



STATE ADMINISTERED GENERAL ASSISTANCE PROGRAM

CHNCT Provider Manual

March 2005

WELCOMING NOTE

Dear SAGA Provider:

Welcome to Community Health Network of Connecticut, Inc. (CHNCT)! We are the Medicaid managed care organization providing the community care component for Connecticut's State Administered General Assistance or "SAGA" Program. We appreciate your participation in the SAGA Program. We would also like you to know that we are committed to providing you with the best in ongoing support. As the Vice President of Health Services for Community Health Network of Connecticut, I would like to thank you personally for joining with us to improve the health of our SAGA members. Our partnership with you is central to what we do. We are available to you for any problems, questions, or concerns.

This SAGA Provider Manual contains detailed information regarding CHNCT's policies and procedures stipulated in your SAGA participation agreement. The goal of this manual is to provide you and your associates with a thorough understanding of the SAGA health services delivery system. Please note, we have included valuable SAGA program information in this manual to provide you with the necessary resources to understand how the program operates and to convey the most current requirements from the Connecticut Department of Social Services (DSS).

If you have any questions about the administration of the SAGA program, your Provider Relations Representative will be happy to assist you. Your representative can be reached by using CHNCT's dedicated provider line at 1-800-440-5071.

Again, welcome. We look forward to a mutually beneficial relationship.

Sincerely,

Lynn E. Childs, RN, BSN, MS
Vice President, Health Services

IMPORTANT TELEPHONE NUMBERS

Provider Relations, Provider Inquiries	1-800-440-5071 Fax: 1-203-265-3609
Care Management Admission to Hospital Appealing a Denial Decision for Services Case Management Services Pre-Certification, Referrals to Specialists Authorizations	1-800-440-5071 Fax: 1-203-265-3994
Member Services Eligibility and Membership Verification Primary Care Provider Verification Transportation for a Members seeking radiation oncology, chemotherapy,	1-866-361-(SAGA)7242
Claims Claims/ Billing Questions or Problems	1-800-440-5071
Management Information Systems Electronic Billing Set-Up Assistance	1-203-949-4000
BeneCare Dental Services	1-800-843-4727
AdvancePCS Pharmacy Questions Pharmacy Prior Authorization	1-800-364-6331
EDS Automated Eligibility Verification System (AEVS) *Need Medicaid Provider ID #	(860) 832-9259

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SECTION 1 - INTRODUCTION

Overview

Community Health Network of Connecticut Inc. (CHNCT) was formed in August 1995 by the Federally Qualified Health Centers (FQHCs) located in Connecticut. We provide the community component of the State Administered General Assistance or SAGA through an administrative services contract with the Connecticut Department of Social Services (DSS). CHNCT's FQHC's have served the state's Medicaid population for over thirty years. CHNCT is building its SAGA provider network by contracting with FQHCs, Community Health Centers (CHC's), and private medical practices associated with Primary Care Providers (PCP)and/or specialist providers throughout Connecticut. CHNCT uses a gatekeeper model in which PCP coordinates each SAGA member's care.

Intentions

CHNCT is a not-for-profit company dedicated to providing care in a manner that emphasizes quality, understanding and respect. It is CHNCT's intent to build strong partnerships with providers aimed at improving the health of our members. As a provider in our network, you can expect the following from CHNCT:

- ◆ open and respectful communication
- ◆ timely response to questions and/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
- ◆ 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
- ◆ feedback on provider's performance and provider utilization

SECTION 2 – GENERAL INFORMATION REGARDING THE SAGA PROGRAM

The State Administered General Assistance Program (SAGA) provides medical assistance to indigent individuals and families in all Connecticut towns, who do qualify for Medicaid.

Eligibility is based on income and assets alone and is determined by eligibility workers at the regional DSS offices.

The State of Connecticut is committed to moving SAGA beneficiaries from the traditional healthcare environment into managed care. DSS has partnered with CHNCT to provide the community component of the SAGA program to achieve the following objectives:

- ◆ Improve the health status of SAGA-eligible persons through better access to healthcare services;
- ◆ Improved continuity and coordination of health care; and
- ◆ Foster a more integrated delivery of SAGA services through the current health care systems based on principles of quality, efficiency, accessibility and accountability.

For a complete listing of our Medical Guidelines, please refer to our web-site www.chnct.org.

SERVICES UNDER THE SAGA PROGRAM

The following health services, when deemed medically necessary, are those services that all CHNCT SAGA members are entitled. Services listed are subject to change as mandated by DSS, and hence CHNCT, under the SAGA program contract.

SAGA Covered Services

- ◆ Ambulatory /Outpatient Surgery
- ◆ Dental Services, including, oral exams, x-rays, fillings, fluoride treatments, oral surgery, sealants, bridge and crown, root canals, full and partial dentures, extractions, and (orthodontia for patients under 21 only)
- ◆ Diagnostic Services
- ◆ Dialysis Services including hemodialysis and peritoneal dialysis
- ◆ Durable Medical Equipment Purchases and Rentals
- ◆ Emergency Medical Care
- ◆ Emergency Transportation or Ambulance Services
- ◆ Family Planning and Pregnancy Termination - as limited by DSS policy
- ◆ Laboratory Services
- ◆ Medical Surgical Supply Purchases
- ◆ Nurse Practitioner Services
- ◆ Nurse-Midwife Services
- ◆ Oncology Services including chemotherapy and radiation therapy

- ◆ Orthotic and Prosthetic Devices - as limited by DSS policy
- ◆ Outpatient Medical Rehabilitation Services as limited by DSS policy
- ◆ Oxygen Therapy
- ◆ Pharmacy Services
- ◆ Physician Services - primary and specialty providers
- ◆ Preventive Care and Services
- ◆ Pre-admission testing
- ◆ Inpatient Services (administered through DSS)
- ◆ Hospital based and FQHC/CHC Community-based Physical Therapy, Occupational Therapy, Speech Therapy, Podiatry, and Audiology (Not covered if performed by independent practitioners.)

SAGA Non-Covered Services

- ◆ All plastic or cosmetic services or procedures performed for reconstructive purposes, including lipectomy, hair transplant, rhinoplasty, dermabrasion.
- ◆ Any services or items furnished for which the provider does not usually charge
- ◆ Drugs used to promote smoking cessation
- ◆ All physical, speech, occupational therapies, naturopathic, podiatry and audiology performed by independent practices
- ◆ Hospice Services
- ◆ Drugs that the FDA has proposed to withdraw from the market
- ◆ Home Care Services
- ◆ Infertility Treatment - i.e. sterilization reversal; artificial insemination; invitro fertilization, etc.
- ◆ Institutions for Mental Disease (IMD)
- ◆ Medical services in the treatment of obesity, including gastric stapling
- ◆ Non-Emergent Transportation excluding transport for radiation oncology, chemotherapy and dialysis treatment / services
- ◆ Procedures or services of an unproven, experimental or research nature
- ◆ Punch hair transplants
- ◆ Powered wheelchairs
- ◆ Recreational or educational programs or memberships
- ◆ Routine physical exams requested by third parties
- ◆ Routine Vision Care
- ◆ Services performed by a non-participating provider
- ◆ Services for a condition that is not medical in nature or are in excess of those deemed medically necessary to treat a patient
- ◆ Services related to transsexual surgery

- ◆ Services which are not within the scope of a practitioner's practice under State law
- ◆ Services not directly related to patient's diagnosis, symptoms or medical history
- ◆ Services in excess of those deemed medically necessary
- ◆ Services and/or procedures considered to be experimental, cosmetic, social habilitative, vocational, tattooing or tattoo removal
- ◆ Services provided while the member is out of the State of Connecticut, except for emergency care

SECTION 3 – SAGA MEMBER INFORMATION

Member Rights

CHNCT is committed to treating members in a manner that respects their rights. By working with providers, we can help our members and their families meet their health care needs. Here are the rights we both agree to:

- Members have the right to receive information about CHNCT, its services, practitioners, providers, and member's right and responsibilities.
- Members have the right to be treated with respect and recognition of their dignity and right to privacy.
- Members have the right to be able to choose primary care providers, within the limits of the plan network, including the right to refuse care from specific providers.
- Members have the right to participate with their providers in decision-making regarding their health care.
- Members have the right to respectful, personal attention regardless of their race, origin, and religion, physical or mental handicap.
- Members have the right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit.
- Members have the right to a "second opinion" regarding their condition and/or diagnosis.
- Members have the right to have access to their medical/dental records as allowed by Federal/State law.
- Members have the right to voice complaints or express grievances regarding any violation of their rights about CHNCT or the care provided by its providers.
- Members have the right to formulate advance directives. A health care advance directive is a document in which members give instructions about their health care if in the future they cannot speak for themselves. Members can give someone the power to make health care decisions for them. Members also can give instructions about the kind of health care they do or do not want.
- Personal health information must be kept confidential by CHNCT employees and agencies it contracts with. Members have the right to confidentiality of all records and communication to the extent required by law.

Identification Card

SAGA members are issued a member identification card with their name, CHNCT member identification (ID) number, PCP's site name and phone number.

Below is a sample identification card issued by CHNCT for the SAGA program. (The State of Connecticut also issues every active recipient a Title 19 card with the recipients Medicaid ID number, date of birth and issue date on the card. You may request this card from the member in an effort to get information needed to identify the member's status within a plan.)

NOTE: Possession of a SAGA member ID card from CHNCT does not guarantee eligibility and/or payment from CHNCT. Eligibility can be verified by calling CHNCT's SAGA toll-free number, which is listed on the back of the membership card.

Checking Eligibility

It is important to check eligibility frequently. SAGA members may only be enrolled in the program for a short time period, customarily ten months, prior to being transferred to another program for which they would be eligible. Providers may contact CHNCT's Member Service Department at 1-866-361-(SAGA)7242 to determine a member's assigned PCP Site. The PCP will not appear on the member's SAGA id card, you will see the name of the facility where the PCP provider is located and the phone number of the facility.

Providers may also use the Automated Eligibility Verification System (AEVS) to check the status of a SAGA member by calling (860) 832-9259. PCPs also have the option of using ePower, our online verification tool. Contact your Provider Relations Representative to find out more about ePower.

