Autism Spectrum Disorder interventions and American Academy of Child and Adolescent Psychiatry, which in 2014 published (an article) in their magazine the article: Practice Parameter for the Assessment and Treatment of Children and Adolescents with Autism Spectrum Disorder.
Behavioral Health	American Psychiatric Association (APA) Practice Guidelines. These provide evidence-based on recommendations for the assessment and treatment of psychiatric disorders such as depression, schizophrenia, panic disorder, and others.
Cancer	National Comprehensive Cancer Network (NCCN), which provides multiple Guidelines related to the treatment and management of cancer and its complications.
Chronic Kidney Disease	Guidelines for the Management of Congestive Heart Failure (2013) of the American College of Cardiology and American Heart Association Foundation.
COPD (Chronic Obstructive Pulmonary Disease)	The Global Strategy for the Diagnosis, Management, and Prevention of COPD has developed a report that includes technical discussions and management of COPD, evidence levels and specific citations from the scientific literature.
COVID-19	COVID-19 is a dynamic and changing disease for which there is new information and changes continuously. There are protocols, clinical guidelines, and clinical trials to manage this condition.

Dementia	American Psychiatric Association (APA). Guidelines on the use of: Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia.
Depression	American Psychiatric Association that provides the Practical Guideline for the treatment of patients with Major Depressive Disorder.
Diabetes	Standards of Medical Care from the American Diabetes Association. Consensus Statement by the American Association of Clinical Endocrinologist and the American College of Endocrinology on the Comprehensive Type 2 Diabetes Management Algorithm.
Hemophilia	World Federation of Hemophilia you will find the Guidelines for the Management of Hemophilia.
Hepatitis B	American Association for the Study of Liver Diseases (AASLD) and the European Association for the Study of the Liver (EASL) related to treatment of Chronic Hepatitis B:
Hepatitis C	The AASLD and the Infectious Diseases Society of America (IDSA), in collaboration with the International Antiviral Society-USA (IAS-USA) released Guidelines for the management and treatment of Hepatitis C
HIV/AIDS	Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents.
Hypercholesterolemia	Guidelines from the American College of Cardiology (ACC) and the America Heart Association (AHA). These include information for the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults.
Hypertension	Evidence-Based on Guideline for the Management of High Blood Pressure in Adults based on the report from the Panel Members Appointed to the Eighth Joint National Committee (JNC). Guides published by the American College of Cardiology and the American Heart Association, about Prevention, Detection, Evaluation, and High Blood Pressure Management in adults.
Lithiasis Surgical Management	American Urological Association (AUA) is for the Practice Guideline for the Treatment of Patients with Urinary Lithiasis. (Published 2016).

Malaria	Treatments for Malaria is provided by the Centers for Disease Control and Prevention (CDC), it is a Guide published in 2013 and World Health Organization (WHO) in 2015.
Multiples Sclerosis	Complementary and Alternative Medicine in Multiple Sclerosis Guidelines based on evidence
Nutrition and Promotion of Healthy Eating	United States Department of Agriculture (USDA) and the Center for Nutrition Policy and Promotion (CNPP). These work to improve the health and well-being by promoting dietary guidance that links scientific research to the nutrition needs of consumers.
Obesity	Clinical Preventive Services Guidelines from the U.S. Preventive Services Task Force (USPSTF) related to Obesity in Adults. These include information related to screening and management of obesity in adults, and Obesity Screening in Children and Adolescents Guidelines. These Organizations are still in the process of updating their Guides. European Society of Endocrinology and the Pediatric Endocrine Society, Clinical Practice Guideline on Pediatric Obesity-Assessment, Treatment, and Prevention.
Pain Management	Guidelines related to pain management. The topics covered by these Guidelines are regarding pain management after a surgery, the effectiveness, and risks of long-term opioid treatment for chronic pain, and low back pain management treatment by injection. “CDC Guideline for Prescribing Opioids for Chronic Pain” of March 2016. These Guidelines provide recommendations for Primary Care Physician who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care.
Phenylketonuria	Guidelines for the diagnosis and management of phenylalanine hydroxylase deficiency published by the American College of Medical Genetics and Genomics (ACMG).
Prostate Cancer	Guidelines related to the management of localized prostate cancer and the guidelines for the diagnosis, treatment, and follow up of prostate cancer. From the American Urological Association: AUS/ASTRO/SUO Published: 2022; From ESMO Clinical Practice

	Guidelines for diagnosis, treatment, and follow-up Published: June 25, 2020, Annals of Oncology.
Rheumatoid Arthritis	American College of Rheumatology 2015 Guide for the Rheumatoid Arthritis Treatment.
Skin and Soft Tissue Infections	Practice Guidelines for the Diagnosis and Management of Skin and Soft Tissue Infections, updated in 2014 by the Infectious Diseases Society of America.
Substance Use Disorders	American Psychiatric Association provides the Practical Guide for the Treatment of Patients with Substance Use Disorders.
Suicide	Clinical Guidelines adopted by the U.S. Department of Veterans entitled: "Clinical Practice Guide for the Evaluation and Management of Patients at Risk of Suicide."
Vaccination	Vaccination Guidelines, for all age groups, from the Centers for Disease Control and Prevention (CDC).
Vascular Access for Hemodialysis	Clinical Practice Guidelines of Vascular Access for Hemodialysis and United Kingdom Renal Association Guidelines.

Links to the information provided are available on the First Medical website at www.firstmedicalpr.com.

9. CLINICAL MANAGEMENT

For over forty-seven (47) years, First Medical has dedicated its efforts to improving the quality of life of our plan participants through the planning and implementation of medical services coverage of the highest quality in a cost-effective manner. Because, when our Members are healthy, they can live a better life. Therefore, we have developed these Medical Management Program to provide assistance interpreting certain standards benefit plans and to ensure that our Network Providers meet all relevant requirements mandated by First Medical's Policies and Procedures.

First Medical will pay for services identified as a covered benefit and medically necessary. First Medical has sole discretion to conduct a medical necessity review of all requests for authorization and claims, within the specified time frame. This review may take place prospectively, concurrent, or retrospectively. First Medical will utilize approved and established approved criteria to

determine medical necessity and will not deny or unreasonably delay medically necessary services to First Medical Members.

9.1 PHYSICAL AND MENTAL HEALTH BENEFIT (PLAN BENEFITS)

First Medical offers physical and mental health services to all eligible members. The benefits for mental health are administered by APS Healthcare of Puerto Rico (APS). APS has eighteen (18) facilities distributed throughout the Island to provide quality mental health care services. APS has a service line available 24 hours a day, seven days a week calling 787-641-9133/1-888-318-0274.

Members can receive covered emergency medical care whenever needed. If a member has a medical emergency or needs urgent care, First Medical will not require prior authorization for emergency or urgent care services.

- **Medical Emergency** means a medical condition manifested by acute symptoms of sufficient severity, including severe pain, to which a layperson, reasonably prudent and with average knowledge of health and medicine, may expect that, in the absence of immediate medical attention, the person's health would be placed in serious jeopardy, or result in serious dysfunction of any limb or organ of the body or, with respect to a pregnant woman who is having contractions, who does not have enough time to move her to other facilities prior to delivery, or who would pose a threat to her health or that of the unborn child.

- **Urgent Care** means a medical condition that arises that does not expose the person to a risk of imminent death or integrity, and that can be treated in medical offices or extended hours offices, not necessarily in emergency rooms, but which, if not treated at the right time and in the right way, could become an emergency.

