Provider Manual

Oklahoma

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INTRODUCTION

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

Our Products: We offer Qualified Health Plans (QHP) to individuals and small groups outside of the state health insurance marketplace, as well as individuals within the health insurance marketplace, Healthcare.gov.

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

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

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

Provider Manual: This manual is intended to help you utilize Friday procedures to better benefit you, our members, other providers, and Friday. The provider manual is available on our website or by mail upon request.

CONTACT US

Friday Care Crew (Customer Service) - Providers can call this number with any questions or concerns regarding Friday Health Plans or its members.

Phone: 1-844-817-1600
Fax: 719-589-4901
Email: questions@fridayhealthplans.com
Hours: 8am to 5pm Central Time except holidays (see below)
TTY Service: 1-800-659-2656 at no cost to you
Translation services: Available by calling the Friday Care Crew

Medical Management: Providers or members may contact the medical management team regarding prior authorizations, inpatient admission notifications or any medical benefit questions.

Phone: 1-844-817-1600
Fax: 1-888-453-1262
Email: ok-medical@fridayhealthplans.com
Hours: 8am to 5pm Central Time Monday through Friday except holidays (see below)

Pharmacy: Pharmacy benefits are managed by Capital Rx. Providers may call with any prescription questions or concerns as well as prescription prior authorizations. This number is also for members.

Phone: 1-844-922-7799
Hours: 24 hours a day 7 days a week

Claims: Providers may contact the claims department with any questions or concerns on claim submissions or payments.

Phone: 1-844-817-1600
Claims Address: Friday Health Plans
P.O. Box 194
Sydney, NE 69162

Appeals and Grievances:

Phone: 1-844-817-1600
Fax: 1-844-280-1794
Email: **appeals@fridayhealthplans.com**
In writing at: Friday Health Plans
700 Main St
Alamosa, CO 81101

Mailing address: 700 Main St
Alamosa, CO 81101

Website: www.fridayhealthplans.com

Friday Health Plans Holiday Schedule

New Year's Day

President's Day

Memorial Day

Independence Day

Labor Day

Thanksgiving

Christmas Day

PROVIDER RESOURCES

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

Language Line

Friday Health Plans, Inc. offers translation and interpretation services in Spanish, and more than 200 other languages. If the member requires translation or interpretation services during a visit, please contact the Friday Care Crew at 1-844-817-1600 for assistance.

Provider Newsletter

Friday Health Plans, Inc. shares important news, updates, and information that affects participating providers and members through the provider newsletter quarterly.

Provider Directory:

On the Friday Health Plans website choose the Member option at the top of the page then "Find a Doctor" option. Select OK from the network list and enter your search criteria.

If you need help finding a provider, you may call the Friday Care Crew at 1-844-817-1600 or email them at questions@fridayhealthplans.com

Provider Portal

Friday has a secure provider portal available 24 hours a day, 7 days a week. The secure portal requires user IDs and passwords for entry. Providers can locate a participating provider, check eligibility, review status of claims and authorizations, and review the formulary via the secure provider portal.

The provider portal is found on our website. To access the portal, choose the Provider heading from the top of the page then click on the Provider Hub option in the drop down menu; then click on Provider portal sign in button.

For questions or problems with the provider portal, please call the Friday Care Crew at 1-844-817-1600, or email our provider operations team at providers@fridayhealthplans.com.

Provider Operations/Contracting teams

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

- New provider orientation/personalized training available upon request,
- Contracting
- Fee schedule
- Electronic filing

The Provider Operations Team can assist providers and their staff with the following:

- Credentialing and re-credentialing application questions
- Provider education
- Provider Manual requests
- Demographic changes
- Provider additions/updates
- National Provider Identifier questions

The Friday Care Crew can assist with the following issues:

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

Providers and their staff may contact the Friday Care Crew by phone at 1-844-817-1600, mail or email to questions@fridayhealthplans.com.

QUALITY PROGRAM

Quality Assurance

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

Definitions:

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

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

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

Quality Assurance Reviews

Identification of Cases for Review

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

- Scheduled peer review activities.
- Utilization management activities.
- Grievances.
- Quality Improvement studies.
- Member or provider complaints.
- Member satisfaction surveys.
- Office/Facility Site Visits.
- Provider claims.
- Pharmacy claims.
- Facility claims
- Data reports.
- Credentialing information.

Review Methodology

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

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

- Accept the reply and require no further action, closing the case.
- Request further information.

- Determine that a consistent pattern exists that may constitute a danger to patient care. The PAC then may set a plan to intensify monitoring of the provider(s) care or exercise other actions.
- Accept the reply but set specific limitations on provider involvement with Friday patients for a defined probationary period.
- Not accept the provider's response and explanation and place the provider on probation. The PAC shall notify the provider in writing of this decision.
- Terminate the provider contract per the Professional Quality of Care or Service Concern Review, Suspension or Termination Determinations and Provider Dispute Process.

Corrective Action Plan

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

- Additional monitoring of provider for specified period
- Education of provider
- Inquiry about quality concerns
- Review of all inpatient admissions related to the practitioner
- Review of all procedures performed by the practitioner
- An ambulatory medical record review either related to a specific diagnosis or to a randomly selected sample of records
- Specific training mandate for the provider
- Other action specific to the case as recommended
- Warning letter to provider

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

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

FRAUD, WASTE, AND ABUSE

The Operating Departments of Friday Health Plans oversee the Fraud, Waste and Abuse system with the assistance of our claims adjudication vendor Zelis.

