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ADVANTAGE *Care Select* Program Provider Manual

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1.0. Introduction to ADVANTAGE HEALTH SOLUTIONS, INC.SM

1.1. Our Company

In 1999, four founding Catholic healthcare systems made a tremendous commitment to the communities they serve by approving the ADVANTAGE Health Solutions, Inc.SM strategic operating plan. Today, this plan serves as the foundation for corporate integrity, advancing the mission of faith based healthcare, and offering innovative health care benefits and solutions to large and small employers in Indiana.

1.2. Vision and Mission

Founded by four prominent Catholic health care organizations in the Midwest, ADVANTAGE combines the collective wisdom and experience of over 400 years of compassionate care to our fellow citizens.

Our vision is to develop into a leader in the managed care industry by becoming not only the largest provider sponsored managed care company in Indiana, but also the best. We plan to lead the industry by enhancing the health of our communities by developing partnerships between payers, providers, employers, and employees. We will help to build an environment that fosters physical, mental, and spiritual health for all men, women, and children by providing high quality, affordable health care. We support the role of Catholic Health Care by following our core values of dignity of persons, fidelity, quality/excellence, and stewardship. We value and support our fellow ADVANTAGE employees through communication, cooperation, and coordination. We value the cooperation and growth of individuals and their organizations that serve these shared values.

Our mission at ADVANTAGE is based on the beliefs that:

- Working collaboratively, we can strengthen the Catholic Health Ministry, by facilitating dialogue, networking, and support;
- Life is enriched through the delivery of holistic and compassionate care throughout its duration;
- The dignity of the person is promoted and defended;
- Each person is respected as having intrinsic worth;
- In all matters, honesty and integrity; and
- ADVANTAGE is best served by common beliefs, mission, and values, which are supported by the sponsors.

Based on our core values, ADVANTAGE will develop into the pre-eminent, managed care program in Indiana. We are confident our members will feel they have made the right choice.

1.3. Commitment to Continuous Quality Improvement for Members

The commitment to improving the health status and level of service provided to all ADVANTAGE members begin at the upper most levels of the corporation with the Board of Directors and extends throughout all levels of the organization. Results of corporate quality improvement (QI) initiatives are reported to the Board of Directors.

ADVANTAGE Health Solutions, Inc. sm (ADVANTAGE) has implemented a customer focused proactive Quality Improvement Program (QIP). The QIP measures the quality of care provided to all members enrolled in ADVANTAGE's commercial, Medicare Advantage, and Medicaid products. Using standard continuous quality improvement techniques, the QIP monitors all aspects of the health care delivery system, including access and availability to care, member, employer, and provider satisfaction, and administrative services provided. Applying established quality standards as benchmarks and determining the degree to which these standards are met, measure quality.

ADVANTAGE makes available to members, providers, and other interested parties, information on the outcomes of medical care provided within our networks. Copies of the current QI Program are available to members upon request to our Member Services Department, and to providers through our Provider Relations Department. The QI Plan sets forth the organizational structure for the QIP. The annual Work Plan establishes focus areas for improvement, measurable objectives, and timeframes for completing QI initiatives. National quality indicators are applied as benchmarks and determine the degree to which accepted standards are met. Data is collected and Health Plan Employer Data and Information Set (HEDIS) measures reported to members within ADVANTAGE. Outcomes of all QI initiatives are reported within the annual QIP evaluation.

The commitment to improving the health status and level of service provided to all ADVANTAGE members begin at the upper-most levels of the corporation with the Board of Directors and extends throughout all levels of the organization. Results of corporate quality improvement (QI) initiatives are reported to the Board of Directors.

2.0 Program Overview

2.1 About This Manual

The ADVANTAGE Health Solutions, Inc. sm ("ADVANTAGE") ADVANTAGE *Care Select* Provider Handbook, for Primary Medical Providers (PMPs) and Office Staff, is a supplement to the Indiana Health Coverage Programs Provider Manual. This Manual describes the Disease Management Organizations (DMO) policies, procedures and

requirements. For detailed information regarding IHCP provider participation please refer to www.indianamedicaid.com to access the IHCP Provider Manual.

2.2 Indiana Care Select Program

The Indiana *Care Select* Program is a statewide voluntary disease management program that will include comprehensive care coordination for the highest-need members diagnosed with a chronic illness listed below.

The Indiana *Care Select* program covers the following populations statewide:

1. Aged, if not eligible for Medicare, or
2. Blind members, or
3. Physically and/or mentally disabled members (collectively known as “the ABD population”), or
4. Wards of the court and foster children, or
5. Children on adoption assistance

However, to be eligible for the program, the populations mentioned above have to be diagnosed with at least one of the following chronic illnesses:

1. Asthma
2. Diabetes
3. Congestive heart failure (CHF) or coronary artery disease (CAD)
4. Hypertension
5. Chronic kidney disease without dialysis
6. Severe mental illness (SMI)
7. Serious emotional disturbance (SED)
8. Depression

ADVANTAGE Health Solutions, Inc. DMO Network

Indiana Health Coverage Programs (IHCP) has established ADVANTAGE Health Solutions, Inc.sm as a Disease Management Organization (DMO) that will arrange for and manage covered Medicaid services for the current Indiana *Care Select* population. As a DMO, ADVANTAGE will provide and coordinate disease management for all members, with care management for a subset of the members based upon acuity. ADVANTAGE will also administer the Prior Authorization program to all ADVANTAGE *Care Select* and Traditional Medicaid (FFS) beneficiaries. Traditional Medicaid (FFS) is defined as services performed for Medicaid members who are not enrolled in the Hoosier Healthwise, Healthy Indiana Plan, or *Care Select* programs.

ADVANTAGE will not reimburse provider claims – this responsibility will remain with the State’s fiscal agent.

2.3 Primary Medical Providers (PMP)

ADVANTAGE encourages enrollees to select a PMP who provides, through an ongoing member/PMP relationship, preventive and primary medical care, as well as authorization and referral for all medically necessary specialty services. All ADVANTAGE *Care Select* Program disease management members are required to have a link to a PMP. The PMP is available 24 hours a day, seven days a week, and assumes total management of the member's non-emergency medical needs. A PMP must be an Indiana Health Coverage Program ("IHCP"/Medicaid) provider in the field of general practice, family practice, general pediatrics, general internal medicine, internal medicine/pediatrics, or obstetrics/gynecology (OB/GYN). A specialist physician, such as a cardiologist, neurologist or oncologist, may also serve as a PMP in the ADVANTAGE *Care Select* Program. An OB/GYN may choose to be a PMP for pregnant women only, or for all women. Primary medical providers in any setting are eligible to be PMPs. Physicians interested in becoming PMPs are educated about the ADVANTAGE *Care Select* Program through face-to-face training sessions, IHCP brochures, banners, bulletins, and this manual. When a physician decides to enroll as a PMP, he/she is required to sign an addendum to the IHCP Provider Agreement to participate in the Indiana *Care Select* Program. A physician must be an IHCP provider before signing an addendum. Once enrolled as an ADVANTAGE *Care Select* Program PMP, each PMP receives a copy of this ADVANTAGE *Care Select* Program Provider Manual that outlines program requirements and claims procedures as well as his/her responsibilities as a member's Primary Medical Provider. IHCP providers not enrolled as PMPs in the ADVANTAGE *Care Select* Program may also provide services to ADVANTAGE *Care Select* Program members, upon receiving prior-authorization for services requiring PA.

2.4 Service Provision and Reimbursement

PMPs are expected to provide or authorize most primary and preventive care services and to provide appropriate referral for specialty services. If the service is authorized, the PMP must document the referral in the member's medical record. PMPs participating in the ADVANTAGE *Care Select* Program assume no financial risk and receive a \$6 monthly administrative fee, (excludes FQHC and RHC participating PMP's), for each enrolled member under their ADVANTAGE *Care Select* Program panel. Reimbursement for services follows the existing Indiana Medicaid Resource Based Relative Value Scale (RBRVS) provider reimbursement system.

2.5 Member Enrollment Process

Twice a month, ADVANTAGE will receive a member enrollment roster from the State's fiscal agent (HP). ADVANTAGE will accept all members as enrolled and will not discriminate against individuals based on health status or need for health care services, race, color, or national origin.

ADVANTAGE will attempt to contact new members, within 10 business days of the member's initial enrollment date, by sending the member a "new member welcome packet". The new member welcome packet includes the following information:

- The member is now enrolled in the Indiana *Care Select* Program
- ADVANTAGE is there to better manage and coordinate the physical and behavioral health care of the member
- The member is eligible to participate in one or more disease management programs, but *Care Select* is an optional program, and the member may opt out
- The member should use ADVANTAGE's member services helpline as the first resource for answers to questions or concerns about *Care Select*, PMP issues, benefits, ADVANTAGE policies, etc.
- The availability of ADVANTAGE's 24-hour Nurse Care hotline

During the enrollment process, the ADVANTAGE *Care Select* Program Member Services Department ensures that all ADVANTAGE *Care Select* Program enrollees are educated about:

- the ADVANTAGE *Care Select* Program,
- the usefulness of primary and preventive care,
- appropriate use of the emergency room, and
- the importance of choosing a PMP.

Physicians may receive copies of the "new member welcome packet" for their office, if they wish, by calling the ADVANTAGE *Care Select* Program Provider Helpline at 1-866-504-6708. ADVANTAGE *Care Select* Program member service representatives provide potential enrollees with a list of their provider options and explain that they have thirty (30) days from the date they are eligible for the ADVANTAGE *Care Select* Program to choose a PMP. This extended period, before autoassignment, allows additional time for the ADVANTAGE *Care Select* enrollee to choose a PMP. If the requested physician is not currently enrolled as an ADVANTAGE *Care Select* PMP, this also allows the ADVANTAGE *Care Select* Provider Relations Department the opportunity to contact the physician to determine if he/she is willing to enroll as an ADVANTAGE *Care Select* Program PMP. The education provided by the member services representative focuses on the choice of a Physician and information about how to access care and services within the ADVANTAGE *Care Select* Program. If a potential enrollee fails to make a PMP selection within thirty days, one will be made for him or her through an autoassignment enrollment mechanism processed by the IndianaAIM system. Once a PMP is chosen or when one is assigned, the enrollee's ADVANTAGE *Care Select* Program enrollment record is updated to include the PMP name and phone number.

2.6 Auto Assignment

The goal of the Indiana *Care Select* Program is to have all members choose a PMP. However, if a member fails to make a PMP selection within 30 days of being determined eligible for the ADVANTAGE *Care Select* Program, the member will be assigned to a PMP through the auto-assignment process. IndianaAIM is the management information system (database) which is used to process claims and houses member and provider information. The IndianaAIM system identifies ADVANTAGE *Care Select* Program members who have not selected a PMP within 30 days of being determined eligible for the ADVANTAGE *Care Select* Program and considers several factors when linking a member and a PMP, including previous PMP relationships.

When there is no previous PMP relationship within the previous Medicaid Select (PCCM), current ADVANTAGE *Care Select* Program or Hoosier Healthwise for the member or the member's family, IndianaAIM looks for an appropriate new PMP assignment by first checking for an appropriate PMP in the member's zip code. If an appropriate PMP/member linkage is not found at the zip code level, the system then follows the same steps for the member's county, or in Marion/Lake County, the member's quadrant. Auto-assignment is discussed further in Section Five of this manual.

3.0 Primary Medical Providers (PMP)

3.1 Primary Medical Providers

Each eligible ADVANTAGE *Care Select* Program member chooses or is assigned to a Primary Medical Provider (PMP). The PMP serves as the member's medical home and gatekeeper for most medically necessary care. The PMP is responsible for providing or authorizing most primary and preventive services, and for reviewing and authorizing necessary specialty care and hospital admissions.

Every physician enrolled as a PMP must be an IHCP enrolled provider who agrees to comply with all IHCP regulations and State standards regarding access to care and quality of services (as defined in this manual and the Indiana Health Coverage Programs Provider Manual.) IHCP enrollment applications can be obtained from the web at www.indianamedicaid.com or by calling HP Customer Assistance at (317)6553240 or 800-577-1278.

To enroll in the ADVANTAGE *Care Select* Program, the physician must complete and sign an Addendum to the Indiana Health Coverage Program's Provider Agreement. The Addendum outlines the PMP's responsibilities in the ADVANTAGE *Care Select* Program. A copy of the addendum is provided in Appendix A of this manual and can be found on the ADVANTAGE *Care Select* website at www.advantageplan.com/advcaresselect under the "Provider Resources" section.

3.2 Provider Specialties

Listed below are the provider specialties that are eligible to participate as PMPs in the ADVANTAGE *Care Select* Program.

- General Practitioner
- Family Practitioner
- General Internist
- General Pediatrician
- Obstetrician/Gynecologist --may choose to serve as the PMP for pregnant women only, or for all women. OB/GYN PMPs must designate their scope of practice.
- Other physician specialty provider types such as Psychiatrist or Geriatric Practitioner

Primary specialty designation as Internal Medicine/Pediatrics requires submitting documentation of training in both Internal Medicine and Pediatrics to the ADVANTAGE *Care Select* Program. Primary medical providers in any care setting are eligible to be PMPs. Physicians who enroll in this program agree to be listed as a PMP in the ADVANTAGE *Care Select* Program Provider Directory. Physicians may enroll as sole practitioners and/or as part of a physician group practice or clinic. Physicians in group practices, Federally Qualified Health Centers (FQHC's), local Health Department primary care clinics (24-hour full service provider), hospital outpatient department clinics, federally funded Maternal Child Health (MCH), primary care clinics (24-hour service provider), and other full service health centers may be eligible to participate as PMPs if they have sufficient physician availability and 24-hour access and coverage.

3.3 PMP Practice Requirements

Following are the practice requirements of a physician enrolling into the ADVANTAGE *Care Select* Program as a Primary Medical Provider (PMP):

Member Panel Size

The PMP must designate a number of ADVANTAGE *Care Select* Program member assignments he/she desires to accept. This is referred to as the PMP's panel size. The panel size may range from 1 to unlimited ADVANTAGE *Care Select* Program members. For various reasons, it is possible that a PMP may have more members than their selected panel size. Please see the section below on Full Panel Member Additions. Physicians who request to provide health care services to more than 1,000 ADVANTAGE *Care Select* Program members will be assessed on a case-by-case basis, following defined policy, to determine whether or not a maximum panel size over 1,000 will be permitted. If a physician has two practice locations, the panel size would represent a combination of both sites. In other words, the patient panel size designation applies to the physician, rather than the site. The panel size designation does not include Medicaid members in programs other than the ADVANTAGE *Care Select* Program. For example, if a physician enrolls as a PMP in both the ADVANTAGE *Care Select* Program and Hoosier Healthwise, the panel sizes are not combined – they are separate between programs.

Member Panel Size Modifications

ADVANTAGE *Care Select* PMPs may increase or decrease their panel size designations by submitting a written request to the ADVANTAGE *Care Select* Provider Relations Department. Requests should be forwarded to the following address or fax to: (317)587-8411

ADVANTAGE *Care Select* Program
Attn: Provider Relations
9045 River Road
Suite 200
Indianapolis, Indiana 46240

Once the request is received, ADVANTAGE will forward the request on to OMPP & HP, the State's fiscal agent, for final approval.

1. PMPs may increase their panel size designation at any time, up to unlimited ADVANTAGE *Care Select* Program members.
2. PMPs may also reduce their panel size designation at any time. However, a panel size designation of less than the current number of assigned members will not result in an immediate reduction of the panel to the new designation. Members will not be removed or reassigned; therefore reduction in the panel size can only occur through attrition.
3. The PMP may request to have their panel placed on "Hold." A panel "Hold" status is always temporary. When a PMP's panel is placed in a "Hold" status, new ADVANTAGE *Care Select* Program members will not be added, with the following exceptions: (1) previously established ADVANTAGE *Care Select* Program members and (2) family members of current ADVANTAGE *Care Select* Program members. These members are added via the Auto-Assignment – Previous PMP and Auto-Assignment – Case Assignment processes to foster continuity of care and to keep family members together. Because of the administrative difficulty of temporarily removing a "hold" status, continuity of care panel additions can only occur via the auto-assignment process and cannot be requested through the full panel add process described below.

Full Panel Member Additions

If a PMP reaches his/her designated maximum panel size, new ADVANTAGE *Care Select* Program members cannot be added, except in the following situations:

1. Previously established ADVANTAGE *Care Select* Program members
2. Family members of established ADVANTAGE *Care Select* Program members, or
3. Member is established with physician through primary insurance

Full panel additions requested by the PMP under situations 1 and 2 require proof that the member, or a family member, is already part of the PMP's practice, i.e., the face sheet from the member's or family member's chart. Requests under situation 3 should include the name of the primary insurance carrier for verification purposes. For ease of adding an established member to the PMP's panel, the provider may use the PMP Full Panel Add Request form. The PMP and member must both sign the form. The required documentation (e.g., the face sheet from a member's or family member's chart to verify that the physician saw the member or family member within the last two years) must accompany the PMP Full Panel Add Request form. A sample copy of this form can be found in Appendix C of this manual. The form can also be requested from the designated *ADVANTAGE Care Select* Provider Relations and Contract Specialist or downloaded from the *ADVANTAGE Care Select* Program website at www.advantageplan.com.

PMP On-Site Availability

A PMP must be available to see members a minimum of twenty (20) hours per week, over at least three days a week. Clinics and group practices may fill this twenty-hour, three (3) days per week requirement with more than one PMP with similar scopes of practice to serve the respective assigned members. Each physician may serve as a PMP at a maximum of two practice locations. Please note the following:

1. While PMPs can accept member assignments at only two sites, they may render services to IHCP members, including those enrolled in *ADVANTAGE Care Select* Program, at any location enrolled in the IHCP.
2. When a physician enrolls as a PMP at a particular site, he or she must be enrolled as an IHCP provider at the same location.

24-Hour Availability

1. Physicians enrolling as PMPs must provide 24 hours-a-day, 7 days-a-week telephone access for their *ADVANTAGE Care Select* Program members.
2. Physicians may utilize a 24-hour telephone service, which can be answered by the PMP, a designee (such as an ~~call~~ physician or nurse practitioner with physician backup), an answering service, or a pager system. An answering machine is not acceptable. If an answering service or pager system is used, the call must be returned within one hour.
3. The PMP or another physician/nurse practitioner must be available to provide medically necessary services.
4. A PMP's covering physician must be an IHCP provider. However, this physician does not need to be an *ADVANTAGE Care Select* Program PMP.
5. Covering physicians are required to follow the referral/authorization guidelines outlined in Section Six of this manual.
6. It is **not acceptable** to direct members to the emergency room via a "blanket" voice message if the PMP is unavailable.

In rural areas where physician coverage is limited, physicians in other locations may provide this 24-hour coverage requirement, as long as the services rendered are provided and billed as any other covering physician. For example, a PMP may develop a relationship with an attending physician in an emergency room to act as a covering physician to receive phone calls and see members, as appropriate, or may make arrangements with a local nurse practitioner with a similar scope of practice and physician back-up. If the covering physician is an emergency room physician, any rendered services must be billed as if they were rendered in an office setting, not as an emergency department service. ADVANTAGE *Care Select* Program will evaluate emergency department utilization and services rendered through PMP authorization. Therefore, any PMP entering into such an agreement must notify the program prior to the effective date of this agreement so that OMPP can include this arrangement in its analysis. Correspondence should be sent to the following address or fax to: (317)587-8411

ADVANTAGE *Care Select* Program
Attn: Provider Relations
9045 River Road
Suite 200
Indianapolis, IN 46240

3.4 PMP Responsibilities

The PMP is responsible for providing or authorizing most primary and preventive care services. Examples of these services, called PMP services, include but are not limited to:

- Physician services.
- Hospital inpatient and outpatient services.
- Ancillary services including, but not limited to, laboratory and radiology, orthotics/prosthetics, EPSDT/HealthWatch screening and services, audiology, durable medical equipment and supplies, and home health services.
- Adhering to accepted practice standards

3.5 PMP Requirements

The PMP is required to maintain certain standards of service and care. These requirements, which are explained more fully elsewhere in this section, include, but are not limited to:

- Providing primary care for all ADVANTAGE *Care Select* Program members assigned to his/her panel

- Providing 24-hour availability
- Maintaining and retaining medical records
- Maintaining a non-discriminatory practice
- Providing referrals for specialty care, as necessary
- Meeting the Indiana Health Coverage Program's appointment standards

3.6 Targeted Member Education

The ADVANTAGE *Care Select* Program offers assistance to PMPs by providing targeted education to members in the following situations:

- Members continuously miss physician appointments, or
- Members inappropriately use emergency room services

Providers, who would like additional assistance with addressing missed appointments or inappropriate emergency room use, should contact the ADVANTAGE *Care Select* Program Provider Helpline at 1866-504-6708. If the PMP or office staff prefers, they may use the Education Request form found in Appendix D of this manual. This form may also be downloaded from the ADVANTAGE *Care Select* Program website at www.indianamedicaid.com. This form may be mailed to the address below or fax to (317) 587-8411.

ADVANTAGE *Care Select* Program
 Attn: Member Services
 9045 River Road
 Suite 200
 Indianapolis, IN 46240

Helpline Representatives will forward all such requests to designated staff who will attempt to contact the member and provide counseling on the importance of making and keeping scheduled appointments as well as the appropriate use of emergency room services. By providing this service, ADVANTAGE *Care Select* Program hopes to reduce the administrative burden faced by PMP offices while at the same time improving member compliance.

Note: Submission of non-reimbursable claims for missed appointments is no longer required.

3.7 Adherence to Universally Accepted Standards of Preventative Care

The PMP must adhere to universally accepted standards of preventive care for pregnant women, infants, children, adolescents and adults. (For further information, see Appendix E of this manual: Practice Standards References.)

Children

1. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT/HealthWatch) screenings, and preventive primary pediatric care must follow the guidelines of the American Academy of Pediatrics (AAP) and the Academy of Family Physicians, as well as the procedures and protocols established by the OMPP as indicated.
2. New pediatric enrollees should receive an initial EPSDT/HealthWatch screening within **one month** of date of attempting to schedule an appointment, unless otherwise medically indicated. Refer to EPSDT/HealthWatch periodicity schedule in Appendix E.
3. Also refer to the EPSDT/HealthWatch manual for further information.

Pregnant Women

1. To assure that pregnant women obtain early access to prenatal care, the initial screening should be scheduled within **one month** of the date of attempting to schedule an appointment.
2. Providers rendering prenatal care should refer to the Indiana Health Coverage Programs Provider Manual, Chapter 8: Billing Instructions.

Non-Pregnant Adults

The initial appointment should be scheduled within **three months**. The appointment standards for pregnant and non-pregnant ADVANTAGE *Care Select* members are program recommendations, but The OMPP understands there may be variances since it may be difficult to contact some patients. Primary Medical Providers (PMPs) must make efforts to contact any new ADVANTAGE *Care Select* Program members assigned to his/her practice within these time frames. The program encourages members to initiate contact with their PMP upon notification of PMP assignment, especially if this is a new physician/patient relationship. If a member selects his/her current physician as a PMP, and has previously accessed care from this physician within the above time frames, providers need not duplicate routine screenings. These members should be seen by the PMP in accordance with universally accepted standards of care.

ADVANTAGE *Care Select* PMPs that have been unsuccessful in contacting the new patient to make or keep an appointment may contact the ADVANTAGE *Care Select* Program Member Services Helpline for assistance at 800-784-3981. Member Service Representatives will forward all such requests to staff for directed intervention with the member.

3.8 Medical Records Retention and Transfer

Providers must maintain comprehensive medical records for each member enrolled in the ADVANTAGE *Care Select* Program. These medical records, including referral/authorization documentation, must be retained by the PMP for at least three (3) years from the date of creation. **Any physician receiving payments from IHCP for rendered services may not charge an IHCP member for medical record copying/transfer.** Federal regulation 42 C.F.R. 447.15 provides that providers

participating in Medicaid must accept the state's reimbursement as payment in full (except that providers may charge for co-payments or non-covered services). Refer to the IHCP Provider Manual for further information.

Section 438.100 of the federal Balanced Budget Act (BBA) Medicaid Managed Care Final Rule, as published in June 2002, will allow members to request and receive copies of their medical records. Members will also be allowed to request that their medical records be corrected or amended. If a member requests his/her medical records, the IHCP expects that the records will be provided. It is not necessary for PMPs to ask members if they would like copies of their medical records. Federal regulation 42 C.F.R. 447.15 supersedes Indiana Code 1639-9-1, which establishes maximum amounts that providers may charge members for copying medical records.

3.9 Nondiscrimination

PMPs may not refuse an assignment, request disenrollment of a member or otherwise discriminate against a member in the provision of medical care on the basis of age, sex, race, color, ancestry, religion, physical or mental disability, or national origin. A PMP may apply appointment and access standards of his/her practice universally to all patients (Medicaid, Hoosier Healthwise, *ADVANTAGE Care Select* & private insurance) under his/her care but the PMP may not refuse to treat an assigned member.

3.10 Member Reassignments

The OMPP recognizes that a positive relationship between members and their PMP is critical to the success of the program in meeting its objectives to provide quality, cost-effective care. The OMPP further recognizes that there may be situations when this relationship breaks down and the physician/patient relationship cannot continue. The OMPP requires physicians to provide PMP services to members linked to the PMP via the *ADVANTAGE Care Select* Program unless the PMP can demonstrate just cause for terminating these responsibilities. Providers may request reassignment of a member to another PMP in certain documented instances. These include:

- **Missed appointments** – The OMPP will allow a member to miss at least three scheduled appointments in the **previous twelve months**, without a defensible reason, before the PMP may request reassignment. A defensible reason can be defined as any legitimate reason or circumstances that the member provides that did not allow the member to notify the PMP's office of the cancellation. Providers are encouraged to contact the member after a missed appointment to determine why the member did not keep the appointment or call to cancel and/or reschedule. The PMP is also encouraged to contact the *ADVANTAGE Care Select* Program Helpline at 800-784-3981, to request member education.

- **Member fraud** – This might include drug-seeking behavior or other evidence of member fraud. The PMP must provide information about the specific incident (s) leading to this request.
- **Threatening, abusive or hostile behavior** – The member or member’s family displays this type of behavior towards the physician or the office staff. The PMP must provide information about the specific incident (s) leading to this request
- **Medical needs better met by another PMP** – The PMP may feel that the member’s medical needs may be better met by another/different type of provider. The PMP must provide information about the member’s medical condition and his explanation for not being able to provide medical care.
- **Breakdown of the Physician/patient relationship** – The PMP must provide specific documentation as to the reasons why he or she feels the relationship has broken down and cannot be salvaged.
- **Member accessing care from another provider** – The PMP may request reassignment when the member consistently seeks primary medical care from a non-selected/non-assigned ADVANTAGE *Care Select* Program PMP and the member does not request a PMP change. The PMP should make an effort to contact the member and determine why they are seeking care elsewhere. A request for reassignment due to emergency room use is not valid and will not be approved. However, the PMP should request educational intervention as previously discussed.
- **Previously approved reassignment** – The PMP may request reassignment when the member was previously reassigned from the practice but was placed back on the PMP’s panel through error or auto-assignment. This request may also be approved if the member was inadvertently placed with another physician within the same practice.
- **Member previously terminated from practice** – The PMP may request reassignment of a member if that member was terminated from the practice before the member became eligible for ADVANTAGE *Care Select* Program.
- **OB reassignments** – The PMP may request reassignment if the PMP has agreed to serve only pregnant members and the member is no longer pregnant. The PMP is required to provide care for a member for sixty days after delivery. If the member has not chosen another PMP and retains eligibility after that time, the PMP may request reassignment.