First Medical will cover the medical emergency/urgent care services provided to eligible members by Contracted or Non-Plan Providers. Ambulance services are also covered in situations where other means of transportation in Puerto Rico would endanger the members' health. Claims billed for emergency visits or urgent care visits will be covered. Although the claims system is designed to suspend claims for certain services that usually require prior authorization, a claim for emergency or urgent care services should not be suspended. First Medical will contact the

Providers who are providing emergency care to help them with timely provision of services and follow up on the care. When emergency care Providers indicates that the members' condition is stable and the medical emergency is over, what happens next is called "post-stabilization care." Follow-up care (post-stabilization care) will be covered according to medical clinical guidelines. However, follow up care will be covered only if the member chooses a provider of First Medical Contracted Provider Network. If not, the member will have to pay to the provider and request First Medical reimbursement for the paid services. Reimbursement for services is based upon the Agreements that First Medical has with its members, Members' benefit application, reimbursement requirements and First Medical Policies and Procedures.

9.2 BEHAVIORAL HEALTH SERVICES

- Psychiatric Hospital (or Unit within a General Hospital), Emergency or Stabilization units shall provide services twenty-four (24) hours a day, seven (7) days a week and shall have available at a minimum one (1) nurse, one (1) social worker and one (1) psychologist/psychiatrist.
- Partial Hospitalization Facilities are required to provide services ten (10) hours per day at least five (5) days per week and shall have available one (1) nurse, one (1) social worker and one (1) psychologist/psychiatrist.

9.3 NON-URGENT CONDITIONS

- Routine physical exams shall be provided to Members ages twenty-one (21) and over within thirty (30) calendar days of the Members request for service, considering both Medical and Behavioral health needs and condition. For minors less than twenty-one (21) years of age, routine physical exams shall be provided within the timeframes of First Medical's EPSDT Program.
- Primary care routine evaluations shall be provided within thirty (30) calendar days unless the Member requests a later date.
- Covered Services shall be provided within fourteen (14) calendar days following the request for service.
- Specialist Services shall be provided within thirty (30) calendar days of Members request for service.
- Dental Services shall be provided within sixty (60) calendar days following the request unless the Member requests a later date.

- Behavioral Health Services shall be provided within fourteen (14) calendar days, following the request, unless the Member requests a later date.
- Diagnostic laboratory, diagnostic imaging, and other testing appointments shall be provided consistent with the clinical urgency, but no later than fourteen (14) calendar days following the request, unless Member requests a later date. If a "walk-in" system is used rather than appointment system, the Member wait time shall be consistent with the severity of the clinical urgency.
- The prescription fill time (ready for pick up) shall be no longer than forty (40) minutes. A prescription phoned in by a practitioner shall be filled within ninety (90) minutes.

9.4 URGENT CONDITIONS

- Emergency Services shall be provided, including the access to an appropriate level of care, within twenty-four (24) hours of the service request.
- Primary medical, dental, and behavioral health care outpatient appointments for urgent conditions shall be available within twenty-four (24) hours.
- Urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability shall be consistent with the clinical urgency, but no later than forty-eight (48) hours.
- Behavioral health crisis services face-to-face appointments shall be available within two (2) hours.
- Detoxification services shall be provided immediately according to clinical necessity.
- Emergency services shall be provided, including access to an appropriate level of care, twenty-four (24) hours a day, seven (7) days a week. The scheduling of follow-up outpatient visits with practitioners shall be consistent with the Member's clinical need.

9.5 PREVENTIVE SERVICES

Preventive services are those health care services provided by a Physician within the scope of his or her practice under Puerto Rico law to detect or prevent disease, disability, Behavioral Health conditions, or other health conditions; and to promote Physical and Behavioral Health and efficiency. Preventive services required by the federal Patient Protection and Affordable Care Act, Public Law No. 111-148 (PPACA), and the Health Care and Education Reconciliation Act of 2010, Public Law No. 111-152 (HCERA) are covered at 100%, $0.00 Co-payment in and out of Network.

Preventive screening services, according to the preschool age of the child, required by Law 296 of September 1, 2000, and in accordance with Regulatory Letter N-AV-7-8-2001 of July 6, 2001, are covered by the contract. These services include general physical examination, vision and hearing screening, clinical laboratory testing (including tuberculin testing), psychological testing and evaluation for psycho-social screening, asthma, and epilepsy screening, according to current standards established by the Department of Health, Mothers, Children and Adolescents Program and the American Academy of Pediatrics. Through the following link, you will have access to the most updated list of preventive services**:** https://www.healthcare.gov/coverage/preventive-care-benefits/

9.6 PHARMACY BENEFIT

9.6.1 COVERED DRUGS FORMULARY

The Pharmacy Coverage Benefits offered by First Medical is a comprehensive one, and includes physical, mental, and dental health medications. The pharmacy benefit, as mandated by the Office of the Commissioner of Insurance of Puerto Rico, has a Formulary Medication Drugs List (FMDL) in addition to an Excluded Formulary List, which includes a list of all the drugs covered. The drugs listed on the FMDL are preferred drugs for First Medical. These drugs have been selected based on safety, effectiveness, high quality, bioequivalent availability, and cost. Physicians are required to only prescribe drugs listed on the FMDL. The pharmacy benefit requires the use of FDA-AB rated bioequivalent generics as first choice. The FMDL identifies these drugs with their names in small letters in bold. Brand name appears only as a reference. The FMDL also identifies those drugs that must go through a management process which is detailed below, for your reference:

MANAGEMENT PROCESS AND PROCESS DESCRIPTION
Prior-Authorization: Drugs that require prior-authorization are identified on the FMDL with "PA." The Provider can initiate the process of requesting a prior authorization for a drug by the First Medical Pharmacy Department at 1-844-550-5540, or by sending the prescription to the following fax number: 787-817-7001. The prescription must include all the information required by, along with the member ID number, diagnosis for which the drug is intended and the Physician NPI. Laboratory results or test results that support the use of the drug should be provided by the prescriber to the health plan.

Step Therapy: Drugs that require step therapy are identified on the FMDL with "ST." These drugs have a clinical protocol that needs to be followed. These are usually second line therapy since there are first line drugs that must have been tried and failed for these drugs to be prescribed.
Quantity Limit: Drugs with quantity limits are identified on the FMDL with "QL." These are drugs in which the pharmacy will not be able to process a quantity greater than the limit that has been established. Limits are based on the FDA indications and the manufacturer recommendations for each drug.
Age Limit: Drugs with age limits are identified on the FMDL with "AL." These are drugs that have an age limit established. These limits are based on the FDA indications and the manufacturer recommendations for each drug.

9.6.2 EXCLUDED DRUGS

The following drugs or categories of drugs are excluded from the Pharmacy Benefit through First Medical:

1. Drugs with a federal legend that have not been recommended in a prescription.
2. All over the counter (PTC) drugs that are not covered under an OTC Drug Program.
3. Any drug, medicine or medication that has on its label: "Caution: Limited by Federal Law for investigation use" or any experimental or investigational drug, medicine, or medication, even if a charge is made for it.
4. Allergen extracts.
5. Therapeutics devices or equipment, including, but not limited to:
    i. Support garments.
    ii. Testing reagents.
    iii. Mechanical pumps for prolonged Administration of medications (except for insulin pumps, which are covered under basic coverage).
    iv. Lancets, glucometer strips (which is covered for members diagnosed with Diabetes Mellitus Type 1)
6. Other non-medical substances.
7. Dietary supplements.