Definitions

Fraud is defined as the intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s).

Waste is defined over as utilization of services, or other practice that result in unnecessary cost, generally not considered caused by criminally negligent actions but rather misuse of resources.

Abuse is defined as a range of the following improper behaviors or billing practices including, but not limited to:

- Billing for a non-covered service
- Misusing codes on the claim (i.e., the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered)
- Inappropriately allocating costs on a cost report

Federal and State Statutes and Regulations Applicable to Friday Health Plans, Inc. Providers:

- The False Claims Act (31 U.S.C. 3729-3733)
- The Anti-Kickback Statute (42 U.S.C. 1320a-7b (b) and 42 C.F.R. 1001.952)
- The Physician Self-Referral Law (42 U.S.C. 1395nn and 42 C.F.R. 411.350)
- The Exclusion Authorities (42 U.S.C. 1320a-7; 1320c-5 and 42 C.F.R. 1001 and 1002)
- The Civil Monetary Penalties Law (42 U.S.C. 1320a – 7a and 42 C.F.R. 1003)
- The Health Care Fraud Statute (18 U.S.C. 1347 and 1349)
- The Patient Protection and Affordable Care Act

Reporting Potential Fraud, Waste, and Abuse and Other Suspicious Activity

Reports are confidential. When reporting suspicious behavior, you may remain anonymous.

To report call: **1-888-533-3696**

Or email at compliance@fridayhealthplans.com

CREDENTIALING AND RE-CREDENTIALING

All participating providers must be in accordance with Friday requirements and URAC standards.

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

Definitions

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

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

Clean Application: A credentialing application that has no defect, Misstatement of facts, improprieties, including a lack of any required substantiating documentation, or circumstance requiring special treatment that impedes prompt credentialing or recredentialing.

Initial Credentialing Application

Application to become a Friday participating provider includes, but is not limited to, CAQH Application Form and supporting documentation. If you have submitted a credentialing application and would like to check the status, please call the Friday Care Crew at 1-844-817-1600 or email us at providers@fridayhealthplans.com.

Applicants must agree to abide by:

- Friday policies and procedures
- Contractual agreements
- Agree to exhaust internal administrative remedies before pursuing litigation in the event of any adverse ruling

Re-credentialing Application

Our credentialing cycle is every 36 months, 6 months prior to the last credential date FHP will submit the provider to our outsourced vendor (CAQH) for re-credentialing. IF the provider has incomplete or expired information, FHP is notified by the vendor (CAQH). At the time of this notification it is considered an unclean re-credential file. Following receipt of the notification a member of the FHP Credentialing Team will reach out to the provider for any missing or incomplete information.

Completion, Verification and Decision

Once an application is received, a confidential file is made or updated for the applicant. If the application is determined to be incomplete, Friday Health Plans (FHP) will notify the provider within 10 calendar days of receipt of the application. If the application is complete, FHP will initiate requests for primary source verification and malpractice history within 7 calendar days. Once the application and verification processes are complete, the file will be forwarded to the PAC. For re-credentialing, the committee shall also be sent any Peer Review or other chart audits; internal or PAC reviews for the past three (3) years; and previous credentialing documents.

The PAC will make the decision about acceptance or denial of the provider as a participating Friday provider. Once the application is deemed clean, FHP have 45 calendar days to credential or recredential a physician or other health care provider. Providers being re-credentialed may consider themselves approved unless otherwise notified. Therefore, re-credentialed providers will only be notified of adverse decisions or concerns from the PAC. The entire credentialing process should never exceed 180 calendar days.

Criteria for credentialing or re-credentialing

A provider seeking initial or re-credentialing from Friday Health Plans, Inc. must meet the following criteria:

- Hold a current, valid, and unrestricted medical license to practice in the state in which the practitioner will treat Friday Health Plans, Inc. members.
- Proof of completion and graduation from medical school or professional school.
- Current professional liability (malpractice) insurance.
- A current and unrestricted Drug Enforcement Administration (DEA) registration, if applicable, in the state in which the practitioner practices.
- Provide hospital affiliations if provider has admitting privileges
- The provider must submit a written description of a formal arrangement for inpatient coverage for his or her patients should any of them require hospitalization if they do not have admitting privileges.

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

Notification of Discrepancies and Credentialing Decisions

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

If initial credentialing is approved, the provider will become a participating provider and receive an approval letter within 10 days of their approval date. The re- credentialing of the approved provider occurs every three (3) years. If credentialing is denied, the Medical Director sends a letter to the provider indicating the reason for denial. If there are issues or questions regarding the application that preclude a final decision by the PAC at the initial review, Friday will send a letter to the provider explaining the issues or questions and outlining steps necessary to allow a final decision.

Right to Review or Correct Credentials Information

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

Non-Participating Provider

Non-participating or “out-of-network” are providers that have not successfully completed the credentialing/contracting process with Friday Health Plans, Inc. Services rendered by these providers will be denied unless they are within an emergency situation or have been approved by Friday Health Plans Medical Management team.

PROVIDER ROLES AND RESPONSIBILITIES

Primary Care Provider (PCP)

As a Participating PCP you will work to assure continuity of care and work with Friday Health Plans to get prior authorizations for specialized care members may need.