The Balanced Budget Act (BBA) rules prohibit requests for member reassignment based on the following:

- A change in the member’s health status, unless the change is such that the member is no longer appropriate for the PMP’s scope of practice,
- The member’s utilization of medical services,
- Diminished mental capacity, or

- Uncooperative or disruptive behavior resulting from his/her special needs except where his/her continued enrollment with the PMP seriously impairs the PMP's ability to furnish services to this member or other members.

Where the PMP has policies or procedures for their office setting that differ from these, the PMP may be allowed to request reassignment based on these policies. The PMP will be required to provide a copy of the policy and also state that the policy applies to his or her entire patient population. No office policy will be accepted if it applies only to *ADVANTAGE Care Select* Program members. For additional information about this reassignment policy, PMPs or office staff should contact their assigned Provider Relations Specialist.

ADVANTAGE Care Select PMPs must use the following procedures to request removal of a member from his/her panel:

- The PMP must send written notification documenting the reasons for the requested removal to the *ADVANTAGE Care Select* Program and to the member. PMPs should instruct members to contact the *ADVANTAGE Care Select* Program Member Helpline at 1-800-784-3981 to select a new PMP.
- The PMP may use the *ADVANTAGE Care Select* Program Reassignment Request Form found in Appendix F of this manual. The form may also be requested from the assigned Provider Relations Specialist or downloaded from the *ADVANTAGE Care Select* Program website at www.advantageplan.com.
- If the request is approved, physicians must continue to act as the PMP for the patient for up to 60 days from the date the letter was received by the program, or until the new PMP linkage is in effect.

All correspondence relating to member reassignment should be mailed to the following address or fax to (317) 587-8411:

ADVANTAGE Care Select Program
Attn: Member Services
9045 River Road
Suite 200
Indianapolis, IN 46240

3.11 Primary Medical Provider Program Disenrollment

Providers who have enrolled as PMPs have entered into an agreement with the OMPP. That agreement is binding. If the PMP chooses to disenroll from the *ADVANTAGE Care*

Select Program, the physician should submit written notification for disenrollment in accordance with their agreement, documenting the reason(s) prompting this decision. Physicians wishing to disenroll should submit this notification to the following address or fax to (317)587-8411.

ADVANTAGE *Care Select* Program
Attn: Provider Relations
9045 River Road
Suite 200
Indianapolis, IN 46240

Upon receiving the written request for disenrollment, a “disenrollment pending” status will be placed on the PMP’s panel, preventing members from being linked to this PMP. The OMPP or designated representative will review the disenrollment request and if the request is granted, the designated representative will contact the PMP to initiate the disenrollment process. **The physician must continue to act as the PMP for assigned members for up to 45 days following disenrollment approval, or until members assigned to this physician choose or are auto-assigned to a new PMP.** When PMP death, loss of licensure, or other situations arise that require immediate PMP disenrollment from IHCP and ADVANTAGE *Care Select* Program, HP must be contacted as soon as possible, to initiate this disenrollment process.

PMP Service Location or Group Disenrollment

Occasionally the ADVANTAGE *Care Select* Program Provider will disenroll from a service location or leave a group practice. **Both HP Provider Enrollment and ADVANTAGE *Care Select* Program Provider Relations must be notified of PMP service location and group enrollment changes 60 days in advance to minimize disruption in the physician/member linkage.** If a PMP leaves a group or service location and fails to notify the ADVANTAGE *Care Select* Program, the PMP’s members and ADVANTAGE *Care Select* Program administrative fees will remain with the group/service location until the PMP notifies ADVANTAGE of the change. If ADVANTAGE learns of this relocation and cannot locate the PMP to establish a new service location, the PMP will be disenrolled and all assigned members will either self-select a new PMP or be assigned to a new PMP. If the PMP notifies ADVANTAGE and HP prior to disenrollment and a new service location can be established, a system-generated letter will be sent to all assigned members notifying them of the upcoming service location/group disenrollment. Members will be given the opportunity to remain with the relocating PMP or choose a new PMP. The HP forms for group disenrollments and service location changes can be found on the web at www.indianamedicaid.com. **It is the responsibility of the PMP to notify established members of his/her new location.** Members who do not select a new PMP should be reassigned to the relocating PMP via the Previous PMP auto-assignment logic, in order to maintain continuity of care.

4.0 Non Primary Medical Providers Overview

4.1 Non-PMP Providers

All non-PMP IHCP enrolled providers are considered to be part of the ADVANTAGE *Care Select* Program network. (See Section Six of this manual: Prior Authorizations and Referrals, and Section Twelve of this manual: Reimbursement Overview and Billing Issues for additional information specific to the ADVANTAGE *Care Select* Program.)

4.2 Specialist

Specialists may provide services to members enrolled in the ADVANTAGE *Care Select* Program. Specialists providing services are strongly encouraged to contact the member's PMP to share information regarding specialty care services provided to the member in order for the PMP to manage the member's health needs. If a physician specialist chooses to become a Primary Medical Provider in the ADVANTAGE *Care Select* Program, he/she may enroll by contacting an ADVANTAGE *Care Select* Program Provider Relations Specialist at 1-866-504-6708 to request an enrollment package. The physician specialist will be required to sign an addendum to the IHCP Provider Agreement. An ADVANTAGE *Care Select* Program Provider Relations Specialist may also contact physician specialists when a member desires that physician specialist to serve as their PMP. The physician specialist may accept and agree to provide services to that one member "only" or others as well if they choose.

4.3 Residents (Physicians in Training)

The Office of Medicaid Policy and Planning (OMPP) supports established relationships between residents and Primary Medical Providers who oversee the care they provide. OMPP recognizes the importance of residents' roles in health care teams and encourages residents to provide appropriate, quality health and medical care to ADVANTAGE *Care Select* Program members. However, residents may not enroll as Primary Medical Providers in the ADVANTAGE *Care Select* Program. Residents may render services to ADVANTAGE *Care Select* Program members under the guidance of a patient's PMP (Faculty Physician). Consistent with standard residency program procedures, the PMP must oversee the resident's plan of care via daily patient rounds, review of the patient's chart, and timely approval and signing off on the resident's treatment plan and orders. After extensive review of residency training programs in Indiana, the OMPP and the ADVANTAGE *Care Select* Program allow resident physicians in residency programs to perform initial visits for ADVANTAGE *Care Select* Program members. The PMP is ultimately responsible for the care provided to his/her ADVANTAGE *Care Select* members. **While a resident is providing care to an ADVANTAGE *Care Select* Program member, a staff physician must be available on a daily basis to supervise the resident's plan of care.**

4.4 Physician Extenders

Mid-level practitioners and advance practice nurses are welcome to participate in the *ADVANTAGE Care Select* Program. Physician Assistants (PA) rendering PMP services to a member must be located in the PMP's *ADVANTAGE Care Select* Program practice site. If you have questions, call *ADVANTAGE Care Select* Provider Relations at 1-866-504-6708.

Special Note About Community Health Centers (CHC's)

The Indiana State Department of Health (ISDH) has designated certain clinics as Community Health Centers. Community Health Centers (CHC) are organized to provide a "medical home" to anyone in a Community who would otherwise lack a regular source of primary and preventive health care services. A full time physician and or nurse practitioner will staff the site, which may also include other full or part-time staff. When the clinic is staffed with a nurse practitioner, a primary medical provider supervises the nurse with a similar specialty. When the supervising physician is also an *ADVANTAGE Care Select* Program PMP, the clinic may be enrolled as the PMP's second location. Once the clinic is enrolled, *ADVANTAGE Care Select* Program members may select the CHC by choosing the PMP that has the affiliation with the CHC. The member is placed on the PMP's panel even though most care will be provided by the nurse practitioner. In essence, members receive services from the nurse practitioner under the supervision of the PMP.

5.0 Member Information

5.1 ADVANTAGE Care Select Program Eligibility

ADVANTAGE Care Select Program Aid Categories

The *ADVANTAGE Care Select* disease management program is voluntary for members who are first eligible for benefits based on the following aid categories:

- Aged
- Blind
- Physically and mentally disabled
- Children receiving adoptive services
- Wards of the Court and foster children

Second, a member must also have one of the following conditions:

- Asthma
- Diabetes
- Congestive Heart Failure (CHF) or Coronary Artery Disease (CAD)
- Hypertension
- Chronic Kidney Disease without dialysis
- Rheumatic Heart Illness
- Severe Mental Illness (SMI)
- Serious Emotional Disturbance (SED)

- Depression

Non ADVANTAGE *Care Select* Disease Management Categories

In general, the following Indiana Health Coverage Programs members are *not* eligible for the ADVANTAGE *Care Select* program:

- Dual eligible or individuals with both, Medicare and Medicaid coverage
- The population on Home and Community Based Service (HCBS) waivers
- MED Works participants
- Individuals receiving room and board assistance
- Breast and Cervical Cancer Group
- Individuals with QMB or SLMB only (not in combination with another aid category)
- Persons in nursing homes, intermediate care facilities for the mentally retarded (ICF/MRs), and state operated facilities
- Persons receiving hospice services
- Persons on spend-down
- Persons with a psychiatric residential treatment facility (PRTF) level of care

5.2 PMP Selection

During enrollment (or the member's redetermination of benefits process), members eligible for Indiana *Care Select* Program disease management are referred to the STATE's designated enrollment broker for assistance in selecting a Primary Medical Provider. The enrollment broker will provide members with an Indiana *Care Select* Primary Medical Provider Directory for their county and explain that the member has 30 days from the date he/she is eligible for Indiana *Care Select* Program benefits to select a PMP. Once a member is assigned to an ADVANTAGE *Care Select* PMP, either by self-selection or auto-assignment, the member receives a letter from the STATE's fiscal agent (HP) informing the member of his/her PMP assignment. This letter contains:

- The PMP's name
- The PMP's address,
- The PMP's telephone number,
- The PMP's health plan,
- The effective date for this assignment and a telephone number to call for questions about the program.

Once a member selects the ADVANTAGE *Care Select* Program, ADVANTAGE *Care Select* Member Services staff sends a new member welcome packet containing member education and informational materials about the program and its benefits. Members receive written and verbal education on primary and preventive care, the differences between ADVANTAGE *Care Select* Program and traditional Medicaid or Hoosier Healthwise programs, and other health topics. Additionally, members receive program brochures and an ADVANTAGE *Care Select* Primary Medical Provider Directory.

5.3 Auto Assignment

The goal of the Indiana *Care Select* Program is to have all members choose a Primary Medical Provider (PMP). However, if a member fails to make a PMP selection within 30 days of being determined or re-determined eligible, a PMP will be assigned to the member through the autoassignment process. The member auto-assignment process considers several factors when linking a member and a PMP. These factors include:

- Claims history of the member
- Previous ADVANTAGE *Care Select* Program or Hoosier Healthwise PMP-member relationships
- Existing ADVANTAGE *Care Select* Program or Hoosier Healthwise PMP relationships within the member's family
- Previous provider group-member relationships
- Geographic proximity,
- The degree to which a PMP has reached the maximum panel designation in relation to other PMPs and
- Appropriate scope of practice and member characteristic matches.

Step 1 – Previous PMP

Once the auto-assignment process begins, there are a series of steps that seek to take advantage of a member's previous ADVANTAGE *Care Select* Program or Hoosier Healthwise PMP assignment. The first step in this process attempts to assign the member to the most recent "Previous PMP" in order to foster continuity of care. This step will be successful if the member was previously enrolled in the ADVANTAGE *Care Select* Program, or Hoosier Healthwise program with a PMP that is still active in ADVANTAGE *Care Select* Program and the PMP's scope of practice is still appropriate for the member. The Previous PMP step is not limited by county boundaries which results in the following two scenarios:

1. The member lives near a county border and routinely accesses care from a PMP outside his/her county of residence. If this member's benefits became subject to redetermination and the member failed to reselect the established PMP, the auto-assignment logic would appropriately reassign the member to the previous PMP. Restricting this step to the county level would create artificial barriers to care. (This is a very common scenario.)
2. An ADVANTAGE *Care Select* Program member moves from a county of residence to a non-contiguous county, many miles away from the established PMP. During the relocation, a break in eligibility occurs, after which the member reestablishes eligibility in the new county, but fails to select a new PMP. In this scenario, the auto-assignment logic would assign the member to the previous PMP, even though the member may not access the PMP for services because of distance. The member may change this autoassignment at any time, but should the

member's care require PMP involvement, the default linkage is made to the PMP who is likely to be the most familiar with the member's medical needs.

Step 2 – Newborn Assignment

Newborns of ADVANTAGE *Care Select* Program members will be automatically eligible for Hoosier Healthwise for the first year. Newborns obviously will not have previous PMPs. The auto-assignment logic will attempt to assign the newborn to the mother's PMP, if possible. If the scope of practice is not appropriate or if the mother's PMP does not participate in Hoosier Healthwise, the newborn will be assigned to another PMP providing services in the Hoosier Healthwise program.

Step 3 – Case Assignment

If neither of the first two conditions result in an appropriate PMP assignment, the third step seeks to make the assignment based on the "family" group. It is important to note that there can be many non-traditional definitions of the family unit in a program such as ADVANTAGE *Care Select* Program or Hoosier Healthwise. Because of the obvious limitations caused by common surnames, parentage, or residence, a more flexible means of identifying common "family" members was necessary. The ADVANTAGE *Care Select* Program and Hoosier Healthwise programs use a Case Identification number to group individuals into "family" units. Case ID numbers are assigned by local DFR offices and serve as the third criteria by which the auto-assignment logic attempts to assign members to appropriate PMPs. For example, if a grandmother is caring for two grandchildren from different daughters, and they are all identified under the same Case Identification number, both children would be assigned to the same Hoosier Healthwise PMP. If the grandmother is eligible for ADVANTAGE *Care Select* Program, all three could be assigned to the same PMP if that PMP participates in both programs and the scope of practice is appropriate to all three individuals.

Step 4 – Group Assignment

If a member was previously assigned to a PMP in a group and that PMP is no longer available, the member may be assigned to another PMP within the group with an appropriate scope of practice to meet the member's needs.

Step 5 – Default Assignment

Only if the auto-assignment logic fails to successfully assign the member to a PMP based on the previous four criteria will it proceed to the default assignment step. The default logic attempts to find an appropriate PMP by geographic proximity, matching member information with the PMP's scope of practice criteria, looking first for a PMP who has a practice in the same zip code as the member. No member is default-assigned outside his/her county of residence. However, a member may select a PMP outside their county of residence and Previous-PMP logic (Step 1) could result in an assignment outside the member's current county of residence.

- A. The default logic first looks for an appropriate PMP within the member's zip code. If the system identifies any PMPs in the member's zip code, the system

then attempts to make an appropriate PMP/member linkage by matching the PMP's scope of practice with the member's information. If the system identifies more than one appropriate PMP in an area, the assignment will be given to the PMP whose actual panel size is the lowest percentage of their panel size designation.

- B. If no appropriate PMP is located within the member's zip code, then auto-assignment looks for PMPs in the member's quadrant (in Marion and Lake Counties only) or member's county. Again, the system runs through the same process, as described above for the member's zip code, until a linkage is made.

5.4 PMP Change Request

In order to achieve continuity of care, *ADVANTAGE Care Select* Program members are encouraged to build long-term relationships with the PMP through appropriately scheduled visits and good communication. However, members are allowed to change their PMP if and when they choose to do so. It may be for one of the following reasons and members will be encouraged to provide a reason for tracking purposes although they are not required to do so:

- Default auto-assignment
- Inconvenient location and/or transportation problems
- Limited availability of appointments
- Excessive waiting time
- Physician unavailability after hours
- Difficulty in obtaining appropriate, medically necessary referrals
- Unacceptable physician/patient relationship

ADVANTAGE Care Select Program members requesting a PMP change should contact the *ADVANTAGE Care Select* Program Member Services Helpline at 1-800-784-3981.

5.5 Changing an Auto-Assignment Request

The *ADVANTAGE Care Select* Program wants all *ADVANTAGE Care Select* Program members to self-select a PMP. When a member fails to select a physician, one is chosen for him/her. This auto-assignment process is described above. When a member has been default auto-assigned, he/she may request a PMP change without giving a cause or reason. The member may contact the enrollment broker or call the *ADVANTAGE Care Select* Program Member Services Helpline at 1-800-784-3981 to make the change.

Frequently the member will ignore the auto-assignment and will present to a PMP office of his/her choice. When a PMP or his/her staff determines that the member is assigned elsewhere but chooses to access care through that location, the PMP may contact the *ADVANTAGE Care Select* Program Helpline for assistance. A Helpline Representative must talk with the member to ensure the member wishes to be assigned to this PMP and will access future care through this PMP. The Helpline Representative will process the request for the PMP change. For more information about this process, contact your

ADVANTAGE Provider Relations Specialist or call the ADVANTAGE *Care Select* Program Provider Helpline at 1-866-504-6708.

5.6 Verify Eligibility

Although member eligibility for IHCP can be determined on any day of the month, new member-PMP assignments will become effective on the first and the fifteenth of every month as completed by Indiana AIM. The PMP will receive a report updating changes to his/her member panel several working days prior to the effective date of the addition or termination of the members on his/her panel. However, members who change from one ADVANTAGE *Care Select* PMP to another can be effective any day of the month. It is critical to check eligibility before every date of service even if a member was on a PMP's previous roster. Memberspecific eligibility, date-of-service eligibility, and PMP assignment information are available through the following IHCP Medicaid/HP verification systems:

- Automated Voice Response (AVR) System, ~~692-0810~~ or 1-800-738-6770, is operational seven days a week, twenty four hours a day with the exception of routine maintenance (Marion County and out-of-state provider must use the 317 number.)
- OMNI -Point-of-Service (POS) Terminal Device,
- Web InterChange

These systems are further explained in Chapter 3 of the Indiana Health Coverage Programs Manual. All ADVANTAGE *Care Select* Program and Hoosier Healthwise Medicaid providers must use one of the eligibility verification systems to verify member eligibility status and managed care enrollment each time services are rendered to ADVANTAGE *Care Select* Program and Medicaid members.

5.7 Pre-Birth PMP Selection

All children born to mothers covered by the ADVANTAGE *Care Select* Program are covered for at least the first year of life under the Hoosier Healthwise program. Pregnant ADVANTAGE *Care Select* Program members are encouraged to select, prior to delivery, a pediatric provider to serve as the PMP for the newborn. This selection may occur at any time prior to the birth of the infant and/or prior to the mother being effectively enrolled into ADVANTAGE *Care Select* Program, as long as she has already been determined eligible for the program. The pre-birth PMP selection can be made by contacting the *Care Select* Enrollment Broker at 1-866-963-7383.

A sample Newborn PreBirth Selection Form is located in Appendix G of this manual. Once a pre-birth selection has been made, confirmation letters will be sent to both the mother and selected PMP. Infants who have a pre-birth selected PMP become effective with that PMP on the first or the 15th of the month (whichever comes first) following

IndianaAIM's receipt of the newborn's RID number. All Hoosier Healthwise covered services rendered to the newborn between the date of birth and the effective date with the Managed Care Organization (MCO) PMP should be billed to Hoosier Healthwise via HP. All services rendered to the newborn after the effective date with the MCO PMP are subject to the authorization requirements of the newborn's MCO and should be billed to the MCO.

5.8 Member Effective Dates for Those Never Before Enrolled in ADVANTAGE CARE SELECT

- For members who have never before been enrolled in the ADVANTAGE *Care Select* Program (newly eligible), all PMP selections entered into the IndianaAIM system by the 10th day of the month become effective on the 15th of the same month.
- PMP selections for newly eligible members entered between the 11th and 25th of the month become effective on the first of the following month.
- Newly eligible member PMP selections entered after the 25th become effective on the 15th of the following month.

5.9 Member Effective Dates for Members with Previous Enrollment in ADVANTAGE CARE SELECT

- For members who have been previously enrolled in ADVANTAGE *Care Select* Program, or for those wishing to change PMP's, selections entered by the 25th day of the month become effective on the first day of the following month.
- All selections made or entered after the 25th day of the month cannot be processed in time to become effective on the first of the following month and must wait until the first of the subsequent month (i.e., a member calls to change PMP's on the 26th of January; the member would not become effective with the new PMP until March 1st.)

Thus, the maximum amount of time it could take for a PMP change to become effective is 36 days (not including the day of selection and allowing for two consecutive 31 day months.) The minimum amount of time is 5 days (not including the day of selection and allowing for a 30-day month.)

5.10 Emergency Services and Access to ER Services

Emergency Services means covered inpatient and outpatient services that are furnished by a qualified provider and needed to evaluate or stabilize an emergency medical condition.

An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent

layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual (or in the case of a pregnant women, the unborn child);
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

In the event of an emergency, *ADVANTAGE Care Select* Program members are instructed to go to the nearest emergency room or call 911 for assistance. *ADVANTAGE Care Select* Program covers emergency situations within the United States at any time.

Emergency care is a covered benefit within and outside of the service area. Prior approval is not required for emergency care meeting the prudent lay person definition.

Emergency services are considered to remain emergency services as long as a transfer to an Indiana Health Coverage Programs (Indiana Medicaid) facility would be considered a risk to the health of the member, or the transfer would be unreasonable given the distance involved in the transfer and the nature of the medical condition. Members are encouraged to have someone call their PMP as soon as possible (within 48 hours). The PMP will coordinate their medical care and assist in a transfer back to a network facility when their medical condition has stabilized.

Members continue to be covered outof-area as long as the medical services provided continues to meet the definition for either emergency or urgently needed care. If an emergency occurs within the Indiana Health Coverage Programs (Indiana Medicaid) service area, members must receive any follow-up care through Indiana Health Coverage Programs (Indiana Medicaid) participating providers. Again, we encourage our members to contact their PMP as soon as possible.

6.0 Prior Authorizations and Referrals

6.1 General Information

The *ADVANTAGE Health Solutions-Free for Service (FFS)* and *ADVANTAGE Health Solutions-Care Select (CS)* PA Departments review all non-pharmacy PA requests for IHCP members, except those enrolled in a Hoosier Healthwise managed care organization (MCO) or in the *MDwise Care Select* program, on an individual, case-by-case basis. *ADVANTAGE* was also selected to function as the prior authorization administrator for all Medicaid Rehabilitation Option (MRO) services.

The department's decisions to authorize, modify, or deny a given request is based on medical reasonableness, necessity, and other criteria in the Indiana Administrative Code

(IAC). The PA Departments use the Office of Medicaid Policy and Planning (OMPP) approved internal criteria in addition to the IAC, PA guidelines, and IHCP bulletins, banner pages, and newsletters. ADVANTAGE *Care Select* may develop its own internal criteria for 405 and 407 IAC rule compliance. Providers can obtain applicable sections of the non-MCO/DMO internal criteria by writing to the following address:

ADVANTAGE Health Solutions
FFS Prior Authorization Department
P.O. Box 40789
Indianapolis, IN 46240

Use of the IAC, internal criteria, and chapter 6 (Prior Authorization) of the IHCP Provider Manual, along with published newsletters, bulletins, and banner pages found at indianamedicaid.com, provides a complete resource for PA policy and procedures. All necessary non-pharmacy PA forms for fee-for-service (FFS) and *Care Select* claims are included in the attached (Appendix H) or can be found in the "Provider/Forms" section of the IHCP Web site at <http://www.indianamedicaid.com>. Providers are responsible for using these tools to ensure accurate, timely PA review and claims processing. Submissions of any unapproved forms are returned to the provider.

6.2 Limitations

The IHCP does not reimburse a provider for any IHCP service requiring PA unless PA is obtained first. An exception to this is if a PA request qualifies for retroactive eligibility as defined in this chapter. PA is monitored by concurrent or ~~post~~ payment review. Exceptions to this policy are listed later in this chapter.

Any authorization of a service by ADVANTAGE Health Solutions ~~FFS~~, or ADVANTAGE Health Solutions DMO/*Care Select*, is limited to authorization for payment of IHCP allowable charges. It is not an authorization of the provider's estimated fees.

PA is not a guarantee of payment. Notwithstanding any PA by the provider's office, the provision of all services and supplies shall comply with the following resources:

- The IHCP Provider Agreement
- The IHCP Provider Manual,
- IHCP newsletters
- IHCP bulletins
- Remittance advice (RA) statements, or 835 transactions
- IHCP banner pages
- PA criteria requested and issued to providers
- any applicable state or federal statute or regulation

Providers can request PA on behalf of the IHCP member. After PA is obtained, the member can choose the provider who renders the service, as long as the member is not restricted to a specific provider of service, such as members with restricted cards and members assigned to a specific primary care provider (PCP).

Note: If a member has other health insurance and a service that is covered by Medicaid requires PA, the provider must obtain PA from both sources prior to rendering services.

6.3 Prior Authorization Criteria

The Indiana Family and Social Services Administration (IFSSA) contracted with ADVANTAGE Health Solutions-FFS for review of most requests for PA on behalf of Traditional Fee-For-Service IHCP members. However with the implementation of the *Care Select* program ADVANTAGE Health Solutions-DMO/*Care Select* will be performing the review of requests for PA on behalf of the *Care Select* members that are assigned to a PMP contracted with the ADVANTAGE *Care Select* Provider Network. ADVANTAGE Health Solutions-FFS, and ADVANTAGE Health Solutions-DMO reviews each request for PA using documentation submitted by the requestor. The decision is based on criteria that, in part, is included in 405 IAC 5-3 and reflects the current standards of practice in the provider community. **Carefully reading the rules provides valuable information about coverage and prior approval policies.** PA is required for all services or items provided under the 590 program, for which the provider charge is \$500 or greater.

Member Eligibility

Granting PA confirms medical necessity, but is valid only if a member is eligible on the date services are rendered.

Note: It is not the responsibility of any of the Prior Authorization Departments in the IHCP to ensure the eligibility status of a member. Providers should also determine whether the member has third party liability (TPL) coverage and whether PA from the third-party carrier is necessary. PA is not a guarantee of payment and member eligibility should be verified by the provider before services are rendered. Because the IHCP is the payer of last resort, claims must be submitted to the thirdparty carrier before they are submitted to the IHCP. The third-party carrier as well as the IHCP might require PA.

6.4 Services Requiring Prior Authorization

The Indiana Health Coverage Programs (IHCP) allows reimbursement for those services outlined in the IHCP Policy Rule at Article 5, 405 IAC 5. The Indiana Administrative Code (IAC) contains the rules and regulations that govern the IHCP and serves as a comprehensive reference for covered services and prior authorization (PA) procedures and parameters. Each IHCP provider is responsible for reading the portions of the IAC that apply to the provider's areas of service. Specific PA criteria are found in 405 IAC 5-3 and 407 IAC.