8. Nutritional products.
9. Minerals.
10. Appetite suppressant or other Weight control medications.
11. Any medication for cosmetic purposes.
12. Any drug or medication that can be legally purchased without a prescription, except insulin, folic acid (400 mcg and 800 mcg), aspirin (81 mg), iron (in children from 4 months to 21 years of age at risk of anemia), and those required by federal or state law.
13. Progesterone crystals or powder, in any compounded dosage form.
14. Drugs intended to induce abortion.
15. Infertility drugs, or drugs used for these purposes.
16. Any medication prescribed for impotence and/or sexual dysfunction.
17. Prescription drugs that must be taken by the member, in whole or in part, during the time he/she is a patient of a facility that normally provides drug to its inpatients. Inpatient facilities include, but are not limited to:
18. Hospitals.
19. Convalescent homes with skilled nursing facility service.
20. Hospices.
21. The following injectable drugs:
22. Immunization agents, except vaccines, which are covered under basic coverage.
23. Biological serum (these are covered during hospitalization).
24. Blood (this covered during hospitalization).
25. Blood Plasma (this covered during hospitalization).
26. Anabolic drugs.
27. Growth hormones.
28. Charges for the administration of prescription drugs or injection of a medication.
29. Medicines for cosmetic or beautifying purposes.
30. Minoxidil in all its forms, including Rogaine.
31. Refills of prescriptions more than the quantity specified by the Physician on the prescription or filled more than one year after the original order. Prescriptions that are invalid or have expired by law dispositions.
32. Any part of a prescription or refill prescription that exceeds a 30-day supply, received by a retail pharmacy that does not participate in our 90 days' supply program, which allows the member to receive a 90 days' supply of medication on a prescription or refill.

33. Any portion of a specialty drug or self-administered injectable drug received by a retail pharmacy or specialty pharmacy that exceeds a 30-day supply.
34. Any drug requiring prior authorization, which has not been obtained.
35. Any drug normally free of charge. Prescription drugs that can be obtained free of charge under local, state, federal or other programs.
36. Any drug, medication or medicine received by the member prior to the inception of coverage; or after the date coverage has terminated.
37. Any prescription or refill prescriptions for drugs that have been lost, stolen, spilled or damage.
38. Implants for the extended administration of medications.
39. More than one prescription or repeat prescription or for an equivalent therapeutic drug, prescribed by one or more Physicians and dispensed by one or more pharmacies, until the member has used at least 80% of the previous prescription (or repeat prescription).
40. Any co-payment the member made for a prescription that has been filled regardless of whether it is refused or changed because of adverse reactions or changes in the dosage or prescription.
41. Drugs which must be taken or administered in full or partial doses, while the member is hospitalized or in a Convalescent home, sanitarium, outpatient treatment or any similar institution, in which the operation of a facility for dispensing drugs or pharmaceuticals is permitted.

9.7 DENTAL BENEFITS

First will cover certain dental services subject to member benefit coverage, some of which may require prior authorization. For more information on eligibility or service availability, please call 787-878-6909. To obtain the applicable codes please visit the Provider Portal https://portal.intermedpr.com/

9.8 UTILIZATION MANAGEMENT PROGRAM

First Medical's Utilization Management Program ensure that First Medical Members have timely access to appropriate, medically necessary, and cost-effective health care services medical management, in a culturally competent decision-making process, that ensures an equal access to high-quality health care; medical management that is respectful and responsive to the needs

of our diverse Members. The Utilization Management Program addresses such issues as: preventive care, in-patient services, and ambulatory care.

The main goals of the Utilization Management Program are to assure quality, relevant care while promoting appropriate utilization of medical services and Plan resources. The objectives of the Utilization Management Program are to:

1. Provide a structured process to continually monitor and evaluate the delivery of health care and services to Members.
2. Improve clinical outcomes by collaboration, system-wide, to identify, develop and implement clinical practice guidelines that address key health care needs of Members.
3. Monitoring and evaluation of health care services.
4. Evaluating the process for providers' feedback regarding utilization.
5. Monitoring of indicators to detect under and over utilization.
6. Monitoring of the utilization practice patterns of the Physicians, contracted hospitals, and contracted ancillary services and specialty providers.
7. Monitoring of compliance with quality standards for the delivery of health services to members.
8. UM timeliness in decision management, organizational determinations,
9. Development and Implementation of clinical practice guidelines.
10. Actions to improve over- and under-utilization.
11. Collaboration with Quality Department to assess and implement actions to Improve continuity and coordination of care.
12. Improve Provider and Member satisfaction by: Assessing and improving Utilization Management satisfaction data from Provider and Member surveys.

The Utilization Review Staff is responsible for obtaining all pertinent clinical indications and medical record information needed to perform assessments of service authorizations. The Utilization Management Staff is responsible for the application of utilization review criteria of clinical practice guidelines (Milliman Care Guidelines® "MCG") to each individual case, to maintain consistency in the decision-making process and for referral to the Medical Director when criteria are not met. The Utilization Management Department Staff is responsible for identifying all potential or actual quality of care issues, and cases of over and underutilization of health care services, during all components of review and authorization.

First Medical uses the Milliman Care Guidelines® for Inpatient Utilization Management through its delegated entity for hospital Utilization Review. The Utilization Management Staff, and Medical Directors are not financially compensated to encourage underutilization or denials. Utilization Management delegated entities will not permit or provide compensation or anything of value to its employees, agents, or contractors, based on a percentage of the amount by which a claim is reduced for payment or the number of claims or the cost of services for which the person has denied authorization or payment; or any other method that encourages a decision to deny, limit, or discontinue a Medically Necessary Covered Service to any Member.

The Utilization Management Committee provides direction and oversight of the Utilization Management Program. This committee:

1. Evaluates the Program effectiveness and performance.
2. Analyzes under and over-utilization patterns, and recommend initiatives and strategies, as needed.
3. Recommends corrective actions based on clinical trends or changes in the standards of care.
4. Reviews and approves guidelines for the delivery of health services to Members.
5. Oversees and monitors all delegated Utilization Management activities.

To offer quality healthcare services to First Medical Members, on an annual basis the First Medical's Clinical Practice Review Committee approves and adopts Clinical Practice Guidelines (CPGs) for prevention, diagnostic, and management of physical and mental health. These guidelines are recognized at a national and international level and correspond to the standards of care and clinical treatments for specific conditions.

We encourage all Providers to use the First Medical's Clinical Practice Guidelines, to collaborate with the quality and consistency of health care management. For detailed information and links of the approved and adopted CPGs, please refer to the Attachment #1: Clinical Practice Guidelines Notification. For your convenience, you can also get the updated CPGs on our website www.intermedpr.com.

9.8.1 PRIOR-AUTHORIZATION

First Medical will ensure that Prior-Authorization is provided for the Member in the following timeframes:

- The decision to grant or deny a Prior-Authorization will not exceed seventy-two (72) hours from the time of the Members Service Authorization Request for all Covered Services if all information is received. In cases where the Provider determines that the Members life or health could be endangered by a delay in accessing services, the Prior-Authorization must be provided as expeditiously as the Members health requires, but no later than twenty-four (24) hours from the receipt of the request if all information is received.

For services that require Prior-Authorization, the Service Authorization Request shall be submitted *at least seven days from the admission date* by the Provider for First Medical evaluation, to provide the authorization within the applicable timeframe. Any denial, unreasonable delay, or rationing of medically necessary services to Members is expressly prohibited. First Medical assures compliance with this prohibition from Network Providers, or any other entity related to the provision of Behavioral Health services to Members.