Pediatricians

For any Covered Child, members may select a pediatrician as the child PCP.

Obstetrical and Gynecology (OB/GYN)

Members do not need Prior Authorization for obstetrical or gynecological care from a participating provider who is an OB/GYN or reproductive health specialist.

REFERRING FRIDAY HEALTH PLANS, INC. MEMBERS TO OUT-OF-NETWORK PROVIDERS ALWAYS REQUIRES PRIOR AUTHORIZATION FROM FRIDAY HEALTH PLANS, INC.

Appointment Wait Times

As a Participating provider you will be expected to maintain the following:

- If provider is a PCP, they shall be available by telephone or by appointment 24-hours per day, 7-days per week to ensure timely evaluation of members’ health needs.
- Routine physical exams shall not exceed a wait time of four (4) months.
- Routine, non-emergent appointments shall be scheduled as soon as is practical to the needs of the member but in no case longer than thirty (30) business days from request.
- The wait time for urgent care appointments shall not exceed forty-eight (48) hours.
- The wait time for an appointment with a specialist shall not exceed four (4) weeks from the time of request.
- In non-emergency situations, the wait time in the provider’s office shall not exceed thirty (30) minutes from the scheduled appointment time.

If the provider is unavailable, it is the responsibility of the provider to arrange for coverage by a participating Friday Health Plans, Inc. network provider.

Restriction or Termination of Provider

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

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

Definitions

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

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

Quality of Care and Quality of Service Concerns

Receipt of Concerns

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

Imminent Threat to Safety

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

In such cases, the Medical Director notifies the practitioner by telephone of the summary suspension with written notice by certified mail to be sent on the same day. The written notice informs the practitioner that an investigation will be conducted to determine whether the suspension will remain in place beyond fourteen (14) days.

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

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

All Other Concerns

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

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

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

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

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

Reporting Requirement

If the final action of the Plan will restrict, suspend over thirty (30) days, or terminate the practitioner's participation in the Plan, the Medical Director will report the final action to the National Practitioner Data Bank (NPDB) and the state specific medical board.

Confidentiality

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

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

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

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

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

The practitioner must submit a written request for a hearing within 30 days. A Medical Director will select a panel of three qualified individuals, including two physicians of which at least one who must be a participating provider who is not otherwise involved in day-to-day operations of Friday and who is in the same specialty (clinical peer) as the practitioner filing the dispute but who is not in direct competition with the practitioner; the panel may not include any person who has previously been involved with the investigation.

The provider and/or their representative has the right to appear before the panel in person. The hearing is conducted outside the formal rules of evidence, with the panel allowing into evidence any evidence that reasonable persons would rely on in serious affairs. However, both sides may examine and cross-examine witnesses; the panel may ask questions of any witness as well. The burden of proof is on Friday. That is, Friday must show that the facts justify its recommendation by a preponderance of the evidence. In the case of a summary suspension, the burden is on Friday to

show that the suspension was necessary, and that investigation could not have been done in the normal course. If the recommendation involves an initial application to Friday, the applicant practitioner has the burden to show that he/she meets the credentialing standards of Friday. The hearing will be recorded if feasible. Only individuals presenting relevant information may attend the hearing. The hearing panel deliberates privately. The hearing panel can accept, reject, or modify the recommendation of the PAC. The hearing panel forwards the findings and recommendations of the hearing panel to the Medical Director.

Within twenty (20) business days after the completion of the hearing the Medical Director notifies the practitioner in writing, by certified mail, of the findings and recommendation of the first level panel.

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

The second-level panel will establish a deadline for written position statements from each party, based on the record from the hearing. No new evidence may be introduced on second level appeal. Within twenty (20) business days of receipt of the position statements, the second level panel will report its recommendations back to the Friday COO, based on its review of the position statements, and the COO of Friday will make a final determination of action against the practitioner. The Medical Director notifies the practitioner in writing, by certified mail, of the final decision of the panel within twenty (20) business days and reports the final action to the appropriate authorities including the NPDB and the BME as required.

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

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

MEDICAL MANAGEMENT

Utilization Management Process

Friday reviews certain health services to determine whether the services are or were medically necessary a covered benefit, or experimental/investigational. This process is called utilization review. Utilization review includes all review activities, whether they take place prior to the service being performed (prior authorization); while the service is being performed (Concurrent); or after the service is performed (Retrospective). This review process results in a service being prior- authorized or denied as a covered benefit.

Prior Authorization Requirements

Service	Authorization Required
Acupuncture	Not covered
Artificial insemination	Not covered
Bariatric Surgery	Not covered
Biopsy – Bone Marrow	Yes
Bone Scan – 3 phase	Yes
Breast Pump	No member gets $250
Breast Reconstruction	Yes
Chemotherapy	Yes
Cleft lip/palate services/surgery	Yes
Cochlear implants	Not Covered
Continuous Glucose Monitor	Yes
CPAP	Yes
CT/CTA Scan	Yes
Dialysis	Yes
DME	Yes items over $500
EEG- Inpatient only	Yes
Elective Abortion	Not covered
Genetic Testing	Yes
Hearing Aids	No 1 per ear/48 months
Hida Scan	Yes
Home Health	No but plan year limit of 30 visits.
Hospice-Inpatient/Home Hospice	Yes after first 6 months
Infertility Testing	Yes
Injectables	Yes for meds over $1000

