



Community Health Network

of Connecticut, Inc.TM

HUSKY & Charter Oak Health Plan Provider Handbook

Welcoming Note

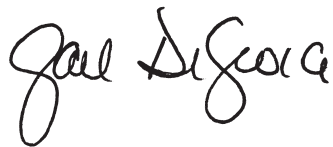
Dear Provider / Practitioner:

Welcome to Community Health Network of Connecticut, Inc. (CHNCT), the State's only not-for-profit community health center-sponsored health plan. We appreciate your participation and we are committed to providing you with ongoing support. As Vice-President of Operations for CHNCT, I would like to thank you personally for partnering with us and your commitment to improve the health of our members by providing access to high quality health care. Our partnership with you is central to what we do. We are available to you for any questions or concerns.

This HUSKY and Charter Oak Health Plan Provider Handbook contains detailed information regarding CHNCT's policies and procedures, program benefits, care management, billing guidelines, claim submission requirements, and key contact information. This handbook is being provided to you as a comprehensive resource to assist you in the daily administration of these programs.

If you have any questions about the administration of our HUSKY and Charter Oak programs, your Senior Network Consultant will be happy to assist you. Your consultant can be reached by using CHNCT's dedicated provider line 1-800-440-5071, option #7.

Sincerely,

A handwritten signature in black ink that reads "Gail DiGioia". The signature is written in a cursive, flowing style.

Gail DiGioia
Vice President of Operations

Community Health Network of Connecticut, Inc. Mission Statement

Mission

To improve the health of underserved and vulnerable populations by providing access to high quality and comprehensive health care, as a not-for-profit community health center-sponsored health plan.

Vision

Our members, providers, policymakers, community organizations and others will recognize CHNCT as a leader in building healthier communities. They will know us for putting our members first, by our organizational integrity, the quality of our services and innovation and success in collaborating with community health centers, other providers and other organizations.

Values Statement

At Community Health Network of CT we take pride in integrity, teamwork and excellence in all areas of our business. We recognize the importance of what we do and the impact on the individuals and communities we serve.

The values that are most important to us are:

- Support community health centers in our joint commitment to improving the health status of vulnerable populations;
- Demonstrate respect, dignity and integrity in serving our members;
- Pursue quality improvement, innovation and opportunities for collaboration; and
- Assure a strong network of primary care and specialty providers to serve our members.

Important Telephone Numbers

This section includes telephone numbers and addresses necessary for the provider community to effectively interact with CHNCT.

CHNCT is the primary source for answering provider questions on all aspects of the CHNCT Managed Care Organization Program. Providers should contact CHNCT for questions regarding claim submission and enrollment.

**Community Health Network of Connecticut, Inc.
11 Fairfield Blvd., Suite 1
Wallingford, CT 06492**

**Provider Call Center 1-800-440-5071 (option 7)
Fax: 1-203-265-3590**

Provider Inquiries

Provider Enrollment and Credentialing Information

Claims / Billing Questions or Problems

Appealing a Denial Decision for Services

**Care Management 1-800-440-5071
Fax: 1-203-265-3994**

Referrals and Authorizations for Specialist Services

Out-of-Network Referrals and Authorizations

Pre-Admission Certification

Healthy Connections 1-800-819-9189

EPSDT Information

Assistance with Non-Compliant Members

HUSKY (Enrollment Broker) 1-800-656-6684

EDS Automated Eligibility Verification System (AEVS) 1-860-832-9259

Need Medicaid Provider ID #Eligibility Dispute Resolution

CHNCT Fraud Reporting Hotline 1-866-700-6109

CHNCT Subcontracted Vendors:

Block Vision

**120 West Fayette Street, Suite 700
Baltimore, MD 21201**

Block Vision: (Routine Vision Services) Provider Assistance: 1-800-243-1401

Coordinated Transportation Solutions (Transportation)

1-800-818-6781

200 Main Street

Ansonia, CT 06401

State Sponsored Programs:

Dental Services;

CT Dental Health Partnership,
managed by BeneCare Dental Plans 1-866-420-2924
www.ctdhp.com

Behavioral Health Services;

Connecticut Behavioral Health Partnership, managed by ValueOptions ...1-877-55-CTBHP
www.ctbhp.com

CHNCT Network Management Staff:

Rafael Batista Jr, Director, Network Management..... 1-203-949-4024
Thomas Kennedy, Contract Manager 1-203-949-6127
Deborah Amato, Service Manager 1-203-949-4152

Senior Network Consultants:

Cynthia Eichholtz 1-203-949-6140
Nancy Esposito 1-203-949-4163
Kim Martin 1-203-949-4106
David Miller 1-203-949-4141
Naida Rosado 1-203-949-6034
Jeffry Wolansky 1-203-949-6054
Denise Consiglio, Senior Team Lead 1-203-949-4142

Network Management Department Facsimile 1-203-265-3590

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Introduction

Overview

Community Health Network of Connecticut, Inc (CHNCT) was formed in August 1995 by Federally Qualified Health Centers (FQHCs). We arrange for the provision of HUSKY A and B, and Charter Oak services through a contract with the State of Connecticut Department of Social Services (DSS). CHNCT's health centers have served the Medicaid population for twenty-eight years. We have successful outreach and education programs that encourage members' participation in their health care. CHNCT has expanded its provider network by contracting with private and group practices, primary care centers, hospitals and ancillary providers throughout the State of Connecticut.

CHNCT is a **not-for-profit organization** dedicated to arranging for care in a manner that emphasizes quality, understanding and respect. It is our intention to build strong partnerships with providers aimed at improving the health of our members. CHNCT has set the following goals for its relationship with you as a provider in the network:

- feedback on provider's performance and provider utilization
- open and respectful communication
- timely response to questions or concerns
- timely processing of credentialing applications and contracts
- timely communication of any changes in policies and procedures
- timely payment for services rendered when they meet CHNCT guidelines
- responsive grievance and appeals process
- face to face contact for orientation, training, and education
- knowledgeable and helpful staff
- assistance with difficult or non-compliant members
- willingness to listen to suggestions or comments
- ongoing commitment to managed care education and training

Chapter 1 – Husky and Charter Oak Health Plan Programs Overview

Community Health Network of Connecticut (CHNCT) is the state's only, not-for-profit community health center-sponsored health plan. We provide health care services for the state's HUSKY A, HUSKY B and Charter Oak health programs.

CHNCT has more than 250,000 members. CHNCT has a statewide network for primary and specialty care. We also have a network of inpatient, rehabilitation and outpatient locations. All provide health services to our members. We contract with outside vendors to provide services for transportation and vision.

HUSKY Program

Healthcare for Uninsured Kids and Youth (HUSKY) is Connecticut's managed care program for children and families created through funds made available by the Balanced Budget Act of 1997. The HUSKY program is funded by the State of CT and the Federal Government and is administered through the Department of Social Services (DSS). This program offers comprehensive health care coverage to low-income children under the age of 19 and pregnant women who are uninsured and who meet certain income guidelines. In addition, parents, relatives, foster parents, legal guardian and caregivers may also qualify for HUSKY coverage, depending on family income. Individuals must be residents of Connecticut and must be a U.S. citizen or qualified immigrant to be eligible for the program.

HUSKY A, also known as Medicaid, is a managed care program with fully subsidized premiums, no member cost sharing and no balance billing. Individuals covered under the HUSKY A program may have additional health care coverage. In such instances, HUSKY A would be considered a "payer of last resort".

HUSKY B is an expanded health insurance program. Nationally this program is known as the Children's Health Insurance Program (CHIP) and includes services provided in accordance with Title XXI of the federal Social Security Act. HUSKY B provides low cost health care coverage for children who are uninsured but are part of families with higher incomes. Families not eligible for HUSKY A may be eligible for HUSKY B.

Services provided under the HUSKY B program may be subject to co-pays. CHNCT will notify providers when members reach their annual copayment limits. Please Note: *HUSKY B is not a supplemental program for families with insurance whose children's expenses have exceeded their plan's covered benefit maximum.*

To learn more about the HUSKY program please visit www.huskyhealth.com or call 1-877-CT-HUSKY (1-877-284-8759).

Charter Oak Health Plan Program

The Charter Oak Health Plan program is an affordable health insurance plan offered to adults aged 19 to 64 regardless of income. The program offers a full range of health insurance coverage including preventative and primary care, emergency room and hospital visits, specialist office visits, prescription medications, behavioral health, and both inpatient and outpatient rehabilitation services.

To learn more about The Charter Oak Health Plan, please visit www.charteroakhealthplan.com or call 1-877-77-CTOAK (1-877-772-8625).

HUSKY A, HUSKY B and Charter Oak Health Plan Benefits

Periodically, changes are made to HUSKY A, HUSKY B and Charter Oak Health Plan benefits. For the most current information on health plan benefits, please refer to Community Health Network of Connecticut's website at www.chnct.org and select "Benefits and Prior Authorizations Grid" from the Provider tab.

The grid does not constitute a legal document. Contents provide a general description of HUSKY A, HUSKY B and Charter Oak benefits. Coverage is subject to change per the Department of Social Services.

Important Information

As noted, many services require prior-authorization when prescribed or rendered by both participating (in network) and non-participating (out of network) providers.

If you have questions regarding our plan, call us at 203-949-4000 or 1-800-440-5071

Charter Oak Health Plan Cost Shares

Deductibles under the Charter Oak Health Plan (CO) will vary based on household size and income. Please see the chart below:

Income Band	Amount of Income	Annual Deductible	Annual Co-insurance Maximums
Income Band C1	0 to 150% of the Federal Poverty Level (FPL)	\$150 for each member	\$150 for each member
Income Band C2	151% to 185% of the FPL	\$200 for one member \$175 for each member if there are two (2) Charter Oak members in the household*	\$200 for one member \$175 for each member if there are two (2) Charter Oak members in the household*
Income Band C3	186% to 235 % of the FPL	\$400 for one member \$300 for each member if there are two (2) Charter Oak members in the household*	\$400 for one member \$300 for each member if there are two (2) Charter Oak members in the household*
Income Band C4	236% to 300% of the FPL	\$750 for one member \$700 for each member if there are two (2) Charter Oak members in the household*	\$750 for one member \$700 for each member if there are two (2) Charter Oak members in the household*
Income Band C5	Over 300% of the FPL	\$900 for one member \$875 for each member if there are two (2) Charter Oak members in the household*	\$900 for one member \$875 for each member if there are two (2) Charter Oak members in the household*

*Note: Charter Oak members are part of the same household if they are married or joined in a civil union, and live together. There is a maximum of two (2) Charter Oak members per household/

family e.g., a married couple, both Charter Oak members, and a 19-year-old child also a Charter Oak member, would count as two households, the married couple constituting the first household and the 19 year old child constituting the second household.

Dental Benefits

Dental benefits for the HUSKY program are managed by Benecare Dental Plan. For information or questions regarding dental benefits contact the Connecticut Dental Health Partnership customer service department at 1-866-420-2924, Monday – Friday 8:00am to 5:00pm or go to their website at www.benecare.com.

For a listing of dental services covered by CHNCT under the Charter Oak medical benefit please refer to the HUSKY A, HUSKY B and Charter Oak Health Plan Summary Grid on the CHNCT website, www.chnct.org.

Behavioral Health

Behavioral health services are managed by the Connecticut Behavioral Health Partnership (CT BHP). For information or questions regarding behavioral health services contact the CT BHP at 1-877-552-8247 between the hours of 9:00am – 7:00pm.

For a listing of Health and Behavior Assessment services covered by CHNCT under the HUSKY A medical benefit please refer to the HUSKY A, HUSKY B and Charter Oak Health Plan Summary Grid on the CHNCT website, www.chnct.org.

Retail Pharmaceutical Services

Retail Pharmacy services are provided through the Department of Social Services (DSS). For information on the State of Connecticut Preferred Drug list or any other questions please go to www.ctdssmap.com and click on Pharmacy Information or contact DSS (HP/EDS) at 1-800-842-8440 or 1-860-269-2028.

Please refer to the HUSKY A, HUSKY B, CHARTER OAK Benefits and Prior Authorization Requirements Grid for Information on pharmacy items covered under the HUSKY and Charter Oak medical benefit, member co-pays and non-covered drugs. For more detailed information, please refer to www.ctdssmap.com.

Sterilization/Tubal Ligation Requirements

Sterilization and Tubal Ligations do not require prior authorization from CHNCT. Through the HUSKY A program, members are allowed family planning services without referrals or prior authorizations and at a location of their choice. DSS has set specific procedures to be followed for members seeking sterilization. The W-612 consent form for sterilizations must be completed by the member and provider. Consent must be obtained at least thirty (30) days, but not more than 180 days, before the date of service. The member must be mentally competent and must be at least twenty-one years old on the date that the consent form is signed. For a more detailed explanation of CHNCT's policies related to sterilization, reference the "Sterilization and Hysterectomy Consent forms" Reimbursement Policy available at www.chnct.org under the provider tab.

To obtain the sterilization consent form, W-612, please contact:

**Department of Social Services
25 Sigourney Street
Hartford, CT 06106-5033**

This form is also located on the internet under www.ctdssmap.com. Select Information, Publications and under other Forms, select Consent to Sterilization, W-612 forms.

The form with original signatures must be submitted with the claim for payment. All questions should be directed to the Provider Relations Department at 1-800-440-5071.

Limitations and Exclusions

Please refer to the HUSKY A, HUSKY B and Charter Oak Health Plan Benefit and Prior Authorization Responsibilities Grid for a listing of benefit limitations and non-covered services and items. This grid is located on the CHNCT website at www.chnct.org.

Out-of-Pocket Expenses HUSKY A

Co-payments and balance billing are not allowed under the HUSKY A Program. In addition, providers are not allowed to bill for cancelled appointments, missed appointments or record transfers.

A provider may only bill a HUSKY A member for goods and services which are not covered by Medicaid, when the member knowingly elects to receive the goods or services and enters into a written agreement to pay for such goods or services prior to receiving them.

HUSKY B and Charter Oak – Balance billing is not allowed under the HUSKY B or Charter Oak programs.

Charter Oak - Annual maximums – Annual maximums are based on the member's anniversary date of enrollment. If a member reaches the maximum during the year, they are issued a temporary zero co-payment card upon re-enrollment.

Chapter 2 – Member Information

Member Rights

Community Health Network of CT, Inc. (CHNCT) is committed to treating members in a manner that respects their rights. Participating providers are expected to treat members in the same fashion. By working together, we can help our members and their families meet their health care needs.

Members have the right to:

- receive information about CHNCT, its services, practitioners, providers, and members' rights and responsibilities
- be treated with respect and recognition of their dignity and right to privacy
- be able to choose primary care providers, within the limits of the plan network, including the right to refuse care from specific providers
- participate with providers in decision-making regarding their health care
- refuse treatment and also to participate in treatment decisions
- respectful, personal attention regardless of race, origin, and religion, physical or mental handicap
- an open discussion of appropriate medically necessary treatment options and alternatives of their conditions, regardless of cost or benefit.
- voice complaints or express grievances regarding any violation of their rights, about CHNCT or the care provided by its providers
- make Advance Directives
- Personal Health Information kept confidential by CHNCT employees and agencies it contracts with and of all records and communications to the extent required by law
- contact their provider in order to advocate on their behalf for medical services
- obtain a copy of their medical records. In certain situations under the HIPAA privacy rule, members may also have the right to request that the records be corrected
- be free from any form of retaliation from CHNCT or freedom to exercise the rights explained above without any negative effect on their treatment from CHNCT, subcontractors or network providers
- be free from any form of restraint or seclusion used as means of coercion, discipline, convenience, or retaliation
- receive services from a PCP for 60 days if the member is in active treatment, newly enrolled and living in a rural area who has an established relationship with a PCP who is not in our network
- obtain a second opinion from an appropriately qualified health care professional
- post stabilization services, or those services that may be needed as a follow up after receiving emergency care

Advance Directives:

Office of the Attorney General
55 Elm Street
Hartford, Connecticut 06106
1-860-808-5318
<http://www.ct.gov/ag/cwp/browse.asp?a=2130&bc=0&c=19278>

To file a complaint against a practitioner:

Practitioner Licensing and Investigations Section
Connecticut Department of Public Health
410 Capitol Ave., MS# 12 INV
Hartford, CT 06134-0308
Phone: (860) 509-7552
Fax: (860) 509-7535
email: oplc.dph@ct.gov

To file a complaint against a facility

Facility Licensing and Investigations Section Connecticut Department of Public Health
410 Capitol Ave., MS# 12 HSR
Hartford, CT 06134-0308
Phone: (860) 509-7400
Fax: (860) 509-7538

HUSKY Eligibility

A broker employed by the State of CT to field membership inquiries determines eligibility for the HUSKY program. Eligibility is primarily based on income and family size. The eligibility for State Medicaid is for a 12-month period for both HUSKY A and HUSKY B. HUSKY B coverage may not be available if a child has been covered by health insurance through a parent's employer during the past two months. There are exceptions to this waiting period, including hardship, so parents are encouraged to call the HUSKY program and apply at 1-877-CTHUSKY.

HUSKY A members are only locked into their chosen MCO plan for a short time. They are given the option to switch to another approved Managed Care plan or PCP if they feel it is in their best interest to do so.

HUSKY B enrollment has a "free-look" period of 90-days during which a HUSKY B member is allowed to switch plans without cause; after this period, a member cannot disenroll or switch plans unless "good cause" is provided.

Newborn Eligibility

- If a newborn's mother has coverage under Medicaid or Healthy Start, the newborn is eligible for HUSKY A at birth, and will be enrolled in the same health plan as the mother. New parents should contact their DSS worker as well as the health plan and make sure the plan knows about the baby.
- If a newborn's mother is uninsured or the mother has insurance that will not cover the birth of the baby, the family should apply for HUSKY benefits no later than 30 days after the baby's date of birth.
- When billing for newborn services you should expect a slight delay in processing from CHNCT. CHNCT may not have received enrollment information on this member from HUSKY (the broker). If this is the case, Member Services will contact HUSKY to verify the newborn enrollment with CHNCT's plan and request the necessary information.

Continuous Eligibility

The state program was designed to prevent children from losing Medicaid or HUSKY eligibility. Continuous eligibility applies only to children under the age of 19 who are enrolled in the Medicaid managed care / HUSKY A and HUSKY B programs. Continuous eligibility refers to a 12-month period during which a child will not lose eligibility for medical coverage even though there has been a change in income that ordinarily would have caused them to lose eligibility. A child's continuous eligibility period begins the month following their determination or re-determination of eligibility for the Medicaid or HUSKY program. There is no limit on the number of continuous eligibility periods a child may have.

