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WELCOME
Welcome to IlliniCare Health. We thank you for being part of IlliniCare Health’s network of participating physicians, hospitals, and other healthcare professionals. Our number one priority is the promotion of healthy lifestyles through preventive healthcare. IlliniCare Health works to accomplish this goal by partnering with the providers who oversee the healthcare of IlliniCare Health members, such as you.

ABOUT US
IlliniCare Health is a Managed Care Organization (MCO) contracted with the Illinois Department of Healthcare and Family Services (HFS) to serve Illinois members through the Integrated Care Program (ICP), the Family Health Plan (FHP) and Managed Long Term Supports and Services (MLTSS). We are also contracted with both HFS and the Centers for Medicare and Medicaid Services (CMS) for the Medicare and Medicaid Alignment Initiative (MMAI), also known as the Duals program or Medicare-Medicaid Plan (MMP). IlliniCare Health has the expertise to work with our members to improve their health status and quality of life. IlliniCare Health’s parent company, Centene Corporation, has been providing comprehensive managed care services to individuals receiving benefits under Medicaid and other government-sponsored healthcare programs for more than 30 years. Centene operates local health plans and offers a wide range of health insurance solutions to individuals and to the rising number of uninsured Americans. Centene also contracts with other healthcare and commercial organizations to provide specialty services. For more information about Centene, visit www.centene.com.

IlliniCare Health is a physician-driven organization that is committed to building collaborative partnerships with providers. IlliniCare Health will serve our members consistent with our core philosophy that quality healthcare is best delivered locally.

MISSION
IlliniCare Health focuses on providing improved health status, successful outcomes, and member and provider satisfaction in a coordinated care environment. Our Plan has been designed to achieve the following goals:
- Ensure access to primary and preventive care services
- Ensure care is delivered in the best setting to achieve an optimal outcome
- Improve access to all necessary healthcare services
- Encourage quality, continuity, and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

All of our programs, policies and procedures are designed with these goals in mind. We hope that you will assist IlliniCare Health in reaching these goals and look forward to your active participation.

HOW TO USE THIS MANUAL
IlliniCare Health is committed to working with our provider community and members to provide a high level of satisfaction in delivering quality healthcare benefits. We are committed to provide comprehensive information through this Provider Manual as it relates to IlliniCare Health operations, benefits, and policies and procedures to providers. Please contact the Provider Services department if you need further explanation on any topics discussed in the manual. You may also access this manual through our web site at www.IlliniCare.com.
Key Contacts

The following chart includes several important telephone and fax numbers available to your office. When calling IlliniCare Health, please have the following information available:
- NPI (National Provider Identifier) number
- Tax ID Number (“TIN”) number
- Member’s ID number or Medicaid ID number

ICP and FHP Key Contacts

<table>
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<tr>
<th>DEPARTMENT</th>
<th>PHONE</th>
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<tbody>
<tr>
<td>Provider Services</td>
<td>866-329-4701</td>
<td>877-666-2074</td>
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<tr>
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MMAI Key Contacts

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MLTSS Key Contacts

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<td>844-316-7562</td>
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CLAIMS KEY CONTACTS

| ADDRESS | IlliniCare Health  
| Attn: Claims  
| PO Box 4020  
| Farmington, MO 63640-4402 |
| IlliniCare Health  
| Attn: Claim Disputes  
| PO Box 3000  
| Farmington, MO 63640-3800 |
| IlliniCare Health  
| Attn: Medical Management  
| 999 Oakmont Plaza Drive  
| Westmont, IL 60559 |
| US Script PBM  
| 2425 W. Shaw Ave  
| Fresno, CA 93711 |
| Cenpatico Behavioral Health  
| 1-866-399-0928  
| 1-866-399-0929 Fax  
<p>| 1-877-861-6124 Help Desk |</p>
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<td>DeKalb</td>
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If you have any questions, please contact: IlliniCare Health c/o Centene EDI Department 800-225-2573, ext. 6075525. Or by email at EDIBA@centene.com

**Tips for 5010 EDI Claims EDI Claims 7**

- Correct Use of the Date of Service/Onset Date Fields
  - If the onset date is the same as the date of service, leave the onset date field blank. Entering the same date on both the onset field and service field will cause an error.
  - If the onset date is prior to the date of service, enter the two dates in their applicable fields.

- National Provider Identifier (NPI) vs Social Security Number (SSN)
  - Be sure to use the NPI and not an employer identification or social security number as the primary identifier on your claim.

Please visit www.ama-assn.org/go/5010 or www.cms.gov Versions5010andDO for more information on data reporting changes in the Version 5010 transactions.
HOME AND COMMUNITY BASED WAIVER SERVICES (HCBS)
IlliniCare Health manages home and community based waiver services for members of the Integrated Care Program, the Family Health Plan and the Medicare-Medicaid Alignment Initiative. These services are provided to members to assist them in remaining out of nursing homes and living independently in the community. IlliniCare Health is responsible for managing the following waivers:

- **Aging Waiver:** For individuals 60 years and older that live in the community.
- **Individuals with Disabilities Waiver:** For individuals that have a physical disability, that are between the ages of 19-59.
- **HIV/AIDS Waiver:** For individuals that have been diagnosed with HIV or AIDS.
- **Individuals with Brain Injury Waiver:** For individuals with an injury to the brain.
- **Supportive Living Facilities:** This is for individuals that need assistance with the activities of daily living, but do not need the care of a nursing facility.

LONG TERM CARE (LTC)
IlliniCare Health also manages room and board for members of the Integrated Care Program, Family Health Plan and Medicare-Medicaid Alignment Initiative that reside in Long Term Care facilities. This also includes managing their medical, behavioral health, dental, vision and pharmacy benefits.

Product Summary

INTEGRATED CARE PROGRAM (ICP)
The Integrated Care Program (ICP) is a Medicaid product available to seniors (age 65 and older) and individuals age 19 and older who receive medical benefits under the Aid to the Aged, Blind, and Disabled (AABD) program.

FAMILY HEALTH PLAN (FHP)
The Family Health Plan (FHP) is a Medicaid product available to pregnant women and families with children under the age of 19. Individuals age 19 to 64 with incomes up to 138% of the Federal Poverty Level (FPL) are also eligible for the FHP.

MEDICARE-MEDICAID ALIGNMENT INITIATIVE (MMAI)
The Medicare-Medicaid Alignment Initiative (MMAI), also known as the Medicare-Medicaid Plan (MMP) and Duals, is available to individuals who qualify for both Medicaid and Medicare.

MANAGED LONG TERM SUPPORTS AND SERVICES (MLTSS)
The Managed Long Term Supports and Services (MLTSS) product is designed for individuals who qualify for Medicaid and Medicare and receive institutional or community-based long-term services and supports (LTSS), but have opted-out of Medicare-Medicaid Alignment Initiative. These members will be required to enroll in MLTSS programs and IlliniCare Health will provide care management for their LTSS services and other care needs.
Verifying Eligibility

MEMBER ELIGIBILITY VERIFICATION AND ID CARDS

All IlliniCare Health members receive an IlliniCare Health member ID card (see samples below). Members should present their ID at the time of service, but an ID card in and of itself is not a guarantee of eligibility; therefore, providers must verify a member’s eligibility on each date of service. Information such as member ID number, effective date, 24-hour phone number for health plan, and PCP information is included on the card. A new card is issued only when the information on the card changes, if a member loses a card, or if a member requests an additional card. If you are not familiar with the person seeking care, please ask to see photo identification. If you suspect fraud, please contact Provider Services immediately.

ID Card:

Integrated Care Program (ICP) ID Card:

Family Health Plan (FHP) ID Card:

Medicare-Medicaid Alignment Initiative (MMAI) ID Card:

Managed Long Term Supports and Services (MLTSS) ID Card:

If you have an emergency, call 911 or go to the nearest emergency room (ER). You do not have to contact IlliniCare Health for an okay before you get emergency services. If you are not sure whether you need to go to the ER, call your PCP or IlliniCare Health nurse line toll-free at 1-866-329-4701 (TTY 1-866-811-2452). The nurse line is open 24 hours a day. www.IlliniCare.com
To verify member eligibility, please use one of the following methods:

1. Log on to the secure provider portal at www.IlliniCare.com. Using our secure provider web portal, you can check member eligibility. You can search by date of service plus any one of the following: member name and date of birth, Medicaid ID number, or IlliniCare Health member ID number. You can submit multiple member ID numbers in a single request.

2. Call our automated member eligibility interactive voice response (IVR) system. Call Provider Services from any touch tone phone and follow the appropriate menu options to reach our automated member eligibility-verification system 24 hours a day. The automated system will prompt you to enter the member ID number, the member date of birth and the month of service to check eligibility.

3. Call IlliniCare Health Provider Services. If you cannot confirm a member’s eligibility using the methods above, call our toll-free number. Follow the menu prompts to speak to a Provider Services representative to verify eligibility before rendering services. Provider Services will need the member name or member ID number and the member date of birth to verify eligibility.

Through IlliniCare Health’s secure provider web portal, primary care providers (PCP) are able to access their panel lists (a list of eligible members who have selected the PCP or have been assigned to the PCP for services). The list is posted as of the first day of the month. The list also provides other important information including date of birth and indicators for patients who are due for an Early Periodic Screening, Diagnosis and Treatment (EPSDT) exam. Since eligibility changes can occur throughout the month and the member list does not prove eligibility for benefits or guarantee coverage, please use one of the methods described above to verify member eligibility on the date of service.
INTERACTIVE VOICE RESPONSE (IVR)

What’s great about the IVR system? It’s free and easy to use! The IVR provides you with greater access to information. Through the IVR you can:

▪ Check member eligibility
▪ Check claims status
▪ Access 24 hours a day, seven days a week, 365 days a year

ILLINICARE HEALTH WEBSITE

Utilizing IlliniCare Health’s website can significantly reduce the number of telephone calls providers need to make to the health plan which enables IlliniCare Health staff to effectively and efficiently perform daily tasks.

IlliniCare Health’s website is located at www.IlliniCare.com. Providers can find the following information on the website.

▪ Member benefits
▪ IlliniCare Health news
▪ Clinical guidelines
▪ Wellness information
▪ Provider Manual and Forms
▪ Billing Manual
▪ Provider newsletters
▪ IlliniCare Health blog

SECURE PORTAL

IlliniCare Health secure provider portal allows providers to check member eligibility and benefits, submit and check status of claims, request authorizations, and send/receive messages to communicate with IlliniCare Health staff. IlliniCare Health’s contracted providers and their office staff have the opportunity to register for our secure provider portal in just four easy steps. Here, we offer tools which make obtaining and sharing information easy! It’s simple and secure! Go to www.IlliniCare.com to register. On the home page, select the Log on link on the top right to start the registration process.

Through the secure provider portal, you can

▪ View the PCP panel (patient list)
▪ View and submit claims and adjustments
▪ View and submit authorizations
▪ View payment history
▪ View member gaps in care
▪ View quality scorecard
▪ Check member eligibility
▪ Contact us securely and confidentially

We are continually updating our website with the latest news and information, so save www.IlliniCare.com to your Internet “Favorites” list and check our site often. Please contact a Provider Relations representative for a tutorial on the secure site.

ELIGIBILITY FOR MLTSS, HCBS WAIVERS, SLFS AND LTC

IlliniCare Health members may qualify for home and community-based services waiver (HCBS), supportive living facility (SLF) or long term care (LTC). Eligibility for these programs is determined by the State of Illinois. This is done through an assessment tool, the Determination of Need (DON). The member will be asked a series of questions, and given an overall score. Based on the member’s DON score, the state will determine if the member is eligible for a waiver service. To confirm if a member is eligible for these services, contact IlliniCare Health’s Provider Services. They will be able to verify if a member is eligible for these types of services.
Provider Responsibilities

PRIMARY CARE PROVIDER (PCP) RESPONSIBILITIES AND MEDICAL HOME
The PCP is the cornerstone of IlliniCare Health’s service delivery model. The PCP serves as the “medical home” for the member. The “medical home” concept assists in establishing a member-provider relationship, supports continuity of care, eliminates redundant services and ultimately improves outcomes in a more cost effective way.

PROVIDER TYPES THAT MAY SERVE AS PCPS
IlliniCare Health offers a robust network of PCPs to ensure every member has access to a PCP within reasonable travel distance standards. Physicians who may serve as PCPs include Internists, Pediatricians, Obstetrician/Gynecologists, and Family and General Practitioners. Non-physicians who may serve as PCPs include physician assistants and nurse practitioners. Physicians, physician assistants, and nurse practitioners in a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC) or Health Department setting may also serve as PCPs.

IlliniCare Health offers pregnant Enrollees, or Enrollees with chronic illnesses, disabilities, or special healthcare needs the option of selecting a specialist as their PCP. An Enrollee, family member, caregiver or Provider may request a specialist as a PCP at any time. A member of our Integrated Care Team (ICT) will contact the Enrollee, caretaker or medical consenter, as applicable, within three business days of the request to schedule an assessment. Our Chief Medical Officer will review assessment results and approve requests after determining that the Enrollee meets criteria and that the specialist is willing to fulfill the PCP role, which includes, but is not limited to, provision of routine well care and immunization service. The ICT member will work with the Enrollee and previous PCP if necessary, to safely transfer care to the specialist.

The PCP must:
- Be available for or provide on-call coverage through other source 24-hours a day for management of member care. After hours access to the Health Home or covering IlliniCare Health provider can be via answering service, pager, or phone transfer to another location; recorded message instructing the Enrollee to call another number; or nurse helpline. In each case, all calls must be returned within 30 minutes.

- Educate members on how to maintain healthy lifestyles and prevent serious illness
- Provide culturally competent care
- Maintain confidentiality of medical information
- Obtain authorizations for selected inpatient and outpatient services as listed on the current prior authorization list, except for emergency services up to the point of stabilization
- Provide screening, well care, and referrals to community health departments and other agencies in accordance with HFS (Health and Family Services) provider requirements and public health initiatives
- Accommodate the physical access and flexible scheduling needs of their enrollees
- Agree to communicate with enrollees in a manner that accommodates the enrollee’s individual needs and work with IlliniCare Health to coordinate specialized services (e.g., interpreters for those who are deaf or hard of hearing and accommodations for enrollees with cognitive limitations)
- Agree to IlliniCare Health’s Waste, Fraud, and Abuse policy and procedures

IlliniCare Health PCPs should refer to their contract for complete information regarding providers’ obligations and mode of reimbursement.
ASSIGNMENT TO PRIMARY CARE PROVIDER (PCP)

For members who have not selected a PCP within 30 days of their enrollment date, IlliniCare Health will use an auto-assignment algorithm to assign an initial PCP by the 45th day. The algorithm assigns members to a PCP according to the following criteria, and in the sequence presented below:

1. Member history with a PCP. The algorithm will first look for a previous relationship with a provider.
2. Family history with a PCP. If the member him or herself has no previous relationship with a PCP, the algorithm will look for a PCP to which someone in the member’s family, such as a sibling, is or has been assigned.
3. Appropriate PCP type. The algorithm will use age, gender, and other criteria to ensure an appropriate match, such as children assigned to pediatricians and pregnant moms assigned to OB/GYNs.
4. Geographic proximity of PCP to member residence. The auto-assignment logic will ensure members travel no more than 30 minutes or 30 miles.

5. Maintain the appointment accessibility standards defined in page 14 and, upon notification of a member’s hospitalization or emergency room visit, a follow up appointment available within seven days of discharge;
6. Coordinate with IlliniCare Health’s Disease Management program including collaborating with case managers as requested;
7. Set up a recall system to outreach to members who miss an appointment to reschedule the appointment as needed;
8. Educate members and remind them of preventive and immunization services, or preventive services missed or due based on the periodicity schedule;
9. Use electronic claim submission for claim transactions IlliniCare Health is able to accept, within six months of the execution of the provider’s agreement;
10. Register with IlliniCare Health Electronic Funds Transfer (EFT) vendor to receive electronic claim payments and remittance advices, upon execution of the Provider Agreement.