Service	No Authorization Required
Allergy Testing	No
Amniocentesis	No
Blood products	No
Bereavement Counseling	No
Biopsy – Breast	No
Bone Density – DEXA only	No
Cardiac Rehab	No plan year limit 36 visits
Carotid Ultrasound	No
Cataract Surgery	No
Chiropractic	Yes after 30 visits
Continuous Glucose Monitor Supplies	No
Colonoscopy or other IFOBT(Screening/Diagnostic including Cologard)	No
CPAP Supplies	No
Depo Provera Injection	No
Diabetes Education	No
Diabetes Testing Supplies	No
Echocardiogram	No
EGD/Endoscopy	No
Epidural Injection	No
Essure	No
Flu Vaccination	No
Holter/Event Monitor	No
Hospital- OBS <23hrs	No
HPV Vaccination-Boys	No
HPV Vaccination-Girls	No

Inpatient Admission-Preplanned	Yes
Inpatient Surgery	Yes
Insulin Pump	Yes
Invitro fertilization	Not covered
IV infusion Home or Outpatient	Yes
Marital Counseling	Not covered
Mastectomy	Yes
Maternity-Vaginal-delivery only	Notification required at time of admission
Maternity- C-section-delivery only	Notification required at time of admission
Maternity- Surrogate	Not covered
Mental Health- Inpatient	Yes
MRI	Yes
Newborn Stay – Beyond Mom's	Yes
Nuclear Medicine	Yes
Nutrition Counseling	No
Nuclear Stress	Yes
Orthotics/diabetic shoes	Yes
Orthotics	Yes
OP Surgery- Hospital/Surgery Ctr	Yes
In-office procedures	Yes >$1000
PET Scan	Yes
Pulmonary Perfusion Test	Yes
VQ Scan	Yes
Radiation	Yes
Radiology/Diagnostic MRI/CT/PET	Yes
SNF (skilled Nursing-Inpatient)	Yes
Sleep Study- in lab	Yes
Specialty Drugs-PBM	Yes
Substance Use (SU) Tx – Inpatient	Yes
Substance ab Tx – Outpatient	No
TMJ Tx	Not covered

Implanon/Nexplanon	No
Insulin pump supplies	No
IUD/Diaphragm	No
Mammograms	No
Maternity-Global	No
Medication port	No
Mental Health- Outpatient	No
Neuropsych Testing	No
O_2 & O_2 concentrator	No
PICC line (all procedures)	No
Pneumococcal Vaccine	No
Pulmonary Function Test-PFT	No
Radiology/Diagnostic/x-ray	No
Shingles <60yo	No
SPECT/Lexiscan	No
Stress Test	No
Tubal Ligation	No
Ultrasounds	No
Vasectomy	No
Wound care- In office	No
Vaccinations	No
PT/OT/ST- rehabilitative	No but Plan year limit 30 visits combined
PT/OT/ST- habilitative	No Plan year limit 30 visits per therapy
Vaccinations	No

Transgender services	Yes
Transplants	Yes
Wigs (Chemo)	Yes

- **Friday Health Plans does not require authorization for emergency medical care**
- **Friday health Plans requires authorization for in-office procedures over $1000 to protect members from unexpected cost sharing expenses. To inquire whether a service requires authorization please contact the Friday Care Crew at 1-844-817-1600.**

Prior Authorization Timeline

All timelines for prior authorization requirements are applicable with state and federal regulations. On receipt of a request from a Participating Provider for Prior Authorization, the Plan shall review and issue a determination indicating whether the health care services are authorized.

Standard Pre-service Prior Authorization- The determination will be issued and transmitted not later than three (3) days after the date the request is received.

Standard Post-Service Prior Authorization- The determination will be issued and transmitted not later than thirty (30) days after the date the request is received.

Concurrent Prior Authorization - For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than twenty-four (24) hours after receipt of your request for services or extension on services.

Expedited Prior Authorization Review - Expedited requests that meet the following standards are approved or denied within 24 hours of the request once all relevant and supporting documentation is received.

Expedited Authorization are: When a health care professional requests an expedited prior authorization and submits to the health insurer a statement that, in the health care professional's opinion that is based on reasonable medical probability, delay in the treatment for which prior authorization is requested could:

- Seriously jeopardize the covered person's life or overall health
- Affect the covered person's ability to regain maximum function
- Subject the covered person to severe and intolerable pain
- Pre-service authorization only

Out-of-Network Prior Authorizations- For routine care that is available in-network, the time frame is 30 days. For out-of-network requests, when the services requested are not available in-network, requests for continuity of care, or expedited requests will be processed per the in-network protocols.

Adverse Determinations

All adverse determinations are certified by a Friday Health Plans, Inc. Medical Director. Participating providers have the opportunity to complete a post-determination peer-to-peer prior to an official appeal with the Medical Director that reviewed the authorization and made the adverse determination.

Case Management

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

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

If you feel your patient would benefit from our Case Management Program, call us at: 1-844-817-1600.

Clinical Preventative Guidelines

The Plan will pay for the preventive services, based on the A or B recommendations of the United States Preventive Services Task Force (USPSTF). The Plan reviews the A and B recommendations throughout the plan year. If the USPSTF makes a change to its A and B recommendations, then those changes will be reflected in the benefits of the following plan year Please see https://www.uspreventiveservicestaskforce.org/uspstf/ for a full list of requirements.