HUSKY B Eligibility Exceptions

There is a requirement that children not be insured through an employer-sponsored health insurance plan for two months prior to receiving HUSKY B coverage. However, there are exceptions that allow children to receive HUSKY B, even if they have had coverage through an employer-sponsored insurance within the last two months. There are exceptions to this waiting period, including hardship, so parents should be encouraged to call the HUSKY program at **1-877-CTHUSKY** for additional information on the HUSKY B eligibility exceptions.

Checking Eligibility

Participating providers can confirm both HUSKY A Husky B and Charter Oak eligibility at 1-800-859-9889 or through the **ePower** utility that is available to CHNCT network providers at no charge. The **ePower** utility is an internet-based tool that links the provider's office to CHNCT's eligibility system in real time. For more information on **ePower**, please contact the Provider Call Center at 1-800-440-5071 or contact your Senior Network Consultant and they will be glad to assist you.

It is important to check eligibility frequently because of the fact that HUSKY A members are given the option to switch to another approved Managed Care plan. Providers may contact CHNCT's Member Services Department at 1-800-859-9889 to determine a member's eligibility and PCP.

Providers may also use the Automated Eligibility Verification System (AEVS) to check the status of a HUSKY A member in a plan by calling 1-800- 842-8440.

HUSKY B members are not in the same system with HUSKY A members. HUSKY B eligibility cannot be confirmed accurately via the Automated Eligibility Verification System (AEVS) therefore please use ePower or call our Member Services Department. If unable to confirm eligibility with the aforementioned options call,1-877-CTHUSKY.

Primary Care Provider (PCP) Assignment

It is CHNCT's policy to link members with a PCP of their choice. Members may select pediatricians, family practitioners, internists, nurse practitioners or physician assistants as their PCP. If members do not initially exercise this choice, CHNCT will assign a member to a PCP based on the criteria outlined below:

- a past history of PCP assignment for member or family
- within a 15 mile radius of the member's address per DSS guidelines
- PCP has a total of less than 1200 HUSKY members across all HUSKY plans
- for newborns, if a facility or head of household calls or submits in writing a request for a PCP for a newborn, the effective date will be the first day of the following month, unless the newborn is less than 30-days old in which case the PCP effective date will be the newborn's date of birth

- PCPs may request a list of eligible CHNCT members who have selected them as PCPs by signing up via e-mail through CHNCT's website

Members are allowed to change PCPs whenever they feel it is in their best interest to do so. To change PCPs, members may contact CHNCT's Member Services Department at 1-800-859-9889, submit a request in writing, or complete a PCP change form found on CHNCT's provider website and fax it to CHNCT at 203-265-3197. PCP changes received after the 1st of the month will become effective the first of the following month. CHNCT monitors records to identify patterns of changes that warrant intervention or corrective action.

Newborn Enrollment

CHNCT will link newborns with a PCP and educate members about the HUSKY A newborn enrollment process. This is a joint effort of the Enrollment Department, Care Management Department and the Claims Department.

- The Care Management and/or Claims Department forward the newborn eligibility issues to the enrollment unit on a daily basis. The enrollment unit contacts the HUSKY enrollment broker for additional information or for eligibility verification.

Removal of a Member from PCP Panel

CHNCT is willing to assist a provider with any concerns or issues that may arise with a CHNCT member. If a provider wishes to be removed as PCP for a CHNCT member, providers must notify CHNCT's Member Services Department at 1-800-859-9889. CHNCT will facilitate the transfer in appropriate circumstances, by notifying the member and assigning a new PCP.

Closing Your Panel of Members

When a PCP feels that it is necessary to close their practice to new patients the practice should notify CHNCT in writing. The provider should indicate the reason for closing their panel and indicate if this is a permanent or temporary decision and if it applies to new patients. Please mail or fax this request to the Provider Relations Department immediately.

When a Specialist has concerns about the number of CHNCT members being referred to their practice, they should contact CHNCT's Provider Call Center at 1-800-440-5071 to discuss their issues regarding access and limiting the number of referrals.

Ending the Physician/Patient Relationship

CHNCT requires that sufficient notice be given to all patients affected by a change in your practice. Providers relocating out of the State of Connecticut, or retiring, must notify their patients in writing at least 30 days in advance, in addition to notifying CHNCT Network Management Department in writing 90 days in advance.

If you are a PCP, advise your patients to contact CHNCT Member Services Department at 1-800-859-9889 to designate a new PCP, even if your practice is being assumed by another physician.

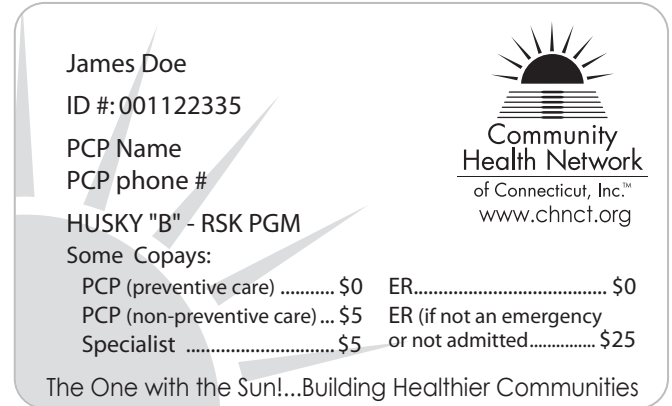
Identification Cards




Jane Doe
 ID #:001122334
 PCP Name
 PCP phone #
 HUSKY "A" - RSK PGM
 No Co-Pays


 Community Health Network
 of Connecticut, Inc.[™]
 www.chnct.org

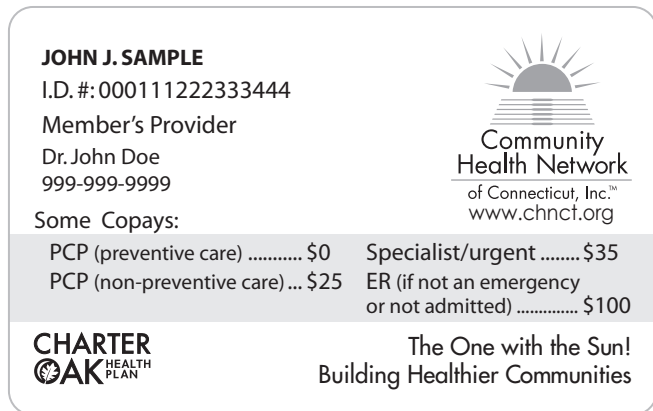
The One with the Sun!...Building Healthier Communities




James Doe
 ID #:001122335
 PCP Name
 PCP phone #
 HUSKY "B" - RSK PGM
 Some Copays:
 PCP (preventive care) \$0 ER..... \$0
 PCP (non-preventive care)... \$5 ER (if not an emergency
 or not admitted..... \$25
 Specialist \$5


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 of Connecticut, Inc.[™]
 www.chnct.org


The One with the Sun!...Building Healthier Communities



JOHN J. SAMPLE
 I.D. #: 000111222333444
 Member's Provider
 Dr. John Doe
 999-999-9999


 Community Health Network
 of Connecticut, Inc.[™]
 www.chnct.org

Some Copays:
 PCP (preventive care) \$0 Specialist/urgent \$35
 PCP (non-preventive care) ... \$25 ER (if not an emergency
 or not admitted) \$100

 The One with the Sun!
 Building Healthier Communities

CHNCT HUSKY A , HUSKY B and CHARTER OAK members are issued a member identification card with their name and PCP's name and phone number. All CHNCT member's Identification Number (ID) is the same as their Medicaid ID number. See above examples of HUSKY A, HUSKY B and Charter Oak identification cards issued by CHNCT.

Possession of a member ID card from CHNCT does not guarantee eligibility and/or payment from CHNCT. Eligibility can be verified by calling CHNCT's toll-free number, which is listed on the back of the membership card. Other options include on line verification via ePower (covered in the eligibility section of this manual) or for HUSKY A members, the State AEVS system also covered earlier in the manual.

HUSKY B and Charter Oak ID cards are similar to HUSKY A, however the card will have either 'HUSKY B or Charter Oak' stated on the front and include co-payment information.

CONNECT Card



The State of Connecticut also issues every active Medicaid recipient a separate card (CONNECT Card) with the recipient's name, 9-digit Medicaid ID number, and the card issue date. Client eligibility does not appear on the CONNECT Card and possession of this card does not guarantee client eligibility.

These cards assist providers in determining client eligibility using the AEVS. It is also used by members to determine eligibility for behavioral health, dental and pharmacy benefits. Providers should request this card from the member in an effort to obtain information needed to identify the member's status within a plan.

Transportation Services (Livery) – HUSKY A Only

It is CHNCT's goal to provide appropriate non-emergent, cost effective, prompt access to providers and clinical facilities for all qualified HUSKY A clients in need of such transportation assistance. In achieving this goal CHNCT has contracted with Coordinated Transportation Solutions, Inc (CTS) to coordinate transportation services. CHNCT's members are educated on transportation guidelines via the new member welcome call, member handbook and newsletters. To request transportation, members should call CTS at 1-800 -818-6781. Urgent Transportation provided 24 hours per day seven (7) days per week.

- Members must be eligible for HUSKY A services in CHNCT's health plan.
- Members must have a scheduled appointment with a CHNCT participating provider, or an "authorized" visit to a non-participating provider. All transportation requests require verification from the provider or clinical facility.
- Transportation must be requested at least 48-hours in advance for a scheduled, non-urgent appointment. The member must not have another way of getting to the appointment. This means:
 - Member does not have a car.
 - Member is not on the bus line or the bus trip is more than 60-minutes one way.
 - Member lives more than one quarter mile from the provider's office/clinical facility or the nearest bus line, or member is medically unable to walk (this needs to be verified with the PCP).
 - Member does not have access to other means of transportation (friend, family member, or social services agency).
 - If the member is sick or is taking a sick or injured child to an urgent care center or medically urgent same – day appointment with the PCP, transportation will be authorized. Urgent care appointments will be verified with the PCP by (CTS).
- Next day follow-up and unusual circumstances are given full consideration for transportation.

- To request transportation, members should call CTS at (800) -818-6781.
- Unescorted Children:
 - Children under 12 years of age must be escorted to medically necessary appointments. The child's parent, foster parent, caretaker, legal guardian or the DCF worker is responsible for providing the escort.
 - For children between 12-15 years of age, a consent form signed by a parent, caretaker, or guardian will be required in order for the child to be transported without an escort, unless access to the service without parental consent is specified by state statute (i.e., for family planning and mental health treatment).
 - For children 16 years and older, no consent form will be required.
- Members are encouraged to call CTS at least two (2) hours in advance to cancel any scheduled transportation.

CHNCT offers several special transportation programs: (HUSKY A members only)

- **THE CARE EXPRESS PROGRAM** allows pregnant members to call for transportation for prenatal appointments and through the post-partum period appointment two (2) hours before their scheduled appointment. Babies are eligible for this program until their first birthday.
- **THE MEDICAL TRANSPORTATION REIMBURSEMENT PROGRAM** allows members to be reimbursed for their travel expenses incurred by driving to health care appointments. The Transportation Coordinator at CTS will determine if the member is eligible and disperse a reimbursement letter and form. Eligibility is based on the following:
 - Members must have prior approval for travel services to verifiable clinical appointments.
 - Members will receive a standard travel expense reimbursement form to be completed and submitted at the end of each calendar month. Reimbursement is being requested for the previous month.
 - The CT Department of Transportation utilizes Public Utility Control Authority (PUCA) Mileage Guide to determine mileage reimbursement.
 - In the case of children requiring adult supervision, the parent or guardian providing the transportation will then qualify for reimbursement.
- **THE BUS PASS PROGRAM** allows CHNCT's members to receive a bus pass on an as needed basis. This service is provided for members that live on a bus route and have continuous use of CHNCT's current livery transportation program:
 - Member must be at least sixteen (16) years old
 - If a member is an un-emancipated minor, a bus pass will also be issued for the parent/guardian.
 - Member must live on a bus route
 - Member must call CTS five (5) business days before their bus pass expires to order a new bus pass.

Chapter 3 – Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT is the early and periodic screening, diagnosis and treatment program. Every person up to the age of 21 who is eligible for HUSKY A benefits is entitled to a full range of health care under the EPSDT Program.

The EPSDT Program for children and teens is designed to:

- furnish comprehensive, preventive health care through early and periodic screening
- provide these services at intervals, which meet reasonable standards of practice, as specified in the Periodicity Schedule
- ascertain physical and mental disabilities
- facilitate the correction or amelioration of identified disabilities and chronic conditions

Screening services are defined as the use of standardized tests performed under medical direction in the examination of a designated population, or to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.

CHNCT is committed to ensuring that all pediatric members receive the full range of EPSDT services and is available to work with providers through member education, case management or outreach efforts.

EPSDT Screening Protocol for PCPs

PCPs are required to conduct the screening examination based on the prescribed periodicity schedule. Screening rates for CHNCT Members are reported to the Connecticut Department of Social Services (DSS) at least annually and in accordance with DSS reporting requirements. The screening examination includes:

- A comprehensive health and developmental history, including assessment of both physical and mental health, development and nutritional status;
- A comprehensive, unclothed physical exam;
- Appropriate immunizations according to age and health history;
- Laboratory tests, including the following:
 - Lead Screening: At least one capillary or venous blood test on or before the child's second birthday.
 - Anemia screening at age 9-12 months and 2 years of age.
 - High risk and WIC patients at 15-18 months, 3, 4, and 5 years of age.
- Weight assessment and counseling for nutrition and physical activity including evidence of BMI percentile documentation, counseling for nutrition and for physical activity.
- Health education, including anticipatory guidance and risk assessment;
- Vision and hearing tests;
- Dental screening;
- Health Education; and
- Diagnosis and treatment of problems found during the screening.

Recommended Frequency of EPSDT Periodic Screenings

- **For infants & toddlers:** Age 2 weeks, 1, 2, 4, 6, 9, 12, 15, and 18 months
- **For Preschoolers:** Annually for ages 2, 3, 4, 5, and 6 years of age
- **Children and Adolescents:** At least every other year from age 7 through 10 years of age, then annually through age 11-20 years of age
- **Dental Care:** Starting at 6 months. Twice each year is recommended for dental exam, parental education and/or prophylaxis and fluoride

EPSDT Referrals for Diagnosis and Treatment

After the screening, the PCP should make all required referrals for diagnosis and treatment and:

- Identify potential specialty diagnosis and treatment providers;
- Schedule appointments for diagnosis and treatment; and
- Remind members of scheduled appointments for diagnosis and treatment.

The PCP serves as the case manager in cases involving a child with complex medical needs or with serious, multiple disabilities.

EPSDT Outreach

Direct outreach is a key ingredient of CHNCT's program to deliver preventive services to HUSKY A, HUSKY B and Charter Oak members. EPSDT recipients, heads of households and guardians must know that the Member is eligible health benefits and how to access the services.

CHNCT's outreach approach is focused and appropriate for the clientele we seek to serve. We use varied channels of communication to send a clear message to parents, heads of households and guardians that their eligible children can, and should, receive free checkups to identify health problems and follow-up services to get the required diagnoses and treatment. All eligible recipients are informed about EPSDT as soon as possible.

EPSDT - Billing Codes

Use the following codes when billing CHNCT. These are the only codes we can accept to track EPSDT services. The EPSDT codes may not be the same codes you used in the fee-for service system. Improper coding will negatively impact your EPSDT compliance.

Newborn Care

99460 – Initial hospital or birthing center care, per day, for evaluation and management of the normal newborn infant.

Initial Health Screenings

The age-appropriate codes below should be used for initial screenings performed the first time you see a patient for a well-child or adolescent visit.

99381 – under age 1

99382 – age 1 through 4 years

99383 – age 5 through 11 years

99384 – age 12 through 17 years

99385 – age 18 through 20 years

Periodic Health Screenings

The age appropriate codes below should be used for periodic health screenings. These periodic exams should be performed after the initial visit based on the age schedule recommended by the HealthTrack (EPSDT) Periodicity Schedule.

99391 – under age 1

99392 – age 1 through 4 years

99393 – age 5 through 11 years

99394 – age 12 through 17 years

99395 – age 18 through 20 years

Diagnostic Codes

Use the preventive diagnostic codes for comprehensive health screenings listed below:

V20 – Health supervision of an infant or child

V20.2 – Routine infant or child health check

V70 – General medical exam

V70.0 – Routine general medical examination at a health care facility

V72.3 – Gynecological exam

Vaccines for Children

The appropriate CPT code should be used to bill for each immunization provided, even if the vaccine was provided free of charge through the Department of Public Health, Vaccines for Children's Program (VFC). The Department of Public Health Immunization Program allows payment for vaccine administration. For a listing of vaccines currently available through the VFC/DPH program visit the following website: <http://www.ct.gov/dph/cwp/view.asp?a=3136&q=388450>. See Chapter 10 - Claims Submission and Payment for VFC billing instructions.

Chapter 4 – Provider Information

How to Join Our Network

Your participation with CHNCT is initiated by signing a formal Agreement with CHNCT. This Agreement is your acceptance with CHNCT that you are willing to treat our members and bill CHNCT for the services that you have provided. If you are not sure if you have an Agreement with CHNCT, please contact the Provider Call Center for assistance at 1-800-440-5071.

Along with signing an Agreement, the Practitioners in the group must be credentialed with CHNCT. CHNCT participates with – the Council for Affordable Quality Healthcare (CAQH) for credentialing. Please refer to CHNCT’s website to obtain the CAQH Provider Data Form at www.chnct.org

CHNCT will notify the practice when the practitioners are credentialed, along with returning a copy of the Practice Group Agreement that has been executed by your practice and CHNCT.

How to Complete an Agreement

Upon receipt of CHNCT’s Agreement it is important that all information is reviewed and understood as this is a binding contract. The date on the Agreement is the date in which CHNCT and your Practice has entered into and agreed to adhere to the language that is written in the Agreement. It is important to sign and return the Agreement immediately.

CHNCT does not assign retroactive Agreement effective dates. The effective date of the agreement is based upon the date of the agreement along with when your practice is willing to start.

Providers that join the group after the effective date of the Agreement will become participating once credentialed with CHNCT.

Sign the Agreement where it is applicable for your practice as well as list any additional information that is required. Alterations made to the Agreement are not acceptable. Only original Agreements and signatures are accepted. Both Agreements must be signed and returned to CHNCT to be executed. One original Agreement will be returned to your practice for your records.

Ensuring Correct Financial Information

In order to ensure that CHNCT is reporting the correct information regarding your practice to the Internal Revenue Services, please make sure the following is verified when the practice is in receipt of CHNCT’s remittance and or when you are calling in to the Provider Call Center.

- The checks are issued in the correct Provider name and or Group name including PC, LLC.
- The address on the remittance is issued to the correct address.
- The provider(s) of service listed on the remittance has rendered medical services to CHNCT’s members that are appearing on the remittance.

