Section 1: On Lok Lifeways Program Description

- Introduction
- Purpose and Organization of the Provider Manual
- Provider Manual Updates
- About On Lok Lifeways
- On Lok Lifeways Center Locations

Section 2: On Lok Senior Health Services Resource Contacts

Section 3: Participant Eligibility

- On Lok Lifeways program benefits
- Eligibility Verification

Section 4: Members/Participants

- Contractor Responsibility for Continuity of Care
- Participant Bill of Rights
- Participant Grievance Process
- Appeals Process
- Cultural and Linguistic Program
- Health Education Program
- Transportation Services
- Advance Directives for On Lok Lifeways Participants
- Experimental and Investigational Therapies for On Lok Lifeways Participants

Attachments:

- On Lok Lifeways Participant Bill of Right
- Information for Participants about the Grievance Process
- Information for Participants about Appeals Process
Section 5: Billing

- Claims Submission
- Timeframe for Submitting Claims
- Claims Payment
- Copayments
- Adjusted Denied or Contested Claims
- Potential Billing Discrepancies
- Incomplete or Pending Claims
- Payment Inquiries from Providers
- Problematic Claims
- Third Party Liability
- Services Provided Without Prior Authorization
- Balance Billing
- Overpayment of a Claim

Section 6: Utilization Management

- Description of Program
- Prior Authorization
- Discharge Planning
- Transportation Services

**Attachments:**

- Sample Authorization Form

Section 7: Pharmacy

- Prescription Drug Benefit
- Copayments

Section 8: Quality Assurance

- Quality Assurance and Improvement Program (QAIP)
- Quality Management
- Quality Assurance Provisions Applicable to Contractor
- Facility and Provider Site Reviews
- Reviews for Contractors

**Attachments:**

- Contract Provider Site Review Instrument
- Contract Specialist Performance Review Supplement
Section 9: Provider Credentialing

- Provider Credentialing Standards
- Confidentiality of Credentialing Information
- Medicare and/or Medi-Cal Certification

Attachments:

- On Lok Lifeways’ current Credentialing Standards and Procedures for Physicians and Contract Specialist Providers
- On Lok Lifeways’ current Credentialing Standards for Organized Medical Groups and Hospital-Based Physicians
- Application for On Lok Senior Health Services’ Provider Panel Physicians and Non-Physician Providers
- Re-Credentialing Application for On Lok Senior Health Services’ Provider Panel Physicians and Non-Physician Providers
- Contract Specialist Performance Review Instrument
- Provider Delegation Oversight Survey Instrument

Section 10: Provider Rights and Responsibilities

- Primary Care Provider Responsibilities
- Specialty Provider Responsibilities
- Provider Rights
- Complaint and Participant Care Problem
- Summary of Dispute Process
- Provider Dispute Resolution Process

Section 11: Fraud Waste and Abuse Prevention
Section 1: On Lok Lifeways Program Description

Introduction

It is our pleasure to welcome you to On Lok Senior Health Services as a contracted provider ("Contractor"). We appreciate your participation in helping us fulfill our mission to provide quality and affordable healthcare for the well-being of frail seniors.

Our program, known as On Lok Lifeways, is a comprehensive health plan that serves frail seniors who reside in San Francisco, southern Alameda County and Santa Clara County who are at risk of nursing home placement. With the medical and personal care assistance offered by On Lok Lifeways, frail seniors can remain in the community, enjoying the comforts of home and family for as long as possible.

Purpose and Organization of the Provider Manual

The Provider Manual guides you and your staff to work with On Lok while providing healthcare services to On Lok Lifeways Participants. It is intended to supplement, and not to replace or supersede, your Provider Services Agreement with On Lok. In the event of any discrepancy between the Provider Manual and the Agreement, the terms of the Agreement shall govern.

The contents of the Provider Manual have been organized according to similar topics and functions. A complete table of contents is located at the beginning of the Provider Manual and includes the subheadings of topics included within each section. The On Lok Senior Health Services Resource Contacts in Section 2 includes names, departments and telephone numbers that will assist you in obtaining answers to questions or rendering services to On Lok Lifeways Participants.

Your satisfaction with On Lok is vital to this relationship. We welcome and encourage your comments and suggestions regarding this Provider Manual or any other aspect of your relationship with On Lok. For clarification, questions or comments about your role as a Contractor for On Lok Senior Health Services, please feel free to contact our Provider Services Department.

Provider Manual Updates

The Provider Manual will be updated periodically in response to changes in regulatory requirements and operational systems. The date in the lower right-hand corner of each page will reflect the most current version.
About On Lok Lifeways

On Lok Lifeways is a comprehensive, integrated health and long term-care delivery system designed exclusively for frail seniors in need of long-term care and medical services. On Lok is the prototype for an innovative delivery system known nationally as the Program of All-Inclusive Care for the Elderly (PACE), which, since 1997, has been recognized as a permanent provider type under the Medicare and Medicaid programs. In the early 1970s, the Chinatown-North Beach community of San Francisco saw the pressing needs of families for long term care services for their elders who had immigrated from China, Italy, and the Philippines. Dr. William L. Gee, a public health dentist, headed the committee that hired Marie-Louise Ansak in 1971 to investigate solutions. Along with other community leaders, Dr. Gee and Mrs. Ansak formed a nonprofit corporation called On Lok Senior Health Services to create a community based system of care.

As a PACE Program, On Lok Lifeways receives fixed monthly payments (capitation) from Centers for Medicare and Medicaid Services (CMS) and the State of California Department of Health Care Services (DHCS) to provide PACE services to Participants. On Lok Senior Health Services is a California licensed Knox Keene health plan that has full financial risk for all the care needed by its Participants.

The On Lok Lifeways Medical Management approach is:

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

SAN FRANCISCO CENTERS

GEE CENTER (JADE Team, ROSE Team)
1333 BUSH STREET
Hours of Operation: 8:00 a.m. to 4:30 p.m., Monday - Saturday
Clinic Telephone Number (415) 292-8829/8820 (Rose/Jade)
Clinic Fax Number (415) 292-8845
TTY Number (415) 292-8898

POWELL CENTER
1441 POWELL STREET
Hours of Operation: 8:00 a.m. to 4:30 p.m., Monday - Friday
Clinic Telephone Number (415) 292-8650
Clinic Fax Number (415) 434-4026
TTY Number (415) 292-8640

30TH STREET CENTER
225 30th STREET
Hours of Operation: 8:00 a.m. to 4:30 p.m. Monday - Friday
Clinic Telephone Number (415) 550-2232
Clinic Fax Number (415) 642-1135
TTY Number (415) 550-2283

IOA CENTER
3575 GEARY BOULEVARD
Institute on Aging*
Hours of Operation: 8:30 a.m. to 5:00 p.m., Monday - Friday
Clinic Telephone Number (415) 379-2643/2673 (Coronet/Geary)
Clinic Fax Number (415) 447-1249

*I Institute on Aging operates the On Lok Lifeways center
at this address.
ON LOK LIFEWAYS CENTERS (continued)

EAST BAY CENTERS

FREMONT CENTER
(Service area includes Fremont, Newark and Union City)
159 WASHINGTON BOULEVARD, FREMONT, CA
Hours of Operation: 8:00 a.m. to 4:30 p.m. Monday - Friday
Clinic Telephone Number (510) 249-2716
Clinic Fax Number (510) 770-9807
TTY Number (510) 249-2798

PERALTA CENTER
(Service area includes Fremont, Newark and Union City)
3683 PERALTA BOULEVARD, FREMONT, CA
Hours of Operation: 8:00 a.m. to 4:30 p.m. Monday - Friday
Clinic Telephone Number (510) 494-3700
Clinic Fax Number (510) 713-1022
TTY Number (510) 818-1888

SANTA CLARA COUNTY CENTERS

SAN JOSE CENTER
(Service area includes all of Santa Clara County except cities of Gilroy, Morgan Hill and San Martin)
299 STOCKTON AVENUE, SAN JOSE, CA
Hours of Operation: 8:00 a.m. to 4:30 p.m. Monday - Friday
Clinic Telephone Number (408) 535-4622
Clinic Fax Number (408) 291-5952
TTY Number (408) 535-4663

EAST SAN JOSE CENTER
(East San Jose Center is an alternative care setting to San Jose Center)
130 NORTH JACKSON AVENUE, SAN JOSE, CA
Hours of Operation: 8:00 a.m. to 4:30 p.m. Monday - Friday
Center Telephone Number (408) 795-3888
Center Fax Number (408) 795-3811
Section 2:

On Lok Senior Health Services Resource Contacts

On Lok Senior Health Services
Administrative Offices

1333 Bush Street
San Francisco, CA 94109
Tel: (415) 292-8888
Fax: (415) 292-8745
Website: www.onlok.org

Toll Free: 1-888-88-ON-LOK (1-888-886-6565)
TTY: (415) 292-8898

Administration ........................................ (415) 292-8888
General information for On Lok Senior Health Services, including location of On Lok medical care facilities and contact information for center program managers.

Authorizations ..................................... (415) 292-8886
Authorization is required for referrals by a contracted specialist to another in-network entity, to non-participating specialists or to request for services such as home care services and DME.

Claims ............................................... (415) 292-8888
Information regarding status of claims and claims payment. Please mail claims to:

Claims Department
On Lok Senior Health Services
1333 Bush Street
San Francisco, CA 94109

Contracts Management ............................. (415) 292-8735
Discussion of contracting terms and conditions, status of contract for participation, addition of providers to an existing medical group contract or get information for participation as a contracted provider with On Lok Senior Health Services.

Credentialing ...................................... (415) 292-8885
Information related to credentialing terms and conditions and status of credentialing application.
Enrollment and Outreach ....................... (888) 886-6565
Speak to an enrollment representative about On Lok Lifeways program benefits, eligibility requirements, medical centers, and enrollment.

Member Services ............................... (415) 292-8888
On Lok Lifeways eligibility requirements, verify Participant eligibility and Primary Care Provider contact information or referral status.

Provider Relations ............................. (415) 292-8864
General program information about out-of-network referrals, request copies of policies and procedures or existing On Lok publications. Serves as Official Liaison to On Lok Senior Health Services.

Quality Management ........................... (415) 292-8796
Information about On Lok’s responsibility for quality of care oversight, specific questions about On Lok Lifeways quality assurance (QA) policies and procedures, QA provider office on-site inspections, and provider reporting requirements.

Utilization Management ....................... (415) 292-8756
The Utilization Management Program is under the direction of the Medical Director and is staffed by the Utilization Management Nurse.
Section 3 - Participant Eligibility

On Lok Lifeways Program Benefits

On Lok Lifeways uses the term “Participant” when referring to its enrollees.

To be eligible to participate in the On Lok Lifeways PACE program, the person must be:

- Age 55 years or older;
- Certified by Department of Health Care Services to need nursing home level of care i.e. individuals with multiple medical conditions that result in functional or cognitive impairment, and/or self-care limitation;
- Able to safely reside in the community;
- Residing in the cities of San Francisco, Fremont, Newark, Union City and all of the cities in Santa Clara County, except Gilroy, Morgan Hill and San Martin.

General description of On Lok Lifeways program benefits:

<table>
<thead>
<tr>
<th>Ambulance Services</th>
<th>Medical social services/case management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiology, Dentistry, Podiatry and Vision, Care</td>
<td>Mental Health Services</td>
</tr>
<tr>
<td>Day center services</td>
<td>Nursing Care</td>
</tr>
<tr>
<td>Diagnostic testing including imaging and laboratory services</td>
<td>Nutrition</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Physician/Professional Services</td>
</tr>
<tr>
<td>Emergency Health Services</td>
<td>Physical/Occupational/Speech Therapy</td>
</tr>
<tr>
<td>End of Life Care</td>
<td></td>
</tr>
<tr>
<td>Hospital Services</td>
<td>Skilled Nursing Facility Care</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>Transportation</td>
</tr>
</tbody>
</table>

Eligibility Verification

On Lok Lifeways utilizes a unique number for Participant identification. This unique identifier is assigned by On Lok Lifeways upon enrollment that avoids the use of protected personal health information as a mechanism for identification. This identifier is printed on the Participant’s ID card and all paperwork related to the care and treatment of the Participant. The unique identifier is either a 4-digit or 5-digit numeric code.
**Notice to all service providers:** This person is eligible to receive covered services that are authorized by On Lok Lifeways. Most covered services require prior authorization. Emergency services do not require prior authorization.

Service Authorization: (415) 292-8888
Billing Information: (415) 292-8888

1333 Bush Street, San Francisco, CA 94109

*Please note:* On Lok Lifeways assigns ID cards according to the assigned center or PCP in the case of our Fremont centers. The only differences are the telephone numbers for urgent care, service authorization, billing information and plan administration.