Mental Health Parity Act Notice of Rights and Services

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

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

PHARMACY MANAGEMENT PROGRAM

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

https://www.fridayhealthplans.com/wp-content/uploads/2021/11/2022-OK-Pharmacies-1.pdf

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

- Tier 1 Preferred Generics
- Tier 2 Non-Preferred Generics
- Tier 3 Preferred Brands
- Tier 4 Non-Preferred Brands
- Tier 5 Specialty Drugs

Capital Rx has a standard policy to allow members, providers, and prescribers to request coverage for medications that are considered non-formulary or are not covered by default for any other reason. These exceptions can be requested by phone at 844-817-1600 and fax at 844-280-1794.

Standard Exception Request: Friday Health Plans, Inc. will notify the enrollee or enrollee's designee and the prescribing provider of the determination to a standard exception request no later than 30 days following receipt of the request.

Expedited Exception Request: Friday Health Plans, Inc. will notify the enrollee or enrollee's designee and the prescribing provider of the determination to a standard exception request no later than 72 hours following receipt of the request.

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

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

Covered drugs may require prior authorization and must be written by a licensed provider. Prior authorization forms can be found on our website at www.fridathealthplans.com or use the link below and select Prescription Drug Prior Authorization Form. https://www.fridayhealthplans.com/wp-content/uploads/2020/12/Prescription-Drug-Prior-Authorization-Form-Dec-2020-Form.pdf

Drugs that are listed on by the Affordable Care Act are covered by Friday Health Plans at $0 cost share to the member.

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

https://caprx.adaptiverx.com/webSearch/index?key=8F02B26A288102C27BAC82D14C006C6FC54D480F80409B68E5FAE0FB47E8C029

Friday Health Plans has multiple pharmacy benefits. Please refer to the specific pharmacy benefit plan purchased by the member.

CLAIMS SUBMISSION AND PAYMENT

Claims Submission Process

Required Information

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

Submitting Claims by Mail

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

Paper claims should be mailed to:

Friday Health Plans
PO Box 194
Sidney, NE 69162

Submitting Claims Electronically

To submit electronic claims directly to Friday, please contact us at 1-844-817-1600. Our electronic payer ID is H0657

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

- Patient's full name
- Member identification number (from ID card)
- Date of birth
- Date of service
- Valid ICD-10 diagnosis code(s)
- Place of service
- Type of service
- Valid Procedure code(s) (i.e. HCPCS, CPT, Revenue codes) *must use CPT4 procedure coding with 2-digit modifier as applicable
- Units of service (Quantity)
- Anesthesia claims require start and stop times in addition to units.
- Amount charged for each service (usual & customary)
- Name of Referring Physician authorization or referral number, if applicable
- Rendering Provider's name, address, and authorized signature
- Rendering Provider's federal tax identification number
- Rendering Provider's NPI

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

Quick Processing Tips

To ensure your claims are processed quickly, please follow these tips:

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

Claims Payment

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

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

Reimbursement

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

Amounts Collectible from the Member

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

For any applicable co-insurance and/or deductibles, Friday recommends either waiting for availability of the Provider Reimbursement Voucher/Hospital Reimbursement Voucher or Explanation of Payment that indicates the member's amount owed, in order to avoid refunds to members.

Remittance Advice

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

https://provider.zelispayments.com/registration

For issues with login or to set up a new login: Zelis Provider Service Line: 877-828-8770

payerservice@zelispayments.com

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

Coordination of Benefits

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

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

Third Party Liability

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

Claim Payment Disputes

Claim payment disputes result when the provider or provider's office believes a claim has been paid or adjudicated in error.

If you believe that a claim(s) has been paid or adjudicated in error, a request for reconsideration must be made in writing to Friday Health Plans, Inc. within 180 days of the initial Evidence of Payment (EOP).

You can submit a reconsideration request to:

Friday Health Plans
Attn: Appeal and Grievance
700 Main St
Alamosa, CO 81101
Or email it to appeals@fridayhealthplans.com

For any questions, please call our Friday Care Crew at 1-844-817-1600 and ask to be transferred to the Appeals Department.

In your documentation, please include the error that has occurred. These reasons may include but are not limited to:

- Corrected claims
- Proof of timely filing
- Calculation of units billed
- Claim was submitted and paid twice
- Claim was paid at the wrong rate (contractual)
- Claim was paid for the wrong date(s) of service(s)
- Claim was paid at a wrong level of care
- Services were span billed with overlapping days on more than one claim
- A compliance audit was conducted
- Post payment recoveries
- Authorization was not applied accurately

All Claims disputes will be resolved in a timely manner but not to exceed sixty (60) days from date of receipt of obtaining all necessary information.

Provider APPEALS AND GRIEVANCES

Friday Health Plans, Inc. takes provider appeals and grievances seriously. Provider appeals and grievances are processed timely to ensure a prompt and thorough investigation in alignment with federal and/or state regulatory requirements.

Definitions:

Grievance: Means a concern that a provider may have regarded:

- Operation of a managed health care plan, including concerns regarding quality of and access to health care services, the choice of health care providers and the adequacy of the plan's provider network

All grievances will be processed in a timely manner but not later than thirty (30) days.