If the provider tax identification number, group name, and or billing address has changed, it is imperative that your practice contact CHNCT’s Provider Network Management department with the changes. Please submit a W-9 with the new information along with a letter. Fax the changes to Network Management at 203-265-3590 or call our Provider Call Center at 1-800-440-5071.

Primary Care Providers

A Primary Care Provider (PCP) may be an Internist, General Practitioner, Family Physician, Pediatrician, Nurse Practitioner, or Physician Assistant. PCPs should establish a relationship that

encourages CHNCT members to seek care from their PCP before utilizing any other health care delivery resources, except in emergency situations or where self-referrals are permitted.

Participating PCP's agree to: (in addition to the above noted provider/practitioner requirements)

Agree to accept all Members who select such Practitioner as the Member's PCP, unless the contracted provider notifies CHNCT that the practice is at capacity and is not accepting any new patients.

We recognize that many potential enrollees have no established provider relationships and are not familiar with the continuity-of-care concept. Therefore, PCPs should establish a personal relationship with the member. The PCP, office staff and support personnel shall be responsive to the member's needs and concerns and efficient in responding to them.

CHNCT recognize that, in many instances, members will select a particular primary care site based on geographic convenience, language capabilities and past experience or familiarity with the medical services available at a particular site. To assist the member in establishing a personal relationship with the PCP, CHNCT will perform telephonic outreach services.

Role of Primary Care Providers

The responsibilities of the PCP include but are not limited to:

- Provide basic Primary Care Services which include: well-child visits; preventive care and screening services; routine gynecological services; hospital and skilled nursing facility visits and admissions; basic lab services; brief, limited and comprehensive PCP visits; immunizations and injections, (including injectables); minor surgery; and dermatology.
- Act as a medical manager providing and coordinating medical care for CHNCT's members. Please refer to Chapter 3- Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT).
- Prescribe laboratory and X-ray services, to ensure medically necessary treatment of physical conditions for the purpose of diagnosis.
- Obtain prior certification for covered services, for non emergency and emergency hospitalizations within 24 hours of an admission.
- Referral of CHNCT members only to CHNCT participating providers and facilities except in emergencies or when CHNCT specifically approves a referral to a non-participating provider. A complete listing of participating providers and facilities can be found on CHNCTS website at www.chnct.org.
- Referral of members to specialists when medically necessary and in accordance with CHNCT's prior authorization policies.
- Ensuring the availability of medically necessary services to members enrolled with the primary care provider on a 24 hours a day, 7 days per week basis. This includes PCP coverage for after hours or when the PCP is otherwise unavailable.
- Maintaining a panel of not more than 1,200 active Managed Medicaid members, including both CHNCT members and non-CHNCT members.
- Being available for patient appointments at the "billing practice" a minimum of twenty (20) hours per week and at least four (4) days per week.

Monthly Provider Reports

If you are a participating provider your practice can sign up to receive CHNCT's Monthly Provider Reporting Package and the best part is that it is free! The reports can assist in managing your practice!

The CHNCT Monthly Provider Reports consists of a standard package of reports that include a

- Claims Activity Report;
- Claims Turnaround Report;
- Denied Claims Report;
- Paid Amount by Check Date; and
- Monthly Patient Roster.

To register for the above reports go to www.chnct.org.

Confidentiality of Medical Records

The relationship and the communication between provider and patient are privileged; therefore, the medical records containing information about that relationship are confidential. The physician's code of ethics, Connecticut and Federal laws and Federal regulations such as the Health Insurance Portability and Accountability Acts' (HIPAA's) Privacy Rule, protect against the disclosure of the contents of medical records to persons or agencies who are not properly authorized to receive such information. Providers may release a patient's health information without an authorization form for purposes of treating the patient, billing for treatment provided, certain health care operation activities and certain government oversight functions. For the provider to release the contents of a patient's medical record to a third party in all other situations, the patient must first authorize the disclosure by completing and signing an authorization form. In the case of minors or the infirm, a parent, guardian or legal representative must authorize the release. Family planning, HIV, behavioral health and substance abuse treatment information must be treated with particular sensitivity to confidentiality, and may be released only by the patient, even if the patient is a minor. (Consult your malpractice carrier for specific circumstances.) If the record is for a deceased individual, the executor of the estate must authorize the release.

To further assure members' privacy, CHNCT restricts access to a patient's health information to that which is the minimum necessary for an employee to perform his or her specific duties. Access to a patient's medical record will be given only to those employees who would require access as part of their daily work, such as medical record personnel and health professionals inside CHNCT who are directly involved in the delivery or evaluation of that patient's care. All requests for medical records information must be handled according to this policy.

Fraud and Abuse

Providers shall comply and cooperate with any CHNCT or DSS programs directed at detecting, investigating and preventing fraud and abuse in the HUSKY A and HUSKY B Programs and Charter Oak Health Plan. Any provider's office should immediately notify CHNCT when it detects a situation of potential fraud or abuse involving an employee, a Provider or a member, including, without limitation, the following: (i) false statements, misrepresentation, concealment, failure to disclose and conversion of benefits; (ii) any giving or seeking of kickbacks, rebates, or similar remuneration; (iii) charging or receiving reimbursement in excess of the agreed upon rate; and (iv) false statements or misrepresentation made by a practitioner, subcontractor or Member in

order to qualify for the HUSKY program. Providers may report suspected fraud or abuse directly to CHNCT's Fraud Reporting Hotline at 1-866-700-6109.

- a. Providers submitting to CHNCT any data, including encounter data, shall be truthful, accurate and complete.
- b. Provider must maintain compliance with all applicable federal and state laws and regulations related to the services provided.
- c. Any Provider that has been suspended, excluded or terminated from or convicted of a civil or criminal offense in connection with their participation in the Medicare or Medicaid programs or other federal health program or has been excluded from participation in any Federal health care program under either Section 1128 or 1128A of the Social Security Act is ineligible to participate in CHNCT's network.
- d. If requested by CHNCT, Providers shall cease any conduct that CHNCT deems to be abusive of the HUSKY Programs or Charter Oak Health Plan and to take any corrective action requested by CHNCT. Providers must provide CHNCT with full and complete information in its possession when it becomes aware of any Participating Provider who has been convicted of a civil or criminal offense related to such practitioner's involvement in the Medicare or Medicaid programs or other federal health program.

Termination of a Practitioner

CHNCT contractually has the right to terminate, suspend or restrict a practitioner's participation in CHNCT's provider network upon determination that the practitioner does not meet CHNCT's credentialing standards or has breached any contractual obligations. The practitioner shall have a period of time as defined in CHNCT's Provider Agreement after such notice to cure such failure or breach to the satisfaction of CHNCT.

CHNCT requires a written notification ninety (90) days in advance for termination without cause.

Access and Availability Standards

CHNCT requires that all participating providers maintain emergency coverage 24 hours a day, 7 days a week. Specifically, on-call coverage is a contractual obligation for any participating PCP. CHNCT should be informed of coverage arrangements.

Provider shall ensure that members have access to a live individual to handle medical problems in an emergency.

Additionally, PCP scheduling practices must ensure that:

- Emergency cases are seen immediately or referred to an emergency facility;
- Urgent cases are seen within 48 hours of PCP notification;
- Routine cases are seen within 10 days of member's request;
- Well-care visits are scheduled within six weeks of PCP notification;
- New member appointments are provided within two weeks of notification;
- Maximum waiting times are within:
 - 30 minutes for scheduled appointments and
 - Within 60 minutes for unscheduled appointments
- Must have 24-hour on-call system; and
- All providers must be available through the contracted practice a minimum of 20-hours each week, and at least 4 days per week

CHNCT evaluates and monitors provider compliance with scheduling requirements. These scheduling requirements are designed to enhance access to health services and to provide assurance of service availability based on the urgency of need.

Accessibility for the Hearing-Impaired Individual and Linguistic Access Cultural Linguistic Access Services Program (CLAS)

CHNCT understands how difficult receiving services can be when there are communication barriers or when English is a second language. CHNCT's Cultural & Linguistic Access Services Program (CLAS) goals are to ensure that all members receive fair and effective treatment in a culturally and linguistically appropriate manner.

The CLAS Program helps CHNCT's members receive verbal & written communication that satisfies their everyday needs. CHNCT's number one priority is to ensure that each one of its members receives knowledgeable & quality services in their primary language regardless of their communication barriers. Some of the CLAS' Program Services include:

- Face-to-Face Interpretation Services – CHNCT provides interpretation services; an interpreter will be present, for eligible members during health care appointments. A 72-hour notice is needed for an interpretation request, except in the case of an emergency. All request need to be received by CHNCT's Member Services Department.
- Sign Language and TDD/TTY Access Services – for the hearing impaired. Please call 1-877-659-1252 for a Telecommunication Device to accept text messages.
- Services for Members with Visual Disability and Braille Services – CHNCT will provide special member services for the visually impaired, materials and other resources.
- Telephonic Interpretations – CHNCT has Interpretation Services through a telephonic hook up. These services can provide Interpretations in any language.

All Cultural Linguistic Access Services are FREE & CONFIDENTIAL for CHNCT active members. For more information or to request services, please call our Member Services Department at 1-800-859-9889. Our staff speaks English & Spanish and is ready to help you Monday through Thursday 8 am to 5pm, Friday 9am to 5pm.

Chapter 5 – Reporting Child Abuse and Neglect

Connecticut law requires certain citizens to report suspected child abuse and neglect. These mandated reporters are people in professions or occupations that have contact with children or whose primary focus is children. The law requires that they report suspected child abuse or neglect. In reporting in good faith, they are immune from civil and criminal liability. However, failure to report could result in fines not less than \$500, up to \$2,500.

The following is an outline of the legal requirements of “mandated reporters,” those professionals who, because their work involves regular contact with children, are mandated by law to report suspected child abuse and neglect.

- Chiropractors
- Clergy
- Dental Hygienists
- Dentists
- Domestic Violence Counselors
- Juvenile or Adult Parole Officers
- Licensed/Certified Emergency Medical Services Providers
- Licensed Marital and Family Therapists
- Licensed or Unlicensed Resident Interns
- Licensed or Unlicensed Resident Physicians
- Licensed Physicians
- Licensed Practical Nurses
- Licensed Substance Abuse Counselors
- Licensed Surgeons
- Medical Examiners
- Mental Health Professionals
- Optometrists
- Osteopaths
- Pharmacists
- Physical Therapists
- Physician Assistants
- Podiatrists
- Police Officers
- Psychologists
- Registered Nurses
- School Coaches
- School Guidance Counselors\
- School Paraprofessionals
- School Principals

- School Teachers
- Sexual Assault Counselors
- Social Workers
- Any person paid to care for a child in any public or private facility, day care center or family day care home licensed by the State.

What must be reported:

- Mandated reporters are required to report or cause a report to be made when, in their professional capacity, they have reasonable cause to suspect or believe that a child under the age of 18 has been abused, neglected or is placed in imminent risk of serious harm by a person responsible for the child’s health, welfare or care, or by a person given access to the child by the responsible person. (Connecticut General Statutes 17a – 101a)
- Child abuse occurs where a child has had non-accidental physical injury inflicted upon him other than by accidental means, has injuries at variance with history given of them, or is in a condition resulting in maltreatment, such as, but not limited to, malnutrition, sexual molestation or exploitation, deprivation of necessities, emotional maltreatment or cruel punishment. (CGS 46b-120)
- Child neglect occurs where a child has been abandoned, is being denied proper care and attention physically, educationally, emotionally, or morally, or is being permitted to live under conditions, circumstances or associations injurious to his well-being (CGS 46b-120)

When making a report, a mandated reporter is required to provide the following information, if known:

- Names and addresses of the child and his parents or responsible caregiver(s)
- Child’s age and gender
- Nature and extent of injury, maltreatment or neglect
- Approximate date and time the injury, maltreatment or neglect occurred
- The circumstances in which the injuries, maltreatment or neglect became known to the reporter
- Previous injury, maltreatment or neglect of the child or siblings
- Name of the person suspected to have caused the injury, maltreatment or neglect
- Any action taken to treat or help the child
- Any other information the reporter believes would be helpful

Mandated reporters who, *outside* their professional capacity, have reasonable cause to suspect or believe that a child under the age of 18 is in imminent risk of being abused or has been abused or neglected, can and should make a report to the DCF Hotline.

How to report:

**To Report Suspected Child Abuse or Neglect, call:
Child Abuse and Neglect Hotline (24 hours a day
1-800-842-2288
TDD number: 1-800-624-5518**

Mandated reporters must report orally to DCF or a law enforcement agency within 12-hours of suspecting that a child has been abused or neglected and must submit a written report (DCF-136 form) to DCF within 48-hours of making the oral report. (DCF is required to tape record all reports to the Hotline).

- Any report about a staff member of a public or private institution or facility that cares for such child, or a public or private school, must report to DCF or the police, and also notify the person in charge of the institution or school that a report has been made.

- After making a report to DCF, mandated reporters who are members of the staff of a public or private institution or facility that cares for children, or a public or private school must also submit a copy of the written report to the head of the school, institution or facility or designee.
- In the case of a report concerning a certified public school employee, a copy of the written report also must be sent by the person in charge of the facility to the Commissioner of Education.
- In the case of a report concerning an employee of a facility or institution that provides care for a child that is licensed by the state, a copy of the written report must also be sent by the mandated reporter to the executive head of the state licensing agency.
- Police must report to DCF immediately upon receipt of any oral report of abuse or neglect.
- DCF reports to the police within 12 hours upon receipt of any oral report alleging sexual abuse or serious physical abuse or serious neglect.

Anonymity:

- Mandated reporters are required to give their name when they make a report to DCF. This greatly aids in the investigation of the report. However, reporters may request anonymity to protect their privacy from the family.
- This means that DCF would not disclose their name or identity unless mandated to do so by law.
- Unless a reporter gives written consent, his/her name would not be disclosed except to:
 - A DCF employee
 - A law enforcement officer
 - An appropriate state's attorney
 - An appropriate assistant attorney general
 - A judge and all necessary parties in a court proceeding
 - A state child care licensing agency, executive director of any institution, school or facility or superintendent of schools
 - Also, if DCF suspects or knows that the reporter knowingly makes a false report, his or her identity shall be disclosed to the appropriate law enforcement agency and to the alleged perpetrator of the incident.

Immunity and penalty:

- Immunity from civil or criminal liability is granted to people who make required reports in good faith.
- Immunity is also granted to people who in good faith have not reported. However, failure to report could result in fines up to \$500 to \$2,500 and mandated reporters could also be sued for damages if further injury is caused to the child because they did not act.
- Anyone who knowingly makes a false report of child abuse or neglect may be fined up to \$2,000 or imprisoned for not more than one year, or both. The identity of any such person shall be disclosed to the appropriate law enforcement agency and to the perpetrator of the alleged abuse.
- Employers may not discharge, discriminate or retaliate against an employee for making a good faith report or testifying in an abuse or neglect proceeding. The attorney general can bring a court action against any employer who violates this provision, and the court can assess a civil penalty of up to \$2,500 plus other equitable relief.

Informing the family:

- Mandated reporters are under no legal obligation to inform parents that they have made a report to DCF about their child. In cases of abuse, reporters should not talk with parents

before DCF investigates the allegations. This may put the child at greater risk and interfere with DCF's investigation as well as any criminal investigation. In deciding whether there is a suspicion of abuse/neglect, a professional may need to talk with parents.

Investigation of abuse or neglect report:

- DCF is responsible for immediately evaluating and classifying all reports of suspected abuse/neglect/imminent risk.
- If the report contains information to warrant an investigation, DCF must make its best effort to begin an investigation within two hours if there is an imminent risk of physical harm to a child or another emergency; and within three days for all other reports.
- In all cases, DCF must complete the investigation in 30 calendar days.
- When conducting a child abuse or neglect investigation, DCF or a law enforcement agency must coordinate activities to minimize the number of interviews with any child.
- DCF must obtain consent from the parent, guardian or person responsible for the child's care for any interview, unless DCF has reason to believe such person or a member of the child's household is the alleged perpetrator.
- When such consent is not required, the interview must be conducted in the presence of a 'disinterested adult' (typically, a person who is impartial and has no self-interest in the case). If a disinterested adult is not available after reasonable search and immediate access is necessary to protect the child from imminent risk of serious harm, DCF or a law enforcement agency will still interview the child.
- If, after the investigation has been completed, serious physical abuse or sexual abuse is substantiated, DCF must notify the local police, and either the Chief State's Attorney/designee or a state's attorney in the judicial district in which the child resides or in which the abuse occurred; A copy of the investigation report must also be sent.

Suspected abuse by a school employee:

- As noted, mandated reporters are required to report any suspected child abuse, neglect or imminent risk of serious harm directly to DCF or the police; this includes situations when the alleged perpetrator is a school employee. Then the reporter must notify the head of the school that a report has been made.
- Investigations of suspected child abuse, neglect or imminent risk of serious harm by a school employee are conducted by DCF.
- If, after such investigation, DCF has reasonable cause to believe that a child has been abused by a certified public school employee (in a position requiring a certificate), DCF shall notify the superintendent of such finding and shall provide him/her with records concerning such investigation.
- The superintendent must suspend such employee. The suspension shall be with pay and will not diminish or terminate the employee's benefits.
- Within 72 hours after such suspension, the superintendent shall notify the local or regional board of education and the Commissioner of Education of the reasons for and conditions of the suspension.
- The superintendent shall disclose the DCF records to the Commissioner of Education and local or regional boards of education or their attorney for purposes of review of employment status of certification.
- The suspension must remain in effect until the local Board of Education takes action.
- If the employee's contract is terminated, the superintendent shall notify the Commissioner of Education or his representative within 72 hours. The Commissioner

of Education may then commence certification revocation proceedings.

- The superintendent may suspend any other school staff member in similar circumstances.

Suspected abuse to a member by an institution or facility providing child care:

- Whenever DCF, based on the results of an investigation, has reasonable cause to believe that a child has been abused or neglected by a staff member of a public or private institution or facility providing child care, DCF shall notify the institution, school or facility and provide records concerning the investigation.
- The institution may suspend the employee. The suspension must be with pay, not diminish or terminate the employee's benefits and remain in effect until resolved by the person's employer.

Chapter 6 – Quality Improvement and Assurance

Quality Improvement Program

The CHNCT Board of Directors has authority and responsibility for the overall quality of care and service provided to the HUSKY and Charter Oak member population. The Board of Directors has designated the Quality Improvement Committee (QIC) as the body charged with development and direct oversight of the Quality Improvement Program.