You may verify a Participant’s On Lok Lifeways eligibility by calling us at (415) 292-8888 Monday through Friday from 8:00 a.m. to 4:30 p.m. For quicker and easier service, please have ready the Participant’s unique identifier, date of birth (DOB) and first and last name.
Section 4: Members/Participant

Contractor Responsibility for Continuity of Care

The California Health and Safety Code Section 1373.96 requires that in the event of a termination of a provider’s contract, the Contractor acknowledges responsibility for continuity of care of On Lok Lifeways Participants under Contractor’s care who meet certain requirements. Eligible Participants have the right to request that the terminated Contractor continue to provide and be compensated for those services that are covered by On Lok Lifeways. This provision also applies to any On Lok Senior Health Services sub-contracting provider, i.e. providers that contract with On Lok Senior Health Services contracted providers.

On Lok Lifeways Participant Eligibility

On Lok Lifeways ensures Participants who are receiving treatment for certain conditions or have been authorized for treatment or procedures to be performed by a Lifeways provider have the right to request continuation of care from the provider if the contract with the provider is terminated by On Lok Senior Health Services or the provider. Upon receiving a request for continuation of care from Participants who are receiving treatment for a certain condition from a terminated provider, Lifeways makes a determination about whether the Participant may continue treatment with that provider. In order to continue treatment, the service must be covered by Lifeways and be used to treat one of the following within the specified time frame:

a. Acute condition - for the duration of the condition
b. Serious chronic condition - not to exceed 12 months from the date of the provider’s termination

If the Participant received authorization for surgery (or other procedure) and scheduled the surgery (or other procedure) within 180 days of the date of the provider’s termination, Lifeways may request that the provider continue to provide the service.

An “acute condition” is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. A “serious chronic condition” is a medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature, and does either of the following: (i) persists without full cure or worsens over an extended period of time and (ii) requires on-going treatment to maintain remission or prevent deterioration.

Contractor Responsibility

The Contractor shall be responsible for providing continuing care under the following conditions:

- Contractor’s termination or non-renewal was voluntary and not for reasons related to a medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the California Business and Professions Code, or fraud or other criminal activity.
• Contractor agrees in writing to be subject to the same contractual terms and conditions of the original contract, including but not limited to credentialing, hospital privileges, utilization review, peer review, and quality assurance requirements.

• Contractor agrees in writing to accept the payment rates and methods which are the same or similar to those used by Lifeways for contractors receiving fee-for-service payment.

If Contractor does not agree to comply with the Lifeways contractual terms and conditions that are imposed upon current contracted providers, or, if Contractor is unable to comply due to retirement, disability, death or a move out of the service area, Lifeways does not approve the request from the Participant for continuation of care services.

**Process for Participant to Request Continuity of Care**

When Lifeways intends to terminate a Contractor, or is notified of a provider’s intent to terminate, it assesses Participants under the care of the Contractor for meeting the criteria for continuation of care. Lifeways notifies eligible Participants that they can request to continue to see the terminated provider for continuation of care.

Lifeways will then arrange for the care to continue under the conditions above until course of treatment is over or until transfer can be made.

**On Lok Lifeways Participant Bill of Rights**

On Lok Lifeways is dedicated to providing Participants with quality health care services, so they may remain as independent as possible. Participants are made aware of their rights and responsibilities at the time of enrollment and at least annually thereafter.

At the end of this Section 4, please find a copy of the On Lok Lifeways Participant Bill of Rights that is given to all Participants.

**On Lok Lifeways Participant Grievance Process**

On Lok Lifeways ensures the Participant, or the Participant’s representative, is able to express his/her concerns or dissatisfaction with services and quality of care delivered by On Lok Lifeways staff or contract providers. The grievance procedure enables On Lok Lifeways to address complaints in a timely and efficient manner when they arise and allow for a systematic resolution.

For complete information, please refer to the “Information for Participants about the Grievance Process” at the end of this Section 4.
On Lok Lifeways Appeals Process

On Lok Lifeways ensures a Participant, a Participant’s representative, or a referring provider has the right to appeal a decision to deny, defer, or modify a particular care-related service or to not pay for a service received by a Participant.

Note: On Lok Lifeways ensures the Participant will not be discriminated against based on the fact that an appeal has been filed. On Lok Lifeways also continues to furnish disputed services until the final appeals determination has been issued when the following conditions have been met: (a) On Lok Lifeways proposes to terminate or reduce services currently being provided, and (b) the Participant requests continuation with the understanding that he/she may be liable for the costs of the contested services if the final determination is not made in his/her favor.

Please refer to the “Information for Participants about the Appeals Process” for details regarding these additional appeal right options, including Independent Medical Review which can be found at the end of this Section 4.

On Lok Lifeways Cultural and Linguistic Program

Cultural and Linguistic (C&L) competence among health care providers is essential to the care satisfaction of recipients of health care and social care services. The goal of On Lok Lifeways Cultural and Linguistic Program is to ensure the members, both with and without limited English proficiency have access to quality health care and services that are culturally and linguistically appropriate. The On Lok Lifeways C&L program includes four main areas 1) Participants, 2) Staffing and Providers, 3) Competency and 4) Monitoring.

Participants

On Lok Lifeways Participants have rights to language assistance services provided by On Lok Lifeways. Interpretation and translation services are provided to Participants at no cost. On Lok Lifeways provides key health plan materials to Participants in threshold languages, including English, Chinese and Spanish.

Staffing and Providers

To the extent possible, On Lok Lifeways recruits culturally and linguistically appropriate staff in both direct patient care and administrative functions for the diverse population On Lok Lifeways serves. In addition, On Lok Lifeways contracts with several language assistance services to provide assistance in situations where staff are not able to provide interpretation or translation services.

Contractors, such as specialty physicians, labs and hospitals, can often provide culturally and linguistically appropriate services to our Participants. Many speak English, Cantonese Spanish and other non-English languages. On Lok Senior Health Services can also provide language assistance upon request at no cost to the Participant.
On Lok Lifeways Health Education Program

On Lok Lifeways provides appropriate quality health care information and education to Participants in an easily accessible manner based on the identified needs of individuals and of the general population of Lifeways enrollees.

Based on the assessment by interdisciplinary team (IDT) members and upon request by the Participant, On Lok Lifeways provides education by:

- Upon enrollment, Lifeways provides general health education materials which are relevant and appropriate for a frail, elderly population to the Participant. Topics include, but are not limited to, diseases such as osteoporosis, arthritis and hypertension.

- Lifeways staff provides individual health education sessions including the distribution of discipline-specific materials per the Participant’s treatment plan.

- Direct education through one-on-one counseling with Participants and/or their family/caregiver, and general group education sessions.

Should Contractor identify an area where health education would be helpful, Contractor should notify an On Lok Lifeways IDT member. Team members will make all reasonable efforts to meet the individual needs of the Participants.

On Lok Lifeways Transportation Services

All On Lok Lifeways Participants have access to medical transportation services that include:

- **Transportation** provided by On Lok Lifeways or a contracted outside service.

- **Wheelchair/Non-Ambulatory Transportation** for Participants requiring wheelchair or other assisted transport to medical appointments or other covered services. These services can be by On Lok Lifeways’ transportation services or an outside contracted service.

- **Basic Life Support (BLS)** which is provided by emergency medical technicians for non-emergency transportation of stable patients.

- **Advance Life Support (ALS)** for use in response to “911” requests. Care is provided by ambulance paramedics.

- **Critical Care Transportation** for Participants who required a higher level of care for services not routinely available at the facility in which they are initially admitted.

- **Air Ambulance Transportation** when medically appropriate.
Advance Directives for On Lok Lifeways Participants

Within six months of enrollment in On Lok Lifeways, Participants are asked by their primary care provider (PCP) or social worker whether they have signed an advance health care directive. The signed advance health care directive is incorporated into the Participant’s medical record at On Lok Lifeways. If they do not have an existing Advance directive the social worker will assist the Participant in filing out a POLST form and the Participant is encouraged to make their health wishes known to their PCP.

Upon admission or transfer to an acute care facility or a SNF, On Lok Lifeways will send a copy of any advance healthcare directive along with the Participant. Otherwise, the Contractor may contact the On Lok Lifeways PCP for any requested information regarding a Participant’s wishes documented in an advance healthcare directive.

Experimental and Investigational Therapies for On Lok Lifeways Participants

Experimental and investigational procedures and therapies are not covered by On Lok Lifeways.

Contractor should contact the Participant’s On Lok Lifeways primary care provider for further information regarding On Lok Lifeways coverage for a proposed experimental and or investigational therapy.
Participant Bill of Rights

At On Lok Lifeways, we are dedicated to providing you with quality health care services, so you may remain as independent as possible. Our staff seeks to affirm the dignity and worth of each Participant by assuring the following rights:

**Respect and Non-Discrimination**

You have the right to be treated with dignity and respect at all times, to have all of your care kept private, and to get compassionate, considerate care.

**You have the right to:**

- Be treated in a respectful manner that honors your dignity and privacy.
- Receive care from professionally trained staff.
- Know the names and responsibilities of the people providing your care.
- Know that decisions regarding your care will be made in an ethical manner.
- Receive comprehensive health care provided in a safe and clean environment and in an accessible manner.
- Be free from harm, including unnecessary physical or chemical restraints or isolation, excessive medication, physical or mental abuse or neglect, and hazardous procedures.
- Be encouraged to use your rights in the PACE program.
- Receive reasonable access to a telephone at the center, both to make and receive confidential calls, or to have such calls made for you if necessary.
- Not have to do work or services for On Lok Lifeways.
- Not be discriminated against in the delivery of PACE services based on race, ethnicity, color, national origin, ancestry, religion, sex, age, sexual orientation, marital status, registered domestic partner status, military status, mental or physical disability, medical condition, genetic information or source of payment.

**Information Disclosure**

You have the right to get accurate, easy-to-understand information and have someone help you make informed health care decisions.

**You have the right to:**

- Be fully informed, in writing, of your rights and responsibilities and all rules and regulations governing participation in On Lok Lifeways.
- Be fully informed, in writing, of the services offered by On Lok Lifeways, including services provided by contractors instead of On Lok Lifeways staff. You must be
given this information before enrollment, at enrollment, and at the time your needs necessitate the disclosure and delivery of such information in order for you to make an informed choice.

- Receive a full explanation of the Enrollment Agreement and an opportunity to discuss it.
- Have an interpreter or a bilingual provider available to you if your primary language is not English.
- Examine the results of the most recent federal or state review of On Lok Lifeways and how On Lok Lifeways plans to correct any problems that are found at inspection.

Confidentiality

You have the right to talk with health care providers in private and have your personal health care information kept private as protected under state and federal laws.

You have the right to:

- Speak with health care providers in private and have all the information, both paper and electronic, related to your care kept confidential within required regulations.
- Be assured that your written consent will be obtained for the release of medical or personal information or photographs or images to persons not otherwise authorized under law to receive it. You have the right to limit what information is released and to whom it is released.
- Be assured that your health record will remain confidential.
- Review and copy your medical records and request amendments to those records and have them explained to you.
- Be assured of confidentiality when accessing Sensitive Services, such as Sexually Transmitted Disease (STD) and HIV testing.

If you have any questions, you may call the Office for Civil Rights toll-free at 1-800-368-1019. TTY users should call 1-800-537-7697.

Choosing Your Provider

You have the right to:

- Choose your own primary care provider and specialists from the On Lok Lifeways provider panel.
- Request a specialist for women’s health services or preventive women’s health services.

Emergency Care

You have the right to:
• Receive health care services in an emergency without prior approval from the On Lok Lifeways Interdisciplinary Team.

Treatment Decisions

You have the right to:

• Participate in the development and implementation of your plan of care. If you cannot fully participate in your treatment decision, you may designate a health spokesperson or representative to act on your behalf.
• Have all treatment options explained to you in a language you understand and acknowledge this explanation in writing.
• Be fully informed of your health status and make your own health care decisions.
• Refuse treatment or medications and be informed of how this may affect your health.
• Request and receive complete information about your health and functional status by the On Lok Lifeways Interdisciplinary Team.
• Request a reassessment by the On Lok Lifeways Interdisciplinary Team at any time.
• Receive reasonable advance notice in writing if you are to be transferred to another care setting for medical reasons or for your welfare or the welfare of other Participants. Any such actions will be documented in your health record.
• Have our staff explain advance directives to you and to establish one on your behalf, if you desire.

Exercising Your Rights

You have the right to:

• Receive assistance in exercising your civil, legal and participant rights, including On Lok Lifeways' grievance process, the Medi-Cal fair hearing process and the Medicare and Medi-Cal appeals processes.
• Voice your complaints and recommend changes in policies and services to our staff and to outside representatives of your choice. There will be no restraint, interference, coercion, discrimination or reprisal by our staff if you do so.
• Appeal any treatment decision made by On Lok Lifeways or our contractors through our appeals process and to request a State fair hearing.
• Disenroll from the program at any time by giving 20-day written notice.