Please include in your grievance all documentation on why you feel the specific procedure or policy should be changed.
If regarding a quality-of-care issue, please include:

- Clinical documentation of the issue
- Any standards of practice you feel were violated

To file a grievance:

Contact the Friday Care Crew at 1-844-817-1600
Email it to: appeals@fridayhealthplans.com
In Writing:
Fax: 1-844-280-1794
Mail it to: Friday Health Plans
Attn. Appeals and Grievances
700 Main St.
Alamosa, CO 81101

For further information regarding member Grievance or Appeal procedures, please contact Friday Care Crew at 1-844-817-1600.

Member APPEALS AND GRIEVANCES

Friday Health Plans, Inc. takes member appeals and grievances seriously. Member appeals and grievances are processed timely to ensure a prompt and thorough investigation in alignment with federal and/or state regulatory requirements. Member or the Member's representatives may file an appeal for any healthcare service that has been denied by the plan.

Appeal Adverse Determinations

Member may request a review if a service has been denied for pre-authorization (certification) for a proposed procedure, has denied full or partial payment for a procedure the member has already received, or is denying or reducing further payment for an ongoing procedure that the member is already receiving and that has been previously covered. (We must notify the member before terminating or reducing coverage for an ongoing course of treatment and must continue to cover the treatment during the appeal process.) This type of denial may also include a refusal to cover a service for which benefits might otherwise be provided because the service is determined to be experimental, investigational, or not medically necessary or appropriate. It may also include a denial of a participant's or beneficiary's eligibility to participate in a plan. These types of denial are collectively called "adverse determinations."

Administrative Decision

Members may also request a review if you object to how the insurer handles other matters, such as its administrative practices that affect the availability, delivery or quality of heal care services; claims payment, handling or reimbursement for health care services; or if your coverage has been terminated.

Member or the Member's representatives may file a grievance on our administrative practices to include claims payment or termination of coverage.

In your documentation, please include any additional documentation not already submitted:

- Proof of timely submission
- A letter stating why you think the service is medically necessary or should be approved
- Clinical documentation to assist with the appeal
- Proof of member's authorization if you are appealing on the member's behalf.

All appeals will be resolved in a timely manner but not to exceed 72 hours for urgent appeals and thirty (30) days for standard appeals from date of receipt if all necessary information has been received.

To file an appeal or grievance:

Must be submitted within 180 days of the receipt of the denial letter.

Contact the Friday Care Crew at 1-844-817-1600
Email it to: appeal@fridayhealthplans.com
In Writing:
Fax: 1-844-280-1794
Mail it to: Friday Health Plans
Attn. Appeals and Grievances
700 Main St.
Alamosa, CO 81101

For further information regarding member Grievance or Appeal procedures, please contact Friday Care Crew at

1-844-817-1600.

Member Rights and Responsibilities

Member Rights:

- To be treated with respect and with due consideration for his or her dignity and privacy;
- To receive information on available treatment options and alternatives, presented in a manner appropriate to his or her condition and ability to understand such information;
- To make and have honored his her advance directive that is consistent with state and federal laws;
- To receive covered services in a nondiscriminatory manner;
- To participate in decisions regarding his or her health care, including the right to refuse treatment;
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion;
- To request and receive a copy of his or her medical records and to request that they be amended or corrected as specified in 45 CFR 164.524 and 526;
- To choose an authorized representative to be involved, as appropriate, in making his or her health care decisions;
- To provide informed consent;
- To voice grievances concerning the care provided by the MCO;
- To appeal any action regarding services that the member or his or her authorized representative or authorized provider believes is erroneous;
- To protect the member, his or her authorized representative or authorized provider who uses the grievance, appeal, and HSD administrative hearing processes from fear of retaliation;
- To choose from among contracted providers in accordance with his or her MCO's prior authorization requirements;
- To receive information about covered services and how to access these covered services, and providers;
- To be free from harassment by FHP or its contracted providers in regard to contractual disputes between FHP and the provider;
- To participate in understanding physical and behavioral health problems and developing mutually agreed-upon treatment goals;
- To be assured that FHP complies with any other applicable federal and state laws including: Title VI of the Civil Rights Act of 1964 as implemented by regulations in 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.
- To be ensured that each member or the member's authorized representative or authorized provider is free to exercise his or her rights, and the exercise of those rights does not adversely affect the way that FHP or provider treats the member or member's authorized representative or authorized provider.
- To be provided to member or his or her authorized representative with written information on advance directives that include a description of applicable state and federal law and regulation, FHP's policy respecting the implementation of the right to have an advance directive, and that complaints concerning noncompliance with advance directive requirements may be filed with HSD; the information must reflect changes in federal and state statute, regulation or rule as soon as possible, but no later than 90 calendar days after the effective date of such a change;
- To have honored advance directives within UM protocols;
- To ensure that a member is offered the opportunity to prepare an advance directive and that, upon request, FHP provides assistance in the process.

- To seek a second opinion from a qualified health care professional within his or her FHP's network, or FHP shall arrange for the member to obtain a second opinion outside the network, at no cost to the member. A second opinion may be requested when the member or his or her authorized representative needs additional information regarding recommended treatment or believes the provider is not authorizing requested care.
- To access services in a timely and confidential manner;and
- To choose a qualified family planning provider who participates in the FHP network or from a provider who does not participate in the member's FHP network;

Member Responsibilities

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

To provide information that the MCO and providers need in order to care for the member, such information includes, but is not limited to the member's:

- Most current mailing address
- Most current email address if one is available
- Most current phone number, including any land line and cell phone, if available; and
- Most current emergency contact information
- To follow the care plans and instructions from his or her provider that have been agreed upon
- To keep a scheduled appointment
- To reschedule or cancel a scheduled appointment rather than simply fail to keep it.