The QIC reviews and has final authority to approve CHNCT's Care Management, Disease Management and Quality Improvement Programs which are reviewed annually. In addition, the QIC monitors performance and program effectiveness via program-specific reporting which includes but is not limited to:

- Annual review and development of the Care Management Program and Quality Improvement Program and Work Plan
- Semiannual review of Quality Improvement Performance Reports
- Review and oversight of the activities of the Credentialing Committee
- Review of Utilization Management performance data
- Review of member and provider satisfaction data
- Feedback to network providers about quality initiatives and performance on utilization and quality indicators
- Development of provider and site-specific performance measures
- Identification of quality improvement initiatives (clinical and non-clinical)

Also reporting to the QIC is the Service Quality Committee (SQC) which is responsible for development, oversight and monitoring of CHNCT's clinical and non-clinical services for all lines of business in accordance with CHNCT's Quality Improvement Program. It reports to CHNCT's Quality Improvement Committee and CHNCT's Quality Oversight Committee, at least quarterly. The primary functions of the SQC are:

- a. To ensure quality services to Members through assessment of established quality improvement activities and performance through data analysis;
- b. To respond to sub-optimal performance by developing alternative programs and/or approaches to service delivery;
- c. To anticipate Member needs resulting from changes in CHNCT's membership and proactively plan for the development of appropriate interventions/activities;
- d. To coordinate cross-functional collaboration to ensure Members receive appropriate services in a timely manner;
- e. To monitor activities of quality improvement workgroups;
- f. To facilitate CHNCT's Quality Improvement Committee's oversight of the Quality Improvement Program.

Quality Improvement Committee (QIC)

The committee meets at least quarterly and is chaired by a clinician administrator from one of the FQHCs, who also sits on the CHNCT Board of Directors. The QIC is comprised of the following individuals:

- Clinicians and administrators from CHNCT's primary care sites
- Behavioral health provider

- CHNCT President and CEO
- CHNCT Vice President, Operations
- CHNCT Vice President, Medical Director
- CHNCT Director, Quality Improvement
- CHNCT Director, Provider Relations
- CHNCT Vice-President, Health Services
- CHNCT Director, Care Management

Preventive Health and Clinical Quality Practice Guidelines

CHNCT adopts and disseminates preventive health and clinical practice guidelines to promote compliance with broadly-accepted preventive health and clinical practice standards of care. These include primary care guidelines for children and adults as well as for pregnant members, and are based on nationally recognized standards as published by various professional organizations and on guidelines as set forth by the Connecticut Department of Social services for the HUSKY Program. Selected preventive health and clinical guidelines are reviewed, amended as indicated, and formally adopted by CHNCT's Clinical Quality Committee on a regular basis.

Please refer to the clinical guidelines posted on CHNCT's web-site.

Office Requirements

PCP and OB/GYN on-site office evaluations are necessary to ensure that all CHNCT service delivery locations comply with defined standards and that each location is a safe, sanitary, and an accessible place in which to deliver health care services to HUSKY and Charter Oak Health Plan members. An office compliance audit is not the only objective of the site visit. The visit also affords an opportunity for CHNCT staff to interact with the provider and their office associates, to explain the workings of the HUSKY and Charter Oak Health Plan program and to inform office personnel about any forthcoming program changes that are on the horizon.

Site visits are performed by the Quality Improvement Clinical Quality Analyst (CQA) who is a Registered Nurse. The CQA uses an on-site review tool to evaluate a provider's office. Conditions such as handicapped access, fire safety, medication safety, medical record documentation, to name a few, are assessed. When the site visit is completed the CQA will send a letter to the office containing the results of the audit. Offices that do not meet CHNCT's standards receive a letter enumerating the deficiencies noted and are afforded a reasonable opportunity to correct them. Thereafter, CHNCT will conduct a follow-up visit.

CHNCT reserves the right to terminate a practitioner from the provider network, if office conditions do not meet CHNCT's defined standards after notice of required corrective action has been provided.

Medical Records Standards

Comprehensive and accurate medical records are necessary to ensure quality and continuity of care provided to HUSKY and Charter Oak Health Plan members. Each provider must maintain, and make available, medical records, in accordance with their HUSKY and Charter Oak Health Plan provider participation agreement with CHNCT. All entries in the medical record should be compiled systematically and filed in chronological order so that information is easily found. Each HUSKY and /or Charter Oak Health Plan patients' medical record must include the following information:

1. **Patient Identification:** Each page of the record shall contain the patient's name or identification number.

2. **Personal Information:** Each chart shall include the patient's full name, date of birth, address, employer, home and work telephone numbers and marital status.
3. **Identification of Author:** All entries shall contain the author's identification, which may be handwritten, stamped and initialed, or a unique electronic identifier.
4. **Entry Date:** All entries shall be dated.
5. **Legibility:** The record shall be legible to someone other than the writer.
6. **Problem List:** The chart shall contain a current problem list with significant medical conditions and illnesses noted. The chart shall also contain evidence that problems from previous visits have been addressed.
7. **Advance Directives:** Documentation of whether or not the member has an Advance Directive is to be placed in a prominent position within the record.
8. **Allergies:** Allergies are prominently noted on the record. If the patient has no known allergies, this is noted in the record.
9. **Immunizations:** A current immunization record shall be present for each pediatric patient.
10. **Hospitalizations:** Each record shall contain summaries of hospitalizations, surgical reports and emergency room visits, if applicable. Discharge summaries shall also be included in each record.
11. **Past Medical History:** Medical history shall be documented for each patient seen more than three times. Medical history documentation includes serious illnesses, accidents, and operations.
12. **History and Physical Exam:** The chief complaint and history of the present illness shall be documented (vital signs appropriate to age and chief complaint). Physical findings are documented.
13. **Risk Factors:** Risk factors shall be documented at physical examination visits (smoking, alcohol, home firearms, safety, substance abuse, domestic violence and child abuse/ neglect).
14. **Diagnosis and Treatment:** A working diagnosis or assessment shall be noted and a treatment plan shall be described.
15. **Tests and Reports:** All ordered diagnostic tests shall be noted in the chart. There shall be evidence (note, signature or initials) that a physician has reviewed test results and there shall be evidence of abnormal test result follow-up.
16. **Follow-up:** Planned follow-up shall be documented. The specific time of return shall be noted in weeks, months or as needed. Patient phone calls and patient instructions shall be documented.
17. **Prescriptions:** New prescriptions and refills shall be documented in the chart: drug name, dose and quantity shall be noted.
18. **Ancillary Services:** There shall be documentation of referrals to specialists and notations of the specialist's findings and recommendations.
19. **Non-Compliance Issues:** Member no-shows and other non-compliance issues shall be noted in the record and a plan for patient contact shall be documented.

Termination of a Practitioner

CHNCT contractually has the right to terminate, suspend or restrict a practitioner's participation in CHNCT's provider network upon determination that the practitioner does not meet CHNCT's credentialing standards or has breached any contractual obligations. The practitioner shall have ten (10) business days after such notice to cure such failure or breach to the satisfaction of CHNCT.

Healthcare Effectiveness Data and Information Set (HEDIS)

CHNCT annually conducts an extensive analysis of performance measures as set forth by the National Commission on Quality Assurance (NCQA). As of 2011, HEDIS is comprised of 75 measures across eight domains of care which include but are not limited to:

- Effectiveness of Care
- Access/Availability of Care
- Satisfaction with the Experience of Care
- Use of Services
- Cost of Care

The production of HEDIS data is in accordance with NCQA requirements and the process is audited by an NCQA certified Auditor to ensure completeness and accuracy. The measures are calculated through the mining of claims data and combined with chart abstraction information as directed by the NCQA specifications. The accuracy of claims data is critical to the success of this project.

There is an exacting process by which charts are randomly selected for medical record abstractions and the specifications for this are as well as the timing of the chart reviews is developed by NCQA. Strict adherence to these specifications is mandatory and also subject to HEDIS auditor oversight. We understand that requests for HEDIS records may be disruptive to a busy medical office and we are sincerely appreciative of your cooperation.

Data obtained from the HEDIS project is reviewed by Senior Management, presented to the SQC and the QIC. Follow up activities include analysis of the results and cross-functional development of interventions designed to encourage and support CHNCT members to obtain needed health care services.

Consumer Satisfaction Surveys: CAHPS

CHNCT measures health care consumer satisfaction with the quality of care and customer service. The results are reported to CHNCT in the aggregate only. Some of the measures include but are not limited to:

- Overall ratings of specialists, personal doctor, health care and the Health Plan;
- Getting needed care;
- Getting care quickly;
- How well doctors communicate
- Customer Service
- Shared decision making;

The result of this survey is presented to CHNCT's Senior Management Team, the SQC and the QIC.

Ongoing Quality Improvement

Multiple cross-functional workgroups are charged with the responsibility of analyzing surveys and utilization reports with the goal of improving Members' health. To this end, the workgroups develop and enhance ongoing interventions designed to encourage CHNCT Members to obtain services available pursuant to Husky and Charter Oak benefits.

Chapter 7 – Practitioner Credentialing

Credentialing Requirements

CHNCT's credentialing process is designed to ensure that only practitioners meeting CHNCT's standards are permitted to participate in CHNCT's provider network. CHNCT credentials all independent practitioners who provide care to its members including: physicians, physician's assistants, nurse practitioners, nurse midwives, osteopaths, etc. Practitioners who provide care to members incidentally and solely through an affiliation with a facility such as a hospital or surgicenter are not directly credentialed by CHNCT, but are instead credentialed by the facility itself. Practitioners must be re-credentialed every 36 months to maintain their participation status in CHNCT's network.

CHNCT participates with the Council for Affordable Quality Healthcare (CAQH), utilizing the universal CAQH application to process an initial or re-credentialing application. Additionally, upon request, CHNCT will register practitioners with CAQH thereby obtaining an identification number for the practitioners' use in completing the CAQH application. CAQH requires practitioners to update information in accordance with standards set by the National Committee for Quality Assurance (NCQA).

Upon receipt of a completed application CHNCT conducts primary source verification of State licensure and board certification, if applicable, or highest level of education. In the event that any information obtained during the credentialing process varies from the information provided to CHNCT by the practitioner CHNCT will notify the practitioner and request clarification as appropriate. Practitioners have the right to correct erroneous information. Further, practitioners have a right to review information submitted in support of their credentialing applications, except for information that is peer review protected.

All credentialing information is maintained by CHNCT in a strictly confidential manner.

Credentialing Committee

The Credentialing Committee is responsible for general oversight of CHNCT's practitioner and provider credentialing and re-credentialing processes. It is charged by CHNCT's Quality Improvement Committee with the responsibility and authority to periodically review and approve CHNCT's credentialing/re-credentialing policies and procedures as well as criteria for participation in CHNCT's provider network. The Committee has final authority for the approval of candidates for initial credentialing and re-credentialing of network practitioners. The Committee conducts peer reviews of: candidates who do not meet minimal criteria for network participation; those candidates who have malpractice claims histories and/or license sanctions; and those practitioners who are brought to the Committee's attention for review of reported clinical performance or service deficiencies. The Committee has the authority to terminate practitioners and providers from CHNCT's network. The Committee reviews appeals from those against whom it has levied sanctions or taken adverse actions.

Reports on Credentialing Committee determinations and actions are submitted to the Quality Improvement Committee as well as to CHNCT's Board of Directors.

Delegated Credentialing

CHNCT may formally delegate credentialing activities to subcontractors, hospitals, and provider organizations with which it contracts. In these arrangements, CHNCT remains responsible for assuring its members that the same standards for participation are maintained throughout

its practitioner network, and CHNCT retains the right to approve, suspend or terminate any practitioners, providers and sites of care. Prior to formal delegation taking place, CHNCT performs a pre-delegation evaluation of the potential delegated entity's ability to carry out credentialing and re-credentialing activities in accordance with CHNCT's minimum standards and criteria. Delegated oversight audits are conducted annually. In the event a delegated entity does not meet CHNCT's standards as documented in the written audit findings, that entity is required to submit a Corrective Action Plan (CAP) for approval within thirty (30) days of the date of the audit report. A follow-up audit addressing the deficiencies addressed in the CAP takes place within three months of the CAP approval date.

Any facilities or provider groups wishing to pursue a delegation contract with CHNCT should contact CHNCT's Provider Relations or Quality Improvement Departments.

Provider Office Site Visits: Required for Primary Care Providers, Primary Care Dentists and OB/GYN Providers

Because most patient care is rendered in practitioners' offices, FQHC's and CHC's, CHNCT has a process for ensuring that the offices of all PCP's and OB/GYN's meet CHNCT's office site standards. The initial credentialing process triggers a site visit that reviews the quality of the facility within which the care is provided. This review of the facility ensures the physical accessibility of the space, the adequacy of the examination and waiting areas, and the adequacy of appointments and of medical/treatment record-keeping practices at each site.

The results of the site visit are communicated to the practitioner in writing. In the event that a site does not meet CHNCT standards, the practitioner is notified of any deficiencies(s) and afforded an opportunity to correct them.

Continuous Monitoring of CHNCT's Practitioner Network Appeal Process for Limitations/Suspensions/Terminations

Ensuring that the network cultivates providers who deliver high-quality health services is a continuing objective. Therefore, on a monthly basis, CHNCT monitors the following which, depending on the findings, may be presented to the Credentialing Committee:

- Member complaints based on quality of care or quality of service;
- Practitioner Medicare or Medicaid sanctions as published by the United States Department of Health and Human Services Office of the Inspector General.
- Current DEA status
- Current Licensure status
- Current Board Certification status
- Site visit results

Additionally for practitioner offices with on-site laboratories, CHNCT requires a copy of the Clinical Laboratory Improvement Amendment (CLIA) certificate.

Quality of Care and Quality or Service Monitoring

CHNCT acts immediately to terminate any provider from participation in the network upon notification from any source that the provider has been terminated or suspended from participation in the Medicaid or Medicare program, has lost his/her license, or has been convicted of a criminal act. In addition, providers who fail to complete re-credentialing requirements in a timely manner or are found to be engaged in behavior or are practicing in a manner that appears to pose a

significant risk to the health, safety of CHNCT's Members are subject to immediate suspension or termination from CHNCT's network.

Appeal Process for Limitations/Suspensions/Terminations

In the event that a practitioner's initial or re-credentialing application is denied, CHNCT sends a letter to the practitioner informing the practitioner of the decision and the reason(s). The practitioner may appeal the decision by forwarding an appeal request, in writing, to the Credentialing Coordinator within thirty days of the date of CHNCT's letter. Thereafter, the practitioner has an additional thirty days to submit any and all information he or she wishes to present for reconsideration. For more detailed information, feel free to contact CHNCT's Quality Improvement Department.

Chapter 8 – Pharmacy

As of February 1, 2008, the Connecticut Department of Social Services (DSS) is managing all the pharmacy benefits for the HUSKY and Charter Oak programs.

HP Enterprise Services (HP) formerly EDS will process pharmacy claims for DSS and HP/EDS will also handle all pharmacy prior authorization requests.

For prior authorizations, please contact the HP/EDS Prior Authorization Call Center which is available 24 hours a day, 7 days a week at 1-866-409-8386 or locally at 860-269-2030. For general provider inquiries, please call 1-800-842-8440 (Monday-Friday, 8:00 AM - 5:00 PM EST).

Please refer to the following web site to access the Department of Social Services Preferred Drug List: www.CTDSSMAP.com.

Chapter 9 – Care Management and Disease Management Services

Care Management Services

The following services are managed in the Care Management Department:

- Prior Authorization
- Utilization Review (including pre-certification and concurrent review)
- Case Management
- Intensive Case Management for Disease Management Programs

Prior Authorization

Prior authorization means obtaining approval from CHNCT prior to rendering the service/procedure. It is the review of specified services/procedures for medical necessity prior to and/or throughout the episode of care.

Prior authorization can be obtained by calling the Care Management Department at 800-440-5071 or by faxing a request to 203-265-3994. The following information is necessary before a prior authorization can be given:

- Member name
- Member ID
- Member date of birth
- Diagnosis or reason for treatment
- Treatment plan such as proposed treatment and pertinent clinical information to support the request. Please refer to the instructions on the applicable authorization request form on the website for the information needed to process the request. For Home Health Services and Therapies, please include the number of visits requested. For DME requests, please include the number of items requested

The Care Management staff will review the request against established criteria and will respond to the provider within 2 business days by sending an authorization or a denial letter to the requesting provider, vendor or facility and the member.

Please refer to CHNCT's website for the Husky A, Husky B and Charter Oak Health Plan Benefit Summary grid.

Maternity Admissions: (HUSKY and Charter Oak Health Plan)

Effective in March 2009, CHNCT participating hospitals in Connecticut are no longer required to notify CHNCT of a routine, uncomplicated, normal maternity admission.

This applies to an admission for a vaginal delivery when the patient and newborn remain in the hospital for 2 days or for a cesarean delivery when the patient and newborn remain in the hospital for the 4 days.

Any hospital admission beyond the 2 or 4 days, or any hospital admission related to a complicated pregnancy or delivery, preterm labor admission, sick newborn admission, etc. require notification to the plan.

Please note that CHNCT will follow up with the delivering OB offices to obtain birth weight information and any other delivery information CHNCT may need to gather for reporting purposes.

The following services do not require a referral or prior authorization regardless of provider participation status:

- Emergency Department Care
- Preventive care
- Family Planning
- Lab services provided by Quest. All other lab requires prior authorization
- Emergent labor room related services

Note: In the event a covered specialty service is not available for a member within CHNCT's provider network, CHNCT may authorize a referral to a non-participating provider. The appropriate number of visits and the duration of the referral will be determined by CHNCT.

Referral forms may be obtained by calling the Care Management Department at 800-440-5071 or from the website at www.chnct.org.

Utilization Review

Pre-certification (elective admissions)

Pre-certification is a form of prior authorization. **Pre-certification is required for:**

- **All elective hospital inpatient admissions**
- **All inpatient admissions to skilled nursing facilities or rehabilitation facilities**

The provider admitting the member for an elective admission needs to request a pre-certification prior to admission. The following information is necessary:

- Member name
- Member ID
- Member date of birth
- Diagnosis and ICD-9 code
- Procedure and CPT-4 code
- Place of service
- Date of service
- Admitting physician
- Length of stay
- Pertinent Clinical Information to support request

Requests should be made at least 2 business days prior to the planned admission. For each admission the Care Management staff will assign a length of stay. Failure to obtain the required pre-certification will result in denial of payment.

Certification (urgent/emergent admissions)

- **Certification is required for emergent hospital admissions**

The provider admitting the member should notify CHNCT upon admission by calling 1-800-440-5071 or faxing 203-774-0551 so that CHNCT utilization managers can assist in managing the member and facilitate any services needed for discharge. Notification must be received within 10 business days. A denial will be issued if notification is received later than 10 business days after admission and the member is no longer inpatient.

Utilization Management staff will review the admission on the first business day or sooner after

being notified of the admission. All information necessary for CHNCT to determine medical necessity and medical appropriateness must be documented in the member's medical record. If necessary, the Utilization Management staff will contact the attending physician to obtain additional information. The Utilization Management staff will assist in the discharge planning process, working with the discharge coordinators at the facilities, and are available to assist in locating and arranging alternatives to hospital care. For assistance, please contact the Care Management department at 1-800-440-5071.