The Indiana Health Coverage Program’s “indianamedicaid.com” website contains an electronic copy of the Medicaid fee schedule, by CPT code. This fee schedule will also signify which procedures require prior authorization, under the Traditional Medicaid FFS program. The Indiana *Care Select* Program services which require prior authorization are the same as Traditional Medicaid.

Transportation by non-emergency ambulance requires prior authorization.

6.5 Prior Authorization Request Form and Submission

All PA requests must be submitted in writing using an Indiana Prior Review and Authorization Request form (with the exception of Inpatient Elective PA request which need to be submitted via telephone request). This form can be found within Appendix H and the “Provider/Forms” section of the IHCP Web site at ww.indianamedicaid.com . The IHCP revised the Indiana Prior Review and Authorization Request and the Prior Authorization System Update Request forms to align the paper PA process with HIPAA changes. Copies of these revised forms and the Indiana Prior Review and Authorization Dental Request form are available within Appendix H and the “Provider/Forms” section of the IHCP Web site at ww.indianamedicaid.com.

Instructions for using the form are shown in Table 6.2 below.

Table 6.2 – Indiana Prior Review and Authorization Request Form Instructions

Field	Description
Medicaid ID/RID# DOB Name/Address/City/State/ZIP/Phone PMP Name/NPI/Phone	Member information. Type the data requested for the member who is to receive the requested service. Type the data requested for the member’s PMP.
Requesting Provider NPI # Tax ID# Service Location Code Provider Name	

	<p>Requesting provider information. Type the data requested.</p> <p>The requesting or rendering provider's National Provider Identifier (NPI) is required if the provider is enrolled in the IHCP.</p> <p>If the requesting provider is not enrolled, type the practitioner's license number in the <i>Requesting Provider #</i> field.</p> <p>The provider's copy of the <i>Indiana Prior Review and Authorization Request Decision</i> form is sent to the address that corresponds to the provider's information entered in this field, if a separate mailing provider ID and service location are not identified on the form.</p> <p>If the requesting provider information does not have a valid service location, a PA decision letter is not generated. Therefore, providers must complete the mailing provider ID and service location fields to ensure that the PA decision letter is mailed to the correct address.</p> <p>If the mailing provider ID and service location fields are completed in conjunction with a requesting provider information that has a valid service location, the mailing provider ID and service location information is selected as the address – not the requesting provider number and service location information for mailing of the PA decision form.</p>
<p>Rendering Provider NPI#</p> <p>Tax ID#</p> <p>Name/Address/City/State/ZIP/Phone/Fax</p>	<p>Rendering provider's NPI number information. Type the data requested for the provider rendering the requested service, if known.</p>
<p>Preparer's Information</p>	<p>Type the name, phone number and fax number of the preparer</p>
<p>Medical Diagnosis Medical Diagnosis.</p>	<p>Type the primary, secondary, and tertiary <i>ICD-9-CM</i> diagnosis code(s).</p>
<p>Assignment Category</p>	<p>Please check which assignment category you are requesting service for.</p>
<p>Dates of Service, Start</p>	<p>Requested start date for the service (For continued services, the start date must be the day after the previous end date.)</p>

Dates of Service, Stop	Requested stop date for the service.
Procedure/Service Code	Type the requested service code, such as Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), revenue, National Drug Code (NDC), and so forth.
Modifier(s)	Type any applicable service code modifiers.
Requested Service	Type a short narrative (or include attachment) of the requested service and like services provided by other payers
Taxonomy	Type any applicable taxonomy codes.
POS	Type the requested place of service (POS).
Units	Type the number of units desired. Units are equal to days, months, or items, whichever is applicable.
Dollars	Type the estimated or known IHCP cost of the service. This is optional, except for home health services, DME equipment, and pharmacy requests.
Notes	Type clinical summary information. Additional pages can be attached, if necessary. A current plan of treatment and progress notes must be attached for the listed services. Requested dates of service should coincide with the plan of treatment dates.
Signature of Qualified Practitioner Date	Authorized provider, as listed in <i>Section 1</i> of this chapter and <i>405IAC 5-3-10</i> , must sign and date the form. Signature stamps can be used.

Submission by Mail

Written requests for PA must be submitted to one the following address's listed below based on the program the member is associated to which can be determined by the eligibility verification obtained on the member.

**ADVANTAGE Health Solutions, Inc.
FFS Prior Authorization Department
P.O. Box 40789
Indianapolis, IN 46240**

ADVANTAGE Health Solutions, Inc.
Care Select Prior Authorization Department
P.O. Box 80068
Indianapolis, IN 46280

ADVANTAGE Health Solutions, Inc.
MRO Prior Authorization
P.O. Box 40789
Indianapolis, IN 46240

Providers should retain a photocopy of the Indiana Prior Review and Authorization Request form for their records. The original of the form must be submitted to the appropriate PA Department address listed above.

Submission by Fax

Providers may fax ADVANTAGE Health Solutions – FFS and ADVANTAGE Health Solutions –*Care Select* PA request, (using an Indiana Prior Review and Authorization Request form) to 1-800-689-2759.

Providers that choose to fax Prior Authorization request to ADVANTAGE Health Solutions – FFS and ADVANTAGE Health Solutions *Care Select* are asked to please submit faxed Prior Authorizations on a daily basis.

Large weekly batches of PA requests are not accepted!!!

Submission by Phone

Providers may call ADVANTAGE Health Solutions – FFS and ADVANTAGE Health Solutions –*Care Select* PA departments directly in order to prior authorize services for members. The PA telephone lines have an automated attendant to direct calls to the appropriate area. When a call is answered, the automated attendant offers the following options.

ADVANTAGE Health Solutions – FFS **1-800-269-5720**

- Option 2 (press 2) – For Medical pre-certification
- Option 3 (press 3) – For Behavioral Health Precertification

ADVANTAGE Health Solutions – *Care Select* **1-800-784-3981**

- Option 1 (press 1) – If you are a member
- Option 2 (press 2) – If you are a provider

If you are calling about an ADVANTAGE *Care Select* member Press 1

- Press 1 for Right Choices Program
- Press 2 for Medical Precertification
- Press 3 For Medical Rehabilitation Option (MRO)
- Press 4 For Behavioral Health Precertification
- Press 6 For Disease Management Services
- Press 7 For Contracting, Credentialing or other Provider-Related inquires
- Press 8 For Elective Medical & Surgical Admissions

If you are calling about a Traditional Fee-For-Service member – Press 2

- Press 1 For Behavioral Health Precertification
- Press 2 For Durable Medical Equipment
- Press 3 For Home Health and Hospice
- Press 8 For Elective Medical & Surgical Admissions

- Option 4 (press 4) – All other parties
- Option 5 (press 5) – Search by name for the party you wish to speak with
- Option 9 (press 9) – If you are experiencing a Behavioral Health Crisis

Submission Via WebInterchange

The TPA Web application on the IHCP Web site allows providers to submit non-pharmacy PA requests and to inquire on requests via Web interChange. Providers can also submit PA requests on paper, by telephone, or by fax, and should continue to follow existing policies when submitting PA requests.

Note: To inquire about existing PAs, providers must have a PA number or be the requesting or service provider of the PA.

Doctors, dentists, home health agencies, hospices, optometrists, health service providers in psychology (HSPP), chiropractors, hospitals, and transportation providers can submit requests. Detailed information about using the Web application is available on the IHCP Web site at <http://www.indianamedicaid.com>.

6.6 Indiana Prior Review and Authorization Dental Request

Send the completed Indiana Prior Review and Authorization Dental Request form to the following address as appropriate:

**ADVANTAGE Health Solutions-FFS
Prior Authorization Department
P.O. Box 40789
Indianapolis, IN 46240**

**ADVANTAGE Health Solutions- Care Select
Prior Authorization Department
P.O. Box 80068
Indianapolis, IN 46280**

This form is available within Appendix H and the “Provider/Forms” section of the IHCP Web site at www.indianamedicaid.com .

Form instructions for the Indiana Prior Review and Authorization Dental Request are contained in Table 6.3.

Table 6.3 – Indiana Prior Review and Authorization Dental Request Form Instructions

Field	Description
Requesting Provider # Name/Address/City/State/Zip/Phone Mailing Provider ID and service location	Requesting provider information. Type the data requested. The requesting or rendering provider number is required if the provider is enrolled in the IHCP. If the requesting provider is not enrolled, type the practitioner’s license number in the <i>Provider #</i> field. The provider’s copy of the Indiana Prior Review and Authorization Dental Request Decision form is sent to the address that corresponds to the provider number entered in this field, if a separate mailing provider ID and service location is not identified on the form. If the requesting provider information does not have a valid service location then a PA decision letter will not be generated. Therefore, you must complete the mailing provider ID and service location fields to ensure that the PA decision letter is mailed to the correct address. If the mailing provider ID and service location fields are completed in conjunction with the requesting provider information that has a valid service location, the mailing provider ID and service location information will be selected as the address not the requesting provider number and service location information for mailing of the PA decision form.
RID NO. DOB Name/Address/City/State/Zip	Member information. Type the data requested for the member who is to receive the requested service.
Dates of Service, Start	Requested start date for the service; for continued services, the start date must be the day after the previous end date.
Field	Description
Date of Service, Stop	Requested stop date for the service.
Service Code	Type the requested service code such as CPT, ADA, HCPCS, revenue, or NDC

Requested Service	Type a short narrative or include attachment of the requested service and like services provided by other payers.
Place of Service	Type the requested place of service.
Units	Type the number of units desired. Units are equal to days, months, or items, whichever is applicable.
Dollars	Type the estimated or known IHCP cost of the service. Optional, except for home health services, DME equipment, and pharmacy requests.
Casworker/Phone	Type the caseworker name and telephone number.
590 Program	Check, if applicable
Is Recipient Employed?	Check either YES or NO.
Circumstances (Place/Type)	Type employment information, if applicable.
Is Recipient in Job Training?	Check either YES or NO.
Type of Job Training	Type training information, if applicable.
Dental Treatment Plan	
Does the Recipient have missing teeth?	Check either YES or NO . If YES, indicate missing teeth with an X on the diagram provided.
1. Endodontics	Indicate on the number graph the tooth or teeth to be treated by root canal therapy (1-32).
2. Periodontics	Briefly summarize the periodontal condition.
3. Partial dentures	Use the diagram to indicate the teeth involved. Date or dates of extractions of missing teeth. Which teeth are to be extracted (tooth#)? Which teeth are to be replaced (tooth#)? Brief description of materials and design of partial. Is patient wearing partials now? Age of present partials.
4. Dentures	Full upper denture, full lower denture, Check one or both. How long endentulous? Is the patient physically and psychologically able to wear and maintain the prosthesis? Is patient wearing dentures now? Age of present dentures.
5. Describe treatment if different from above	Type description of any treatment to be provided that was not listed previously on this form.
6. Is the member on parenteral or enteral nutritional supplements?	Check either YES or NO . If YES, a plan of care to wean the member from the nutritional supplements must be attached. If the plan of care is not provided, dentures, partials, relines, and repairs will be denied.
Brief Dental/Medical History	Type pertinent information known to the provider about the member's dental and/or medical history.
Signature of Requesting Dentist	
Date of Submission	Type the date the form was actually submitted.

Providers should retain a photocopy of the Indiana Prior Review and Authorization Dental Request form for their records. The original of the form must be submitted to the appropriate PA Department address listed above.

6.7 Time Parameters

The provider is responsible for submitting new requests for PA for ongoing services at least 30 days before the current authorization period expires to ensure that services are not interrupted. The decision about PA is made as quickly as possible. For the *Care Select* Program, if a decision is not made within 5 days, weekends and holidays excluded, after receipt of all required documentation, authorization is deemed to be granted within the coverage and limitations specified (405 IAC 5-14). The provider must wait until the approved PA decision form or the 278 response is returned to bill for the service or until verification can be made that ADVANTAGE Health Solutions- *Care Select* received the form or the 278 request and did not render a decision on the request within 5 calendar days. Verification is accomplished using Web interChange PA inquiry or the automated voice response (AVR) system. When additional information is requested, the 5 working days begin on receipt of the information by the ADVANTAGE Health Solutions- *Care Select* organization's PA Department. The established mechanism to allow time for the provider to supply this information is achieved by suspending the first request form and having the provider submit another request form with the additional information.

Note: Suspending the request does not mean the request is denied; it gives the provider additional time to provide clinical information that facilitates a more accurate and appropriate determination.

If documentation is not received within 30 days, the request is denied. Examples of reasons for suspending a request include a lack of complete medical history, missing medical clearance forms, or missing plan of treatment. If the determination involves a denial or modification of a continuing service, such as home healthcare, at least 10 days notice plus three days additional mailing time must be given before the effective date of the change begins. Additional clinical information to justify medical necessity or additional information needed for clarification, including, but not limited to, X-rays, ultrasound, lab, and biopsy reports may be required. Photographs may be necessary in some instances such as breast reduction surgery or wound management.

Send the completed Indiana Prior Review and Authorization Request form to the following address as appropriate:

ADVANTAGE Health Solutions
-FFS Prior Authorization Department
P.O. Box 40789
Indianapolis, IN 46240

ADVANTAGE Health Solutions
- Care Select Prior Authorization Department
P.O. Box 80068
Indianapolis, IN 46280

ADVANTAGE Health Solutions, Inc.
MRO Prior Authorization
P.O. Box 40789
Indianapolis, IN 46240

Providers should retain a photocopy of the Indiana Prior Review and Authorization Request form for their records. The original of the form must be submitted to ADVANTAGE Health SolutionsFFS or ADVANTAGE Health Solutions- *Care Select* PA Departments address as appropriate.

6.8 Prior Authorization Decision Form

After a decision is reached about a PA request, IndianaAIM automatically generates an Indiana Prior Review and Authorization Request Decision form. If the PA request is not approved, additional information is included with the decision form to explain the decision. For example, IAC reference and administrative review and appeal rights are included for modified and denied decisions. A suspension is a request for additional information. Providers must return the additional information within 30 days or the request is denied. If the PA request is rejected, providers will receive a PA decision letter documenting the rejected status of the PA request noting that the PA was submitted to the wrong PA vendor based on the assignment of the member to a specific IHCP program. PA decisions are mailed to the member and the requesting provider. The rendering provider, if not also the requesting provider, must contact either the requesting provider or the member to secure a copy of the PA decision.

An explanation of the Indiana Prior Review and Authorization Request Decision content follows:

- The top left area of the form provides requesting provider and member information.
- Specific information about the requested service is provided below the provider and member information.
- Space for narrative about the decision is provided below the service information.

Instead of submitting another PA request, certain authorization information can be updated by telephone or letter.

6.9 Rejected PA Requests

PA requests that are submitted via paper or by fax to the incorrect PA vendor for Traditional Medicaid or *Care Select* will be rejected. Providers will receive a PA decision letter documenting the rejected status of the PA, noting that the PA was submitted to the wrong PA vendor based on the assignment of the member to a specific IHCP program. It is important to note that providers must verify member eligibility to

determine which IHCP program the member is associated to determine the correct PA address for submission of the PA request.

6.10 Prior Authorization (PA) Update Requests

Submit PA update requests on the Prior Authorization Update Request Form. Written PA update requests can be submitted on the provider's letterhead stationery, with "**PRIOR AUTHORIZATION UPDATE**" written boldly across the top. Pertinent information, such as RID, PA number, and information to be corrected, changed, or updated should be included. A copy of the original PA request and system-generated letter should be attached to verify the item to be updated. The request should be sent to the following address as appropriate based on the program assignment of the member.

ADVANTAGE Health Solutions
-FFS Prior Authorization Department
P.O. Box 40789
Indianapolis, IN 46240

ADVANTAGE Health Solutions
- Care Select Prior Authorization Department
P.O. Box 80068
Indianapolis, IN 46280

ADVANTAGE Health Solutions, Inc.
MRO Prior Authorization
P.O. Box 40789
Indianapolis, IN 46240

The Prior Authorization PA Update Request Form is available within Appendix H and the "Provider/Forms" section of the IHCP Web site at ww.indianamedicaid.com .

Examples of appropriate PA update requests are as follows.

- A provider that discovers a clerical error in entering PA data in the system may call or write to request the correction of the system, depending on the complexity of the situation. If the error does not require research or review of the original PA request, the correction can be updated over the telephone. However, some items may be too complicated to resolve with a telephone call and may require additional medical documentation to support the request. Providers may need to send the original request and the system-generated letter for review. An explanatory letter is helpful.

- A request to increase home health services, except in the case of urgent or emergency services, requires a written request with supporting documentation of medical necessity.
- Extending the dates on an approved surgery because rescheduling was necessary is appropriate for a telephone update.

When the system is updated, a ~~generated~~ Indiana Prior Review and Authorization PA Update Decision form is sent automatically to the requesting provider and the member.

6.11 PA Update Decision Form

When an existing PA is updated, IndianaAIM automatically generates an Indiana Prior Review and Authorization Update Decision form. This form highlights the information that was changed in a narrative at the bottom of the form. An explanation of the Indiana Prior Review and Authorization Update contents follows:

- Requesting provider information
- Member information
- Specific information about the requested service provided

6.12 Outstanding Prior Authorizations

If a member changes programs between Traditional Medicaid (FFS), *Care Select*, and Hoosier Healthwise, or between Hoosier Healthwise or *Care Select* plans, all existing PAs are honored for 30 days. The PAs may be for a specific procedure, such as surgery, or for ongoing procedures authorized for a specified duration, such as physical therapy or home healthcare. During this transition, the IHCP honors the PA for 30 days or for the remainder of the PA dates of service, whichever come first. Requiring a duplicate authorization from the new plan places an additional burden on the provider and can result in delayed or inappropriately denied treatments or services to the member. When providers check eligibility, they should notify the new plan of any outstanding PAs.

6.13 Prior Authorization Suspension

PA requests are suspended when additional information is needed by the provider and/or member. The requested documentation must be received within thirty (30) calendar days or the PA will be denied. Suspended requests, that are later approved, are authorized with the dates of service indicated on the original request. When a member is reassigned to a different DMO, during a PA suspension period, the requesting provider must send the added documentation to the DMO which received the original PA request from the provider. Providers should verify member eligibility via web-interchange prior to sending documentation.

6.14 Retroactive Prior Authorization

PA is given after services have begun or supplies have been delivered only under the following circumstances:

- Pending or retroactive member eligibility; The PA request must be submitted within 12 months of the date when the member's caseworker entered the eligibility information.
- Mechanical or administrative delays or errors by the contractor or county office of the Division of Family Resources (DFR);
- Services rendered outside Indiana by a provider that had not yet received an IHCP provider number;
- Transportation services authorized under 405 IAC 5-30; The PA request must be submitted within 12 months of the date of service.
- Provider was unaware that the member was eligible for services at the time services were rendered; PA is granted in this situation only if the following conditions are met:
 - The provider's records document that the member refused or was physically unable to provide the RID number;
 - The provider can substantiate that reimbursement was continually pursued from the member until IHCP eligibility was discovered;
 - The provider submitted the request for PA within 60 days of the date that IHCP eligibility was discovered;
 - Any situation in which the physician cannot determine the exact procedure to be done until after the service has been performed

6.15 Pharmacy Prior Authorization

PA requests for drugs submitted through the pharmacy must be directed to ACS.

ADVANTAGE Health SolutionsFFS or ADVANTAGE Health Solutions- *Care Select* is not responsible for handling PAs for the IHCP pharmacy benefit. All PAs for drugs and drug utilization review (DUR) edits are approved by the ACS Clinical Call Center at 1-866-879-0106.

A series of prompts direct calls to the appropriate PA specialist.

Providers needing PA for Prospective Drug Utilization Review (ProDUR) are directed to a PA pharmacy technician. This type of PA is needed to authorize payment for early refill, severity level one drug-to-drug interactions, drugs restricted to a 34-day supply, and brand name medically necessary. Providers needing PA for Preferred Drug List (PDL) prescriptions are directed to an ACS PDL pharmacist.

ACS accepts faxed requests for PAs for ProDUR from long term care (LTC) facilities, growth hormone, Synagis, Arthrotec, and brand name NSAIDs. Providers can fax requests to 1-866-780-2198. **Faxes are not currently accepted for PDL authorizations.**

The hours of the ACS Clinical Call Center are 8 a.m. to 8 p.m., Monday through Friday. The ACS Clinical Call Center is closed on weekends and federal holidays. The emergency supply feature, as outlined in Chapter 9 of the IHCP Provider Manual, should be used when the PA desk is unavailable.

For questions about this process, contact the ACS Clinical Call Center by calling 1-866-879-0106, or check the IHCP Web site at <http://www.indianamedicaid.com>.

6.16 Making Referrals to Specialist

PMPs are responsible for making appropriate referrals to specialists when members have medical needs for which the PMP cannot provide. PMPs must refer members to specialists that are part of Indiana Health Coverage Program's (IHCP/Indiana Medicaid) contracted provider network. Contracted physicians may be found at www.indianamedicaid.com.

A formal written referral is not necessary for *Indiana Care Select* members to receive care from IHCP participating specialist and ancillary providers.

Reimbursement

A referral does not guarantee reimbursement. Reimbursement for services depends on the Member's enrollment on the date(s) of services, medical necessity of the service provided and Health Plan limitations and exclusions, as stated in rules and regulations governing *Indiana Care Select*, and *Indiana Care Select* policies and procedures. Members will be financially responsible for costs associated with non-covered services, and for payment of required copayments, deductibles and/or coinsurance.

6.17 Self-Referral Services

Self referral services do not require PMP authorization. Self referral services include:

- Podiatry
- Chiropractic
- Mental Health
- Dental
- Vision
- Family Planning
- HIV/AIDS Targeted Case Management
- Immunizations
- Diabetes Self-management
- Pharmacy

Note: Some self-referral services do require Prior Authorization.

6.18 Prior Authorization Appeal Rights

Provider Administrative Review

ADVANTAGE *Care Select* Providers, who desire a review of a modification or denial decision of a prior authorization request, must submit a written request for administrative review within SEVEN (7) working days of the receipt of notification of the modification or denial. (Rejection is NOT modification or denial)

When administrative review is desired but the member continues to be hospitalized, ADVANTAGE *Care Select* must receive a letter notifying the ADVANTAGE *Care Select* Hearings and Appeals Department of the intent to request an administrative review within seven working days of the receipt of notification of modification or denial. If the provider wants to continue with the appeal, ADVANTAGE *Care Select* must receive the entire medical record within 45 calendars after discharge.

To initiate an administrative review, provider must include the following information with the request:

- Copy of the original Indiana Prior Review and Authorization Request form. This form can be found within Appendix H of this provider manual or in the “Provider/Forms” section of the IHCP web site at www.indianamedicaid.com.
- Summary letter, including pertinent reasons the services are medically necessary. Include the PA number, member’s name, and member identification (RID) number.
- All documentation including medical records, equipment consultations, progress notes, case histories, and therapy evaluation. Documentation should be pertinent to the case and support the medical necessity of the requested service.
- Name, telephone number, and address of the provider submitting the request. (This information is required in the event it is necessary to contact the provider for additional information or clarification.)
- Entire medical record sent with requests for inpatient hospitalizations.

Request for administrative review should be sent to the following address:

ADVANTAGE Health Solutions
-FFS Attn: Administrative Review
P.O. Box 40789
Indianapolis, IN 46240

ADVANTAGE Health Solutions
- *Care Select* Attn: Administrative Review

P.O. Box 80068
Indianapolis, IN 46280

OR
Fax to: 1-866-368-2644

NOTICE:

1. Failure to request a timely Administrative Review will result in the loss of the right to request an Administrative according to 405 IAC 1-7-6 (a)
2. The review decision of the contractor will be rendered within SEVEN (7) working days of the receipt of the request.
3. The review will assess medical information pertinent to the case in question.
4. The Medicaid Medical Director or his/her designee will perform the review.
5. The requesting provider and the recipient will receive written notification of the decision containing:
 - The determination reached by the Medicaid contractor and the rationale for the decision.
 - Provider/recipient appeal rights through the Family and Social Services Administration.
6. If you are the provider, that is requesting an Administrative Review of the PA decision, you must submit your request to the Disease Management Organization (DMO) or Fee for Service (FFS) organization that denied the PA request.

Provider and Member Administrative Hearing

Any provider that has submitted a request for prior review and authorization can appeal a denial or modification of the request after exhausting the administrative review process. The administrative hearing request must be in writing and must be signed by the requesting provider or designee. Administrative Hearings are conducted in accordance with 470 IAC 1-4. The filing must be within 30 days, plus three days mailing time, of the date the adverse decision was received or takes effect, whichever is later.

If a member disagrees with a denial or modification of a PA request for services by the IFSSA, the county office of the Division of Family Resources (DFR), or the ADVANTAGE *Care Select* Program, the member can ask for an administrative hearing pursuant to 42 CFR 431.200 et seq. and 470 IAC 1-4. An administrative hearing is requested by filing a signed written Appeal and Request for Hearing with the county office or with the Hearings and Appeals Section of Family and Social Services Administration (FSSA). The filing must be within 30 days, plus tree days mailing time, of the date the adverse

decision was received or takes effect, whichever is later. If the request is for a continuing service (for example, home health care), at least 10 day notice plus three days mailing time must be given before the effective date of the denial or modification, except as permitted under 42 CFR 431.213 and 42 CFR 431.214.

As required by statute, if the request for a hearing is received prior to the effective date of the denial or modification of continuing services, services are continued at the authorized level of the previous PA. The request must state which requested item the member is appealing. At the hearing, the member has the right to self-representation or to be represented by legal counsel, a friend, a relative, or another spokesperson of the member's choice. The member is given the opportunity to examine the entire contents of his/her case file and any and all materials used by the FSSA, county office, or the contractor that made the adverse determination. Other IHCP and assistance benefits are not affected by a request for a hearing.

Notification Procedures

Requests for Administrative Hearings by providers or members should be sent to the following address:

MS04
Indiana Family and Social Services Administration
Division of Family Resources
402 West Washington St.
Room E034
Indianapolis, IN 46204
Attention: Hearings and Appeals

Members may send the written request for appeal to the local county office of the Division of Family Resources.

7.0 Disease Management

7.1 Introduction

The Disease Management Program provides resources and educational services to Members so that Members can work with their medical provider(s) to understand their condition(s), utilize effective tools and interventions, and to have better health outcomes. Each Member in Disease Management will be assessed and a disease management plan will be developed that reflects the physical and psychosocial needs of the Member. The Member's compliance with the plan will be monitored. The care manager interacts routinely with the PMP, the Member, the behavioral health care provider (if indicated), and the Member's care giver/family.

7.2 Disease Management

Referrals to Disease Management

A referral to the Disease Management Program will now be made by a two step process.

First step is that the member must be eligible for Medicaid with one of the following aid categories:

- Aged
- Blind
- Disabled Physically and mentally disabled
- Wards of the court and foster children
- Children receiving adoptive services

Second, a member must also have one of the following conditions:

- Asthma
- Diabetes
- Congestive Heart Failure (CHF) or Coronary Artery Disease (CAD)
- Hypertension
- Chronic Kidney Disease without dialysis
- Rheumatic Heart Illness
- Severe Mental Illness (SMI)
- Serious Emotional Disturbance (SED)
- Depression

The member must also be selected by Medicaid and choose to enroll.