TERMINATING CARE OF A MEMBER

A Primary Care Provider (PCP) may terminate the care of a member in his/her panel if the member:

- Repeatedly breaks appointments
- Repeatedly fails to keep scheduled appointments
- Is abusive to the provider or the office staff (physically or verbally)
- Fails to comply with the treatments plan
- The provider may discontinue seeing the member after the following steps have been taken:
  - The incidents have been properly documented in the member’s chart
  - A certified letter has been sent to the member documenting the reason for the termination, informing the member that the provider will be available for emergency care for the next 30 days from the date of the letter, and instructing the member to call IlliniCare Health’s member services department for assistance in selecting a new primary care provider
  - A copy of the letter must be sent to IlliniCare Health and a copy must be kept in the member’s chart

PRIMARY CARE CASE MANAGEMENT PROGRAM (PCCM)

To promote the “medical home” concept, IlliniCare Health allows PCPs to participate in our “Primary Care Case Management Program” (PCCM). Providers who participate in this program are eligible to receive a monthly capitation amount for each member who either selects the provider as his/her PCP, or who has been assigned to him/her as a PCP. A provider must be willing to meet the criteria described below in order to qualify for the PCCM program reimbursement:

1. Participate in or coordinate the members’ care during and after an inpatient admission;
2. Provide members with comprehensive primary care services and covered preventive services in accordance with the recommendation of the U.S. Preventive Health Services Task Force: medically indicated physical examinations, health education, laboratory services, referrals for necessary prescriptions and other services such as mammograms and pap smears;
3. Provide or arrange for all appropriate immunizations for members;
4. Maintain office hours of no less than thirty (30) hours per week for PCP’s in an individual (solo) practice. PCP’s in a group practice may have office hours less than twenty four (24) hours per week as long as their group practice hours equal or exceed forty (40) hours per week;
5. Maintain the appointment accessibility standards defined in page 14 and, upon notification of a member’s hospitalization or emergency room visit, a follow up appointment available within seven days of discharge;
6. Coordinate with IlliniCare Health’s Disease Management program including collaborating with case managers as requested;
7. Set up a recall system to outreach to members who miss an appointment to reschedule the appointment as needed;
8. Educate members and remind them of preventive and immunization services, or preventive services missed or due based on the periodicity schedule;
9. Use electronic claim submission for claim transactions IlliniCare Health is able to accept, within six months of the execution of the provider’s agreement;
10. Register with IlliniCare Health Electronic Funds Transfer (EFT) vendor to receive electronic claim payments and remittance advices, upon execution of the Provider Agreement.
Agree to communicate with enrollees in a manner that accommodates the enrollee’s individual needs and work with IlliniCare Health to coordinate specialized services (e.g., interpreters, hearing impaired services for those who are deaf or hard of hearing and accommodations for enrollees with cognitive limitations)

Agree to IlliniCare Health’s Fraud, Waste and Abuse policy and procedures

IlliniCare Health providers should refer to their contract for complete information regarding providers’ obligations and mode of reimbursement.

**WAIVER SERVICE PROVIDERS RESPONSIBILITIES:**

- Work collaboratively with IlliniCare Health’s care coordination team to provide services according to the care plan
- Provide only the services as outlined in the care plan. If you believe a change is necessary for the member’s well-being, contact IlliniCare Health’s Integrated Care Team to discuss the change
- Provide culturally competent care
- Maintain confidentiality of medical information
- Maintain contact with the PCP
- Obtain authorization from an IlliniCare Health Care Coordinator as needed before providing services
- Must allow member freedom of choice and access to all willing and qualified providers
- Report any instances of alleged fraud, abuse, neglect or exploitation within required reporting parameters
- Obtain authorizations for selected inpatient and outpatient services as listed on the current prior authorization list, except for emergency services up to the point of stabilization

**SPECIALIST RESPONSIBILITIES**

The PCP is responsible for coordinating the members’ healthcare services and making referrals to specialty providers when care is needed that is beyond the scope of the PCP. The specialty physician may order diagnostic tests without PCP involvement by following IlliniCare Health referral guidelines. The specialty physician must abide by the prior authorization requirements when ordering diagnostic tests; however, the specialist may not refer to other specialists or admit to the hospital without the approval of a PCP, except in a true emergency situation.

The specialist provider must:

- Maintain contact with the PCP
- Obtain referral or authorization from the member’s PCP and/or IlliniCare Health Medical Management department (Medical Management) as needed before providing services
- Coordinate the member’s care with the PCP
- Provide the PCP with consult reports and other appropriate records within five business days
- Be available for or provide on-call coverage through another source 24-hours a day for management of member care. After hours access can be via answering service, pager, or phone transfer to another location; recorded message instructing the member to call another number; or nurse helpline. In each case, all calls must be returned within 30 minutes
- Maintain the confidentiality of medical information
- Accommodate the physical access and flexible scheduling needs of their enrollees
SUSPENDING SERVICES OF A MEMBER
A home and community-based services provider may suspend the services of a member if the member or authorized representative causes a barrier to care or unsafe conditions. Any incidents of barriers to care and/or unsafe conditions should be reported to the IlliniCare Health Care Coordinator by calling Member Services. The Care Coordinator will work directly with the provider to resolve any potential issues, and if necessary, temporarily suspend services.

VOLUNTARILY LEAVING THE NETWORK
Providers must give IlliniCare Health notice of voluntary termination following the terms of their participating agreement with our health plan. In order for a termination to be considered valid, providers are required to send termination notices via certified mail (return receipt requested) or overnight courier. In addition, providers must supply copies of medical records to the member’s new provider upon request and facilitate the member’s transfer of care at no charge to IlliniCare Health or the member.

IlliniCare Health will notify affected members in writing of a provider’s termination. If the terminating provider is a PCP, IlliniCare Health will request that the member select a new PCP. If a member does not select a PCP prior to the provider’s termination date, IlliniCare Health will automatically assign one to the member.

Providers must continue to render covered services to members who are existing patients at the time of termination until the later of 60 calendar days or until IlliniCare Health can arrange for appropriate healthcare for the member with a participating provider.

Upon request from a member undergoing active treatment related to a chronic or acute medical condition, IlliniCare Health will reimburse the provider for the provision of covered services for up to 90 calendar days from the termination date. In addition, IlliniCare Health will reimburse providers for the provision of covered services to members who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery.

Exceptions may include:
- Members requiring only routine monitoring
- Providers unwilling to continue to treat the member or accept payment from IlliniCare Health

SUPPORTIVE LIVING FACILITIES AND LONG TERM CARE FACILITY RESPONSIBILITIES:

- Notify IlliniCare Health’s Medical Management department of emergency hospital admissions, elective hospital admissions within 24-48 hours of the admission
- Notify the PCP, when possible, within 24-48 hours after the member’s visit to the emergency department
- Notify IlliniCare Health’s Medical Management department of IlliniCare Health member emergency room visits for the previous business day. This can be done via Fax or electronic file. The notification should include member’s name, Medicaid ID, presenting symptoms, diagnosis, date of service, and member phone number, if available

MEMBER FREEDOM OF CHOICE AND ACCESS TO ALL WILLING AND QUALIFIED PROVIDERS
IlliniCare Health ensures that members have freedom of choice of the providers they utilize for waiver services and long term care. IlliniCare Health members have the option to choose their providers, which includes all willing and qualified providers. Subject to the member’s care plan, member access to in-network non-medical providers offering waivered services will not be limited or denied except when quality, reliability or similar threats pose potential hazards to the well-being of our members. Freedom of choice with network providers will not be limited for plan participants, nor will providers of qualified services be stopped from providing such service as long as the goal of high quality, cost efficient care is met or exceeded and providers adhere to the contractual standards outlined in the IlliniCare Health contract with the state of Illinois. We encourage our providers to share this information with members as well.
Provider Accessibility Standards and Procedures

APPOMTMENT ACCESSIBILITY STANDARDS
IlliniCare Health follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. IlliniCare Health monitors compliance with these standards on an annual basis. Providers must offer hours of operation no less than those hours offered to commercial enrollees or Medicaid fee-for-service enrollees. Below is a table detailing the type of service and the scheduling time frame that must be followed by all providers: In addition to the above accessibility standards and in accordance to the requirements set forth by the Illinois Department of Healthcare and Family Services, a Primary Care Provider’s panel size may not exceed 600 IlliniCare Health members.

<table>
<thead>
<tr>
<th>TYPE OF SERVICE</th>
<th>SCHEDULING TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent Care</td>
<td>Immediate</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Non-urgent symptomatic</td>
<td>Within three weeks</td>
</tr>
<tr>
<td>Routine - preventive care</td>
<td>Within five weeks</td>
</tr>
<tr>
<td></td>
<td>1st trimester - 2 weeks</td>
</tr>
<tr>
<td></td>
<td>2nd trimester - 1 week</td>
</tr>
<tr>
<td>Initial Visit - pregnant women</td>
<td>3rd trimester - 3 days</td>
</tr>
<tr>
<td>Average office wait time</td>
<td>Equal to or less than one hour</td>
</tr>
<tr>
<td>Provider appointments</td>
<td>No more than six scheduled per hour</td>
</tr>
<tr>
<td>After Hours</td>
<td>24/7 coverage (voicemail only not acceptable)</td>
</tr>
</tbody>
</table>

TELEPHONE ARRANGEMENTS
PCPs and Specialists must:

- Answer the member’s telephone inquiries on a timely basis
- Prioritize appointments
- Schedule a series of appointments and follow-up appointments as needed by a member
- Identify and reschedule no-show appointments
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments)
- Adhere to the following response time for telephone call-back waiting times:
  - After-hours telephone care for non-emergent, symptomatic issues within 30 minutes
  - Same day for non-symptomatic concerns
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider’s absence
- After-hours calls should be documented in a written format in either an after-hour call log or some other method, and then transferred to the member’s medical record

IlliniCare Health will monitor appointment and after hours availability on an on-going basis through its Quality Improvement Program (QIP).

COVERING PROVIDERS
PCPs and specialty physicians must arrange for coverage with another IlliniCare Health network provider during scheduled or unscheduled time off. The covering provider must have an active Illinois Medicaid ID number and an active NPI number in order to receive payment. The covering physician is compensated in accordance with the terms of his/her contractual agreement.
24-HOUR ACCESS
IlliniCare Health’s PCPs and specialty physicians are required to maintain sufficient access to facilities and personnel to provide covered physician services and shall ensure that such services are accessible to members as needed 24-hours a day, 365 days a year as follows:
- A provider’s office phone must be answered during normal business hours
- After-hours, a provider must have arrangements for:
  - Access to a covering physician,
  - An answering service,
  - Triage service, or
  - A voice message that provides a second phone number that is answered
- Any recorded message must be provided in English and Spanish

The selected method of 24-hour coverage chosen by the member must connect the caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision. The PCP, specialty physician, or covering medical professional must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the medical office’s daytime telephone number.

IlliniCare Health will monitor providers’ offices through scheduled and unscheduled visits conducted by IlliniCare Health’s Provider Relations staff.

MEMBER PANEL CAPACITY
All PCPs reserve the right to limit the number of members they are willing to accept into their panel. IlliniCare Health DOES NOT guarantee that any provider will receive a certain number of members.

If a PCP declares a specific capacity for their practice and wants to make a change to that capacity, the PCP must contact IlliniCare Health Provider Services. A PCP shall not refuse to treat members as long as the provider has not reached their requested panel size.

Providers shall notify IlliniCare Health in writing at least 45 calendar days in advance of their inability to accept additional Medicaid covered persons under IlliniCare Health agreements. In no event shall any established patient who becomes a covered person be considered a new patient. IlliniCare Health prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-Medicaid members.
Cultural competency within IlliniCare Health is defined as “the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective which values differences and is responsive to diversity at all levels in an organization. Cultural competency is developmental, community focused and family oriented. In particular, it is the promotion of quality services to understand, racial/ethnic groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.”
Studies have found that culturally and linguistically diverse groups and those with limited English proficiency experience less adequate access to care, lower quality of care and poorer health status outcomes.

There are five steps associated with becoming culturally competent. They are:

1. Valuing diversity and being accepting of differences;
2. Being self-aware;
3. Being conscious of the impact of culture; when we interact;
4. Having knowledge of our member’s cultures; and
5. Employing an adaptation of skills to our member’s cultural needs.

Similarly, when communicating across cultures, we should:

- Maintain formality;
- Show respect;
- Communicate clearly; and
- Value diversity.

It is equally important to maintain “Disability Awareness”. The Americans with Disabilities Act (ADA) defines a person with a disability as:

- A person who has a physical or mental impairment that substantially limits one or more major life activities, and includes people who have a record of impairment, even if they do not currently have a disability, and individuals who do not have a disability, but are regarded as having a disability.

It is unlawful to discriminate against persons with disabilities or to discriminate against a person based on that person’s association with a person with a disability. Accommodations for people with disabilities include:

- Physical accessibility;
- Effective communication;
- Policy modification; and
- Accessible medical equipment.

To successfully meet the demands for “disability awareness”, you must “know your patients”. This includes capturing information about accommodations that may be required, recording information in patient’s charts or electronic health records, and if making referrals to other providers, communicating with the receiving provider regarding any necessary accommodations that may be required.

Person centered planning and self-determination require that providers support member “freedom” to choose a meaningful life in the community, grant them the “authority” to control the resources they need to build that life, “support” for the member in selecting services and supports best suited to their individual needs, enabling them to take “responsibility” for their lives, and “confirming” that the member plays an important role in designing or re-designing their system of care.

IlliniCare Health is committed to the development, strengthening, and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate, and quality care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

IlliniCare Health, as part of its credentialing, will evaluate the cultural competency level of its network providers and provide access to training and tool kits to assist providers in developing culturally competent and culturally proficient practices.
### Benefit Explanation & Limitations

**ILLINICARE HEALTH BENEFITS**

IlliniCare Health network providers supply a variety of medical benefits and services some of which are outlined on the following pages. For specific information not covered in this provider manual, please contact Provider Services at from 8:00 a.m. to 5:00 p.m. CST, Monday through Friday (excluding holidays). A Provider Services Representative will assist you in understanding the benefits. Providers can also reference our website for the most recent benefit updates at:

http://www.IlliniCare.com/for-members/benefit-information/

**ILLINICARE HEALTH PLAN COVERED SERVICES AND PRIOR AUTHORIZATION REQUIREMENTS**

Please contact IlliniCare Health with questions regarding pre-authorization requirements if service is not listed below. For an up to date list, please reference: http://www.IlliniCare.com/for-providers/auths/

### Prior Auth Requirements Table

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>ICP</th>
<th>FHP</th>
<th>MMAI</th>
<th>MLTSS</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>n/a</td>
<td>Inclue HFS Form 2399</td>
</tr>
<tr>
<td>Air Ambulance - Fixed Wing</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>n/a</td>
<td>Prior Authorization required after 12 visits per calendar year</td>
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<tr>
<td>Dental Anesthesia</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Dental Care</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>n/a</td>
<td>Extractions, emergencies, and denture for patients with diabetes only</td>
</tr>
<tr>
<td>Dental Care for Kids</td>
<td>n/a</td>
<td>No</td>
<td>n/a</td>
<td>n/a</td>
<td>Members under age 21</td>
</tr>
<tr>
<td>Dental Care for Pregnant Women</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>n/a</td>
<td>Oral exams and cleanings only</td>
</tr>
<tr>
<td>Dental Practice Visit</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>greater than $500</td>
<td>Yes</td>
<td>Yes</td>
<td>May be required</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>less than $500</td>
<td>May be required</td>
<td>May be required</td>
<td>May be required</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Emergency Department (ED) Services</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Emergency ambulance transportation only</td>
</tr>
<tr>
<td>Emergency Transportation</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td></td>
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</table>
## PRIOR AUTH REQUIREMENTS

<table>
<thead>
<tr>
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<th>MLTSS</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enteral and Parenteral Nutrition at Home</td>
<td>No</td>
<td>No</td>
<td>May be required</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>EPSDT (Early and Periodic Screening, Diagnosis and Treatment)</td>
<td>No</td>
<td>No</td>
<td>n/a</td>
<td>n/a</td>
<td>Members under age 21</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>n/a</td>
<td>1 eye exam per year</td>
</tr>
<tr>
<td>Eye Glasses or Contacts</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Genetic Counseling and Testing</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>n/a</td>
<td>1 pair every 3 years. Hearing aids over $500 will require DME authorization</td>
</tr>
<tr>
<td>Hearing Screenings</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Home Health Care Services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>May be included</td>
<td>Including, but not limited to: skilled nursing services, home health aide, personal care attendants, therapies, hospice and wound therapy, IV infusion</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Yes</td>
<td>Yes</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Hospital Inpatient Services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>n/a</td>
<td>Include HFS Form 2360 and HFS Form 1977</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>Yes</td>
<td>Yes</td>
<td>n/a</td>
<td>n/a</td>
<td>Include HFS Form 2360 and HFS Form 1977</td>
</tr>
<tr>
<td>Laboratory Services</td>
<td>No</td>
<td>No</td>
<td>May be required</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Mental and Behavioral Health Services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Observation Stays</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>n/a</td>
<td>Prior Authorization required for purchases of $500 or greater</td>
</tr>
<tr>
<td>Orthotics and Prosthetics</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>n/a</td>
<td>Prior Authorization required for purchases of $500 or greater</td>
</tr>
<tr>
<td>Out-of-Network Services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Except ED services and Family Planning services</td>
</tr>
</tbody>
</table>
## PRIOR AUTH REQUIREMENTS

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>ICP</th>
<th>FHP</th>
<th>MMAI</th>
<th>MLTSS</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-State Services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>May be included</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Except ED services</td>
</tr>
<tr>
<td>Outpatient Therapy - After first 6 visits</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>n/a</td>
</tr>
<tr>
<td>Outpatient Therapy - First 6 visits</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td>n/a</td>
</tr>
<tr>
<td>Pain Management Services</td>
<td>Yes</td>
<td>No</td>
<td>May be required</td>
<td>n/a</td>
<td>Services that for cosmetic purposes only are not covered</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>n/a</td>
</tr>
<tr>
<td>Podiatrist Services - After first 3 visits</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td>n/a</td>
</tr>
<tr>
<td>Podiatrist Services - First 3 visits</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td></td>
<td>n/a</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>May be required</td>
<td>May be required</td>
<td>May be required</td>
<td>May be required</td>
<td>Consult Preferred Drug List (PDL)</td>
</tr>
<tr>
<td>Primary Care Provider (PCP) Office Services</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Radiology Services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Only for specialty radiology</td>
</tr>
<tr>
<td>Sleep Study</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td>n/a</td>
</tr>
<tr>
<td>Sterilization Procedures</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td></td>
<td>Include HFS Form 2189</td>
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<tr>
<td>Surgery</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Non-emergency surgeries only</td>
</tr>
<tr>
<td>Transplants</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>n/a</td>
</tr>
<tr>
<td>Transportation</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
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<td>Yes , only for Adult Day Care</td>
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<td></td>
<td>Non-emergent air transportation and non-emergent ambulance transportation only</td>
</tr>
<tr>
<td>Ultrasounds - Non-Pregnancy</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td></td>
<td>n/a</td>
</tr>
<tr>
<td>Ultrasounds - Pregnancy</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
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<td></td>
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<td></td>
<td>2 allowed in a 9 month period. Any additional require authorization except when performed by a Perinatologist</td>
</tr>
<tr>
<td>Sleep Study</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td>n/a</td>
</tr>
<tr>
<td>Sterilization Procedures</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td></td>
<td>Include HFS Form 2189</td>
</tr>
<tr>
<td>Surgery</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>n/a</td>
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<td></td>
<td></td>
<td>Non-emergency surgeries only</td>
</tr>
<tr>
<td>Transplants</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>n/a</td>
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<tr>
<td>Transportation</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>Yes</td>
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<td></td>
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<td></td>
<td></td>
<td>2 allowed in a 9 month period. Any additional require authorization except when performed by a Perinatologist</td>
</tr>
</tbody>
</table>

21
Please note we will NOT authorize for services for out of network or non-participating providers, unless the services are necessary for continuity of care reasons. We may also authorize services for out of network providers at our discretion, if the services are not available through our in-network providers.