If you feel any of your rights have been violated or you are dissatisfied and want to file a grievance or an appeal, please report this immediately to your social worker or call our office during regular business hours at 415-292-8895 or our toll-free telephone number at 1-888-996-6565.

If you would like to talk to someone outside of On Lok Lifeways about your concerns you may contact 1-800-MEDICARE (1-800-633-4227) or 1-888-452-8609 (California Department of Health Care Services Office of the Ombudsman.)
Please refer to other sections of your On Lok Lifeways Member Enrollment Agreement Terms and Conditions for details about On Lok Lifeways as your sole provider; a description of On Lok Lifeways services and how they are obtained; how you may obtain Emergency Services and Urgent Care outside On Lok Lifeways’ network; the grievance and appeals procedure; disenrollment; and a description of premiums, if any, and payment of these.

Participant Responsibilities

We believe that you and your caregiver play crucial roles in the delivery of your care. To assure that you remain as healthy and independent as possible, please establish an open line of communication with those participating in your care and be accountable for the following responsibilities:

You have the responsibility to:

- Cooperate with the Interdisciplinary Team in implementing your care plan.
- Accept the consequences of refusing treatment recommended by the Interdisciplinary Team.
- Provide the Interdisciplinary Team with a complete and accurate medical history.
- Utilize only those services authorized by On Lok Lifeways.
- Take all prescribed medications as directed.
- Call the On Lok Lifeways physician for direction in an urgent situation.
- Notify On Lok Lifeways within 48 hours or as soon as reasonably possible if you require Emergency Services or Urgent Care when out of the service area.
- Notify On Lok Lifeways in writing when you wish to initiate the disenrollment process.
- Notify On Lok Lifeways of a move or lengthy stay outside of our service area.
- Pay required monthly fees as appropriate.
- Treat our staff with respect and consideration.
- Not ask staff to perform tasks that they are prohibited from doing by PACE or agency regulations.
- Voice any dissatisfaction you may have with your care.
INFORMATION FOR PARTICIPANTS ABOUT THE GRIEVANCE PROCESS

All of us at On Lok Lifeways share responsibility for your care and your satisfaction with the services you receive. Our grievance procedures are designed to enable you or your representative to express any concerns or dissatisfaction you have so that we can address them in a timely and efficient manner. At any time, should you wish to file a grievance, we are available to assist you. If you do not speak English, a bilingual staff member or interpreter or translation service will be available to assist you.

A grievance is defined as a complaint, either written or oral, expressing dissatisfaction with the services provided or the quality of your care. A grievance may include, but is not limited to:

- Quality of services you receive in your home, at your On Lok Lifeways center or during an inpatient stay (e.g., hospital or skilled nursing facility);
- Waiting times on the telephone, in the waiting room or exam room;
- Behavior of any of the care providers or program staff;
- Adequacy of center facilities;
- Quality of the food provided;
- Transportation services; and
- Violation of a participant's rights

Filing of Grievances

The information below describes the grievance process for you or your representative to follow should you or your representative wish to file a grievance. You may file a grievance yourself, or your representative may file a grievance on your behalf, within 180 calendar days following the incident or action that is the subject of the dissatisfaction.

1. You can verbally discuss your grievance either in person or by telephone with your social worker, the home care supervisor or the program manager of the center you attend. This person will make sure that you receive written information on the grievance process and that your grievance is documented on the grievance report form. Be sure to give complete information so the appropriate staff can help to resolve your grievance in a timely manner. If you wish to submit your grievance in writing, please send your written grievance to:

   Health Plan Associate
   On Lok Lifeways
   1333 Bush Street
   San Francisco, CA 94109

You may also contact our Health Plan Associate at 415-292-8895, or our toll-free telephone number at 1-888-996-6565, to request a grievance report form and receive
assistance in filing a grievance. For the hearing impaired, please call our TTY number, **415-292-8898**. Our Health Plan Associate will provide you with written information on the grievance process. You may access our website at **www.onlok.org** to file a grievance or receive information about our grievance process.

2. The staff member who receives your grievance will help you document your grievance (if your grievance is not already in writing) and coordinate investigation and action. All information gathered during the investigation will be kept confidential.

3. You will be sent a written confirmation of receipt within five (5) calendar days of filing your grievance. We will investigate, find solutions and take appropriate action.

4. The staff will make every attempt to find a solution to your grievance within thirty (30) calendar days of receipt of your grievance. If you are not satisfied with that resolution, you and/or your representative have the right to pursue further action.

5. In the event resolution is not reached within thirty (30) calendar days, you or your representative will be notified in writing of the status and estimated completion date of the grievance solution.

**Expeditied Review of Grievances**

If your grievance involves an imminent and serious threat to your health, including, but not limited to, potential loss of life, limb or major bodily function, severe pain, or violation of your Participant Rights, we will expedite the review process to a decision within 72 hours of receiving your written grievance. You may request an expedited review, or On Lok Lifeways may determine the need for an expedited review. In an expedited review, you will be immediately informed by telephone of: (a) the receipt of your request for expedited review and (b) your right to notify the Department of Social Services through the State fair hearing process and the Department of Managed Health Care of the grievance.

**Resolution of Grievances**

Upon completion of the investigation and reaching a final resolution of your grievance, the Chief Medical Officer, the Director of Health Plan Services or the Health Plan Associate will send you a report describing the problem’s resolution, the basis for the resolution, and the review process if you are still dissatisfied.

**Grievance Review Options**

If you or your representative are still dissatisfied after completing the grievance process or participating in the process for at least thirty (30) calendar days, you or your representative may pursue the options described below. (NOTE: If the situation involves an imminent and serious threat to your health, you need not complete the entire grievance process nor wait thirty (30) calendar days.) Your grievance review options are:

1. If you are covered by Medi-Cal only or by Medi-Cal and Medicare, you are entitled to pursue your grievance with the California Department of Health Care Services, by writing to:
Ombudsman Unit
Medi-Cal Managed Care Division
California Department of Health Care Services
P.O. Box 997413, Mail Station 4412
Sacramento, CA 95899-7413
Telephone: 1-888-452-8609
TTY: 1-800-735-2922

2. You may also contact the California Department of Managed Health Care:

Department of Managed Health Care
California Help Center
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725
Telephone: 1-888-466-2219
Fax: 916-255-5241
TTY: 1-877-688-9891

Since On Lok Lifeways is a health care service plan, the California Department of Managed Health Care wants you to know the following:

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 415-292-8895 or 1-888-996-6565 and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online."

State Fair Hearing Process: At any time during the grievance process, per California State law, you may also request a fair hearing from the California Department of Social Services by contacting or writing to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430
Telephone: 1-800-952-5253
Fax: 916-229-4110
TTY: 1-800-952-8349
If you want a State fair hearing, you must ask for it within ninety (90) days from the date of receiving the letter for the resolved grievance. You or your representative may speak at the State hearing or have someone else speak on your behalf, including a relative, friend or an attorney. You may also be able to get free legal help. We will provide you or your representative a list of Legal Services in the county where you live at the time you file a grievance.

**Home Health Hotline:** If you have a question or concern regarding On Lok Lifeways’ home health services, we recommend that you first discuss the matter with your home health nurse, social worker or program manager. However, please be informed that the State of California has established a confidential, toll-free telephone number to receive questions or complaints about home health services. The telephone number is: **1-800-554-0353**, and it is available Monday through Friday, from 9 a.m. to 5 p.m.

**Other Disputes:** Except for disputes subject to a Medicare appeal procedure, any other dispute, disagreement or claim that you have with On Lok Lifeways after you have completed On Lok Lifeways’ grievance and appeals process including any dispute as to medical malpractice—that is, as to whether any medical services rendered to you were improperly or negligently or incompetently performed—will be determined by submission to arbitration in accordance with On Lok Lifeways’ Arbitration Plan.
INFORMATION FOR PARTICIPANTS ABOUT THE APPEALS PROCESS

When On Lok Lifeways decides not to cover or pay for a service you want, you may take action to change our decision. The action you take—whether verbally or in writing—is called an “appeal.” You may make your appeal by calling (415-292-8895, or for the hearing impaired, (TTY) 415-292-8898) or writing to our Health Plan Associate (1333 Bush Street, San Francisco, CA 94109).

Below is a description of our appeals process. We have provided the definition of an appeal, the process for standard and expedited appeals, the types of decisions that can be made on an appeal, and finally, what happens once a final decision is made.

Definition: An appeal is a participant’s action taken with respect to our organization’s decision not to cover, or not to pay for, a service, including denials, reductions or termination of services.

You will receive written information on the appeals process when you enroll and annually after that, as well as whenever On Lok Lifeways denies a request for services or payment. You have the right to file an appeal if we deny, defer, or modify your request for a service or payment for a service. You may file your appeal either verbally or in writing. The reconsideration of our decision will be made by a person(s) not involved in the initial decision-making process. We will ensure that this person(s) is both impartial and appropriately credentialed to make a decision regarding the necessity of the services at issue. You or your representative may present or submit relevant facts and/or evidence for review, either in person or in writing to us.

Standard and Expedited Appeals Processes: There are two types of appeals processes: standard and expedited appeals processes. We describe both of these processes below.

If you request a standard appeal, your appeal must be filed within one hundred and eighty (180) calendar days of when your request for service or payment of service was denied, deferred or modified. This is the date which appears on the Notice of Action for Service or Payment Request. (The 180-day limit may be extended for good cause.) Within five calendar days of receiving your appeal, On Lok Lifeways will acknowledge in writing that the appeal has been received. We will issue a decision on your appeal as quickly as your health requires, but no later than thirty (30) calendar days after we receive your appeal.

If you believe that your life, health or ability to get well is in danger without the service you want, you or any physician may ask for an expedited appeal. If any physician asks for an expedited appeal for you, or supports you in asking for one, we will automatically make a decision on your appeal as promptly as your health requires, but no later than seventy two (72) hours after we receive your request for an appeal. We may extend this time frame up to fourteen (14) days if you ask for the extension or if we justify to the California Department of Health Care Services the need for more information and how the delay benefits you.
If you ask for an **expedited appeal** without support from a treating physician, we will decide if your health condition requires us to make a decision on an expedited basis. If we decide to deny you an expedited appeal, we will let you know within seventy two (72) hours. In this case, your appeal will be considered a standard appeal.

**Note:** *On Lok Lifeways will continue to provide the disputed service(s) if you choose to continue receiving the service(s) until the appeals process is completed. If your initial decision to NOT cover or reduce services is upheld, you may be financially responsible for the payment of disputed service(s) provided during the appeals process.*

The information below describes the appeals process for you or your representative to follow should you or your representative wish to file an appeal:

1. If you or your representative has requested a service or payment for a service and On Lok Lifeways denies, defers or modifies the request, you may appeal the decision. A written *"Notice of Action for Service or Payment Request"* (NOA) will be provided to you and/or your representative which will explain the reason for the denial, deferral or modification of your service request or request for payment.

2. You can make your appeal either verbally, in person or by telephone, or in writing with PACE program staff of the center you attend. The staff person will make sure that you are provided with written information on the appeals process, and that your appeal is documented on the appropriate form. You will need to provide complete information of your appeal so the appropriate staff person can help to resolve your appeal in a timely and efficient manner. You or your representative may present or submit relevant facts and/or evidence for review, either in person or in writing to us at the address listed below. If more information is needed, you will be contacted by our Health Plan Associate or a PACE program staff member of the center you attend who will assist you in obtaining the missing information.

3. If you wish to make your appeal by telephone, you may contact our Health Plan Associate at 415-292-8895, or our toll-free telephone number at 1-888-996-6565, to request an appeal form and/or to receive assistance in filing an appeal. For the hearing impaired, please call TTY: 415-292-8898.

4. If you wish to submit your appeal in writing, please ask a staff person for an appeal form. Please send your written appeal to:

   Health Plan Associate  
   On Lok Lifeways  
   1333 Bush Street  
   San Francisco, CA 94109

5. You will be sent a written acknowledgement of receipt of your appeal within five (5) working days for a standard appeal. For an expedited appeal, we will notify you or your representative within one (1) working day by telephone or in person that the request for an expedited appeal has been received.

6. The reconsideration of On Lok Lifeways decision will be made by a person(s) not involved in the initial decision-making process in consultation with the Interdisciplinary
Team. We will ensure that this person(s) is both impartial and appropriately credentialed to make a decision regarding the necessity of the services you requested.

7. Upon On Lok Lifeways completion of the review of your appeal, you or your representative will be notified in writing of the decision on your appeal. As necessary and depending on the outcome of the decision, On Lok Lifeways will inform you and/or your representative of other appeal rights you may have if the decision is not in your favor. Please refer to the information described below:

The Decision on your Appeal:

If we decide fully in your favor on a standard appeal for a request for service, we are required to provide or arrange for services as quickly as your health condition requires, but no later than thirty (30) calendar days from when we received your request for an appeal. If we decide fully in your favor on a request for payment, we must make the requested payment within sixty (60) calendar days after receiving your request for an appeal.

