This manual is intended as a reference and resource guide for participating Health Alliance providers and office staff. It contains relevant policies and procedures as well as accompanying explanations and exhibits.

The first goal in our association with our participating providers is to develop a mutually beneficial relationship with each of you that results in the delivery of the highest quality care to our members. As a provider, you are integral to successfully coordinating and providing medical care to Health Alliance members. Your independence and clinical freedom are essential to program effectiveness. The better you understand the Health Alliance products and procedures, the greater the likelihood of success for practicing quality, cost-effective medicine with an emphasis on patient education, health promotion and discharge management. However, this requires all our participating providers to cooperate and comply with the terms of the Participating Provider Agreement and to fulfill their responsibilities set forth in the agreement and this Provider Manual.

This manual will help maximize the value of care to your Health Alliance patients. Please remember, however, that Health Alliance administers many different product lines and plans, and members should be referred to the Health Alliance Customer Service Department for clarification of coverage issues. In most cases, the self-funded plans have their own requirements; please call your client consultant for assistance with self-funded group plan patients.

Health Alliance will update this manual annually based on experience and changes in our products. Your input and advice are appreciated. Please direct your comments to your Health Alliance provider relations specialist.
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Section 1

Introduction
Overview

Health Alliance Medical Plans, Inc.

Health Alliance Medical Plans, Inc., is a domestic stock insurance company organized under the laws of the State of Illinois in November 1989. Health Alliance Medical Plans is a wholly owned for-profit subsidiary of Carle Clinic Association in Urbana, Illinois. CarleCare, Inc., predecessor of Health Alliance, was organized in 1979 as an HMO. Health Alliance Midwest, Inc., is a wholly owned profit subsidiary of Health Alliance Medical Plans.

Health Alliance offers insured health insurance products such as HMO, PPO and POS products. Health Alliance is also a third party administrator (TPA) for self-funded employer plans. Following is brief description of products.

Health Alliance HMO, an insured HMO, represents both a non-federally qualified HMO and federally qualified HMO product.

All Health Alliance HMO members select a Primary Care Physician who coordinates medical services. This plan features member cost-sharing mechanisms such as physician office visit copayments and inpatient hospital copayments. All covered services must be provided by a Health Alliance HMO provider, except in emergent medical situations. Referrals to contracted specialists may require a Primary Care Physician referral. Tertiary referrals require a Primary Care Physician referral and written preauthorization from a Health Alliance Medical Director.

Health Alliance Point of Service (POS) plans are a combination of an HMO plan (with fixed copays and an annual out-of-pocket maximum) and an Indemnity plan (with limited out-of-network coverage). Coverage is determined at the point of service, depending on which provider members see. Members choose a PCP to coordinate all medical care.

Health Alliance PPO is a Preferred Provider Organization. Members are not required to select a Primary Care Physician. There is a financial incentive to receive care from a preferred or contracted provider. Members may seek services from non-preferred providers, but are responsible for a higher deductible and percentage of coinsurance (except for emergency services).

Third Party Administration is also offered. Health Alliance is licensed to provide Administrative Services Only (ASO) for self-funded employer plans. This means Health Alliance, on behalf of the employer, processes claims and performs utilization management activities. The employer is at risk financially for the utilization of the group.
If You Have Questions, We Have Answers

On the Phone
You can call our Customer Service Department at 1-800-851-3379. Please listen carefully to the menu options available when you call. To be connected to a direct extension, press 1 then enter the extension when prompted.

Press 3 to access the provider option menu. From there, you can select from the following options:

Press 1 to check member eligibility.

Press 2 for questions about your contract or how to become a Health Alliance provider.

Press 3 for preauthorization information.

Press 4 to speak to the Pharmacy Department.

Press 5 for electronic claims submission.

Press 6 for claim status.

Press 7 for all other inquiries.
Contact Information, continued

Urbana, Illinois
Health Alliance Medical Plans
Corporate and Administrative Headquarters
301 S. Vine St.
Urbana, IL 61801
Phone: 217-337-8100 or 1-800-851-3379
Fax: 217-337-3438

Springfield, Illinois
Health Alliance Medical Plans
2040 W. Iles Ave., Suite B
Springfield, IL 62704
Phone: 217-698-0022 or 1-888-465-0022
Fax: 217-698-8679

Iowa
Health Alliance Midwest
Phone: 1-800-851-3379
Fax: 217-337-3438

Washington
Health Alliance Northwest
316 Fifth St.
Wenatchee, WA 98801
Medicare Phone: 1-877-750-3350
Fax: 509-662-0735

Health Alliance Northwest
1701 Creekside Loop #100, Building 11
Yakima, WA 98902
Medicare Phone: 1-877-795-6117

Compliance Line
For confidential reporting of potential fraud, abuse and any privacy concerns contact the Health Alliance Compliance Line at 217-383-8304. This service is available 24 hours a day, 365 days a year.