Please contact IlliniCare Health with questions regarding pre-authorization requirements if service is not listed above at. For an up to date list, please reference: www.IlliniCare.com/for-providers/auths/
ADDITIONAL BENEFITS FOR FAMILY HEALTH PLAN

PREGNANCY AND MATERNITY SERVICES

▪ Outpatient doctor services including routine prenatal care before and after delivery for problems or complications resulting from pregnancy or childbirth.
▪ Inpatient hospital services in participating hospitals and out-of-network emergency labor and delivery services.
▪ Care from the Comprehensive Perinatal Services Program (CPSP), including a medical/obstetrical, nutritional, psychosocial and health education assessment at the first prenatal visit, once each trimester thereafter, and at the post-partum visit.
▪ The newborn child’s healthcare for the month of delivery and the month after delivery. By that time, the newborn should be enrolled separately.

GENERAL PREVENTIVE CARE SERVICES

▪ Eye exams. We cover an eye exam every 2 years (unless the member has a medical need for more frequent exams). We cover refractions to determine a prescription for glasses.
▪ Health education programs including, but not limited to: diabetes education, heart health education, nutritional education, etc. Look for information on health education in our Member newsletter and on our website. IlliniCare Health may also mail our members information.
▪ Child and adult immunizations.
▪ Immunizations are covered according to the Advisory Committee on Immunization Practices (ACIP), the Illinois Adult Immunization and the United States Preventive Services Task Force recommendations.
▪ Periodic check-ups. A complete history and physical exam every one to three years.
▪ Medical screening such as for diabetes, high cholesterol, osteoporosis and tuberculosis.
▪ Cancer screening for cervical, breast, BRACA1, BRAC2, colorectal, prostate and skin.
▪ Any test recommended by IlliniCare Health and medical professionals is covered.

We recommend that our members a checkup according to the following schedule:

<table>
<thead>
<tr>
<th>EXAM AGE</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under Age 21</td>
<td>Annually</td>
</tr>
<tr>
<td>Age 22-65</td>
<td>Every 3 years</td>
</tr>
<tr>
<td>Age 65 and above</td>
<td>Annually</td>
</tr>
</tbody>
</table>

PREVENTIVE CARE FOR WOMEN:

<table>
<thead>
<tr>
<th>EXAM</th>
<th>AGE</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAP</td>
<td>21 - 28</td>
<td>Every 1-3 years, dependent upon results of prior testing</td>
</tr>
<tr>
<td></td>
<td>29+</td>
<td>Every 3-5 years if prior testing was normal</td>
</tr>
<tr>
<td>Clinical</td>
<td>20 - 40</td>
<td>Every 1 - 3 years</td>
</tr>
<tr>
<td>Breast Exam</td>
<td>40+</td>
<td>Annually dependent on prior findings</td>
</tr>
<tr>
<td>Mammogram</td>
<td>40 - 49</td>
<td>Biennially dependent on prior findings</td>
</tr>
<tr>
<td></td>
<td>50 - 74</td>
<td>Annually dependent on prior findings</td>
</tr>
</tbody>
</table>
WELL-CHILD CARE

The Child Health & Disability Prevention (CHDP) program offers:
- Health history
- Medical, dental, nutritional and developmental assessment
- Immunizations
- Vision and hearing testing
- Some laboratory tests (e.g., tuberculin, sickle cell, blood and urine tests, pap smears)
- Health education, including smoking and information on second-hand smoke

VOLUNTARY FAMILY PLANNING SERVICES

We cover the cost of contraceptives, including the birth control device, and fitting or inserting the device (such as diaphragms, IUDs, Norplant). Our members can get services from any qualified family planning provider. He/she does not have to be a Participating Provider. Our members do not need a referral from PCP and do not have to get permission from IlliniCare Health to get these services.

VOLUNTARY STERILIZATION SERVICES

We cover vasectomies and tubal ligations.

ADDITIONAL BENEFITS FOR MLTSS AND HCBS WAVERS

IlliniCare Health network providers supply a variety of benefits and services some of which are outlined on the following page. These are benefits that are only available to those who qualify for waiver service. Each of the services below must be a part of the member’s approved care plan in order for the service to be rendered.

For specific information not covered in this provider manual, please contact Provider Services 2 from 8:00 a.m. to 5:00 p.m. CST, Monday through Friday (excluding holidays). A Provider Services Representative will assist you in understanding the benefits.

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>AGING WAIVER</th>
<th>DISABILITY WAIVER</th>
<th>HIV/AIDS WAIVER</th>
<th>BRAIN INJURY WAIVER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day Service</td>
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<tr>
<td>Adult Day Service</td>
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<tr>
<td>Transportation</td>
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<tr>
<td>Environmental Adaptations</td>
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<tr>
<td>Supported Employment</td>
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<tr>
<td>Home Health Aide</td>
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<tr>
<td>Nursing, Intermittent</td>
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<tr>
<td>Nursing, Skilled</td>
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<tr>
<td>Occupational Therapy</td>
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<tr>
<td>Physical Therapy</td>
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<tr>
<td>Speech Therapy</td>
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<tr>
<td>Prevocational Services</td>
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<tr>
<td>Day Habilitation</td>
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<tr>
<td>Home Care Aide</td>
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<tr>
<td>Home Delivered Meals</td>
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<tr>
<td>Personal Assistant</td>
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<tr>
<td>Personal Emergency Response</td>
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<tr>
<td>System</td>
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<td>Respite</td>
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<tr>
<td>Adaptive Equipment</td>
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<tr>
<td>Behavioral Services</td>
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</table>
SUPPORTIVE LIVING FACILITIES (SLFS) COVERED SERVICES
The following services are included in the global rate, and should be provided to IlliniCare Health members:

- Nursing Services
- Personal Care
- Medication administration, oversight and assistance in self-administration
- Laundry
- Housekeeping
- Maintenance
- Social and recreational programming
- Ancillary Services
- 24 hour response/security staff
- Health promotion and exercise
- Emergency call system
- Daily checks
- Quality assurance plan
- Management of resident funds, if applicable

LONG TERM CARE FACILITIES (LTC) COVERED SERVICES
For Long Term Care Facilities, IlliniCare Health covers room and board for qualified members.

ILLINICARE HEALTH NON-COVERED SERVICES

<table>
<thead>
<tr>
<th>NON-COVERED SERVICES:</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical/Surgical Procedures solely for cosmetic purposes</td>
<td></td>
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<tr>
<td>Diagnostic and/or therapeutic procedures related to infertility/sterility</td>
<td></td>
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<tr>
<td>Services that are experimental and/or investigational in nature</td>
<td></td>
</tr>
<tr>
<td>Intermediate Care Facility for Mentally Retarded/ Developmentally Disabled (ICF/DD/MR Facility)</td>
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<tr>
<td>Nursing Facility beginning on ninety-first (91st) day</td>
<td></td>
</tr>
<tr>
<td>Services provided by an out-of-network provider and not prior-authorized by IlliniCare Health</td>
<td>Except Family Planning services in the State and ER services (in/out of State), All waiver services require prior authorization.</td>
</tr>
<tr>
<td>Services that are provided without first obtaining a required referral or prior-authorization as per IlliniCare Health policy.</td>
<td></td>
</tr>
</tbody>
</table>
VALUE ADDED BENEFITS – ICP & FHP

No Copays
No copays for medical visits or prescriptions.
- Annual dental cleaning for adults
- Additional time for dental visits

Dental Services
- “Practice visits” if needed

Gynecologic Visits
“Practice visits” for enrollees with developmental disabilities or serious mental illness if needed

Telemonitoring
Eligible members will get devices to help check on health problems at home

CentAccount
Program provides prepaid MasterCard with funds added when members utilize certain screenings and preventing care services

Connections Plus Program
Provides cell phones to eligible members who don’t have access to a phone so that you can call your doctor, 911, or care coordinator
- Annual eye exam
- Pair of eyeglasses every two years (calendar year)
- Additional options include:
  - Opt-out of formulary frame selection and receive $100 toward purchase of frames. Member responsible for any costs above $100 allowance.
  - Option to receive contacts in lieu of glasses, and receive $80 allowance toward contact purchase. Any cost above $80 is member’s responsibility.

Vision Services
Contact fitting is covered at no cost to the member.

VALUE ADDED BENEFITS – MMAI

Over-The-Counter Medications
$25/month

Nurse Advice Line
Available 24/7, 365 days a year
No copays/coinsurance, diagnostic, restorative, endodontics/periodontics/extractions, prosthodontics, other oral/maxillofacial surgery

Comprehensive Dental
Annual Dental Maximum
$1,000/year for comprehensive services

Vision
Routine Eye Exam
1 per year, or as medically necessary

Glasses
1 every two years, no maximum

Hearing
Routine Hearing Exam
1 per year

Fitting/Evaluation for Hearing Aid
1 every three years

Hearing Aid
No maximum
OVERVIEW AND MEDICAL NECESSITY
IlliniCare Health’s Medical Management department hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m., CST (excluding holidays). Medical Management services include the areas of utilization management, care coordination/case management, disease management, pharmacy management, and quality review. The department clinical services are overseen by the IlliniCare Health Medical Director. The Vice President of Medical Management has responsibility for direct supervision and operation of the department.

To reach the Medical Director or Vice President of Medical Management, please contact:

**IlliniCare Health**
*Utilization Management*
ICP & FHP Phone: 1-866-329-4701
ICP, FHP & MLTSS Fax: 1-866-534-5979

MMAI Phone: 1-877-941-0482
MMAI Fax: 1-855-332-7456
MLTSS Phone: 844-316-7562

**REFERRALS, PRIOR AUTHORIZATIONS AND NOTIFICATIONS**

**REFERRALS** - As promoted by the Medical Home concept, PCPs should coordinate most of the healthcare services for IlliniCare Health members. PCPs can refer a member to a specialist when care is needed that is beyond the scope of the PCP’s training or practice parameters; however, paper referrals are not required. To better coordinate a members’ healthcare, IlliniCare Health encourages specialists to communicate to the PCP the need for a referral to another specialist rather than making such a referral themselves.

**NOTIFICATIONS** - A provider is required to promptly notify IlliniCare Health when prenatal care is rendered. Early notification of pregnancy allows the health plan to assist the member with prenatal care coordination of services.

**PRIOR AUTHORIZATIONS** - Some services require prior authorization from IlliniCare Health in order for reimbursement to be issued to the provider. All out-of-network services require prior authorization. To verify whether a prior authorization is necessary or to obtain a prior authorization, call:

**IlliniCare Health**
*Medical Management/Authorization Department*
ICP & FHP Phone: 1-866-329-4701
ICP & FHP Inpatient Fax: 1-877-650-6937
ICP & FHP Outpatient Fax: 1-877-779-5234

MMAI Phone: 1-877-947-0482
MMAI Fax: 1-855-332-7456
MLTSS Phone: 844-316-7562
MLTSS Fax: 877-650-6937

Prior Authorization requests may be done electronically following the ANSI X 12N 278 transaction code specifications. For more information on conducting these transactions electronically contact:

**IlliniCare Health**
*co Centene EDI Department*
1-800-225-2573, extension 607525
Or by e-mail at: EDIBA@centene.com

**UTILIZATION MANAGEMENT**
The IlliniCare Health Utilization Management Program (UMP) is designed to ensure members of IlliniCare Health receive access to the right care at the right place and right time. Our program is comprehensive and applies to all eligible members across all product types, age categories, and range of diagnoses. The UMP incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, long term care, and ancillary care services.

IlliniCare Health’s UMP seeks to optimize a member’s health status, sense of well-being, productivity, and access to quality healthcare, while at the same time actively managing cost trends. The UMP aims to provide services that are a covered benefit, medically necessary, appropriate to the patient’s condition, rendered in the appropriate setting and meet professionally recognized standards of care.
IlliniCare Health clinical staff will request clinical information that is minimally necessary for clinical decision making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), IlliniCare Health is entitled to request and receive protected health information (PHI) for purposes of treatment, payment and healthcare operations.

Information necessary for authorization of covered services may include but is not limited to:
- Member’s name, Member ID number
- Provider’s name and telephone number
- Provider location if the request is for an ambulatory or office procedure
- Reason for the authorization request (e.g., primary and secondary diagnoses, planned surgical procedures, surgery date)
- Relevant clinical information (e.g., past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Discharge plans

Notification of newborn deliveries should include the mother’s name, date of delivery, method of delivery, and weight.

If additional clinical information is required, an IlliniCare Health nurse or medical management representative will notify the caller of the specific information needed to complete the authorization process.

CLINICAL DECISIONS
IlliniCare Health affirms that utilization management decision making is based only on appropriateness of care and service and the existence of coverage. IlliniCare Health does not specifically reward practitioners or other individuals for issuing denials of service or care.

The treating physician, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The PCP, in consultation with the IlliniCare Health Medical Director and other clinical staff, is responsible for making utilization management (UM) decisions in accordance with the member’s plan of covered benefits and established medical necessity criteria. Failure to obtain authorization for services that require plan approval may result in payment denials.
MEDICAL NECESSITY

Medical necessity is defined for IlliniCare Health members as healthcare services, supplies or equipment provided by a licensed healthcare professional that are:

- Appropriate and consistent with the diagnosis or treatment of the patient’s condition, illness, or injury
- In accordance with the standards of good medical practice consistent with evidence based and clinical practice guidelines
- Not primarily for the personal comfort or convenience of the member, family, or provider
- The most appropriate services, supplies, equipment, or level of care that can be safely and efficiently provided to the member
- Furnished in a setting appropriate to the patient’s medical need and condition and, when supplied to the care of an inpatient, further mean that the member’s medical symptoms or conditions require that the services cannot be safely provided to the member as an outpatient service
- Not experimental or investigational or for research or education

REVIEW CRITERIA

IlliniCare Health has adopted utilization review criteria developed by McKesson InterQual® products to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. The Medical Director reviews all potential medical necessity denials and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department. Practitioners also have the opportunity to discuss any medical or pharmaceutical utilization management adverse determination with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination.

NEW TECHNOLOGY

IlliniCare Health evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and/or Medical Management staff may identify relevant topics for review pertinent to the IlliniCare Health population. Centene’s Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

If you need a new technology benefit determination or have an individual case review for new technology, please contact the Medical Management department.

The Medical Director may be contacted by calling Provider Services and asking for the Medical Director. A medical management nurse may also coordinate communication between the Medical Director and requesting practitioner.

Members or healthcare professionals with the member’s consent may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to:

IlliniCare Health
Provider Appeals
P.O. Box 3000
Farmington, MO 63640-3800
NOTIFICATION OF PREGNANCY
IlliniCare Health provides care coordination for pregnant members. It is critical to identify members as early in their pregnancy as possible. IlliniCare Health asks that managing physician notify the IlliniCare Health prenatal team by completing the Notification of Pregnancy (NOP) within five days of the first prenatal visit. Providers are expected to identify the estimated date of confinement and delivery facility. IlliniCare Health will facilitate the physician’s order of a 90-day supply of prenatal vitamins for the member to be delivered to the managing provider’s office by the member’s next prenatal visit. See the Care Coordination/Case Management section for information related to our Start Smart for Your Baby® Program and our 17-P Program for women with a history of early delivery.