If we do not decide in your favor on a standard appeal, or if we fail to provide you with a decision within thirty (30) days, you have the right to pursue an external appeal through either the Medicare or Medi-Cal program (see Additional Appeal Rights below). We also are required to notify you as soon as we make a decision that is not fully in your favor and to notify the federal Centers for Medicare and Medicaid Services and the California Department of Health Care Services. We will inform you in writing of your appeal rights under Medicare or Medi-Cal managed care, or both. We will help you choose which to pursue if both are applicable. We also will send your appeal to the appropriate review.

If we decide fully in your favor on an expedited appeal, we must give permission for you to get the service or give you the service as quickly as your health condition requires, but no later than seventy two (72) hours after we received your request for an appeal.

If we do not decide in your favor on an expedited appeal or fail to notify you within seventy two (72) hours, you have the right to pursue an external appeal through either the Medicare or Medi-Cal program (see Additional Appeal Rights below). We also are required to notify you as soon as we make a decision that is not fully in your favor and to notify the federal Centers for Medicare and Medicaid Services and the California Department of Health Care Services. We will inform you in writing of your appeal rights under Medicare or Medi-Cal managed care, or both. We will help you choose which to pursue if both are applicable. We also will send your appeal to the appropriate review.

Additional Appeal Rights Under Medi-Cal, Medicare or the Department of Managed Health Care (DMHC)

If we do not decide in your favor on an appeal or fail to provide a decision to you within the required time frame, you have additional appeal rights. Your request to file an external appeal can be made either verbally or in writing. The next level of appeal involves a new and impartial review of your appeal request through either the Medicare or Medi-Cal program, or both, or the California Department of Managed Health Care.
The Medicare program contracts with an "independent review organization" to provide external review on appeals involving PACE programs. This review organization is completely independent of our PACE organization.

The Medi-Cal program conducts their next level of appeal through the State's fair hearing process. If you are enrolled in Medi-Cal, you can appeal if your requested service or payment for service is denied, deferred, modified, delayed, reduced or stopped. Until you receive a final decision, you may choose to continue to receive these services. However, you may have to pay for these services if the decision is not in your favor.

If you are enrolled in both Medicare and Medi-Cal, we will help you choose which appeals process you should follow. We are required to send your appeal to the appropriate review.

If you are not sure if you are enrolled in Medicare or Medi-Cal, or both, ask us. The Medicare and Medi-Cal external appeals processes are described below.

Medi-Cal External Appeals Process

If you are enrolled in both Medi-Cal and Medicare OR Medi-Cal only, and choose to appeal our decision using Medi-Cal's external appeals process, we will send your appeal to the California Department of Social Services. You may request a fair hearing at any time during the appeals process up until ninety (90) days from the date of the decision through:

California Department of Social Services  
State Hearings Division  
P.O. Box 944243, Mail Station 19-37  
Sacramento, CA 94244-2430  
Telephone: 1-800-952-5253  
Fax: 916-229-4410  
TTY: 1-800-952-8349

If you choose to request a State fair hearing, you must ask for it within ninety (90) days from the date of receiving the Notice of Action (NOA) for Service or Payment Request from On Lok Lifeways.

You may speak at the State hearing or have someone else speak on your behalf such as someone you know, including a relative, friend or attorney. You may also be able to get free legal help. We will provide you with a list of Legal Services offices in the county where you live at the time that we deny, modify or defer a service or payment of a service.

If the Administrative Law Judge's (ALJ) decision is in your favor of your appeal, On Lok Lifeways will follow the judge's instruction as to the time frame for providing you with services you requested or payment for services for a standard or expedited appeal.

If the ALJ's decision is not in your favor of your appeal, for either a standard or an expedited appeal, there are further levels of appeal, and we will assist you in pursing your appeal.
Medicare External Appeals Process

If you are enrolled in both Medicare and Medi-Cal OR Medicare only, you may choose to appeal using Medicare's external appeals process. We will send your case file to Medicare's independent review organization for you. Medicare currently contracts with the Center for Health Dispute Resolution (CHDR) to impartially review appeals involving PACE programs like us. CHDR will contact us with the results of their review. CHDR will either maintain our original decision or change our decision and rule in your favor. You may contact CHDR through:

Maximus Federal Services
PACE Appeal Project
3750 Monroe Avenue, Suite 702
Pittsford, New York 14534-1302
Telephone: 585-348-3300
Fax: 585-425-5292

Standard External Appeal

You can request a standard external appeal if we deny your request for a non-urgent service or do not pay for a service. For a standard external appeal, you will get a decision on your appeal no later than 30 calendar days after you request the appeal.

If CHDR's decision is in your favor for a standard appeal:

If you have requested a service that you have not received, we must provide the service as quickly as your health condition requires.

OR

If you have requested payment for a service that you have already received, we are required to pay for the service.

Expedited External Appeal

You can request an expedited external appeal if you believe your health would be jeopardized by not receiving a specific service. In an expedited external appeal, we will send your case file to CHDR as quickly as your health requires. CHDR must give a decision to us within seventy two (72) hours after they receive the appeal. CHDR may ask for more time to review the appeal, but they must give their decision to us within fourteen (14) calendar days.

If CHDR's decision is in your favor for an expedited appeal:

We must provide the service or arrange for you to receive the service as quickly as your health condition requires.

If CHDR's decision is not in your favor for either a standard or an expedited appeal, there are further levels of appeal, and we will assist you in pursuing your appeal.
Department of Managed Health Care Independent Medical Review (IMR) Process

The Department of Managed Health Care (DMHC) operates an Independent Medical Review ("IMR") process for those health care service plan enrollees who are NOT enrolled in Medicare (one is “enrolled in Medicare” if one is enrolled in both Medicare and Medi-Cal or is enrolled in Medicare only). If you are eligible for IMR, On Lok Lifeways will provide you with a separate written description of your rights under this program.

“The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 415-292-8895 or 1-888-996-6565 and use your health plan’s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department’s Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.”
Section 5: Billing and Payment

Claims Submission

Claims for services rendered to On Lok Lifeways Participants must be submitted on a current CMS 1500 form for professional services or CMS 1450 (UB-04) form for facility services. The claim must contain all required data elements. Incomplete or incorrect claims will be rejected and returned to provider. On Lok follows Medicare or Medi-Cal rules and regulations for claims payment.

Timeframe for Submitting Claims

Claims must be submitted within the timeframe stated in the Provider Services Agreement (generally 120 days). You may submit claims to On Lok via the following:

<table>
<thead>
<tr>
<th>US Mail</th>
<th>Fax</th>
<th>EDI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please mail claims to:</td>
<td>Please fax claims to:</td>
<td>Please send electronic</td>
</tr>
<tr>
<td>On Lok Senior Health</td>
<td>On Lok Senior Health</td>
<td>claims to your</td>
</tr>
<tr>
<td>Services Attn: Claims</td>
<td>Services Attn: Claims</td>
<td>clearinghouse:</td>
</tr>
<tr>
<td>Department 1333 Bush</td>
<td>Department Fax # 415-292-8745</td>
<td>On Lok Payor ID: 99485</td>
</tr>
<tr>
<td>Street</td>
<td></td>
<td></td>
</tr>
<tr>
<td>San Francisco CA 94109</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Claims Payment

On Lok Senior Health Services will make payment within thirty (30) working days of the date of receipt of a completed and properly submitted claim. Late payments on all claims (excluding those for emergency services) shall automatically include interest at the rate of fifteen percent (15%) per annum for the period of time that the payment is late.

Late payment for a complete claim for emergency services, which is neither contested nor denied, shall automatically include the greater of fifteen dollars ($15) for each 12-month period or portion thereof on a non-prorated basis, or interest at the rate of fifteen percent (15%) per annum for the period of time that the payment is late.

Copayments

There are no copayments or deductibles for On Lok Lifeways Participants.
Adjusted, Denied or Contested Claims

If your claim is adjusted, denied or contested, On Lok Senior Health Services will provide a written explanation of the specific reasons for the action taken and direct the provider to access information regarding the provider dispute resolution process. For questions about the written explanation, please scroll further down this Section 5 for the paragraph title “Payment Inquiries from Providers,” for contact information. Additionally, detailed information regarding On Lok Senior Health Services Provider Dispute Resolution Process can be found in Section 10 of this Provider Manual.

Potential Billing Discrepancies

Should billing discrepancies occur, On Lok Senior Health Services will make an initial attempt to resolve any potential billing errors, which may include differences between the bill and Lifeways records, with the provider. We may request a copy of the medical record as well as other supplemental documentation by submitting a clear, accurate and written explanation of the necessity for the request to the provider.

Incomplete or Pending Claims

On Lok Senior Health Services shall contest or deny incomplete claims as well as claims for which information necessary to determine payer liability has been requested and held or pended awaiting receipt of additional information in writing within the time frames set forth in the regulations.

Payment Inquiries from Providers

The On Lok Senior Health Services administrative services organization initially handles all payment inquiries from providers. Please have the Participant’s name, On Lok Lifeways ID#, name and address of where facilities were rendered, and date of service (DOS) ready when calling the administrative services organization. If any issues cannot be resolved, the administrative services organization refers the provider to the Provider Relations Specialist for additional resolution options, including the Provider Dispute Resolution process as described in Section 10 of this Provider Manual.

Problematic Claims

For claims that appear suspect to possible fraud, misrepresentation, or unfair billing practices, the claim will be forwarded to On Lok Senior Health Services’ Chief Medical Officer, Provider Relations Specialist and/or other external agencies for review. Further information about On Lok’s Fraud Waste and Abuse Prevention program can be found in Chapter 11.
Third Party Liability

In the event that an On Lok Lifeways Participant has suffered damages as a result of a third party and has the right to recover funds from a liable third party i.e., casualty insurance or tort, the On Lok Senior Health Services contract with the Department of Health Care Services will prevail for the recovery of funds for medical expenses. On Lok Senior Health Services will not exercise cost avoidance for medical care services, unless the On Lok Lifeways Participant has other health coverage (OHC) and the services are covered by the OHC.

Services Provided Without Prior Authorization

In the case where Participants pay out of pocket for non-emergency services without prior-authorization, such claims will be paid by On Lok Senior Health Services at the discretion of the Interdisciplinary Team (IDT) and/or the Chief Medical Officer. If the services are deemed not medically necessary or an alternate in-network provider was available, the social worker will discuss payment responsibility with the Participant.

Balance Billing

As a reminder, upon entering into a contract with On Lok Senior Health Services to provide services for On Lok Lifeways Participants, all providers agree to accept On Lok Senior Health Services’ payment(s) as payment in full with no right to seek additional payments from Medi-Cal, Medicare, other insurance companies, or the Participants. For payment of non-authorized services where the Participant is deemed responsible, as determined by On Lok Senior Health Services policy and procedures, center staff will speak to the Participant and/or family regarding payment.

Overpayment of a Claim

If On Lok determines that it has overpaid a claim to a provider, On Lok will notify the provider in writing through a separate notice that clearly identifies that claim, the name of the participant involved, the date of service(s), and a clear explanation of the basis upon which On Lok believes the amount paid on the claim was in excess of the amount due, including any interest or penalties on the claim.

If the provider contests On Lok’s notice of overpayment of a claim, the provider, within thirty (30) working days of the receipt of the notice of overpayment of a claim, must send written notice to On Lok stating the basis upon which the provider believes that the claim was not overpaid. On Lok shall then process the contested notice in accordance with the provider dispute resolution process outlined in Section 10 of the Provider Manual.

If the provider does not contest On Lok’s notice of overpayment of a claim, the provider shall reimburse On Lok within thirty (30) working days of the provider’s receipt of the notice of overpayment of a claim.
If the provider does not contest On Lok’s notice of overpayment of a claim, On Lok may choose to offset the overpayment amount indicated in the notice of overpayment against that provider’s current claim submission when: (i) the provider fails to reimburse On Lok within the timeframe noted in the above third paragraph, and (ii) On Lok’s contract with the provider specifically authorizes On Lok to offset the overpayment amount indicated in the notice of overpayment from the provider’s current claims submissions. In the event that an overpayment of a claim is offset against a provider’s current claim pursuant to this section, On Lok shall provide the provider a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.
Section 6: Utilization Management

Description of Program

On Lok Lifeways assures quality of care by establishing overall organizational controls including a process for utilization management and review. On Lok Lifeways’s utilization management program differs from traditional utilization management programs in that On Lok Lifeways relies on the professional judgment of its staff PCPs to make medical care decisions and relies on experts on the Interdisciplinary Team (IDT) to make decisions in their respective disciplines. The only exceptions are in instances of out of network services which must be approved by the On Lok Lifeways Chief Medical Officer.

Prior Authorization

There are three general areas where authorization may be required for some services. They include:

- Referrals made by a contracted specialist to another in-network entity, including another specialist or a diagnostic center. Such referrals must be reviewed and approved by the Participant’s PCP.