YourHealthAlliance.org
Log on to:
- View guidelines and medical policies
- Submit and manage preauthorization requests and claims reprocessing inquiries
- Check the status of authorizations and claims
- Connect to member eligibility information, contracted providers and forms and resources

See Section 11 for more information.
Section 2

Physician Responsibilities
There are many Health Alliance plans and products which require that members designate a Primary Care Physician (PCP). The PCP may be a Family Practice, General Practice, Internal (Adult) Medicine or Pediatric physician. The PCP is responsible for providing and coordinating the medical care of the member. Females can select a Woman’s Principal Health Care Provider (WPHCP) in addition to a PCP.

Other physician responsibilities include:

1) Availability to members twenty-four hours a day either directly or by call coverage (See covering provider form, section 8).
2) Cooperating fully with Health Alliance Medical and Quality Management programs, which includes access to medical records for these purposes (See Medical Management, section 4, and Quality Management and Risk Adjustment Revenue Management, section 5).
3) Maintaining a conventional patient-physician relationship. Health Alliance encourages open practitioner-patient communication regarding appropriate treatment alternatives and does not penalize practitioners for discussing medically necessary or appropriate care of the patient.
4) Access to specialists
   - Standing Referral: If a member has a condition that requires ongoing specialty care, he or she may ask their PCP for a standing referral. The standing referral can be effective for a time period up to one year or a specified number of visits, whichever is less.
   - Woman’s Principal Health Care Provider (WPHCP): Female members may obtain services from their designated WPHCP (specializing in OB-Gyn or Family Practice) without a referral from their PCP.
   - Before you refer to a specialist or make an appointment for a member, verify that the practitioner is affiliated. Visit our website, HealthAlliance.org, or call the Health Alliance Customer Service Department.
5) Forwarding member coverage or referral issues to Health Alliance for analysis and benefit determination, and advising patients to check with their insurance companies regarding specific insurance coverage information. Frequently, patients mistake their physician’s referral for approval from their insurance company, or they assume their physician knows which providers are plan providers.
6) Information disclosure to members. The Illinois Managed Care Reform and Patient Rights Act requires health care providers to supply the following information upon request of a member:
   - Educational background, experience, training and board certification
   - The names of facilities where the providers have privileges
   - Continuing education and compliance with any licensure, certification or registration requirements
7) Contractual requirements
   - Continuity of Care: If a health care provider terminates a provider agreement with Health Alliance, the provider must continue to provide continued care at the member’s request if he or she has a condition that requires ongoing treatment or is in the 2nd or 3rd trimester of pregnancy. The provider will be required to honor the contracted reimbursement rates to qualify for this continued care provision.
   - Notice of Termination: The Illinois Managed Care Reform and Patient Right Act requires providers to give 90 days notification, in writing (See Provider Addition/Change Form, section 8) for termination of a provider agreement without cause. Health Alliance must give at least 60 days notice to members serviced by a terminating provider, therefore, it is imperative that providers follow the termination guidelines noted here.
8) Allow Health Alliance to use practitioner performance data for purposes including, but not limited to, quality improvement activities and public reporting to consumers.
Physician offices are responsible for collecting copayments. Members are instructed that copayments are due at the time of service. The office visit copayment amount is usually printed in the lower left-hand corner of the member’s Health Alliance identification card.

**Copayment Exclusions:**

- Copayments may or may not be required for office visits with the following health care providers: nurse, nurse practitioner, physician assistant, technician, audiologist and other ancillary personnel (except speech, occupational and physical therapy) or physician extenders. However, this varies by plan. Please verify copayment responsibility at YourHealthAlliance.org for providers or call the Health Alliance Customer Service Department.

- Office copayments for members are waived when Medicare Part B is primary and Health Alliance is the secondary payor. The member's ID card will indicate “$0” in the office visit copayment section. Refer to the member’s ID card or call the Health Alliance Customer Service Department for verification.

**Other Types of Office Visit Copayments:**

- Plans with vision coverage allow self-referred optometry visits for routine vision testing with separate and specific copayment amounts. Services from an optometrist for a medical condition (if the optometrist is licensed and contracted to perform such services) shall be subject to the medical office visit copayment and may require a PCP referral.