DISCHARGE PLANNING
The IlliniCare Health UM staff will coordinate the discharge planning efforts with the member/member’s family or guardian, the hospital’s UM and discharge planning departments and the member’s attending physician/PCP in order to ensure that IlliniCare Health members receive appropriate post-hospital discharge care.

RETROSPECTIVE REVIEW
Retrospective review is an initial review of services provided to a member, but for which authorization and/or timely notification to IlliniCare Health was not obtained due to extenuating circumstances related to the member. Requests for retrospective review, for services that require authorization by IlliniCare Health, must be submitted promptly upon identification but no later than 90 days from the first date of service. A decision will be made within 30 calendar days following receipt of all necessary information for any qualifying service cases.
A phone or fax-in process is available for PA requests:

**US Script Contacts**
- Prior Authorization Fax: 1-866-399-0929
- Prior Authorization Phone: 1-866-399-0928
- Clinical Hours: Monday - Friday, 10:00 a.m.–8:00 p.m. (EST)
- Mailing Address: US Script, 2425 W Shaw Ave, Fresno, CA 93711

When calling, please have patient information, including the member ID number, complete diagnosis, medication history, and current medications readily available.

- **If the request is approved**, information in the online pharmacy claims processing system will be changed to allow the specific members to receive this specific drug.

- **If the request is denied**, information about the denial and appeal rights will be provided to the clinician.

Clinicians are requested to utilize the PDL when prescribing medication for those patients covered by the IlliniCare Health pharmacy program. If a pharmacist receives a prescription for a drug that requires a PA request, the pharmacist should attempt to contact the clinician to request a change to a product included in the IlliniCare Health PDL.

**WORKING WITH ILLINICARE HEALTH'S PHARMACY PROGRAM**

IlliniCare Health is committed to providing appropriate, high quality, and cost effective drug therapy to all IlliniCare Health members. IlliniCare Health works with providers and pharmacists to ensure that medications used to treat a variety of conditions and diseases are covered. IlliniCare Health covers prescription drugs and certain over-the-counter (OTC) drugs when ordered by an IlliniCare Health physician/clinician. The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage and/or maximum quantities.

This section provides an overview of IlliniCare Health pharmacy program. For more detailed information, please visit our website at www.IlliniCare.com.

**WORKING WITH ILLINICARE HEALTH’S SPECIALTY PHARMACY PROVIDER**

Certain medications are only covered when supplied by IlliniCare Health’s preferred specialty pharmacy provider, AcariaHealth Specialty Pharmacy. These products are listed on the AcariaHealth Supplied Biopharmaceutical document available on the IlliniCare Health website.

The IlliniCare Health Pharmacy Program Director and Medical Director oversee the clinical review of these medications. Follow these guidelines for the most efficient processing of the Prior Authorization requests:

1. Providers can request that AcariaHealth deliver the specialty drug to the office/member. If you would like AcariaHealth to deliver the specialty drug to the office/member call AcariaHealth at 1-855-535-1815.
The IlliniCare Health P&T Committee continually evaluates the therapeutic classes included in the PDL. The committee is composed of the IlliniCare Health Medical Director, the IlliniCare Health pharmacy program director (Pharmacy Program Director), and several community-based primary care physicians and specialists. The primary purpose of the P&T Committee is to assist in developing and monitoring the IlliniCare Health PDL and to establish programs and procedures that promote the appropriate and cost-effective use of medications. The P&T committee schedules meetings at least quarterly during the year and coordinates therapeutic class reviews with the parent company’s national P&T Committee.

PHARMACY PRIOR AUTHORIZATION (PA) PROCESS

The IlliniCare Health PDL includes a broad spectrum of generic and brand name drugs. Clinicians are encouraged to prescribe from the IlliniCare Health PDL for their patients who are members of IlliniCare Health. Some preferred drugs require PA. Medications requiring PA are listed with a “PA” notation throughout the PDL.

SPECIFIC EXCLUSIONS

The following drug categories are not part of the IlliniCare Health PDL:

- Fertility enhancing drugs
- Anorexia, weight loss, or weight gain drugs
- Experimental or investigational drugs
- Drug Efficacy Study Implementation (DESI) and Identical, Related and Similar (IRS) drugs that are classified as ineffective
- Infusion therapy and supplies
- Oral vitamins and minerals (except those listed in the PDL)
- Drugs and other agents used for cosmetic purposes or for hair growth
- Erectile dysfunction drugs prescribed to treat impotence
- Over-the-Counter (OTC) Medications (except those listed in the PDL)

The IlliniCare Health pharmacy program covers a variety of OTC medications. All covered OTC medications appear in the PDL. All OTC medications must be written on a valid prescription, by a licensed provider.

PREPARED DRUG LIST (PDL)

The IlliniCare Health PDL describes the circumstances under which contracted pharmacy providers will be reimbursed for medications dispensed to members covered under the program. The PDL does not:

- Require or prohibit the prescribing or dispensing of any medication
- Substitute for the independent professional judgment of the physician/clinician or pharmacist, or
- Relieve the physician/clinician or pharmacist of any obligation to the patient or others

IlliniCare Health’s Pharmacy and Therapeutics (P&T) Committee has reviewed and approved, with input from its members and in consideration of medical evidence, the list of drugs requiring prior authorization (PA). The PDL attempts to provide appropriate and cost-effective drug therapy to all participants covered under the IlliniCare Health pharmacy program. If a patient requires medication that does not appear on the PDL, the clinician can submit a PA request for a non-preferred medication. It is anticipated that such exceptions will be rare and that currently available PDL medications will be appropriate to treat the vast majority of medical conditions encountered by IlliniCare Health providers. A copy of IlliniCare Health’s PDL may be found on the health plan website under the Provider section. Please note that dual eligible members (MMAI) have a separate PDL, also located on the IlliniCare Health Website.
Members enrolled in the dual Medicare-Medicaid program are encouraged to utilize the IlliniCare Health OTC Catalog Benefit. Through the program, members may get many OTC products delivered to their home free of charge. Orders may be placed by calling RxDirect at 1-877-851-3994. A list of available products and program details may be found on the IlliniCare Health website.

**MAINTENANCE MEDICATIONS**
IlliniCare Health offers a 90 day supply (3 month supply) of maintenance medications- at many retail pharmacies or through IlliniCare Health’s mail order pharmacy, RxDirect. Please visit our website at www.IlliniCare.com for a listing of products considered maintenance medications. Contact an IlliniCare Health Provider Service Representative if you have any additional questions regarding this program. To transfer a current prescription to mail order you may call RxDirect at 1-800-785-4197.

**QUANTITY LIMITATIONS**
Quantity limitations have been implemented on certain medications to ensure the safe and appropriate use of the medications. Quantity limitations are approved by the IlliniCare Health P&T Committee and noted throughout the PDL.

**STEP THERAPY**
Medications requiring Step Therapy are listed with an “ST” notation throughout the preferred drug list. The US Script claims system will automatically check the member profile for evidence of prior or current usage of the required agent. If there is evidence of the required agent on the member’s profile, the claim will automatically process. If not, the claims system will notify the pharmacist that a PA is required.

**AGE LIMITS**
Some medications on the IlliniCare Health PDL may have age limits. These are set for certain drugs based on FDA approved labeling and for safety concerns and quality standards of care. Age limits align with current FDA alerts for the appropriate use of pharmaceuticals.

**NEWLY APPROVED PRODUCTS**
Newly approved drug products will not normally be placed on the PDL during their first six months on the market. During this period, access to these medications will be considered through the PA review process.

**UNAPPROVED USE OF PREFERRED MEDICATION**
Medication coverage under this program is limited to non-experimental indications as approved by the FDA. Other indications may also be covered if they are accepted as safe and effective using current medical and pharmaceutical reference texts and evidence-based medicine. Reimbursement decisions for specific non-approved indications will be made by IlliniCare Health. Experimental drugs, investigational drugs and drugs used for cosmetic purposes are excluded from coverage.

**GENERIC SUBSTITUTION**
IlliniCare Health requires that generic substitution be made when a generic equivalent is available. All branded products that have an A-rated generic equivalent will be reimbursed at the maximum allowable cost (MAC). The provision is waived for the following products due to their narrow therapeutic index: Aminophylline, Amiodarone, Carbamazepine, Clozapine, Cyclosporine, Digoxin, Disopyramide, Ethosuximide, Flecaïnide, L-thyroxine, Lithium, Phenytoin, Procalamine, Propafenone, Theophylline, Thyroid, Valproate Sodium, Valproic Acid, and Warfarin.

The IlliniCare Health MMAI program covers many branded products. These products are available under Tier 2, and may require a copay. Please see the MMAI PDL, located on the IlliniCare Health website, for details.

**EXCEPTION REQUESTS**
In the event that a clinician or member disagrees with the decision regarding coverage of a medication, the clinician may request an appeal by submitting additional information to IlliniCare Health. The additional information may be provided verbally or in writing. A decision will be rendered and the clinician will be notified with a faxed response. If the request is denied, the clinician will be notified of the appeals process at that time.

An expedited appeal may be requested at any time the provider believes the adverse determination might seriously jeopardize the life or health of a patient. Call the IlliniCare Health complaint and grievance coordinator. A response will be rendered within 24 hours of receipt of complete information. In circumstances that require research, a 24 hour response may not be possible.
Behavioral Health Services

IlliniCare Health offers our members access to all covered, medically necessary behavioral health services through our affiliate, Cenpatico.

IlliniCare Health members seeking mental health or substance abuse services may self-refer to a network provider for five (5) standard outpatient sessions per member but prior authorization is required for subsequent visits. For assistance in identifying a behavioral health provider or for prior authorization for inpatient or outpatient services, Cenpatico may be reached at Member Services.

In the event that the physician or practitioner is unable to provide timely access for a member, IlliniCare Health will assist in securing authorization to a physician or practitioner to meet the member’s needs in a timely manner.

COORDINATION OF BEHAVIORAL HEALTH SERVICES
IlliniCare Health partners with our Behavioral Health affiliate, Cenpatico, to deliver Mental Health and Substance Use Disorder services to our Members. For information regarding Behavioral Health Services, locating providers, or for assistance in coordinating services for the Member, contact IlliniCare Health’s Integrated Medical Management department at.

BEHAVIORAL HEALTH SERVICES ACCESSIBILITY
To ensure members have access to care, providers are required to comply with the following appointment standards:
- Urgent Care - within 24 hours
- Non-urgent - (symptomatic) within 30 days
- Well Care - 3 months
- Emergent Care – immediately (24 hours per day, 7 days per week)
- PCP and specialists (24 hours per day, 7 days per week)
- Post Discharge Follow Up - within 7 days
- Office Wait Times - not to exceed 1 hour

CONTINUITY OF CARE COORDINATION
When Members are newly enrolled and have been previously receiving Behavioral Health Services, Cenpatico will make best efforts to maximize the transition of members care through providing for the transfer of pending prior authorization information; and work with the Member’s Cenpatico Provider to honor those existing prior authorizations.

COORDINATION AND COMMUNICATION BETWEEN BEHAVIORAL HEALTH PROVIDERS AND PCP
IlliniCare Health encourages PCPs to consult with their Members’ mental health and substance use treatment Practitioners. In many cases the PCP has extensive knowledge about the Member’s medical condition, mental status, psychosocial functioning, and family situation. Communication of this information at the point of referral or during the course of treatment is encouraged with Member consent, when required. We encourage all service providers to coordinate care with a member’s entire treatment team, including but not limited to PCPs and mental health and/or substance use treatment Practitioners. Additionally, IlliniCare Health and Cenpatico will offer trainings to PCPs and mental health and/or substance use treatment Practitioners focused on the concepts of integrated care, cross training in medical, behavioral and substance use disorders, and screening tools.

Network Practitioners should communicate and coordinate with the Member’s PCP and with any other behavioral health service providers whenever there is a behavioral health problem or treatment plan that can affect the Member’s medical condition or the treatment being rendered to the Member. Examples of some of the items to be communicated include:
- Prescription medication.
- Results of health risk screenings.
- The Member is known to abuse over-the-counter, prescription or illegal substances in a manner that can adversely affect medical or behavioral health treatment.
- The Member is receiving treatment for a behavioral health diagnosis that can be misdiagnosed as a physical disorder (such as panic disorder being confused with mitral valve prolapse).
- The Member’s progress toward meeting the goals established in their treatment plan.
Prior Authorization Requirements:

BEHAVIORAL HEALTH SERVICES INCLUDES SUBSTANCE USE DISORDER

- Inpatient Psychiatric
- Partial Hospitalization
- Intensive Outpatient Therapy
- Psychological Testing
- Neuropsychological Testing
- Electroconvulsive Therapy (ECT)
- Substance Use Disorder Treatment/Rehabilitation

Please see the benefits grid online at www.cenpatico.com for the most up-to-date authorization requirements and a comprehensive list of covered benefits.

COMMUNITY SUPPORT SERVICES:

BEHAVIORAL HEALTH

- Psychological Testing.
- Community Support: Prior Authorization required after 200 units.
- Case Management: Prior Authorization required after 200 units.
- Psychological Rehabilitation: Prior Authorization required after 800 units.

Please see the benefits grid online at www.cenpatico.com for the most up-to-date authorization requirements and a comprehensive list of covered benefits.

DIVISION OF ALCOHOL AND SUBSTANCE ABUSE SERVICES- DASA

- Detoxification
- Residential Rehabilitation
- Day Treatment

** Authorization is not required for outpatient therapy services.

Cenpatico requires that Network Practitioners report specific clinical information to the Member’s PCP in order to preserve the continuity of the treatment process. With appropriate written consent from the Member, it is the Network Practitioner’s responsibility to keep the member’s PCP abreast of the Member’s treatment status and progress in a consistent and reliable manner.

The following information should be included in the report to the PCP:

- A copy or summary of the intake assessment;
- Written notification of Member’s noncompliance with treatment plan (if applicable);
- Member’s completion of treatment;
- The results of an initial psychiatric evaluation, and initiation of and major changes in psychotropic medication(s) within fourteen (14) days of the visit or medication order; and
- The results of functional assessments.

A form to be used in communicating with the PCP and other behavioral health providers is located on our website at www.IlliniCare.com and www.cenpatico.com. Network Providers can identify the name and contact information for a Member’s PCP by performing an eligibility inquiry on the IlliniCare Health Provider Secured Portal or by contacting Provider Services. Network practitioners should screen for the existence of Co-Occurring mental health and substance use conditions and make appropriate referrals. Practitioners should refer Members with known or suspected untreated physical health problems or disorders to the PCP for examination and treatment. Cenpatico will also offer provider training on screening tools that can be used to identify possible behavioral health and substance use disorders. Resources and training will include referral processes for providers to assist members in accessing supports through Cenpatico.

Cenpatico will work with Members to ensure the development and implementation of a treatment plan that addresses both medical and behavioral health issues. Cenpatico will also offer provider training on screening tools that can be used to identify possible behavioral health and substance use disorders. Resources and training will include referral processes for providers to assist members in accessing supports through Cenpatico.

Cenpatico requires that Network Practitioners report specific clinical information to the Member’s PCP in order to preserve the continuity of the treatment process. With appropriate written consent from the Member, it is the Network Practitioner’s responsibility to keep the member’s PCP abreast of the Member’s treatment status and progress in a consistent and reliable manner.

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- Member’s completion of treatment;
- The results of an initial psychiatric evaluation, and initiation of and major changes in psychotropic medication(s) within fourteen (14) days of the visit or medication order; and
- The results of functional assessments.

Please see the benefits grid online at www.cenpatico.com for the most up-to-date authorization requirements and a comprehensive list of covered benefits.

DIVISION OF ALCOHOL AND SUBSTANCE ABUSE SERVICES- DASA

- Detoxification
- Residential Rehabilitation
- Day Treatment

** Authorization is not required for outpatient therapy services.
The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service is Medicaid’s comprehensive and preventive child health program for individuals under the age of 21, provision of which is mandated by state and federal law. EPSDT services include periodic screening, vision, dental and hearing services.

IlliniCare Health provides coverage for the full range of EPSDT services as defined in, and in accordance with, HFS policies and procedures for EPSDT services. Such services shall include, without limitation, periodic health screenings and appropriate up to date immunization using the Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule and the American Academy of Pediatrics periodicity schedule for pediatric preventative care. The following minimum elements are to be included in the periodic health screening assessment:

- Comprehensive health and development history (including assessment of both physical and mental development)
- Comprehensive unclothed physical examination
- Immunizations appropriate to age and health history
- Assessment of nutritional status
- Laboratory tests (including finger stick hematocrit, urinalysis (dip-stick)
- Sickle cell screen, TB skin testing and RPR serology if not previously performed); Blood lead levels must be tested pursuant to the EPSDT provider manual
- Developmental assessment
- Vision screening and services, including at a minimum, diagnosis and treatment for defects in vision, including eyeglasses
- Dental screening and services, including at a minimum, relief of pain and infections, restoration of teeth and maintenance of dental health. Although an oral screening may be part of a physician examination, it does not substitute for examination through direct referral to a dentist
- Hearing screening and services, including at a minimum, diagnosis and treatment for defects in hearing, including hearing aids
- Health education and anticipatory guidance

Provision of all components of the EPSDT service must be clearly documented in the PCP’s medical record for each Member.