Concurrent Review/Continued Stay Review

Utilization Management staff will follow the case concurrently while the member remains inpatient. Concurrent review is performed to:

- Determine medical necessity and medical appropriateness for the member's continued stay in the hospital
- Monitor and assess the plan of treatment and continuity of care
- Determine whether the level of care is still appropriate for the member's medical needs
- Discover duplication of services or service delays
- Coordinate and establish timely discharge planning and services

Case Management

CHNCT provides case management services to CHNCT members across the continuum of the health care delivery system. CHNCT systematically identifies members with complex health care needs and refers them to the Care Management department for case management services. Types of cases that may be evaluated for case management include:

Diagnosis Based Criteria:

- Asthma
- Cardiac anomalies
- Adults and Children with Special Health Care Needs
- Chronic Heart Disease
- Chronic renal failure
- Congenital defects
- COPD
- Diabetes Mellitus
- High Risk Pregnancy
- Human immunodeficiency virus (AIDS)
- Major burns
- Multi/Head Traumas
- Neonates admitted to neonatal ICU
- Neoplasms
- Neuromuscular dysfunctions
- Organ or bone marrow transplants
- Requests for home health care or skilled nursing visits for over 60 days
- Requests for ongoing authorization for members receiving outpatient rehabilitation (PT/OT/ST) after an initial eight (8) weeks are authorized

- Spinal cord injuries /disorders

Claim based Criteria:

- Frequent hospitalizations (> 2 in 6 months)
- High inpatient, outpatient/home care claims (> \$30,000 per year)
- Frequent ER visits (> 2 in 6 months)
- Readmission within 15 days

Psychosocial based Criteria:

Ailments in combination with poor social environment may signal further assessment. Some of these are:

- Lives alone or with someone with a disability
- Chronic mental illness or substance abuse
- Poor adherence to health promoting activity
- Homelessness/inadequate residential environment

Other:

- Multiple providers, particularly in different locations

Following are some of the sources used to identify Members for case management:

- Welcome Calls: Welcome call alerts are forwarded to the Care Management Triage Unit for review and follow up. These alerts assist in the identification of members with special health care needs and contain information obtained from members regarding their current health status and services being received.
- UM Referrals: The Care Management Triage Unit is notified of inpatient admissions requiring follow up by case management via a reminder in the system.
- BHP Referrals: CTBHP, the state Administrative Service Organization will FAX a referral form to the Care Management Triage Unit for screening and assignment to a Case Manager when it is determined that a member who is being treated by their clinicians also presents with medical issues, whether due to the behavioral health diagnosis or not. The Care Management Triage Unit will assign the case to a Case Manager for review and will concurrently distribute the notification to CHNCT's Behavioral Health liaison.
- DSS Eligibility Files: DSS eligibility files identify members on SSI and/ or DCF. These members are referred to Care Management Triage Unit for review, follow up and potential assignment to a Case Manager.
- Emergency Department Faxes: Emergency Department Faxes are faxed to CHNCT on a daily basis by some of our contracted hospitals. These are screened for trigger diagnoses and frequency of ER use.
- Reports: Various reports are received and/or run on weekly/monthly basis to identify members that may need further screening and assignment to a Case Manager. These may include, but are not limited to, reports from Care Analyzer (our predictive modeling reporting tool), High Spend, Lead, Charter Oak, Readmission, Emergency Room Use and Nurse Advice Line.
- Other Referrals: Referrals from providers, state agencies (DCF, DDS, DSS) and self-referrals.

Members not meeting criteria for Case Management are contacted by telephone and provided information regarding other resources and services available to assist them within the community.

The RN Case Manager assesses each case and in collaboration with the member or legal guardian, the primary care physician and other involved health professionals, conducts an

assessment and creates a plan of care. The assessment is completed within 30 calendar days and includes an evaluation of the member's health status, environment, support system, financial and community resource needs, specific treatment goals, barriers to care, specific services to be provided and their expected duration, and current providers. The clinical assessment is done to determine any existing physical, behavioral, nutritional, social and developmental conditions warranting case management. Members and their PCPs are contacted as part of the assessment. The Case Manager also provides health education during many communications with the member. The member may also be referred to a specific agency or website that can assist in providing additional information. Educational mailings are also sent as appropriate, i.e., EPSDT educational mailing.

The Case Manager re evaluates each case on a regular basis to assess responses to interventions and to identify new risk factors that may warrant an adjustment to the initial care plan. The plan is then modified to address new risk factors or changes in health status. The frequency of follow up is based on the member's individual needs and adheres to the guidelines for the acuity level of the case. All cases are reassessed until all goals have been met, the member is able to function independently, case management services no longer benefit the member, the member declines case management services or the member is no longer eligible for benefits.

Intensive Case Management for Disease Management Programs

Disease Management (DM) programs focus on appropriate resource consumption and cost reduction as well as improving disease knowledge and self care.

- Implementing intensive outreach measures for those members classified as high-risk but who are not yet enrolled in a DM program
- Developing specific policies and procedures to improve enrollment, interventions and reporting capabilities
- Enhancing data analytic capability to improve member identification, stratification, and program outcome management through predictive modeling and gaps in care methodology
- Promoting self care using motivational interviewing skills to promote education and behavior modification

Healthy Airways

CHNCT's Healthy Airways program offers the highest level of asthma care to members with a diagnosis of asthma. The program includes identification of members with asthma, member education and self management tools, as well as the establishment and implementation of an asthma action plan.

The goals of the Healthy Airways program include but are not limited to:

- Empower members with asthma self-management tools, education and awareness;
- Promote the asthma action plan in the home and outside the home at school and play;
- Encourage adherence to the physician's prescribed asthma treatment plan;
- Reinforce self-management goals by identifying barriers and establishing member specific goals;
- Promote the member – physician relationship;
- Promote healthy lifestyle choices; and
- Assist members and their families to identify environmental triggers that may exacerbate their disease.
- Promote prevention of potential behavioral related symptoms.

Program Components include:

- Member identification
- Administration of health needs and risk assessment
- Depression screening and referral to CT Behavioral Health Partnership if indicated
- Telephonic access to a registered nurse asthma educator
- Targeted educational mailings
- Follow up support and movement toward graduation/self management of their disease

Healthy Beginnings

CHNCT's Healthy Beginnings program promotes healthy pregnancies and birth outcomes by encouraging the early entry of CHNCT's pregnant members into prenatal care. All pregnant members are enrolled in a program that includes educational mailings throughout the pregnancy and postpartum period, telephonic interventions, intensive case management of all high-risk members and ongoing reassessment of risk factors with appropriate referrals as needed. Because each Healthy Beginnings team member is empowered to provide the most appropriate services, they establish exceptional rapport with the member.

Healthy Beginnings has shown to increase:

- The frequency of prenatal care
- The frequency of postpartum care

Healthy Beginnings has shown to decrease:

- The number of members who receive no prenatal care
- The incidence of low birth-weight infants
- Neonatal intensive care unit admissions, lengths of stay and other costs

The key features of CHNCT's Healthy Beginnings program include;

- Early identification of risk
- A proactive model with a focus on education and support; providing members with the tools to have a healthy pregnancy
- Evidenced-based practice guidelines
- Member empowerment strategies
- Goals that move a member and their baby toward positive outcomes by improving overall health
- The program uses an identification and stratification methodology to place pregnant members into low, medium and high opportunity risk groups. This stratification process helps CHNCT to determine which subpopulations of pregnant women require more extensive services.
- High and Medium risk members are managed by experienced Disease management Registered Nurses
- Low risk members are screened and provided education by Licensed Practical Nurses working on a collaborative team

Healthy Living with Diabetes

CHNCT's Healthy Living with Diabetes program is aimed at improving health outcomes for people with diabetes and diabetes-related conditions. This program uses a multi-faceted approach based on needs assessments, tailored education, monitoring, and evaluation. It incorporates best practice models and interventions that reflect on CHNCT's disease and care management

program goals. Evidenced-based American Diabetes Association's (ADA) Clinical Practice Guidelines were used in the development of the program design and tools. These guidelines were adopted and approved by CHNCT's Quality Improvement Committee (QIC)

The key features of CHNCT's Healthy Living with Diabetes program include:

- A proactive model with a focus on prevention of complications
- Evidence-based practice guidelines
- Member empowerment strategies
- Goals are to evaluate clinical, humanistic and economic outcomes as well as improve overall health

The program uses an identification process and stratification methodology to place members with diabetes into low, medium and high opportunity risk groups.

- Members placed in the high opportunity risk group typically have multiple co-morbidities and/or are actively using high risk treatment modalities. These risk factors designate them as having complex care needs.
- Members placed in the moderate opportunity risk group are managed through outreach by the diabetes disease management program registered nurses.
- Members identified as no or low opportunity risk group are provided with CHNCT plan activities related to improving HEDIS rates and other quality performance improvement projects.

Healthy Cells

Healthy Cells is CHNCT's telephonic disease management program for members ages 0-18 years with a primary diagnosis of Sickle Cell Disease. Because of complications associated with Sickle Cell; children affected by this disease are at risk for poor growth and development and frequent hospitalization, which may ultimately affect their quality of life. The mission of the Healthy Cells program is to optimize the health and well-being of members with Sickle Cell by focusing on health maintenance strategies and preventive therapies. Nurses provide education to members and their families on the importance of recognizing the early signs of life threatening and chronic complications.

Interventions:

- Educate about pain recognition and control
- Educate about warning signs and measures that may prevent pain or infection crises
- Support treatment plans of hematology specialists and ensure that members have no barriers to medical care
- Provide information on support organizations i.e., Sickle Cell Disease Association of America, CT Chapter
- Work collaboratively with physician offices to support goals of care

Outcome Goals:

- Continuity of care and improved Quality of Life
- Adequate pain control
- Appropriate use of acute care services

Chapter 10 – Claims Submission and Payment

General Information

For all claim inquiries, please contact the Provider Call Center at 1-800-440-5071, option 7.

Claims Mailing Address:

Medical/Surgical: Community Health Network of Connecticut, Inc.
Claims Processing Center
PO Box 830704
Birmingham, AL 35283-0704

Correspondence and Medical Records:

Community Health Network of Connecticut, Inc.
11 Fairfield Blvd., Suite 1
Wallingford, CT 06492

CHNCT has the following timely filing periods that need to be followed, unless defined differently in your Provider Agreement:

- 120 days from the date of service for new and corrected claims
- 180 days from the primary payer's remittance for Coordination of Benefits
- 90 days from the date of notification for request of additional information
- 60 days from the date of notification for reconsideration
- 60 days from the date of notification for level 1 claim appeals

If medical records or other additional documentation is necessary by CHNCT in order to adjudicate a claim, providers will receive a notification on their CHNCT remittance. CHNCT must receive the requested information within 90 days from the date on the CHNCT Remittance.

Claims submitted after the timely filing periods, as defined in your Provider Agreement, will not be paid, absent extenuating circumstances as determined by CHNCT.

CHNCT shall not be liable for payment to any provider/practitioner for services rendered to or for an individual determined not to be a member of CHNCT on the date(s) of service.

Before a claim can be adjudicated, all necessary information on the CMS 1500 and the UB04 forms must be formatted according to CMS standards and as indicated by CHNCT policies and procedures. This includes all CMS 1500, UB04 and interim billing on UB04 forms. Prior authorization requirements must be met as indicated in Benefits and Prior Authorization Requirements" grid located in Chapter 1 of this manual.

If the claim is not completed correctly or authorization is not obtained, it may be delayed or denied.

All clean claims will be adjudicated within sixty days. A clean claim is defined as a bill for service(s) or goods, a line item of services or all services and/or goods for a recipient contained on one bill which can be adjudicated without obtaining additional information from the provider of service(s) or a third party; a clean claim does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

A clean claim not paid within the 60 day time period will be paid interest at the rate of fifteen percent (15%) per annum commencing on the sixty-first day after receipt.

If CHNCT finds that claims are overstated based on medical or financial audits, an appropriate reduction in reimbursement will be made. Similarly, if CHNCT finds that an overpayment has been

made, the provider will be notified that CHNCT is owed a refund. CHNCT reserves the right to reduce future claims payments by the overpayment amount.

To view a detailed explanation of CHNCT's EOP Remittance Advice, please visit CHNCT's website at www.chnct.org/providers.

Members Held Harmless

By entering into an agreement with CHNCT, providers have agreed to accept payment directly from CHNCT. Payment from CHNCT constitutes payment in full for all covered services rendered to CHNCT HUSKY A, HUSKY B and Charter Oak Health Plan members, except any permissible co-payment or co-insurance amounts allowed by the HUSKY B and Charter Oak Health Plan program. Providers may not balance bill CHNCT HUSKY A, HUSKY B and Charter Oak Health Plan members for the difference between your actual charge and the contracted amount. Federal law prohibits billing any Medicaid recipient for covered services. A provider may only bill a HUSKY A member for goods and services, which are not covered by Medicaid, when the member knowingly elects to receive the goods or services and enters into an agreement in writing to pay for such goods or services prior to receiving them.

Co-payment Limitations for HUSKY B

Providers may not collect co-payments for HUSKY B Covered Services from members of federally recognized American Indian tribes and Native Alaskans who have been determined to qualify for this exemption. The notation "NO COPAY" on the HUSKY B identification card identifies such Members, and providers should ensure that such members do not pay a co-payment by looking at the identification card.

Other families participating in HUSKY B may be eligible for an annual aggregate co-payment limit, and are not obligated to pay any co-payment once that limit has been reached in a plan year. When an eligible family reaches the annual aggregate co-payment limit, CHNCT shall inform providers that the co-payment limit has been met, that the providers and any subcontractors cannot charge further co-payments within the annual period, and the date when the annual period ends. CHNCT provides this same information to the member.

Providers are required to repay any erroneously collected co-payments (either because the member is a "NO COPAY" member, or has met the applicable co-payment limit) to the member within 3 months of detection of the erroneous collection.

Coordination of Benefits

Providers are encouraged to ask members whether duplicate coverage exists or may exist. If it does, we ask that the provider indicate on the claim form whether a member is covered by another plan. When CHNCT is the secondary payer/insurance, the provider must bill the primary payer/insurance first.

CHNCT for Husky A is always the payer of last resort. When CHNCT is the secondary payer, claims must be submitted with the primary payer's Explanation of Benefits/Remittance (EOB) within 180 days from the payment or denial date on the primary payer's EOB. This claim must be submitted hardcopy/paper with the EOB attached and a note on the claim indicating EOB attached.

Coordination of benefits (COB) is a process, regulated by State law that allows health plans to eliminate the opportunity for a person to profit from duplicate coverage. Under detailed rules, generally one health plan is determined to be "primary" and that plan pays without regard to the other. The "secondary" plan then makes only a supplemental payment, which results in a total

payment of not more than the amount payable for the covered service or more than the total billed. CHNCT coordinates benefits with Medicare and any other plan that may be responsible for paying for a member's health care.

CHNCT is responsible for educating its members on how to access services when a third party insurer covers a member. If a third party insurer requires the member to pay any co-payment, coinsurance or deductible, CHNCT is responsible for making these payments on behalf of the member based on CHNCT's allowed amount.

If the member's third party insurer pays for only some of the services submitted on the claim or for only part of a particular service, CHNCT is liable up to the amount covered by CHNCT's fee schedule for the full extent of services covered, even if the services are provided outside the CHNCT provider network. When submitting a claim for coordination of benefits the original claim must match the primary EOB in order for CHNCT to review for coordination of benefits. CHNCT is not bound by any prior authorization and or administrative denials /decisions made by the primary insurer.

Workers' Compensation and No-Fault Automobile insurance insurance/payers, if applicable, are always primary. HUSKY A is always the payer of last resort. If clinical care rendered as a result of a motor vehicle accident, CHNCT would not deny a claim for covered services. CHNCT contracts with an outside entity that investigates and pursues monies which have been paid out in third party liability situations, such as motor vehicle accident related care.

Providers are required to inform CHNCT of any potential third-party coverage available to the member or if a provider becomes aware that a member has lost eligibility for third-party coverage previously available.

There is no Coordination of Benefits with HUSKY B. If a HUSKY B child has other insurance coverage, he or she would be ineligible for HUSKY B and HUSKY Plus. This program is for uninsured children, ages birth through 18.

There is no Coordination of Benefits with Charter Oak Health Plan. If a Charter Oak member has other insurance coverage, he or she would be ineligible for the Charter Oak Health Plan. This program is for uninsured adults, ages 19-64.

Claim Requirements

CHNCT requires certain information to be included on a claim in order for it to be considered and adjudicated. The criteria listed below do not define a "clean claim" or determine if a claim will be adjudicated; it only establishes the minimum requirements for CHNCT to consider the form a claim.

The following information should be submitted on a CMS 1500 Form, or in an electronic format acceptable to CHNCT, in order for the information to be considered a claim:

<u>Form Locator</u>	<u>Item Description</u>
1a	Insured's ID Number
2	Patient's Name
3	Patient's Birth Date and Sex
4	Insured's Name
10a	Patient's Condition- Employment
10b	Patient's Condition- Auto Accident
10c	Patient's Condition- Other Accident

11	Insured's Policy Group Number (if provided on ID card)
11d	is there another health benefit plan?
21	Diagnosis Code(s)
23	CLIA Number
24A	Dates of Service (NDC Number should be placed over date, as needed)
24B	Place of Service
24D	Procedures, Services or Supplies (CPT4 or HCPC)
24E	Diagnosis Code(s)
24F	Charges
24G	Days or Units
24J	Rendering Provider NPI
25	Federal Tax ID Number
28	Total Charge
31	Signature of Provider or Supplier with Date
32	Name & Address of Facility where Services were Rendered
33	Provider's or Supplier's Billing Name, Address, Zip Code, Phone Number and Medicaid Number
33A	Vendor NPI

The following information should be submitted on a UB-04 Form, or in an electronic format acceptable to CHNCT, in order for the form to be considered a claim:

<u>Form Locator</u>	<u>Item Description</u>
1	Provider Name and Address
3	Patient Control Number
4	Type of Bill
5	Federal Tax ID Number
6	Statement Covers Period
8	Patient Name
10	Patient's Birth Date
11	Patient's Sex
12	Admission Date
13	Admission Hour
14	Type of Admission
16	Discharge Hour

17	Discharge Status
	Condition Codes
	Occurrence/Date
	Occurrence/Span
39-41	Value Amount/Codes
42	Revenue Codes
43	Revenue Description/Drug name and NDC #
44	HCPCs/ CPT4 Codes
45	Service Date
46	Service Units
47	Total Charges by Revenue Codes
50	Payer ID
51	Provider's Medicaid Number
56	Vendor NPI Number
58	Insured's Name
60	Patient's ID Number
62	Insurance Group Number (if on ID card)
66A and B	Diagnosis
69	Admitting Diagnosis
72	E-Code
74-74E	Principal Procedure
76	Attending NPI Number
78 and 79	Other Physician

***There may be additional requirements for providers who submit claims electronically to CHNCT. For more information on electronic claims submission, please contact the Provider Call Center or your Network Management Representative. For issues requiring additional investigation, the Representative may place you in contact with our Information Systems Department.*

Corrected Claim - CMS 1500

When submitting a corrected CMS 1500 claim form due to a billing error (i.e. 5th digit diagnosis denial, invalid CPT-Codes, etc.), please have the corrected claim stamped to clearly identify that this is a "Corrected Claim." This will prevent the claim from being denied as a duplicate claim. Include all charges for which you seek reimbursement on the corrected claim, even if some of the charges have been previously paid based on the submission of the initial claim. Corrected claim submissions are subject to the timely filing limitation of 120 days from the date of service, unless defined differently in your Provider Agreement.