NOTICE OF PRIVACY PRACTICES

Medical Records

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

Requirements for charting include:

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

Request for Medical Records

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

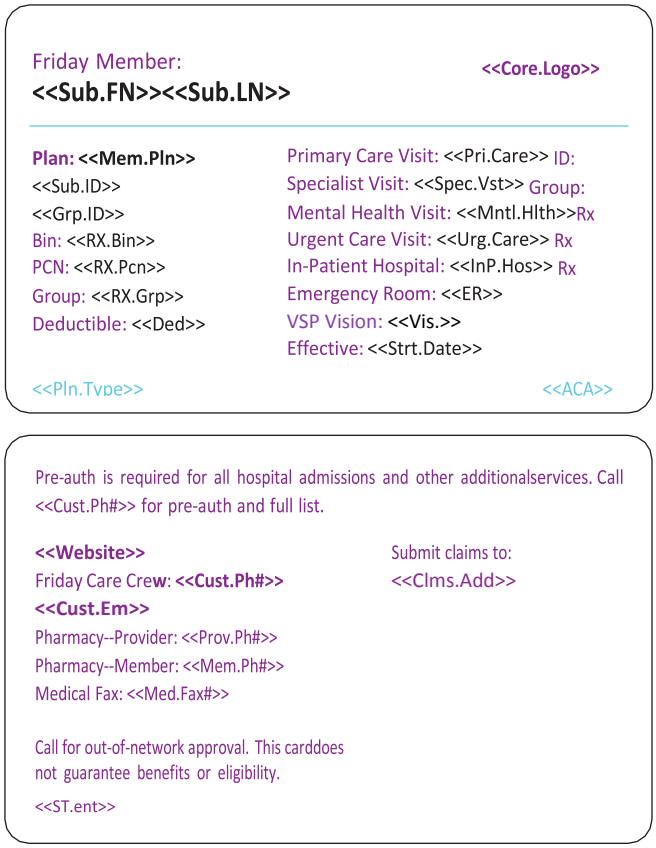
HIPAA Information & Disclosure

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

ATTACHEMENTS

Sample IDcard

Oklahoma



friday health plans

Prior Authorization Form

Prior Authorization (PA) Request Form Fax completed form to: 1-888-453-1262 Phone number: 1-844-817-1600

Email: OK-medical@fridayhealthplans.com

*** = Required Information**

Requestor's Contact Name:_____ Requestor's Phone & Fax:_____

PATIENT INFORMATION

*Name:_____ *Date of Birth: _____

*Member ID Number:_____ *Member Phone Number: _____

*Preferred Language: ☐English ☐Spanish

*Service Is: ☐ **Elective/Routine** ☐ **Expedited/Urgent** ☐**Resubmission** ☐**Additional Services**_____**auth**

Note: Select Expedited/Urgent to prevent serious deterioration in health or ability to regain maximum

*REFERRAL SERVICE TYPE

Inpatient	Outpatient	Behavioral Health	Other
☐ Surgical Procedure	☐ Surgical Procedure	☐ Inpatient	☐ Home Health (SN/PT/OT/SP)
☐ Elective Admission	☐ Imaging/Diagnostic	☐ Partial Hospitalization	☐ Durable Medical Equipment
☐ Skilled Nursing Facility	☐ Infusion Therapy	☐ Intensive Outpatient	☐ Dental
☐ Rehabilitation	☐ Chemotherapy		☐ Exception to Benefit
☐ Transplant listing	☐ Radiation		☐ Out of Network Exception
☐ Other	☐ Transplant Evaluation		

PROCEDURE INFORMATION

***ICD-10** Diagnosis: _____ Diagnosis Description _____

***CPT/HCPCS** Code and Description *(For PT, OT or ST, please indicate if Rehabilitative or Habilitative.)(Include units of measure/visits and please indicate if Robotic Assisted and include all implant codes)*

_____

* Date(s) of Service:_____ * Number of Visits: _____

PROVIDER INFORMATION

Ordering ☐ *Primary Care Physician*

*Name: _____ *NPI: _____ *TIN: _____

*Fax: _____ *Phone: _____

*Address: _____

Servicing ☐ *Same as Ordering*

*Name: _____ *NPI: _____ *TIN: _____

*Fax: _____ *Phone: _____

*Address: _____

Facility: *N/A*

☐

*Name: _____ *NPI: _____ *TIN: _____

*Fax: _____ *Phone: _____

*Address: _____

Request for extension to authorization: _____

ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY. INCOMPLETE INFORMATION MAY DELAY THE PROCESS.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in the transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. If you are not the intended recipient, any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

fridayhealthplans.com
844-817-1600

700 Main Street
Alamosa, CO 81101

Oklahoma

NON-COVERED SERVICES LIST

The Services listed below contains some of the most common non-covered services but is **not all inclusive. Please call Customer Services 1-844-817-1600** if there is any question about what services are covered.