- Referrals to an out-of-network provider. These requests are reviewed and authorized by the On Lok Lifeways Chief Medical Officer.

- Recommendations for home care services, attendance in the adult day health center, rehabilitation services, nursing home placement, DME, glasses hearing aids and dentures, nutritional supplements and portable meals are reviewed and approved by the Participant’s IDT.

Emergency services, preventive services, sensitive services and confidential services do not require prior authorization by On Lok Lifeways.

The Authorization Form delineates the reason for the referral and the scope of the requested service. The Authorization Form includes a numeric authorization number. The Contractor responds to the referring On Lok Lifeways physician in writing on the Form regarding the professional opinion, recommended treatment plan and anticipated follow up care. All additional services recommended by Contractor, including referrals to other providers, diagnostic tests and treatments must be explicitly authorized by On Lok Lifeways. A sample Authorization Form can be found at the end of this Section 6.
Discharge Planning

Upon discharge from an inpatient hospital, the On Lok Lifeways primary care provider or IDT coordinates discharge planning with the hospital staff. The On Lok Lifeways Utilization Management Nurse may assist in discharge planning process.

Transportation Services

As detailed in Section 4, On Lok Lifeways provides or otherwise arranges for transportation to/from the Contractor’s service location. On Lok Lifeways may also provide an escort for the Participant.
MEDICAL CONSULTATION AUTHORIZATION AND REPORT

Authorization Code

Effective Date:
Expiration Date:
# Visits:

Prt Name: Prt #: SSN: DOB:
Center: JADE PCP: Sup MD:
PCP Phone: (415) 292-8888 NH MD:

Consultant Name: Specialty:
Address: Group:
Phone: Fax:

Appointment Date: Appointment Time: Priority:

PCP of Record: Date: Entered by:

Reason for Referral:

Clinical Information / Comments:

(See additional information attached.)

Billing Instructions:
1) Please use HCFA-1500 Claim Form ONLY.
2) Each claim must include the following:
   a) All ICD-9-CM diagnosis codes must be entered in the 4th or 5th digit in Box 21 (e.g. Diabetes, Type II uncomplicated is 250.00).
   b) Each CPT code in Box 24-D points to only one ICD-9 diagnosis.
   c) Mental Health DSM codes must be converted to comparable ICD-9-CM codes.
   d) Authorization Code (in the upper right-hand corner of this document) must be entered in Box 23 (Prior Authorization Number).
   e) Physician's NPI number (not license #, not Medicare billing #) must be entered in Box 33.
3) Incomplete claims will be returned for revision and resubmission.
4) Please send all completed HCFA-1500 Claims Forms to:
   On Lok Senior Health, Attention: Accounts Payable
   1333 Bush Street
   San Francisco, CA 94109
5) For billing inquiries, please call (415) 292-8869

FOR ON LOK USE ONLY (Staff initials & date)
Report Reviewed By:
Service Provided Date Entered By:
Report Received Date Entered By:

Please return this consult request form and a copy of your typed consult note to On Lok Lifeways:
FAX:
CONSULTANT'S REPORT
Please record findings and recommendations. Attach separate sheet if necessary. All additional services, including referrals, diagnostic tests and treatments must be authorized explicitly by On Lok.

All Consultants:

Consultant Signature: ___________________________ Date: ________________

For psychiatry or psychology consultants only:
Number of treatments: ______ Duration of treatment: ____________________
Section 7: Pharmacy

Prescription Drug Benefits

Each Participant enrolled with On Lok Lifeways is entitled to Medicare and Medi-Cal covered services, including prescription drugs. The Participant’s primary care provider (PCP) is responsible for managing the care of the Participant, including prescription drugs. Recommendations for a drug therapy made by a pharmacist will be reviewed by the PCP and ordered as appropriate. On Lok Senior Health Services will not assume financial responsibility for unauthorized drugs/medications ordered by providers outside of On Lok Lifeways except in the case of an emergency.

Copayments

As a reminder, On Lok Lifeways Participants pay no copayments or deductibles for covered services, including prescription drug coverage benefits.
Section 8 – Quality Assurance

Quality Assurance and Improvement Program (QAIP)

The On Lok Lifeways Quality Assurance and Improvement Program (QAIP) enables On Lok to measure, assess and improve important aspects of health care delivery and the health care outcomes of On Lok Lifeways Participants.

Goals of the Quality Improvement Program

The On Lok Lifeways Quality Assurance and Improvement Program adheres to the principles of the National Committee on Quality Assurance (NCQA). The Quality Assurance (QA) department of On Lok Lifeways objectively and systematically monitors and evaluates the quality and appropriateness of Participant care at least quarterly, and more frequently when appropriate. The results are reported to the Quality Management Team (QMT) and Quality Assurance and Improvement Committee (QAIC). The goals of the review process are to assure that all care is provided at a high level of quality, and that any problems that could affect care are identified, assessed and resolved.

The QAIP is reviewed annually, and revised if major changes have occurred or when new healthcare regulations are in effect. The revisions to the QAIP are presented to the On Lok Senior Health Services Board of Directors for approval on an annual basis.

QAIP Committee Structure

Three standing committees of the Board facilitate the Board’s oversight of quality:

- The Quality Assurance and Improvement Committee;
- The Plan Policy Advisory Committee and
- The Ethics Committee.

The Quality Assurance and Improvement Committee receives information from the following committees for review and action: the Quality Management Team, the Infection Control Committee, the Dental Review Committee, the Home Healthcare Review Committee, the Utilization Management Committee, and the Service Utilization Review Committee.

Quality Management

As part of the QAIP program, providers are monitored for:

- Participant access to care and availability of care and services;
- Compliance with OnLok Lifeways policies and procedures;
- Participant satisfaction with care provided;
- Coordination of care by the primary care provider, specialist physicians, mental health providers and community facilities caring for the Participant;
- Cultural and linguistically appropriateness of care, including availability of bilingual staff and telephonic language assistance services and;
- Program performance and resource utilization management.

On Lok Senior Health Services
Provider Manual
By monitoring services and addressing problems as they arise, On Lok Lifeways is able to keep its mission and vision of providing quality, affordable care services for the well-being of the frail elderly and to continually lead the movement to improvement of care for the elderly.

**Quality Assurance Provisions Applicable to Contractor**

In addition to complying with the On Lok Lifeways credentialing requirements detailed in Section 9, the Contractor is to cooperate and comply with quality assurance provisions that include coordination of care, accessibility standards, office waiting time, Participant satisfaction surveys, grievances and appeal activities and communication regarding unusual incidents.

Upon request, Contractor may receive a copy of the On Lok Lifeways QAIP. Please contact the Provider Relations Specialist at the telephone number listed in Section 2 of this Provider Manual for further information.

**Facility and Provider Site Reviews**

On Lok Lifeways conducts site reviews to meet On Lok Lifeway’s quality improvement standards and to ensure compliance with applicable local, state, and federal laws and regulations.

Please find a copy of the Contract Provider Site Review Instrument at the end of Section 8.

**Reviews for Contractors**

Annual site reviews will be conducted for all contracted Primary Care Providers. Annual site reviews will also be conducted for specialists who provide a high volume of services. High volume is defined as 20 or more unique encounters in the year.

Please find a copy of the Contract Specialist Performance Review Supplement at the end of Section 8.
**On Lok Senior Health Services**  
**Contract Provider Site Review Instrument**

**Provider Name:**  
**Address:**  
**Specialty:**  
**Medical Group:**  
**Reviewer:**  
**Date:**

<table>
<thead>
<tr>
<th>Practice Environment</th>
<th>Met</th>
<th>Not Met</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office adequately identified</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parking available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Handicapped parking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elevator available, if office is not on ground floor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting room and entry accessible, free of obstruction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office hours posted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exits marked</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office suite is clean, neat and well maintained</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam rooms and restrooms wheelchair accessible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam rooms appropriately equipped</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of staff licenses and training on file</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Office Safety</th>
<th>Met</th>
<th>Not Met</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is an OSHA exposure control plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is an Infection Control and hazardous waste plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fire extinguisher on premises and properly maintained</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoke detector or sprinkler system present</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLIA licensure up to date if office has a lab</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refrigerator for medication storage has temperature 36 - 46 degree F</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No food in medication refrigerator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autoclaving / sterilization of instruments dated and documented</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Records Management</th>
<th>Met</th>
<th>Not Met</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a policy for maintaining confidentiality of records</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical records are stored in a secure location accessible to staff only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office has an appointment system documenting missed appointments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications</td>
<td>Met</td>
<td>Not Met</td>
<td>Comment</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-----</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Emergency medication supply available and listed by drug class</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency medications not outdated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample medications not outdated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Narcotics stored in locked areas, with limited secure access</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a narcotic sign out log</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician's DEA certification is verified and current</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Procedures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedure for Emergency / Urgent care of patients is posted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff have appropriate CPR training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff are aware of procedures to handle violent or abusive patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Provider credentials</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>California license current and valid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEA certificate current and valid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malpractice liability insurance at $1 million occurrence/$3 million annual aggregate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contract with On Lok Senior Health Services signed with updated attachments</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*N/A - Not Applicable*
Specialist Providers
PERFORMANCE REVIEW SUPPLEMENT

Provider:

Grievance/s since last appointment:

**Note:** If this document is blank, the physician has not had an On Lok participant encounter.

<table>
<thead>
<tr>
<th>Review Period: [Month/Year] to [Month/Year]</th>
<th>Plan Standard</th>
<th>Total Appointments</th>
<th>Total Compliant Appointments</th>
<th>% Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent/Urgent Appointments</td>
<td>Within 48 hours of request</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Routine New Appointments (Medical/Dental)</td>
<td>Within 15 business days of request</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Routine New Appointments (Psychiatry/Psychology)</td>
<td>Within 10 business days of request</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Review Period: [Month/Year] to [Month/Year]</th>
<th>Plan Standard</th>
<th>Total Appointments</th>
<th>Total Compliant Appointments</th>
<th>% Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wait Time in Office on Appointment Date</td>
<td>Within 30 minutes of appointment time</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:

Reviewer: ___________________________  Date: ___________________________
Section 9: Provider Credentialing

Provider Credentialing Standards

On Lok Lifeways has developed and implemented credentialing and re-credentialing policies and procedures for Contractors.

At the end of this section 9, please find a copy of On Lok Lifeways’ current Credentialing Standards and Procedures for Physicians and Contract Specialist Providers and the Credentialing Standards for Organized Medical Groups and Hospital Employed Physicians.

Also at the end of this section 9, please find a copy the Credentialing Application for On Lok Lifeways’ Provider Panel Physicians and Non-Physician Providers.

In addition, you will find a copy of:

• Re-Credentialing Application for Provider Panel Physicians and Non-Physician Providers
• Contract Specialist Performance Review Instrument that is completed by the referring On Lok Lifeways provider
• Provider Delegation Oversight Survey Instrument (for medical groups that are being considered for delegation of credentialing)

Confidentiality of Credentialing Information

All information obtained during the credentialing and re-credentialing process is considered to be confidential except as otherwise required by law.

For additional information regarding credentialing and re-credentialing requirements and policies, please contact the Quality Assurance Department at (415) 292-8885 or qa_department@onlok.org.

Medicare and/or Medi-Cal Certification

All facility based providers eligible for Medicare and/or Medi-Cal certification must be Medicare and/or Medi-Cal certified.

Physician or other professionals that are not Medicare and/or Medi-Cal certified must not be ineligible for participation in the Medicare and/or Medi-Cal programs.
On Lok Lifeways
Quality Assurance & Improvement Program

CREDENTIALING STANDARDS AND PROCEDURES
FOR PHYSICIAN AND CONTRACT SPECIALIST PROVIDERS

The purpose of the credentialing process is to verify that participating physicians and other professionals have the necessary and appropriate credentials to provide their services to the Plan participants. The following standards and process are modeled after standards and procedures developed by National Committee on Quality Assurance (NCQA).

A. Standards for Participating Practitioners

1) Have a current and valid license to practice in California, without restrictions, as a physician or surgeon.

2) Have a current and valid Drug Enforcement Agency (DEA) certificate (if applicable).

3) Board Certification Certificate (as appropriate)

4) Have malpractice liability coverage in the amount of at least $1 million per occurrence per year and $3 million in the aggregate per year.

5) Verification of hospital privileges in good standing, including review of past history of curtailment or suspension of medical staff privileges.

6) Have practitioner profile evaluation with National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB).

7) Current Curriculum vitae that includes past work history with verification of job references and training as applicable.

B. Credentialing Procedures for Participating Physicians

1) The physician submits an application to the Plan as a staff physician or an independent contract physician.

2) The physician submits the following documents:

   a) Current Curriculum vitae.

   b) Valid California Physician’s license.

   c) Current DEA certificate.

   d) Malpractice liability coverage certificate.

   e) Board certification certificate if appropriate.
f) History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the provider.

g) Signed application and statement permitting the Plan to make inquiries to other institutions regarding the competence of the physician’s practice and attestation that the physician can perform essential functions of the position with or without accommodation, history of loss of license or felony convictions, history or loss or limitation of privileges or disciplinary activity, lack of present drug use, and correctness and completeness of the application.