IlliniCare Health requires that providers cooperate to the maximum extent possible with efforts to improve the health status of Illinois citizens, and to actively participate in the increase of percentage of eligible members obtaining EPSDT services in accordance with the adopted periodicity schedules. IlliniCare Health will cooperate and assist providers to identify and immunize all Members whose medical records do not indicate up-to-date immunizations.

Provider shall participate in the Vaccines for Children (VFC) program. Vaccines from VFC should be billed with the specific antigen codes for administrative reimbursement. No payment will be made on the administration codes alone.
Value Added Services

24/7 NURSE ADVICE LINE
Our members have many questions about their health, their primary care provider, and/or access to emergency care. Our health plan offers a nurse line service to encourage members to talk with their physician and to promote education and preventive care.

NurseWise provides 24-hour, seven days per week nurse advice line for IlliniCare Health members. Registered nurses provide basic health education, nurse triage, and answer questions about urgent or emergency access. The staff often answers basic health questions, but is also available to triage more complex health issues using nationally-recognized protocols. Members with chronic problems, like asthma or diabetes, are referred to case management for education and encouragement to improve their health.

Members may use the nurse advice line to request information about providers and services available in your community after hours, when the IlliniCare Health Member Services department is closed. The nurse advice line staff is available in both English and Spanish and can provide additional translation services if necessary.

We provide this service to support your practice and offer our members access to a registered nurse on a daily basis. If you have any additional questions, please call Provider Services or our nurse advice line.

CENTACCOUNT® PROGRAM
The goal of the CentAccount program is to increase appropriate utilization of preventive services by rewarding ICP and FHP members for practicing a targeted healthy behavior. The program will strengthen the relationship with the medical home as members regularly access preventive services, and will promote personal responsibility for and ownership of the member’s own healthcare.

CentAccount benefits ICP and FHP members because it provides them with credits to purchase healthcare items, such as over-the-counter medications that they might otherwise not be able to afford. Services that may qualify for rewards through the program include completion of an initial health risk screening, primary care medical home visits within 90 days of enrollment, annual adult well visits, certain disease-specific screenings, and completion of prenatal and postpartum care.

How does it work? FHP and ICP members will receive a prepaid MasterCard® debit card. Credit will be added to the account balance once the member receives certain screenings or preventive care. Members may use the cards to purchase approved healthcare goods and services online or at any retailer that accepts MasterCard debit cards. CentAccount goods and services are those recognized by the Internal Revenue Service as healthcare expenses for flexible spending accounts.

The CentAccount program is available to ICP and FHP members only, not MMAI or MLTSS.

TRANSPORTATION
Members can schedule transportation to and from a medical visit. Members should call us at least two (2) business days in advance. Call Member Services and ask for a transportation specialist, and they will arrange appropriate transportation.
MEMBERCONNECTIONS® PROGRAM
MemberConnections is IlliniCare Health’s outreach program designed to provide education to our members on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable. The program components are integrated as a part of our case management program in order to link IlliniCare Health and the community served. The program recruits staff from the communities serviced to establish a grassroots support and awareness of IlliniCare Health within the community. The program has various components that can be provided depending on the need of the member.

MemberConnections Representatives (MCRs) are health outreach employees hired from within the communities we serve to ensure that our outreach is culturally competent and conducted by people who know the unique characteristics and needs of the local area. MCRs are an integral part of our Integrated Care Team which benefits our Enrollees and increases our effectiveness. MCRs will make home visits to Enrollees we cannot reach by phone. They assist with Enrollee outreach, conduct member home visits, coordinate with social services, and attend community functions to provide health education and outreach. MCRs will work with Providers to organize Healthy Lifestyles events and work with other local organizations for health events. Providers may request MemberConnections assistance by contacting the IlliniCare Health Medical Management Department.

CONNECTIONS PLUS®
Connections Plus is a program where MemberConnections Representatives work together with the integrated care team to provide phones to high risk members who do not have safe, reliable phone access. When a member qualifies because he/she has been deemed to be a high risk member by our case management department, a MemberConnections Representative visits the member’s home and gives them a free, pre-programmed cell phone with limited use. Members may use this cell phone to call the health plan case manager, PCP, specialty physician, NurseWise, 911, or other members of their healthcare team. In some cases, the plan may provide MP-3 players with pre-programmed education programs for those with literacy issues or in need of additional education.

To refer a member call:
IlliniCare Health Member Connections
ICP & FHP: 1-866-329-4701
MMAI: 1-877-941-0482
MLTSS: 1-844-316-7562

DISEASE MANAGEMENT PROGRAMS
As a part of IlliniCare Health’s services, disease management programs are offered to members. Components of the programs available include:

- Increasing coordination between medical, social and educational communities
- Severity and risk assessments of the population
- Profiling the population and providers for appropriate referrals to providers
- Ensuring active and coordinated physician/specialist participation
- Identifying modes of delivery for coordination care services such as home visits, clinic visits, and phone contacts depending on the circumstances and needs of the member and his/her family
- Increasing the member’s and member’s caregiver ability to self-manage chronic conditions; and coordination with a IlliniCare Health care coordinator for case management services

The disease management programs target members with selected chronic diseases which may not be under control. The new members are assessed and stratified in order to accurately assign them to the most appropriate level of intervention. Interventions may include mailed information for low intensity cases, telephone calls and mailings for moderate cases, or include home visits by a health coach for members categorized as high risk. In addition, IlliniCare Health provides telemonitoring services to the highest-risk members. These home wireless biometric monitoring devices will allow health coaches, care coordinators and treating Providers to monitor key health indicators and provide opportunities for real-time, “teachable moment” interventions.

IlliniCare Health’s affiliated disease management company, Nurtur, will administer disease management programs which include services for chronic diseases such as asthma, diabetes, hypertension, heart failure and obesity. Our specialty pharmacy, Caremark offers disease management services for IlliniCare Health members with hemophilia.

To refer a Member for disease management call:

IlliniCare Health
Health Coach
ICP & FHP: 1-866-329-4701
MMAI: 1-877-941-0482
MLTSS: 1-844-316-7562
IlliniCare Health’s care coordination model consists of an integrated team of registered nurses, licensed mental health professionals, social workers and non-clinical staff. The model is designed to help your IlliniCare Health members obtain needed services and assist them in coordination of their healthcare needs whether they are covered within the IlliniCare Health array of covered services, from the community, or from other non-covered venues. Our model will support our provider network whether you work in an individual practice, large multi-specialty group setting, long term care facility, supportive living facility or a home and community-based service provider.

The program is based upon a coordinated care model that uses a multi-disciplinary care coordination team in recognition that multiple co-morbidities will be common among our membership. The goal of our program is to collaborate with the member and the member’s PCP to achieve the highest possible levels of wellness, functioning, and quality of life.

The program includes a systematic approach for early identification of members, completion of their needs assessment tools, and development and implementation of an individualized care plan that includes member/family education and actively links the member to providers and support services as well as outcome monitoring and reporting back to the PCP. The PCP is included in the creation of the care plan as appropriate to assure that the plan incorporates considerations related to the medical treatment plan and other observations made by the provider. The care plan is made available to the provider in writing or verbally. Our care coordination team will integrate covered and non-covered services and provide a holistic approach to a member’s medical and behavioral healthcare, as well as function, social and other needs. Our program incorporates clinical determinations of need, functional status, and barriers to care such as lack of caregiver supports, impaired cognitive abilities and transportation needs.

A care coordination team is available to help all providers improve the health of IlliniCare Health members. Listed below are programs and components of special services that are available and can be accessed through the care coordination team. We look forward to hearing from you about any IlliniCare Health members that you think can benefit from the addition of an IlliniCare Health care coordination team member.

To contact a care coordinator call:

**IlliniCare Health**

**Care Coordination Department**

ICP & FHP: 1-866-329-4701

MMAI: 1-877-941-0482

MLTSS: 1-844-316-7562

**HIGH RISK PREGNANCY PROGRAM**

IlliniCare Health will place high risk pregnancy members in our Start Smart for Your Baby (Start Smart) program which incorporates case management, care coordination, and disease management with the aim of decreasing preterm delivery and improving the health of moms and their babies. Start Smart is a unique prenatal program with a goal of improving maternal and child health outcomes by providing pregnancy and parenting education to all pregnant members and providing case management to high and moderate risk members through the postpartum period. A care coordinator will work with members at high risk of early delivery or who experience complications from pregnancy. The care coordinators have physicians advising them on overcoming obstacles, helping identify high risk members, and recommending interventions. These physicians will provide input to IlliniCare Health’s Medical Director on obstetrical care standards and use of newer preventive treatments such as 17 alpha-hydroxyprogesterone caproate (17-P).

IlliniCare Health offers a premature delivery prevention program by supporting the use of 17-P. When a physician determines that a member is a candidate for 17-P, which use has shown a substantial reduction in the rate of preterm delivery, he/she will write a prescription for 17-P. This prescription is sent to the IlliniCare Health care coordinator who will check for eligibility. The care coordinator will coordinate the ordering and delivery of the 17-P directly to the physician’s office. The care coordinator will contact the member and complete an assessment regarding compliance. The nurse will remain in contact with the member and the prescribing physician during the entire treatment period. Contact the IlliniCare Health medical management at with any questions regarding this program.

**THE INTEGRATED CARE TEAMS**

Care Coordinators are familiar with evidence-based resources and best practice standards specific to conditions common among IlliniCare Health
members. These teams will be led by clinical licensed care coordinators with experience working with people with physical and/or mental health conditions. In addition, a team will be specifically dedicated to assisting members with developmental disabilities. The teams will have experience with the member population, the barriers and obstacles they face, and socioeconomic impacts on their ability to access services. IlliniCare Health will use a holistic approach by integrating referral and access to community resources, transportation, follow-up care, medication review, specialty care, and education to assist members in making better healthcare choices.

CARE PLANS
The following members can have a care plan developed and implemented:

- ICP and FHP: Members in high and moderate acuity
- MMP: All Members
- HCBS Waivers and LTC: All Members
- MLTSS: All Members

This care plan will be developed in conjunction with the member, his or her family and caregiver, as well as other individuals part of the member’s care team. The member will agree to the developed care plan, and the care plan will be signed off by a physician before implementation.

For members receiving waiver services, the care plan will include services such as home health, home delivered meals, personal emergency response systems, adult day service, home modification, adaptive equipment, etc.

Based on that member’s care plan, IlliniCare Health care coordinators will work directly with home and community-based services providers in order to execute the care plan. This includes securing the service with the provider and authorizing the number of hours/units approved. The care coordinator will give an authorization number to the provider. The provider is then able to render the service that has been authorized.

IlliniCare Health’s care coordination team will guide members through the process of obtaining covered services. Each member is assigned to a care coordinator. Care coordinators responsibilities include:

- Help members to obtain services
- Visit members in their residence to assess health status, needs, and develop a care plan
- Communicate with providers on services that are authorized according to the care plan
- Discharge planning
- Support quality of life for members

Please contact the care coordination department for changes in a member’s status, questions regarding services, or other member issues.

TRANSITION OF CARE COORDINATION FUNCTIONS
Once the appropriate state agency determines eligibility, IlliniCare Health will be responsible for all care coordination for IlliniCare Health members including those members part of the home and community-based waiver services and residing in long term care facilities or supportive living facilities. IlliniCare Health has processes and procedures in place to ensure smooth transitions to and from IlliniCare Health’s care coordination to other plans/agencies such as another Managed Care Organization, the Department on Aging, the Department of Rehabilitative Services and the Department of Healthcare and Family Services. During transitions between entities, IlliniCare Health will assure 180 days of continuity of services and will not adjust services without the member’s consent during that time frame.

TRANSPLANTS
A Transplant Coordinator will provide support and coordination for members who need organ transplants. All members considered as potential transplant candidates should be immediately referred to the IlliniCare Health medical management department for assessment and case management services. Each candidate is evaluated for coverage requirements and will be referred to the appropriate agencies and transplant centers.
BILLING FORMS
Submit claims for professional services and durable medical equipment on a CMS 1500.
Submit claims for hospital based inpatient and outpatient services as well as swing bed services on a UB 04 form.

For detailed requirements for either the CMS 1500 or the UB 04 form, see the Provider Billing Manual.

THIRD PARTY LIABILITY
Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance, and worker’s compensation) or program that is or may be liable to pay all or part of the healthcare expenses of the member.

IlliniCare Health, like all Medicaid programs, is always the payer of last resort. IlliniCare Health providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to IlliniCare Health members. If the provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third party resources, the provider shall inform IlliniCare Health that efforts have been unsuccessful. IlliniCare Health will make every effort to work with the provider to determine liability coverage.

If third party liability coverage is determined after services are rendered, IlliniCare Health will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

BILLING GUIDELINES FOR ATYPICAL PROVIDERS
Through IlliniCare Health’s waiver services program, a variety of atypical providers contract directly with IlliniCare Health for payment of covered services. Atypical providers include adult day service, home/car adaptations, home health agencies, habilitation, homemaker services, home delivered meals, personal emergency response systems, respite, specialized medical equipment and supplies and supportive living facilities (SLFs).

It is important that providers ensure IlliniCare Health has accurate billing information on file. Please confirm with our Provider Relations department that
the following information is current in our files:

- Provider name (as noted on current W-9 form)
- Tax Identification Number (TIN)
- Taxonomy code
- Physical location address (as noted on current W-9 form)
- Billing name and address

Claims missing the required data will be returned, and a notice sent to the provider, creating payment delays. Such claims are not considered “clean” and therefore cannot be accepted into our system.

We recommend that providers notify IlliniCare Health 30 days in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a Provider’s TIN and/or address are NOT acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service
- The service provided is a covered benefit under the member’s contract on the date of service, and
- Prior authorization processes were followed

Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in this manual and the Billing Manual.

PROGRAM PAYMENTS

In the event IlliniCare Health does not receive full program premium payments from HFS for two or more consecutive periods, IlliniCare Health’s obligation to make timely payments to you is suspended until such time as HFS makes payment in full to IlliniCare Health under the program contracts. Your obligations to submit claims and/or encounters for the services you render shall not be postponed or otherwise modified. This program payment suspension provision supersedes any conflicting communication from IlliniCare Health or any provision in the Provider Manual or your provider contract with IlliniCare Health. IlliniCare Health shall post notice of suspensions of program payments on its website or provide you with written notice.

TIMELY FILING

To be eligible for reimbursement, providers must file claims within a qualifying time limit. A claim will be considered for payment only if it is received by IlliniCare Health no later than 180 days from the date on which services or items are provided. This time limit applies to both initial and resubmitted claims. Rebilled claims, as well as initial claims, received more than 180 days from the date of service will not be paid. Any claim disputes/reconsiderations must be received within 180 days of the DOS or date of discharge, whichever is later.

When IlliniCare Health is the secondary payer, claims must be received within 90 calendar days of the final determination of the primary payer.

CLAIMS FOR WAIVER SERVICES AND SUPPORTIVE LIVING FACILITIES

Atypical providers and supportive living facilities will be required to submit claims to IlliniCare Health on a CMS 1500 form. This can be done through our secure provider portal or via submission of paper claims. Billing guides and instructions for our online secure provider portal are available on our website at www.IlliniCare.com.

Basic Guidelines for Completing the CMS-1500 Claim Form:

- Use one claim form for each recipient.
- Enter on procedure code and date of service per claim line.
- Enter information with a typewriter or a computer using black type.
- Enter information within the allotted spaces.
- Make sure whiteout is not used on the claim form.
- Complete the form using the specific procedure or billing code for the service.
- Use the same claim form for all services provided for the same recipient, same provider, and same date of service.
- If dates of service encompass more than one month, a separate billing form must be used for each month.

CLAIMS FOR LONG TERM CARE FACILITIES

Long Term Care facilities are required to bill on a UB-04 claim form. Both short term acute stays and custodial care are covered benefits. When submitting claims for short term sub-acute stays, facilities must ensure they are utilizing the appropriate revenue codes reflecting the short term stay.

PATIENT CREDIT FILE

In order for Long Term Care facility claims to be
processed, the member the facility is billing must be on the Patient Credit File. This file is provided by the Department of Healthcare and Family Services and shows the amount the member needs to pay for residing in the facility. In certain instances, there can be a delay in the member appearing on the Patient Credit File. As a result, some LTC facility claims may be denied. A specific code, call an Explanation Code or an EX code will display on the denied claim that reads “DENY:Mbr not currently on PT Credit File – will reconsider on file.”

IlliniCare Health has put a process in place to ease the administrative burden of long term care facilities in these instances. Each month when the Patient Credit File is received, IlliniCare Health will check each member on the file against any previously denied claims. If there are claims that have been denied as a result of the member not appearing on the Patient Credit File, and all other necessary information is included in the claim, IlliniCare Health will process and pay the previously denied claim.