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

SERVICES THAT ARE NOT COVERED		
CATEGORY	**SERVICES NOT COVERED**	**Comments**
Complementary and Alternative Medicine	Acupuncture, Massage, etc.	
Dental	All dental-related services including most oral surgery	TMJ treatment, anesthesia and facility charges may be covered in some situations.
Devices and DME	Comfort items, disposable items and items available over the counter.	
Education	Education services other than diabetic education, nutrition therapy and tobacco cessation.	
Experimental or Investigational	All experimental or investigative services	
Genetic counseling	Only with approved prior authorization for genetic testing	
Home Births	Any and all services related to a birth not completed in a certified birthing center, hospital or emergency personnel	
Immunizations	Immunizations that are required for travel.	
Long Term Care	Nursing homes, custodial care	
Mental Health	All services for sexual, marital, or occupational counseling; and court-ordered care	.
Obesity Treatment	Any procedures such as liposuction, and all bariatric surgery services.	
Ophthalmology	Vision testing or other vision services for non-medical conditions	Medical ophthalmology services are covered
Over the counter supplies	Any medical supplies that can be purchased over the counter.	
Plastic or Cosmetic	Cosmetic services or surgery of any kind unless part of reconstruction following medical illness or trauma with authorization or breast reconstruction post-mastectomy for breast cancer	Some transgendered services are covered with auth. Call for details.
Podiatry	Routine podiatric care including treatment of flat feet, nail trimming, corns, and calluses.	
Reproductive Services	Reversal of any voluntary infertility causes, any procedures related to treatment of infertility and services related to conception by artificial means	Only diagnostic services are covered.
Residential Treatment	Treatment that is residential in nature and lasting longer than 30 day programs or does not have 24 hour nursing/physician care.	
Surrogate Pregnancy	Any services related to a pregnancy where the pregnant women enter into a contract prior to getting pregnant to surrender the newborn child at time of birth.	

Notification and Pre-Authorization List

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

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

For notification or preauthorization:

Phone: 1-844-817-1600 **Medical Fax: 1-888-453-1262**
Email:ok-medical@fridayhealthplans.com **Online: fridayhealthplans.com**

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

SERVICES REQUIRING PREAUTHORIZATION

This list may not be all-inclusive. Services **must be provided by participating providers**. **Please call** if you are uncertain whether a referral is necessary, or a provider is participating.

CATEGORY	SERVICE	COMMENT
Admissions	**All** planned or scheduled inpatient medical and surgical admissions including acute, rehab, and skilled nursing facility.	
Ambulance or Air Transport	**Non-emergent** transport or transfer	Generally, not covered
Breast reconstruction	Post- mastectomy for breast cancer and revisions.	Breast reductions also covered with authorization.
Cardiac Procedure	EP studies, ablations cardiac catheterizations.	Diagnostic testing covered another section
Dental	All dental related services	Generally, not covered
DME/ Devices Replacement of devices every 48 months	Durable medical equipment over $500	Authorization not needed for bilirubin bed for a newborn, cpap supplies, diabetic supplies, oxygen and supplies.
	Cochlear implants	Max benefit of $1000 every 36 months.
	Hearing aids	

SERVICES REQUIRING PREAUTHORIZATION

This list may not be all-inclusive. Services **must be provided by participating providers**. **Please call** if you are uncertain whether a referral is necessary, or a provider is participating.

CATEGORY	SERVICE	COMMENT
Diagnostic Procedures (cont'd)	Arteriogram	
	CT scans	
	Upper Endoscopy advanced procedures	CPT codes 43235, 43236 and 43539 simple EGD do not require auth
	MRIs, MRA's	Except Breast MRI
	Myelogram	
	PET or SPECT scans other than	
	Sleep studies	except home sleep studies
	MCOT	
	Transesophageal Echocardiogram	
Dialysis	All services	
Genetic testing	All services	Except BRCA
Habilitative Therapies	Physical Therapy	Plan max 30 visits/year
	Occupational Therapy	Plan max 30 visits/year
	Speech Therapy	Plan max 30 visits/year
Hematology and Oncology	Cancer treatment including chemo, radiation, and surgery	Submit treatment plan as soon as known to facilitate rapid approval of necessary services.
Home Services	Home care	Limited to 60 visits per plan year combined modalities.
	Home infusion services	
	Hospice services	Required after first 6months
	Medical foods or enteral nutrition	Oral foods and over the counter items generally not a covered benefit
	Total parenteral nutrition	
Injections and Infusions	Back injections	ESI, RFA, MBB, Facet
	Medical injectables >$1000	
	Infusion pumps	
	All infusions	Saline infusions exempt
Mental Health/Substance Abuse	Electroconvulsive therapy	
	Transcranial Magnetic Stimulation	
	Partial Hospitalization	
Ophthalmology	Medical eye condition treatments	Cataracts and Yag laser covered without auth
Out-of-Network Services	Any service	Generally, not a covered benefit. Only approved if medically necessary **AND** not available in-network.
Outpatient Services	Any in-office procedure costing >$1000	Call Friday Health Plans for details
	Hyperbaric oxygen therapy	
	Infertility services	Diagnostic services of involuntary infertility only.
	Photodynamic therapy	
Podiatry	All procedures	Routine foot care is generally not covered.
Rehabilitation therapies	Chiropractic care	No plan max but authorization required after 30 visits/year
	Physical Therapy	Plan max 30 visits/year
	Occupational Therapy	Plan max 30 visits/year
	Speech Therapy	Plan max 30 visits/year.
Transgendered services	All services that require authorization in the other categories	Some services are not covered. Call Friday Health Plans to check.
Transplants	All services	