7.3 Types of Disease Management

The objectives of Disease Management programs are to:

- Identify Members that would benefit from the specific disease management program
- Educate Members on their disease, symptoms and effective tools for self-management
- Monitor Members to encourage/educate about self care, identify complications, assist in coordinating treatments and medications, and encourage continuity and comprehensive care
- Provide evidence-based, nationally recognized expert resources for both the Member and the provider
- Monitor effectiveness of interventions

Asthma

The Asthma Disease Management program offers coordination of care for identified Members with primary medical providers, specialist, community agencies, the Members' caregivers and/or family. Member education and intervention is targeted to empower and enable compliance with the physician's treatment plan. Providers play an

important role in helping Members manage this chronic disease by promoting program goals and strategies, including:

- Preventing chronic symptoms
- Maintaining “normal” pulmonary function
- Maintaining normal activity levels
- Maintaining appropriate medication ratios
- Preventing recurrent exacerbation and minimizing the need for emergency treatment or hospitalizations
- Providing optimal pharmacotherapy without adverse effects
- Providing education to help Members and their families better understand the disease and its prevention/treatment

ADVANTAGE *Care Select* Program has adopted Asthma Outpatient Practice Guidelines from the American Lung Association that are reviewed annually. These guidelines may be viewed on the ADVANTAGE Web site at www.advantageplan.com.

Congestive Heart Failure (CHF) and Rheumatic Heart Illness

The CHF and Rheumatic Heart Disease Management program is designed to develop a partnership between the ADVANTAGE *Care Select* Program, the primary care provider and the Member to improve self-management of the disease. The program involves identification of Members with CHF and Rheumatic Heart Illness and engages them in subsequent targeted education and interventions.

The objectives of the CHF and Rheumatic Heart Disease Management Program are to:

- Educate Members with CHF or Rheumatic Heart Illness on their disease process
- Educate members on the following:
 - Cardiac symptoms
 - Emotional/Psychological aspects of the CHF or Rheumatic Heart illness
 - Blood pressure management
 - Weight management
 - Nutritional requirements
 - Smoking cessation

The ADVANTAGE *Care Select* Program has adopted CHF guidelines from ACC/AHA that are reviewed annually. These guidelines may be viewed on the ADVANTAGE Web site at www.advantageplan.com.

Diabetes

The Diabetes Disease Management program is designed to develop a partnership between the ADVANTAGE *Care Select* Program, the primary medical provider and the Member to improve self-management of the disease. The program involves identification of Members with diabetes and subsequent targeted education and interventions. In addition, the program offers providers assistance in increasing Member compliance with diabetes care and self-management regimens.

Providers play an important role in helping Members manage this chronic condition. ADVANTAGE *Care Select* appreciates providers' efforts in promoting the following program goals and strategies:

- Referrals for formal diabetes education through available community programs
- Referrals for annual diabetic retinal eye exams by eye care professionals as defined in ADVANTAGE *Care Select* Program's Diabetes Management Practice Guidelines
- Laboratory exams that include:
 - Glycohemoglobins at least twice annually
 - Micro albumin
 - Fasting Lipid profile annually
- Management of co-morbid conditions like blood pressure, CHF, and blood cholesterol.

ADVANTAGE *Care Select* Program has adopted Hypertensive Heart Disease Outpatient Practice Guidelines from the ACC/AHA that are reviewed annually. These guidelines may be viewed on the ADVANTAGE Web site at www.advantageplan.com.

Chronic Kidney Disease (CKD) or Hypertensive Heart and Kidney Disease

The Chronic Kidney Disease program is designed to develop a partnership between the ADVANTAGE *Care Select* Program, the primary medical provider and the Member to improve self-management of the disease. The program involves identification of members with Chronic Kidney Disease and subsequent targeted education and interventions. In addition, the program offers providers assistance in increasing Member compliance with Chronic Kidney Disease care and self-management tools to monitor their condition.

Providers play an important role in helping Members manage this chronic condition. ADVANTAGE *Care Select* appreciates providers' efforts in promoting the following program goals and strategies:

- Educate Members on the following:
 - Emotional/Psychological aspects of Kidney disease
 - Blood Pressure management

- Weight management
 - Nutritional requirements
 - Smoking cessation
 - When to seek medical care
- Work with the doctor to perform lab tests to check and monitor kidney functioning:
 - Glomerular Filtration Rate (GFR)
 - Micro albumin
 - Additional physician recommended testing
 - Promote appropriate dietary management
 - Identify medications to avoid such as over-the-counter remedies

The ADVANTAGE *Care Select* Program has adopted the KDOQI Clinical Practice Guidelines for Chronic Kidney Disease from the National Kidney Foundation that are reviewed annually. Please refer to the ADVANTAGE Web site at www.advantageplan.com for further information.

Behavioral Health Disease Management Conditions

The Behavioral Health Disease Management Program contains the following conditions:

- Depression
- Severe Mental Illness Management (SMI)
- Serious Emotional Disturbance (SED)

The programs are all designed to develop a partnership between the ADVANTAGE *Care Select* Program, the primary care provider and/or the behavioral health provider and the Member to improve self-management of the disease. The program involves identification of Members with certain behavioral health conditions that will receive education and interventions for their behavioral health conditions.

The objectives of the Behavioral Health Disease Management Programs are to:

- Educate Members with behavioral health conditions on their disease process
- Educate members on the following:
 - Provide disease-specific education to the member and caregiver or family
 - Connect member to community resources
 - Educate the member on self-referral services for behavioral health treatment
 - Enhance continuity of care as evidenced by medication and behavioral health appointment adherence

- Promote awareness of stressors and regular patterns of activity and sleep
- Work with the patient to anticipate and address early signs of relapse
- Management of co-morbid conditions like Asthma, Diabetes, CHF, Hypertensive Heart Disease, Hypertensive Heart and Kidney Disease, and other behavioral health conditions.

The ADVANTAGE *Care Select* Program has adopted Depression Guidelines, Bipolar Disorder Guidelines, Schizophrenia Disorder Guidelines, and Major Depression Guidelines from the Department of Health and Human Services, American Psychiatric Association, and the Academy of Child and Adolescent Psychiatry that are reviewed annually. Please refer to the ADVANTAGE *Care Select* Program web site at www.advantageplan.com for further information.

7.4 Care Management

ADVANTAGE *Care Select* provides Care Management services to Members who meet the complex medical and/or behavioral health requirements for the short term intensive Care Management aspect of the Disease Management Program. These complex Members are assigned to an RN or social work care manager who works closely with the PMP, behavioral health provider (if indicated), and Member to coordinate care and services. The care manager works with community resources, Community Mental Health Centers, home health services, and primary care physicians to coordinate medical and behavioral health care to assure appropriate access to medical and social services. Each Member in Care Management will be assessed and a care plan will be developed that reflects the physical and psychosocial needs of the Member. The Member's compliance with the plan will be monitored. The care manager interacts routinely with the PMP, the Member, the behavioral health care provider (if indicated), and the Member's caregiver/family.

8.0 Inpatient Concurrent Review

8.1 Introduction

ADVANTAGE *Care Select's* Utilization Management Program encompasses activities directed toward prospective, retrospective and concurrent utilization review. Prospective review (prior authorization) determines the medical necessity and appropriateness of the service before it is provided. Concurrent review occurs throughout a Member's inpatient stay. It determines the appropriateness of the level of care and the length of stay. Retrospective review involves aggregate and provider specific assessment of the appropriateness of medical services after the services have been provided. ADVANTAGE *Care Select's* inpatient utilization management practices are described in this chapter. Outpatient authorization and review criteria are available

upon request. Requests for criteria should be directed to your Provider Services representative or to the Medical Services Department. The prior authorization/referral section of utilization management is described in Chapter 6.

8.2 Concurrent Review

The ADVANTAGE *Care Select* Program conducts concurrent utilization review on each Member admitted to an inpatient facility, including skilled nursing facilities and freestanding specialty hospitals. Concurrent review activities include both admission certification and continued stay review. The review of the Member's medical record assesses Medical Necessity for the admission, and appropriateness of the level of care, using the Milliman Care Guidelines® and the AHCCCS NICU / Nursery / Step-Down utilization guidelines. Admission certification is conducted within twenty-four (24) hours of receiving notification. Continued stay reviews are conducted before the expiration of the assigned length of stay. Providers will be notified of approval or denial of length of stay. An ADVANTAGE *Care Select* Program nurse performs these reviews. The nurses work with the medical directors in reviewing medical record documentation for hospitalized Members. ADVANTAGE *Care Select* medical directors make rounds one to two times per week in selected hospitals.

8.3 Milliman Care Guidelines®

ADVANTAGE *Care Select* uses the Milliman Care Guidelines® to ensure consistency in hospital-based utilization practices. The guidelines span the continuum of patient care and describe best practices for treating common conditions. The Milliman Care Guidelines are® updated regularly as each new version is published. A copy of individual guidelines pertaining to a specific case is available for review upon request.

8.4 Discharge Planning Coordination

Effective and timely discharge planning and coordination of care are key factors in the appropriate utilization of services and prevention of readmissions. The hospital staff and the attending physician are responsible for developing a discharge plan for the Member, and for involving the Member and family in implementing the plan. The ADVANTAGE *Care Select* care manager works with the hospital discharge team and attending physicians to ensure that cost-effective and quality services are provided at the appropriate level of care. This may include, but is not limited to:

- Assuring early discharge planning
- Facilitating or attending discharge planning meetings for Members with complex and/or multiple discharge needs
- Providing hospital staff and attending physician with names of contracted ADVANTAGE *Care Select* providers (i.e., home health agencies, DME/medical supply companies, other outpatient providers)
- Informing hospital staff and attending physician of covered benefits as indicated

It is also a responsibility of the CRN to coordinate discharge planning for ALTCS Members with the *ADVANTAGE Care Select* Program LTC case managers.

8.5 Physician Medical Review

ADVANTAGE Care Select Program medical directors conduct medical review for each case with the potential for denial of authorization. The CRN (Inpatient) or the Prior Authorization Nurse (Outpatient) reviews the documentation for evidence of Medical Necessity according to established criteria. When the criteria are not met, the case is referred to an *ADVANTAGE Care Select* medical director. The medical director reviews the documentation, discusses the case with the nurse and may call the attending or referring physician for more information. The requesting physician may be asked to submit additional information. Based on the discussion with the physician or additional documentation submitted, the medical director will decide to approve, deny, modify, reduce, suspend or terminate an existing or pending service.

Utilization management decisions are based only upon appropriateness of care and service. *ADVANTAGE Care Select* does not reward practitioners, or other individuals involved in utilization review, for issuing denials of coverage or service. The decision to deny a service request based upon medical necessity will only be made by a physician.

For inpatient denials, the attending physician and hospital staff are verbally notified when *ADVANTAGE Care Select* is stopping payment. The hospital will receive written notification with the effective date of termination of payment or reduction in level of care. The attending or referring physician may dispute the finding of the medical director informally by phone or formally in writing. If the finding of the medical director is disputed, a formal appeal may be filed according to the established *ADVANTAGE Care Select* appeals process.

9.0 Behavioral Health Services

9.1 Introduction

Comprehensive behavioral health and substance abuse services are available to all *ADVANTAGE Care Select* Program Members. Services are provided through *ADVANTAGE Care Select* Program contracted behavioral health providers for *ADVANTAGE Care Select* Program Members.

9.2 Provider Requirements

Contracted *ADVANTAGE Care Select* Program behavioral health providers are required to notify *ADVANTAGE* and the member's Primary Medical Provider (PMP) of a member's behavioral health visit and information about the treatment plan, diagnosis, medications, etc.

All *ADVANTAGE Care Select* Program behavioral health network providers shall:

- Notify *ADVANTAGE Care Select* and the member's PMP within five (5) days of a member's visit;
- Submit information to *ADVANTAGE Care Select* and the member's PMP about the member's treatment plan;
- Submit information to *ADVANTAGE Care Select* and the member's PMP about the member's diagnosis;
- Submit information to *ADVANTAGE Care Select* and the member's PMP about the member's medications;
- Submit additional information to *ADVANTAGE Care Select* and the member's PMP as may be beneficial to the member's overall treatment and care coordination.

All *ADVANTAGE Care Select* Program contracted behavioral health providers will be contractually required to document and share the following information with *ADVANTAGE* and the member's PMP. This shall occur initially and whenever there are any changes to the following items:

- A written summary of a member's treatment plan
- Primary and secondary diagnoses
- Findings from assessments
- Medications prescribed
- Any other relevant information.

NOTE: Disclosure of mental health records by the provider to *ADVANTAGE* and to the PMP is permissible under HIPAA and State law (IC 16-39-2-6(a)) without consent of the patient because it is for treatment.

NOTE: Consent from the patient is necessary for substance abuse records.

9.3 Services

Contracted *ADVANTAGE Care Select* Program behavioral health providers are responsible for screening and evaluation of *ADVANTAGE Care Select* Program Members, for eligibility, for behavioral health services. Comprehensive behavioral health services that may be provided are:

- Behavior management (behavioral health personal assistance, family support, peer support)
- Care Management related to behavioral health (with limitations)
- Behavioral health nursing services
- Emergency behavioral health care

- Emergency/non-emergency transportation
- Evaluation and assessment
- Individual, Group and Family therapy and counseling
- Inpatient hospitalization for behavioral health and psychiatric disorders
- Non hospital inpatient psychiatric facilities services
- Laboratory and radiology services for psychotropic medication regulation and diagnosis
- Opioid Agonistic treatment
- Partial care (supervised, therapeutic and medical day program)
- Psychosocial rehabilitation (living skills training, education and development, job coaching and employment support, and pre-job training)
- Psychotropic medication
- Psychotropic medication adjustment and monitoring
- Respite care (with limitations)
- Rural substance abuse transitional agency services
- Screening
- Therapeutic foster care
- Health and behavioral assessment procedures

9.4 Health and Behavioral Intervention

ADVANTAGE *Care Select* acknowledges and services the Member in a holistic approach by addressing the physical, emotional, and psychosocial factors that influence a person's well-being. Medically necessary health and behavioral assessment procedures are covered services when used to identify and treat the psychological, behavioral, emotional, cognitive and social factors important to the prevention, treatment and management of physical health problems. The focus of the assessment should be on the stresses, expectations, lifestyle and perceptions associated with the underlying

condition and not on mental health. Interventions must be short term and focused on physical health problems. Services are limited and require prior authorization.

9.5 Emergency Services

ADVANTAGE *Care Select* Program is responsible for up to three (3) days of inpatient behavioral health services per emergency episode (not to exceed twelve (12) days per contract year) for acute and DD Members who are not enrolled in a CMHC. The Member's benefit, however, is not limited to three (3) days. A referral to a CMHC should be made as soon as possible after admission for an intake evaluation and psychiatric and behavioral health follow up.

9.6 Medication Management

ADVANTAGE *Care Select* Program Members may receive medication management (prescription of medications, monitoring visits, associated laboratory tests) through their PMP's for symptoms of mild depression, anxiety or attention deficit disorders. ADVANTAGE *Care Select* Program covers prescriptions written by PMPs and the prescriptions can be filled at contracted ADVANTAGE *Care Select* pharmacies. Prior authorization is required for medications not on the preferred drug list.

Members may be referred to the CMHC for concurrent therapy and counseling services while receiving medication management through their PMP. PMPs are required to refer Members to the CMHC if they are in need of a greater intensity of services and psychiatric care. This includes Members that are not responding to treatment, have been in an inpatient hospital for a behavioral health diagnosis, or are presenting with a behavioral health diagnosis other than mild depression, anxiety or attention deficit disorder. In all cases, PMPs are responsible for maintaining close communication and coordination with the CMHC behavioral health provider.

Each CMHC will make psychiatric consultation available for ADVANTAGE *Care Select* Program PMPs. You may request a telephone consult, a face-to-face evaluation by a psychiatrist, or a comprehensive assessment by a CMHC evaluation specialist. PMPs should specify what information they are seeking: medication recommendations, diagnostic consult or other treatment recommendations.

9.7 Accessing Behavioral Health Services through the CMHC's

All CMHC's use a common referral form that can be sent or faxed directly to the CMHC. The PMP is required to refer and transition care over to the CMHC for Members who:

- Do not respond to treatment and therefore need additional behavioral health services such as counseling and/or more intense medication monitoring

- Present with a behavioral health disorder other than the three disorders cited above
- Have experienced a sentinel event (e.g. attempted suicide) or an inpatient hospitalization for a behavioral health diagnosis
- The PMP is not comfortable treating

Acute and DD Members may also refer themselves directly to the CMHC or may be referred from schools, state agencies or other service providers. Members do not need a referral from their PMP or prior approval from *ADVANTAGE Care Select* to contact the CMHC for services. However, the CMHC referral form is a useful tool to use to supply the CMHC with medical history, current medications and treatment, and current behavioral health diagnosis. It also assists in establishing communication between providers for continuity of care and best practice purposes.

9.8 Transfer of Behavioral Health Care Plan

Members referred to the CMHC for any of the above reasons are required to have a transition care plan. The transition care plan must include:

- Giving the Member enough of a prescribed behavioral health medication through the transition so that there is no interruption in the medication regime before the Member's intake appointment with the CMHC
- Transferring all applicable records to the CMHC provider per HIPAA guidelines, including but not limited to, reason for referral, diagnostic information, medical history, medication history and all prescriptions that have been provided to the Member
- Documentation in the PMP's medical record of ongoing treatment during the transition period
- PMPs who refer Members to the CMHC need to document the date the Member was referred, the reason the Member was referred, receiving contact name and pertinent information, the date that the medical record was forwarded to the CMHC and any other pertinent information. The transition period to the CMHC provider should take place within 30 days, and no later than 90 days.

PMP's are required to respond to a request for Member information from a CMHC within ten (10) business days of receiving the request.

9.9 Behavioral Health Care Coordination

The PMP will be informed of the Member's behavioral health provider so that communication may be established. It is very important that PMPs develop a strong communication link with the behavioral health provider. PMPs are expected to exchange any relevant information such as medical history, current medications, current behavioral health diagnosis and treatment. The behavioral health provider should supply the PMP with information regarding services that they are providing so that they may be included in the Member's permanent medical record. Please be advised that intake appointments to the CMHC can take up to 30 days or longer and that Member continuity of care is of major importance. Therefore, if you are referring a Member to the CMHC for behavioral health treatment, it is imperative that the Member is given transition of care treatment and services. This includes any prescribed psychotropic medications, monitoring visits, associated laboratory tests, etc. The PMP will need to continue to prescribe medications and administer the above services until the Member's care is transitioned appropriately over to the CMHC provider.

9.10 Behavioral Health Records

PMPs must maintain any behavioral health records pertaining to Members, even if a Member has not yet been seen. PMPs are required to maintain all behavioral health records received from the CMHC as part of the Member's medical record. The PMP is also required to respond within ten (10) business days to requests for information from the CMHC or contracted provider such as current diagnosis, medication, pertinent laboratory results, last PMP visit and last hospitalization. The PMP must initial and date any incoming documents to demonstrate that the records have been reviewed. Coordination of care efforts and further treatment recommendations must also be documented in the Member's medical record. PMPs shall treat all Member behavioral health records with confidentiality according to HIPAA guidelines.

9.11 Behavioral Health Referral Follow Up

PMP's will receive a return fax with a "Notice of Enrollment Status" or a "Notification of Assessment" after a referral form has been faxed to the CMHC. If the PMP does not receive feedback from the CMHC, the medical record must reflect that follow-up was initiated by the PMP with the CMHC and/or the Member to inquire about the status of the referral. If there is a problem in communicating with the local CMHC regarding a particular referral, the ADVANTAGE Care Select Program Behavioral Health Coordinator may be called for assistance at (800) 784-3981.

PMP's are required to complete EPSDT screening forms on all Members up to age 21 in compliance with the AHCCCS periodicity schedule. ADVANTAGE *Care Select* tracks and monitors EPSDT forms that indicate a need for behavioral health referrals. A follow-up letter with referral information, including CMHC locations and phone numbers, is sent to the identified Members' parent or guardian, as well as to the assigned PMP. These letters are sent every time it is indicated in the behavioral health box on the EPSDT

form. Records for these Members may be audited by AHCCCS for documentation of the referral and follow-up indicating whether the Member is receiving services.

10.0 Cultural Competence

10.1 Introduction

Cultural competence can be defined as a combination of knowledge, clinical skills and behaviors that lead to positive outcomes with culturally diverse populations. Studies have shown that consideration of individual cultures, preferences and needs in the provision of health care services may reduce non-compliance in patients, increase patient satisfaction and retention, and improve health outcomes. In addition, we know that culture has a profound impact on how people respond to preventive intervention and health services, as well as in how they experience illness, how they access care and the process of getting well.

In accordance with Title VI of the 1964 Civil Rights Act, national standards for culturally and linguistically appropriate health care services and State requirements, *ADVANTAGE Care Select* is required to ensure that Limited English Proficient (LEP) Members have meaningful access to health care services. Due to language differences and inability to speak or understand English, LEP persons are often excluded from programs they are eligible for, experience delays or denials of services or receive care and services based on inaccurate or incomplete information.

10.2 Cultural Competency Program

The Health Plan has a comprehensive program for meeting cultural competence requirements. As part of that program, *ADVANTAGE Care Select* Program provides over the phone interpretive services twenty-four hours a day in over 170 languages at no cost to the Member or provider. In addition, if a Member is hearing impaired, a TTY number is available or sign language interpreters can be scheduled statewide to accompany a Member to an appointment.

To schedule sign language or foreign language interpreters, call Member Services at 1-800-784-3981.

To contact *ADVANTAGE Care Select* via TTY please call (866)859-7812

For more detailed information on cultural competence, please refer to the guide at the end of this chapter entitled “Culturally Competent Patient Care: a Guide for Providers and Their Staff” by Georgia Hall, Ph.D. The guide was developed as a cooperative effort on behalf of AHCCCS health plans to assist providers and is reprinted with the permission of the author.

CULTURALLY COMPETENT PATIENT CARE

A Guide for Providers and Their Staff

Institute for

Health Professions Education

Georgia G. Hall, Ph.D., MPH

October 2001

INTRODUCTION

This guide is intended to help providers and their staff meet the challenge of caring for an increasingly diverse patient population whose culture, including: language, lifestyle, values, beliefs and attitudes, may differ from those of the dominant society. Since these and other elements of culture can influence the experience of illness, access to care, and the process of getting well, providers and their staff are compelled to learn about them and incorporate that knowledge into the patient care plan. Cultural competence can be defined as a combination of knowledge, clinical skills, and behaviors that lead to positive outcomes of patient care with ethnically and culturally diverse populations. Central to cultural competency is the provision of services, education and information in appropriate languages and at appropriate comprehension and literacy levels.

BENEFITS OF A CULTURALLY COMPETENT APPROACH TO CARE:

- Devise more appropriate plans of care
- Improve quality of patient care and outcomes
- Reduce patient non-compliance
- Improve patient satisfaction
- Provide enhanced individual and family care
- Gain sensitivity to patient needs
- Work more effectively with diverse patient populations
- Adhere to federal and state requirements

SECTION TWO

CULTURALLY COMPETENT HEALTHCARE

An understanding of value systems and their influence on health is essential to providing culturally competent health care. Every culture has a value system that dictates behavior directly or indirectly by setting and encouraging specific norms. Health beliefs and practices, in particular, reflect that value system.

Providing care for patients from diverse backgrounds requires understanding one’s own values as well as the values of other groups. There is a natural tendency for people to be culture bound; that is, to assume that their values, customs, attitudes and behaviors are always appropriate and right. The following list, comparing dominant Anglo–American values with those of other cultures demonstrates their differing views.

VALUES	
<i>Anglo-American</i>	<i>Other cultures</i>
Personal control over environment	Fate
Change	Tradition
Time dominates	Human interaction dominates
Human equality	Hierarchy/rank/status
Individualism/privacy	Group welfare
Self-help	Birthright inheritance
Competition	Cooperation
Future Orientation	Past orientation
Action/goal/work	“Being” orientation
Orientation/informality	Formality
Directness/openness/honesty	Idealism
Practicality/efficiency	Spiritualism
Materialism	

UNDERSTANDING YOUR VALUES AND BELIEFS

Cross-cultural healthcare requires providers and their staff to care for patients without making judgments about the superiority of one set of values over the other. Providers are not only influenced by the cultural values they were raised with, but also by the culture of medicine which has its own language and values. The complexity of the health care system today is time oriented, hierarchical and founded on disease management and the preservation of life at any cost. Realizing these values as part of the current medical culture will be useful when dealing with patients with different values.

KNOWING YOUR PATIENT

The difference between a provider who is culturally competent and one who is culturally aware is in the service that person provides. A culturally competent provider is aware of cultural differences and even more aware of the individual and his or her personal needs.

APPRECIATE THE HETEROGENEITY THAT EXISTS WITHIN CULTURAL GROUPS

As studies about cultural and ethnic groups demonstrate, there are distinctive characteristics that contribute to their uniqueness. Knowledge about these unique characteristics is important to the development of culturally relevant programs.

Since significant variability may exist between and among individuals from the same cultural and ethnic group, over-generalization is a danger. Such variability can be due to: age, level of education, family, rural/urban residence, religiosity, level of adherence to other customs, and for immigrant patients, degree of assimilation and acculturation.

THE ROLE OF ECONOMICS

The culture of poverty is as important as a person's ethnicity, social status and cultural background. Economic status may influence the patient's ability to acquire medical supplies or other resources (such as running water, electricity, adequate space, healthful or specific diet, etc.) needed for continuity of care and wellness. Decisions that are made about lower income patients' care must be sensitive to the differing degrees of access to resources.

THE ROLE OF RELIGIOUS BELIEFS

Religious beliefs often influence a patient's decision about medical treatment. Because of their religious faiths, patients may request diagnosis but not treatment. If a particular treatment is absolutely necessary, providers may find it helpful to consult with the patient's spiritual leader. Patients who seek mainstream medical care may also seek treatment from healers in their culture. Rather than discouraging this, especially if the alternative treatment is not harmful, providers and their staff may want to incorporate traditional healing into the general treatment plan.

THE ROLE OF THE FAMILY

Other cultures place a greater emphasis on the role of the family. Decision making about health issues may be a family affair. In some cultures (i.e., Muslim), the husband or other males in the family may be the primary person for decision making. It can be helpful for providers and their staff to take this into account as medical decision making takes place.

QUESTIONS TO CONSIDER

- Who and How many family Members can accompany the patient into the room?
- Should friends be allowed in the room?
- Who can or should be told about the patient's condition?
- Who should be included in health care decision-making?

SECTION THREE

CULTURAL ASSESSMENT

Cultural assessment of the patient is an important step in identifying their views and beliefs about health and illness. Beliefs about the cause, prevention, and treatment of illness vary among cultures. Such beliefs dictate the practices used to maintain health and treat illness. Studies have classified health practices into several categories: folk, spiritual, or psychic healing practices, and conventional medical practices.