**ELECTRONIC CLAIMS SUBMISSION**

Network providers are encouraged to participate in IlliniCare Health’s electronic claims/encounter filing program. IlliniCare Health can receive ANSI X12N 837 professional, institution or encounter transactions. In addition, it can generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP). Providers that bill electronically have the same timely filing requirements as providers filing paper claims. In addition, providers that bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

IlliniCare Health’s Payor ID is 68066. Our Clearinghouse vendors include Emdeon, Envoy, WebMD, and Gateway EDI. Please visit our website for our electronic Companion Guide and our Billing Manual which offers more detailed information regarding claims billing instructions. For questions or more information on electronic filing please contact:

**IlliniCare Health**  
co Centene EDI Department  
1-800-225-2573, extension 6075525  
by e-mail at: EDIBA@centene.com

**PAPER CLAIMS SUBMISSION**

For IlliniCare Health members, all claims and encounters should be submitted to:

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**IlliniCare Health**  
**ATTN: CLAIMS DEPARTMENT**  
P.O. Box 4020  
Farmington, MO 63640-4402

**REQUIREMENTS**

IlliniCare Health uses an imaging process for paper claims retrieval. To ensure accurate and timely claims capture, please observe the following claims submission rules:

**Do’s**

- Do use the correct P.O. Box number
- Do submit all claims in a 9” x 12” or larger envelope
- Do type all fields completely and correctly
- Do use typed black or blue ink only at 9-point font or larger
- Do include all other insurance information (policy holder, carrier name, ID number and address) when applicable
- Do attach the EOP from the primary insurance carrier when applicable

**Note:** IlliniCare Health is able to receive primary insurance carrier EOP [electronically]

- Do submit on a proper original form - CMS 1500 or UB 04

**Don’ts**

- Don’t submit handwritten claim forms
- Don’t use red ink on claim forms
- Don’t circle any data on claim forms
- Don’t add extraneous information to any claim form field
- Don’t use highlighter on any claim form field
- Don’t submit photocopied claim forms (no black and white claim forms)
- Don’t submit carbon copied claim forms
- Don’t submit claim forms via fax

**CLEAN CLAIM DEFINITION**

A clean claim means a claim received by IlliniCare Health for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by IlliniCare Health.
NON-CLEAN CLAIM DEFINITION
Non-clean claims are submitted claims that require further documentation or development beyond the information contained therein. The errors or omissions in claims result in the request for additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

COMMON CAUSES OF UPFRONT REJECTIONS
- Unreadable Information
- Missing Member Date of Birth
- Missing Member Name or Identification Number
- Missing Provider Name, Tax ID, or NPI Number
- The Date of Service on the Claim is Not Prior to Receipt Date of the Claim
- Dates Are Missing from Required Fields
- Invalid of Missing Type of Bill
- Missing, Invalid or Incomplete Diagnosis Code
- Missing Service Line Detail
- Member Not Effective on The Date of Service
- Admission Type is Missing
- Missing Patient Status
- Missing or Invalid Occurrence Code or Date
- Missing or Invalid Revenue Code
- Missing or Invalid CPT/Procedure Code
- Incorrect Form Type

IlliniCare Health will send providers a detailed letter for each claim that is rejected explaining the reason for the rejection.

COMMON CAUSES OF CLAIM PROCESSING DELAYS AND DENIALS
- Incorrect Form Type
- Diagnosis Code Missing 4th, 5th, and 6th character requirements and 7th character extension requirements.
- Missing or Invalid Procedure or Modifier Codes
- Missing or Invalid DRG Code
- Explanation of Benefits from the Primary Carrier is Missing or Incomplete
- Invalid Member ID
- Invalid Place of Service Code
- Provider TIN and NPI Do Not Match
- Invalid Revenue Code
- Dates of Service Span Do Not Match Listed Days/Units
- Missing Physician Signature
- Invalid TIN
- Missing or Incomplete Third Party Liability Information

IlliniCare Health will send providers written notification via the EOP for each claim that is denied, which will include the reason(s) for the denial.

For more detailed information on common billing errors refer to the provider billing manual.

ELECTRONIC FUNDS TRANSFERS (EFT) AND ELECTRONIC REMITTANCE ADVICES (ERA)
IlliniCare Health provides Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) to its participating providers to help them reduce costs, speed secondary billings, and improve cash flow by enabling online access of remittance information, and straightforward reconciliation of payments. As a Provider, you can gain the following benefits from using EFT and ERA:
- Reduce accounting expenses – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying
- Improve cash flow – Electronic payments mean faster payments, leading to improvements in cash flow
- Maintain control over bank accounts – You keep TOTAL control over the destination of claim payment funds and multiple practices and accounts are supported
- Match payments to advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily

For more information on our EFT and ERA services, please contact Provider Services.

CLAIM PAYMENT
Clean claims will be adjudicated (finalized as paid or denied) at the following levels:
- 90% within 30 business days of the receipt
- 99% within 90 business days of the receipt
CLAIM REQUESTS FOR RECONSIDERATION, CLAIM DISPUTES, AND CORRECTED CLAIMS

If a provider has a question or is not satisfied with the information they have received related to a claim, there are four (4) effective ways in which the provider can contact IlliniCare Health.

1. Contact an IlliniCare Health Provider Services Representative. Providers may discuss questions with IlliniCare Health Provider Services Representatives regarding amount reimbursed or denial of a particular service.

2. Submit an Adjusted or Corrected Claim to IlliniCare Health, Attn: Corrected Claim, PO Box 4020, Farmington MO 63640-4402. The claim must clearly be marked as “RE-SUBMISSION” and must include the original claim number or the original EOP must be included with the resubmission. Failure to mark the claim as a resubmission and include the original claim number (or include the EOP) may result in the claim being denied as a duplicate, a delay in the reprocessing, or denial for exceeding the timely filing limit.

3. Submit a "Request for Reconsideration" to IlliniCare Health, Attn: Reconsideration, PO Box 4020, Farmington MO 63640-4402. A request for reconsideration is a written communication from the provider about a disagreement in the way a claim was processed but does not require a claim to be corrected and does not require medical review. The request must include sufficient identifying information which includes, at minimum, the patient name, patient ID number, date of service, total charges and provider name. The documentation must also include a detailed description of the reason for the request.

4. Submit a "Claim Dispute Form" to IlliniCare Health, Attn: Dispute, PO Box 3000, Farmington MO 63640-3800. A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration. The Claim Dispute Form can be found in the provider section of our website at www.IlliniCare.com.

If the claim dispute results in an adjusted claim, the provider will receive a revised EOP. If the original decision is upheld, the provider will receive a revised EOP or a letter detailing the decision and steps for escalated reconsideration.

IlliniCare Health shall process, and finalize all adjusted claims, requests for reconsideration and disputed claims to a paid or denied status 45 business days of receipt of the corrected claim, request for reconsideration or claim dispute.

OVERPAYMENT RECOVERY PROCEDURES

An overpayment may occur due to, but not limited to, the following reasons:

- Duplicate payment by IlliniCare Health,
- Payment to incorrect provider or incorrect member, or
- Overlapping payment by IlliniCare Health and a third party resource (TPR).

The provider has the option of refunding the overpayment by issuing a check to IlliniCare Health or by requesting a recoupment by contacting their Provider Relations Representative. The refund check should be accompanied with documentation regarding the overpayment, including:

- Refunding provider’s name and provider identifier;
- Member name and ID;
- Date of service; and
- A copy of the Explanation of Payment (EOP) showing the claim to which the refund is being applied.

Failure to refund an overpayment may result in an offset against future claim payments until the amount of overpayment has been fully recovered.

To submit a refund check, please mail the check and supporting documents to:

IlliniCare Health
75 Remittance Drive
Department 6903
Chicago, IL 60675-6903
Encounters

**WHAT IS AN ENCOUNTER VERSUS A CLAIM?**

An encounter is a claim which is paid at zero dollars as a result of the provider being pre-paid or capitated for the services he/she provided our members. For example; if you are the PCP for an IlliniCare Health member and receive a monthly capitation amount for services, you must file an encounter (also referred to as an “proxy claim”) on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the encounter or “proxy claim” is paid at zero dollar amounts. It is mandatory that your office submits encounter data. IlliniCare Health utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by HFS and by the Centers for Medicare and Medicaid Services (CMS). Encounters do not generate an EOP.

A claim is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial. For each claim processed, an EOP will be mailed to the provider who submitted the original claim. Claims will generate an EOP.

You are required to submit either an encounter or a claim for each service that you render to an IlliniCare Health member.

**PROCEDURES FOR FILING A CLAIM/ENCOUNTER DATA**

IlliniCare Health encourages all providers to file claims/encounters electronically. See the Electronic Claims Submission section and the Billing Manual for more information on how to initiate electronic claims/encounters.

**BILLING THE MEMBER**

IlliniCare Health reimburses only services that are medically necessary and covered through the IlliniCare Health program. Providers are not allowed to “balance bill” for covered services.

Providers may bill members for services NOT covered by either Medicaid or IlliniCare Health or for applicable copayments, deductibles or coinsurance as defined by the State of Illinois.

In order for a provider to bill a member for services not covered under the IlliniCare Health program, or if the service limitations have been exceeded, the provider must obtain a written acknowledgment in advance of services being rendered from the member using the following language:

> I understand that, in the opinion of (provider’s name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Integrated Care Program as being reasonable and medically necessary for my care. I understand that IlliniCare Health through its contract with the Illinois Department of Healthcare and Family Services determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

For more detailed information on IlliniCare Health billing requirements, please refer to the Billing Manual available on the website www.IlliniCare.com.
The credentialing and re-credentialing process exists to ensure that participating providers meet the criteria established by IlliniCare Health, as well as government regulations and standards of accrediting bodies. All providers who participate in the Integrated Care Program, Family Health Plan or MMAI must also be a Medicaid provider in good standing.

Note: In order to maintain a current provider profile, providers are required to notify IlliniCare Health of any relevant changes to their credentialing information in a timely manner.

Providers must submit at a minimum the following information when applying for participation with IlliniCare Health:

- Complete signed and dated Illinois Standardized Credentialing application or authorize IlliniCare Health access to the CAQH (Council for Affordable Quality Health Care) for the Illinois Standardized Credentialing application.
- Signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance registration and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation.
- Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider’s name, or evidence of compliance with Illinois regulations regarding malpractice coverage.
- Copy of current Illinois Controlled Substance registration certificate, if applicable.
- Copy of current Drug Enforcement Administration (DEA) registration Certificate.
- Copy or original of completed Internal Revenue Service Form W-9.
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable.
- Copy of current unrestricted medical license to practice in the state of Illinois.
- Current copy of specialty/board certification certificate, if applicable.
- Curriculum vitae listing, at minimum, a five (5) year work history (not required if work history is completed on the application).
- Signed and dated release of information form not older than 120 calendar days.
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training.
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable.

IlliniCare Health will verify the following information submitted for credentialing and/or re-credentialing:

- Illinois license through appropriate licensing agency.
- Board certification, or residency training, or medical education.
- National Practitioner Data Bank-Health Integrity Practitioner Data Bank (NPDB-HIPDB) for malpractice claims and license agency actions.
- Hospital privileges in good standing at a participating IlliniCare Health hospital.
- Review five year work history.

Once the application is completed, the IlliniCare Health Credentialing Committee will render a final decision on acceptance following its next regularly scheduled meeting.

Providers must be credentialed prior to accepting or treating members. PCPs cannot accept member assignments until they are fully credentialed.

**CREDENTIALING COMMITTEE**

The Credentialing Committee has the responsibility to establish and adopt as necessary, criteria for provider participation, termination, and direction of the credentialing procedures, including provider participation, denial, and termination.

Committee meetings are held at least quarterly and more often as deemed necessary.

**NOTE:** Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.
Site visits may be performed at practitioner offices within 60 calendar days of any member complaints related to physical accessibility, physical appearance, and adequacy of waiting and examining room space. If the practitioner’s site visit score is less than eighty percent (80%), the practitioner may be subject to termination and/or continued review until compliance is achieved. A site review evaluates appearance, accessibility, record-keeping practices and safety procedures.

**RE-CREDENTIALING**

To comply with accreditation standards, IlliniCare Health conducts the re-credentialing process for providers at least every three years, in compliance with the Illinois Register Department of Public Health, Section 965.300 Single Credentialing Cycle. The purpose of this process is to identify any changes in the practitioner’s licensure, sanctions, certification, competence, or health status which may affect the ability to perform services the provider is under contract to provide. This process includes all practitioners, primary care providers, specialists, and ancillary providers/facilities previously credentialed to practice within the IlliniCare Health network.

In between credentialing cycles, IlliniCare Health conducts ongoing sanction monitoring activities on all network providers. This includes an inquiry to the appropriate Illinois state licensing agency, board, or commission for a review of newly-disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry insures that providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, IlliniCare Health reviews monthly reports released by the Office of Inspector General to review for any network providers who have been newly sanctioned or excluded from participation in Medicare and/or Medicaid programs.

Additionally, between credentialing cycles, a provider may be requested to supply current proof of any credentials such as Illinois licensure, malpractice insurance, DEA registration, a copy of certificate of cultural competency training, etc. that have expiration dates prior to the next review process.

A provider’s agreement may be terminated if at any time it is determined by the IlliniCare Health’s Board of Directors (Board of Directors) or the Credentialing Committee that credentialing requirements are no longer being met.

**RIGHT TO REVIEW AND CORRECT INFORMATION**

All providers participating within the IlliniCare Health network have the right to review information obtained by IlliniCare Health to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and the State Licensing Agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected.

Should a provider believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, they have the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to the IlliniCare Health credentialing department. Upon receipt of this information, the provider will have 14 calendar days to provide a written explanation detailing the error or the difference in information to the IlliniCare Health. The IlliniCare Health Credentialing Committee will then include this information as part of the credentialing/re-credentialing process.

**RIGHT TO BE INFORMED OF APPLICATION STATUS**

All providers who have submitted an application to join IlliniCare Health have the right to be informed of the status of their application upon request. To obtain status, contact the IlliniCare Health Provider Relations department.

**RIGHT TO APPEAL ADVERSE CREDENTIALING DETERMINATIONS**

Existing provider applicants who are declined for continued participation for reasons such as quality of care or liability claims issues have the right to appeal the decision in writing within 14 calendar days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant’s reconsideration for participation in the IlliniCare Health network. Appeals will be reviewed by the Credentialing Committee at the next regularly scheduled meeting, but in no case later than 60 calendar days from the receipt of the additional documentation. The applicant will be sent a written response to his/her request within two weeks of the final decision.
Disclosure of Ownership and Control Interest Statement

The Enrollment Disclosure Statement Form (HFS form 1513 - http://www2.illinois.gov/hfs/SiteCollectionDocuments/hfs1513.pdf) is required documentation and verification of your eligibility to provide services. In addition, the federal regulations set forth in 42 CFR 455.105 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency certain business transactions. Failure to submit the accurate, complete information requested in a timely manner may lead to the termination or denial of enrollment into the network as specified in 42 CFR 455.416.

42 CFR 455.105 states in relevant part:
“(a) Provider agreements. A Medicaid agency must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions in accordance with paragraph (b) of this section.