Out-of-Pocket Expenses

Balance billing is not allowed under the SAGA Program. A SAGA member may not be billed for covered services even if the provider claim payment is denied and regardless of the reason for denial. A provider may only bill a SAGA 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. Providers may also not bill for cancelled or missed appointments and for record transfers.

Primary Care and Provider Assignment

Each SAGA member chooses or is assigned to a PCP site that coordinates his/her care. We anticipate 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. We also recognize that many potential enrollees have not established provider relationships and are not familiar with the continuity-of-care concept. Therefore, we emphasize the educational component of the selection process and explain that establishing a personal relationship with a PCP means that the PCP and his or her support personnel will be responsive to the member's needs and concerns and efficient in responding to them.

Members are allowed to change their PCP site when they feel it is in their best interest to do so. Members may contact CHNCT's Member Services Department at 1-866-361-(SAGA)7242, submit a request in writing, or complete a PCP change form (see Appendices Section of this manual) and fax it to CHNCT at 203-265-2806. PCP site changes are effective the day they are received.

Removal of a Member from PCP Panel

CHNCT is willing to assist a provider with any concerns or issues that arise, particularly those which have the potential to cause harm to the member or member's family member. Contact Member Services at 1-866-361-(SAGA)7242 for more information.

If a provider wishes to be removed as a PCP for a SAGA member, providers must notify CHNCT's Member Services Department at 1-866-361-(SAGA)7242. CHNCT will facilitate the transfer by notifying the member and assigning a new PCP site.

If a provider wishes to be removed as a PCP site for a SAGA member, providers must notify CHNCT's Member Services Department at 1-866-361-(SAGA)7242. CHNCT will facilitate the transfer by notifying the member and assigning a new PCP site.

MEMBER SERVICES DEPARTMENT

Our Member Services Department has bilingual staff available to answer questions for any CHNCT member on a variety of issues including SAGA benefits and services. For many SAGA members, the CHNCT plan and the selection and function of a PCP may be new concepts. To ensure that our system of care is understood, CHNCT is committed to provide training for both members and providers. Please direct any members with concerns to 1-866-361-(SAGA)7242.

SECTION 4 - PROVIDER INFORMATION

GENERAL PROGRAM REQUIREMENTS

Participating providers agree to:

- ◆ Accept CHNCT SAGA members as patients and provide needed services to these patients within the scope of benefits and in accordance with CHNCT's policies and procedures.
- ◆ Not discriminate against CHNCT SAGA members on the basis of race, sex, age, religion, sexual orientation, marital status, place of residence, perceived health status, or source of payment.
- ◆ Refer CHNCT SAGA members only to CHNCT SAGA participating providers. Refer to the CHNCT's SAGA Provider Directory on the web site for a complete listing.
- ◆ Maintain and make accessible, if requested, such records as are necessary to disclose the extent of the services provided to CHNCT's SAGA members. All CHNCT SAGA members have signed a release of information covering CHNCT on such occasions.
- ◆ Accept payments made by CHNCT as full payment for covered services. A provider may only bill a SAGA member for goods and services which are not covered, 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. Providers may not bill for cancelled/missed appointments or for record transfers.
- ◆ Cooperate fully with any utilization review, quality improvement, peer review, or other program established by the CHNCT Board of Directors to promote high standards of medical care and to ensure the proper use of health services.
- ◆ Ensure sufficient access to services for SAGA members with visual and hearing disabilities and limited English proficiency. Providers may contact the CHNCT Member Services department to access interpreter services.

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.

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 PCP notification.
- ◆ 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. Maximum time for a provider to respond back is within 15 minutes for urgent care needs and within 45 minutes for semi-urgent needs.
- ◆ Office hours remain open at least 20 hours a week and at least four days a 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.

Coordination of Care

A PCP's role is that of a medical manager, providing and coordinating medical care for members. The responsibilities of the PCP are listed below:

- ◆ Diagnosis, including laboratory and X-ray services, and medically necessary treatment of physical conditions not requiring a referral or inpatient hospitalization.
- ◆ Preventive services, such as immunizations, screening for early detection of illness and health supervision.
- ◆ Medically necessary covered services to members provided in the same manner and within the same time availability, as any other patients without regard to insurance plan.
- ◆ Coordination and case management to assure continuity of care of covered services provided to members.
- ◆ Referral of members to specialists when medically necessary and in accordance with the prior authorization policies of the health plan.
- ◆ Necessary and appropriate arrangements to assure the availability of medically necessary services to members enrolled with the PCP on a 24 hours a day, 7 days per week basis, including arrangements which assure coverage of PCP's patients after hours or when the PCP is otherwise unavailable.
- ◆ Claims submission for each encounter or the generation of encounter information in a format approved by CHNCT within the allotted time from the date of service.

Role of Primary Care Providers

The coordination of care for each member must be available on a 24-hour basis to provide coverage, review information within the medical record and ensure continuity of patient care. The PCP coordinates all medical services rendered to the member. In essence, the PCP is responsible for coordinating and monitoring primary and other medical care on behalf of the member to ensure that appropriate and medically necessary specialty services are received. The PCP need not authorize self-referred services identified below:

- ◆ Dental -- Dental services available through the BeneCare's network of Dentists
- ◆ Obstetrics -- Obstetric services available through any CHNCT participating Obstetrician
- ◆ Family Planning Services -- Family Planning services are available through any licensed provider.

Covering Physicians

CHNCT strongly recommends prior notification if a physician will be out of their office for any length of time and will require alternative coverage of their patients. Please notify coverage to Provider Relations Department at (800) 440-5071.

CHNCT requires that the covering physician is a participating provider who is familiar with and complies with CHNCT's Policies and Procedures. Because CHNCT is a gatekeeper plan, members are assigned and identified by their PCPs, therefore, if prior notification is not received from the physician regarding patient coverage, claims may be subject to denial.

SPECIALTY PROVIDERS

Role of Specialty Providers

- ◆ Provide medically necessary covered services to members in the same manner and within the same time availability as any other patients without regard to insurance plan.
- ◆ Provide the specialty services indicated on the referral form.
- ◆ Verify that the member was referred by his or her PCP.
- ◆ Provide a complete report of services rendered, including clinical diagnosis and recommended treatment, to the referring PCP.
- ◆ Advise the PCP in writing of any ongoing treatment program.
- ◆ Notify the PCP if another specialist is needed.
- ◆ Pre-certify diagnostic testing, ancillary services according to guidelines.
- ◆ Meet accessibility standards for appointment availability. Minimum 20 hours a week.
- ◆ Claims submission for each encounter or the generation of encounter information in a format approved by CHNCT within the allotted time from the date of service.

PROVIDER RELATIONS DEPARTMENT

The Provider Relations Department at CHNCT handles any provider issues related to policies and procedures. The staff acts as the liaison between CHNCT, hospitals, physicians and other providers of health care. Provider Relations Representatives are available to talk with providers and their staff, answer questions, assist in resolving problems and provide training on our policies and procedures. Your CHNCT Provider Relations Representatives can be reached at 1-800-440-5071.

SECTION 5 – REFERRALS AND PRIOR AUTHORIZATION

REFERRALS

SAGA members require referrals from their PCPs to access medically necessary specialty care services that are not available through their PCP. These include most services rendered by a specialist.

Following CHNCT referral procedures is vital to ensuring coordination of care and payment for services rendered. The purpose of referrals is to determine the medical necessity and appropriateness of care on a prospective basis and to ensure that care is provided in the most clinically suitable and most cost-effective setting.

The referral forms used within CHNCT consist of three copies:

- ◆ One (white) copy of the referral form to the SAGA specialty provider or consultant.
- ◆ One (yellow) copy to CHNCT
- ◆ One (pink) copy to be filed by the PCP in the SAGA member's medical record.

Referral Process

1. PCP decides it is necessary for a SAGA member to receive specialty care services.
2. PCP or office selects a participating SAGA provider using the SAGA Provider Look-up on CHNCT's web site and completes the triplicate referral form as instructed.
3. PCP or office staff must assist the SAGA member with scheduling an appointment for the referral.
4. PCP or office staff should provide the SAGA member with a photocopy of the referral form.
5. PCP or office staff must notify CHNCT by one of the following methods prior to the service being rendered:
 - ◆ Fax a copy to CHNCT's Care Management Staff at 1-203-265-3994, 48 hours prior to the member's specialty appointment, or
 - ◆ Mail a copy to CHNCT, Attention Care Management Department
6. When the referral is approved CHNCT mails out an authorization letter that provides documentation of the services requested and authorization number to the PCP, specialty provider and SAGA member. When the referral is rejected CHNCT notifies the PCP, specialty provider and the SAGA member of why the referral was denied.
7. SAGA member arrives for specialty visit and provider or office associates verifies eligibility and validity of referral.

If further visits/interventions are necessary, the specialist must provide the PCP and CHNCT with a treatment plan specifying the course of treatment, anticipated visits, and any other diagnostic/treatment data necessary for the PCP to function effectively as the gatekeeper and coordinator of care for this SAGA member.

Specialist Referral Guidelines

If a SAGA member requires specialty care, the PCP refers the member to a specialist listed in the SAGA provider directory. A physician who is both a PCP and a specialist may treat a member of his/ her patient panel within the scope of their practice without a referral. A PCP may refer to a specialist within their provider group. A SAGA specialist may not refer to other specialists. If a specialist determines that another specialist is needed, PCP approval is required. A new referral must be submitted to CHNCT by the PCP for the additional specialist.

Specialist providers are responsible for verifying eligibility through CHNCT and coordinating the treatment plan with the PCP before completing any tests or procedures that are not authorized on the referral form. The specialist provider should contact CHNCT's Care Management (CM) Department at (800) 440-5071 for authorization of emergency treatment.

When a SAGA member has been hospitalized under a specialist's care and must continue that care in the specialist's office after discharge, the PCP must issue a subsequent referral, unless a valid referral is still in place. To verify if a valid referral is in place call CHNCT's CM Department at (800)-440-5071.

PRIOR AUTHORIZATION

Prior authorization means obtaining permission from CHNCT before rendering the service. This is an integral part of the managed care process. Authorization can be obtained by phoning the CM Department at (800) 440-5071. The following information is generally requested before authorization is given:

- ◆ SAGA Member's Name and Identification Number
- ◆ Date of Birth
- ◆ Diagnosis or Reason for Treatment
- ◆ Treatment Plan including Number of Visits or Duration of Proposed Treatment

During the prior authorization process, the CM staff reviews the request against established criteria and generally responds to the provider within one (1) business day by sending an authorization letter to the PCP, specialist office, and the member.