In addition to the general data collected from a patient, the following checklists may be helpful in gaining specific cultural information:

- Where were you born?
- If you were born outside the USA, how long have you lived in this country?
- Who are the people you depend upon the most for help? (Family Members, friends, community services, church etc.)
- Are there people who are dependent on you for care? Who are they? What kind of care do you provide?
- What languages do you speak?
- Can you read and write in those languages?
- What is the first thing you do when you feel ill?
- Do you ever see a native healer or other type of practitioner when you don't feel well?
- What does that person do for you?
- Do you ever take any herbs or medicines that are commonly used in your native country or cultural group?
- What are they, and what do you take them for?
- What foods do you generally eat? How many times a day do you eat?
- How do you spend your day?
- How did you get here today?

- Do you generally have to arrange for transportation when you have appointments? The questionnaire below will help determine a patient's beliefs about his or her problem:

Tools To Elicit Health Beliefs

- What do you call your problem? What name does it have?
- What do you think caused your problem?
- Why do you think it started when it did?
- What does your sickness do to you? How does it work?
- How severe is it? Will it have a short or long course?
- What do you fear most about your disorder?
- What are the chief problems that your sickness has caused for you?
- What kind of treatment do you think you should receive? What are the most important results you hope to receive from treatment?

Further Questions to Consider

- Do individuals in this culture feel comfortable answering questions?
- When the provider asks questions, does the patient, or family, perceive this as a lack of knowledge?
- Who should be told about the illness?
- Does the family need a consensus or can one person make decisions.
- Does the patient feel uncomfortable due to the gender of the provider?
- Does more medicine mean more illness to the patient?
- Does no medication mean healthy?
- Does the patient prefer to feel the symptoms, or mask them?
- Does the patient prefer ONE solution or choices of treatment?

- Does the patient want to hear about risks?

Source:

Kleinman, Arthur A. Patients and Healers in the Context of Culture. The Regents of the University of California. 1981.

SECTION FOUR

COMMUNICATION

Intercultural communication is a key clinical issue in medicine and can determine quality of care. The language barrier is a particularly serious problem for providers and patients alike. Since effective communication between patients and providers is necessary for positive outcomes, the use of translators is essential.

Even with English speaking populations, it can be a challenge for the patient to try to understand the medical jargon that is commonplace among professionals in the healthcare setting. For example, words like “diet” have different meanings to professionals than they have in the general public.

OTHER FACTORS INFLUENCING COMMUNICATION

Conversational style: It may be blunt, loud and to the point – or quiet and indirect. *Personal space:* People react to others based on their cultural conceptions of personal space. For example, standing “too close” may be seen as rude in one culture and appropriate in another.

Eye contact: In some cultures, such as Native American and Asian, avoiding direct eye contact may be a sign of respect and represents a way of honoring a person’s privacy.

Touch: A warm handshake may be regarded positively in some cultures, and in others, such as some Native American groups, it is viewed as disrespectful. In some cultures (i.e., Muslim) touch between members of the opposite sex who are not married/close family is taboo. Greeting with an embrace or a kiss on the cheek is common among some cultures.

Response to pain: People in pain do not always express the degree of their suffering. Cultural differences exist in patient’s response to pain. In an effort to “be a good patient” some individuals may suffer unnecessarily.

Time orientation: Time is of the essence in today’s medical practice. Some cultural groups are less oriented to “being on time” than others.

What’s in a name: Some patients do not mind being called by their first name; others resent it. Clarify the patient’s preference early on in the patient-provider relationship.

Nonverbal communication: Messages are communicated by facial expressions and body movements that are specific to each culture. Be aware of variations in nonverbal communication to avoid misunderstandings.

When English is a second language: According to the US Census Bureau, 14% of Americans speak a language other than English in their home and 6.7 million people have limited or no English skills. As these numbers continue to grow, the need for multilingual care becomes more significant. Patients with limited English proficiency may have more difficulty expressing thoughts and concerns in English and may require more time and patience. It is best to use simple vocabulary and speak slowly and clearly. Do not assume that because the patient can speak English that he can read and write in English as well. Remember, just because somebody speaks with a “perfect” American accent, doesn’t mean that they will have complete and full mastery of the English language.

Translators: Often volunteers from the community or relatives are brought by the patient to help with translation. This should not be encouraged, as patients may be reluctant to confide personal problems with non-professionals and may leave out important facts. Realize that it may be difficult for patients to discuss personal issues in front of a third non-professional party. The use of employees as translators (secretaries, house keeping etc.) may not be a better solution. Minors should never serve as a translator as they should never be placed in a position to communicate sensitive and potentially emotionally laden information to another person. Translators should understand and speak a language well enough to manage medical terminology. The ideal translator is a professional. If a professional translator is not available, over the phone translation services can be used.

ENHANCING CROSS-CULTURAL COMMUNICATION

Communicate effectively: Allow more time for cross-cultural communication, use translators who are not family Members and ask questions about cultural beliefs.

Understand differences: Realize that family integration is more important than individual rights in many cultures. Involve spiritual or religious advisors when appropriate. Be aware of your own cultural beliefs and biases. Be sensitive to your authority as a medical professional.

Identify areas of potential conflict: Determine who the appropriate person is to make decisions and clarify and discuss important ethical disagreements with them.

Compromise: Show respect for beliefs that are different from your own. Be willing to compromise about treatment goals or modalities whenever possible. Remember that taking care of patients from other cultures can be time-consuming and challenging. In

almost all instances, however, the extra time and effort expended will result in more satisfied patients, families and professionals.

SECTION FIVE

CULTURAL RESOURCES AND INTERPRETATION SERVICES

ALL AHCCCS contracted Health Plans and Program Contractors provide a variety of cultural competency resources, including interpretation/translation services and cultural awareness training. Under the AHCCCS program, these organizations are required to provide these services to providers and Members free of charge.

If you need interpretation/translation services for patient care or wish to receive more information about available cultural competency resources, please contact *ADVANTAGE Care Select* to make the necessary arrangements. AHCCCS and its participating Health Plans and Program Contractors encourage you to use professional interpretation/translation services. Use of nonprofessional interpretation/translation services such as by bilingual staff and/or a patient's family Member may jeopardize patient outcomes.

INTERNET RESOURCES There are many cultural competency resources available on the Internet. The following listing is intended for informational purposes only.

General Reference sites:

AMA Cultural Competence Initiative - <http://www.ama-assn.org/ethic/diversity/>
National Center for Cultural Competence: Bureau of Primary Health Care Component
<http://www.dml.georgetown.edu/depts/pediatrics/gucdc/nccc.html>
Homepage <http://www.dml.georgetown.edu/depts/pediatrics/gucdc/cultural.html>

Ethnomed: University of Washington: cultural profiles cross cultural topics, patient education <http://healthlinks.washington.edu/clinical/ethnomed/>
[http://www.baylor.edu/~Charles_Kemp//hispanic health.htm](http://www.baylor.edu/~Charles_Kemp//hispanic%20health.htm) Great site for information on Hispanic and other cultures (i.e. Bosnian refugees).

Society of Teachers of Family Medicine: Multicultural Health Care and Education <http://stfm.org/corep.html>. General curriculum information and listings of print, experiential exercises, games, simulations and video resources (not online). STFM homepage <http://stfm.org/index.html>

AMSA (American Medical Student Association):

<http://www.amsa.org/programs/gpit/cultural.htm>

Cross Cultural Health Care Program (CCHCP) Site offers schedules/location/fees for cultural competency training, interpreter training, research projects, community collaboration, and other services. Online registration for training sessions, interpreter and translation services. <http://www.xculture.org/>

Opening Doors: in progress -cultural issues of health care -contains discussion forum on cultural issues in healthcare, articles, etc. <http://www.opening-doors.org/>

Bridge to Wellness: Cultural Competency <http://www.serve.com/Wellness/culture.html>.
Homepage: www.serve.com/ Wellness-Developed for Adult Psychiatry-list of cultural competency principles for health care clinicians.

U.S. Department of Health and Human Services: The Initiative to Eliminate Racial and Ethnic Disparities in Health [http://raceandhealth.hhs.gov/National Institute of Health Office of Research on Minority Health](http://raceandhealth.hhs.gov/National%20Institute%20of%20Health%20Office%20of%20Research%20on%20Minority%20Health) <http://www1.od.nih.gov/ormh/main.html>

Health and Human Services: Health Resources and Services Admin.: news articles <http://www.hrsa.dhhs.gov/>

US Department of Health and Human Services: Office of Public Health and Sciences: Office of Minority Health Resource Center <http://www.omhrc.gov/>

Bureau of Primary Health Care Supported Community Health Programs <http://www.bphc.hrsa.dhhs.gov/databases/fqhc/fqhcquery.cfm>

The Center for Cross Cultural Health: (410 Church Street, Suite W227, Minneapolis, MN 55455) <http://www.umn.edu/ccch/>

Cross Cultural Health Care Program (Pacific Medical Clinics / 1200 12th Avenue South, Seattle, WA 98144-2790 / Phone: (206) 326-4161) <http://www.xculture.org/>

Department of Health and Human Services / Health Resources and Services Administration / Bureau of Primary Health Care (4350 East West Highway, Bethesda, MD 20814) Simulation Training System (218 Twelfth Street, Del Mar, CA 92014 -0901) / Resources for Cross-cultural Health Care: <http://www.diversityrx.org/>

National Urban League (Phone: 212-310-9000) or <http://www.nul.org/>

African Community Health and Social League (Phone: (764)(510) 839) <http://www.progway.org/ACHSS.html>

Association of Asian Pacific Community Health Organizations (Phone: (510) 275-336) <http://www.aapcho.org>

National Coalition of Hispanic Health and Human Services Organizations / Phone: (202) 387-5000 <http://www.cossmho.org>

Center for American Indian and Alaskan Native Health Phone: (410) 955 931 /
http://ih1.sph.jhu.edu/cnah/ www.culturalorientation.net or www.erc.msh.org
“Providers Guide to Quality and Culture)

11.0 Quality Improvement Overview

11.1 Introduction

ADVANTAGE Health Solutions, Inc.sm (ADVANTAGE) has implemented a customer focused proactive Quality Improvement Program (QIP). The QIP measures the quality of care provided to all members enrolled in The ADVANTAGE *Care Select* Program, commercial and Medicare Advantage products. Using standard continuous quality improvement techniques, the QIP monitors all aspects of the health care delivery system, including access and availability to care, member, employer, and provider satisfaction, and administrative services provided. Applying established quality standards as benchmarks and determining the degree to which these standards are met, measure quality.

The QIP is designed to provide a formal process for continuously and systematically monitoring, evaluating and improving the adequacy and appropriateness of health and administrative services provided within ADVANTAGE. This proactive process provides the mechanism to examine the multifaceted components of managed health care, recommend changes when opportunities for improvement are identified, incorporate enhancements, and re-examine the components to assure improvements.

11.2 Scope

The scope of the ADVANTAGE QIP is broad, encompassing a wide range of clinical care and administrative service issues relevant to enrolled members. The program focuses on activities influencing the entire range of services, quality and outcome of clinical care delivered to members in the treatment of acute and chronic illnesses or for health promotion. The scope of the QIP includes members in all age groups, locations, and care settings (inpatient and outpatient), and all types of medical services provided (primary and specialty) within the delivery system network. The QIP also monitors a variety of administrative services provided to members, employers and network providers¹ by the ADVANTAGE staff or contracted provider organizations, including customer service, claims processing and marketing of products.

The following table defines ADVANTAGE’s quality improvement functions:

ADVANTAGE Health Solutions, Inc.sm Quality Improvement Functions
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<p>Clinical Care</p> <ul style="list-style-type: none"> <input type="checkbox"/> Quality of care for: <ul style="list-style-type: none"> • Inpatient • Ambulatory • Acute and chronic disease • Behavioral health • Substance abuse • Maternal and child health • Prescription drugs <input type="checkbox"/> Utilization of services (HEDIS measures) <input type="checkbox"/> UM Committee monitoring <input type="checkbox"/> Medical record review <input type="checkbox"/> Preventive health care <input type="checkbox"/> Wellness & Lifestyle Management <input type="checkbox"/> Outcomes management 	<p>Access & Availability</p> <ul style="list-style-type: none"> <input type="checkbox"/> Appointment waiting time <input type="checkbox"/> Travel distance to provider <input type="checkbox"/> Types of providers needed <input type="checkbox"/> Member complaints regarding access <input type="checkbox"/> Open practices <input type="checkbox"/> After hours access to providers <input type="checkbox"/> Cultural diversity <input type="checkbox"/> Complaints and Appeals <input type="checkbox"/> Identification of providers that speak various languages. <input type="checkbox"/> Monitor member access and availability to their personal medical records at provider Offices.
<p>Compliance & External Reporting</p> <ul style="list-style-type: none"> <input type="checkbox"/> Closed claims and litigation review <input type="checkbox"/> Occurrence reporting review <input type="checkbox"/> Statutory and regulatory compliance review 	<p>Other Administrative Services</p> <ul style="list-style-type: none"> <input type="checkbox"/> I.D. card service <input type="checkbox"/> Enrollment process review
<p>Network Management</p> <ul style="list-style-type: none"> <input type="checkbox"/> Provider credentialing and recredentialing <ul style="list-style-type: none"> • Provider termination and appeals process • Impaired provider management <input type="checkbox"/> Hospital/organizational providers credentialing <input type="checkbox"/> Provider recruitment to assure access & availability standards are met <input type="checkbox"/> Monitoring of PMP/SCP turnover <input type="checkbox"/> Provider network satisfaction monitoring <input type="checkbox"/> Improving patient safety and reducing medical errors <input type="checkbox"/> Cultural Competency Training <input type="checkbox"/> Sponsor annual Provider Educational Conference (CME accredited) and other educational seminars during the year <input type="checkbox"/> Quarterly Provider Newsletter <input type="checkbox"/> Impaired Provider Management 	<p>Member Satisfaction and Quality of Service</p> <ul style="list-style-type: none"> <input type="checkbox"/> Member services monitoring <ul style="list-style-type: none"> • Member services telephone access (performance against standards) • Call analysis • Ongoing audits of call tracking issues <input type="checkbox"/> Satisfaction with physicians, other providers and services of the Plan <ul style="list-style-type: none"> • Member satisfaction assessment • Complaints received in conjunction with requests to change primary medical provider • Voluntary disenrollment feedback • Satisfaction with pharmacy benefits • Satisfaction with Behavioral Health Services <input type="checkbox"/> Complaint and appeal management <ul style="list-style-type: none"> • Distribution of Member Rights document <input type="checkbox"/> Quarterly Member Newsletters <input type="checkbox"/> CAHPS – Consumer Assessment of Health Plans.
<p>Patient Safety</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pharmacy Management <input type="checkbox"/> Coordination of care <input type="checkbox"/> Appropriate antibiotic usage <input type="checkbox"/> Assessing hospital initiatives <input type="checkbox"/> Member and provider education 	

"Providers" refers to individuals and organizations that provide care to members of ADVANTAGE Health Solutions, Incsm

11.3 Objectives

The objectives of the QIP are designed to capitalize on opportunities to improve services and patient care by:

- Promoting customer satisfaction;
- Overseeing, monitoring and reviewing the adequacy and continuity of health care services, including monitoring/management of adverse clinical outcomes, readmissions, HEDIS effectiveness of care measures and delegated functions;
- Making recommendations related to the provision of health and administrative services utilizing problem identification, analysis and resolution processes and risk identification techniques;
- Promoting professional peer review of participating providers to identify and analyze factors that may contribute to decreased quality of care, increased cost, or inefficient use of medical resources;
- Conducting credentialing and re-credentialing to develop and maintain quality provider networks;
- Improving clinical outcomes through disease state management, prenatal education programs, and clinical practice and preventive health guidelines;
- Ensuring the communication to and from customers is handled appropriately in a clear, confidential and timely manner;
- Integrating quality improvement into all organizational functions. Identifying opportunities for process/system improvements and intervening to correct identified problems and prevent reoccurrence;
- Providing feedback on implemented QI initiatives to ADVANTAGE providers and members.
- Continuously reassessing and improving the quality of care and administrative services provided to ADVANTAGE members;
- Reducing the risk of liability and the incidence of litigation through the establishment of loss control and prevention programs;
- Sharing meaningful aggregate data and providing input to the ADVANTAGE Utilization Management (UM) Program;
- Preparing organizational processes for external quality accreditation.

11.4 Quality Improvement Process

Program performance is measured through identifying priority areas in which to improve processes or outcomes of health care delivery. Affected populations within the enrolled membership are identified for each initiative. Measurable objectives and action steps are established. Outcomes are measured against regional and national benchmarks to determine the desired level of improvement. Meaningful data are collected and analyzed throughout the process for each measure. This analysis determines whether performance is appropriate (within thresholds and benchmarks) and, if not, identifies the barriers to improving performance.

Quality indicators and UM techniques are combined to provide a tool for identifying potential areas for quality improvement. UM and QI Departments at ADVANTAGE use the same criteria and standards for monitoring the care provided. UM staff identifies opportunities for QI during their pre-service, concurrent, or post-service reviews. Information reflecting trends and provider practice patterns, potential issues, or opportunities to improve care is reported to the ADVANTAGE QI staff for investigation. Interventions are implemented to address identified opportunities for improvement.

11.5 Participants in the Quality Improvement Program

Some of our Quality Improvement subcommittees were formed to ensure adequate peer review discussion and input into the quality improvement and utilization review processes. The committees include:

- **Quality Improvement Committee (QIC)** in conjunction with a network of subcommittees that supports the Quality Improvement Program (QIP). The QIC is a crossfunctional management team that oversees, directs and prioritizes quality improvement activities related to quality of service and care. The QIC along with the CEO/President provides oversight and guidance to the Quality Improvement Subcommittees is supported and directed by the Participants on the QIC and all QI subcommittees are responsible for informing their staff members of QI initiatives, coordinating QI activities within their areas of responsibility, and coordinating QI activities with other departments. This coordination includes the identification of continuous quality monitors and focused review activities, identification of opportunities for improvement within each department and assistance to other departments with quality improvement activities that impact more than one department.
- **Physician Advisory Committee (PAC)**, a subcommittee of the QIC, was established in accordance with Peer Review Statute IC Section 3430-15 et seq., its purpose is to provide guidance on clinical quality and utilization, and service initiatives to improve processes and/or health outcomes and administrative services. Additionally, this group functions as peer review for Plan health care issues. PHO Medical Directors participate in the PAC, bringing depth peer review knowledge from the networks to discussions. All documents reviewed and all documentation developed and maintained in the peer review process is

protected by peer review immunity and are not discoverable in court. All clinical decisions are made under the direction of the Vice President, Medical Affairs.

- **Credentialing Committee** – a subcommittee of the QIC was established in accordance with Peer Review Statute IC Section 12-34 et seq. The Credentialing Committee purpose is to make recommendations on credentialing and re-credentialing decisions for the practitioners and providers in the ADVANTAGE network.
- **Delegation Oversight Committee** – a subcommittee of the QIC was established to coordinate and review issues related to the Plan’s delegated functions. It is responsible for oversight of delegated credentialing and UM activities for all delegates. The committee is responsible for communicating its findings and making recommendations to the QIC.

Utilization Management Committee is a subcommittee of the QIC and is a subset of the PAC. The committee reviews plan wide utilization and pharmacy data for in and out patient care and sets and compares benchmarks based on industry standards.

11.6 Monitoring

Continuous monitoring and evaluation is designed to assess all aspects of clinical and administrative services. Monitoring activities are documented and communicated through regular reports and reviewed by committees, each with the function of identifying improvement opportunities and developing initiatives and corrective actions. QI initiatives resulting from the monitoring process use the following format:

1. Assign responsibility	6. Collect data
2. Delineate scope	7. Evaluate data
3. Indentify important aspects	8. Implement improvement initiatives
4. Identify indicators	9. Assess for improvement
5. Establish thresholds for evaluation	10. Communicate information

11.7 Confidentiality

All information, records, reports, committee minutes, conclusions, and data collected for quality improvement activities will be considered privileged and strictly confidential. Access to quality documentation is restricted to those who have a functional role in the process. All staff or delegated staff involved in the creation and maintenance of the data will recognize their responsibility to preserve the confidentiality of the information. Information and documentation prepared for or generated by the risk bearing partnerships in the course of investigating potential quality issues should be treated as confidential and privileged as well.

Information containing individual patient or provider identifiers will not be released without the consent of the patient or provider. Disclosure of information is limited to that required by contract and/or allowed by law. Reports of the outcome of clinical studies may be released in aggregate form.

All employees and committee members are trained on the importance of maintaining the confidentiality of all medical information. All employees and committee members sign a confidentiality form annually. The forms shall remain in each employee's personnel file. All contracted committee members will sign a committee charter agreement annually. The agreement shall address confidentiality requirements for peer review committee proceedings.

11.8 Conflict of Interest

Committee Members will not participate in any action in which their professional judgment may be compromised. No member will participate in the proceedings when the member is aware that he/she is in direct economic competition with the professional health care provider under review or when the member has been involved in the issue under review.

11.9 Annual Evaluation

The QIP will be reviewed and approved annually by the Board of Directors to ensure the scope, goals, and quality improvement activities remain consistent with the strategic plan. This evaluation will be a written description of the ability of ADVANTAGE to implement the QIP, meet local QI objectives, improve the quality of care in the community, and improve the care and services offered. The evaluation will assess the impact on clinical care and services delivered and achievements of goals and objectives. It will address barriers and recommend revisions to the next year's QI Program and/or work plan as deemed necessary.

Revisions to the QIP are submitted annually to the Board of Directors or the Executive Committee no later than the initial Board of Directors meeting following January 1st of the calendar year.

11.10 Components

The QI Work Plan further defines the scope of work to be performed throughout the year and includes a section for each component of the QIP. For each topic, the work plan identifies objective measures for assessing progress toward achieving the stated goals, and establishes a timeframe for meeting these goals.

Components of the Work Plan are:

- Clinical/Preventive Health Activities
- Provider Network/Access/Satisfaction

- Member Satisfaction/Services/Access
- Cultural Competency Components
- Corporate QI Initiatives

12.0 Reimbursement Overview and Billing Issues

12.1 Reimbursement Overview

The reimbursement methodology and process for the ADVANTAGE *Care Select* Program includes the following:

- The State's Fiscal Agent, HP, continues to reimburse providers directly based on the standard IHCP fee-for-service schedule.
- PMP's receive a monthly \$6 administrative fee for each ADVANTAGE *Care Select* Program member enrolled with the PMP, in addition to the fee-for-service reimbursement.

12.2 Reimbursement for PMP's

Indiana Health Coverage Providers and PMP's providing services to ADVANTAGE *Care Select* Program members should continue to bill the State's fiscal agent via HP. Reimbursement for these services is based on the standard IHCP fee-for-service schedule.

12.3 ADVANTAGE *Care Select* Program Administrative Fee

- PMP's enrolled in the ADVANTAGE *Care Select* Program network, not receiving cost-based reimbursement (i.e., not in a Federally Qualified Health Center or Rural Health Center), will receive a \$6 per member monthly administrative management fee.
- Reimbursement is sent automatically, by the State's fiscal agent, HP, on or about the fifteenth of each month. The administrative management fee is not a separate payment.
- The administrative management fee will be included on the physician's Remittance Advice for all members assigned to the PMP's member panel as of the first of that month.
- Administrative management fees are not pro-rated for members who are effective with the PMP for only half of the month.

12.4 Care Coordination Conference Billing

One of the covered benefits for the *Care Select* Program for PMP's is the care coordination conference. Care coordination conferences can occur up to once per member per rolling calendar year (conferences will be scheduled on an annual basis, per PMP request).

These conferences can be held in person at the PMP's office or via phone conference.

The ADVANTAGE *Care Select* Care Management Department will coordinate with its *Care Select* PMP's to perform care coordination conferences to review a member's plan of care and the progress with that plan of care. PMPs, or their designees (i.e. nurse practitioner -NP or physician assistant (PA) who works for the PMP or PMP's employer such as a group or clinic) are eligible to receive reimbursement from Indiana Health Coverage Programs (IHCP) for their participation in the care coordination conferences.

The purpose of this section is to explain the billing guidelines so that PMP's may be reimbursed appropriately. As a reminder, PMP's, NP's, or PA's employed by Federally Qualified Health Centers (FQHC's) or Rural Health Centers (RHC's) are not permitted to bill and receive reimbursement for care coordination conferences due to their enhanced reimbursement from the Indiana Health Coverage Programs (IHCP).

The following are the billing guidelines related to Care Coordination Conferences:

- Both the DMO and the PMP will be responsible for checking eligibility on the date of the care coordination conference.
- Submit claims for members discussed during the care coordination conferences to HP as with all other covered *Care Select* services.
- No prior authorization is required for care coordination conferences.
- Care coordination conferences are carved out of the Third Party Liability requirements for *Care Select* so providers do not need to submit claims for these services to the member's private insurance company prior to submitting them to HP for reimbursement.
- Submit claims on a CMS – 1500 claim form using the CMS – 1500 paper claim format found in Chapter 8, Section 4 of the IHCP Provider Manual. Providers may also submit these claims electronically using their proprietary software or using HP's web interChange.
- The primary diagnosis providers should use when billing for care coordination conferences is either the member's last known diagnosis related to the member's disease state or V70.9.
- All PMP's or NP's must be linked to the billing group.
- The DMO and provider will identify via the DMO's Annual Care Coordination Conference Checklist, potential members to be reviewed and discussed during the conference. If neither the PMP nor the DMO

have issues resulting in a discussion of the member's plan of care, the provider cannot bill for a care coordination conference for that member.

- The Biannual Care Conferences Checklist verifies the PMP's review regarding the plan of care. Providers are required to keep a copy of the Bi-annual Care Conferences Checklist for auditing and documentation purposes.
- PMP's are limited to billing for one care coordination conference annually per member per rolling calendar year.
- The service code to be used to identify billing for care coordination conferences for each Care Select member is 99211 SC – "Office or other outpatient visit for the evaluation and management of an established patient." Note: Please refer to both IHCP Bulletins BT200723 & BT200804 for further details.
- If the PMP's NP is in the same group or clinic as the PMP who performs the care coordination conference with the member's DMO care manager, the NP's IHCP provider number is appended to 99211 SC. If the NP is not enrolled in the IHCP, providers must append modifier SA. PA's cannot enroll in the IHCP, but can participate in the care coordination conference and be reimbursed. The care coordination service code 99211 SC must be billed along modifier HN or HO (use the modifier that corresponds to the PA's education level).
- Services for NP's not linked to the PMP's clinic or group will be denied because that practitioner does not participate in the same group or clinic as the member's PMP and it will be assumed that those practitioners have no practical experience with that member and are not in a position to discuss that member's plan of care.

The PMP or the PMP's NP or PA will be reimbursed by the IHCP at a rate of \$20 per member per conference. PMPs or their NP or PA who refuse to participate or do not attend a scheduled care coordination conference cannot bill the IHCP for that conference.

12.5 Appropriate Claim Filing

Consistent with ADVANTAGE *Care Select* Program policy, all ADVANTAGE *Care Select* Program providers are required to submit claims to The OMPP's fiscal agent (HP) using the appropriate claim filing methodology when requesting reimbursement for medical services rendered to ADVANTAGE *Care Select* Program members.

For specific details, please refer to Chapter 8 of the Indiana Health Coverage Programs Provider manual.