(b) Information that must be submitted. A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about—

1. The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and
2. Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

(c) Denial of Federal financial participation (FFP).
1. FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under paragraph (b) of this section or under § 420.205 of this chapter (Medicare requirements for disclosure).
2. FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the Medicaid agency and ending on the day before the date on which the information was supplied.”
MEMBER RIGHTS AND RESPONSIBILITIES

Members have the rights and responsibilities:

- To receive information about IlliniCare Health, its benefits, its services, its practitioners and providers and member rights and responsibilities
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand
- To be treated with respect and with due consideration for his/her dignity and the right to privacy and non-discrimination as required by law
- To access all covered services, including certified nurse midwife services and pediatric or family nurse practitioner services
- To participate with their providers and practitioners in making decisions regarding their healthcare, including the right to refuse treatment
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion
- To receive healthcare services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid Fee-For-Service (FFS) and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition
- To receive assistance from both Illinois Department of Healthcare and Family Services and IlliniCare Health in understanding the requirements and benefits of IlliniCare Health
- To receive family planning services from any participating Medicaid doctor without prior authorization
- To a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage
- To receive information on the Grievance, Appeal and Medicaid Fair Hearing procedures
- To voice grievances or file appeals about IlliniCare Health decisions that affect their privacy, benefits or the care provided
- To request and receive a copy of your medical record
- To make recommendations regarding IlliniCare Health’s member rights and responsibilities policy
- To request that your medical record be corrected
- To expect their medical records and care be kept confidential as required by law
- To receive IlliniCare Health’s policy on referrals for specialty care and other benefits not provided by the member’s PCP
- To privacy of healthcare needs and information as required by federal law (Standards for Privacy of Individually Identifiable Health Information)
- To exercise his or her rights, and that the exercise of these rights does not adversely affect the way IlliniCare Health and its providers treat the members
- To allow or refuse their personal information be sent to another party for other uses unless the release of information is required by law
- To choose a PCP and to change to another PCP in IlliniCare Health’s network
- To receive timely access to care, including referrals to specialists when medically necessary without barriers
- To file for a Medicaid Fair Hearing
- To receive materials – including enrollment notices, information materials, instructional materials, available treatment options and alternatives, etc. - in a manner and format that may be easily understood
- To make an advance directive, such as a living will
- To choose a person to represent them for the use of their information by IlliniCare Health if they are unable to
- To make suggestions about their rights and responsibilities
- To get a second opinion from a qualified healthcare professional
- To information about your rights and responsibilities, as well as the IlliniCare Health providers and services
- To receive oral interpretation services free of charge for all non-English languages
- To be notified that oral interpretation is available and how to access those services
- To receive services at an Indian Healthcare Provider if the member is an American Indian
- As a potential member, to receive information about the basic features of managed care; which populations may or may no enroll in the program and IlliniCare Health responsibilities for coordination of care in a timely manner in order to make an informed choice

- To inform IlliniCare Health of the loss or theft of their ID card

- To present their ID card when using healthcare services

- To be familiar with IlliniCare Health procedures to the best of their ability

- To call or contact IlliniCare Health to obtain information and have questions clarified

- To provide information (to the extent possible) that IlliniCare Health and its practitioners and providers need in order to provide care

- To follow the prescribed treatment (plans and instructions) for care that has been agreed upon with your practitioners/providers

- To inform your provider on reasons you cannot follow the prescribed treatment of care recommended by your provider

- To understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible

- To keep your medical appointments and follow-up appointments

- To access preventive care services

- To follow the policies and procedures of IlliniCare Health and the State Medicaid program

- To be honest with providers and treat them with respect and kindness

- To get regular medical care from their PCP before seeing a specialist

- To follow the steps of the appeal process

- To notify IlliniCare Health, Illinois and your providers of any changes that may affect your membership, healthcare needs or access to benefits. Some examples may include:
  - If you have a baby
  - If your address changes
  - If your telephone number changes
  - If you or one of your children are covered by another plan
  - If you have a special medical concern
  - If your family size changes

- To keep all your scheduled appointments; be on time for those appointments, and cancel twenty-four (24) hours in advance if you cannot keep an appointment

- If you access care without following IlliniCare Health rules, you may be responsible for the charges
Members that are part of the Disability, HIV/AIDS or Brain Injury waivers have specific rights and responsibilities, which include:

- Apply or reapply for waiver services
- Receive a timely decision on eligibility for waiver services based on a complete assessment of member’s disability
- Receive an explanation in writing, should they be determined ineligible for waiver services, telling the member why services were denied
- Receive an explanation about waiver services that the member may receive
- Partner with care coordinator in making informed choices for waiver services care plan
- Be assured of the complete confidentiality of case records
- Review rehabilitation case record with a staff member present
- Participate with care coordinator in any decision to close member’s case
- Appeal any decision which the member does not agree
- Be informed of the Client Assistance Program (CAP)
- Be provided with a form of communication appropriate to accommodate the member’s disability
- Fully participate in the waiver services care plan
- Set realistic goals and participate in writing waiver services care plan with care coordinator
- Follow through with member’s plan for rehabilitation
- Communicate with care coordinator and ask questions when member does not understand services
- Keep a copy of waiver services plan and any amendments related to the plan
- Notify care coordinator of any change in personal condition or work status
- Be aware of financial eligibility requirements for some services
- Keep original documents and send only copies to care coordinator’s office

Members that are part of the Aging waiver have specific rights and responsibilities, which include:

- To not be discriminated against because of race, color, national origin, religion, sex, ancestry, marital status, physical or mental disability, unfavorable military discharge or age.
- All information about the member and his or her case is confidential, and may be used only for purposes directly related to the administration of his or her aging waiver services as follows:
  - Finding and making needed services and resources available
  - Assuring the health and safety of the member
- Information about the member and his or her case cannot be used for any other purpose as indicated above, unless the member has given his or her consent to release that information.
- Freedom of choice of member’s providers for waiver services.
- The right to choose not to receive waiver services.
- The right to transfer from one provider to another provider.
- The right to request a provider to furnish more services than are allowed by the member’s care plan. The member will be required to pay 100% of the cost for any additional services not included in his or her care plan.
- The right to report instances to his or her provider’s supervisor or an IlliniCare Health care coordination when the member does not believe his or her personal care worker:
  - Is following the care plan
  - Does not come to the member’s home as scheduled
  - Is always late
- To not discriminate against the member’s personal care worker because of race, color, national origin, religion, sex, ancestry, marital status, physical or mental disability, unfavorable military discharge or age. To do so is a Federal offense.
- The member must report changes that affect him or her. This includes:
  - Change of address, even if temporary.
  - Change in number of family members.
  - Changes needed in waiver services.
- To notify the member’s IlliniCare Health care coordinator if the member is entering a hospital, nursing home or other institution for any reason. The member’s services will be temporarily suspended until he or she returns home.
- Notify the member’s care coordinator in advance of his or her return home.
- If the member is hospitalized or in a nursing home or other institution for more than 60 calendar days, the member’s services will be terminated.
If the member returns home after such termination and need services, he or she must contact the Illinois Department of Human Services to reapply.

Notify the member’s IlliniCare Health care coordinator if the member is away from his or her home, for any reason, for over 60 calendar days. Services cannot be provided if the member is not at home. If this is the case, services will be terminated.

Must notify the provider and the member’s IlliniCare Health care coordinator if the member intends to be absent from his or her home when scheduled services are to be provided. The member must notify the provider when you are leaving and when the member is expected to return. The provider will resume services upon the member’s return.

Must cooperate in the delivery of services. The member must:

- Notify the provider agency at least one day in advance if the member will be away from home on the day services are to be rendered.
- Allow the authorized worker into the home.
- Allow the worker to provide the services included in the care plan.
- Do not require the worker to do more or less than what is in the care plan.

If the member wants to change the care plan, he or she must contact an IlliniCare Health care coordinator. The worker is unable to change it.

The member or other persons in his or her home must not harm or threaten to harm the worker or other participants, or display any weapon.

Members that reside in supportive living facilities have specific rights, which include:

- Be free from mental, emotional, social and physical abuse, neglect and exploitation.
- All housing and services for which the member has contracted and paid.
- Have member records kept confidential and released only with the member’s consent or in accordance with applicable law.
- Have access to member records with 48 hours notice (excluding weekends and holidays)
- Have member’s privacy respected.
- Refuse to receive or participate in any service or activity once the potential consequences of such refusal have been explained to the member and a negotiated risk agreement has been reached between the member, his or her designated representative and the service provider, so long as others are not harmed by the refusal.
- Remain in the supportive living facility, forgoing recommended or needed services from the facility or available from others.
- Arrange and receive non-Medicaid covered services not available from the contracted facility service provider at the member’s own expense so long as he or she does not violate conditions specified in the resident contract.
- Be free of physical restraints.
- Control time, space and lifestyle to the extent the health, safety and well-being of others is not disturbed.
- Consume alcohol and use tobacco in accordance with the facility’s policy specified in the resident contract and any applicable statutes.
- Have visitors of the member’s choice to the extent the health, safety and well-being of others is not disturbed and the provisions of the resident contracts are upheld.
- Have roommates only by the member’s choice.
- Be treated at all times with courtesy, respect and full recognition of personal dignity and individuality.
- Make and act upon decisions (except those decisions delegated to a legal guardian) so long as the health, safety and well-being of others is not endangered by your actions.
- Participate in the development, implementation and review of their own service plans.
- Maintain personal possessions to the extent they do not pose a danger to the health, safety and well-being of themselves and others.
- Store and prepare food in the member’s apartment to the extent the health, safety and well-being of the member and others is not endangered and provisions of the resident contract are not violated.
- Design or accept a representative to act on the member’s behalf.
- Not be required to purchase additional services that are not part of the resident contract; and not be charged for additional services unless prior written notice is given to the member of the amount of the charge.
- Be free to file grievances according to supportive living facility policy and be free from retaliation from the facility.
Have access to information about IlliniCare Health’s quality improvement programs, including program goals, processes, and outcomes that relate to member care and services

This includes information on safety issues

Contact IlliniCare Health’s Provider Services with any questions, comments, or problems, including suggestions for changes in the QIP’s goals, processes, and outcomes related to member care and services

Treat members with fairness, dignity, and respect

Not discriminate against members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency

Maintain the confidentiality of members’ personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality

Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider’s practice/office/facility

Provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA

Allow members to request restriction on the use and disclosure of their personal health information

Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records

Allow members to obtain a second opinion, and answer members’ questions about how to access healthcare services appropriately

**PROVIDER RIGHTS AND RESPONSIBILITIES**

Providers have the rights and responsibilities to:

- Be treated by their patients and other healthcare workers with dignity and respect
- Receive accurate and complete information and medical histories for members’ care
- Have their patients act in a way that supports the care given to other patients and that helps keep the doctor’s office, hospital, or other offices running smoothly
- Expect other network providers to act as partners in members’ treatment plans
- Expect members to follow their directions, such as taking the right amount of medication at the right times
- Help members or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
  - Recommend new or experimental treatments
  - Provide information regarding the nature of treatment options
  - Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may be self-administered
  - Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment
  - Make a complaint or file an appeal against IlliniCare Health and/or a member
  - File a grievance with IlliniCare Health on behalf of a member, with the member’s consent

- Make a complaint or file an appeal against IlliniCare Health and/or a member

- File a grievance with IlliniCare Health on behalf of a member, with the member’s consent
▪ Collaborate with other healthcare professionals who are involved in the care of members
▪ Obtain and report to IlliniCare Health information regarding other insurance coverage
▪ Follow all state and federal laws and regulations related to patient care and patient rights
▪ Participate in IlliniCare Health data collection initiatives, such as HEDIS and other contractual or regulatory programs
▪ Review clinical practice guidelines distributed by IlliniCare Health
▪ Comply with IlliniCare Health’s Medical Management program as outlined in this manual.
▪ Notify IlliniCare Health in writing if the provider is leaving or closing a practice
▪ Contact IlliniCare Health to verify member eligibility or coverage for services, if appropriate
▪ Disclose overpayments or improper payments to IlliniCare Health
▪ Invite member participation, to the extent possible, in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible
▪ Provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language
▪ Provide members, upon request, with information regarding the provider’s professional qualifications, such as specialty, education, residency, and board certification status
▪ Not be excluded, penalized, or terminated from participating with IlliniCare Health for having developed or accumulated a substantial number of patients in the IlliniCare Health with high-cost medical conditions
▪ Object to providing relevant or medically necessary services on the basis of the provider’s moral or religious beliefs or other similar grounds
▪ Disclose to IlliniCare Health, on an annual basis, any physician incentive plan (PIP) or risk arrangements the provider or provider group may have with physicians either within its group practice or other physicians not associated with the group practice even if there is no substantial financial risk between IlliniCare Health and the physician or physician group
MEMBER GRIEVANCES AND PROVIDER COMPLAINTS

IlliniCare Health Grievance System includes an informal complaints process and a formally structured grievance and appeals process. IlliniCare Health’s Grievance System is compliant with Section 45 of the Managed Care Reform and Patient Rights Act and 42 CFR Section 438 Subpart F, including procedures to ensure expedited decision making when a member’s health so necessitates. The filing of a grievance will not preclude the member from filing a complaint with the Illinois Department of insurance (DOI), nor will it preclude DOI from investigating a complaint pursuant to its authority under Section 4-6 of the Health Maintenance Organization Act.

A member grievance is defined as any expression of dissatisfaction by a member about any matter other than an Action. The grievance process allows the member, or the member’s appointed representative (guardian, caretaker, relative, PCP or other treating physician) acting on behalf of the member, to file a grievance either verbally or in writing or an appeal or request a State Fair Hearing. IlliniCare Health values its providers and will not take punitive action, including and up to termination of a provider agreement or other contractual arrangements, for providers who file a grievance on a member’s behalf.

ACKNOWLEDGEMENT

IlliniCare Health shall acknowledge receipt of each grievance in writing. The IlliniCare Health staff member will document the substance of an oral grievance, and attempt to resolve it immediately. For informal complaints, defined as those received verbally and resolved immediately to the satisfaction of the member or appointed representative, the staff will document the resolution details. The Grievance and Appeals Coordinator will date stamp written grievances upon initial receipt and send an acknowledgment letter, which includes a description of the grievance procedures and resolution time frames, within three (3) business days of receipt.

TIMEFRAME AND NOTICE OF RESOLUTION

Grievance investigation and review by the Grievance Committee (for those grievances not resolved informally) will occur as expeditiously as the member’s health condition requires, not to exceed fifteen (15) days from the receipt of all information or thirty (30) days from the date the grievance is received by IlliniCare Health. The determination by the Committee may be extended for a period not to exceed fourteen (14) days in the event of a delay in obtaining the documents or records necessary for the resolution of the grievance. Members have the right to attend and participate in the formal grievance proceedings and may be represented by a designated representative of his or her choice. Resolution is determined by majority vote. Any individuals who make a decision on grievances will not be involved in any previous level of review or decision making. In any case where the reason for the grievance involves clinical issues or relates to denial of expedited resolution of an appeal, IlliniCare Health shall ensure that the decision makers are healthcare professionals with the appropriate clinical expertise in treating the member’s condition or disease [see 42 CFR § 438.406].

Written notification of the grievance resolution will be made within five (5) days after the determination and will include the resolution and HFS requirements, including but not be limited to, the decision reached by IlliniCare Health, the reason(s) for the decision, the policies or procedures which provide the basis for the decision, and a clear explanation of any further rights available to the member.

Grievances may be submitted verbally or in writing to:

**IlliniCare Health**

**Grievance and Appeals Coordinator**

999 Oakmont Plaza Drive
Westmont, IL 60559
ICP & FHP: 1-866-329-4701
MMAI: 1-877-941-0482
MLTSS: 1-844-316-7562

**APPEALS**

An appeal is the request for review of a “Notice of Adverse Action”. A Notice of Adverse Action is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service excluding technical reasons; the failure to render a decision within the required timeframes; or the denial of a member’s request to exercise his/her right under 42 CFR 438.52(b)(2) (ii) to obtain services outside the IlliniCare Health network. The review may be requested in writing or verbally within 60 days of the Notice of Adverse
Action, however verbal requests for appeals must be followed by a written request. All appeals must be registered initially with IlliniCare Health and may be appealed to the Department of Healthcare and Family Services when IlliniCare Health’s process has been exhausted.

Upon submission of a standard appeal, IlliniCare Health will notify the filing party, within three (3) business days of receipt, of any additional information required to evaluate the appeal request. Appeals will be fully investigated without deference to the denial decision. The appeal will be reviewed by an appropriately licensed clinical peer who was not involved in any previous level of decision making regarding the request. IlliniCare Health will render a decision and provide written notification within 15 business days after receipt of required information, not to exceed 30 calendar days of receipt of the request. A member or an authorized representative may request a standard or expedited External Independent Review (EIR) of a final adverse determination.

EXPEDITED APPEALS
Expedited appeals may be filed when either IlliniCare Health or the member’s provider determines that the time expended in a standard resolution could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expedited resolution or supports a member’s appeal. In instances where the member’s request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

IlliniCare Health will notify the filing party, within 24 hours of receipt, of any additional information required to evaluate the appeal request. IlliniCare Health will render a decision and provide notification within 24 hours after receipt of required information, not to exceed 72 hours of receipt of the initial request. IlliniCare Health will make reasonable efforts to provide the member, PCP and any healthcare provider who recommended the service with prompt verbal notice of the decision followed by written notice within three (3) calendar days after the initial verbal notification.

NOTICE OF APPEAL RESOLUTION
Written appeal resolution notice shall include the following information:

- The decision reached by IlliniCare Health
- The date of decision
- For appeals not resolved wholly in favor of the member the right to request a State fair hearing and information as to how to do so; and
- The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the member may be held liable for the cost of those services if the hearing decision upholds the IlliniCare Health decision.

Appeals may be submitted verbally or in writing to:

**IlliniCare Health**

Complaint and Grievances Coordinator (CGC)

999 Oakmont Plaza Drive

Westmont, IL 60559

ICP & FHP: 1-866-329-4701

MMAI: 1-877-941-0482

MLTSS: 1-844-316-7562

**STATE FAIR HEARING PROCESS**

Any adverse action or appeal that is not resolved wholly in favor of the member by IlliniCare Health may be appealed by the member or the member’s authorized representative to HFS for a Fair Hearing conducted in accordance with 42 CFR § 431 Subpart E. Please contact:

**Illinois Department of Healthcare and Family Services**

Bureau of Administrative Hearings

69 W. Washington Street, 4th Floor

Chicago, IL 60602

Toll-free: 1-855-418-4421

TTY: 1-800-526-5812

Fax: 1-312-793-2005

IlliniCare Health is responsible for providing to the HFS an appeal summary describing the basis for the denial. IlliniCare Health will comply with HSM’s fair hearing decision.

**REVERSED APPEAL RESOLUTION**

In accordance with 42 CFR §438.424, if IlliniCare Health or the state fair hearing decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, IlliniCare Health will authorize the disputed services promptly and as expeditiously as the member’s health condition requires. Additionally, in the event that services were continued while the appeal was pending, IlliniCare Health will provide reimbursement for those services in accordance with the terms of the final decision rendered by HFS and applicable regulations.
Provider Complaint

IlliniCare Health has established a provider complaint system that allows a provider to dispute the policies, procedures, or any aspect of the administrative function, including the proposed action.