Corrected Claim - UB-04

Corrected claims for UB-04 providers are identified by the last digit in the bill type. Corrected claims for UB-04 are accepted both on paper and electronically, with the exception of Coordination of Benefits (COB) claims. Please refer to the Coordination of Benefits claim submission guidelines above. Corrected claim submissions are subject to the timely filing limitation of 120 days from the

date of discharge, unless defined differently in your Provider Agreement

Electronic Claims Submission

Electronic Claims: Community Health Network of Connecticut fully supports HIPAA standard transactions and is capable of adjudicating these transactions electronically. CHNCT does not accept claims electronically in any other format. Claims submitted with codes or information that does not conform to HIPAA regulations will be rejected.

Community Health Network of Connecticut accepts claims electronically in two ways. You may use either method to submit your claims to CHNCT.

Commercial Clearinghouse: CHNCTs uses Emdeon as its commercial clearinghouse. The only transactions currently supported by this portal are the 837 Institutional and the 837 Professional. Costs to the provider for any transactions sent via the Emdeon portal are the responsibility of the provider.

Emdeon provides reports back to providers for claims submitted via their network. CHNCT has no control over these reports and cannot add to them.

To send claims via the Emdeon clearinghouse, use CHNCT's payer number: 62149.

Some other clearinghouses have agreements with Emdeon and can forward claims to CHNCT via these agreements. If you use ProxyMed, NDC or another clearinghouse, contact your clearinghouse representative and they will assist you in forwarding claims to CHNCT.

Direct Connection: CHNCT has established two direct connection web portals that are available, free of charge, to our providers. CHNCT currently utilizes Post-n-Track and AdminiStep for 837 Institutional and Professional claims.

For information regarding setup, go to: (<http://www.chnct.org/providers/claimsdirect.aspx>)

For issues concerning a specific claim(s) call the Provider Call Center at 800-440-5071, Option 7.

ePower: CHNCT also provides a web based claims and eligibility verification system. See the description under ePower.

Submit your claims directly to Community Health Network of Connecticut

Community Health Network of Connecticut has two direct connect portals you may use to submit your claims.

Here is how it works. Your software creates a claim file that you can drop off at one of CHNCT direct connect websites. This file is forwarded to CHNCT and notification is sent electronically, with the number of claims received, accepted and which claims were rejected. There are additional claims reports available. Submitted claims can be reviewed in the same format as a printed claim.

You may view the 835 Electronic Remittances and other electronic files returned to your practice. CHNCT contracts with Emdeon for online remittance advise services. For additional information, please refer to www.chnct.org/providers/pdf/CHN_PM_Announcement.pdf.

What do you need? Your system must be capable of connecting to a direct connect portal on the Internet. This is accomplished using your Internet browser and connection. Check with your software vendor to see if you can go direct or produce the necessary HIPAA compliant file formats to upload. Some systems are limited to using a specific clearinghouse so verify that you can connect and use a direct portal. Make sure your system can generate HIPAA compliant transactions.

How do you start? After you have verified that your software can direct connect and supports

HIPAA transactions, visit either of our direct connect websites for instructions on how to register. If you need assistance in picking a site, contact your Network Management Representative at Community Health Network of Connecticut. The number is 1-800-440-5071, Option 7. You will have to sign a business partner agreement with the operators of the site to start. After the paper work is complete, you will be given instructions on how to access the site. You will need to complete a testing adjudication that includes sending test files or receiving return test files for the transactions you want to use.

Provider Billing Instructions

For specific benefit information and authorization requirements please refer to CHNCT's "Benefits and Prior Authorization Requirements" grid located under the Provider section of CHNCT's website at <http://www.chnct.org>

Home Health Services

All home health services require prior authorization. These include home nursing visits, home therapies and home health aide visits.

Home health services for behavioral health diagnoses should be authorized through the Connecticut Behavioral Health Partnership (CTBHP) and the claims should be billed directly to HP/EDS.

Paper claims for services listed above should be submitted on a UB-04 with all required fields listed above under "Claim Requirements". Paper claims for Home Infusion services should be submitted on a CMS 1500 with all required fields listed above under "Claim Requirements".

For questions on electronic claims, please see the Electronic claims section above.

Clinical Lab Services

CHNCT uses Quest Diagnostics as its preferred laboratory. Standard outpatient clinical lab services performed at Quest Diagnostics do not require prior authorization.

Outpatient laboratory services billed with a behavioral health diagnosis should be billed directly to CHNCT. Please contact CHNCT for any questions regarding HUSKY or Charter Oak behavioral health related lab charge questions.

MEDS/DME

All DME or medical supplies over \$1000 require prior authorization and may be subject to benefit limitations. Please refer to the CHNCT Benefits and Prior Authorization Grid under the Provider section of our website at <http://www.chnct.org>.

All rentals require prior authorization. All requests for DME or supplies from non-participating providers require prior authorization.

Miscellaneous HCPC codes require prior authorization and submission of an invoice that includes the Manufacturer's Suggested Retail Price (MSRP).

For DME or medical supplies, please complete the CMS 1500 claim form with all required fields listed above under "Claim Requirements". For questions on electronic claims, please see the Electronic claims section above.

Skilled Nursing Facilities (SNFs)

All skilled nursing facility stays require prior authorization.

For paper claims submission, please submit the UB-04 claim form and complete all required fields listed above in the “Claims Requirements” section. For questions on electronic claims, please reference the Electronic claims section above.

Ambulatory Surgical Centers

Effective for dates of service September 1, 2009, DSS requires all Ambulatory Surgical Centers to bill on a CMS 1500 form using current CPT coding guidelines. The facility’s NPI should appear in Box 24J to ensure accurate claims adjudication. CHNCT recommends utilization of the SG modifier to additionally identify those services performed by the Surgical Center.

Multidisciplinary Claims - MDE

When submitting claims for multidisciplinary exams, a provider must bill with the diagnosis code V62.5 (Legal Circumstances) and the approved CPT/HCPC codes in order for CHNCT to adjudicate the claim appropriately.

Newborn Claims

All claims for newborns must be billed with the baby’s new identification number. CHNCT will not allow payment for newborns under the mother’s identification number.

When billing newborn claims to CHNCT, expect a slight delay in the claims adjudication process. At the time a newborn claim is received, CHNCT may not have received enrollment information on this member from DSS. If the newborn is not in CHNCT’s system, the Enrollment Department will contact DSS to verify the newborn should be enrolled with CHNCT’s plan and request that the necessary information is forwarded to CHNCT. The CHNCT Enrollment Department uses a specified DSS notification form to notify DSS of any newborns born to a CHNCT HUSKY A member.

CHNCT’s Billing Guidelines for the VFC Program

In order to be reimbursed for the administration code(s) CHNCT requires both the administration and vaccination codes be billed together. Only the administration code(s) should be billed with the applicable charge(s). However, for specific vaccines that are administered to children 19-26 years of age CHNCT may reimburse for the vaccine(s) as well as the administration charges. In this instance the vaccine and administration charges should be billed on the same claim.

Notification of Emergent Admissions

Based on Federal Regulations, CHNCT must receive notification within 10 business days of an emergent admission. Failure to notify CHNCT of an emergent admission within this timeframe may result in a denial due to untimely notification.

Chapter 11 – Provider Complaint and Appeal Process

Provider Appeal Process for Administrative Denials

Definitions

The following definitions apply to our provider appeal process:

Claim dispute: relates to issues regarding the claim adjudication process, i.e., processing error, etc.

Utilization Review (UR) dispute: relates to issues regarding decisions made during the pre-authorization, concurrent review or retrospective review process. The Provider Appeal Process applies to appeals received after the services have been rendered. (The member appeal process applies to those appeals related to pre-service or concurrent review.)

Reconsideration: a formal review conducted by the Claims Department at the request of a provider/hospital of a previous claim payment decision

Level 1 Claim Appeal: a request by a provider/hospital to change an adverse reconsideration decision

Level 2 Claim Appeal: a written request by a provider/hospital to change an adverse Level 1 Claim Appeal.

Level 1 Appeal: a written request by a provider/hospital to change an adverse initial UR decision.

Level 2 Appeal: a written request by a provider/hospital to change a level 1 Appeal decision.

Appeal Level Committee: a written request by a provider/hospital to change a level 2 Appeal (UR decisions only). This is the final level of review for UR decisions.

Provider Appeal Process

The provider appeal process should be followed if a provider/hospital wishes to appeal a claim or UR decision. All requests must be made within 60 days of the notice of denial.

All appeals are logged and tracked to ensure timely resolution.

CHNCT will provide assistance and information to providers who wish to file an appeal on behalf of a member for whom a service was denied, reduced, suspended or terminated on the basis of medical necessity. Upon request, CHNCT will inform the provider of the member appeal process for Husky A, Husky B and Charter Oak Members. Because the provider must obtain member consent prior to initiating an appeal, CHNCT will supply the provider with a copy of the appropriate Member consent form. Once the Member consent form is received, CHNCT will process the appeal in accordance with the Member Appeal Policy and Procedure and, as necessary:

- Assist the provider in communicating with the Member
- Coordinate all pertinent Member information from all relevant sources
- Answer questions and explain process;
- Ensure that both the provider and member are kept informed.

Copies of CHNCT Member appeal policies and procedures and relevant criteria used in decision-making are available to providers filing an appeal on behalf of a Member.

Claim Disputes

Level 1 Claim Appeal

A provider/hospital may request a Level 1 Appeal within 60 days of the claims denial decision. Upon receipt of the request, the files are reviewed and a decision is made within 60 days. If additional information is needed for further review of the appeal, CHNCT will notify the provider/hospital. The provider/hospital has 45 days to submit the additional requested information. Upon receipt of the additional requested information, CHNCT will review and make a decision.

If the Level 1 Claim Appeal decision is in the provider's/hospital's favor CHNCT will reprocess the claim for those services affected by the decision within 60 days of receipt of the appeal request. If the decision is not in the provider's/hospital's favor CHNCT will issue the decision in writing within 60 days of receipt of the appeal or additional requested information. The provider may request a Level 2 Claim Appeal. Instructions on how to request this next level of review will be provided in the letter.

Level 2 Claim Appeal

This is the next level of review for a claim dispute and is available to providers upon request. If a provider/hospital feels such a level is warranted, the appeal must be submitted in writing to the Provider Appeal Coordinator within 45 days of the Level 1 Claim Appeal decision.

If the Level 2 Claim Appeal decision is in the provider's/hospital's favor CHNCT will reprocess the claim for those services affected by the decision. If the decision is not in the provider's/hospital's favor CHNCT will issue the decision in writing within 60 days of receipt of the appeal. The provider may request a Level 3 Claim Appeal. Instructions on how to request this next level of review will be provided in the letter.

Claim Appeal Committee - level 3 (Final Review)

This is the final level of review for a claim dispute and is available to providers upon request. If a provider/hospital feels such a level is warranted, the appeal must be submitted in writing to the Provider Appeal Coordinator within 45 days of the Level 2 Claim Appeal decision. Members of the executive staff will review this final level of claim appeal. A decision will be made in writing within 60 days of receipt.

Utilization Review Disputes

Level 1 Appeal

A provider/hospital may request a Level 1 Appeal within 60 days of the denial decision. Upon receipt of the request, CHNCT will review the files and make a decision within 60 days. If additional information is needed for further review of the appeal, CHNCT will notify the provider/hospital. The provider/hospital has 45 days to submit the additional requested information. Upon receipt of the additional requested information, CHNCT will review and make a decision.

If the Level 1 Appeal decision is in the provider's/hospital's favor CHNCT will reprocess the claim for those services affected by the decision. If the decision is not in the provider's/hospital's favor CHNCT will issue the decision in writing within 60 days of receipt of the appeal or additional requested information. A provider may request a Level 2 Appeal. Instructions on how to file a Level 2 Appeal will be provided in the letter.

Level 2 Appeals (Final Review)

A provider may request a Level 2 Appeal within 45 calendar days from the date of the Level 1 Appeal decision.

A reviewer not associated with CHNCT's Level 1 Appeal review will review the files. It will notify the provider of CHNCT's decision in writing within 60 days of receipt of the appeal. If CHNCT needs additional information, CHNCT will request the information and issue its decision within 60 days of receipt of the information.

If the Level 2 Appeal decision is in the provider's/hospital's favor CHNCT will reprocess the claim for those services affected by the decision. If the decision is not in the provider's/hospital's favor CHNCT will issue the decision in writing within 60 days of receipt of the appeal. This is the final level of appeal for a UR dispute

Questions

For questions, please call CHNCT's provider call center at 800-440-5071 or provider appeal coordinator at 800- 440-5071 ext. 4148.

Chapter 12 – Member Appeals and Grievances

Member Appeals: Charter Oak and HUSKY B Members

Charter Oak and HUSKY B

It is Community Health Network of CT's (CHNCT) policy that CHARTER OAK AND HUSKY B members and their legally authorized representatives (herein referred to as "the Member" or "Members") are educated about, and have access to, a unified process for filing appeals, in the event that CHNCT or its subcontractor partially or fully denies, suspends, reduces or terminates authorization of the provision of goods/services. All appeals will be reviewed fairly and objectively, by appropriate CHNCT decision-makers, in a time frame appropriate to the exigencies of the situation, but no later than thirty (30) calendar days from the date of receipt of the appeal. There is a process for expedited review of appeal requests, and for external review of appeals by the CT Department of Insurance (DOI).

CHARTER OAK AND HUSKY B Members may submit an appeal to CHNCT within sixty (60) calendar days of the date of the denial letter sent to the Member by CHNCT (or its subcontractor). Appeals received by CHNCT after sixty (60) calendar days shall be considered untimely, in which case CHNCT shall notify the Member in writing that they have lost their appeal opportunity.

Upon request, CHNCT shall assist the HUSKY B Member with the Member Appeals process and shall provide translation services, or services for vision or hearing impaired Members as appropriate. A letter of appeal may be completed and filed by a provider on behalf of a member with the member's written consent. A provider may file an appeal on behalf of a member in instances where CHNCT has denied authorization for a service, which has not yet been rendered to the member and the provider is seeking approval for the service on behalf of the member.

All oral appeals should be directed to CHNCT's Member Services Department at: **1-800-859-9889**. All written appeals should be directed to:

**CHNCT Manager of Member Services
11 Fairfield Blvd. Suite 1
Wallingford, CT 06492.**

Expedited appeals may be initiated by the Member, or by a practitioner acting on behalf of the Member. CHNCT will expedite its review in all cases concerning admissions, continued stays, or other health care services for a Member who has received emergency services but has not been discharged from a facility. If the oral or written request is for an expedited appeal, CHNCT will determine within one (1) business day of receipt of the appeal, with written notice to the Member, and to DSS (for CHARTER OAK AND HUSKY B Members only), whether to expedite the review or whether to perform the review according to the standard time frames. An expedited review must be performed when the standard time frames for determining an appeal could jeopardize the life or health of the Member or the Member's ability to regain maximum functioning. CHNCT must expedite its review when an expedited review is requested by the Member's treating physician or PCP, or by DSS).

If the Member has exhausted CHNCT's internal appeals mechanism and has received a final written appeal determination from CHNCT upholding the original denial of the good or service, the Member may file an external appeal with the DOI within thirty (30) calendar days of receiving CHNCT's written appeal decision. Members may obtain information about the external review process and request a form from:

**The Connecticut Department of Insurance
P.O. Box 816
Hartford, CT 06142**

Or the member may call: (860) 297-3862.

Member Appeals (Grievances): HUSKY A Members

It is Community Health Network of CT's (CHNCT) policy that HUSKY A Members and their legally authorized representatives (herein referred to as "the Member" or "Members") are educated about, and have access to, a unified process for filing appeals and requesting DSS Fair Hearings, in the event that CHNCT or its subcontractor (a) fails to respond within fourteen (14) business days to a request for goods/services, or (b) partially or fully denies, suspends, reduces or terminates authorization of the provision of goods/services. All appeals will be reviewed fairly and objectively, by appropriate CHNCT decision-makers, in a time frame appropriate to the exigencies of the situation, but by the date of the DSS Fair Hearing, and no later than thirty (30) calendar days from the date of receipt of the Appeal/Administrative Hearing request at DSS.

A Member may request an appeal either orally or in writing. When requesting an oral appeal, unless the member is requesting an expedited review, the member must follow-up with a written, signed appeal form within five (5) business days of the oral request. The Member must file the written, signed Appeal/Administrative Hearing request form in order to receive an appeal review by CHNCT and a Fair Hearing before DSS. The Member will be instructed to submit the completed Appeal/Administrative Hearing request form to DSS by faxing it to (860)-424-5729 or mailing it to:

**State of Connecticut - Department of Social Services (DSS)
Office of Administrative Hearings and Appeals - HUSKY A Appeals
25 Sigourney Street 12th Floor Hartford, CT 06106**

Upon request, CHNCT shall assist the Member in completing an Appeal/Administrative Hearing request form, and shall provide translation services, or services for vision or hearing impaired Members as appropriate.

An Appeal/Administrative Hearing request form may be completed and filed by a provider on behalf of a member with the member's written consent. A provider may file an appeal on behalf of a member in instances where CHNCT has denied authorization for a service, which has not yet been rendered to the member and the provider is seeking approval for the service on behalf of the member.

A written appeal decision will be mailed to the Member, by certified mail, with a copy to the DSS liaison and the Central Fair Hearing Office, no later than thirty (30) calendar days from the date on which the appeal was received by CHNCT (or its subcontractor) or DSS, or by the date of the scheduled Fair Hearing, whichever is sooner.

If the Member is dissatisfied with CHNCT's decision, or if CHNCT does not render a decision by the time of the scheduled DSS Administrative Hearing, the Member may automatically proceed to the Administrative Hearing. If the Administrative/Fair Hearing request was in response to an advance Notice of Action (NOA), and the Member submitted the request within ten (10) business

days of the date the advance NOA was mailed by CHNCT (or its subcontractor), the disputed goods and services must continue to be maintained, pending the Administrative Hearing decision

NOTE: A provider may not file an appeal on behalf of a member in instances where the service has already been rendered to the member and the provider has been denied payment for the service.