3) The Plan verifies the physician’s education, training, licensure and hospital affiliations using correspondence with primary sources, the American Medical Association physician profile service, California Medical Board, or Osteopathic Medical Board of CA, reviewing the licensing verification system as well as through direct query of hospitals and, in the case of recent graduates of training programs, of training program directors.

4) The Plan queries the NPDB for evidence of prior malpractice action, civil judgments and criminal convictions against the candidate.

Note: The credentialing procedures are the same for physician and non-physician providers, except that non-physicians providers do not require verification of DEA certification and hospital privileges. For dentists, Lifeways receives information on sanctions or limitation on licensure form the State Board of Dental Examiners. For Podiatrists, Lifeways receives information on sanctions and limitations on licensure from the State Board of Podiatric Examiners.

5) When all the credentials have been verified, the candidate’s file is submitted to the credentialing committee (a subcommittee of the quality assurance and improvement committee) for consideration and approval at the next scheduled meeting.

6) When the candidate’s credentials have been reviewed and accepted by the credentialing subcommittee and the quality assurance & improvement committee, the practitioner is offered a contract by the Plan to perform services for Plan participants.

7) When necessary, such as hiring of a staff physician before the credentialing subcommittee and the quality assurance & improvement Committee has its next meeting, the Plan Medical Director may interview the candidate, verify the credentials and allow the physician to begin providing services prior to approval by the physician members of the Quality Assurance & Improvement Committee.

8) If at any time the Plan acquires knowledge that a participating provider has had a revocation of license to practice, has been disciplined by any entity including Medicare, Medicaid, hospitals or the State of California Medical Board, has been
convicted of a felony or has been denied malpractice coverage by any carrier, the
provider will be suspended from providing further services to participants. Such a
provider will be notified by certified mail of the suspension which may include an
amendment or termination of the contract.

C. Site Review of primary care physician

For primary care physicians that are contracted by Lifeways and see participants
at their own practice site, the quality assurance staff visits the practice site and
conducts a site review using the “Contract Provider Site Review Instrument”
(Attachment 07-06-01) as part of the credentialing process.

D. Re-verification of practitioner’s credentials. Every three years, each physician’s
credentials are re-verified for:

1) Current California licensure

2) DEA certification

3) Malpractice liability coverage

4) Updated Curriculum Vitae

5) Any actions listed in the NPDB and HIPDB

6) American Medical Associations physician’s profile (if applicable)

7) Medical Board of California and State of California Department of Consumer
Affairs for license verification and any disciplinary action against the
practitioner.

8) Verification of hospital privileges in good standing in at least one of the
hospitals that contract with the Plan.

9) History of professional liability claims that resulted in settlements or
judgments paid by or on behalf of the provider.

10) Signed renewal application and statement permitting Lifeways to make
inquiries to other institutions regarding the competence of the practitioner’s
practice and attestation statement by the applicant that the practitioner can
perform essential functions of the position with or without accommodation,
history of loss of license or felony convictions, history or loss or limitation of
privileges or disciplinary activity, lack of present drug use, and accuracy and
completeness of the application. If any credentials cannot be verified, the
physician will be contacted immediately and requested to submit current
credentials.
11) Performance reviews will be conducted for contracted specialist providers who have provided at least one office consultation during the specified time period using the "Contract Specialist Performance Review Supplement" (Attachment 07-06-02) and "Contract Specialist Performance Review Supplement" (Attachment 07-06-03).

12) The quality assurance staff also performs a site review of all high volume contract specialists using the "Contract Provider Site Review Instrument" (Attachment 07-06-01). High volume is defined as 20 or more encounters in the year prior to re-credentialing.
On Lok Lifeways
Quality Assurance & Improvement Program

CREDENTIALING STANDARDS FOR ORGANIZED MEDICAL GROUPS AND HOSPITAL-EMPLOYED PHYSICIANS

The purpose of the credentialing process is to verify that participating physicians and other professionals have the necessary and appropriate credentials to provide their services to the Plan participants. The Plan delegates responsibility for credentialing to Hospitals under contract who employ physicians and organized Medical Groups. The Hospitals or Medical Groups must implement a credentialing process that is modeled after standards and procedures developed by the National Committee of Quality Assurance (NCQA).

A. Delegation of credentialing for contracted medical groups and organized independent practice associations (collectively known as “group”)

1. The quality assurance and improvement committee reviews and approves the group’s credentialing standards and procedures in order to confirm that they meet Lifeways’ standards and processes, as stated in the Credentialing Standards and Procedures for Physician and Contract Specialist Providers listed in this packet.

2. Lifeways ensures the group agrees to comply with the Lifeways credentialing standards that are modeled after the standards and procedures developed by the National Committee on Quality Assurance (NCQA). This requires the group to complete the following:

   a. Provide Lifeways with a list of participating physicians who will be a part of the Lifeways provider network on an annual basis.

   b. Report additions or deletions to the provider list to Lifeways on a quarterly basis.

   c. Verify that each participating physician is properly credentialied, using the Lifeways credentialing standards stated below.

   d. Submit pertinent credentialing information of all of its providers to the Lifeways quality assurance department for review by the credentialing subcommittee according to Lifeways procedures.

   e. Give written notice to Lifeways whenever it acquires knowledge that any of the participating providers has had a revocation of a license to practice, has been disciplined by any entity (including Medicare, Medicaid,
California Medical Board, or any hospital), has been convicted of a felony, or has been denied malpractice insurance coverage by any carrier.

3. For each group, Lifeways reviews a random sample of 5% of the credentialing files on an annual basis using the “Provider Delegation Oversight Survey Instrument” (Attachment 07-06-04). Lifeways requires that a practitioner roster is provided in a spreadsheet form including the following items:
   a. Name and degree,
   b. Date of birth,
   c. CA professional license number and expiration date,
   d. DEA Number and expiration date,
   e. Practitioner Specialty,
   f. Work address,
   g. Board certification,
   h. NPI number,
   i. Name of medical school attended and year of graduation.

4. Lifeways removes any provider from the participating panel who lacks proper credentials or has been disciplined by any entity.

B. Removal of participating provider by Lifeways

1. If Lifeways receives information at any time that a participating provider has had a revocation of license to practice, has been disciplined by any entity (including Medicare, Medicaid, California Medical Board, or any hospital), has been convicted of a felony, or has been denied malpractice coverage by any carrier, Lifeways suspends the provider from providing further services to participants.

2. Lifeways notifies the provider and the group by certified mail of the suspension, which may include an amendment or termination of the contract.
Credentialed Application for Provider Panel Physicians and Non-Physician Providers

1. Applicant Information

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Middle Name:</th>
<th>Degree:</th>
</tr>
</thead>
</table>

Maiden Name/ Other Names Used: | Practice Specialty: |

Primary Practice Address:

Office Phone: | Office Fax: |

Office Hours Provider is Available:

<table>
<thead>
<tr>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time:</td>
<td>Time:</td>
<td>Time:</td>
<td>Time:</td>
<td>Time:</td>
<td>Time:</td>
<td>Time:</td>
</tr>
</tbody>
</table>

Cell Phone: | Email: |

Date of Birth: | Place of Birth: | Citizenship: |

Gender: Male □ Female □ | Language(s) spoken by provider only: |

Social Security Number: | NPI Number: |

Home Address:

2. Education

College/ University: | Degree: |

Address: | Dates of Attendance: | Graduation Date: |

3. Medical Education

Medical School: | Degree: |

Address: | Dates of Attendance: | Graduation Date: |
### 4. Post-Graduate Training

*Please check training type and complete for each*

<table>
<thead>
<tr>
<th>Internship</th>
<th>Residency</th>
<th>Fellowship</th>
<th>Date of Training</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital/University</th>
<th>Address</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Internship</th>
<th>Residency</th>
<th>Fellowship</th>
<th>Date of Training</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital/University</th>
<th>Address</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Internship</th>
<th>Residency</th>
<th>Fellowship</th>
<th>Date of Training</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital/University</th>
<th>Address</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 5. Licensure

<table>
<thead>
<tr>
<th>California License Number:</th>
<th>Exp. Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DEA Registration Number:</th>
<th>Exp. Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ECFMG Number (if applicable):</th>
<th>Exp. Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6. Board Certificate

Are you certified by a specialty board that is recognized by the American Board of Medical Specialties (ABMS)?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Board Eligible in (if not yet certified):

If intending to sit for Board examination, specify date:

<table>
<thead>
<tr>
<th>Primary Specialty:</th>
<th>Certification Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Board:</td>
<td>Re-certification Date:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary Specialty:</th>
<th>Certification Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Board:</td>
<td>Re-certification Date:</td>
</tr>
</tbody>
</table>

7. Malpractice Insurance

Name of Carrier:  

<table>
<thead>
<tr>
<th>Coverage Limits:</th>
</tr>
</thead>
</table>

Name of Prior Carrier (past five years):

Have you ever been involved in malpractice claims?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Any malpractice claims pending?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If yes, please provide details on a separate sheet of paper

8. Medical Group

Are you currently part of a Medical Group?

(If yes, please check or list below)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

UCSF Medical Group  

Galen Inpatient Physicians

Pacific Inpatient Management Group  

Washington Township Medical Foundation

Paragon Physicians Medical Group  

Other:
9. Hospital privileges  please check if affiliated with the hospitals below and applicable boxes

San Francisco County:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Yes</th>
<th>No</th>
<th>Active</th>
<th>Courtesy</th>
<th>Provisional</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinese Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>California Pacific Medical Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>San Francisco General Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Francis Memorial Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Luke’s Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Mary’s Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UCSF Medical Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

San Mateo County:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Yes</th>
<th>No</th>
<th>Active</th>
<th>Courtesy</th>
<th>Provisional</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seton Medical Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Alameda County:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Yes</th>
<th>No</th>
<th>Active</th>
<th>Courtesy</th>
<th>Provisional</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washington Hospital, Fremont, CA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Santa Clara County:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Yes</th>
<th>No</th>
<th>Active</th>
<th>Courtesy</th>
<th>Provisional</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Samaritan Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O’Connor Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Santa Clara County Valley Medical Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. Practice Information

Years in Practice: Current Status: Full time  Part time

Name(s) of Associates:

Name(s) of Covering Physicians (when you are not available):

11. Teaching Appointments

University or Medical School:

Dates: Faculty Rank:

12. Professional Society Memberships:  Please list below


**13. Disciplinary Action**

1. Has your license to practice medicine in any jurisdiction ever been limited, suspended or revoked, or is such action pending?  
   | Yes | No |

2. Has your registration with the Drug Enforcement Administration ever been limited, suspended, revoked, not renewed or have action pending?  
   | Yes | No |

3. Have your privileges at any hospital, medical organization, or health plan ever been suspended diminished, revoked, or not renewed, or is such action pending?  
   | Yes | No |

4. Have you ever been denied staff membership or renewal of membership because of disciplinary action at any hospital, medical organization, or health plan or is such action pending?  
   | Yes | No |

5. Have you ever resigned from a hospital medical staff, a medical organization, or health plan to avoid disciplinary action?  
   | Yes | No |

6. Have you ever been convicted of a felony?  
   | Yes | No |

**14. Health Status**

1. Are you able to perform the essential functions of this contract, with or without reasonable accommodation, according to accepted standards of professional performance and without posing direct threat to patients?  
   | Yes | No |

2. Do you have any physical or mental health problem that might affect your ability to practice medicine/clinical duties?  
   | Yes | No |

*If yes, please explain:*  

3. Are you engaged in the use of illegal drugs, or the use of controlled substances not under the supervision of a licensed healthcare professional (including self-administration of such drugs)?  
   | Yes | No |

*If yes, please explain:*  

4. Do you have a history of chemical dependency/substance abuse or are you currently engaged in such activity?  
   | Yes | No |

*If yes, please explain:*
15. Disclosure of Financial Interest

Please list the health-care related companies or health-care related facilities, if any, in which you or an immediate member/owner and have a material (5% or more) financial interest:

| Yes ☐ | Not applicable ☐ |

*If yes, please specify in details below:*

16. Reference Request

*In order to complete the processing of your application, we are requesting two references from physicians/professionals who are familiar with your current work and competence*

<table>
<thead>
<tr>
<th>Reference # 1</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Degree:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td>Fax:</td>
<td></td>
</tr>
<tr>
<td>Email Address:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reference # 2</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Degree:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td>Fax:</td>
<td></td>
</tr>
<tr>
<td>Email Address:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
17. Declaration

I understand On Lok Lifeways is responsible for the evaluation of my professional competence and qualifications, and has the obligation to inquire into my professional training, experience, professional conduct and judgment.