NOTE: The process for appeals of medical necessity decisions (actions) is outlined above in the Member Appeals Section of this Manual.

Providers may submit a complaint via telephone, written mail, electronic mail or in person. IlliniCare Health has designated a Provider Complaints Coordinator (PCC) to process provider complaints. Provider complaints will be thoroughly investigated using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying IlliniCare Health’s written policies and procedures. After the complete review of the provider complaint, the PCC will provide a written notice of resolution to the Provider within thirty (30) days from the date of the decision.

Provider Complaints may be submitted verbally or in writing to:

IlliniCare Health
999 Oakmont Plaza Drive, Suite 400
Westmont, IL 60559
ICP & FHP: 1-866-329-4701
MMAI: 1-877-941-0482
MLTSS: 1-844-316-7562

In addition to communicating the provider complaint process through this Manual, IlliniCare Health communicates the provider complaint process during provider orientation and on its website.

Fraud, Waste and Abuse (FWA)

IlliniCare Health takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a fraud, waste and abuse (FWA) program that complies with the State of Illinois and federal laws. IlliniCare Health, in conjunction with its management company, Centene, successfully operates a Special Investigation Unit (SIU) that manages the review and investigation of reported concerns. IlliniCare Health performs front and back end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system, please review the Billing and Claims section of this manual. SIU performs back end audits which in some cases may result in taking the appropriate actions against those who, individually or as a practice, commit fraud, waste and/or abuse, including but not limited to:

- Remedial education and/or training around eliminating the egregious action
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Any other remedies available to rectify

Some of the most common FAW submissions seen are:
- Unbundling of codes
- Up-coding
- Add-on codes without primary CPT
- Diagnosis and/or procedure code not consistent with the member’s age/gender
- Use of exclusion codes
- Excessive use of units
- Misuse of Benefits
- Claims for services not rendered

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our free anonymous and confidential hotline at 1-866-685-8664. IlliniCare Health and Centene take all reports of potential fraud, waste and/or abuse very seriously and investigate all reported issues. IlliniCare Health and Centene has a no retaliation policy for anyone reporting a concern.

AUTHORITY AND RESPONSIBILITY

IlliniCare Health’s Vice President of Compliance and Regulatory Affairs has overall responsibility and authority for carrying out the provisions of IlliniCare Health’s compliance program. IlliniCare Health is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

The IlliniCare Health provider network will cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.
Critical Incident Reporting

IlliniCare Health adheres to a systematic approach to promote the identification of any potential critical incident(s). Any concerns identified as a potential critical incident must be promptly reported, reviewed, investigated, and appropriate corrective actions must be taken as necessary. The primary focus is to identify and report instances that have the potential for harm to a member.

Examples of critical incidents include, but are not limited to:

- Abuse, neglect, exploitation or any incident that has the potential to place a member or a member’s services at risk including those which do not rise to the level of abuse, neglect, or exploitation
- Suicide attempts
- Willful infliction of injury
- Financial misconduct: Misuse or withholding of a person’s resources
- Failure to notify a health care professional when needed; failure to provide or arrange necessary services to avoid physical or psychological harm
- Inappropriate use of restraints in the Long term Care setting

All suspected critical incidents should be reported to:

- IlliniCare Health Provider Services department: 1-866-329-4701

All information is kept private and confidential.
Quality Improvement

The Quality Improvement Committee (QIC) is a senior management committee with physician representation that is directly accountable to the BOD. The purpose of the QIC is to promote a system-wide approach to Quality Assurance, provide oversight and direction in assessing the appropriateness of care and services delivered, encourage Provider participation, and to continuously enhance and improve the quality of care and services provided to members. In addition, the QIC has the responsibility for developing and implementing the QAPI program. This will be accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems; the identification of opportunities to improve member outcomes; and the education of the member, Providers and staff regarding the QA, UM, and Credentialing programs.

The following sub-committees report directly to the QIC:

- Credentialing Committee
- Pharmacy and Therapeutics Committee
- Utilization Management Committee
- Performance Improvement Team
- Grievance and Appeal Committee
- Delegation Oversight Committee
- Peer Review Committee (Ad Hoc Committee)

The Consumer Advisory Committee, Community Stakeholder Committees and Physician Advisory Committee report indirectly to the QIC through the Performance Improvement Team.

PRACTITIONER INVOLVEMENT

IlliniCare Health, recognizing the integral role practitioner involvement plays in the success of its quality improvement program, encourages provider representation in various levels of the process. The QIC consists of a cross representation of all types of Providers, including PCPs, specialists, dentists and long term care representatives from IlliniCare Health network and across the service area. IlliniCare Health encourages PCP, behavioral health, specialty, and OB/GYN representation on key quality committees such as, but not limited to, the QIC, Credentialing Committee, Pharmacy and Therapeutics Committee, and select ad-hoc committees.

PROGRAM STRUCTURE

IlliniCare Health’s Board of Directors (BOD) has the ultimate authority and accountability for the oversight of the quality of care and service provided to members. The BOD oversees the QAPI program and has established various standing and ad-hoc committees to monitor and support it.
ILLINI CARE HEALTH

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPI) SCOPE AND GOALS

The scope of IlliniCare Health’s QAPI Program addresses both the quality of clinical care and the quality of services provided to Enrollees and Providers. IlliniCare Health QA activities encompass all demographic groups, benefits and care settings; and, address all services, including medical and behavioral healthcare, preventive, emergency, primary, and specialty care; as well, as acute care, short-term care, long-term care, home care, pharmacy and ancillary services. Areas subject to quality oversight include:

- Acute and chronic care management and disease management
- Adoption and compliance with preventive health and clinical practice guidelines
- Behavioral healthcare management and coordination with medical practitioners
- Continuity and coordination of care
- Delegated entity oversight
- Department performance and service
- Employee and Provider cultural competency
- Disparities in Care
- Enrollee Grievance and Appeals
- Enrollee satisfaction
- Health education and promotion
- Network accessibility and appointment availability, including specialty practitioners
- Patient safety including appropriateness and quality of healthcare services
- Provider satisfaction
- Selection and retention of skilled, quality-oriented practitioners and facilities (credentialing and re-credentialing)
- Utilization Management, including under and over utilization
- Compliance with preventive health and practice guidelines

PERFORMANCE IMPROVEMENT PROCESS

IlliniCare Health QIC reviews and adopts an annual QAPI program and QAPI work plan based on managed care Medicaid appropriate industry standards. The QAPI adopts traditional quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area, and includes targeted interventions that have the greatest potential for improving health outcomes or the service.

Performance improvement projects, focused studies and other quality improvement initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each quality improvement initiative is also designed to allow IlliniCare Health to monitor improvement over time.

Annually, IlliniCare Health develops a Quality Assessment Performance Improvement (QAPI) Work Plan for the upcoming year. The QAPI work plan serves as a working document to guide quality improvement efforts on a continuous basis. The work plan integrates quality improvement activities, reporting and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QIC as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI work plan.

IlliniCare Health communicates activities and outcomes of its quality improvement program to both members and providers through avenues such as the member newsletter, provider newsletter and the IlliniCare Health web portal. At any time, IlliniCare Health providers may request additional information on the health plan programs including a description of the QAPI program and a report on the IlliniCare Health progress in meeting the QAPI program goals by contacting IlliniCare Health Quality Improvement department.
WHO WILL BE CONDUCTING THE MEDICAL RECORD REVIEWS (MRR) FOR HEDIS?
IlliniCare Health will contract with a national medical record review vendor to conduct the HEDIS medical record reviews on its behalf. Medical record review audits for HEDIS are usually conducted March through May each year. At that time, providers may receive a call from a medical record reviewer representative if any of your patients are selected into HEDIS samples for IlliniCare Health. Prompt cooperation with these requests is greatly needed and appreciated.

The medical record review vendor will sign a HIPAA compliant Business Associate Agreement with IlliniCare Health which allows them to collect PHI on our behalf.

WHAT CAN BE DONE TO IMPROVE HEDIS SCORES?
- Understand the specifications established for each HEDIS measure
- Submit claim/encounter data for each and every service rendered. All providers must bill (or report by encounter submission) for services delivered, regardless of contract status. Claim/encounter data is the most clean and efficient way to report HEDIS. If services are not billed or not billed accurately they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation
- Ensure chart documentation reflects all services provided
- Bill CPT codes related to HEDIS measures such as diabetes, eye exam, and blood pressure

HEALTH EMPLOYER DATA INFORMATION SET (HEDIS)
HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of NCQA Health Plan Accreditation and IlliniCare Health’s contract with the Department of Healthcare and Family Services for the provision of coordinated care services within the Integrated Care Program.

HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider as well. IlliniCare Health purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a Health Insurance Company’s ability to demonstrate an improvement in preventive health outreach to its members.

HOW ARE HEDIS RATES CALCULATED?
HEDIS rates may be calculated using two methodologies: administrative data methodology or hybrid methodology. Administrative data methodology is calculated from claims or encounter data submitted to the health plan. Measures typically calculated using administrative data methodology include: annual mammogram, annual chlamydia screening, annual pap test appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

Hybrid methodology consists of both administrative data and a sample of medical records. Hybrid methodology requires review of a random sample of member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data and submission of appropriate CPT II codes can reduce the necessity of medical record reviews. Measures typically requiring medical record review include: diabetic HgA1c, LDL, eye exam and nephropathy, controlling high-blood pressure, and prenatal care and postpartum care.
If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the IlliniCare Health Quality Improvement department.

PROVIDER SATISFACTION SURVEY
At least annually, IlliniCare Health conducts a provider satisfaction survey which includes questions to evaluate provider satisfaction with our services such as claims, communications, utilization management, and provider services. The survey is conducted by an external vendor. Participants are randomly selected by the vendor, meeting specific requirements outlined by IlliniCare Health, and the participants are kept anonymous. We encourage you to respond timely to the survey as the results of the survey are analyzed and used as a basis for forming provider related quality improvement initiatives.

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDER SYSTEMS (CAHPS) SURVEY
The CAHPS survey is a member satisfaction survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to members by an NCQA certified survey vendor. The survey provides information on the experiences of IlliniCare Health members with the health plan and practitioner services and gives a general indication of how well we are meeting the members’ expectations. Member responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability.

PROVIDER PROFILING
In recent years, it has been nationally recognized that pay-for-performance and other incentive and/or bonus programs, which include provider profiling, have emerged as a promising strategy to improve the quality and cost-effectiveness of care. IlliniCare Health has implemented a physician profiling as a tool to encourage providers to promote appropriate care and services for IlliniCare Health members which have been shown to lead to better health outcomes.

Provider profiling promotes efforts that are consistent with the Institute of Medicine’s aims for advancing quality (safe, beneficial, timely, patient-centered, efficient and equitable) as well as recommendations from other national agencies such as the CMS-AMA Physician Consortium, NCQA, and NQF. Additionally, that the program encourages accurate and timely submission of preventive health and disease monitoring services in accordance with evidence-based clinical practice guidelines. Physicians, who meet a minimum panel threshold will receive a quarterly profile report with an individual score for each measure. Scores will be benchmarked per individual measure and compositely to the IlliniCare Health network average and as applicable, to the then available NCQA Medicaid mean. Provider profile indicator data is not risk adjusted and scoring is based on provider performance within the service area range.

PCPs who meet or exceed established performance goals and who demonstrate continued excellence or significant improvement over time may be recognized by IlliniCare Health in publications such as newsletters, bulletins, press releases, and recognition in our provider directories.
**Overview and Model of Care**

**WHAT IS THE MODEL OF CARE?**
Model of Care defines the management, procedures and operational systems that provide access, coordination and structure needed to provide services and care to IlliniCare Health members.

*IlliniCare Health’s Model of Care includes the following elements:*

- Measurable goals
- Staff structure and care management roles
- Interdisciplinary care team
- Provider network having special expertise and use of clinical practice guidelines
- Model of care training
- Health risk assessment
- Individualized Care Plan
- Communication network
- Care Management
- Performance and health outcome measurements

*IlliniCare Health ensures all of our members have:*

- Access to essential available services such as medical, behavioral and social services
- Access to affordable care
- Care coordination through an identified point of contact
- Seamless transitions of care
- Improved access to preventive health services
- Appropriate utilization of healthcare services
- Overall improved health outcomes

**HEALTH RISK SCREENING (HRS) - COMPLETED WITH NEW MEMBERS WITHIN 30 DAYS TO IDENTIFY THOSE WITH UNMET OR ONGOING NEEDS.**

*Work with the member to assess:*

- Functional Abilities
- Physical and Behavioral Health Conditions
- Social, Environmental, and Cultural Issues
- Ability to Live Independently
- Mobility
- Economic Self-sufficiency
- Medications
- And Other Needs that Form the Basis of Our Integrated, Holistic Care Plan

*Member Outreach is Critical to our Model*

- Explain benefits, provide health education, including how to access care (ex. appropriate Emergency Room utilization)
- Participate in community events and establish partnerships with local community agencies, churches, and high volume provider offices to promote healthy living and preventive care
- Influence consumers’ beliefs and behaviors because they are hired from within the community
- Identify and engage high-risk consumers
- Facilitate communication across medical and behavioral health specialties
Our Approach

- Focus on early identification before condition worsens
- Facilitate communication and coordination of services across medical and behavioral health specialties
- Identify and engage high-risk consumers
- Identify barriers to adherence with current treatment plans and goals
- Coordinate with consumer, their support system, and physicians to customize a plan of care
- Holistic model: Care Coordination Team can link to local community resources such as shelter/housing, clothing, utilities assistance, and domestic violence agencies

IlliniCare Health strives to work with the provider community to ensure members' individual needs are met leveraging our care coordination approach. To reach the Medical Director or Vice President of Medical Management for additional information on our Model of Care, please contact:

**IlliniCare Health Clinical Management**
ICP & FHP: 1-866-329-4701
MMAI: 1-877-941-0482
MLTSS: 1-844-316-7562
MEDICAL RECORDS
IlliniCare Health providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to members. To ensure the member’s privacy, medical records should be kept in a secure location.

REQUIRED INFORMATION
Medical record is defined as the complete, comprehensive member records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the member’s participating primary care physician or provider, that document all medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Providers must maintain complete medical records for members in accordance with the following standards:
- Member’s name, and/or medical record number on all chart pages
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.)
- Prominent notation of any spoken language translation or communication assistance
- All entries must be legible and maintained in detail
- All entries must be dated and signed, or dictated by the provider rendering the care
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented
- An up-to-date immunization record is established for pediatric members or an appropriate history is made in chart for adults
- Evidence that preventive screening and services are offered in accordance with IlliniCare Health’s practice guidelines
- Appropriate subjective and objective information pertinent to the member’s presenting complaints is documented in the history and physical
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and
- ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses
- Working diagnosis is consistent with findings
- Treatment plan is appropriate for diagnosis
- Documented treatment prescribed, therapy prescribed and drug administered or dispensed including instructions to the member
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns
- Signed and dated required consent forms
- Unresolved problems from previous visits are addressed in subsequent visits
- Laboratory and other studies ordered as appropriate
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the primary care provider (PCP) to signify review
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services and services for the treatment of sexually transmitted diseases
- Health teaching and/or counseling is documented
- For members ten (10) years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for members seen three or more times substance abuse history should be queried)
- Documentation of failure to keep an appointment
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem
- Confidentiality of member information and records protected
- Evidence that an advance directive has been offered to adults 18 years of age and older

**Medical Records Release**

All member medical records shall be confidential and shall not be released without the written authorization of the covered person or a responsible covered person’s legal guardian. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis.

**Medical Records Transfer for New Members**

All PCPs are required to document in the member’s medical record attempts to obtain historical medical records for all newly assigned IlliniCare Health members. If the member or member’s guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers then this should also be noted in the medical record.

**Medical Records Audits**

IlliniCare Health will conduct random medical record audits as part of its QAPI Program to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to members, including over/under utilization of specialists, as well as the outcome of such services also may be assessed during a medical record audit. IlliniCare Health will provide verbal or written notice prior to conducting a medical record review.
To contact the provider relations specialist for your area by phone, please call the Provider Services toll free help line. If you prefer to send an email, please include your name, call-back phone number, and provider Tax ID with your inquiry to ProviderRelations_IL@centene.com. Provider Services Representatives work with Provider Relations specialists to serve as your advocates to ensure that you receive necessary assistance and maintain satisfaction with IlliniCare Health.

TOP 10 REASONS TO CONTACT A PROVIDER RELATIONS REPRESENTATIVE

1. To report any change to your practice (i.e., practice TIN, name, phone numbers, fax numbers, address, and addition or termination of providers, or patient acceptance).
2. Initiate credentialing of new providers.
3. To schedule an in-service training for new staff.
4. To conduct ongoing education for existing staff.
5. To obtain clarification of policies and procedures.
6. To obtain clarification of a provider contract.
7. To request fee schedule information.
8. To obtain responses to membership list questions.
9. To obtain responses to claims questions.
10. To learn how to use electronic solutions on web authorizations, claims submissions, and check eligibility.