Member Grievances: HUSKY A, HUSKY B and Charter Oak Members

It is Community Health Network of CT's (CHNCT) policy that all external grievances, whether they are from members or their legally authorized representatives (herein referred to as "the Member" or "Members"), be logged and resolved within thirty (30) business days from the date of the receipt of the grievance.

A "Grievance" is a verbal or written expression of dissatisfaction (complaint) with some aspect of the provision of, or payment for, a good or services for a CHNCT Member.

In the event that a Member has a grievance, the Member is encouraged to discuss the matter with those directly involved, such as the health care provider, support staff, or administrative personnel. If the Member's grievance is not resolved as a result of such communication, the Member can voice their grievance with CHNCT. All verbal grievances should be directed to CHNCT's Member Services Department at: **1-800-859-9889**. All written grievances should be directed to:

**CHNCT Manager of Member Services
11 Fairfield Blvd., Suite 1
Wallingford, CT 06492.**

An electronic description of all Member grievances are logged by Member Services staff and sent to the specific department involved, for a review and response. If the subsequent intervention resolves the Member's grievance; the Manager of Member Services should confirm the Member's satisfaction with the outcome within ten (10) business days of the grievance resolution and a postcard is mailed to the member acknowledging the resolution. If the grievance is provider-specific, a summary of the outcome of the grievance resolution is forwarded to CHNCT's Quality Improvement Department for inclusion in the provider's CHNCT credentialing file.

If the member's grievance remains unresolved or unsatisfactory, the Manager of Member Services will inform the member that the unresolved grievance may be brought to a higher level and will offer to bring the grievance to CHNCT's Medical Director (for clinical issues) or CHNCT's Vice President of Operations (for administrative issues) who will respond to the grievance within 10 business days of his or her notification.

If the intervention by the Medical Director/Vice President resolves the Member's grievance, a summary of the outcome of the grievance resolution process is prepared. This documentation is forwarded to the CHNCT's Manager of Member Services for logging. The Manager of Member Services forwards a copy of the documentation to the CHNCT QI Coordinator. If related to a specific provider or provider office, the QI Coordinator will include a copy in the provider's CHNCT credentialing file.

Chapter 13 – Fraud and Abuse Policies and Procedures

The purpose of this chapter is to provide contractors and agents of Community Health Network of Connecticut, Inc. (CHNCT) with CHNCT's policies regarding fraud and abuse, the federal False Claims Act (established under sections 3729 through 3733 of Title 31, United States Code); administrative remedies for false claims and statements (the Program Fraud Civil Remedies Act of 1986 established under chapter 38 of title 31, United States Code); Connecticut state laws pertaining to civil or criminal penalties for false claims and statements involving federal health care programs, including Medicaid; and whistleblower protections under such laws, as required by the Deficit Reduction Act of 2005 (DRA).

Policy Statement on Fraud and Abuse

As a government contractor, CHNCT recognizes the importance of protecting the integrity of the programs it administers. CHNCT is committed to conducting all activities in accordance with high ethical standards and in compliance with all applicable laws and regulations.

- CHNCT does not tolerate any type of fraud or abuse, whether committed by a provider, member, employee or vendor.
- CHNCT is dedicated to aggressively detecting, investigating and preventing fraud and abuse in the government programs we administer.
- CHNCT fully cooperates with law enforcement and government agencies in their efforts to prosecute individuals or entities that commit fraud.
- CHNCT strives to educate our employees, members and providers on fraud and abuse and the negative effects it has on our economy. CHNCT encourages these individuals to report any concerns about fraud and abuse they have to us.
- CHNCT will ensure that all employees, including management, and any contractors or agents of CHNCT are educated regarding the federal and state false claims laws and the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs.

CHNCT'S Compliance and Ethics Program

CHNCT developed its Compliance and Ethics program in 2002. As part of this program, the Compliance and Government Affairs area is responsible for program integrity, which includes investigating reports of fraud and abuse. CHNCT's Program Integrity Analyst's responsibilities include, but are not limited to, the following:

- Performing health care fraud investigations, which include: reviewing, researching and documenting potential fraud and abuse activities through claims screening, system research, information gathering and policy reference;
- Identifying and investigating potential fraud from reports and referrals;
- Analyzing data through CHNCT's fraud detection software; and
- Conducting fraud awareness training.

With respect to Program Integrity, CHNCT's goals are to:

- Prevent, detect and investigate potential fraud and abuse committed by practitioners/ providers, members and/or employees;
- Implement internal policies and processes when appropriate to prevent future errors from occurring;
- Coordinate with the appropriate government agencies and/or law enforcement to report all instances of suspected fraud;

- Cooperate fully with all investigations of fraud conducted by government agencies and/or law enforcement;
- Recover payments lost to fraudulent and/or abusive billing;
- Educate staff on identifying fraud and abuse as it relates to CHNCT; and
- Provide effective methods for internal and external individuals to report suspected fraud or abuse to CHNCT.

Reporting Suspected Fraud or Abuse

CHNCT offers a toll-free hotline to report suspected fraud and abuse. Individuals may call 1-866-700-6109 to report concerns. Please include as much information about the activity as possible.

Laws Creating Penalties for False Claims and Statements in the Medicaid Program

1. Federal False Claims Act, 31 U.S.C. § 3279: The federal False Claims Act is one of the Government's primary ways to fight fraud and abuse in government funded contracts or programs, including Medicaid. Under the False Claims Act, it is a violation for anyone (including entities such as businesses and managed care providers) to **knowingly**:

- Present or cause to be presented, a false claim for reimbursement by a Federal health care program, including Medicaid or Medicare;
- Make, use or cause to be made or used, a false record or statement material to a false or fraudulent claim;
- Repay less than what is owed to the Government;
- Make, use or cause to be made or used, a false record or statement material to reducing or avoiding repayment to the Government; and/or
- Conspire to defraud the Federal Government through one of the actions listed above.

Claims

- The False Claims Act is not limited to false health care claims but also includes any false statements or records that are material to the claim.
- In addition, the government has prosecuted health plans that fail to comply with applicable Medicaid statutes and regulations that are a condition or a requirement of payment.
- For Medicaid managed care plans like CHNCT, fraud can occur in the areas of contract procurement (e.g., falsifications), marketing (e.g., misleading potential members), enrollment and disenrollment (e.g., cherry picking enrollees), underutilization (delaying or discouraging care), and data collection and submission (e.g., misclassifying enrollees).

Liability

- A health plan or anyone that violates the False Claims Act can be subject to civil monetary penalties ranging from \$5,500 to \$11,000 for each false claim submitted.
- In addition to this civil penalty, a health plan or anyone who has violated the False Claims Act can be required to pay three times the amount of damages sustained by the U.S. government.
- If a health care organization is convicted of a False Claims Act violation, the OIG may seek to exclude the health care organization from participation in federal health care programs.

Examples of Acts That Would Violate the False Claims Act Include, But Are Not Limited To:

- Filing a claim for services that were not rendered;
- Double billing for items or services;
- Prescribing unnecessary medications or drugs;

- Failing to provide correct data on hospital cost reports to the Government;
- Falsifying medical records to maximize payments;
- Falsely certifying as to medical necessity;
- Filing a claim for a more expensive service than the one actually provided (upcoding);
- Improperly retaining overpayments, even when there is no false claim submitted;
- A contractor falsifying information regarding the cost of products/ services it sells to the Government; and/or
- Knowingly making false statements or falsifying records that would cause a claim to be submitted.

2. Program Fraud Civil Remedies Act of 1986, 31 U.S.C. § 3801: The Program Fraud Civil Remedies Act (herein referred to as “Act”) of 1986 is a law similar to the federal False Claims Act. It provides additional penalties separate from the False Claims Act for improper claims and improper statements.

Improper Claims

- A person violates the Act if they know or have reason to know they are submitting a claim that is:
 - False, fictitious or fraudulent; or
 - Includes or is supported by written statements that are false, fictitious or fraudulent; or
 - Includes or is supported by a written statement that omits a material fact; the statement is false, fictitious or fraudulent as a result of the omission; and the person submitting the statement has a duty to included the omitted facts; or
 - For payment for property or services not provided as claimed.
- A violation of this provision of the Act carries a penalty of \$5,000 for each such improper claim. In addition, an assessment of two times the amount of the claim may be made, unless the claim has not actually been paid.

Improper Statements

- A person violates the Act if they submit a written statement which they know or should know:
 - Asserts a material fact which is false, fictitious or fraudulent; or
 - Omits a material fact and is false, fictitious or fraudulent as a result of the omission. In this situation there must be a duty to include the fact and the statement submitted contains a certification of the accuracy or truthfulness of the statement.
- A violation of the provision for submitting an improper statement carries a civil penalty of up to \$5,000.

Connecticut Laws and Regulations Pertaining to Fraud and Abuse: In addition to the federal false claims provisions, Connecticut laws also contain provisions pertaining to false statements and fraud and abuse in connection with the submission of health care claims.

1. Vendor Fraud, Connecticut General Statutes (CGS). §53a-290 – 53a-296, CGS §17b-99 and CGS §17b-25a: Under Connecticut law, a person commits “vendor fraud” when the person, acting individually or on behalf of an entity, and acting with the intent to defraud, provides goods or services to a beneficiary of one of several DSS programs (including Medicaid, Charter Oak and SAGA) and does any of the following:

- Presents a false claim for payment;
- Accepts payment for goods or services performed that exceeds the amount due;
- Solicits a beneficiary for the purpose of performing services or selling them goods that the beneficiary is not in need of;
- Sells goods to or performs services for a beneficiary without prior

authorization from DSS when prior authorization is required; or

- Accepts additional compensation from any other person than the state that is in excess of the amount authorized by law.

A person guilty of vendor fraud is subject to criminal penalties that vary depending on the value of the goods or services fraudulently provided. A “vendor” for purposes of this statute includes all providers and suppliers of goods and services for which a claim would be submitted under the applicable DSS program.

In addition to criminal penalties, individuals or entities found guilty of vendor fraud are also subject to administrative penalties by the State, which include, but are not limited to:

- Forfeiture, suspension or revocation of any license held from the state;
- Termination from participation in any federal or state funded program, such as Medicare, Medicaid, Charter Oak and SAGA; and/or
- Recovery by the State of any money paid as a result of vendor fraud.

Under CGS §1 7b-25a, the Commissioner of DSS is required to provide a toll-free telephone line for individuals to report vendor fraud in any program operated by DSS. Reports of vendor fraud can be made to DSS at 1-800-842-2155.

2. Prohibition on Reimbursement of Sanctioned Individuals, CGS §17b-99(a). Vendors are not eligible to receive reimbursement for any goods or services provided by a person who is convicted of a crime involving fraud in federal or state funded programs. Vendors are required to notify DSS within 30 days after the date of employment or conviction of certain information related to the extent of services performed by a person convicted of a crime involving fraud in Medicare, Medicaid, Charter Oak, SAGA or other state or federal funded assistance programs. Vendors are also required to notify DSS of the identity of any person convicted of a crime involving fraud in such programs that has ownership or control interest in the vendor or is an agent or an employee of the vendor.

3. DSS Authority to Impose Administrative Sanctions Against Vendors and/or Providers of Goods and Services under Medicaid Program, Regulations of Connecticut State Agencies, §§1 7-83k-1 – 17-83k-7: These regulations describe policies and procedures for administrative sanctions to be imposed against vendors and providers of goods and services provided to beneficiaries of certain federal and state programs, including Medicare, Medicaid, Charter Oak and SAGA.

- Violations that may trigger administrative sanctions include:
 - False statements or representations knowingly and willfully made or caused to be made for the purpose of claiming or determining payment;
 - Services furnished or ordered in excess of the recipient’s need;
 - Failure to adhere to the conditions of vendor/provider participation in the program;
 - Accepting payment in excess of the amount authorized by law;
 - Submitting requests for payment containing charges or costs in excess of customary charges or costs; and
 - Any fraudulent acts and/or false reporting proscribed by federal or state statutes.
- Sanctions may include, but are not limited to, any one or more of the following:
 - An order to make restitution with interest;
 - Suspension from participation; and/or

- Limitation on a provider's participation.
- Notice of DSS' decision shall be given to any applicable professional society and licensing agency.
- Vendors that have been convicted in any state or federal court of a crime involving fraud in any of these programs shall be terminated from participation in such programs.

4. Health Insurance Fraud Act, CGS. §§53-440 – 53-445: Connecticut's criminal statutes include provisions for health insurance fraud. A person or entity is guilty of health insurance fraud when that person or entity, with the intent to defraud or deceive any insurer:

- Makes oral or written statements that are false, incomplete, deceptive or misleading (or omits material information) in connection with an application for insurance or a claim for payment under a plan providing health care benefits, or
- Assists, solicits or conspires with another to prepare or present false or misleading written or oral statements in support of an insurance application or claim for payment.
- "Misleading information" under this statute includes, but is not limited to, falsely representing that goods or services were medically necessary in accordance with professionally accepted standards.

A person or entity found guilty of health insurance fraud may be subject to penalties of up to \$15,000 for each separate offense and/or imprisonment. In addition to any fines or term of imprisonment, such person or entity would also be required to pay back the insurer, including reasonable attorneys' fees and investigation costs. This law also protects individuals who file reports of suspected health insurance fraud in good faith to the Insurance Commissioner from liability for libel, slander or any other civil liability in connection with this filing or furnishing of information.

5. False Claims Act for DSS Programs, P.A. 09-05: Connecticut's False Claims Act applies to the medical assistance programs administered by DSS, including Medicaid, SAGA, HUSKY B, and Charter Oak, P.A. 09-05. With respect to goods and services provided through DSS medical assistance Programs, Connecticut's False Claim Act prohibits anyone from:

- knowingly presenting, or causing to be presented to a state employee or officer, a false or fraudulent claim for payment or approval;
- knowingly making, using, or causing to be made or used, a false record or statement to secure payment or approval of a false or fraudulent claim under these programs;
- conspiring to defraud the state by securing the allowance or payment of a false or fraudulent claim;
- having possession or control of property or money used, or to be used, by the state, and, with intent to defraud the state or willfully conceal the property, pay or cause to be paid less than the amount owed;
- being authorized to make or deliver a document certifying receipt of property used, or to be used, by the state relative to these programs and, with intent to defraud the state, make or deliver the document without completely knowing that the information on it is true;
- knowingly buying, or receiving public property from a state employee or officer who may not legally sell the property; and
- knowingly making, using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease a payment to the state.

Penalties for violating the False Claims Act may include:

- a penalty between \$5,000 and \$10,000;
- three times the amount of damage incurred by the state because of the violation; and/or
- investigation and prosecution costs.

A claim may be brought by either the Attorney General or an individual acting on the state's behalf. In the event the state receives penalties or damages by either a court award or settlement, the person bringing the action must receive between 15% and 25% of the proceeds, based on the extent to which he or she contributed to the prosecution.

Employers are prohibited from retaliating against an employee who files or participates in a false claims action. Employees who are discharged, demoted, suspended, threatened, harassed, or discriminated against may seek relief, including (i) reinstatement with the same seniority status, and (ii) twice the amount of any back pay, plus interest, special damages, litigation costs, and reasonable attorneys' fees.

Other Connecticut Criminal Statutes: Other Connecticut criminal statutes may become implicated in any type of fraud or abuse committed in connection with health care programs.

These include:

- Tampering with or Fabricating Physical Evidence, CGS §53a-155: A person is guilty of tampering with or fabricating physical evidence, if the person is aware that an official proceeding is pending or about to begin, and that person: (a) alters, destroys conceals or removes any record, document or thing meaning to impair its verity or availability in such proceeding; or (b) makes, presents, or uses any record, document or thing knowing it to be false and meaning to mislead a public servant who is or may be engaged in such official proceeding. Tampering with physical evidence is a class D felony.
- False Statement Intending to Mislead Public Servant, CGS §53a-157b: A person is guilty of a false statement in the second degree when he/she knowingly and intentionally makes a false written statement under oath or on a form with a notice that false statements made therein are punishable, with the intent to mislead a public servant in the performance of his official function. This offense is a class A misdemeanor.
- larceny, CGS §53a-118 et seq: A person commits larceny when, intending to deprive another of property or to appropriate such property, he/she wrongfully takes, obtains or withholds such property from an owner. Examples of larceny include embezzlement, obtaining property by false pretenses or misrepresentations, falsely authorizing, certifying or filing a claim for benefits from a governmental agency and accepting benefits from a claim known to be false. Larceny is classified as a range of felonies and misdemeanors depending upon the nature of the offense and the dollar amount involved.

Laws Related to the Reporting of False Claims and Statements in the Medicaid Program

1. Qui Tam Whistleblower Provisions, 31 U.S.C. §3730(h): To encourage individuals to come forward and report misconduct involving false claims, the Federal False Claims Act includes a "qui tam" or whistleblower provision. This provision essentially allows any person with actual knowledge of allegedly false claims to the government to file a lawsuit on behalf of the U.S. government. Such persons are referred to as "relators."

Qui Tam Procedure

- The whistleblower/ relator must file his or her lawsuit on behalf of the government in federal district court.
- The lawsuit will be filed "under seal," meaning the lawsuit is kept confidential while the government reviews and investigates the allegations contained in the lawsuit and decides how to proceed.

Rights of Parties to Qui Tam Actions

- If the government determines the lawsuit has merit and decides to intervene, the prosecution of the lawsuit will be directed by the U.S. Department of Justice.
- If the government decides not to intervene, the whistleblower can continue with the lawsuit on his or her own.

Award to Qui Tam Whistleblowers

- If the lawsuit is successful, and provided certain legal requirements are met, the relator or whistleblower may receive an award ranging from 15 to 30 percent of the amount recovered. The whistleblower may also be entitled to reasonable expenses including attorneys' fees and costs for bringing the lawsuit.
- If, however, the whistleblower is convicted of criminal conduct related to his or her role in the preparation or submission of the false claims, the whistleblower will be dismissed from the civil action and will not receive any portion of the funds recovered.

Whistleblower Rights

- The False Claims Act prohibits employers from retaliating against employees, contractors or agents who file or participate in the prosecution of a whistleblower suit.
- Employees, contractors or agents who are discharged, demoted, suspended, threatened, harassed or in any way discriminated against in the terms and conditions of employment by their employer for "blowing the whistle" are entitled to recover all relief necessary to make the employee, contractor or agent whole.
- Damages available to the employee, contractor or agent who proves retaliation include: reinstatement with the same seniority status; two times back pay; interest on back pay; compensation for special damages (i.e., emotional distress); and litigation costs and attorneys fees.