*** Please refer to the appendices for authorization grid.

SECTION 6 –CARE MANAGEMENT & CARE COORDINATION

The Care Management/Care Coordination Department works to ensure that CHNCT's SAGA members get the care, which meets their needs. This goal is achieved through utilization management and case management in the outpatient setting, in collaboration with the community health centers and other providers and vendors.

CASE MANAGEMENT SERVICES

Case Management (CM) is a collaborative process, which evaluates options and services to meet complex health needs through communication and available resources to promote quality, cost effective outcomes. Successful case management occurs across a continuum of care and addresses the ongoing needs of the SAGA member.

CHNCT takes steps to manage the care of all SAGA members, including those with catastrophic or chronic illnesses. We operate a case management system that coordinates all primary, secondary, tertiary, and ancillary care that is required by enrolled SAGA recipients.

The Case Management Team consists of RN Case Managers, Referral Coordinator's, and the Medical Director. Although the PCP maintains overall responsibility for implementing case management activities, this case management team helps to ensure that all SAGA members have a "medical home" that promotes access and continuity within the SAGA network. This team can offer consultation and can suggest alternative care options available through the plan.

CHNCT assists PCPs by providing management information system (MIS) support, quality assurance (QA) and Care Management (CM) expertise and the services of an experienced case management nurse who gives advice and guidance on implementing a case management system.

A multidisciplinary care plan will be established for each SAGA member accepted into the case management program. The care plan will include a complete assessment of the patient's condition, environment, social setting, financial/community resources, specific treatment goals, and specific services to be provided with expected duration and evaluation of progress toward goals.

Progress toward established goals will be evaluated quarterly and the care plan updated and modified where appropriate.

Role of the Care Management Team

The SAGA population often demands intensive case management to coordinate and monitor the provision of health care services on their behalf. The case management team therefore supplements the PCP's efforts in dealing with individuals who have special needs or with particularly difficult members. The goals of the case management team are to:

- ◆ Move from an episodic care delivery system to care built around the overall preventive care and special needs of the SAGA members.
- ◆ Improve the compliance levels of members by following good health care practices in general.

Referrals for case management may come from any source. An evaluation for potential case management services will be initiated within one (1) working day of the referral. All case management evaluations will be completed within five (5) working days of the referral.

Information concerning other resources available within the community will be recommended to SAGA patients who do not meet the criteria for case management. Types of cases that must be evaluated for case management include:

- ◆ Head Trauma
- ◆ Human immunodeficiency virus (AIDS)
- ◆ Neonates requiring neonatal intensive care unit services
- ◆ Neuromuscular dysfunction
- ◆ Cardiac anomalies
- ◆ Chronic renal failure
- ◆ High risk pregnancies
- ◆ Spinal cord injuries/disorders
- ◆ Neoplasm
- ◆ Transplant patients
- ◆ Asthma
- ◆ Diabetes Mellitus
- ◆ Congenital defects
- ◆ Major burns
- ◆ Chronic pain management

DURABLE MEDICAL EQUIPMENT

Durable medical equipment (DME) includes medically necessary appliances, equipment and supplies required for the care of a SAGA patient, outside a hospital, rehabilitative facility or other health care facility. CHNCT requires pre-certification before rental or purchase of DME valued greater than \$200.00.

The RN case manager evaluates the medical necessity and appropriateness of DME items that providers have requested for their SAGA patients. CM staff coordinates with the PCP, as required, to ensure that appropriate and necessary services are made available to SAGA members in need.

DME is equipment that can stand repeated use; is primarily and customarily used to serve a medical purpose and is generally not useful to a person in the absence of an illness or injury. Medical supplies are those items that are prescribed by a physician to meet the needs or requirement of a specific medical and/or surgical treatment. They are generally dispensable and not reusable.

SECTION 7 – OTHER SERVICES

DENTAL SERVICES

CHNCT has contracted with BeneCare to manage and provide dental services to our SAGA members. Members may self-refer to any dentist in the SAGA network; they do not need a referral from their Primary Care Physician. Specialty dental services may require an authorization; please refer to BeneCare's Provider Manual. A complete listing of participating dental providers can be found in the SAGA Provider Directory. For any questions regarding authorization, claims submission or claims payment, please contact BeneCare at 1-800-843-4727.

LABORATORY AND RADIOLOGY

Laboratory services are covered without prior authorization when ordered by a participating SAGA provider. Lab work can be performed at any participating hospital within the SAGA network, or at any contracted independent laboratory within the CHNCT SAGA network. For the nearest laboratory drawing station contact the Provider Relations Department at 1-800-564-5465.

Radiology services are covered without prior authorization when ordered by a participating SAGA provider. SAGA members may go to any participating hospital within the DSS SAGA network or diagnostic center within the CHNCT SAGA network.

SECTION 8 – PHARMACY SERVICES – SAGA MEMBERS

CHNCT subcontracts its pharmacy benefit management services to Caremark to assist in managing this benefit for CHNCT SAGA members. This affiliation allows CHNCT to ensure access, high quality service, as well as real time, on-line claims adjudication and prior authorization processing. Refer to the SAGA provider directory for a listing of all participating pharmacies within CHNCT's pharmacy network.

Drugs and supplies are prescribed by SAGA member's provider, however, some drugs and supplies need to be prior authorized through CHNCT or Caremark before they can be obtained (See Prior Authorization Section below)

The amount of a prescription drug, which will be dispensed per prescription or refill on an urgent basis when the prescribing provider is not reachable, will be up to a 5-day supply for the SAGA Program. However, no controlled drugs will be given as an emergency 5 – day supply.

The following drugs are covered and do not require prior authorization:

COVERED DRUGS - SAGA
Generic Drugs – Mandatory Generic Substitution)
Brand, (exception: Generic alternatives for Atypical antipsychotics for SAGA clients who have had the same brand name atypical antipsychotic dispensed within the last 60 days
Compounded drugs
Non- maintenance medications prescribed for less than 15 days
OTC – Insulin syringes and needles

Prior Authorization:

Prior Authorization must be obtained for the following categories:

(SAGA Medical Exception Request Form and a MedWatch Form must be completed and faxed to CHNCT –203-265-3994)

- Brand name drugs when a generic equivalent is available
- Drugs over \$500 for up to a 30 day supply (Except for HIV medications)
- Certain **Injectable** Medications (See Section – “SpecialtyRx-Injectables” below)
- Early refills (when less than 75% of medication should have been taken by the time another supply is requested)
- Exceptions: Vacations and lost medications can be made according to plan benefit specifications on time in a 6-month period.

Please contact CHNCT’s Pharmacy Department at 1-800-440-5071, prompt # 3 for Medical Exception Request Form and MedWatch Form

Dispensing Limitations

The amount of drug, including insulin, which is to be dispensed per prescription or refill, will be in quantities prescribed up to a 30-day supply with a maximum of 240 units.

SpecialtyRx –Injectables

Caremark is the exclusive pharmaceutical provider of selected injectable drugs and ancillary medications for CHNCT's HUSKY members. These drugs are supplied for HUSKY members in a timely, efficient manner through its distribution program. Please refer to the list of injectable drugs and ancillary medications included in this program and the Patient Referral Form to order medications.

CHNCT requires that you use Caremark SpecialtyRx for all new prescriptions for listed drugs. When ordering medications, you must complete a Patient Referral Form, which you can get either in the Appedices section of this manual or on CHNCT's web-site, www.chnct.org; or contact CHNCT (203) 949-4074, or contact SpecialtyRx at (866) 295-2779.

Your request needs to be faxed to Caremark (866-295-2778). Caremark will review the information provided and begin processing your request. If Caremark receives the request by 4:00 PM, your order will be sent the next day or on a date you designate. Program representatives at Caremark SpecialtyRx are available Monday through Friday, 8 a.m. through 7 p.m. ET.

Medications Available through Caremark SpecialtyRx™ (Therapeutic Category List)

Actimmune NF [®]	Genotropin [®]	Polygam [®] S/D
Advate [™]	Gleevec [®]	Pregnyl [®] (males only)
Aldurazyme [®]	Helixate-FS [®]	Procrit [®]
Alferon-N	Hemofil-M [®]	Profilnine-SD [®]
Alphanate [®]	Herceptin [®]	Progesterone in oil
AlphaNine SD [®]	Humate-P [®]	Proleukin [®]
Amevive [®]	Humatrope [®]	Pulmozyme [®]
Amicar [®]	Humira [®]	Raptiva [®]
Aminocaproic Acid	Hyalgan [®]	Rebetol [®]
Aralast [™]	Infergen [®]	Rebetron [®]
Aranesp [®]	Intron A [®]	Rebif [®]
Autoplex T	Iressa [®]	Recombinate
Avonex [®]	Iveegam [®] EN	Refacto [®]
BayGam [®]	Kineret [®]	Remicade [®]
Bebulin VH [®]	Koate-DVI [®]	Remodulin [®]
Benefix [®]	Kogenate FS [®]	Ribavirin [®]
Betaseron [®]	Leukine [®]	Rituxan [®]
Botox [™]	Leuprolide Acetate	Roferon [®] -A
Carimune [®] NF	Lupron [®]	Saizen [®]
Ceredase	Lupron Depot [®]	Sandostatin [®]
Cerezyme [®]	Lupron Depot-Ped [®]	Sandostatin LAR [®]
Copaxone [®]	Monarc-M	Sensipar [®]
Copegus [®]	Monoclata-P [®]	Serostim [®]
Cytogam [®]	Mononine [®]	Stimate [®]
Delestrogen [®]	Myobloc [®]	Supartz [®]
Eligard [™]	Neulasta [®]	Synvisc [®]
Enbrel [®]	Neumega [®]	Temodar [®]
Epogen [®]	Neupogen [®]	Thalomid [®]

Fabrazyme[®]
Feiba VH Immuno[®]
Flebogamma[®]
Flolan[®]
Forteo[®]
Fuzeon[®]
Gamimune[®] N
Gammagard[®] S/D
Gammar[®]-P I.V.
Gamunex[®]
Genarc[™]

Norditropin[®]
Novantrone[®]
Novarel[®] (males only)
NovoSeven[®]
Nutropin[®]
Nutropin AQ[®]
Octagam[®]
Orthovisc[®]
Panglobulin[®]
Pegasys[®]
Peg-Intron[®]

Thyrogen[®]
TOBI[®]
Tracleer[®]
Trelstar Depot[™]
Trelstar LA[™]
Viadur[®]
Visudyne[®]
Xeloda[®]
Xolair[®]
Zoladex[®]
Zorbtive[™]

This list is current as of January 1, 2005. Medications shown in bold require prior authorization. Products distributed by Caremark and therapies covered may change. Please call Caremark SpecialtyRx at 1-866-295-2779 for prior authorization or with questions regarding medications not on this list.