First Medical employees are trained professionals to supervise all Prior-Authorization decisions and will specify the type of personnel responsible for each type of Prior-Authorization in its policies and procedures. Any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, is made by a Provider who possesses the appropriate clinical expertise for treating the Member's condition. For service authorization requests for dental services, licensed dentists are authorized to make determinations. Neither a Referral nor Prior-Authorization shall be required for any Emergency Service, and notwithstanding whether there is ultimately a determination that the condition for which the Member sought treatment in the emergency room was not an emergency medical condition or psychiatric emergency.

9.8.2 DENIAL PROCESS

First Medical will evaluate all Prior-Authorization requests. If the medical information related to the request indicates that it does not meet with the applicable criteria for approval, the Utilization Management Review Specialist will refer it to the Medical Director for the medical review process. The Medical Director may:

- Approve the request;
- Contact the care Physician or attending Physician for additional medical information;
- Contact the care Physicians or attending Physician to discuss an alternative treatment plan; or Deny the request.

First Medical will ensure that all denial notifications are handled in a timely manner. Members, Authorized Representatives, and Physicians will be informed by an outbound call and will be explained of their right to appeal. The Member and Provider will receive a written denial notice whether coverage is denied in whole, in part, or discontinued. The notification will include the appeal rights, reconsideration process and timeframes.

Members or their Authorized Representatives may file an appeal to an adverse determination verbally by calling the following number 1-888-318-0274 or in writing by sending a fax to 787-300-3931 with all the pertinent information supporting the appeal or any new information not provided during the initial prior-authorization process.

9.8.3 UTILIZATION REVIEW PROGRAM COMPONENTS

The Hospital Utilization Review Program components are designed to effectively reduce, and alert unnecessary and costly hospital stays and to assist with identifying alternative treatment settings. The program components include: (1) Admission Notification Program; (2) Pre-admission review and admission review; (3) Concurrent review; (4) Discharge Planning; (5) Retrospective Review; (6) Ancillary Services; (7) Skilled Nursing Facility; (8) Inpatient Rehabilitation Facility (IRF) Review; (9) Case Management; and (10) Emergency Room Utilization Review.

9.8.4 NOTIFICATION OF ACUTE CARE FACILITY ADMISSION

First Medical requires facilities to notify all Hospital Inpatient admissions (including deliveries) and discharges for hospital services to be covered. This information must be reported to:

Information	
InHealth **Hospital Care Department** **During works days,** **and before 10:00 a.m.**	**Phone: (787)-622-3000** **Ext. 8334, 8369, 8368, 8372, 8371, 8362, 8364, 8374, 8304, 8295, and 8367**
	Fax: 787-999-1744
inpatient@inhealth-pr.com	

The InHealth Hospital Use and Review Department will verify the Members eligibility on the date that the medical services were rendered. If the Member is eligible to receive the services, the InHealth Coordinator will provide the reference number to the hospital provider.

Admissions and Discharges occurring after 10:00 a.m., may be registered on the next workday. However, we stress the need to keep a correct census. The provider shall have a maximum of three (3) workdays, from the date of admission, to report it to the InHealth Hospital Use and Review Department to request the case reference number. In cases where an admission is notified retrospectively, the hospital shall bring the case to the Concurrent Review Nurse (CRN) assigned to your hospital, who shall be responsible for obtaining the reference number, if the case meets the criteria established in this description of the InHealth Physical Health Operational Hospital Review Processes.

9.8.5 CONCURRENT REVIEW

Refers to the review of the patient's clinical file while Member (he/she) still admitted in the hospital facility. Admissions created will be available immediately, so the Concurrent Review Nurse (CRN) may begin reviewing the case, using the clinical guidelines adapted by InHealth (MCG, formerly known as Milliman Care Guidelines) as a frame of reference.

The hospital is responsible for making all files of admitted patients available for review (including ER admissions) and easing the review process during the work hours of Mondays through Fridays, from 8:00 a.m. to 5:00 p.m. The facility will have a period of no more than ninety (90) calendar days, after the discharge date, to submit the file to our CRN for closure.

9.8.6 DISCHARGE PLANNING

The hospital provider shall report all patient discharges from the First Medical Health Plan Inc., within three (3) workdays from the date when the patient was discharged, through the telephone number previously mentioned.

Reporting Schedule: Regular work hours are from Monday to Friday, from 7:30 a.m. to 5:00 p.m. Admissions and discharges may also be reported during weekends by fax at 787-999-1744 the reference number for admissions reported during weekends shall be provided on the next workday.

9.8.7 RETROSPECTIVE REVIEW

The facility will have a period of no more than ninety (90) calendar days, from the date of discharge, to submit the file to the CRN for InHealth. The CRN shall take no more than fifteen (15) workdays to complete the case review process. If a file is submitted after its expiration (ninety [90] calendar days after the date of discharge), it will not be audited by our staff. The file will be sealed with a recommendation for administrative denial.

9.8.8 APPEALS PROCESS

The facility will have a period of thirty (30) calendar days from the close date to request in writing the appeals process to InHealth Grievance Department to the following address:

Hospital Facility Appeals InHealth
UM Impacient Department
P.O. Box 71114
San Juan, PR 00936-8014

9.8.9 EMERGENCY ROOM UTILIZATION REVIEW

First Medical will conduct retrospective Emergency Room Utilization Review (ER-UR) to evaluate records of emergency room high utilizers and quality issues, including overutilization patterns.

9.8.10 AMBULANCE SERVICE

First Medical will cover emergency transportation in compliance with Puerto Rico laws and regulations. Sea, air, and land transportation will be covered within Puerto Rico territory limits in cases of emergency. Emergency transportation does not require prior authorization.

9.9 CARE MANAGEMENT PROGRAM

First Medical has developed the Care Management Program to improve the health of First Medical Members. This program includes subprograms and projects designed to coordinate services and provide support for Members with Special Needs. These subprograms and projects are based on clinical and non-clinical criteria. The following sections describe each subprogram, project, its processes, and services, and explain how these are integrated to achieve the main goal.

9.9.1 CARE PROGRAM MANAGEMENT STATEMENT

First Medical's Care Management Program defines a collaborative process between the Member, Physician, Specialists, Subspecialists Providers, and the Plan's Subprograms as an integrated system to help our Members to address their necessities. Members' health medical management support is worked through evidenced-based medicine, best practices, and quality of care protocols to achieve their unique needs and goals. Main activities such as assessments to identify physical, behavioral, and social determinant needs, individualized care plan and coordination of services are performed. Clinical and non-clinical dedicated staff along with an interdisciplinary care team have been appointed to conduct the Program. This team manages decision support and alliances with communities' resources. Quality of services, health outcomes, program and individual case results, Member satisfaction and individual case managers' performance are some of the key elements to determine the effectiveness of the Care Management Program.

9.9.2 CARE MANAGEMENT PROGRAM COMPONENT

First Medical conducts its medical review and evaluation of health care services utilizing nationally recognized policies, standards of care, and evidence based clinical guidelines. Examples of such health care services include inpatient and outpatient care, medications, and other services required for coordinating care for the Members.

First Medical Staff uses such policies, standards, and guidelines from the Centers for Medicare and Medicaid Services (CMS) and its carriers, national professional organizations (e.g., American Diabetes Association, American Heart Association) and other federal government organizations such as the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention (CDC), and the Agency for Health Care Research and Quality (AHRQ). See more details related to the Evidenced Based Guidelines in the section related to Utilization Management Program.