12.6 Non-PMP Billing

All medical providers, other than the member's PMP, who are rendering services to ADVANTAGE *Care Select* Program members, must contact the member's PMP prior to providing any services, unless the member is accessing a self-referral provider. Medical providers other than the PMP must obtain authorization from the member's PMP in order to submit claims to the ADVANTAGE *Care Select* Program. This authorization process is outlined in Section Six of this manual. If the provider rendering care to an ADVANTAGE *Care Select* Program member is not the member's PMP, all submitted claims must indicate the referring PMP's IHCP provider number, and ~~digit~~ certification code. (UB92 claims use the PMP's license number and certification code to indicate PMP authorization.) Without this information, the claim will not be paid. As noted in Section Four, this requirement does not apply to PMP enrolled physicians within a group practice or clinic enrolled under the same billing number. Reimbursement for care provided to an ADVANTAGE *Care Select* Program member follows the same procedures whether the rendering provider is a resident, a mid-level practitioner or another physician who is not the member's PMP. Providers rendering services to ADVANTAGE *Care Select* Program members are reimbursed under the existing IHCP Fee Schedule.

(See the current IHCP Fee Schedule on the web at www.indianamedicaid.com.)

Ancillary Type Services

Providers of ancillary type services should submit claims for reimbursement to IHCP. All providers must verify ADVANTAGE *Care Select* eligibility and managed care enrollment through the various member eligibility verification systems, and submit claims for reimbursement accordingly. For ADVANTAGE *Care Select* Program members, pharmacy, home health and transportation providers should submit claims directly to HP. Providers of these types of service must continue to complete Prior Authorization requests to HCE for members in ADVANTAGE *Care Select* Program as directed in the Indiana Health Coverage Programs Manual.

Family Planning Services

Providers of family planning services rendering care to a ADVANTAGE *Care Select* enrollee should continue to seek reimbursement from HP. Claims submitted for these types of services do not require the PMP's authorization if services are billed using a procedure code from Table B in conjunction with a diagnosis code from Table A located in Appendix I of the IHCP Provider Manual.

13.0 Abuse and Fraud

13.1 General Information

This section outlines utilization review activities and provides the reporting procedures to be followed if Indiana Health Coverage Programs (IHCP) abuse or fraud is suspected or discovered.

13.2 Federal Requirements

Title XIX of the Social Security Act, Sections 1902 and 1903, and regulations found in 42 CFR 456, mandate that utilization review of IHCP services ensures that services rendered are necessary and of optimum quality and quantity.

These federal regulations also require that the IHCP agency be able to identify and, if warranted, refer cases of suspected abuse or fraud to the Indiana Attorney General's Medicaid Fraud Control Unit (MCFU) for investigation and prosecution. Utilization review guards against unnecessary medical care and services, and it ensures that payments are appropriate according to the coverage policies established by the IHCP.

13.3 Utilization Monitoring

Health Care Excel (HCE) performs Surveillance and Utilization Review (SUR) audits that may result based on referrals, random selection, or ranking. HCE uses an application called DSS Profiler to create random samples and profiles of providers to assist them in performing their SUR audits. IndianaAIM creates quarterly computerized reports that profile individual provider practices by flagging areas in which the provider differs from peers. This system also produces rankings that list the providers with the greatest degree of deviation from their peers.

HCE selects those providers with the greatest degree of peer deviation for further review. Reviews are conducted on an ongoing basis. The cases for review are selected from quarterly reports and referrals.

13.4 Provider Utilization Review

IHCP Abuse Defined

The term abuse describes incidents or practices of IHCP providers that, although not usually considered fraudulent, are inconsistent with accepted sound medical, business, or fiscal practices. These practices can result in unnecessary costs to the IHCP, improper payment, or payment for services that fail to meet recognized standards of care or are medically unnecessary. The following are some examples of abuse:

- Billing and receiving payment from an IHCP member for the difference between the provider charge and the IHCP reimbursement for the service.

- Billing the IHCP at a higher fee than for private pay patients
- Submitting claims for services not medically necessary in relation to a member's diagnosis
- Excessive charges for services or supplies
- Violation of any of the provisions of the IHCP provider agreement

IHCP Fraud Defined

The term Fraud describes an intentional deception or misrepresentation made by the provider or member, which would result in an unauthorized benefit, such as an improper payment being made to an IHCP provider. Some examples of fraud are listed below:

- Altering a member's medical records to generate fraudulent payments
- Billing for group visits, such as a provider billing for several members of the same family in one visit; although, only one family member was seen or was provided medically necessary services
- Billing for services or supplies that were not rendered or provided
- Misrepresenting services provided (for example, billing a covered procedure code).

14.0 Clinical Practice Guidelines

14.1 General Information

Clinical Practice Guidelines (CPG's) are systematically developed standards to assist the practitioner and patient in making decisions about appropriate health care for specific conditions. The CPG's are developed by organizations that use rigorous review, analysis of peer reviewed research and the use of expert teams. ADVANTAGE Health Solutions, Inc.'s (Physician Advisory Committee (PAC) is charged with reviewing and adopting the CPG's regarding disease and condition states that affect the ADVANTAGE *Care Select* Program population. The PAC is a peer review committee consisting of multi disciplinary team of practitioners.

To encourage the implementation of CPG's and thereby assisting in meeting the strategic plan of ADVANTAGE, the PAC has reviewed and approved these CPG's specifically for the ADVANTAGE *Care Select* Program:

- Attention-Deficit/Hyperactivity Disorder (ADHD) Guidelines

- Alcohol and Drug Dependency Guidelines
- Asthma Guidelines
- Bipolar Disorder Guidelines
- Coronary Artery Disease (CAD) Guidelines
- Congestive Heart Failure (CHF) Guidelines
- Chronic Obstructive Pulmonary Disease (COPD) Guidelines
- Depression in Adults, Child and Adolescent Guidelines
- High Blood Pressure in Adults, Children and Adolescents Guidelines
- Schizophrenia Guidelines

For access to the ADVANTAGE *Care Select* Clinical Practice Guidelines please visit the ADVANTAGE Web Site at www.advantageplan.com.

15.0 Provider and Member Grievances

15.1 General Information

Providers and member may express verbal or written dissatisfaction with issues related to authorization requests. Grievances are issues not meeting the definition “actions”, which follow the appeals process. The term action, as defined in 42 CFR 438.400(b), includes:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Failure to provide services in a timely manner, as defined by the State; or
- Failure of a Disease Management Organization to act within the required timeframes.

All grievances, pertaining to issues not meeting the above definitions of “actions”, must be filed within 30 days of the decision or event. Grievances may be filed by contacting the ADVANTAGE *Care Select* Grievance department.

Mail: ADVANTAGE *Care Select* Program
 Attn: Medicaid Grievance
 PO Box 40999
 Indianapolis, IN 46240

-OR-

Phone: 866-591-6737 (toll free) Monday through Friday, 8:00 a.m. to 5:00 p.m. (Eastern). Hearing Impaired: 800-743-3333.

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Fax: 317-536-3323

Receipt of all grievances filed with ADVANTAGE *Care Select* will be acknowledged in writing to the person filing the grievance. Grievances will be resolved within 20 business days.

16.0 HIPAA Information

16.1 Introduction

ADVANTAGE Health Solutions, Inc.sm and the ADVANTAGE *Care Select* Program has established Health Information Policies and Procedures to ensure our obligations to protect the privacy of *individually identifiable health information* that we create, receive or maintain as a *health plan*. ADVANTAGE implements Health Information Policies and Procedures as a matter of sound practice to protect the interests of our members, and to fulfill our legal obligations under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and its implementing regulations at 45 CFR Parts 160, 162, and 164.

Each employee of the ADVANTAGE *workforce* and each *business associate* is obligated to follow our organizations Health Information Policies and Procedures faithfully. Failure to do so may result in disciplinary action including termination of employment or affiliation with ADVANTAGE.

16.2 HIPAA General Information

The Health Insurance Portability and Accountability Act (HIPAA) was enacted by the U.S. Congress in 1996 and contains the following three major provisions:

- Portability
- Medicare Integrity Program/Fraud and Abuse
- Administrative Simplification

The portability provisions, implemented in 1997, provide available and renewable health coverage and remove the pre-existing condition clause, under defined guidelines, for individuals changing employers and health plans.

The Medicare Integrity Program (MIP), implemented in 1998, guarantees that the Centers for Medicare & Medicaid Services (CMS) has a funding source for integrity activities and expands its authority to hire antifraud contractors.

The Administrative Simplification provision implements standard transaction and code sets, identifiers, security, and privacy rules across the healthcare industry.

16.3 Administrative Simplification Requirements of HIPAA

Title II of HIPAA, known as the Administrative Simplification (AS) provisions, requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers.

The Administrative Simplification provisions also address the security and privacy of health data. The standards are meant to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in the U.S. health care system.

The four major requirements of Administrative Simplification are the following:

- Transaction and code sets
- Identifiers
- Security
- Privacy

Additional information can be found on the Indiana Health Coverage Programs (IHCP) Web site at <http://provider.indianamedicaid.com> and the Centers for Medicare & Medicaid Services Web site at <http://www.cms.gov/HIPAAInfo/>.

16.4 Entities Affected by the HIPAA (AS) Requirements

The following entities are affected by the HIPAA Administrative Simplification requirements:

- All health plans, including Medicaid, Medicare, and commercial insurance plans
- Providers that transmit health information electronically
- Health clearinghouses

The final rule defines the requirements and standards that must be implemented to comply with HIPAA regulations.

Additional information can be found on the Indiana Health Coverage Programs (IHCP) Web site at <http://provider.indianamedicaid.com> and the Centers for Medicare & Medicaid Services Web site at <http://www.cms.gov/HIPAAGenInfo/>.

16.5 National Provider Identifier

Effective May 23, 2008, the IHCP requires all healthcare providers (atypical providers excluded) rendering healthcare services that transmit health information via a standard format to obtain a National Provider Identifier (NPI). The IHCP requires prospective providers that want to enroll in the IHCP to have obtained their NPI prior to completing the *Provider Enrollment Application*. The prospective provider should report the NPI on the *Provider Enrollment Application*. Existing IHCP providers (those that have a legacy IHCP provider number) must report their NPI using the NPI Reporting Tool on <http://provider.indianamedicaid.com>. Providers must indicate the NPI on the provider application and maintenance form when notifying the IHCP of a change to the PMF information.

The NPI Reporting Tool (a Web-based application) was developed to allow active healthcare providers to report their NPI to the IHCP. Inactive providers may not access the NPI Reporting Tool. Inactive healthcare providers that wish to continue submitting claims to the IHCP after the compliance date, must obtain and NPI from the National Plan and Provider Enumeration System (NPPES) and report it to the IHCP. To report NPI to the IHCP, inactive providers may download a *National Provider Identifier Reporting Form*, available on the IHCP Web site at <http://provider.indianamedicaid.com> or contact the HP Provider Enrollment and Waiver helpline at 1-877-707-5750 to request a copy of the form.

The *National Provider Identifier Reporting Form* must be completed, signed, dated, and mailed to:

**HP Provider Enrollment
P.O. Box 7263
Indianapolis, IN 46207**

ADVANTAGE *Care Select* Program Addendum to the Indiana Health Coverage Programs/Medicaid Provider Agreement

This is an addendum to the Indiana Health Coverage Programs/Medicaid (IHCP/Medicaid) Provider Agreement ("the Agreement"). All other matters previously agreed to and set forth in the Agreement, and not affected by this addendum, shall remain in full force and effect.

By execution of this addendum, to the IHCP/Medicaid Provider Agreement, the undersigned physician requests enrollment as a Primary Medical Provider (PMP) in the above-referenced Care Management Organization's (CMO) provider network for the *Care Select* Program ("*Care Select* Program").

Enrollment Requirements

1. The provider is a physician in the field of General Practice, Family Practice, General Pediatrics, General Internal Medicine or Obstetrics/Gynecology and operates a primary care mode of practice OR a physician in any specialty who agrees to the responsibilities and requirements of a *Care Select* Program *PMP*.
2. For group practices and clinics, the qualified physician agrees to act as the primary care provider for each member assigned to him/her. It is preferred that each physician in a group or clinic enroll as a PMP in the *Care Select* Program. However, not all physicians in the group have to enroll as PMPs for other group members to participate in the program.
3. The PMP agrees to submit, as a prerequisite to the effectiveness of this addendum, the information set out in the PMP Enrollment Form (Schedule A) and the PMP must be approved as a PMP by the *Care Select* Program.
4. The PMP shall update any changes in the information listed in the Enrollment Form of this addendum at least 30 days prior to the effective date of the changes. The most recent copy of the addendum and Enrollment Form submitted by the PMP shall supersede (unless noted to the contrary) the current addendum and Enrollment Form as applicable.
5. The PMP must also notify IHCP Provider Enrollment of all provider file changes, using the appropriate group or provider number.
6. Each PMP must designate a panel size on the Enrollment Form, i.e., the number of *Care Select* Program members he/she is willing to accept

General Responsibilities of the Provider

7. The provider's PMP activities will be governed by the guidelines and policies set forth in the *Care Select* Program *Provider Manual* (*Care Select* Manual), as amended from time to time, as well as all PMP bulletins and notices. This includes, but is not limited to, full participation and cooperation with the *Care Select* Program quality improvement and utilization management requirements as outlined in

the *Care Select* Manual. Adherence to these requirements shall be binding upon receipt of this addendum. Any amendments to the *Care Select* Manual, as well as provider bulletins and notices, communicated to the PMP shall be binding upon receipt. Receipt of amendments, bulletins, and notices by the PMP shall be presumed when mailed to the PMP's current "mail to" address on file with the Office of Medicaid Policy and Planning (OMPP) or its fiscal agent.

8. The provider agrees to be listed as a PMP in the *Care Select* Program provider listing.
9. Hospital Privileges. The PMP shall have admitting privileges at a local accredited hospital. PMPs without such privileges must make arrangements for admissions with a physician of similar specialty who does have admitting privileges. These arrangements must be documented in writing and are subject to approval of the *Care Select* Program. PMPs who provide prenatal services must also have delivery privileges. PMPs who withdraw from or lose their hospital admitting or delivery privileges must notify the *Care Select* Program within seven (7) days.
10. Non-Emergency Admissions. Non-emergency inpatient admissions require approval from the PMP. The PMP shall not refuse to approve any appropriate, medically necessary inpatient admissions.
11. Multiple Office Locations. A physician may select multiple office locations at which he/she will serve as a PMP, i.e., accept assignments to his/her practice panel. Physicians are not restricted as to where they can provide medical care; however, the provider must be enrolled in IHCP at each of the service locations he/she chooses as his/her location.
12. Minimum Office Hours. A PMP in private practice must be available to see patients for a minimum of 20 hours per week, 3 days per week. A PMP with multiple locations may meet this minimum requirement between both locations. In group practice or clinic settings, one or more appropriate on-site physicians of the same scope of practice may meet this minimum requirement.
13. 24-Hour Availability. The PMP must provide reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions. The PMP agrees to be available 24 hours per day, seven days per week, via telephone to a live voice or a paging system. The live voice must be the PMP, an employee or designee of the PMP, or an answering service. The pager system must immediately page an on-call medical professional and the on-call professional shall respond to the page within one hour of being paged.
14. The PMP will, from time to time and with reasonable notice, permit and make arrangements for the OMPP or its contractors and the *Care Select* Program to review medical records of *Care Select* Program members for quality of care studies.
15. The PMP agrees to participate in access to care monitoring audits.
16. The PMP agrees to have specific written policies allowing members to receive information on available treatment options or alternative courses of care, regardless of whether or not the benefits are covered by the *Care Select* Program.
17. The PMP may not discriminate in enrollment, disenrollment, re-enrollment, or the provision of covered services, based on the member's age, sex, race, color, national origin, ancestry, religion, income level, physical or mental disability, health status or need for health services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs, except when continued enrollment with the PMP seriously impairs the PMP's ability to furnish

services to this particular member or other members or when that illness or condition can be better treated by another provider type.

18. The PMP agrees to provide *Care Select* Program covered services to members in the same manner as services are provided to all other patients, that is, according to the severity of medical need and availability of personnel, equipment, and/or necessary facilities. Members shall not be discriminated against on the basis of an adverse change in health status, utilization of medical services, or on being a member of the *Care Select* Program.
19. The PMP agrees to accept members as assigned by the *Care Select* Program, except as modified herein, up to the limit specified by the PMP on the Enrollment Form. A patient/physician relationship for this program is initiated by a member's selection of a PMP or assignment by the program if the member fails to choose. PMPs cannot designate their practice as open to his/her current patients only.
20. Once the PMP's panel size has reached the designated limit, the PMP will not be assigned members by default. The PMP understands that the actual number of members on the panel roster may exceed the designated limit, under the following circumstances:
 - a. if the member had a previous relationship with the PMP;
 - b. if a family member with the same Case ID number is already assigned to the PMP; or
 - c. if the PMP requests, in accordance with the procedure outlined in the *Care Select* Manual, that the member be added to his/her panel, and such request is approved by the program.
21. A physician who has reason to believe that a child under eighteen years of age is a victim of child abuse or neglect shall make a report to the local child protection service or local law enforcement agency as required by Indiana law (I.C. 31-33-5-1). If the reporting physician is part of a public or private facility or agency, then that person must also notify the individual in charge of the public or private facility or agency of the report (I.C. 31-33-5-2). Failure to comply with these provisions is a Class B Misdemeanor (I.C. 31-33-22-1).
22. PMPs will maintain a comprehensive medical record for each patient enrolled in the *Care Select* Program in accordance with 405 IAC 1-5-1. The PMP shall retain all records relating to the provision of services under this addendum for at least 7 years from the date of creation.
23. The PMP will transfer, at no cost to the member, a summary or copy of the member's medical records to another PMP or to the *Care Select* Program if the member is reassigned, or to the OMPP or its designee upon request.
24. The PMP must have specific written policies and procedures to allow members to have access to his or her medical records in accordance with applicable Federal and State laws.

Delivery of Services

25. The provider agrees to function in the role of PMP, as an authorized provider for the *Care Select* Program's provider network. In this role, the PMP will provide, or will arrange for the provision of, routine comprehensive preventive services, medically necessary primary care treatment and urgent care services, in keeping with the universally accepted standards as defined by Paragraph 29 of this addendum.
26. In particular, the PMP will provide, coordinate or seek referrals for the following services:
 - a. physician services;

- b. hospital inpatient and outpatient services; and
 - c. ancillary services including but not limited to: laboratory and radiology; orthotics/prosthetics; HealthWatch/EPSTD; audiology; and durable medical equipment and supplies specified in the *Care Select* Manual and any services added in Provider bulletins amending the *Care Select* Manual.
27. The PMP agrees to provide patient management services in accordance with the *Care Select* Manual and on a timely basis. The PMP agrees to work with the *Care Select Program* nurse care managers and other related health care professionals as needed based on the member's care plan.
 28. HealthWatch/EPSTD Services. The PMP will promote and provide HealthWatch services for members under age 21 or refer members to other appropriate providers, in accordance with the IHCP EPSTD/HealthWatch Provider Manual.
 29. Adherence to Universally Accepted Standards of Care. The PMP agrees to adhere to universally accepted standards or periodicity schedules, of preventive care for pregnant women, infants, children, adolescents and adults. These standards or periodicity schedules are endorsed by the Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetrics and Gynecology, and the American Society of Internal Medicine, as listed in the *Care Select* Manual.
 30. Advance Directives. The PMP must comply with requirements of Federal and State law with respect to advance directives.

Referrals

31. The PMP must make referrals to appropriate physicians and other practitioners who are IHCP providers to ensure that services are furnished to members promptly and without compromise to quality of care.
32. The PMP may refer a member under his/her care to another IHCP participating provider for any medically necessary service. Referrals may be given in writing or by telephone. Referrals must be documented in the medical record by the PMP. The PMP must specify which services are covered by the referral and may cover one or multiple visits to complete a plan of care. An optional sample referral form is included in the *Care Select* Manual.
33. The PMP shall refer a member to his/her selected specialist if the member is already an established patient of that physician, and the physician is an IHCP provider.
34. If, at the time of assignment, a member has an established relationship with another provider from whom the member requires immediate medical attention, the PMP shall make a referral to that provider in order to maintain continuity of care for the member. Examples of this situation include members who enroll in the *Care Select* Program during late stages of pregnancy or have previously scheduled surgery with a physician other than the PMP.
35. The PMP shall make a referral to an IHCP provider for a second opinion if requested by the member. This referral shall apply only to the consultation. Any subsequent treatment by the second opinion provider, if necessary, shall require a separate referral.
36. The following services do not require a PMP referral:
 - a. Emergency services, as defined in the *Care Select* Manual
 - b. Eye Care (except eye surgical services)

- c. Family Planning Services
- d. Dental Care
- e. Chiropractic Care
- f. Pharmacy
- g. HIV/AIDS Targeted Case Management Services
- h. Podiatry Services
- i. Behavioral Health Care, including mental health, substance abuse and chemical dependency services, provided by behavioral health provider specialty
- j. Disease/Case Management Services.

The above list may be amended in the future via provider bulletins.

Responsibilities to *Care Select* CMO

37. Subject to Network Requirements. Provider participation in the CMO provider network is subject to review and approval by the CMO. Acceptance of provider participation by the CMO is dependent upon CMO provider network and member access needs.
38. Provider Credentialing.
- a. Provider will submit to and abide by the CMO's Credentialing programs with respect to Provider's application for and continued participation in the CMO provider network. To the extent Provider operates a facility that provides services subject to review and accreditation by a recognized accrediting body under the CMO's then-current credentialing requirements, Provider shall obtain and maintain such accreditation at all times during the term of this addendum.
 - b. Provider shall notify the CMO within ten (10) business days following Provider's receipt of any notice regarding an adverse action related to any restrictions upon, or any suspension, loss or surrender of, any professional license, certification or registration; privileges; Drug Enforcement Administration provider number; or any other action that impacts Provider's ability to render Covered Services. In the case of a Provider who operates a facility, this requirement shall apply to any adverse action related to any restrictions upon, or any suspension or loss of, the provider's accreditation as required under the CMO's then-current credentialing requirements.
 - c. Subject to applicable law, State Contract, and the *Care Select* Program requirements, this addendum shall immediately terminate upon any such expiration, surrender, revocation, restriction, or suspension as described in this section.
39. Coordinated Care. Provider shall participate in the CMO's programs designed to facilitate the coordination of all medically necessary Covered Services, including both physical and behavioral health healthcare services, as well as other non-medical services that a Member may be receiving or be in need of receiving. Subject to medical judgment, patient care interests, and a patient's express instructions, and recognizing that the level of Covered Services provided by Provider may be affected by the Provider's scope of services, Provider shall abide by all applicable laws and regulations, the State Contract and all *Care Select* Program and CMO requirements governing the referral of Members. For Members requiring hospitalization, Provider shall abide by all applicable CMO policies and procedures and all State Contract, Program and CMO utilization review requirements.
40. Responsibility for Medical Care Decisions. Provider shall be solely responsible for all medical advice and services provided by Provider to Members, and acknowledges and agrees that the CMO will neither be responsible nor liable for the manner or method by which Provider provides services to Members.

Provider acknowledges and agrees that payment may be denied for provider services rendered to a Member that it determines are not Medically Necessary, are not Covered Services pursuant to the State Contract, or are not otherwise provided in accordance with this Agreement, the State Contract and all *Care Select* Program and CMO requirements. Neither such a denial nor any other action taken by the *Care Select* Program pursuant to a utilization review, referral or discharge planning program shall operate to modify Provider's obligation to provide appropriate services to a Member under applicable law and any applicable code of professional responsibility.

41. Noninterference with Medical Care. Provider agrees to provide treatment to Members in a manner consistent with sound medical judgment and practice. Nothing in this Agreement shall be construed to require Provider to take any action inconsistent with Provider's professional judgment concerning the medical treatment to be provided to Members. The CMO shall not prohibit or restrict Provider from advising a Member about his or her health status, medical care or treatment options, regardless of whether benefits for such care are provided under the Program, as long as Provider is acting within his or her scope of practice. However, the CMO reserves the right to make coverage decisions when a dispute exists regarding the Medical Necessity of a Covered Service. Provider will maintain the relationship of physician and patient with Member, without intervention in any manner by the CMO or its agents or employees, and Provider will be solely responsible for all medical advice to and treatment of his or her patients and for the performance of all medical services in accordance with accepted professional standards and practice.
42. Quality and Utilization Management. Provider agrees to participate in quality improvement activities, care coordination activities, grievance procedures, continuing medical education requirements and other policies and programs of the CMO as may be required from time to time. Provider shall cooperate with the CMO in satisfying the accreditation standards of NCQA and OMPP, among others. Provider agrees to participate in and cooperate with the decision, rules and regulations established by the CMO's medical management and disease management programs. Provider also agrees to abide by the terms of the CMO's *Care Select* quality improvement incentive plan, if applicable.
43. Provider agrees to request and encourage members to sign a consent that permits release of substance abuse treatment information to the CMO and to the PMP or behavioral health provider, if appropriate. The disclosure of mental health records by the provider to the CMO and to the PMP is permissible under HIPAA and State law (IC 16-39-2-6(a)) without consent of the patient because it is for treatment.
44. Adherence to Policies and Procedures. Provider shall adhere to such reasonable policies and procedures as may be developed and implemented by the CMO from time to time during the term(s) of this addendum. The CMO will provide Provider with any revised or new policies and procedures with thirty (30) days prior notice unless otherwise required by the *Care Select* Program.
45. Proprietary Information. All information and materials provided, directly or indirectly, by the CMO to Provider (including without limitation, contracts, procedures, manuals, operations manuals and or software) shall remain proprietary to the CMO or OMPP, as the case may be. Provider shall not disclose or permit the disclosure of any such information or materials or use them except as provided in this addendum.
46. Provider Listing. Provider acknowledges and agrees that the CMO shall be entitled to use (i) the name(s), business address(es), and phone number(s) of Provider and (ii) in addition to the foregoing,

information about education, specialty, subspecialty, licensure, certification, hospital affiliation, office hours, languages spoken, and any other demographic information for any individual Participating Provider employed by or under contract with Provider to provide services under this addendum, for the purposes of enrolling and referring Members, marketing, complying with *Care Select* Program and CMO program requirements, reporting, and otherwise carrying out the terms and conditions of this addendum.

Miscellaneous Provisions

47. The provider agrees to provide PMP services for each *Care Select* member listed on the panel roster, unless the PMP can demonstrate just cause for terminating these responsibilities and requests that a member be assigned to another PMP. If a PMP wishes to terminate these responsibilities for a specific member, he/she must continue to perform PMP functions for the assigned member for up to 30 days or until the member has been linked to another PMP, whichever comes first. The PMP must notify the member of his/her intention to request removal of the member from his/her caseload prior to submitting the request to the *Care Select* Program. The PMP shall forward any correspondence requesting the removal of a member from his/her panel to the program, in accordance with the *Care Select* Manual. Requests will be considered for the following reasons only:
- a. Missed appointments
 - b. Member fraud
 - c. Threatening, abusive or hostile behavior
 - d. Medical needs better met by another PMP
 - e. Breakdown of the physician/patient relationship
 - f. Member accessing care from another provider
 - g. Previously approved reassignment
 - h. OB reassignments

For further information, please see the *Care Select* Manual.