SECTION 9 – CLAIMS SUBMISSION AND PAYMENT

General Information

- ◆ Before a claim can be processed for payment all necessary information on the HCFA 1500 or UB92 forms must be completed correctly or the claim may be denied. For referred services, the appropriate prior authorizations must be obtained and appear on the claim form, for payment to be made. For non-referred services, only the services specified by contract are paid. Without all necessary information claims processing is delayed and claim payment may be denied.
- ◆ All clean claims are processed and paid within forty-five (45) 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 processed 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.*
- ◆ If CHNCT finds that claims are overstated based on medical or financial audits, an appropriate reduction in reimbursement is made. Similarly, if CHNCT finds that an overpayment has been made, the provider is notified that CHNCT is owed a refund payable within 45 days after notification. If repayment is not made within the 45-day period, CHNCT reduces future claims payments by the overpayment amount.
- ◆ Providers shall submit any late charges with appropriate documentation. For late charges to be paid, the following information is required:
 - a) Copy of the late charges itemized statement
 - b) Copy of original charges
 - c) UB92 for late charges
 - d) Medical records associated with late charges
- ◆ All claim forms should be submitted within 120 days from the date of service.
- ◆ When submitting claims for multidisciplinary exams, providers must bill with the diagnosis code V62.5 (Legal Circumstances) in order for CHNCT to process the claim appropriately.

SAGA Members Held Harmless

By entering into a provider agreement with us, you have agreed to accept payment directly from CHNCT. Payment from CHNCT constitutes payment in full for the covered services you render to CHNCT SAGA members. Providers may not balance bill CHNCT SAGA 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 SAGA 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.

Claim Requirements

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

The following information should be submitted on a **HCFA 1500 Form** in order for the form to be considered a claim:

<u>Item Number</u>	<u>Item Description</u>
1a	Insured’s Identification (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)
24A	Date(s) of Service
24B	Place of Service
24D	Procedures, Services or Supplies
24E	Diagnosis Code(s)
24F	Charges
24G	Days or Units
25	Federal Tax ID Number
28	Total Charge
31	Signature of Physician or Supplier with Date
32	Name & Address of Facility where Services were Rendered
33	Physician’s, Supplier’s Billing Name, Address, Zip Code, Phone Number, and Medicaid Number

The following information should be submitted on a **UB-92 Form** in order for the form to be considered a claim:

<u>Item Number</u>	<u>Item Description</u>
1	Provider Name and Address
5	Federal Tax Identification (ID) Number
6	Statement Covers Period
12	Patient’s Name
14	Patient’s Birth Date
15	Patient’s Sex
21	Revenue Codes
42	Revenue Description
43	HCPCS/ CPT4 Codes
44	Service Date
45	Service Units
46	Total Charges by Revenue Codes
50	Payer ID
51	Provider’s Medicaid Number

58	Insured's Name
60	Patient's ID Number
62	Insurance Group Number (if on ID Card)
67	Principal Diagnosis Code
80	Principal Procedure Code and Date
81	Other Procedure Code and Date
82	Attending Physician's Medicaid Number

**There may be additional requirements for providers who submit claims electronically to CHNCT. For more information on electronic claims submission, please contact CHNCT's Management Information Systems Department at 203-949-4000.

Notification of Changes

Notify the Provider Relations Department immediately of any changes in your Taxpayer Identification Number (TIN) and your billing or office address. Failure to do so may result in delays or incorrect reimbursement. The Internal Revenue Service requires that we obtain your accurate and complete TIN. If the TIN you provide is incorrect, we may withhold all payments until the error is corrected. Included within the Appendices Section is a *Provider Change of Information Form* that you can complete and fax to the Provider Relations Department to notify our office of any changes.

Claims Mailing Addresses:

Medical/Surgical Services: Community Health Network of Connecticut, Inc.
 Claims Department
 11 Fairfield Boulevard
 Wallingford, CT 06492-1828

Dental Services: BeneCare
 Attention: Claims
 620 Chestnut Street
 Suite 472
 Philadelphia, PA 19106-3487

Pharmacy Services: All claims submitted electronically

SECTION 10 – QUALITY IMPROVEMENT AND ASSURANCE

QUALITY IMPROVEMENT PROGRAM

Ultimately, the CHNCT Board of Directors has authority and responsibility for the overall quality of care and service provided to the SAGA 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 QI Program addresses the quality of operations and programs in the following broad areas: subcontractor oversight, utilization management (including dental and pharmacy), care coordination, access to services, preventive health initiatives, disease management, and member and provider satisfaction. The Pharmacy and Therapeutics Committee and the Credentialing Subcommittee of the Board of Directors report their activities to the QIC as well.

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 (including behavioral health and dental clinicians, and a representative from a hospital emergency department.)
- ◆ Behavioral health Medical Director
- ◆ CHNCT President and CEO
- ◆ CHNCT Vice President, Operations
- ◆ CHNCT Vice President, Medical Director
- ◆ CHNCT Director, Quality Improvement and Wellness Outreach
- ◆ CHNCT Director, Provider Relations
- ◆ CHNCT Vice-President, Health Services
- ◆ CHNCT Director, Care Management

The role of the QIC is to oversee the quality management and quality improvement activities conducted at CHNCT, through the following functions:

- ◆ Annual review and development of the Quality Improvement Program and Work Plan
- ◆ Semiannual review of Quality Improvement Performance Reports
- ◆ Review and oversight of the activities of the Credentialing Subcommittee
- ◆ Review and oversight of the activities of the Pharmacy and Therapeutics 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)

OFFICE AND FACILITY REQUIREMENTS

On-site office and facility 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 SAGA 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 SAGA program and to inform office personnel about any forthcoming program changes that are on the horizon.

The credentialing staff uses the on-site review tools and standards to evaluate a provider's office. For a provider to be considered as a CHNCT participant, all office areas must be compliant with the "conditions of participation". Offices that are found to be "marginally acceptable" receive a follow-up visit within 90 days of the original evaluation. CHNCT reserves the right to cancel a provider participation contract, 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 SAGA members. Each provider must maintain, and make available, medical records, in accordance with their SAGA 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 SAGA patient's 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. **Allergies:** Allergies are prominently noted on the record. If the patient has no known allergies, this is noted in the record.
8. **Immunizations:** A current immunization record shall be present for each pediatric patient.
9. **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.
10. **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.

11. **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.
12. **Risk Factors:** Risk factors shall be documented at physical examination visits (smoking, alcohol, home firearms, safety, substance abuse, domestic violence and child abuse/ neglect).
13. **Diagnosis and Treatment:** A working diagnosis or assessment shall be noted and a treatment plan shall be described.
14. **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.
15. **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.
16. **Prescriptions:** New prescriptions and refills shall be documented in the chart: drug name, dose and quantity shall be noted.
17. **Ancillary Services:** There shall be documentation of referrals to specialists and notations of the specialist's findings and recommendations.
18. **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.

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.

SECTION 11 – PROVIDER COMPLAINT AND APPEAL PROCEDURES

PROVIDER APPEAL PROCESS FOR ADMINISTRATIVE DENIALS

This appeal process is created for denials received due to the failure of the provider to comply with administrative policies. Providers may request and must be granted an appeal to any CHNCT decision, action, or unresolved complaint within 60 days of notice of denial. Resubmitting a claim(s) is not considered an appeal unless it is accompanied by a letter stating the intent to appeal.

Level I: Director, Care Management or Director, Claims Department

All requests for appeals must be made in writing within sixty (60) days of the Remittance Advice to the Director, Care Management (CM) Department or Director, Claims Department. A written notification of the decision is forwarded to the appealing provider and member within thirty (30) days of the time the appeal and required documentation were received.

Level II: Vice-President, Operations

If the provider or member is still in disagreement with the decision on an administrative appeal, they may request that the appeal be reviewed at the next level. The appeal must be submitted in writing with all necessary information to the CM Director or Director, Claims Department. Upon completion of the review by the Vice-President, Operations, Medical Director or Vice-President and Chief Financial Officer, a decision is made within thirty (30) days and the provider and member are notified in writing.

Level III: Appeal Committee

The Appeal Committee is currently an ad hoc multidisciplinary panel comprising the following members: Medical Director (chair); Vice-President, Health Services; Vice-President and Chief Financial Officer, Vice-President, Operations; Director, Care Management and Director, Claims Department.

If the health care provider requests an appeal based on the Level II review, the Director, Care Management convenes the Appeal Committee. The provider is notified of the Appeal Committee hearing at least ten (10) working days prior to the hearing. The provider is notified of the appeal decision within thirty (30) days from the date the Level III appeal was filed and the provider will be notified in writing within two (2) business days.

PROVIDER APPEAL OF CARE MANAGEMENT DECISIONS (RETROSPECTIVE)

This appeal process is created to ensure a mechanism whereby providers may appeal utilization management decisions and that appeals are properly investigated and resolved in a timely manner. Providers may request and must be granted an appeal to any CHNCT's decision, action, or unresolved complaint within sixty (60) days of notice of denial.

Level I: Medical Director

All requests for appeals must be made in writing to the Care Management (CM) Department. The Medical Director will review the information and consult with the providers involved. If the appeal cannot be resolved the Medical Director will review the appeal with at least one provider in a specialty related to the case. A decision must be made within thirty (30) business days of receiving the request for

the appeal. A written notification of the decision will be forwarded to the appealing provider within five (5) business days of the time of making the decision and must include information on Level II appeals.