9.9.3 MEMBER'S PROGRAM GOALS

First Medical Care Management Program main goal is to coordinate available and accessible services while supporting and guiding Members to recover and improve their health. The Program objectives are:

1. To ensure that the Member with intensive use services and special health needs that requires a course of regular monitoring of care or treatment, receives needed services in a supportive, efficient, timely, and cost-effective manner with quality of care.
2. To continually perform the activities of assessment, planning, coaching, education, and advocacy for Members throughout the continuum(sequence) of care, consistent with evidence based clinical guidelines.
3. To collaborate and communicate with the Member ’s family, the Physician and other health care providers in the implementation of the care plan that is driven by the Members goals for health improvement.
4. To accomplish the goals established in the individual Members care plan.
5. To provide Members and their families with information and education that promotes self-care management.
6. To educate and involve the Member and family in the coordination of services.
7. To assist Members across the transition between settings of care; appropriate discharge planning for short and long-term hospital and institutional stays settings, by providing information and support.
8. To maintain the Member in the setting that best aligns with Members preferences, while being clinically appropriate to manage a condition and medical needs.
9. To assist Members in optimizing use of available benefits.
10. To improve Member and provider satisfaction.
11. To ensure timely interventions that increase effectiveness and efficiency of care delivery.
12. To promote the effective utilization and monitoring of health care resources while ensuring that services arranged or coordinated are appropriate for the Member.
13. To promote the health, independence, and optimal functioning of Members.
14. To ensure optimum therapeutic outcomes for Members through improved medication adherence and reducing adverse drug interactions.
15. To promote preventive health services.

9.9.4 MEMBER’S PROGRAM DESCRIPTION

Our Care Management Program is driven by quality-based outcomes such as: better maintained functional status, improved maintained clinical status, enhanced quality of life, Member satisfaction, adherence to the care plan, improved Member safety, cost saving and autonomy. The program includes a set of Member-centered, goal-oriented, culturally relevant, and logical steps to assure that a Member receives needed services in a supportive, effective, efficient, timely

and cost-effective manner. It also emphasizes prevention, continuity of care and coordination of care, which advocates for, and links Members to, services as necessary across Providers and settings.

The Care Management Program main areas are:

1. Early identification of Members who have or may have special needs;
2. Assessment of Members needs;
3. Development of a care plan;
4. Referrals and assistance to ensure timely access to Providers;
5. Coordination of care actively linking the Member to Providers, medical services, residential, social, behavioral, and other support services where needed;
6. Progress status and monitoring of events;
7. Continuity of care;
8. Follow-up and documentation.

9.9.5 ICT COMMITTEE

First Medical has contracted clinical and non-clinical staff to conduct the care management activities under its Program, subprograms, and projects. The staff receives training related to policies, procedures and documents governing the Care Management Program components. Changes on count and type of health professionals are made according to the profile of population that is managed and as a result of gaps identified in the annual evaluation of the Program. ICT Committee staff is composed of:

- Physicians
- Health Educators
- Registered Nurses/Case Management
- Pharm-D
- Social Workers

First Medical has adopted an Interdisciplinary Care Team (ICT) Committee, composed of a team of health and administrative professionals. The ICT is responsible for providing oversight to the Members care planning and care management processes, assuring compliance of the established processes, and assisting on complex cases by providing their expertise in management of certain medical and behavior health conditions. The ICT also coordinates and identifies referrals needed and ensure engagement with Providers.

9.9.6 ASSESSMENT PROCESS

Then, an updated assessment will be conducted annually. A Member profile is established to perform program activities. A Plan of Care is developed according to the identified needs considering the actual treatment plan performed by the Member's Physician to ensure that the Member complies with the establish goals for improvement.

9.9.7 ROLES AND RESPONSIBILITIES OF FIRST MEDICAL'S CARE MANAGEMENT PROGRAM STAFF

First Medical's Care Management Program is based on a collaborative practice model to include Physician and Support-service Providers. In general, the Physician's role is to lead the efforts to assess Members condition and health needs, develop a treatment plan, with the Members participation, and in consultation with any specialists caring for the Member. Physician's will monitor adherence to clinical guidelines and protocols, promote the pre-approved educational materials to be used and support program rollout to ensure outcomes.

9.9.8 ELIGIBILITY CRITERIA FOR FIRST MEDICAL'S CARE MANAGEMENT PROGRAM AND ITS SUBPROGRAMS

First Medical requires that Physicians have implemented an effective system of practices to identify any Member in need of care management services. To assure compliance with this requirement all new Members must be screened using behavioral and physical tools to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening.

Any member identified as Care Management Program potential will have a comprehensive needs assessment. The Physician will also identify those who have conditions specified to require intensive assistance, extended services as required by the Member's medical conditions, as well as ongoing care coordination and management as appropriate, in a primary care setting. First Medical Care Management Program serves Members through its subprograms and projects.

9.10 EXCLUSIONS

Each particular coverage sets forth the exclusions applicable thereto. Such exclusions may include the following:

1. Services to be rendered while the contract is not in effect.
2. Services which may be received under Workers' Compensation Laws, employer's liability, private workers' compensation plans, automobile accidents (ACAA) and services available under state or federal law, for which the covered person is not legally obligated to pay. Such services shall also be excluded when such services are denied by the governmental agencies concerned, for reason of noncompliance or violation of the requirements or provisions of the above laws, even though such noncompliance or violation does not constitute a crime.
3. Treatment resulting from the commission of a crime or failure to comply with the laws of the Commonwealth of Puerto Rico or any other country by the covered person except for those injuries resulting from an act of domestic violence or medical condition.
4. Services that are received free of charge or paid for by donations.
5. Personal comfort services such as telephone, television, admission kit, supervised care, rest home, nursing home.
6. Services rendered by health professionals other than Doctor of Medicine or dentistry, except audiologists, optometrists, podiatrists, psychologists, chiropractors, and others that are specified in the contract.
7. Expenses for physical examinations may be or are required by the employer.
8. Services that are not medically necessary, or services considered experimental or investigational, according to the criteria of the Food and Drug Administration (FDA), Department of Health and Human Services (DHHS) and the Puerto Rico Department of Health for the specific indications and methods that are ordered.
9. Expenses or services for new medical procedures that are not considered experimental or investigative, until First Medical determines their inclusion in the coverage offered under this contract, except as required by any state or federal law. Also not covered are medical expenses related to investigational clinical studies or treatments (i.e., clinical trials), or tests and medications administered to be used as part of these studies, or medical expenses that must be paid by the entity conducting the study. This provision applies even if the Member has enrolled in a clinical trial to treat a life-threatening condition for which there is no effective treatment and obtains the physician's approval for participation in the

trial because the trial offers the patient a potential benefit. In this case, First Medical will cover "routine patient medical expenses," meaning that "routine patient medical expenses" are not those related to the study, or tests administered for use as part of the study, nor expenses that should be paid by the entity conducting the study. Once these services are included in the coverage, First Medical will pay for such services an amount no greater than the average amount it would have paid if such medical service had been rendered through conventional methods, until a rate is established for these procedures.

10. Expenses for cosmetic or beautifying operations, treatments to correct defects in physical appearance, except for newborn children, newly adopted or placed for adoption. In addition, hospitals, medical-surgical services, and complications associated with this exclusion are excluded, regardless of whether there is medical justification for the procedure.
11. Orthopedic or orthotic devices, prostheses, or implants; except breast prostheses after mastectomy, pacemakers (replacement will not be covered), valves, stents, defibrillators, or electric shock devices and any other covered. Services necessary for the implantation thereof will be covered.
12. Surgical interventions to surgically restore the ability to procreate, infertility treatment or treatment for conception by artificial means; all expenses and complications associated with these are excluded. Laboratories ordered for the treatment of infertility will be covered, if it is a laboratory covered under this contract.
13. Scalenectomy services - division of the anticus scalene muscle without resection of the cervical rib, when for cosmetic purposes.
14. Organ and Tissue Transplantation. Removal of organs for transplantation into another person, even in the case of a member. Services related to transplants and complications thereof when the same is not a covered benefit.
15. Sports Medicine, Music Therapy, Natural Medicine, Homeopathy, Acupuncture, Acupressure, Hypnotism, Aromatherapy, Massages, Psychosurgery, and other forms of alternative medicine.
16. Intravenous or inhalation analgesia administered in the office of the oral surgeon or dentist.
17. Maxillofacial surgery, except as provided in the Surgical-Medical Services section.
18. Excluded dental services: orthodontics, periodontics, endodontics, prosthodontics, and full mouth reconstruction.
19. Treatment of temporomandibular joint syndrome (jaw joint) by any method to correct the condition.