I consent to communication of information and documents between On Lok, other medical staffs, medical schools, training programs, medical societies, professional associations, professional liability insurance companies, and licensing authorities in jurisdictions in which I have trained, resided, or practiced, for evaluation of my professional training, experience, character, conduct and judgment. In this regard, the utmost care shall be taken to safeguard the privacy and confidentiality of records.

I hereby affirm that the information furnished by me to On Lok is true to the best of my knowledge and is furnished in good faith. I understand that willful and substantial omissions or misrepresentations may result in denial or suspension from providing services to On Lok participants.

I present this information, and arrange for the submission of other information as part of this credentialing process, in the expectation that the confidentiality and these materials will only be released or disclosed as part of current and future credentialing, peer review and quality assurance processes.

I hereby apply formally to be a member of On Lok Lifeways Panel, and agree to abide by On Lok's established guidelines.

<table>
<thead>
<tr>
<th>Name (print or type):</th>
<th>Degree:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If there is a change in the following, please contact On Lok’s Credentials Office immediately at 415.292.8885 or 415.292.8796

- Hospital/ Institutional affiliation
- Malpractice Coverage
- DEA Certification
- Disciplinary action
- Health Status
- Licensure
Re-Credentialing Application for Provider Panel Physicians and Non-Physician Providers

### 1. Applicant Information

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Middle Name:</th>
<th>Degree:</th>
</tr>
</thead>
</table>

Maiden Name/ Other Names Used:  
Practice Specialty:  

Primary Practice Address:  

<table>
<thead>
<tr>
<th>Office Phone:</th>
<th>Office Fax:</th>
</tr>
</thead>
</table>

Office Hours Provider is Available:  
Mon ☐  Tues ☐  Wed ☐  Thurs ☐  Fri ☐  Sat ☐  Sun ☐  
Time: ☐  ☐  ☐  ☐  ☐  ☐  ☐  

Cell Phone:  
Email:  

Date of Birth:  
Place of Birth:  
Citizenship:  

Gender:  
Male ☐  Female ☐  
Language(s) spoken by provider only:  

Social Security Number:  
NPI Number:  

Home Address:  

### 2. Malpractice Insurance

<table>
<thead>
<tr>
<th>Name of Carrier:</th>
<th>Coverage Limits:</th>
</tr>
</thead>
</table>

Name of Prior Carrier (past five years):  

Have you ever been involved in malpractice claims?  
Yes ☐  No ☐  

Any malpractice claims pending?  
Yes ☐  No ☐  

If yes, please provide details on a separate sheet of paper
### 3. Medical Group

Are you currently part of a Medical Group?

*If yes, please check or list below*

<table>
<thead>
<tr>
<th>Medical Group</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>UCSF Medical Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Galen Inpatient Physicians</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pacific Inpatient Management Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washington Township Medical Foundation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paragon Physicians Medical Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 4. Hospital privileges  *please check if affiliated with the hospitals below and applicable boxes*

**San Francisco County:**

- Chinese Hospital
- California Pacific Medical Center
- San Francisco General Hospital
- St. Francis Memorial Hospital
- St. Luke’s Hospital
- St. Mary’s Hospital
- UCSF Medical Center

**San Mateo County:**

- Seton Medical Center

**Alameda County:**

- Washington Hospital, Fremont, CA

**Santa Clara County:**

- Good Samaritan Hospital
- O’Connor Hospital
- Santa Clara County Valley Medical Center

Other:

### 5. Disciplinary Action

1. Has your license to practice medicine in any jurisdiction ever been limited, suspended or revoked, or is such action pending?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

2. Has your registration with the Drug Enforcement Administration ever been limited, suspended, revoked, not renewed or have action pending?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
3. Have your privileges at any hospital, medical organization, or health plan ever been suspended diminished, revoked, or not renewed, or is such action pending?  
   | Yes | No |

4. Have you ever been denied staff membership or renewal of membership because of disciplinary action at any hospital, medical organization, or health plan or is such action pending?  
   | Yes | No |

5. Have you ever resigned from a hospital medical staff, a medical organization, or health plan to avoid disciplinary action?  
   | Yes | No |

6. Have you ever been convicted of a felony?  
   | Yes | No |

6. **Health Status**

   1. Are you able to perform the essential functions of this contract, with or without reasonable accommodation, according to accepted standards of professional performance and without posing direct threat to patients?  
      | Yes | No |

   2. Do you have any physical or mental health problem that might affect your ability to practice medicine/clinical duties?  
      | Yes | No |

      *If yes, please explain:*

   3. Are you engaged in the use of illegal drugs, or the use of controlled substances not under the supervision of a licensed healthcare professional (including self-administration of such drugs)?  
      | Yes | No |

      *If yes, please explain:*

   4. Do you have a history of chemical dependency/substance abuse or are you currently engaged in such activity?  
      | Yes | No |

      *If yes, please explain:*

7. **Disclosure of Financial Interest**

   Please list the health-care related companies or health-care related facilities, if any, in which you or an immediate member/owner and have a material (5% or more) financial interest:  
   | Yes | Not applicable |

   *If yes, please specify in details below:*
8. Declaration

I understand On Lok Lifeways is responsible for the evaluation of my professional competence and qualifications, and has the obligation to inquire into my professional training, experience, professional conduct and judgment.

I consent to communication of information and documents between On Lok, other medical staffs, medical schools, training programs, medical societies, professional associations, professional liability insurance companies, and licensing authorities in jurisdictions in which I have trained, resided, or practiced, for evaluation of my professional training, experience, character, conduct and judgment. In this regard, the utmost care shall be taken to safeguard the privacy and confidentiality of records.

I hereby affirm that the information furnished by me to On Lok is true to the best of my knowledge and is furnished in good faith. I understand that willful and substantial omissions or misrepresentations may result in denial or suspension from providing services to On Lok participants.

I present this information, and arrange for the submission of other information as part of this credentialing process, in the expectation that the confidentiality and these materials will only be released or disclosed as part of current and future credentialing, peer review and quality assurance processes.

I hereby apply formally to be a member of On Lok Lifeways Panel, and agree to abide by On Lok’s established guidelines.

<table>
<thead>
<tr>
<th>Name (print or type):</th>
<th>Degree:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

If there is a change in the following, please contact On Lok’s Credentials Office immediately at 415.292.8885 or 415.292.8796

- Hospital/ Institutional affiliation
- Malpractice Coverage
- DEA Certification
- Disciplinary action
- Health Status
- Licensure
ORGANIZATIONAL PROVIDER CREDENTIALING APPLICATION
ON LOK LIFEWAYS

Please complete this application and return to the address below. Attach all required documentation with the application. Please PRINT all responses.

On Lok Lifeways
1333 Bush Street
San Francisco, CA 94109
Attention: QA – Credentialing

Telephone: 415-292-8324 Fax: 415-292-2822

I. PROVIDER INFORMATION

Date of application (mm/dd/yyyy):

Organization Name:

Address:

City / State / Zip:

Telephone: Fax:

Email: Contact person:

Federal Tax ID: NPI:

Medicare #: MediCal #

II. ORGANIZATIONAL TYPE (Check all applicable)

☐ Hospital ☐ Skilled Nursing Facility
☐ Home Health Agency ☐ Inpatient Psychiatric Facility
☐ Ambulatory Surgery Center ☐ Dialysis Center
☐ Medicare Hospice ☐ Residential Hospice
☐ Residential Care Facility for the Elderly ☐ Laboratory
☐ Outpatient Radiology and Imaging Center (free standing only) ☐ Durable Medical Equipment
☐ Chemical Dependency Detoxification Facility ☐ Pharmacy
☐ Ambulance ☐ OTHER (please specify)

III. Licensure and Insurance - Attach a current copy of the following:

☐ State of California Department of Health Services License (or other applicable licensure)
☐ Malpractice Liability Coverage Policy showing coverage amounts and dates of coverage – minimum $1 million per occurrence and $3 million annual aggregate
☐ General Liability Coverage Policy showing coverage amounts and dates of coverage – minimum $1 million per occurrence and $3 million annual aggregate

IV. ACCREDITATION AND CERTIFICATION - Check all applicable and attach copy of current certificate. Must be Medicare or MediCal certified at minimum

☐ Medicare ☐ MediCal
☐ Joint Commission on Accreditation of Health Care Organizations (JCAHO)
☐ Other (please specify):

V. QUALITY ASSURANCE and IMPROVEMENT PLAN Attach copy of current plan if not JCAHO accredited.
Contract Specialist Performance Review Instrument

Review provided for: (Name, degree) ____________________________________________

The following form is to review current providers applying for reappointment to the On Lok Specialist panel. Please answer the questions below based on your personal knowledge of the practitioner’s performance and as soon as possible. Your answers will be kept confidential.

Sincerely,

Catherine Eng, MD
Medical Director

Please select the appropriate boxes below:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>During the previous 3 years have you had the opportunity to directly observe this practitioner’s practice of medicine?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you related to the practitioner as family or through a professional partnership or financial association?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Poor</th>
<th>Average</th>
<th>Good</th>
<th>Outstanding</th>
<th>No Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>In general, how would you rate the practitioner’s medical knowledge?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In general, how would you rate the practitioner’s clinical and technical skills?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How would you rate the practitioner’s availability for consultation in his/her area of specialty?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How would you rate the practitioner’s thoroughness in patient care?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you have any reservations or concerns regarding the practitioner’s performance in his/her specialty? No
Yes(explain)________________________________________________________________________

Please provide any additional comments regarding the practitioner’s medical knowledge, competence, clinical skills and abilities. Include any concerns regarding clinical competence, skill in performance of procedures and any adverse outcomes of care.
__________________________________________________________________________________

07-06-02 (rev. 06/16)  Page 1 of 2
Please rate the following:

<table>
<thead>
<tr>
<th></th>
<th>Satisfactory</th>
<th>Needs Improvement</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Interactions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interactions with On Lok medical staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interactions with other medical practitioners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interactions with other Healthcare providers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional attitudes, character and ethics</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please contact the Medical Director, Dr. Catherine Eng, at 415-292-8886 if you have additional concerns related to the professional performance of this provider.

Reviewer Name and degree (MD, DO, NP) ______________________________________

Reviewer Signature ________________________________________________________

Date __________________________

Please email or fax this form to:
Christina Vincent
QA Department
Phone: 415.292.8324
Fax: 415.292.2822
Email: cvincent@onlok.org
<table>
<thead>
<tr>
<th>Met</th>
<th>Not Met</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A current and valid license to practice in California, without restrictions, as a physician or surgeon.

A current and valid Drug Enforcement Agency (DEA) certificate.

Documentation of appropriate training and experience in a designated specialty, or have Board Certification in a recognized medical or surgical subspecialty.

Malpractice liability coverage in the amount of at least $1 million per occurrence per year and $3 million in the aggregate per year.

Verification of hospital privileges in good standing at

Practitioner profile evaluation with the National Practitioner Data Bank (NPDB-HIPD).

Curriculum vitae which include past work history with verification of job references and training as applicable.

Attestation remark by the medical group representative regarding: (1) reasons of any inability to perform the essential functions of the position, with or without accommodation, and (2) any history of chemical dependency or substance abuse (3) any history of license revocation (4) any history of disciplinary action.
Section 10: Provider Rights and Responsibilities

Primary Care Provider Responsibilities

The On Lok Lifeways PCP acts as the primary care manager to his or her assigned Participants. The PCP is an integral part of the interdisciplinary team that makes the PACE model unique.

Ongoing Responsibilities
On an ongoing basis, the PCP has the following responsibilities:

- See every Participant assigned to him or her every three months.
- See every “comfort care” Participant assigned to him or her every thirty (30) days.
- Attend a weekly IDT meeting to discuss the health status of their assigned Participants.
- Coordinate and direct appropriate care for Participants by means of an initial diagnosis and treatment, refer Participants for second opinions as necessary, and consult with contracted specialty providers.
- Follow-up on referrals made to contracted specialty providers to assess the outcome of care, medication regimen and special treatments to ensure a seamless delivery of care.
- Be available to provide health care services, 24 hours a day, 7 days a week.

On Lok Senior Health Services assists the PCP as follows:

- Coordinates specialty visits by making appointments with the specialty provider and transports the Participant to the appointment.
- Provides pharmacy consultation regarding the appropriate use of the pharmacy drug benefit.
- Helps educate the Participant on disease prevention practices and early diagnostic services.
- Assist in the transfer of the Participant to another PCP, if necessary or as requested.

Specialty Provider Responsibilities

With authorization by On Lok Lifeways, the specialty provider has the responsibility to render medical care within their scope of specialization.