Level II: Appeal Committee

The Appeal Committee will be an ad hoc multidisciplinary panel comprised of the following members: Medical Director; Vice-President, Health Services; Vice President, Operations; Vice-President and Chief Financial Officer; Director, Care Management; and a Clinician (specialist within the area of practice of the provider appeal).

In the event the health care provider requests an appeal based on the initial review, the UM/CC Manager will convene the Appeal Committee. The provider will be notified of the Appeal Committee hearing at least ten (10) working days prior to the hearing. A physician in a specialty related to the case must be a participant on the Appeal Committee. Only the involved health care provider(s) may appear, if desired, before the Appeal Committee. The Appeal Committee will make a decision within (30) business days from the receipt of Level II level appeal request. The provider will be notified of the Appeal Committee's decision within two (2) business days from the date the Level II appeal was decided.

PROVIDER APPEAL OF CARE MANAGEMENT DECISIONS (PROSPECTIVE OR CONCURRENT)

This appeal process is created to ensure a mechanism whereby providers may appeal utilization management decisions for prospective or concurrent care and that appeals are properly investigated and resolved in a timely manner. Providers may request and must be granted an appeal to any CHNCT decision, action, or unresolved complaint within sixty (60) days of notice of denial.

Appeals Process for Non-Urgent Prospective Medical Denial of Services

Level I: Medical Director

All requests for appeals must be made in writing to the Care Management Department. The Medical Director will review the information and consult with the providers involved. If the appeal cannot be resolved the Medical Director will review the appeal with at least one provider in a specialty related to the case. A decision must be made within thirty (30) business days after receiving all necessary documentation. A written notification of the decision will be forwarded to the appealing provider within two (2) business days of the time of making the decision with information on how to appeal to the next level.

Level II: Review by the Appeal Committee

The Appeal Committee is currently an ad hoc multidisciplinary panel, including the following members: Medical Director; Vice-President, Health Services; Vice-President Operations; Vice-President and CEO, Care Management; Director, Member Services (as needed), and a Clinician (specialist within the area of practice of provider appeal).

If the provider requests an appeal based on the initial review, the Director, Care Management convenes the Appeal Committee. The provider is notified of the Appeal Committee hearing at least ten (10) working days prior to the hearing. A physician in a specialty related to the case is a participant on the Appeal Committee. Only the involved health care provider may appear, if desired, before the Appeal Committee. A decision must be made no later than thirty (30) business days from receipt of Level II

appeal request. The provider will be notified of the Appeal Committee's decision within two (2) business days from the date of the decision.

Expedited Appeals (Concurrent or Urgent Prospective Review)

If the provider feels that waiting the standard timeframe for an appeal determination will jeopardize the life or health of the member, or threaten the ability of the member to regain maximum function, he or she may initiate an oral or written request for an expedited appeal by contacting the Director, Care Management Department.

If the provider requests an appeal based on the initial review, the Director, Care Management Department convenes the Appeal Committee and the provider is notified of the Appeal Committee hearing. A physician in a specialty related to the case is a participant on the Appeal Committee. Only the involved health care provider may appear, if desired, before the Appeal Committee. The member and provider(s) will be notified of the decision as expeditiously as the medical condition requires, but no later than forty-eight (48) hours after the review commences. A written confirmation of the decision will be provided within two (2) working days of providing notification of that decision (if the initial decision was not in writing).

PROVIDER COMPLAINTS

Level I Complaints

In the event that a provider has a complaint, he or she should contact CHNCT's Provider Relations Department, either in writing or via telephone call.

Level II Complaints

If intervention by the Vice-President, Health Services does not resolve the provider's complaint, the provider may submit a formal complaint for presentation to CHNCT's Medical Director (for clinical issues) or Vice-President, Operations (for administrative issues). The Medical Director or Vice-President, Operations should respond to the request within ten (10) working days.

Level III Complaints

If intervention by the Medical Director or Vice-President, Operations does not resolve the provider's formal complaint, he or she may contact CHNCT's President and CEO. The President and CEO should respond to the request within ten (10) working days.

Level IV Complaints

If intervention by the President and CEO does not resolve the provider's complaint, the matter should be referred to the Quality Management and Improvement Committee (QMIC) of CHNCT's Board of Directors. The Chair of the QMIC should respond to the appeal request in thirty (30) working days.

SECTION 12 – PROVIDER 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 through an independent relationship with CHNCT including: physicians, physician's assistants, nurse practitioners, nurse midwives, osteopaths, etc. Practitioners who provide care to members incidentally (i.e., they are not listed by name in CHNCT's provider directory) and solely through an affiliation with a facility such as a hospital or surgi-center are not directly credentialed by CHNCT, but are instead credentialed by the facility itself. There is a process for notifying a practitioner of any information obtained during the credentialing process that varies from the information provided to CHNCT by the practitioner, and practitioners have a right to review information submitted in support of their credentialing applications, except for information that is peer review protected. Practitioners have a right to correct erroneous information. All credentialing information is maintained by CHNCT in a strictly confidential manner. Practitioners must be recertified every 36 months to maintain their participation status in CHNCT's network.

PCPs must demonstrate evidence of the following in order to maintain credentialing approval status with CHNCT:

- a) Current hospital privileges (CHNCT is required to list attestation questions pertaining to any history of loss or limitation of privileges)
- b) A valid Drug Enforcement Agency (DEA) certification;
- c) Current malpractice insurance coverage (minimum \$1 million-\$3 million);

* All participating practitioners must have a valid Connecticut State License to practice medicine.

Credentialing Committee

The Credentialing Committee is responsible for general oversight of CHNCT's practitioner and provider credentialing/recertification process. It is charged by CHNCT's Quality Improvement Committee with the responsibility and authority to periodically review and approve CHNCT's credentialing/recertification policies and procedures. This charge includes responsibility for reviewing criteria for participation of practitioners in CHNCT's provider network. The Committee has final authority for the approval of candidates for initial credentialing as well as for recertification of network practitioners. Reports on its determinations and actions submitted to the Quality Improvement Committee as well as to CHNCT's Board of Directors. 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 and providers 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, including those in the network through subcontractor agreements. The Committee reviews appeals from those against whom it has levied sanctions or taken adverse actions.

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 recredentialing activities in accordance with CHNCT's minimum standards and criteria. Any facilities or provider groups wishing to pursue a delegation contract with CHNCT should contact CHNCT's Provider Relations Department.

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 includes 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.

APPEAL PROCESS FOR LIMITATIONS/SUSPENSIONS/TERMINATIONS

Ensuring that the network cultivates providers who deliver high-quality health services is our continuing concern. Based on contractual obligations, we use a variety of techniques to monitor provider performance and develop quality-of-care indicators. Among the indicators to be applied are:

- ◆ **Member Comments and Complaints:** We closely monitor the activities associated with member complaints and grievances, quality assurance and utilization management review as they relate to specific provider performance. The reports of these activities are used to trigger separate actions and inquiries about performance.
- ◆ **Office Site Reviews:** We undertake a variety of site assessments as part of our quality assurance activities and provider services activities. The results of these reviews are made part of the file of performance factors and indicators assessed during the recredentialing process.
- ◆ **Compliance With Access Standards:** We conduct special surveys to assess the degree of compliance with access standards. Member comments and complaints may trigger special reviews with respect to specific providers. The results of these reviews are considered in the recredentialing process.
- ◆ **Education Sessions:** Providers must provide proof of attendance at an educational session on case management.

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, we suspend providers who fail to complete recredentialing requirements in a timely manner or fail to provide certification of malpractice coverage on a timely basis.

SECTION 13 – APPENDICES

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GLOSSARY OF TERMS

Access/Accessibility - A patient's ability to obtain medical care. The ease of access is determined by components such as the availability of medical services and their acceptability to the patient, the location of health care facilities, transportation, hours of operation and cost of care.

Accreditation - Approval of an organization or facility according to a set of standards established by the appropriate voluntary, non-governmental organization. Accreditation is usually sought on a voluntary basis. Example: Accreditation by the National Committee for Quality Assurance (NCQA).

Ambulatory Care - Health care services that do not require hospitalization of a patient, such as those delivered at a physician's office, clinic, medical center or outpatient facility

Ambulatory Setting - An institutional health setting in which organized health services are provided on an outpatient basis, such as a surgery center, clinic or other outpatient facility. Ambulatory care settings also may be mobile units of service, e.g. mobile mammography, MRI.

Ambulatory Surgery Center - A facility other than a medical or dental office used mainly to perform outpatient surgery. It must be licensed as an outpatient clinic according to the state and local laws and must meet all requirements for an outpatient clinic providing surgical services.

Ancillary - A term used to describe additional services performed related to care such as lab work, x-ray and anesthesia.

Ancillary Services - Services for inpatient hospital care other than room, board, medical and nursing services. Bandages, prescriptions, operating room services, and lab services are examples of ancillary services.

Appeals Process - The formal process a provider of service and/or a member can use to request review of a plan decision.

Balance Billing - The practice of a Provider billing a patient for all charges not paid for by the insurance plan, even if those charges are above the plan's UCR or are considered medically unnecessary. Most health plan providers are prohibited from balance billing except as allowed for co pays, coinsurance, and/or deductibles.

Billed Amount - The dollar amount charged by a hospital, physician, or other healthcare provider for a unit of service, such as a day's stay in an inpatient unit or a specific medical procedure.

Board Eligible - Any physician who is eligible to take the specialty board examination by virtue of having graduated from an approved medical school, completed a specific type of length of training, and practiced for a specified amount of time.

Capitation Payment (Cap) - A dollar amount established to cover the cost of health care delivered for a person. A negotiated fixed monthly payment that is made to a contractor by CHNCT for each member enrolled with contractor for capitated services.

Carve-out - A decision to purchase separately a service, which is typically a part of a managed care plan. Example: CHNCT "carves out" the behavioral health benefit and selected Merit Behavioral Health as the specialized vendor to supply these services on a stand-alone basis.

Case Management - The system of assessment, treatment planning, referral, and follow-up that ensures the provision of cost effective quality care.

CHNCT Policies and Procedures - Rules, regulations, policies, and procedures established or promulgated by CHNCT from time to time, copies of which shall be provided to contractors by CHNCT.

CHNCT Provider Manual - Document that provides an overview of CHNCT's policies and procedures that directly relates to participating primary care and specialty providers.