20. Excision of granulomas or root cysts (periapical) originating from infection to the pulp of the tooth, services to correct vertical dimension or occlusion, removal of exostoses (mandibular or maxillary tori, etc.).
21. Immunotherapy for allergy.
22. Services rendered for induced abortion.
23. Services rendered in Ambulatory Surgical Centers for procedures that can be performed in the Physician's office.
24. Inpatient services (including ancillary services) for procedures and/or surgeries which may be performed on an outpatient basis, or which are excluded from coverage or for diagnostic purposes.
25. Services by marine ambulance.
26. Services rendered by residential treatment facilities outside of Puerto Rico, whether or not there is medical justification for the treatment.
27. Surgeries for the removal of excess skin following bariatric surgery or gastric bypass will not be covered, except if the physician certifies that it is necessary to remove the excess skin because it affects the functioning of a body member. Requires prior authorization from the plan.
28. Expenses for trigger point tendon injections and skin tag removal. Likewise, expenses for the following three services are excluded from coverage in cases of cosmetic cause (not due to physiological condition or uncertainty of being benign or malignant, which must be corroborated by a pathology study): a) excision of other benign lesions; b) repair of eyelid ptosis and c) excision of nails.
29. Expenses for laboratory tests: heavy metals; doping; HLA Typing; paternity tests.
30. Laboratory tests that are not codified in the Laboratory Manual will be evaluated on an individual basis, prior to being recognized for payment and First Medical will determine their inclusion or exclusion in the coverage offered under this contract. First Medical will determine which laboratory tests are not coded as covered under this contract. Laboratory tests, considered experimental or investigational, will not be recognized for payment by First Medical.
31. Expenses related to the administration of an employer drug screening program, as well as any rehabilitative treatment following a member's positive test. Once the member is terminated from the employer program, any other services needed by the member will be covered by the plan, even if the service is related to the employer program.

32. Expenses for occupational therapy and speech therapy, except for those provided under post-hospital services and for the condition of autism.
33. Immunizations for travel purposes or against occupational hazards and risks when these are required for employment purposes.
34. Services rendered and ordered by immediate family members of the patient (parents, children, siblings, etc.).
35. Diagnosis, services, treatments, implants, and surgeries to correct erectile dysfunction and the condition of impotence.
36. Tuboplasty and other operations or treatments whose purpose is to restore the ability to procreate.
37. Treatment for the condition of fertility, artificial insemination and in vitro fertilization and all types of treatment for the condition of fertility. Laboratories ordered for the treatment of infertility will be covered, provided it is a laboratory covered under this contract.
38. Cosmetic surgery or microsurgery for cosmetic purposes to correct defects in physical appearance (deformities), except for newborn children, newly adopted children or children placed for adoption who will be covered for health care services for injuries or illnesses, including care and treatment of congenital defects and abnormalities diagnosed by a physician; removal of tattoos or scars, acne treatments and cosmetic treatment of cellulite.
39. Hyperbaric chamber is covered, except for persons diagnosed with Autism Spectrum Disorder, provided it is recommended by a medical practitioner or licensed health care professional and the treatment is permitted by federal laws and regulations.
40. Delegated maternity.
41. Services related to disability because of being on active military duty.
42. Expenses incurred for payments that a person covered under the member’s contract contract makes to a participating provider without being obligated under the member’s contract to make such payments.
43. Services not required in accordance with accepted standards of medical practice or services provided more than those normally required for the diagnosis, prevention or treatment of an illness, injury, organ system dysfunction or condition of pregnancy.
44. Services rendered outside the hospital while the patient is hospitalized.
45. Services, treatments, and surgeries for weight gain and/or weight loss.
46. Treatments for leprosy.

47. Purchase or rental of medical equipment, orthopedic appliances and shoes, personal comfort equipment such as humidifiers, except ventilators as required by Act 125 of September 21, 2007, and physical activity enhancement devices.
48. TENS (Transcutaneous Electrical Nerve Stimulation).
49. Medications at the outpatient level, except under optional prescription drug coverage.
50. Pregnancy tests, except under a physician's order.
51. Eyeglasses, contact lenses, intraocular lenses, and hearing aids.
52. Laboratory and invasive radiology that is not expressly included.
53. Expenses for services covered under miscellaneous insurance policies.
54. Surgical Assistance and Multiphasic Screening Clinics.
55. Microsurgery, Radial Keratotomy. LASIK and other vision correction surgeries.
56. Laser beams, except in ophthalmology.
57. Gamma rays.
58. Hospitalization services when the covered person, against medical advice, refuses or discontinues the treatment or service ordered.
59. Growth hormone treatment and allergy shots (desensitization).
60. Physical examinations for medical certificates, regardless of the purpose, except for services required under Act 296, better known as the "Law for the Preservation of the Health of Children and Adolescents of Puerto Rico".
61. Expenses occasioned by war, civil insurrection, or international armed conflict; except in those cases where the services received are related to an injury suffered while the member was active in the military (service connected), in which case First Medical will reimburse the Veterans Administration.
62. First Medical does not recognize payment claims for services and tests rendered in mobile units by any participating provider, except those previously authorized and/or registered with the Puerto Rico Department of Health. Payments issued for these services will be subject to recoupment.
63. Benefits not expressly included as covered benefits and/or services are excluded from coverage, except as may be required by law.

10. CULTURAL AND LINGUISTIC APPROPIATE SERVICES

The constant demographic changes produced in recent years in society have a great impact on health services. Patient panels are increasingly diverse, and needs are becoming more complex. It is important for Providers and Facilities to have the knowledge, resources, and tools to offer culturally competent and linguistically appropriate care. First Medical wants to help work together to achieve health equity.

First Medical has a comprehensive Cultural Competency Plan that describes how we ensure that services are offered to all our members in a culturally competent manner. Our Cultural Competency Plan describes how providers, employees, and systems will effectively serve people of different cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, gender identity, or religion, in a way that recognizes values, affirms, and respects the individual worth of members, and protects and preserves the dignity of each individual.

The U.S. Department of Health and Human Services defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff Members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment.

Our primary objective is to ensure that our members have access to health services in a culturally competent environment where employees and providers value diversity within the organization to meet the needs of linguistic services. First Medical's Cultural Competency Plan will assist you in integrating the knowledge, attitudes, and skills that are reflected in a culturally competent organization, to ensure the provision of services to all members, including those with limited Spanish proficiency. First Medical defines limited Spanish proficiency as those Members who have difficulty speaking, reading, writing, or understanding the Spanish language.

First Medical submits a copy of the complete Cultural Competency Plan to providers free of charge during the hiring process and upon request. Additionally, the Cultural Competency Plan training is posted on First Medical’s website under the Providers Section, allowing our providers to participate in the training at their own pace. This training addresses the same elements described in the training offered to our employees. Providers will be responsible for providing Cultural Competency Plan training to their office staff. First Medical will provide the training materials at

no cost. If you need a copy of First Medical's Cultural Competency Plan, feel free to contact Providers Department at 1-844-347-7802.