48. *Care Select* Program members may request a PMP change at any time. If a change is approved by the program, the current PMP must continue to perform PMP functions for the assigned member for up to 30 days, or until the member has been linked to another PMP, whichever comes first.
49. PMPs enrolled in the *Care Select* Program will receive a six dollar (\$6.00) monthly administration fee for each member on the panel roster. Administration fees will not be paid for any month during which the PMP's license lapsed or was terminated for all or part of that month. Further, failure to comply with all *Care Select* Program guideline-based care may result in forfeiture of this fee, as appropriate and as approved by OMPP.
50. Reimbursement for services provided will follow the IHCP fee schedule. Fees for services provided will not be paid for any month during which the PMP's license lapsed or was terminated for all or part of that month.
51. Reimbursement under this Agreement shall immediately terminate with or without notice upon:
- a. the death or retirement of the PMP,
 - b. the sale of the PMP's practice; or
 - c. the termination of the PMP from participation in the IHCP Program and or the *Care Select* Program.
52. The PMP shall notify the *Care Select* Program if he/she is sued or receives any contact from a

member/patient or his/her attorney or other representative about a possible lawsuit or claim arising from the provision of services under this addendum.

53. The PMP authorizes the OMPP to intervene, at the OMPP's discretion, in any litigation arising from the provision of services under this addendum.
54. This addendum, including the rights, benefits or duties hereunder shall not be assigned in whole or in part either directly or indirectly by either party, unless documented in writing and agreed upon by both parties.
55. This addendum contains all the terms and conditions pertaining to the *Care Select* Program agreed upon by the parties. All other matters previously agreed to and set forth in the Agreement, and not affected by this addendum, shall remain in full force and effect. Where the terms of the addendum and the Agreement conflict, the terms of the addendum shall supersede those of the Agreement.
56. If any provision of this addendum is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; each provision not so affected shall be enforced to the fullest extent permitted by law.
57. Inconsistency or Ambiguity. Any inconsistency or ambiguity in this addendum shall be resolved by giving precedence in the following order:
 - a. the express terms of this addendum;
 - b. the *Care Select* Manual;
 - c. the IHCP/Medicaid Provider Agreement;
 - d. the IHCP/Medicaid Manual;
 - e. Exhibit 1 to this addendum;
 - f. any other document, standards, laws, rules or regulations incorporated by reference in the above materials, all of which are hereby incorporated by reference.

Sanctions

58. At the option of the OMPP and after appropriate review, OMPP may sanction any PMP who:
 - a. Fails substantially to provide medically necessary services that the PMP is required to provide, under law or under its agreement with the OMPP, to a member enrolled on his/her panel.
 - b. Imposes on members any co-pays or charges that are in excess of allowable co-pays or charges permitted under the program.
 - c. Acts to discriminate among members on the basis of their health status or need for health care services.
 - d. Misrepresents or falsifies information submitted to the OMPP or CMS.
 - e. Misrepresents or falsifies information that he/she furnishes to a member, potential member or health care provider.
 - f. Distributes, directly or indirectly, any marketing materials or information that has not been approved by the OMPP or that contains false or misleading information.
 - g. Violates any applicable requirements of federal or state laws, rules or regulations.

Sanctions may include, but are not limited to, panel size limitations, case management fee withdrawal, civil monetary penalties or termination of the addendum, as well as termination of the Medicaid Provider Agreement. Prior to imposing sanctions, the OMPP will provide written notification about the basis and nature of the sanctions as well as any due process protections that the OMPP provides.

Sanctions are further addressed in the *Care Select* Manual.

Term and Termination

59. This addendum shall be effective upon approval by CMS for the *Care Select* Program.
60. This addendum will expire concurrent with any termination or expiration of the Agreement. This addendum may also be terminated as follows:
 - a. By the OMPP for the PMP's breach of any provision of this addendum as determined by OMPP, or
 - b. By the OMPP upon 60 days written notice.
61. In the event the PMP desires to terminate his/her participation in the *Care Select* Program or in the IHCP Program, the PMP shall provide sixty (60) days advanced written notification including his/her reasons for seeking termination of this addendum and/or the Medicaid Provider Agreement to the OMPP, or its agent, and the *Care Select* CMO. Within thirty (30) days of OMPP, or its agent's, receipt of the PMP's written notice, the OMPP, or its agent, shall provide written confirmation of the PMP's request. The termination shall be effective forty-five (45) days from the date of OMPP, or its agent's, written confirmation. Termination effective dates shall not be granted retroactively.
 - a. The PMP shall notify each *Care Select* member under his/her care of the PMP's decision after confirmation from the OMPP and prior to the effective date of said termination. This notification must be made individually and in writing to members prior to the effective date of termination. The PMP must provide a copy of the notification to the OMPP, or its agent, by the effective date of termination.
 - b. In order to ensure continuity of care for members affected by the PMP's termination from the *Care Select* Program, whether that termination is initiated by the PMP, or the OMPP, or its agent, the PMP will continue to comply with all of the terms of this addendum and Agreement until the effective date of termination.
 - c. The *Care Select* CMO shall facilitate the transfer of *Care Select* Program members enrolled with the PMP to new PMPs in an expeditious manner. In no event shall any *Care Select* Program member remain assigned to the PMP after the effective date of the termination.
 - d. The OMPP shall continue payment of monthly case management fees for each *Care Select* Program member who continues to be assigned to the PMP up to the effective date of the termination, or until all *Care Select* Program members are reassigned, whichever comes first.
62. Termination of the *Care Select* Program or the termination of the CMO provider network contract will result in the termination of this addendum. Termination of the *Care Select* Program in the county or counties served by the PMP will also result in the termination of this addendum for the county or counties where the *Care Select* Program is terminated. Termination under this paragraph may be communicated to the PMP through a provider bulletin or notice, and will be effective forty-five (45) days after the date of the bulletin or notice, unless a later effective date is announced in the bulletin or notice.
63. Notwithstanding any other provision herein, this addendum shall become effective only upon the PMP's completion of the IHCP provider enrollment process and a determination by the OMPP or its designee that the PMP meets all of the requirements for participation in the *Care Select* Program. In the event that this condition precedent is not met, this addendum shall be null and void.

The undersigned, being the provider, or having the specific authority to bind the provider to the terms of this

agreement, and having read this agreement and understanding it in its entirety, hereby agrees, both individually and on behalf of the provider as a business entity, to abide by and comply with all the stipulations, conditions, and terms set forth herein

Signature

Date

PMP's Full Name or PMP Group Name (Typed or Printed)

PMP's IHCP Provider ID (if PMP Group, please attach list)

PMP's or PMP Group Practice Name (If Different)

County



INSTRUCTIONS FOR ENROLLMENT AND CREDENTIALING WITH HOOSIER HEALTHWISE (HHW), HEALTHY INDIANA PLAN (HIP) AND CARE SELECT MANAGED CARE ENTITIES

To reduce the need for practitioners to complete multiple enrollment and credentialing forms for participation in multiple IHCP Managed Care MCO/CMOs, the following forms have been developed. **Please complete all applicable forms and return to the MCO/CMO with which you seek participation.**

PRACTITIONERS (HHW, HIP AND CARE SELECT):

All practitioners must complete the **IHCP MCO/CMO Provider Enrollment Form**. If you participate in the Council for Affordable Quality Healthcare (CAQH), the Provider Enrollment Form is the only form you will be required to submit for the enrollment/credentialing process. Please add the appropriate IHCP MCO/CMO as an authorized plan, giving permission to print a provider CAQH application.

CAQH is a credentialing data warehouse that allows you to keep all of your credentialing information in a central location. This information can be accessed by a variety of credentialing entities and can save you time when seeking participation with multiple health plans.

If you do not participate in CAQH, you must also complete and submit a credentialing application. OMPP will require utilization of the CAQH application as the universal credentialing application. You may obtain the application through a link at the OMPP Web site at www.indianamedicaid.com or directly from the CAQH Web site at <https://upd.caqh.org>.

PROVIDERS (HHW, HIP AND CARE SELECT):

Facilities such as hospitals, home health agencies, etc, are not eligible to participate in CAQH. As such, you must fill out the **Hoosier Healthwise Managed Care Organization Hospital/Ancillary Credentialing/Enrollment Form** and return to the appropriate MCO/CMO with the required documentation

If you have any questions about the enrollment or credentialing process, please contact the appropriate MCO/CMO at:

ADVANTAGE Health Solutions

Phone: 1-866-504-6708

Web: www.advantageplan.com

Anthem

Phone: 1-800-455-6805

Web: www.anthem.com

Managed Health Services

Phone: 1-877-647-4848

Web: www.managedhealthservices.com

MDwise

Phone: 1-800-356-1204

Web: www.mdwise.org



HOOSIER HEALTHWISE, HEALTHY INDIANA PLAN AND CARE SELECT PROVIDER ENROLLMENT FORM

This form is for use in enrolling as a participating provider with one of the IHCP MCO/CMOs.

Please select the program(s) for which this form applies:

- Healthy Indiana Plan (HIP)
 Hoosier Healthwise (HHW)
 Care Select

- New Enrollment**
 Update (Fill in only updated info)

PRACTITIONER DATA

CAQH Number			
Provider First Name	MI	Last Name	Suffix
Degree (check one): <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DMD <input type="checkbox"/> DPM <input type="checkbox"/> CRNA <input type="checkbox"/> NP <input type="checkbox"/> CNM <input type="checkbox"/> Other: _____			
SSN	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
NPI	Taxonomies (list all)		
DEA #	CSR #		
License Number & State	UPIN	LPI (Medicaid) Number	
Enrolling as: <input type="checkbox"/> PMP with Panel <input type="checkbox"/> Physician Specialist <input type="checkbox"/> NP-supporting a PMP <input type="checkbox"/> Other _____ <input type="checkbox"/> NP-supporting a Specialty <input type="checkbox"/> Certified Mid-Wife <input type="checkbox"/> Prenatal Care Coordinator			
Primary Specialty	Secondary Specialty	NP - specialty supported	
Are you: <input type="checkbox"/> A Locum Tenem <input type="checkbox"/> Hospital-based Physician <input type="checkbox"/> Hospitalist			
The National Committee for Quality Assurance (NCQA) requires that health plans assess the cultural, ethnic, racial and linguistic needs of members to the practitioners in the network. Please provide the following information:			
Ethnicity: <input type="checkbox"/> Asian <input type="checkbox"/> African-American/Black <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other (please specify) _____			
Practitioner E-mail _____		Fax	Phone
Maximum membership accepted (PMPs only) - panel size			

Scope of Practice (OB/GYN PMPs only)	
All Women (OB/GYN) includes pregnant and non-pregnant members, <i>Family Practitioners cannot render to All Women</i>	
<input type="checkbox"/> YES <input type="checkbox"/> NO	
OB Only <input type="checkbox"/> YES <input type="checkbox"/> NO	

Age Restrictions (PMPs only) check one					
<input type="checkbox"/>	None Internal Med & OB/GYN Practitioners <u>cannot</u> select this category (Only Family Practitioners and General Practitioners can select this category)				
<input type="checkbox"/>	0 – 2 years Internal Med & OB/GYN Practitioners <u>cannot</u> select this category				
<input type="checkbox"/>	0 – 12 years Internal Med & OB/GYN Practitioners <u>cannot</u> select this category				
<input type="checkbox"/>	0 – 17 years Internal Med & OB/GYN Practitioners <u>cannot</u> select this category				
<input type="checkbox"/>	0 – 20 years Internal Med & OB/GYN Practitioners <u>cannot</u> select this category				
<input type="checkbox"/>	3+ years Internal Med & OB/GYN Practitioners <u>cannot</u> select this category				
<input type="checkbox"/>	<input type="checkbox"/> 13+ years	<input type="checkbox"/> 13 – 17 years	<input type="checkbox"/> 13 – 20 years	<input type="checkbox"/> 17+ years	<input type="checkbox"/> 21+ years <input type="checkbox"/> 65+ years

PRACTITIONER DATA – cont'd

Hospital Privileges YES NO

Name	Address
Name	Address
Name	Address

If you do not have Hospital Privileges, state relationship privileges below:

Relationship Privileges YES NO

Physician	Hospital	Address
-----------	----------	---------

Any Primary Medical Provider (PMP) who renders OB services must have delivery privileges and/or relationship privileges to deliver

Delivery Privileges YES NO

Name	Address
------	---------

If you do not have Delivery Privileges, state relationship privileges below

Delivery Privileges YES NO

Physician	Name	Address
-----------	------	---------

ARE YOU ENROLLING AS:

- Individual
 Group
 FQHC
 RHC
 Clinic (Type: _____)
 Urgent Care
 Health Department

PRIMARY PRACTICE INFORMATION

Practice Group Name							
Does this location utilize Nurse Practitioner or Physician Assistant? <input type="checkbox"/> NP <input type="checkbox"/> PA							
Service Location Address (include ZIP + 4)							
Primary Phone			Primary Fax		If PMP, assign membership to this location <input type="checkbox"/> YES <input type="checkbox"/> NO		
Office Contact Name				Office Contact E-mail			
County			Group IHCP Number (including Alpha suffix)				
Group NPI			Taxonomies				
Medicare Group Number							
Office Hours:	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Is this office: Handicap accessible <input type="checkbox"/> YES <input type="checkbox"/> NO On a bus route <input type="checkbox"/> YES <input type="checkbox"/> NO							
Does the site offer: Weekend hours <input type="checkbox"/> YES <input type="checkbox"/> NO Evening hours <input type="checkbox"/> YES <input type="checkbox"/> NO CSHCN (Children w/Special Needs) <input type="checkbox"/> YES <input type="checkbox"/> NO							
Our office is fluent in the following languages other than English:							
<input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> French <input type="checkbox"/> Burmese, dialect _____ <input type="checkbox"/> Russian <input type="checkbox"/> Other (please specify) _____							

PAY TO INFORMATION

Billing Name		TIN
Billing (Pay To) Address		
Billing Phone	Billing Contact Name	Billing Contact E-mail

MAILING ADDRESS

<input type="checkbox"/> Mailing Address same as Primary Practice Address
Mailing Address

OTHER PRACTICE LOCATIONS

Please list up to two additional Practice Locations in which you will see IHCP members

Practice Group							
Does this location utilize Nurse Practitioner or Physician Assistant? <input type="checkbox"/> NP <input type="checkbox"/> PA							
Service Location Address (include ZIP + 4)							
Primary Phone		Primary Fax			If PMP, assign membership to this location <input type="checkbox"/> YES <input type="checkbox"/> NO		
Office Contact Name				Office Contact E-mail			
County			Group IHCP Number (including Alpha suffix)				
Group NPI			Taxonomies				
Medicare Group Number							
Office Hours:	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Is this office: Handicap accessible <input type="checkbox"/> YES <input type="checkbox"/> NO On a bus route <input type="checkbox"/> YES <input type="checkbox"/> NO							
Does the site offer: Weekend hours <input type="checkbox"/> YES <input type="checkbox"/> NO Evening hours <input type="checkbox"/> YES <input type="checkbox"/> NO CSHCN (Children w/Special Needs) <input type="checkbox"/> YES <input type="checkbox"/> NO							
Our office is fluent in the following languages other than English: <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> French <input type="checkbox"/> Burmese, dialect _____ <input type="checkbox"/> Russian <input type="checkbox"/> Other (please specify) _____							

Practice Group							
Does this location utilize Nurse Practitioner or Physician Assistant? <input type="checkbox"/> NP <input type="checkbox"/> PA							
Service Location Address (include ZIP + 4)							
Primary Phone		Primary Fax			If PMP, assign membership to this location <input type="checkbox"/> YES <input type="checkbox"/> NO		
Office Contact Name				Office Contact E-mail			
County			Group IHCP Number (including Alpha suffix)				
Group NPI			Taxonomies				
Medicare Group Number							
Office Hours:	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Is this office: Handicap accessible <input type="checkbox"/> YES <input type="checkbox"/> NO On a bus route <input type="checkbox"/> YES <input type="checkbox"/> NO							
Does the site offer: Weekend hours <input type="checkbox"/> YES <input type="checkbox"/> NO Evening hours <input type="checkbox"/> YES <input type="checkbox"/> NO CSHCN (Children w/Special Needs) <input type="checkbox"/> YES <input type="checkbox"/> NO							
Our office is fluent in the following languages other than English: <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> French <input type="checkbox"/> Burmese, dialect _____ <input type="checkbox"/> Russian <input type="checkbox"/> Other (please specify) _____							

For additional addresses, please copy and complete this page and submit with application.

Indiana Health Coverage Program Managed Care Organization and or Care Management Organization (IHCP MCO/CMO)

ATTESTATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the Indiana Health Coverage Program Managed Care Organization and/or Care Management Organization (IHCP MCO/CMO), its representatives, agents or designees, to obtain from any source, information and/or documents regarding my professional credentials and qualification related to this application for new or continued network provider privileges (hereinafter referred to as “Credentialing Information”).

I understand and agree that acceptance of this application does not constitute approval or acceptance of participating provider status for any IHCP MCO/CMO contracted network, and grants me no rights or privileges of participation until such time as I receive actual written notice of acceptance and participating provider status. Termination of my request for application is not an adverse action within the reporting requirements of the National Practitioner Data Bank and does not entitle me to any appeal or hearing.

I understand that the IHCP MCO/CMO will conduct an independent verification of this Credentialing Information and such information will be used to evaluate my credentials according to the IHCP MCO/CMO standards. I hereby consent to the release of Credentialing Information to the IHCP MCO/CMO, its agents, representatives or designees. This authorization to release Credentialing Information shall include, but not be limited to, sources such as the medical staff office and/or Chief(s) of clinical Departments of any hospital or facility with which I have at any time been affiliated, all National Practitioner Data Bank and/or Peer Review Committee information and reports, including utilization review information, and information from professional boards, state regulatory and licensing agencies, professional societies, accrediting agencies, and any companies from which I have obtained professional liability insurance. I hereby release all third party sources of Credentialing Information from any and all liability related to the release of such information that is provided in good faith and without malice.

I hereby release and hold harmless from any and all liability all members of the IHCP MCO/CMO, the Board of Directors, its officers, agents, peer review committee members and employees, for all activities executed in good faith and without malice regarding the evaluation of my credentials and qualifications or the denial or termination of participating provider status in any IHCP MCO/CMO contracted network or the IHCP MCO/CMO.

A photocopy of this authorization will serve as an original. I understand that the IHCP MCO/CMO, the Credentialing Committee and/or their designees will utilize this information only in connection with my application for credentialing or re-credentialing purposes. I understand the IHCP MCO/CMO, its Credentialing Committee and their designees will treat this information as confidential.

The undersigned certifies and attests that the forgoing is truthful, correct and complete in all respects, and the undersigned further understands the intentional submission of false or misleading information or the withholding of relevant information is grounds for denial or immediate termination from the IHCP MCO/CMO provider networks. The undersigned hereby agrees to report to IHCP MCO/CMO any changes in the above information within thirty (30) days of change.

Printed Name _____ Title _____

Signature _____ Date _____

During the credentialing and re-credentialing process, the IHCP MCO/CMO will obtain information from various outside sources (e.g., state licensing agencies, National Practitioner Data Bank) to evaluate your application. You have the right to review any primary source information that the IHCP MCO/CMO collects during this process. These rights do not include information obtained as references, recommendations or other information that is peer review protected.

Should you believe any of the information used in the credentialing and re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by you, as the practitioner, you will have the right to correct any information and submit your comments and explanations for any other factual information.

Please keep a copy for your records.

GLOSSARY OF *INDIANA CARE SELECT PROGRAM* TERMS

ADVANCED PRACTICE NURSE	Is defined in IC 25-23-1-1(b) as a(n): <ul style="list-style-type: none">• Pediatric nurse practitioner• Obstetric nurse practitioner• Family nurse practitioner• CRNA (Certified Registered Nurse Anesthetist)• Certified nurse midwife• Psychiatric clinical nurse specialist
AUTOMATED VOICE RESPONSE (AVR)	System used to verify member eligibility information utilizing a touchtone telephone. Care Management information included in AVR is: <ul style="list-style-type: none">• Name and telephone number of assigned PMP• Name and telephone number of <i>Indiana Care Select Program</i> health plan <p>AVR is explained further in the IHCP Manual, Chapter 3.</p>
BENEFIT ADVOCATE	The <i>Indiana Care Select Program</i> Representative located either at the County Division of Family Resources, commonly referred to as the DFR office, or at the central office of the contracted Enrollment Broker. The Benefit Advocate is responsible for education and enrollment of all <i>Indiana Care Select Program</i> enrollees eligible in his/her county and or area.
CMS (Formerly HCFA)	Centers for Medicare and Medicaid Services (formerly known as HCFA), the federal agency responsible to oversee and provide funds for Medicaid, Hoosier Healthwise and the <i>Indiana Care Select</i> program.
COMMUNITY PARTNER	A local agency or organization contracted with IHCP to provide education and choice counseling.
DIVISION OF FAMILY RESOURCES (commonly known as the DFR office)	The county office where eligibility for <i>Indiana Care Select Program</i> is approved.
EPSDT (or HealthWatch)	Early Periodic Screening, Diagnosis, and Treatment services Required by federal law and defined in 405 IAC (Indiana Administrative Code). It includes a core component of preventive health care services for children. The Indiana EPSDT program is called HealthWatch and is included in the <i>Indiana Care Select Program</i> .
ENROLLMENT BROKER	The organization contracted with the OMPP to enroll and educate potential members in the <i>Indiana Care Select Program</i>

managed care program, maintain the *Indiana Care Select Program* Helpline, and employ the Benefit Advocates.

EXPLANATION OF BENEFITS (EOB)

Claims processing summary statement sent to providers explaining the level of payment for submitted claims.

FSSA

Indiana Family & Social Services Administration. FSSA is the State agency that administers human services programs, in which the Indiana Health Coverage Programs resides.

HOSPICE

A person or healthcare provider who owns or operates a hospice program or facility, or both, that uses an interdisciplinary team directed by a licensed physician to provide a program of planned and continuous care for hospice program patients and their families.

HOSPICE MEMBER

A Medicaid enrollee who has elected the hospice benefit and who meets the criteria of having been diagnosed by his/her physician as having a terminal condition and a prognosis of 6 months or less to live.

HEWLETT-PACKARD (HP)

Fiscal agent (claims payer) for the Indiana Health Coverage Programs, which includes Traditional Fee-for-Service Medicaid, and the *Indiana Care Select Program*.

INDIANA AIM

IndianaAIM (Advanced Information Management System) is the State of Indiana's Medicaid Management Information System (MMIS).

INDIANA CARE SELECT PROGRAM

Originally a Care Management program started in November 2007 for Medicaid enrollees in certain aid categories including the Aged, Blind, Disabled, Home and Community Based Services (Waiver), Wards of the Court, Foster Children, members receiving adoption assistance, and MEDWORKS participants.

In October 2010 the program was restructured as a Disease Management for Medicaid enrollees in limited aid categories including the Aged, Blind, Disabled, Wards of the Court, Foster Children, and children receiving adoption assistance. Also, eligible members, per aid category stated above, must be diagnosed as having one of the following chronic conditions:

- Asthma
- Diabetes
- Congestive Heart Failure (CHF) or Coronary Heart Disease (CHD)
- Hypertension
- Chronic Kidney Disease without dialysis
- Severe Mental Illness (SMI)

- Serious Emotional Disturbance (SED)
- Depression

INDIANA CARE SELECT PROGRAM

ADMINISTRATIVE FEE The case management fee paid to *Indiana Care Select Program* primary medical providers (PMPs) on a monthly basis for all *Indiana Care Select Program* members enrolled in his/her practice.

**INDIANA HEALTH
COVERAGE PROGRAMS
(IHCP)**

The Indiana Family and Social Services Administration (IFSSA) has created the Indiana Health Coverage Programs (IHCP). IHCP includes the 590 program, Traditional Medicaid, Hoosier Healthwise and *Indiana Care Select Program*. IHCP is described in further detail in the IHCP Provider Manual available on the web at www.indianamedicaid.com.

MANAGED CARE

Term used to describe the coordination of financing and provision of health care to produce high-quality health care on a cost-effective basis.

MEDICAID

Medicaid is a state and federally funded medical assistance Program administered by the state to provide reasonable and necessary medical care for persons meeting both medical and financial eligibility requirements pursuant to federal law 42 U.S.C. 1396 and state law IC 12-15. See also the definition of Indiana Health Coverage Programs.

**MEDICAID COVERED
SERVICE**

A service provided or authorized by a Medicaid provider for a Medicaid enrollee for which payment is available under the Indiana Medicaid program as set forth in 405 IAC 5.

MEMBER (OR ENROLLEE) An individual enrolled in *Indiana Care Select Program* who is linked to a *Indiana Care Select Program* PMP.

MEMORANDUM OF COLLABORATION (MOC) A written agreement specific to the *Indiana Care Select Program* which provides a formal description of the terms of collaboration between a PMP and a preventive health care service provider (PHCSP). This agreement specifies the referred services and the responsibilities of each participant and must be signed by both parties, and approved by OMPP.

**MID-LEVEL
PRACTITIONER**

Is defined as:

- Nurse Practitioners (Pediatric, Obstetric, and Family Nurse Practitioners, Certified Nurse Midwives, and Psychiatric Clinical Nurse Specialists) (IC 25-23-1)
- Physician Assistants (IC 25-27.5-2-10)
- Anesthesiology Assistant

OMNI MACHINE	Sometimes referred to as the “swipe” machine, this is the point of service eligibility verification system, used by swiping the enrollee’s plastic Hoosier Health Card through the OMNI 380 terminal device.
OFFICE OF MEDICAID POLICY AND PLANNING (OMPP)	The office within the FSSA that is the designated state agency responsible to administer the Medicaid program. The Complex and Acute Membership Programs Unit of OMPP is responsible for planning, developing, designing and implementing all new and amended policies and initiatives pertaining to care management (Hoosier Healthwise and <i>Indiana Care Select Program</i>). The Complex and Acute Membership Programs Unit administers the <i>Indiana Care Select Program</i> ; oversees all care management contracts and develops appropriate contractual requirements; and monitors managed care reimbursement arrangements and systems implementation.
PANEL SIZE	Maximum number of <i>Indiana Care Select Program</i> member assignments a PMP is willing to accept. The minimum panel size is 1 and the maximum is unlimited. The panel size designation is included in the PMP’s <i>Indiana Care Select Program</i> addendum.
PRIMARY MEDICAL PROVIDER (PMP)	Those physicians who are responsible for the management of <i>Indiana Care Select Program</i> enrollees assigned to their panel. PMPs provide primary and preventive medical care to <i>Indiana Care Select Program</i> enrollees and arrange for medically necessary specialty care.
PMP REFERRAL	The informal process by which a PMP refers a <i>Indiana Care Select Program</i> member to another IHCP-enrolled provider for necessary health care services. The PMP referral/authorization is not to be confused with a Prior Authorization (PA) request/approval.
PRACTICE STANDARDS	Specific, professionally agreed upon guidelines or recommendations for medical practice used within or among health care organizations in an attempt to standardize practice, to achieve consistent quality outcomes. Practice standards may be instituted when triggered by specific clinical indicators.
PRIOR AUTHORIZATION (PA)	The process of obtaining approval in the <i>Indiana Care Select Program</i> for coverage of medical services and supplies that are outside of the PMP’s approval or referral authority. ADVANTAGE Health Solutions processes prior authorization decisions for <i>Indiana Care Select Program</i> . Prior authorization

decisions are based on medical reasonableness and necessity and other criteria described in 405 IAC 5-3. Without this approval, the service is not covered.