Claim - The information submitted by a provider or a covered person to establish that medical services were provided to a covered person, from which processing for payment to the provider or covered person is made. The term generally refers to the liability for health care services received by covered persons.

Concurrent Review - Intermittent reviews conducted to determine the medical necessity and appropriateness of a patient's stay in the hospital or other inpatient facility.

Continuous Quality Improvement (CQI) - A process improvement approach that seeks to improve quality within an organization. The CQI approach is data driven. The steps in the CQI process are: identification of the problem; identification of root causes and development and implementation of solutions to improve effectiveness; monitoring and reporting of results; and implementation of new process across the organization.

Coordination of Benefits (COB) - This is the term used when a patient has duplicate coverage. Two different insurance companies work together to make sure the patient receives all of the health insurance coverage, from both insurance plans, that they are entitled to.

Cosmetic Surgery - A procedure performed primarily to preserve or improve appearance rather than to restore the anatomy and/or functions of the body, which are lost or impaired due to an illness or injury.

Current Procedural Terminology (CPT) - Current Procedural Terminology is a listing of descriptive terms and identity codes for reporting medical services and procedures performed by physicians. The CPT codes are revised periodically to include the newest services and procedures.

Credentialing - A process of review to approve a provider who applies to participate in CHNCT. Specific criteria and prerequisites are applied in determining initial and ongoing participation in the health plan.

Custodial Care - Services and supplies that are furnished primarily to assist an individual in the activities of daily living such as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a healthcare provider.

Department of Social Services (DSS), State of Connecticut - The single State agency responsible for administering the Medicaid Managed Care Program; or such other governing entity to which such powers may be delegated.

Discharge Planning - Planning and arrangements undertaken to insure that patients are discharged from the hospital or other facility with timely arrangements made for all necessary and appropriate post-hospital care.

Disease Management - Finding a population of members with a disease or condition and managing that population in the context of an integrated multi-disciplinary approach. To improve the patients' quality of life, helping them avoid incidents, reducing severity of flare-ups, and prevention of recurrence.

Detoxification - A medical regime that systematically reduces the amount of a toxic agent in a patient's body, provides reasonable control of active withdrawal symptoms, and averts a potential life-threatening medical crisis. Frequently applied to withdrawal or removal from the effects of abusable substances that produce dependency. The regime is supervised by a physician.

Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) - A manual that provides diagnostic criteria, classification, and descriptions of mental disorder diagnoses. All official DSM-III-R codes are included in the ICD-9-CM.

Durable Medical Equipment (DME) - Equipment which can stand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use at home. Examples of durable medical equipment include hospital beds, wheelchairs and oxygen equipment.

Early and Periodic Screening, Diagnosis, and Treatment - A program, including the periodicity and immunization schedules promulgated there under, mandated by the Federal Government and administered in the State of Connecticut by DSS as the Health Track program. EPSDT aims at improving access, utilization, comprehensiveness, continuity and quality of care for targeted children, and coordination of services. For members who are eligible for EPSDT services, many services that are not usually covered under Medicaid are covered by CHNCT.

Effective Date - 12:01 a.m. on the date entered on the records is the date when coverage under the Contract begins. The date on which a CHNCT agreement goes into effect. The effective date for each member appears on the members CHNCT identification card.

Emergency - A medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention would result in placing the patient's health in serious jeopardy, resulting in or causing serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. Such conditions include but are not limited to: heart attack symptoms, shock, unconsciousness, sudden loss of vision, severe pain, seizures, severe burns, uncontrolled bleeding, heat stroke, severe breathing difficulties, spinal injuries, gunshot wounds and symptoms of labor.

Emergency Center - facility that is designed, organized, equipped, and staffed to provide medical care on a 24-hour per day basis for injuries and illnesses, including those that are life-threatening, that provides laboratory and radiographic services and has established arrangements for transporting critical patients or patients requiring hospitalization once stabilized, and that does not provide continuity of care but treats episodic, urgent and emergency cases.

Emergency Out-Of-Area Services - appropriate emergency care, wherever rendered, will be reimbursed at the preferred level. If the emergency results in a hospital admission, the covered member or a representative may need to notify the health care plan within 24-48 hours.

"Emergency" Visit - An urgent encounter requiring immediate decision-making and medically necessary action to prevent death or any further disability for patients in health crises (including labor and

delivery). Such conditions are manifested by acute symptoms such as those described above, with onset within seventy-two (72) hours preceding the encounter.

"Non-Emergency" Visit - A medically necessary non-urgent encounter presenting a medical condition, which does not meet the requirements for an emergency visit as defined above, but rather requires a routine level of ambulatory health care. Such conditions may be characterized by the fact that they may also be treated in an alternate health care setting because such medical conditions do not require the skills, resources, and equipment of a hospital emergency room.

Enrollee - An individual who is enrolled for coverage under a health plan contract and who is eligible on his/her own behalf (not by virtue of being an eligible dependent) to receive the health services provided under the contract.

Experimental or Investigational Procedures and Treatments - Medical, surgical and other health care procedures and treatments which are experimental or investigational in nature. "Experimental" means treatment methods, which are classified as "experimental" by the Food and Drug Administration and/or have not entered a phase III clinical trial and/or are not widely accepted standard medical practices. (See "Investigational".)

Explanation of Benefits (EOB) Statement - A statement provided to a provider explaining the payment or denial of a claim.

Family Planning Services - Include any medically approved diagnostic procedures, treatment, counseling, drugs, supplies, or devices that are prescribed or furnished by a provider to individuals of child-bearing age for the purpose of enabling such individuals to freely determine the number and spacing of their children.

Federally Qualified HMO - HMO that meets federal criteria including financial solvency and scope of coverage.

Fee-for-Service (FFS) Reimbursement - The traditional health care payment system, under which providers receive a payment that does not exceed their billed charge for each unit of service provided. This is the payment for Medicaid Covered Services not included in the capitation payment.

Fee Schedule - List of established charges or allowances for specified medical services.

Follow-Up-Care to Emergency Services - Any care provided to the member after the patient's immediate medical condition is no longer considered emergent. These services must be authorized.

Formulary - A preferred list of drugs. It is intended as a guide for each physician to make appropriate drug prescribing decisions.

Gatekeeper Model - A situation in which a primary care physician, the "gatekeeper," serves as the patient's initial contact for medical care and referrals. Also called closed access or closed panel.

HCPCS (HCFA Common Procedure Coding System) - The system of procedural coding adopted by Medicare and other major third-party payers.

Health Care Center - A "one-stop" medical center that provides convenient access to most health care services, including primary care physicians, specialists, pharmacies, labs, and X-ray facilities.

Health Care Financing Administration (HCFA) - Component of the U.S. Department of Health and Human Services that administers the Medicare program and certain aspects of state Medicaid programs.

Health Maintenance Organization (HMO) - An entity that provides, offers or arranges for coverage of designated health services needed by plan members for a fixed, prepaid premium. A prepaid health care plan that meets the criteria established by the 1973 HMO Assistance Act, as amended and interpreted by the Department of Health and Human Services. The HMO must be a separate legal entity that provides or arranges for basic and supplemental health services to its members on a prepaid, monthly per capita basis

Health Plan - Health maintenance organization, preferred provider organization, insured plan, self-funded plan or other entity that covers health care services.

Home Health Agency - A licensed agency or organization certified under Medicare Part, A which provides home healthcare. Services must be authorized by CHNCT's UM staff.

Home Healthcare - The provision and coordination of Health Services and equipment in the home. The visit must have been determined to be medically necessary. Services must be pre-certified by CHNCT's UM staff.

Hospice Care - Palliative care that addresses the physical, spiritual, emotional, psychological, social, and financial needs of the dying patient and his or her family, that is provided by an interdisciplinary team of professionals and volunteers in a variety of settings, both inpatient and at home, and that includes bereavement care for the family.

Hospital, Accredited - Hospital recognized upon inspection by the Joint Commission on Accreditation of Health Care organizations as meeting its standards for quality of care, for the safety and maintenance of the physical plant, and for organization, administration and governance.

Hospital Service - A service furnished and billed by a hospital or skilled nursing facility that is authorized by CHNCT.

(ICD-9-CM) International Classification of Diseases, 9th Edition (Clinical Modification) - A listing of diagnosis and identifying codes used by physicians for reporting diagnoses of health plan enrollees. The coding and terminology provide a uniform language that can accurately designate primary and secondary diagnoses and provide for reliable, consistent communication on claim forms.

Informed Consent - Legal concept requiring a patient or the patient's guardian to be advised of and to understand the risks attendant to a proposed procedure or treatment prior to approving such procedure or treatment, usually indicated by a signed written statement.

In-Network - When medical care is provided by participating physicians and providers and benefits are provided in accordance with the In-Network Schedule of Health Benefits.

Inpatient - Medical or other health-related services while in a hospital or other healthcare institution for at least one night.

Integrated Delivery System - A generic term referring to a joint effort of physician/hospital integration for a variety of purposes. Some models of integration include physician-hospital organization (PHO) and management services organization (MSO).

Investigational Procedures - "Investigational" means that the treatment or procedure is not approved by the Food and Drug Administration and/or is still being evaluated in a phase III clinical trial and/or is not widely accepted standard medical practice.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) - Private not-for-profit organization composed of representatives of the American College of Surgeons, American College of Physicians, American Hospital Association, American Medical Association, and American Dental Association whose purpose is to establish standards for the operation of health facilities and services, conduct surveys and award accreditation.

Long-term Care - Provision of health, social and/or personal care services on a recurring or continuous basis to persons with chronic physical or mental conditions who live in environments ranging from institutions to their own homes.

Long-term Care Facility - Residential facility that provides supervision and assistance in activities of daily living with medical and nursing services when required.

LOS - Length of Stay, number of days of confinement.

Managed Care - A system of health care delivery that influences utilization and cost of services and measures performance. The goal is a system that delivers value by giving people access to quality, cost-effective health care.

Medicaid - A federal program created by Title XIX--Medical Assistance, a 1965 amendment to the Social Security Act, administered and operated individually by participating state and territorial governments which provides medical benefits to eligible low income persons needing health care. The program's costs are shared by the federal and state's governments.

Medicaid Covered Services -Those services to which members are entitled pursuant to the requirements of the Medicaid Managed Care Program of the State of Connecticut.