First Medical appreciates the shared commitment by Provides and Facilities to ensure Members receive culturally and linguistically appropriate services to support effective care and improved health outcomes.

First Medical complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. First Medical Customer Service Department offers language and sign language interpreter services free of charge. This includes service alternate formats such as; Braille, enlarged print and translation into other languages, verbal or written, among others. If your patient needs plan information in another format or language, please contact our Customer Service Department.

10.1 CULTURAL COMPETENCY PLAN

The constant demographic changes produced in recent years in society have a great impact on health services. First Medical has a comprehensive Cultural Competency Plan that describes how we ensure that services are offered to all our Members in a culturally competent manner. Our Cultural Competency Plan describes how providers, employees, and systems will effectively serve people of different cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, gender identity, or religion, in a way that recognizes values, affirms, and respects the individual worth of Members, and protects and preserves the dignity of each individual.

Our primary objective is to ensure that our Members have access to health services in a culturally competent environment where associates and providers value diversity within the organization to meet the needs of linguistic services. First Medical Cultural Competency Plan will assist you in integrating the knowledge, attitudes, and skills that are reflected in a culturally competent organization, to ensure the provision of services to all Members, including those with limited Spanish proficiency. First Medical defines limited Spanish proficiency as those Members who have difficulty speaking, reading, writing, or understanding the Spanish language.

Every year, First Medical submits a copy of its Cultural Competency Plan to each provider Additionally, the Cultural Competency Plan training is posted on First Medical's website under the Providers Section, allowing our providers to participate in the training at their own pace. This training addresses the same elements described in the training offered to our employees. Providers will be responsible for providing Cultural Competency Plan training for their office staff. First Medical will provide the training materials at no cost. If you need a copy of First Medical's Cultural Competency Plan, feel free to contact the Providers Department at 1-844-347-7802.

11. INTEGRITY PROGRAM – FRAUD, WASTE AND ABUSE

Health care fraud and abuse is a federal crime**.** First Medical is committed to protecting the integrity of First Medical's health care programs and the effectiveness of operations by preventing, detecting and investigating fraud, waste and abuse (FWA). First Medical *zero tolerance* policy to FWA is not limited to cases of fraud or abuse. First Medical also investigates instances of waste as well as any inappropriate activities. The purpose of investigating these activities is to protect the members, government, and/or First Medical from paying more for a service than it is obligated to pay.

Combating FWA begins with knowledge and awareness.

- Fraud: Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it -- or any other person.
- Waste: Includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- Abuse: When health care providers or suppliers do not follow good medical practices resulting in excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

One of the most important steps to help prevent Member fraud is as simple as confirming the individual's name on their photo ID is the same as the name on the Member identification card. This ensures the Member identification card to confirm that the individual seeking services is the same as the Member listed on the card. It is the first line of defense against possible fraud.

11.1 REPORTING FRAUD, WASTE AND ABUSE

If someone suspects a Member or Provider/Facility has committed fraud, waste or abuse, they have the right and the duty to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and any other information will be kept in strict confidence by investigators.

Any incident of fraud, waste or abuse may be reported to First Medical anonymously; however, First Medical's ability to investigate an anonymously reported matter may be limited if First Medical doesn't have enough information. We encourage Providers and Facilities to give as much information as possible.

Examples of Member Fraud, Waste and Abuse

- Forging, altering or selling prescriptions
- Letting someone else use the Member's ID (Identification) card
- Using someone else's ID card

When reporting concerns involving a Member include:

- The Member's name
- The Member's date of birth, Member ID or case number if available
- The city where the Member resides
- Specific details describing the fraud, waste or abuse

Examples of Provider/Facility Fraud, Waste and Abuse (FWA):

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling – when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding – when a provider bills a health insurance payer using a procedure code for a more expensive service than was performed.

When reporting concerns involving a provider (a doctor, dentist, medical supply company, etc.) include:

- Name, address and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Number of the provider and facility, if applicable
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Dates of events
- Names and phone numbers of other witnesses who can help in the investigation
- Summary of what happened

Any questions involving inappropriate activities or clarification should be forwarded to the SIU. Reports to the Fraud, Waste and Abuse Hotline may be made twenty-four (24) hours a day/seven (7) days a week. Callers may choose to remain anonymous. All calls will be investigated and will remain confidential. Fraud, Waste and Abuse reports may be made through one of the following:

Fraud and Compliance Alert Line	
In writing to: **First Medical Health Plan, Inc.** **Special Investigations Unit** **PO Box 191580** **San Juan, PR 00918-1580**	**1-866-933-9336**
alertacumplimiento@firstmedicalpr.com	

The provider or their employees must report any alleged inappropriate activity. Providers may do so confidentially without disclosing his/her name and information. First Medical will not tolerate retaliation in any form, toward any reporter of potential fraud, waste, or abuse.

11.2 INVESTIGATION PROCESS

The First Medical's Special Investigations Unit ("SIU") investigates suspected incidents of FWA for all types of services. First Medical may take corrective action with a Provider or Facility, which may include, but is not limited to:

- Written warning and/or education: We send certified letters to the provider documenting the issues and the need for improvement. Letters may include education or requests for recoveries or may advise of further action.
- Medical record review: We review medical records to substantiate allegations or validate claims submissions.
- Prepayment Review: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- Recoveries: We recover overpayments directly from the provider. Failure of the provider to return the overpayment may result in reduced payment of future claims and/or further legal action.

In addition to the previously mentioned actions, First Medical may refer suspected criminal activity committed by a Member, Provider or Facility to the appropriate regulatory and/or law enforcement agencies.

12. DEFINITIONS

- **Abuse**: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and that result in unnecessary costs or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for the provision of health care. It also includes Member practices that result in unnecessary costs to the First Medical.
- **Access**: Adequate availability of Benefits to fulfill the needs of Members.
- **Act 408:** The Puerto Rico Mental Health Code (Act No. 408 of October 2, 2000, as amended), which established the public policy and procedures regarding the delivery of Behavioral Health services in Puerto Rico.
- **Adult**: An individual age twenty-one (21) or older unless otherwise specified.
- **Appeal**: A Member request for a review of an Adverse Benefit Determination. It is a formal petition by a Member, a Member's Authorized Representative, or the Members Provider, acting on behalf of the Member with the Members written consent, to reconsider a decision in the case that the Member or Provider does not agree with an Adverse Benefit Determination taken.

- **Basic Coverage**: The physical and Behavioral Health Services available to all First Medical Members (different from Special Coverage, which is available only to Members with certain diagnoses after a registration process).
- **Behavioral Health**: The umbrella term for mental health conditions (including psychiatric illnesses and emotional disorders) and substance use disorders (involving addictive and chemical dependency disorders). The term also refers to preventing and treating co-occurring mental health conditions and substance use disorders ("SUDs").
- **Benefits**: The services set forth in this Contract, for which the Contractor has agreed to provide, arrange, and be held fiscally responsible, including Basic Coverage, dental services, Special Coverage, and Administrative Functions.
- **Breach**: As defined in 45 CFR 164.402, the acquisition, access, use, or disclosure of Protected Health Information in a manner not permitted under 45 CFR 164, subpart E which compromises the security or privacy of such Information.
- **Clean Claim**: A Claim received by the Contractor for adjudication, which can be processed without obtaining additional information from the Provider of the service or from a Third Party. It includes a Claim with errors originating in the Contractor's Claims system. It does not include a Claim from a Provider who is under investigation for Fraud, Waste, or Abuse, or a Claim under review to determine Medical Necessity.
- **Complaint**: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination that is resolved at the point of contact rather than through filing a formal Grievance.
- **Covered Services:** Those Medically Necessary health care services provided to Members by Providers, the payment or indemnification of which is covered under this Contract.
- **Credentialing**: The Contractor's determination as to the qualification of a specific Provider to render specific health care services.
- **Credible Allegation of Fraud**: Any allegation of Fraud that has been verified by another State, the Government, or OCS, or otherwise has been preliminary investigated by the Contractor, as the case may be, and that has evidence of reliability that comes from any source.
- **Cultural Competency**: A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among, and between groups and the sensitivity to know how these differences influence relationships with the Members. This requires a willingness and

ability to draw on community-based values, traditions, and customs, to devise strategies to better meet culturally diverse Member needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports.