The specialty provider has the responsibility to:

- Set a specialty appointment within 14 days of the request.
- Communicate findings of visit to the Participant’s PCP, including recommendations for further diagnostic procedures or therapy.
- Coordinate laboratory and x-ray request(s) with the On Lok Lifeways Center.
- Maintain medical records consistent with state and federal regulations.
- Comply with the On Lok Lifeways Quality Assurance policies and procedures. (See section 8)
- Contact the On Lok Lifeways PCP if a specialist referral to another specialist is recommended.
- Provide Continuity of Care services to On Lok Lifeways Participants if specialty provider’s contact with On Lok Senior Health Services is terminated. (as detailed in Section 4: Members and Participants)
Provider Rights

On Lok Senior Health Services will make every effort to assist a provider in the resolution of complaints or problems encountered while providing services to On Lok Lifeways Participants. Please see the section below, “Provider Dispute Resolution Process” for more information.

Complaint and Participant Care Problem

For assistance in resolving administrative or contractual complaints or problems related to Participant care, please contact the Provider Relations Specialist. The Provider Relations Specialist will confer with other departments as necessary, to provide a response to the provider’s complaint. Examples of administrative issues include clarification of authorization or referral process, billing or payment issues.

Summary of Dispute Process

Providers should report any administrative, operational, contractual or claims/payment concerns, issues or disputes in writing to the On Lok Senior Health Services Provider Relations Specialist. Disputes must be filed within 365 calendar days of On Lok Senior Health Service’s action, or in the case of inaction, within 365 calendar days after the time for contesting or denying claims has expired. When making a complaint, please make sure to include the following:

- Provider’s name and identification number (i.e. NPI).
- Provider’s contact information, including address, telephone number and fax number of the provider’s contact person.
- An explanation of the dispute or issue, including any relevant attachments, documentation, and supplemental information.
- The name, ID # and date of service of the On Lok Lifeways Participant for disputes involving a service provide to a specific Participant.

Provider Dispute Resolution Process

For complete information, please refer to the ‘Provider Dispute Resolution Mechanism’ at the end of this Section 10.
I. POLICY

On Lok Lifeways (Lifeways) manages a dispute resolution mechanism in order to process and resolve administrative, operational, contractual, and payment disputes from contracted and non-contracted providers in a timely, fair, and cost-effective manner. Lifeways makes best efforts to resolve provider disputes on a timely basis with the mutual satisfaction of all parties.

II. DEFINITIONS

A. A provider dispute is a written notice from a contracted or non-contracted provider to the plan that challenges, appeals, or requests consideration for payment, contractual obligations, administrative responsibilities, or services provided to participants.

B. The date of receipt is the working day that the provider dispute is delivered to Lifeways.

III. PROCEDURE

A. Notifying providers of dispute resolution mechanism

Lifeways notifies all contracted and non-contracted providers of the dispute resolution mechanism.

B. Processing provider disputes

1. Contracted and non-contracted providers should report any administrative, operational, contractual, or claims/payment concerns, issues, or disputes to Lifeways in writing. The written dispute must include the following information:

   a. Provider’s name

   b. Provider’s contact information, including name, address, and telephone number of the provider’s contact person
c. An explanation of the dispute or issue, including any relevant attachments, documentation, and supplemental information

d. The name of the participant, participant identification number, and date of service (if the dispute involves a service provided to a Lifeways participant)

2. The provider must file all disputes within 365 calendar days of the Lifeways action, or in the case of inaction, within 365 calendar days after the time for contesting or denying claims has expired.

3. The Lifeways provider relations specialist will acknowledge receipt of the dispute within five working days, or two working days if the dispute was submitted electronically, using the “Acknowledgment Letter of Provider Dispute” (Attachment 18-02-01).

4. The provider relations specialist logs the provider dispute in a summary log and assigns a tracking number for the dispute. The log contains the following data elements:

   a. Date of receipt of provider dispute

   b. Assigned tracking number

   c. Name of provider

   d. Description of issue being disputed

   e. Final determination

   f. Date of correspondence (i.e., acknowledgement and resolution letters)

   g. Any other pertinent information (i.e., informal communication with provider regarding dispute)

5. If the information provided in the written dispute is not adequate, the provider relations specialist will request missing or additional information in writing. However, Lifeways does not request that the provider resubmit any claim information or supporting documentation that the provider previously submitted to Lifeways as part of the claims adjudication process.

6. The provider may submit an amended dispute within 30 working days of the request for additional information.

7. Depending on the type of dispute, the provider relations specialist contacts the following department representatives to facilitate resolution:
a. For administrative or operational disputes, the provider relations specialist notifies and consults with the chief medical officer, the chief operating officer, or designees.

b. For contractual disputes, the provider relations specialist notifies and consults with the provider services manager.

c. For payment disputes, the provider relations specialist notifies and consults with the director of claims administration or designee.

d. For disputes involving quality of care, the provider relations specialist notifies and consults with the chief medical officer or designee.

Note: Any dispute submitted by a provider on behalf of a participant should be treated as a grievance by Lifeways; therefore, Lifeways should not use the provider dispute resolution mechanism.

8. The provider relations specialist will resolve or deny all provider disputes within 30 working days from the date of receipt. The provider relations specialist uses the “Notification of Resolution” (Attachment 18-02-02) to inform the provider about details of the resolution, including the implementation date of the resolution and any corrective action plans.

9. If the provider relations specialist anticipates the dispute resolution to exceed 30 working days from the date of receipt, the delay and the anticipated date for resolution will be communicated in writing to the provider.

10. Lifeways adheres to the following time frames for implementing the dispute resolution:

   a. Immediately upon reaching a decision whenever possible.

   b. For payment disputes, if the resolution involves additional payment to the provider, the payment will be made no later than five working days from the date of resolution.

   c. For all non-payment related disputes, no later than 30 calendar days from the date of determination except in extenuating circumstances.

11. In the event Lifeways requests reimbursement of an overpayment, and the provider disputes the overpayment, Lifeways will work with the provider to find a mutually acceptable resolution to the dispute.

C. Retaining documentation and correspondence

The provider relations specialist maintains and files all documentation and
correspondence regarding provider disputes for a period of 10 years from the date of determination.

D. Preparing data for annual report to California Department of Managed Health Care (DMHC)

1. The provider relations specialist prepares an aggregate provider dispute resolution report that shows the following:
   a. The number and types of providers using the dispute resolution mechanism
   b. The number and types of disputes
   c. A summary of the disposition for all disputes

2. The provider relations specialist forwards the report to the provider services manager, who will then verify the results with the chief medical officer within four working days after the close of the calendar year.

3. The chief financial officer, or designee, submits the “Annual Plan Claims Payment and Dispute Resolution Mechanism Report” to the DMHC no later than 15 days after the close of the calendar year.

IV. MONITORING

The chief medical officer, or designee, provides oversight for the maintenance of the provider dispute resolution mechanism.

V. REGULATORY CITATIONS

A. PACE: 42 CFR 460.70

B. Knox-Keene Health Care Service Plan Act of 1975, Section 1367 (h)(1)

C. Knox-Keene Regulations: 28 CCR § 1300.71.38

VI. ATTACHMENTS

A. 18-02-01 – Acknowledgment Letter of Provider Dispute

B. 18-02-02 – Notification of Resolution
Section 11: Fraud, Waste, and Abuse Prevention

Prevention of Fraud, Waste and Abuse
On Lok takes health care fraud, waste and abuse (FWA) seriously and we are committed to preventing FWA in our programs in accordance with the Deficit Reduction Act and federal and state laws, such as the False Claims Act. It is our policy to provide information to all employees, contractors and agents about the federal and state false claims acts, remedies available under these acts and how employees, contractors, and agents can use them, and about whistleblower protections available to those who report a violation of the federal or state false claims acts. We also inform our employees, contractors and agents of the policy and procedures we have in place to detect health care fraud and abuse. On Lok works in partnership with its contracted providers to identify and report suspected FWA and our contracts with providers require compliance with all applicable state and federal FWA laws and regulations.

Federal False Claims Act
What it does:
Allows a civil action to be brought against a health care provider who:
- Knowingly makes, uses or causes to be made or used a false record or statement to get a false or fraudulent claim paid; or
- Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval to any federal employee;
- Conspires to defraud the government by getting a false of fraudulent claim allowed or paid (31 USC sec. 3729(a)).

Examples of a false claim:
- Falsifying information in the medical record
- Billing for procedures not performed
- Upcoding
- Misuse of coding modifiers
- Violation of another law, for example a claim was submitted appropriately but the service was the result of an illegal relationship between a physician and the hospital (physician received kick-backs for referrals)

Penalties
Health care providers and suppliers who violate the False Claims Act can be subject to civil monetary penalties ranging from $5,500 to $11,000 for each false claim submitted. In addition to civil penalties, providers and suppliers can be required to pay three times the amount of damages sustained by the U.S. government. The Office of Inspector General of the Department of Health and Human Services may also seek to exclude the provider or supplier from participation in federal health care programs.

Whistleblower Rights and Protections
To encourage individuals to come forward and report misconduct involving false claims, the False Claims Act includes a provision to allow any person (a “whistleblower”) with actual knowledge of alleged false claims to the government to file a lawsuit on behalf of the U.S. government. Federal law prohibits an employer from discriminating against an employee who is a
whistleblower in the terms or conditions or his or her employment because the employee initiated or otherwise assisted in a false claims action. The employee is entitled to relief necessary to make the employee whole (31 USC 3730(h)).

The whistleblower with the actual knowledge of a false claim must file his or her lawsuit on behalf of the government in a federal district court. The lawsuit will be kept confidential while the government reviews and investigates the allegations and determines how it will proceed.

If the government decides to proceed with lawsuit, the prosecution of the lawsuit will be directed by the U.S. Department of Justice. If the government decides not to intervene, the whistleblower may continue to pursue the lawsuit on his or her own.

If the lawsuit is successful, and provided that certain requirements are met, the whistleblower may receive an award from the government ranging from 15 to 30 percent of the amount received by the U.S. government, as well as reasonable expenses.

No Retaliation
In addition to the financial reward, the False Claims Act entitles employees who are whistleblowers that file a lawsuit with the government additional protection, including employment reinstatement, back pay, and any other compensation that may have arisen from retaliatory conduct against the employee for filing an action. On Lok has a policy prohibiting retaliation against its own employees for engaging in protected activity and strongly encourages employees to raise concerns about what they perceive to be false claims or false statements with their supervisor, another administrator or the On Lok Compliance Officer. Providers contracted with On Lok are required to do the same.

Statute of Limitations
A statute of limitations says how much time may pass before an action may no longer be brought for violation of the law. Under the False Claims Act, the statute of limitations is six (6) years after the date of violation or three years after the date when material facts are known or should have been known by the government, but no later than ten (10) years after the date on which the violation was committed.

California False Claims Act
The California False Claims Act was the first state statute passed after the federal law. The California law prohibits the knowing presentation of a false claim for payment to a state government agency, including the Medi-Cal program. California's law is similar to the Federal law, except that the State law also requires a person who unknowingly submitted a false claim and then later discovers the claim was false, to report the false claim to the State, or face penalties. California also has other laws dealing with fraud, including Labor Code §1102.5, Health and Safety Code §1278.5, Insurance Code §1871.7, Penal Code §550 and Welfare and Institutions Code §14107.
What you should do if you suspect FWA or submission of a false claim:

- If you or one of your employees suspect FWA involving care of an On Lok participant must report it to On Lok immediately and we will investigate. You can report On Lok in the following ways:
  - On Lok Compliance Officer – (415) 292-8888
  - On Lok Compliance hotline – (800) 361-4637
  - Fax – (415) 292-8745 (Attn: On Lok Compliance Dept)
  - Email – compliance@onlok.org
  - Mail – On Lok Lifeways
    Attn: Compliance Dept
    1333 Bush St
    San Francisco, CA 94109

- Reports to the On Lok Compliance Department may remain anonymous if you prefer.
- All information received by the On Lok Compliance Department will be treated as confidential and investigation results will not be shared with anyone who does not have a valid or legal reason to receive such information. We may be required to share investigation results with state and federal authorities, legal counsel, and/or senior management.
- You are not required to report a possible false claims act violation to On Lok first. You may report the incident directly to the federal Department of Health and Human Services Office of Inspector General by phone (800-HHS-TIPS) or online https://forms.oig.hhs.gov/hotlineoperations
- Your complaint will be investigated by On Lok and we may follow-up with you with additional questions. If appropriate, the appropriate government agencies will be notified as required by law. Depending on the outcome of the investigation, On Lok will follow-up with you if remediation or correction is required to prevent FWA in the future (e.g., education, policies, monitoring, etc.).

Policies and procedures for detecting fraud and abuse

On Lok maintains its own policies for detecting and preventing FWA. According to On Lok's policy 22-20-00, Prevention and Investigation of Fraud and Abuse, On Lok employees are encouraged to report suspected incidences to their supervisor or On Lok Compliance Officer. Cases are investigated in an objective and timely manner by the On Lok Compliance Officer or other third party, if appropriate. The On Lok Compliance Officer will report the incident to the On Lok Compliance Committee and the On Lok Board. You may obtain a copy of this policy upon request from your On Lok Provider Relations specialist or send a request to the On Lok compliance email: compliance@onlok.org.