2. Connecticut Laws Pertaining to Whistleblowing: Connecticut law also has provisions to encourage reports of fraud or abuse in government-funded programs and contracts and to protect individuals who make such reports. These laws include the following:

- Whistleblowing, CGS §4-61dd and Regulations of Connecticut State Agencies §§4-61dd-1 et seq.:
 - Anyone with knowledge of corruption, fraud, abuse, gross waste of funds, unethical practices or violation of state laws or regulations occurring in any state department or agency or under any large state contract may report such information to the Auditors of Public Accounts for further review and inquiry.
 - State and state agency officers and employees, and officers/employees of a large state contractor are prohibited from threatening or taking any personnel action against an employee of a state agency or contractor in retaliation for making report of information under the above provision, under mandated reporting statutes, or to the appropriate state agency (i.e. DSS) concerning information involving a large state contract. Violation of this provision may result in inquiry by the Attorney General's office and the imposition of civil penalties against the agency or large state contractor.
 - An employee against whom personnel action violating (2) above has been threatened or taken may make a complaint to commence a hearing before the Chief Human Rights Referee in accordance with the procedures set forth in Connecticut Regulations §§4-61dd-1 et seq, or may alternatively bring a civil action, for reinstatement, back pay and other damages and costs to the employee.
 - State agencies and large state contractors are prohibited from threatening to impede, canceling or not renewing a contract with a subcontractor in retaliation for the disclosure of information under (1) above and may be subject to civil action for damages and costs for such an action.
 - All reports of information must be in good faith. Employees may be subject to discipline and dismissal for malicious and false reports.
- Protection of Employees for Disclosure of Employer Conduct, CGS §31-51m and §31-51g: Under Connecticut labor laws, employers are prohibited from discharging, disciplining or otherwise penalizing any employee because the employee in good faith:

- Reports a violation or suspected violation of local, state or federal laws or regulations to a public body;
- Participates in an investigation, hearing, inquiry or court action upon the request of a public body, or
- Exercises certain of the employee's constitutional rights in a manner that does not interfere with the employee's job performance.

Employers may be subject to a civil action for damages and costs for violation of such prohibitions

3. Regulations Providing a Financial Incentive for Reporting Vendor Fraud, Regulations of Connecticut State Agencies, §§17b-102-01 – 17b-102-04 and CGS §17b-102: Connecticut law permits the Commissioner of DSS to provide a financial incentive to report vendor fraud in any DSS program through offering a person up to fifteen percent (15%) of any amount recovered by DSS as a result of the person's report; the award is subject to the following conditions and limitations defined by state regulations:

- The Commissioner of DSS shall determine whether or not a person is entitled to a financial incentive and if so, what the amount of the financial incentive will be.
- Payment shall not exceed 15% of the amounts recovered by the State that are directly attributed to the person's report.
- A financial incentive is authorized when the person reporting has not participated in or benefited from the fraudulent activity being reported, there is a direct correlation between the information reported and amounts recovered by the State and the person reporting submits a claim for the financial incentive in the form and manner directed by DSS.
- A financial incentive is not authorized if the person reporting requests to remain anonymous, DSS or another state or federal agency has initiated an audit, investigation or similar proceeding prior to the person's report of fraud, or the person reporting (or a member of his/her immediate family) is employed in a job that involves auditing, investigation or enforcement involving DSS programs.

Chapter 14 – Connecticut Department of Social Services Marketing Guidelines

CHNCT is required to provide our Network Providers with the Connecticut Department of Social Services (“the Department” or “DSS”) Marketing Guidelines that apply to the HUSKY A, HUSKY B and Charter Oak programs.

Effective April 1, 2010, DSS issued adjustments to the Marketing Guidelines as follows:

It is DSS’ intent that state capitation monies are to be used only for health care, other member services and administrative activities that directly support the provision of services to members, such as provider recruitment and enrollment. In that spirit

1. The Managed Care Organization (MCO) may not conduct mass marketing with capitation dollars.
2. The MCO may not use capitation dollars to market to individuals or the general public with the intention of inducing HUSKY clients to join a particular plan or to switch membership from one plan to another.
3. Participation in health fairs and other community outreach events with the general public is permitted, subject to the following conditions: The MCO’s participation may include use of the plan’s name, logo and contact information on either a banner or sign identifying the plan or on educational materials. All information or written materials provided to the public must be entirely educational or factual in nature; written materials must address a health-related matter. In participating at events, the plans may answer specific factual questions about their respective plans. However, the plans may not discuss or compare the attributes or relative merits of different plans. The use of capitation dollars for trinkets or other promotional give-away items for the general public is prohibited.
4. The MCO may provide educational materials for display in provider lobbies. Health education posters with the plan’s logo or contact information may not be posted in providers’ offices until further notice, unless non-capitation dollars are used. Posters already placed in providers’ offices may remain.
5. Public relations efforts, such as involvement with a local school to promote awareness of asthma, are acceptable if they meet criteria 1 - 3 and are not intended to induce members to switch HUSKY plans. Such efforts targeting the general public are to be health educational in nature. Charitable efforts, such as a food or clothing drive conducted by the plan’s employees to benefit a local charity, are permitted.
6. The plans may facilitate the provision of a free item or service that will promote a member’s health or safety, such as connecting a local vendor willing to provide a free infant car seat with a member. Such activity is permitted if the plans’ commitment of time and expense is minimal or nominal.
7. Corporate sponsorship of non-profit fund-raisers, conferences and other special events using capitation dollars is prohibited. Exhibitor fees to attend health fairs and other community events are permitted, but may not exceed \$250.00 per event.
8. As outlined in earlier guidelines, health education and promotion efforts with the MCO’s current members is not only encouraged, but required. Efforts targeting the MCO’s members, including tokens, give-aways, incentive, awards, etc. are permitted. Such efforts are to be health motivational in nature, for example, to encourage pre-natal care or encourage adolescents to receive preventive care.
9. Participation in provider-only events is permitted. Participation in such events is not considered marketing or community outreach and does not need to be reported to DSS on the Monthly MCO Marketing and Community Outreach calendar. However, the MCO will provide notification of participation in such events to the MCO liaison and the DSS marketing contact.

All marketing and community outreach efforts, including those permitted only with non-capitation dollars, remain subject to existing contractual requirements and approval processes.

The following are the DSS Marketing Guidelines included in the MCO contracts, which have been amended by the April 1, 2010 Adjustments above:

The MCO shall obtain prior approval from the Department for all MCO-specific marketing activities and materials targeting the HUSKY and Charter Oak populations, including, but not limited to

1. Annual marketing plans and revisions to such plans, including description of proposed marketing approaches and marketing procedures.
2. HUSKY or Charter Oak application materials or information that mentions Medicaid, Medical Assistance, Title XIX, Title XXI State Children's Health Insurance Program (SCHIP), HUSKY or Charter Oak.
3. The use of the HUSKY or Charter Oak logo and name in their marketing materials, subject to the following:
 - a. The HUSKY logo shall be used in conjunction with and placed in the vicinity of the HUSKY name or the following language unless alternative language has been prior approved by the Department.
 - HUSKY gives families the freedom of choice to enroll in one of several participating health plans. Toll-free information: 1-877-CT-HUSKY;
 - A HUSKY health plan, 1-877-CT-HUSKY.
 - b. The Charter Oak logo shall be used in conjunction with and placed in the vicinity of the Charter Oak name or the following text unless alternative text has been prior approved by the Department.
 - Charter Oak gives families the freedom of choice to enroll in one of several participating health plans. Toll-free information: 1-877-77-CTOAK;
 - A Charter Oak health plan: 1-877-77-CTOAK
 - c. The font size for the HUSKY and/or Charter Oak phone number shall not be smaller than the MCO's phone number.
4. Corporate marketing that includes HUSKY A, HUSKY B or Charter Oak. No prior approval is required for corporate marketing that exclusively promotes the corporate brand and does not mention HUSKY or Charter Oak.

The MCO shall not promote its managed care plan through misleading, inaccurate or deceptive electronic, printed or artistic materials characterized by the following:

1. **Accuracy:** The MCO shall present accurate material. The Department will disallow any information that it determines is inaccurate (including misleading or exaggerated). This includes, but is not limited to, inaccurate statements about the nature of the eligibility or enrollment process, the positive attributes of the managed care plan, about the disadvantages of competing managed care plans or implying that a given managed care plan is the only HUSKY or Charter Oak managed care plan;
2. **Misleading or Exaggerated Claims:** The MCO shall not present misleading or exaggerated claims about the MCO's positive attributes. Misleading references include, but are not limited to, any MCO advertisement that its health care services are free to its Medicaid (HUSKY A) Members since potential Members could conclude from the advertisement that only this managed care plan provides free services. The MCO may differentiate itself by promoting its legitimate positive attributes;

3. **Endorsements:** The MCO shall not present false or misleading statements or assertions that the MCO or any of its products is endorsed by the Department or the Centers for Medicare and Medicaid Services (CMS) or any other governmental entity;
4. **Threatening Messages:** The MCO shall not create, advertise or present threatening implications about the Department's mandatory assignment process for HUSKY A or HUSKY B Members or other aspects of HUSKY A, HUSKY B or Charter Oak or create, advertise or present threatening scenarios that do not accurately depict the consequences of choosing a different managed care plan including, but not limited to those messages that suggest that a potential Member by not selecting a particular managed care plan or the failure to join a particular managed care plan would lose or not qualify for HUSKY or Charter Oak benefits or would endanger the Member's health status, personal dignity or the opportunity to succeed in various aspects of their lives;
5. **Deceptive Practices:** The MCO shall not engage in deceptive, fraudulent or abusive practices for any purpose including but not limited to enticing prospective Members to change managed care plan membership or to retain managed care plan membership;
6. **Discrimination:** The MCO shall not discriminate against any eligible individual on the basis of health status or need for future health care services;
7. **Parallel Promotions:** The MCO shall not promote enrollment in HUSKY A, HUSKY B or Charter Oak or the MCO in conjunction with the sale or offering of private insurance (exclusive of dental and other riders approved in advance by the Department and offered by the MCO to Charter Oak clients for purchase); and
8. The MCO shall not influence enrollment in conjunction with the sale or offering of any private insurance (exclusive of dental and other riders approved in advance by the Department and offered by the MCO to Charter Oak clients for purchase).

The MCO shall distribute marketing materials to its entire service area.

The Department will review materials submitted for Department approval and respond to review requests from the MCO within thirty (30) days from the receipt of the material. If the Department does not respond to materials submitted for approval within thirty (30) days, the MCO may use the materials as presented to the Department. However, the Department reserves the right to request revisions or recall specific materials at any time.

MCO representatives shall not actively solicit new Members at provider sites.

MCO representatives shall not distribute materials at DSS offices including hospital located eligibility offices and shall not position their representatives at or near DSS eligibility offices or at the sites of DSS contractors for the purposes of marketing and solicitation; however, the MCO may provide its materials to the Department, who will display those materials.

The MCO shall not conduct personal, small group or face-to-face marketing activities except as provided below.

The MCO shall distribute this section of the contract to all its network providers and prohibit providers from marketing or promoting any managed care plan. Network providers may display Department-approved materials and brochures. Providers may inform their patients of the managed care plans in which they participate and may explain that the patients must enroll in one of these managed care plans if they wish to preserve their existing relationship.

The MCO shall not market or promote its managed care plan through any means of telemarketing, mass mailings or any other means by which the MCO may establish unsolicited personal contact with potential Members; however, the MCO may respond with permitted information to unsolicited

telephone calls from potential Members and may return calls to them when the potential Member requests a return call. The MCO may also provide Department-approved materials when requested by a potential Member. Notwithstanding this provision, an MCO may send a limited amount of unsolicited mail to actual Charter Oak Members regarding the availability of dental and other riders approved in advance by the Department and offered by the MCO to Charter Oak clients for purchase. The MCO may also discuss these riders with potential Members during routine contacts initiated by the potential Members. However, the MCO may not make unsolicited calls or other contacts to potential or actual Charter Oak Members about these riders.

The MCO shall not conduct promotional group meetings or individual solicitation with potential Members at:

1. The offices of the MCO;
2. Private clubs;
3. Private residences including, but not limited to, situations where the potential Member desires and/or requests a home visit. MCO staff may visit Member homes after enrollment becomes effective, as part of their orientation/ education efforts; and
4. Employer sites, including but not limited to, soliciting employees directly or soliciting employers to promote the MCO to their employees or customers.

The MCO may conduct outreach or market their managed care plan at events and meetings open to the general public including those events held at public facilities, churches, health fairs or other community sites and those they organize or sponsor when the MCO:

1. Notifies the Department in advance of such meetings by submitting to the Department on a monthly basis schedules or calendars of educational and marketing events for the following month. The schedules shall contain sufficient information to allow the Department to attend the events and to monitor them;
2. Utilizes the Department-approved materials in the presentations and complies with the Department's marketing guidelines; and
3. Restricts their information request from potential Members to their name, address, phone number and family size.

The MCO and its marketing staff or representatives shall not under any circumstance request or require personal contact information of potential Members in return for a gift item nor access the following personal information from the MCO's data bank or from the potential Member or any other source: social security numbers, birth dates or children's names or any other individual information related to family members or potential Members.

The MCO (and its providers) may disseminate promotional token gifts of nominal value (magnets, pens, bags, jar grippers, etc.) at approved events and with approved materials to potential Members when:

1. The Department has approved them in advance of their dissemination; and
2. Their unit cost value is less than two dollars (\$2) and the aggregate cost per potential Member shall not knowingly exceed four dollars (\$4) per occasion.

The MCO may provide the following to Members when the Department has approved the items and the criteria for distributing the items before the MCO distributes them:

1. Token gifts to Members including magnets, phone labels and other nominal items that promote the MCO's care coordination programs (e.g. through advertising the Member Services hotline

and/or the PCP office phone number) or to reinforce medically “good” behavior (e.g. baby T-shirt showing immunization schedule once a woman completes targeted series of prenatal visits);

2. “Welcome” packets sent to new Members; and
3. Health education materials; which include but are not limited to, videos, CDs, DVDs, cassettes and other media.

The MCO shall not provide or sponsor incentives unless explicitly approved by the Department. Such incentives include, but are not limited to:

1. Cash or gifts, including gift certificates, to Member or potential Members;
2. Gifts of any kind to agencies that host meetings with potential Members;
3. Beverages or light refreshments at marketing events or in conjunction with marketing activities; and
4. Raffles in association with marketing-related activities or for the purpose of collecting information for marketing activities.

The MCO shall not coerce or intimidate Members from changing their managed care plan through enticements or performing the action on behalf of the Member.

The MCO may disseminate general health information materials to their Members without prior approval from the Department however; the MCO shall submit a copy of the general health information materials to the Department upon initial distribution.

The MCO may conduct health education and prevention activities at FQHCs and other provider sites when the MCO notifies the Department of such events through its monthly schedule or calendar, the materials conform to the relevant provisions of the Marketing Guidelines and such activities are not associated with marketing or promotional activities.

The MCO shall follow Department-approved procedures when approached by Members or potential Members including:

1. An MCO representative shall use an approved script when promoting the MCO’s managed care plan.
2. MCO representatives may provide potential Members the use of their cell phones to call the enrollment broker when the potential Member initiates an interest in calling the enrollment broker and requests the use of a phone. However, before providing a phone, the MCO representative shall advise the potential Member that:
 - a. The potential Member has a choice of which managed care plan to select; and
 - b. The potential Member should request the enrollment broker to verify that his/her PCP is included in the managed care plan that he/she has selected.
3. An MCO representative may dial the telephone number to the enrollment broker, however, when the enrollment broker answers the telephone, the MCO representative shall identify him/herself by name and managed care plan to the enrollment broker and then hand the phone over to the potential Member. The MCO representative shall provide the potential Member privacy when he/she is on the phone with the enrollment broker. For purposes of this provision, privacy means that the MCO’s representative shall remove himself/herself physically from the area so he/she cannot overhear the conversation between the potential Member and enrollment broker.
4. An MCO representative shall not call the enrollment broker or utilize a third party and change the managed care plan on behalf of a potential Member.
5. An MCO representative shall not coach or coerce potential Members during or after the use of the telephone for a call with the enrollment broker.

6. An MCO representative may attempt to contact a potential Member not more than twice following an initial contact at an event to follow-up.

The MCO shall not compensate marketing staff, whether they are employees, independent contractors, independent insurance brokers or marketing representatives, through the use of a per Member incentive for managed care plan changes or enrollment and shall hold the Department harmless for any and all claims, complaints or causes of actions that shall arise as a result of this contractually imposed salary, benefits and other compensation structure for marketing representatives through the use of a per Member incentive or similar bonus type of reimbursement.

The MCO shall implement policies and procedures to manage the actions of marketing staff to ensure compliance with marketing guidelines.

The MCO shall obtain the Department's prior approval for marketing/ outreach training curricula for marketing personnel. Such material shall include, at a minimum, marketing and outreach expectations and limitations and these guidelines and shall require all its marketing personnel to participate in training sessions that the Department may develop or require.

Expenditures on marketing and marketing-related activities shall not exceed one percent (1%) of the MCO's administrative expenditures during the first three years of the resultant contract. Marketing expenditures shall not exceed one half of one percent (0.5%) of administrative expenditures during the last two years of the resultant contract.

The following grid provides a summary of the Marketing Guidelines:

Permitted = 1 / Not Permitted = 2 / Permitted with DSS Approval = 3

Marketing Guidelines Summary		1	2	3
1	Marketing materials and approaches			X
2	MCO marketing in provider care sites		X	
3	MCO advertising in DSS-eligibility offices, including hospital-based			X
4	Face-to-face allowed marketing activities			X
5	Provider communications with Medicaid patients about MCO options			X
6	Potential Member-initiated telephone conversations with MCO and Provider staff	X		
7	Mailings by MCO in response to potential Member requests			X
8	Unsolicited MCO mailings		X	
9	Cold calling and telemarketing		X	
10	MCO group meetings held at MCO		X	
11	MCO marketing at public facilities such as churches, health fairs			X
12	MCO group meetings held in private clubs or private homes		X	
13	Individual solicitation at residences		X	
14	Marketing at employer sites and employer solicitation		X	
15	Gifts, cash, incentives or rebates to potential Members			X
16	Raffles to prospective Members		X	
17	Gifts to Members for specific health events			X

	Marketing Guidelines Summary	1	2	3
18	Phoning by potential Members from health care provider locations		X	
19	Beverages and light refreshments for potential Members at meetings		X	
20	Use HUSKY or Charter Oak name and logo (as specified)	X		
21	Generic Health Education materials	X		
22	HUSKY or Charter Oak specific Health Education materials			X
23	Health education and prevention activities at provider sites, as specified	X		
24	Soliciting contact information from members, prospective Members, as specified			X
25	Communication with Members by marketing/ outreach staff, telephone use, as specified only			X