- **Encounter**: A distinct set of services provided to a Member in a face-to-face setting on the dates that the services were delivered, regardless of whether the Provider is paid on a Fee-for-Service, **Capitated**, salary, or alternative payment methodology basis. Encounters with more than one (1) Provider, and multiple Encounters with the same Provider, which take place on the same day in the same location will constitute a single Encounter, except when the Member, after the first Encounter, suffers an illness or injury requiring an additional diagnosis or treatment.
- **Formulary of Medications Covered ("FMC"):** A published subset of pharmaceutical products used for the treatment of physical and Behavioral Health conditions.
- **Fraud:** An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit or financial gain to him/herself or some other person. It includes any act that constitutes Fraud under applicable Federal or Puerto Rico law.
- **Grievance:** An expression of dissatisfaction about any matter other than an Adverse Benefit Determination.
- **Health Care Provider:** An individual engaged in the delivery of health care services as licensed or certified by Puerto Rico in which he or she is providing services, (including but not limited to Physicians, podiatrists, optometrists, chiropractors, psychologists, psychiatrists, licensed Behavioral Health practitioners, dentists, Physician's assistants, physical or occupational therapists and therapists assistants, speech-language pathologists, audiologists, registered or licensed practical nurses (including nurse practitioners, clinical nurse specialist, certified registered nurse anesthetists, and certified nurse midwives), licensed certified social workers, registered respiratory therapists, and certified respiratory therapy technicians).
- **Health Information Technology for Economic and Clinical Health ("HITECH") Act:** Public Law 111-5 (2009). When referenced in this Guidelines, it includes all related rules, regulations, and procedures.
- **Health Insurance Portability and Accountability Act ("HIPAA"):** A law enacted in 1996 by the US Congress. When referenced in this Guidelines, it includes all related rules, regulations, and procedures.

- **Medicare:** is federal health insurance for people 65 or older, some younger people with disabilities, people with End-Stage Renal Disease.
- **Member:** A person who is currently enrolled in First Medical.
- **National Provider Identifier ("NPI"):** The 10-digit unique-identifier numbering system for Providers created by the Centers for Medicare and Medicaid Services (CMS), through the National Plan and Provider Enumeration System.
- **Network:** The entire group of Providers with Provider Contracts with the Contractor, including those that are and those that are not members of the Contractor's Preferred Provider Network.
- **Network Provider**- A enrolled Provider that has a contract with First Medical under First Medical Program. This term includes both Providers in the General Network and Providers in the Preferred Provider Network.
- **Office of the Women's Advocate:** An office of the Government created by Act 20 of April 11, 2001, as amended, which is tasked, among other responsibilities, with protecting victims of domestic violence.
- **Out-of-Network Provider:** A Provider that does not have a Provider Contract with First Medical under First Medical.
- **Overpayment:** Any funds that a person or entity receives which that person or entity is not entitled to under Title XIX of the Social Security Act as defined in 42 CFR 438.2. Overpayments shall not include funds that have been subject to a payment suspension or that have been identified as a Third-Party Liability as set forth in Section 23.4.
- **Pediatric Member:** A Member aged zero (0) through twenty (20) (inclusive) unless otherwise specified.
- **Prevalent Non-English Language:** A non-English language spoken by a significant number or percentage of Potential Members and current Members in Puerto Rico, as determined by the Government.
- **Preventive Services:** Health care services provided by a Physician or other Provider within the scope of his or her practice under Puerto Rico law to detect or prevent disease, disability, Behavioral Health conditions, or other health conditions; and to promote physical and Behavioral Health and efficiency.
- **Primary Care:** All health care services, and laboratory services customarily furnished by or through a general practitioner, family Physician, internal medicine Physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner to the extent the furnishing of those services is legally authorized where the practitioner furnishes them.

- **Primary Care Physician:** A Licensed Medical Doctor (MD) who is a Provider and who, within the scope of practice and in accordance with Puerto Rico Certification and licensure requirements, is responsible for providing all the required Primary Care to Members
- **Prior Authorization:** Authorization granted by the Contractor to determine whether the service is Medically Necessary. In some instances, this process is a condition for receiving the Covered Service.
- **Provider:** Any Physician, hospital, facility, or other Health Care Provider who is licensed or otherwise authorized to provide physical or Behavioral Health Services in the jurisdiction in which they are furnished.
- **Provider Contract:** Any written contract between the Contractor and a Provider that requires the Provider to order, refer, provide, or render Covered Services under this Contract. The execution of a Provider Contract makes the Provider a Network Provider.
- **Protected Health Information ("PHI"):** As defined in 45 CFR 160.103, individually identifiable health Information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.
- **Quality Assessment and Performance Improvement Program ("QAPI"):** A set of programs aimed at increasing the likelihood of desired health outcomes of Members through the provision of health care services that are consistent with current professional knowledge; the **QAPI Program includes incentives to comply with HEDIS standards, to provide adequate Preventive Services**, and to reduce the unnecessary use of Emergency Services.
- **Quality Management/Quality Improvement ("QM/QI"):** The process of developing and implementing strategies to ensure the delivery of available, accessible, timely, and Medically Necessary Services that meet optimal clinical standards. This includes the identification of key measures of performance, discovery and Data collection processes, identification and remediation of issues, and systems improvement activities.
- **Special Coverage:** A component of Covered Services provided by the Contractor which are more extensive than the Basic Coverage services, and for which Members are eligible only by "registering." Registration for Special Coverage is based on intensive medical needs occasioned by serious illness.
- **Specialist**- A doctor who provides health care services for a specific disease or part of the body, or certain age groups. Examples include oncologists (who care for patients with cancer), or cardiologists (who care for patients with heart conditions).

- **Utilization:** The rate patterns of service usage or types of service occurring within a specified time frame.
- **Utilization Management ("UM"):** A service performed by First Medical which seeks to ensure that Covered Services provided to Members are in accordance with, and appropriate under, the standards and requirements established by First Medical.
- **Waste:** Health care spending that can be eliminated without reducing quality of care.

13. LINKS CONTAINING ADDITIONAL INFORMATION

13.1 NO SURPRISE ACT

Click the following links to access important information regarding the United States No Surprises Act and the Puerto Rico Local Act for Patient Protection from Surprise Medical Bills:

- https://www.firstmedicalpr.com/wp-content/uploads/2022/02/FM-COM_CS_22.30_19_S_FMHP_Derechos-y-Protecciones-contra-%E2%80%9CFacturas-M%C3%A9dicas-Sorpresa%E2%80%9D_Spanish_Approved-02232022.pdf

- https://www.firstmedicalpr.com/ley-sorpresa/

13.2 TRANSPARENCY ACT

Click the following link to access important information regarding the Transparency Act:

- https://www.firstmedicalpr.com/ley-transparencia/