Medical Director - A physician licensed to practice medicine in all its branches in the State of Connecticut and appointed by CHNCT to manage, coordinate and monitor the clinical operational responsibilities of CHNCT.

Medical Management Programs - The policies and procedures designated and adopted from time to time by the health plan related to, without limitation, credentialing and recredentialing of Participating Providers, utilization management and review, quality management, case management, grievance procedures and provider appeals.

Medically Necessary Services and Supplies - Services that are not experimental or investigative, are provided by a health facility or health professional, and are; 1) appropriate for the symptoms and diagnosis or treatment of a condition, illness, or injury.

Medical Record Review/Documentation Audits - Audits performed to assure that primary care providers maintain a medical record system that permits prompt retrieval of information. Also performed to assure that medical records are legible, contain accurate and comprehensive information, and are readily accessible to health care providers; state and federal HMO regulations mandate medical record review.

Medically Necessary - The medical care that is required for identifying and treating illness or injury.

Medicare - Federal program, created by Title XVIII--Health Insurance for the Aged, a 1965 amendment to the Social Security Act, that provides health insurance benefits primarily to persons over the age of 65 and others eligible for Social Security benefits.

Medicare, Part A - Hospital insurance program, the compulsory portion of Medicare, which automatically enrolls all persons aged 65 entitled to benefits under Old Age, Survivors, Disability and Health Insurance Program or railroad retirement, persons under 65 who have been eligible for disability for more than two years, and insured workers (and their dependents) requiring renal dialysis or kidney transplantation.

Medicare, Part B - Supplementary Medical Insurance Program, the voluntary portion of Medicare, which includes physician's services and in which all persons entitled to Part A, may enroll on a monthly premium basis.

Medigap Policy (also known as Medifill) - Supplemental insurance sold by private insurance companies to pay for medical expenses not covered by Medicare.

Member - Anyone entitled to receive services under CHNCT. An individual who has been certified by DSS as eligible to enroll in the Medicaid Managed Care Program, is enrolled in CHNCT, and whose name appears on the DSS enrollment information that CHNCT will transmit to each Contractor in accordance with an established notification schedule.

National Practitioner Data Bank (NPDB) - This entity has the task of collecting all reports of dysquality by practitioners and of making them available to credentialing and accreditation organizations. Federally qualified organizations must by law report to the NPDB actions taken by them as a result of discovered dysquality. If you participate in a federally qualified plan (and the states are rapidly getting on the bandwagon), make absolutely sure the quality of care you deliver or arrange to be delivered by others is excellent.

Network - A large group of doctors, hospitals and other providers in a specific geographical area who are employed by or contracted with an insurance company to provide services for a predetermined fee.

Newborn - An infant from birth through 30 days of life.

Nurse Practitioner - A registered nurse with advanced training who independently makes decisions about the health care needs of individuals, families, and groups. The nurse practitioner functions cooperatively with physicians and other health care providers through consultation, collaboration, referral, and the use of standardized procedures.

On-Site Facility Assessments - The audits performed to assess the quality of care and services provided by prospective or contracted providers; structural elements of quality of care and service are evaluated. On-site assessments must be performed for all primary care physicians, OB/GYN and high volume specialists prior to initial credentialing and recredentialing.

Out-of-Plan (OOP) - The portion of payments for health services required to be paid by the enrollee, including co-payments, coinsurance and deductibles.

Participating Facility - Any institution that has an agreement with the insurance carrier to provide services to members upon proper authorization.

Participating Provider - A licensed healthcare provider who has contracted with CHNCT to deliver medical services to covered persons. The provider may be a hospital, pharmacy or other facility or a physician who has contractually accepted the terms and conditions as set forth by the health plan.

Participation Agreement - The contract between the insurance company and a participating provider.

PCP - Personal/Primary Care Physician

Peer Review - An evaluation or review of the qualifications, competence and/or performance of colleagues by professionals with similar types and degrees of expertise (e.g., the evaluation of one physician's practice or provision of care by another physician). The term is often used for credentialing, utilization management, and quality management activities.

Performance Indicators - The measurable, reliable, valid, meaningful indicators of a Health Plan or provider's performance across the four dimensions of quality (i.e., cost effectiveness, clinical outcomes, satisfaction and conformance to standards).

Physician's Withhold (The "Withhold") - The portion of the monthly capitation payment to physicians withheld by the HMO until the end of the year or other time period to create an incentive for efficient care. If the physician exceeds utilization norms for other members of his group or geographic region, he/she loses the fund, physician's whose funds are in surplus at the end of the year are entitled to have the withhold returned each year. The principle of the withhold fund may be applied to hospital services, specialty referrals, laboratory usage, etc.

Place of Service - The location where health services are rendered (e.g. office, home, hospital, etc.).

Per member per month (PMPM) - The unit of measure related to each effective member for each month the member was effective. The calculation is: number of units/member months (MM).

Postoperative Care - The provision of medical, nursing, and other health-related services to patients following surgery.

Practice Guidelines - Systematically developed guides to assist providers and patients in making appropriate health care decisions in specific clinical circumstances.

Pre-Admission Certification (PAC) - A review of the need for inpatient hospital care, done prior to the actual admission. Established review criteria are used to determine the appropriateness of inpatient care.

Pre-Certification Review - a review process whereby a provider and/or member is required to request authorization for healthcare services prior to services being rendered.

Preoperative Care - physiological and psychological preparation of a patient for surgery.

Prescription Drug - written order by a physician, dentist, or other designated professional for medication to be dispensed by a pharmacy for use by a patient.

Preventative Care - comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization and well person care.

Preventive Health Services - services designed to promote good health and a healthy lifestyle and thereby prevent illness.

Primary Care - basics of general health care, traditionally provided by family practice, pediatrics and internal medicine. See also Secondary care and Tertiary Care.

Primary Care Provider (PCP) - The participating provider responsible for coordinating and controlling the delivery of covered services to member. Primary care providers include general and family practitioners, internists, pediatricians, obstetrician/gynecologists, nurse practitioners and physician assistants.

Prior Authorization - Prior authorization means obtaining permission from the health plan before rendering the service.

Provider - A physician, hospital, group practice, nursing home, pharmacy or any individual or group of individuals that is licensed or certified to provide health care service.

Provider Satisfaction Surveys - Process by which providers are asked to provide information pertaining to their perceptions of the level of service provided by the Plan; accessibility of Plan personnel (e.g., Provider Service Reps, UM Nurses, Medical Directors), reimbursement/claims payment mechanisms, the UM process (pre-certification, concurrent review, referrals, denials, appeals process), credentialing, practice feedback, and communication of information.

Quality - Conformance to specifications; specifications are defined by plan sponsors, members, state and federal regulators, external accreditation entities, and include professionally recognized standards of practice, treatment, protocols and clinical guidelines. Four dimensions of quality include: outcomes, satisfaction, conformance and cost effectiveness.

Quality Assurance - Activities to safeguard or improve the quality of medical care by assessing the quality of care or service and taking action to improve it.

Quality of Care - The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Quality Management Committee - A committee established to perform peer review functions and direct the quality management program activities. Membership includes local network providers and the Plan Medical Director, Quality Management Director, Network Management Director and other Plan staff. The committee functions independently of all medical groups, IPAs and hospital Quality management/Quality Assurance Committees.

Quality Management Program - A program designed to demonstrate that patient care and services are adequate and essential through the ongoing assessment, evaluation and treatment of critical aspects of patient care.

Referral - The recommendation by a physician and/or health plan for a covered person to receive care from a different physician of facility.

Referral Provider - A provider that renders a service to a patient who has been sent to him/her by a participating provider in the health plan.

Rehabilitation Service - Restorative services designed to allow a patient to reach optimal level of functionality after an illness or injury.

Respite Care - Patient care provided intermittently in the home or institution in order to provide temporary relief to the family home care giver.

Routine Cases - Routine cases are defined as those that involve a symptomatic situation (such as nagging back pain) for which the patient is seeking care but for which treatment is neither of an emergency nor an urgent nature.

Service Agreement - The contract between CHNCT and DSS that specifies the health care services to be arranged or provided by CHNCT for members and the terms and conditions under which those services are to be provided.

Skilled Nursing Facility (SNF) - Facility with an organized professional staff that provides medical, continuous nursing, and various other health and social services to patients who are not in an acute phase of illness but who require primarily restorative or skilled nursing care on an inpatient basis.

Social Work Service - Service providing assistance and counseling to patients and their families in dealing with social, emotional and environmental problems associated with illness or disability.

Specialist Physician - Any participating provider who has entered into a written agreement with CHNCT to provide agreed to specialist services to members upon referral by PCP's.

Standard of Care - In a medical malpractice action, the degree of reasonable skill, care, and diligence exercised by members of the same health profession practicing in the same or a similar locality in light of the present state of medical or surgical science.

Tertiary Care - Those health care services provided by highly specialized providers such as neurosurgeons, thoracic surgeons and intensive care units. These services often require highly sophisticated technologies and facilities.

Triage - The classification of the sick or injured persons according to severity in order to direct care and ensure the efficient use of medical and nursing staff and facilities.

Urgent Care Center - Urgent cases are defined as those that involve illnesses or injuries of a less serious nature than those constituting emergencies, but which are 1) required to prevent a serious deterioration in the patient's health, 2) cannot be delayed, without imposing undue risk on the patient's well-being, until the patient either returns to the service area (if outside CHNCT's service area at the time) or until the patient's is able to secure services from his/her regular provider.

Utilization Management (UM) - A process of integrating review and case management of services in a cooperative effort with other parties, including patients, employers, providers and payers.

Utilization Review (UR) - A formal assessment of the medical necessity, efficiency, and/or appropriateness of health care services and treatment plans on a prospective, concurrent and retrospective basis.

Vendor - An independent supplier with whom the health plans contracts to provide specified health care or managed care services. Example: National Laboratory Services Vendor.

Walk-In Center - Facility that provides urgent care treatment on a less-than-24-hour per day basis and that is supported by laboratory and radiology services but does not receive patients transported by ambulance. It is not equipped to treat true medical emergencies such as heart or stroke victims, and does not provide continuity of care.

Well Care Visits - Well care visits are defined as those that involve patient requests for routine physical examinations, immunizations, and other preventative services that are prompted by the presence of any adverse medical symptoms.