QUALITY IMPROVEMENT (QI) QI is a method of measuring and monitoring program performance and the quality of care and services that PMPs arrange for or administer to their patients.

REDETERMINATION A process periodically performed by the Division of Family Resources (DFR) caseworkers, to determine whether a currently eligible member continues to be eligible to receive *Indiana Care Select Program* benefits.

RESOURCE-BASED RELATIVE VALUE SCALE (RBRVS) A classification system used to determine reimbursement to physicians based on training and skill required to perform a given health care service.

REFERRAL A recommendation or approval by a PMP for a patient to receive care from another physician, provider or facility.

REIMBURSEMENT RATES Pre-established rates of payment for services rendered.

REMITTANCE ADVICE (RA) Claims payment summary statement issued to providers.

“SWIPE” MACHINE Please see OMNI Machine.

WEB INTERCHANGE A web-based resource for checking claims status and verifying eligibility for *Indiana Care Select Program* members.

*For a full detailed list of applicable IHCP Terms and definitions please visit the Indiana Health Coverage Program Web site at: <http://provider.indianamedicaid.com/general-provider-services/ihcp-glossary.aspx>.



Full Panel Add Request

All fields must be completed

Today's date: _____ Name of Staff Completing Form: _____

Member's Name: _____

Member's Indiana Care Select RID #: _____

Social Security #: _____

Member's Address: _____

Phone number where member can be reached (write "none" if no phone): _____

Name of Indiana Care Select PMP member is selecting: _____

As PMP, I agree to add the above Indiana Care Select member to my full panel.

PHYSICIAN SIGNATURE

PROVIDER ID NUMBER

MEMBER SIGNATURE

DATE SIGNED

This form must be completed in its entirety, signed by the physician, signed by the member and dated. The form should be submitted to ADVANTAGE Health Solutions for processing. Incomplete forms will be returned to the physician.

PMPs, please fax the form to (317) 587-8411.



Missed Appointment and ER Misuse Education Request

Please fax this form to ADVANTAGE Care Select Provider Relations at (317)587-8411
Please contact the following members for re-education:

MEMBER'S NAME RID # PHONE #

PLEASE CHECK ONE: MISSED APPOINTMENTS ER MISUSE

If missed appointments, please list missed appointment dates

MEMBER'S NAME RID # PHONE #

PLEASE CHECK ONE: MISSED APPOINTMENTS ER MISUSE

If missed appointments, please list missed appointment dates

MEMBER'S NAME RID # PHONE #

PLEASE CHECK ONE: MISSED APPOINTMENTS ER MISUSE

If missed appointments, please list missed appointment dates

MEMBER'S NAME RID # PHONE #

PLEASE CHECK ONE: MISSED APPOINTMENTS ER MISUSE

If missed appointments, please list missed appointment dates

Name of office staff filling out form _____

PRACTICE STANDARDS REFERENCES

PMPs are required to adhere to universally accepted standards of preventive care for pregnant women, infants, children, adolescents and adults. These standards include: Periodicity schedules endorsed by the Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetrics and Gynecology and the American Society of Internal Medicine. These scheduled standards/guidelines are as follows:

1. Early Periodic Screening, Diagnosis and Testing (EPSDT)

*Recommended Childhood Immunization Schedule; United States 2001, Consensus Group – Advisory Committee on Immunization Practices (ACIP), American Academy of Family Physicians (AAFP) and American Academy of Pediatrics (AAP), MMWR, January 2001.

*Must be checked for updates annually.

Recommendations for Preventive Pediatric Health Care; American Academy of Pediatrics (AAP), Committee on Practice and Ambulatory Medicine, March 2000.

Recommendations for Blood Lead Screening of Young Children Enrolled in Medicaid: Targeting a Group at High Risk; Advisory Committee on Childhood Lead Poisoning Prevention (ACCLPP), MMWR, December 2000.

For more information about HealthWatch, the IHCP EPSDT program, refer to the HealthWatch Manual and the IHCP Provider Manual.

2. PERINATAL CARE

"Guidelines for Perinatal Care," 4th edition. American Academy of Pediatricians and American College of Obstetricians and Gynecologists August 1997. (1-800-762-2264.)

Standards for Obstetric-Gynecologic Services, 7th edition. The American College of Obstetricians and Gynecologists, 1997.

For more information about perinatal care, refer to the IHCP Provider Manual.

3. ADULT PREVENTIVE CARE

"Implementing Preventive Care: Family Practice Management," American Academy of Family Physicians (AAFP), (U.S. P.H.S.), PPIP Initiative, February 2001.

"The Fundamentals of Managed Care in a Primary Care Context." Primary Care Syllabus, MKSAP11, American College of Physicians, American Society of Internal Medicine (ACPASIM), September 2000.

The *Indiana Care Select Program* continues to assess and develop performance standards and disease management approaches for various focused clinical areas, which may include the following:

- Adolescent Immunization
- Asthma
- Breast Cancer/Mammography
- Cervical Cancer/Pap Smears
- Cholesterol Screening
- Diabetes

- Domestic Violence Awareness and Prevention
- HIV/AIDS
- Hypertension/Cardiovascular Disease
- Influenza Prevention
- Motor Vehicle Accident Prevention
- Obesity Prevention and Management
- Other Cancer & Adult Preventive Screening
- Smoking Prevention and Cessation

These standards are being developed based on consultation with and recommendations from the *Indiana Care Select Program* Quality Improvement Committee, the *Indiana Care Select Program* Clinical Advisory Committee, *Indiana Care Select Program* providers, and the Indiana medical community at large. Input is also being obtained from the federal Agency for Healthcare Research and Quality (AHRQ), the Center for Disease Control and Prevention (CDC), the National Center on Healthcare Quality (NCQA), and other Department of Health and Human Services (DHHS) programs and collaborative efforts.

The *Indiana Care Select Program* Quality Improvement Committee has established appointment guidelines for *Indiana Care Select Program* PMPs and members. The following table outlines the timeframes that are acceptable for a *Indiana Care Select Program* member attempting to schedule an appointment:

Appointment Type	Appointment Timeframe
Urgent/Emergent Care	24 hours/day
Non-Urgent Symptomatic	3 weeks
Routine Physical Exam	5 weeks
Routine OB/GYN Exam	5 weeks
Initial Appointment (non-pregnant adult)	2 months
New OB Patient	5 days
Initial Appointment Well Child	1 month
Children with Special Health Care Needs	1 month
Average Office Wait Time	Less than or equal to 1 hour
Specialist Referral	
1. Emergency	Within 24 hours
2. Urgent	Within 48 hours

ADVANTAGE Care Select Program Reassignment Request Form
ADVANTAGE Health Solutions, Inc
9045 River Road
Indianapolis, IN 46240
Fax (317) 578-8411

Indiana Care Select Program Provider _____ Provider ID _____

Provider Address _____ City _____ Zip Code _____

We are requesting that the member(s) below be removed from our panel. *(Please list different families on separate request forms.)*

Name _____ ID# _____

Name _____ ID# _____

Name _____ ID# _____

The reason for this request is circled below.

1. **Missed Appointments** - Please provide appointment dates. If less than three appointments have been missed, also include a copy of your office policy regarding missed appointments for all patients.
2. **Member Fraud** - Please state the circumstances leading to this suspicion or conclusion. Drug seeking behavior is considered member fraud.
3. **Threatening, Abusive or Hostile** – The member or a family member has displayed this type of behavior towards the provider or staff members. Please include the date(s) of and brief description of the incident.
4. **Medical Needs Better Met by Another Provider** - Please provide documentation of member’s condition and explanation of the reason for the decision.
5. **Breakdown of the Physician /Patient Relationship** - Please provide explanation and documentation that the breakdown is mutual.
6. **Member Accessing Care from Another Provider** - Please provide documentation to support this conclusion. Note: Abuse of the Emergency Room is *not* a reason for reassignment!
7. **Previously Approved Reassignment** – Appropriate reason when member was previously reassigned but placed back on panel through error or auto-assignment. May also be used when previous request was denied due to ending eligibility or when the member is reassigned to another PMP in the same practice. Please provide a copy of your original reassignment request for the member.
8. **Member Previously Terminated from Practice** – Appropriate reason when member was terminated from practice prior to becoming eligible through *Indiana Care Select Program*. Please provide documentation such as a copy of the previous letter that advised the member of termination.
9. **OB Reassignments** - Physician is contracted to serve pregnant members only and member is no longer pregnant. Please provide delivery date.

Please be sure to send the appropriate documentation with your request. You *must* send a copy of the letter you sent to the member advising them of the reassignment request. This information will assist us in providing member education to minimize future problems. It will also allow us to process your request more quickly.

Person completing this form _____ Phone Number _____

Date _____



INDIANA CARE SELECT PROGRAM Pre Birth Selection Form

All fields must be completed

Today's date: _____ Name of staff completing form: _____

Member's Name: _____

Member's Indiana Care Select Program RID#: _____

Social Security #: _____

Member's Address: _____

Phone number where member can be reached (write none if no phone): _____

Full name of Hoosier Healthwise PMP member is selecting for baby:

PMP ID Number _____

Mother's estimated due date: _____

Mother's signature: _____

If PMP panel is full, PMP must sign below authorizing the addition to his/her panel.

PMP Signature _____ Date _____

PMPs should fax to:
ADVANTAGE Care Select Program
Fax: (317) 587-8411

Indiana Health Coverage Programs Prior Authorization Request Form

Check the box of the plan in which the member is enrolled.

Traditional	<input type="checkbox"/> Advantage Traditional	P: 800-269-5720	F: 800-689-2759
Hoosier Healthwise	<input type="checkbox"/> Anthem Hoosier Healthwise	P: 866-408-7187	F: 866-406-2803
	<input type="checkbox"/> MDwise Hoosier Healthwise	See www.mdwise.org	
	<input type="checkbox"/> MHS Hoosier Healthwise	P: 877-647-4848	F: 866-912-4245
Healthy Indiana Plan	<input type="checkbox"/> Anthem HIP	P: 866-408-7187	F: 866-406-2803
	<input type="checkbox"/> MDwise HIP	See www.mdwise.org	
	<input type="checkbox"/> MHS HIP	P: 877-647-4848	F: 866-912-4245
Care Select	<input type="checkbox"/> Advantage Care Select	P: 800-784-3981	F: 800-689-2759
	<input type="checkbox"/> MDwise Care Select	P: 866-440-2449	F: 877-822-7186

Please complete all appropriate fields.

Patient Information					
Medicaid ID/RID#:					
DOB:					
Patient Name:					
Address:					
City/State/Zip:					
Patient/Guardian Phone:					
PMP Name:					
PMP NPI:					
PMP Phone:					
Medical Diagnosis (Use of ICD-9 Diagnostic Code is Required)					
Dx1		Dx2		Dx3	

Requesting Provider Information:
NPI#:
Tax ID#:
Service Location Code:
Provider Name:
Rendering Provider Information
Ordering Physician NPI#:
Tax ID#:
Name
Address:
City/State/Zip:
Phone:
Fax:
Preparer's Information:
Name:
Phone:
Fax:

Please check the requested assignment category below:

- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> DME | <input type="checkbox"/> Inpatient | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Purchased | <input type="checkbox"/> Observation | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Rented | <input type="checkbox"/> Office Visit | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Other |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Outpatient | |

Dates of Service Start	Stop	Procedure/Service Codes	Modifier(s)	Requested Service	Taxonomy	POS	Units	Dollars

Notes: _____

PLEASE NOTE: Your request **MUST** include medical documentation to be reviewed for medical necessity.

Signature of Qualified Practitioner _____ Date: _____

Field	Description
Medicaid ID/RID# DOB Name/Address/City/State/ZIP/Phone PMP Name/NPI/Phone	Member information. Type the data requested for the member who is to receive the requested service. Type the data requested for the member's PMP.
Requesting Provider NPI # Tax ID# Service Location Code Provider Name	Requesting provider information. Type the data requested. The requesting or rendering provider's National Provider Identifier (NPI) is required if the provider is enrolled in the IHCP. If the requesting provider is not enrolled, type the practitioner's license number in the <i>Requesting Provider #</i> field. The provider's copy of the <i>Indiana Prior Review and Authorization Request Decision</i> form is sent to the address that corresponds to the provider's information entered in this field, if a separate mailing provider ID and service location are not identified on the form. If the requesting provider information does not have a valid service location, a PA decision letter is not generated. Therefore, providers must complete the mailing provider ID and service location fields to ensure that the PA decision letter is mailed to the correct address. If the mailing provider ID and service location fields are completed in conjunction with a requesting provider information that has a valid service location, the mailing provider ID and service location information is selected as the address – not the requesting provider number and service location information for mailing of the PA decision form.
Rendering Provider NPI# Tax ID# Name/Address/City/State/ZIP/Phone/Fax	Rendering provider's NPI number information. Type the data requested for the provider rendering the requested service, if known.
Preparer's Information	Type the name, phone number and fax number of the preparer
Medical Diagnosis Medical Diagnosis.	Type the primary, secondary, and tertiary <i>ICD-9-CM</i> diagnosis code(s).
Assignment Category	Please check which assignment category you are requesting service for.
Dates of Service, Start	Requested start date for the service (For continued services, the start date must be the day after the previous end date.)
Dates of Service, Stop	Requested stop date for the service.
Procedure/Service Code	Type the requested service code, such as Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), revenue, National Drug Code (NDC), and so forth.
Modifier(s)	Type any applicable service code modifiers.
Requested Service	Type a short narrative (or include attachment) of the requested service

	and like services provided by other payers.
Taxonomy	Type any applicable taxonomy codes.
POS	Type the requested place of service (POS).
Units	Type the number of units desired. Units are equal to days, months, or items, whichever is applicable.
Dollars	Type the estimated or known IHCP cost of the service. This is optional, except for home health services, DME equipment, and pharmacy requests.
Notes	Type clinical summary information. Additional pages can be attached, if necessary. A current plan of treatment and progress notes must be attached for the listed services. Requested dates of service should coincide with the plan of treatment dates.
Signature of Qualified Practitioner Date	Authorized provider, as listed in <i>Section 1</i> of this chapter and <i>405IAC 5-3-10</i> , must sign and date the form. Signature stamps can be used.

Prior Authorization

System Update Request Form

Date: _____

Requesting Provider Number: _____

Mail to Provider ID: _____

Service Location: _____

Provider Name: _____

Contact Person: _____

Phone: _____

Member Name: _____

Member ID (RID): _____

Prior Authorization #: _____

Service Code (CPT/Modifier/Taxonomy, HCPCS, ICD-9-CM, and so forth):

Summary of requested action(s):

Change(s) prompting the system update request:

Prior Authorization Department Use Only

Reviewer: _____

Date System: _____

Update: _____

Decision and comments:

Mail to: <http://www.indianamedicaid.com/ihcp/ProviderServices/PAAttachmentAddresses.aspx>

A copy of the decision will be provided to the requesting provider and to the member.

INDIANA PRIOR REVIEW AND AUTHORIZATION DENTAL REQUEST

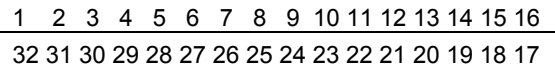
Requesting Provider # _____ Phone: _____ RID NO: _____ DOB: _____
 Mail to Provider ID: _____ Service Location: _____
 Name: _____ Name: _____
 Address: _____ Address: _____
 City/State/ZIP Code: _____ City/State/ZIP Code: _____

DATES OF SERVICE		SERVICE CODE REQUIRED	REQUESTED SERVICE	PLACE OF SERVICE	UNITS	DOLLARS
START MMDDCCYY	STOP MMDDCCYY					

Caseworker: _____ Phone: _____ MCO () 590 () FFS () MS () CS ()
 Is Member Employed? YES NO Circumstances (Place/Type):: _____
 Is Member in Job Training? YES NO Type of Job Training: _____

Dental Treatment Plan

1. Endodontics – Indicate on diagram below the tooth/teeth to be treated by root canal therapy.



2. Periodontics – Evaluate the periodontal condition

3. Partial dentures (use chart to right to indicate teeth involved)

- A. Date or dates of extractions of missing teeth.
- B. Which teeth (use tooth number) are to be extracted?
- C. Which teeth (use tooth number) are to be replaced?
- D. Brief description of materials and design of partial.

E. Is member wearing partials now? YES NO Age of present partials _____

4. Dentures (check one or both): Full upper denture _____ Full lower denture _____

A. How long edentulous _____

B. Is member wearing dentures now? YES NO Age of present dentures _____

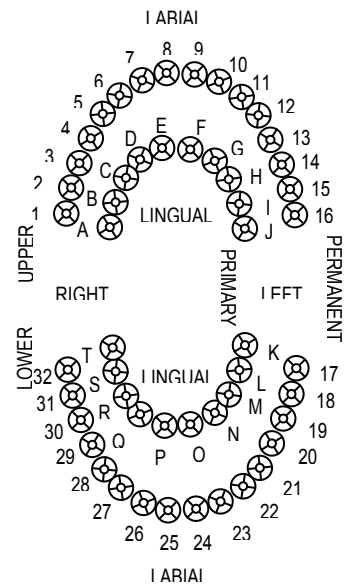
5. Describe treatment if different from above: _____

6. Is the member on parenteral/enteral nutritional supplements? YES NO

If YES, a plan of care to wean the member from the nutritional supplements must be attached. If the plan of care is not provided, dentures, partials, relines, and repairs will be denied.

Brief Dental/Medical History: _____

Does the Member have missing teeth? YES NO
If YES please indicate missing teeth with an X.



Signature of Requesting Dentist _____ Date of Submission: _____

(original signature required) The above sections must be completed or the request will be rejected.

Mail to: <http://www.indianamedicaid.com/ihcp/ProviderServices/PAAttachmentAddresses.aspx>

EDS-10-08-07 / PAU-8002



Medicaid Appeal Request Form

I am appealing a decision of the Office of Medicaid

First Name of Medicaid Applicant/Recipient	Middle Name	Last Name
Street or Post Office Box		
City	State	ZIP Code
Contact Telephone Number (s)		
Medicaid Case Number or RID Number	Social Security Number	
The date on the letter or date I was told about the Medicaid decision		
The person who spoke or wrote to me telling me about the action that I am appealing		
Name		Title
Telephone Number		

The Office of Medicaid (*check the appropriate space*):

- Denied me medical services or prior authorization for medical services
- Delayed my receipt of covered medical services. Name of service: _____
- Changed, denied, or proposed a change to my nursing home level of care
- Took other action which affected my receipt of Medicaid or medical services
- Declared me ineligible or canceled my eligibility for _____

I have a representative *A representative is <u>not</u> required	Name:
	Address:
	Telephone:

Signature Of Appellant	Date

Medicaid Appeal Request Form Instructions

1. Complete this form as fully as possible or write a letter with the same information.
2. Include the names, addresses, and telephone numbers requested. Please print this information.
3. The Medicaid applicant or recipient should sign the form. If the applicant or recipient cannot sign the form, explain why you are the appropriate representative. If you hold Power of Attorney include a copy of the power of attorney agreement.
4. Mail this form or your letter to the address shown below.
 - The Appeal form or letter must be postmarked within thirty days of the date of agency's action. If you were supposed to get a decision, but did not, the appeal form or letter must be postmarked within thirty days of the date you were supposed to get a decision.
 - If neither of the above is appropriate for your situation, mail in the appeal form or letter as soon as possible to protect your appeal rights.

Send the completed form to:

Family and Social Services Administration, Appeals and Hearings Section
402 W Washington Street, Room E034
Indianapolis, IN 46204


If you are not mailing the appeal form or letter within 30 days of the agency's action, please answer the questions below.

1. Did you get a denial or cancellation notice? Yes No
What was the postmark date on the envelope? _____
When did you get the notice? _____
2. If you did not get a notice, how did you learn of the denial or cancellation?

3. Have you had any problems getting mail?
What kind of problems? _____
Were these problems reported to the post office? _____
4. Has your address changed? Yes No When? _____
Did you tell the agency? Yes No When? _____
5. Why didn't you file an appeal within 30 days of the agency action?

ADVANTAGE Health Solutions, Inc. SM

POLICY AND PROCEDURE

Policy Number: CS-MBR-SERV-001		
Policy Name: Member Rights and Responsibilities		
Policy Approved by: Amy Brown, VP of Government Programs		Replaces Policy #:
Signature: 	Date: 02/14/11	Effective Date: 02/14/11
		Revision Date:
		Review Date: 02/14/11
Applies to: <input checked="" type="checkbox"/> ADVANTAGE <i>Care Select</i> (Medicaid)		

OTHER DOCUMENTS/MATERIALS IMPACTED

POLICY:

This policy describes the statutory and contractual rights and responsibilities of ADVANTAGE *Care Select* Program and members and describes how the rights and responsibilities are communicated to members and providers.

The objectives of this policy are to:

- Meet federal and state requirements
- Describe members' rights and responsibilities
- Describe the process to disseminate these rights and responsibilities to members and participating providers

The Plan supports and promotes all member rights and responsibilities and disseminates them to all members and participating providers. All organizational departments and participating providers are responsible for seeing that member/enrollee rights are respected and protected.

The Member and Enrollment Services Department is responsible for publishing member rights and responsibilities in the Member Handbook. Provider Services is responsible for publishing member rights and responsibilities in the Provider Manual.

All members are expected to uphold their responsibilities.

PROCEDURE:

Rights

- Members, their families and/or guardians have the right to information related to the member's treatment in a language they can understand. This includes, but is not limited to:
 - Names of primary healthcare and participating providers and, if appropriate, care managers
 - Copies of medical records as allowed by law
 - A description of ADVANTAGE *Care Select* Program covered benefits
 - A description of their rights and responsibilities as members
 - How ADVANTAGE *Care Select* Program provides for after-hours and emergency health care services
 - Information about how ADVANTAGE *Care Select* Program pays providers, controls costs and the use of services
 - Summary results of member surveys and grievances
 - Information about the cost to a member if the member chooses to pay for a service that is not covered
 - Available treatment options and alternative choices of care
 - Procedures for obtaining services, including authorization requirements
 - A description of how ADVANTAGE *Care Select* Program evaluates new technology for inclusion as a covered benefit
 - What treatment choices or types of care are available to the member, and the benefits or drawbacks of each choice
 - Advance Directives-ADVANTAGE *Care Select* Program encourages involvement by the member or representative in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment
 - Health-care benefit or network changes
- Members have a right to respect, fairness and dignity. This includes, but is not limited to:
 - An ability to receive covered services without concern about payer source, race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, ability to pay or ability to speak English
 - Quality medical services that support personal beliefs, medical condition and background
 - Interpreter services for members who do not speak English or who have impaired hearing or request written information in an alternative format
- Members have a right to participate in decision making about their health care, and/or have a representative facilitate care or treatment decisions when necessary. This includes, but is not limited to:
 - Choosing a participating primary medical provider (PMP) to help with planning and coordinating care

Policy Name: Member Rights and Responsibilities

Policy Number: CS-MBR-SERV-001

Effective/Revision Date: 02/14/11

- The right to see a women's health specialist without a referral
 - Timely access to providers and care from a specialist when it is needed; timely access to prescriptions from a network pharmacy
 - The right to know about all treatment options, no matter what they cost or whether they are covered
 - The right to be told about any risks involved in care
 - The right to be told in advance if a proposed care or treatment is part of a research experiment and the right to refuse experimental treatments
 - Changing primary medical providers, if necessary
 - Requesting specific, condition-related information from a PMP
 - Requesting information about procedures and who will perform them
 - Deciding who should be in attendance at treatments and examinations
 - Choosing to have a female in the room for breast and pelvic exams
 - Refusing a treatment, including leaving the hospital even though a doctor advises against it, and requesting an explanation of consequences. Eligibility or medical care does not depend on a member's/enrollee's agreement to follow a treatment plan
 - The right to stop taking medications
 - Written notification when health care services are reduced, suspended, terminated or denied. Notification is accompanied by appeal instructions
- Members have a right to seek emergency care and specialty services. These rights include:
 - Obtaining emergency services without prior approval from the PMP or *ADVANTAGE Care Select* Program when they have an emergency
 - Obtaining services from a specialist with a referral from the PMP
 - Refusing care from a specialist the member was referred to and requesting another referral
- Members have a right to confidentiality and privacy. This includes, but is not limited to:
 - Privacy and confidentiality of health care information. Information will be distributed only if allowed by law
 - The right to receive a copy of their medical records and to ask that additions or corrections be made to the records
 - The right to ask how their health care information has been given out and used for non-routine procedures
 - The right to talk to health-care professionals and case managers privately
- Members have a right to report concerns to *ADVANTAGE Care Select* Program. This includes, but is not limited to:
 - Grievances about quality of care or services, interpersonal relationships, failure to respect rights, etc
 - Appeals. Members may file an appeal and expect a timely decision
 - Recommendations for changes to policies and services

Policy Name: Member Rights and Responsibilities

Policy Number: CS-MBR-SERV-001

Effective/Revision Date: 02/14/11

- The right to a detailed explanation if a member believes that an ADVANTAGE *Care Select* Program provider has denied care the member believes they are entitled to receive

<i>Responsible Individual(s)</i>	<i>Task(s)</i>
ADVANTAGE <i>Care Select</i> Program Members, their families, and/or guardians	<ul style="list-style-type: none">• Knowing the name of the assigned PMP and/or care manager• Familiarizing themselves about their coverage and the rules they must follow to get care• Respecting the healthcare professionals providing service• Sharing any concerns, questions or problems with ADVANTAGE <i>Care Select</i> Program• Providing all necessary health related information needed by the professional staff providing care and requesting more explanation if a treatment plan or health condition is not understood• Following instructions and guidelines agreed upon with the health professionals giving care• Protecting their member identification card and providing it each time they receive services• Disclosing other insurance they may have and/or applying for other benefits they may be eligible for• Scheduling appointments during office hours, when possible• Arriving for appointments on time• Notifying the healthcare professionals if it is necessary to cancel an appointment• Bringing immunization records to all appointments for children less than eighteen (18) years of age.
Appeals & Compliance	<ul style="list-style-type: none">• Process, research and resolve member grievances & appeals about quality of care or services, interpersonal

Policy Name: Member Rights and Responsibilities

Policy Number: CS-MBR-SERV-001

Effective/Revision Date: 02/14/11

	relationships, failure to respect rights, etc.
ADVANTAGE Care Select Member Services	<ul style="list-style-type: none">• Members rights and responsibilities are published in the Member Handbook and in the Provider manual, which are distributed to all members and participating providers annually• Members are notified in writing when services are reduced, suspended, terminated, or denied. Along with the notification, members are notified of their right to appeal a decision.
ADVANTAGE Care Select Provider Services	<ul style="list-style-type: none">• Provider Services is responsible for publishing member rights and responsibilities in the Provider Manual.