COMMUNITY HEALTH NETWORK OF CONNECTICUT

Referral must be faxed or mailed to CHNCT prior to initial visit.

11 Fairfield Boulevard

Fax # 1-203-265-3994

Phone # 1-800-440-5071

REFERRAL REQUEST FORM

MEMBER		REFERRING PRIMARY CARE PROVIDER	
ID #:	Date of Birth:	PCP Name:	
Last Name:	First Name:	Site/Address:	
Address:	Phone #:	Phone #:	
		PCP Signature:	Date of Referral:
CONSULTANT			
Last Name:	First Name:	Services/Specialty:	
Place of appointment:		Phone #:	Fax #:
		Appointment date/time:	
TO THE CONSULTANT		SERVICE REQUESTED	
INITIAL DIAGNOSIS/DIAGNOSES:		<input type="checkbox"/> CONSULTATION: (1 DATE OF SERVICE ONLY) <input type="checkbox"/> CHIRO, OT, PT, ST: (1 EVAL ONLY – UM DEPARTMENT WILL REVIEW FOR FURTHER TREATMENT.) <input type="checkbox"/> SPECIALTY SERVICES: (UP TO 3 DATES OF SERVICE) <input type="checkbox"/> OTHER:	
HISTORY/REASON FOR REFERRAL:			
REFERRAL POLICY FOR CONSULTANT			
<ul style="list-style-type: none"> VERIFY MEMBER ELIGIBILITY BEFORE DELIVERING SERVICES CALL 1-800-440-5071 FOR AN AUTHORIZATION NUMBER IF WRITTEN CONFIRMATION HAS NOT BEEN RECEIVED FROM CHNCT. INCLUDE THE AUTHORIZATION NUMBER ON THE CLAIM. REFERRAL IS VALID 6 MONTHS FROM THE DATE OF ISSUE. REQUESTS FOR ADDITIONAL SERVICES MUST COME FROM THE PCP AND MAY REQUIRE CHNCT PRIOR AUTHORIZATION. REFER TO THE CHNCT PROVIDER MANUAL FOR MORE DETAIL. CLAIMS ARE SUBJECT TO REVIEW TO DETERMINE ELIGIBILITY, BENEFIT COVERAGE, AND MEDICAL NECESSITY. 			
FOR CHNCT UM USE ONLY			
Eligibility Date:		Approved:	
Authorization #		Denied:	
		Pended	Date:
			Initials:
Copy Distribution: White – Consultant		Yellow - Community Health Network	
		Pink – PCP	
		2/00	



PROVIDER CHANGE OF INFORMATION FORM

Provider Name: _____ **Date:** _____

(Please Print)

Contact Name: _____

Type of Change: Practice Address Billing Address Tax Identification Number

Panel Size (PCP only) Other

Please complete the fields where information has changed:

Current Information

Group/Contract Name:

Tax ID Number: _____

Address: _____

Phone Number: _____

Billing Address: _____

Phone Number: _____

Panel Change: _____

Other: _____

New/Changed Information

Group/Contract Name:

Tax ID Number: _____

Address: _____

Phone Number: _____

Billing Address: _____

Phone Number: _____

PCP CHANGE FORM

PCP Change Form and Visit Authorization
Formulario para Cambiar el PCP y Autorizacion de Vista

Head of Household: _____ Telephone: _____
 Jefe de Familia: Last Name/Apellido, First Name /Primer Nombre Teléfono

Address: _____
 APARTAMENTO CITY/CIUDAD ZIP CODE/CODIGO POSTAL Dirección STREET APT#/CALLE/# DE

Member's New Name: _____ **New Telephone #:** _____
 Nombre Nuevo del Miembro: Nuevo Numero de Teléfono:

Member's New Address: _____
 Nueva Dirección del Miembro STREET APT#/CALLE # DE APARTAMENTO CITY/CIUDAD ZIP CODE/CODIGO POSTAL

CHNCT MEMBER NAME NOMBRE DEL MIEMBRO	CHNCT ID NUMBER NUMERO DE IDENTIFICACIÓN	HAS THIS MEMBER BEEN SEEN? ¿ESTE MIEMBRO FUÉ VISTO?	IF YES, DATE OF SERVICE. SI ES SI, FECHA DE SERVICIO.	NEW PRIMARY SITE NUEVO LUGAR PRIMARIO	NEW PCP NUEVO PCP

DATE: _____ MEMBER'S SIGNATURE: _____ SENDER'S NAME/FAX#: _____
 FECHA FIRMA DEL MIEMBRO NOMBRE DEL ENVIADOR/FAX#

(For CHNCT personnel use only/Para uso del personal de CHNCT solamente)

CHNCT STAFF INITIALS _____ CHANGE DATE _____ EFFECTIVE DATE _____

Phone: 1-800-361-7242 Fax: (203) 265-2806

SAGA Member Services Phone 1-866-361-SAGA (7242) (Eligibility/Benefits)

Care Management-Phone 1-800-440-5071 Fax # 203-265-3994

Provider Relations Phone 1-800-440-5071 Fax #203-265-3609

SAGA AUTHORIZATION GRID

<p>Specialist Services: NON PAR PROVIDERS WILL NOT BE COVERED. All outpatient services provided by a specialist require a referral from the primary care provider <i>and</i> prior authorization by CHNCT. There must be a valid authorization in place to the participating specialist for reimbursement of related procedures, diagnostic procedures, injections, infusions, immunizations or Durable Medical Equipment that will be billed by the specialist. Par specialist to par specialist referrals must be done in coordination with the PCP and require a separate referral initiated by the PCP as well as prior authorization by CHNCT. If the situation is emergent in nature, the specialist may call CHNCT for an urgent referral. OB/GYN providers do not require referrals. Patients may self refer for OB/GYN care. (GYN/Oncology providers do require a referral.) Patients may also elect an OB/GYN provider as their PCP if they so choose.</p> <p>Covered Services Include: Pharmaceutical Drugs Primary Care Services and Specialty Services (with referral) Rehab Facility Care (inpatient acute rehab) DME and Medical Supplies PT, OT, Speech, Podiatry, Audiologist, Chiropractic or Naturopathic Services performed in an FQHC, outpatient clinic or hospital clinic. NOT COVERED WHEN PERFORMED BY INDEPENDENT PRACTITIONERS.</p> <p><u>The following services and or procedures require prior authorization by CHNCT.</u> Cardiac rehabilitation</p> <p>Dialysis (hemodialysis and peritoneal) Durable Medical Equipment Rentals Durable Medical Equipment and Medically necessary supply purchases >\$200 Non-pharmacy program drugs and brand medications when generics are available as well as injectible drugs included in the CHNCT Injectable Drug Program & drugs > \$500 Pain Management Pulmonary Rehab / Respiratory Therapy Rehab Facility Care (inpatient acute rehab) PT, OT, Speech, Podiatry, Audiologist, Chiropractic or Naturopathic Services performed in an FQHC, outpatient clinic or hospital clinic. NOT COVERED WHEN PERFORMED BY INDEPENDENT PRACTITIONERS.</p> <p>PLEASE NOTE: NON PAR PROVIDERS WILL NOT BE COVERED There is no office co-pay for SAGA members. SAGA members will have a unique SAGA/CHNCT ID card. Revised July 29,2004</p>	<p><i>Outpatient Procedures requiring prior authorization regardless of where they are performed:</i> Bunionectomy Carpal Tunnel Release Stripping and ligation of varicose veins TMJ related procedures/treatment</p> <p><i>Rehab Hospital Admissions:</i> Admissions for inpatient rehabilitation facilities must be prior authorized.</p> <p><u>The following Services do not require a referral or prior authorization :</u></p> <p>Anesthesia Emergency Department Care Family Planning OB/GYN Lab Radiology</p> <p>Special Circumstances: Nebulizers and spacers do not require prior authorization.</p> <p>Transportation for Radiation Oncology, Chemotherapy and Dialysis will be arranged by CHNCT by calling in advance to: Member Services @ 1-866-361-SAGA(7242)</p>	<p>Exclusions: <i>this is a general listing and includes but is not limited to the following:</i> Infertility treatment (I.e. reversal sterilization; artificial insemination; invitro fertilization; fertility drugs) All services or procedures of a plastic or cosmetic nature performed for reconstructive purposes, including but not limited to lipectomy, hair transplant, rhinoplasty, dermabrasion Services for conditions not medical in nature or in excess of those deemed medically necessary to treat patient Experimental services PT, OT, Speech, Podiatry, Audiologist, Chiropractic or Naturopathic Services WHEN PERFORMED BY INDEPENDENT PRACTITIONERS. Routine Vision Care Non Emergent Transportation (except for radiation oncology, chemotherapy & dialysis) Home Care Services Services by a non-par provider</p> <p><i>Further questions regarding exclusions, prior authorizations or review of medical necessity should be directed to CHNCT's Care Management Department.</i></p> <p><u>CHNCT's Subcontractors:</u> For Dental benefit issues contact: BeneCare Customer Service (1-800-843-4727) For Pharmacy benefit issues: Advance PCS Customer Service (1-800-364-6331)</p>
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SAGA PHARMACY PROGRAM

PRIOR AUTHORIZATION FORM

Prior Authorization Form for Brand Medically Necessary, Early Refill, greater than \$500

Fax: 203-265-3994 Phone: 1-800-440-5071 #3 (Pharmacy Services)

Please Print All Information

Patient's First and Last Name: _____ Patient's Date of Birth: _____

CHNCT's SAGA Member ID Number: _____

Prescriber's Full Name: _____ Phone Number: _____ Prescriber's Fax Number: _____

Brand Medically Necessary Request

Brand Name Drug and Strength Requested: _____ Diagnosis: _____

Did the patient experience an adverse reaction to the generic or the generic did not provide therapeutic benefit? If yes, please explain (please provide copy of notes in clin record):

*** You must attach the following items for Brand approval: MedWatch Form and PA Form**

Early Refill Request

Drug (Name and Strength): _____ Diagnosis: _____

Reason for Request: _____

Please Note: No replacement for lost or stolen medication.

Authorization for Medication greater than \$500 per maximum 30 day fill

Drug (Name and Strength): _____ Diagnosis: _____

Reason for Request: _____

Prescriber Acknowledgement

I certify that the information given on this form is true and accurate for the medication requested.

Signature of the Prescriber: _____ Date: _____