- Outpatient Mental Health Care and Substance Abuse treatment have separate copayments. These services require a copayment regardless of whether they are provided by a physician or other mental health professional.

- Physical Therapy, Occupational Therapy and Speech Therapy services are also subject to a separate copayment.

- Obstetrical Care normally requires only one global copayment to cover all physician visits for routine prenatal care and the post-partum check-up. Specialty visits during pregnancy and services by a perinatologist outside the scope of routine prenatal care have an additional office visit copayment.
## Appointment Scheduling Guidelines

<table>
<thead>
<tr>
<th>Access Descriptions</th>
<th>Definition</th>
<th>Accessibility Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Preventive Care</td>
<td>Well-child exam, annual physical, wellness visits, or gynecological exams</td>
<td>Within 4-8 weeks of request</td>
</tr>
<tr>
<td>2. Routine Primary Care</td>
<td>Primary care for non-urgent symptomatic conditions (differentials it from wellness visits), such as chronic health problem or ongoing illness in which the member is experiencing no significant change in ADL's; i.e., HTN, seasonal allergies, medication checks</td>
<td>Within 10-14 days of request</td>
</tr>
<tr>
<td>3. Urgent Care</td>
<td>Sudden, severe onset of illness or health problem requiring medical attention; i.e., sore throat with fever, localizing abdominal pain</td>
<td>Within 1 business day</td>
</tr>
<tr>
<td>4. Emergency Care</td>
<td>Sudden, severe injury or symptoms requiring immediate attention; i.e., chest pain with cardiac HX/unrelieved by NTG, uncontrolled bleeding</td>
<td>Provide and/or refer for emergency care immediately</td>
</tr>
</tbody>
</table>
| 5. After-hours Care       | • Practitioners are available to members 24 hours a day either directly or by call coverage*  
• Calls are answered within 45 seconds at least 95 percent of the time | Answering system that arranges access of:  
• ER calls = 30 min  
• Urgent = 24 hr  
• Life-threatening = refer to appropriate health care facility |

*If you use an answering machine, please make sure the recording specifically includes the following information. NCQA requires messages include instructions for the terms urgent, emergency and life threatening. “If this is an urgent situation, please contact (appropriate contact). If this is an emergency or life-threatening situation, please call 911 or go to the nearest emergency room.”
## Accessibility Standards for Behavioral Health Issues

<table>
<thead>
<tr>
<th>Access Descriptions (NCQA NET 2)</th>
<th>Maximum Allowable Waiting Time (defined by NCQA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Non Life-Threatening Emergency</td>
<td>6 hours</td>
</tr>
<tr>
<td>2. Urgent Care</td>
<td>48 hours</td>
</tr>
<tr>
<td>3. Initial Visit for Routine Care</td>
<td>10 business days</td>
</tr>
<tr>
<td>4. Follow-up Visit for Routine Care</td>
<td>8 weeks</td>
</tr>
</tbody>
</table>
Communications

Appropriate Conversations with Patients
Health Alliance encourages providers to have open and honest communications with patients. It is recommended that you advise your patients on any of the following:
- the patient’s health status
- medical care and treatment options
- the risks, benefits and consequences of treatment or non-treatment
- the opportunity for the patient to refuse treatment
- future treatment options.

Regardless of the patient’s Health Alliance coverage, the patient has a right to know about all treatment options available. Please encourage patients with coverage questions to call the Health Alliance Customer Service Department at the number listed on the back of his or her ID card, or to visit HealthAlliance.org.

Inappropriate Conversations with Patients
It is inappropriate for you or your staff to initiate discussions with patients about disenrolling from any Health Alliance plan.

Communications
The Health Alliance Communications Department is happy to assist you in your communications needs as an affiliated provider. If you have questions, please call the department at (217) 337-8083 or 1-800-851-3379, extension 8083.

1. Use of the Health Alliance name and logo
Health Alliance works continuously to maintain a positive brand identity. To this end, Health Alliance closely regulates the use of its name, logo and other identifying references. All providers and other entities must obtain written approval from the Health Alliance Communications Department prior to use of the Health Alliance name, logo, and/or identifying references in publicly disseminated materials including, but not limited to, newspaper ads, fliers, direct mail, pamphlets, brochures, signage, radio and television broadcasts. We ask that you allow 48 hours for review.

2. Media Relations
HMOs and managed care are popular media topics and will continue to be so for some time to come. It is in the best interest of our providers and Health Alliance that all media relations be carefully coordinated for consistency.

If you are contacted by the media with inquiries related to Health Alliance, before you respond:
- Tell the reporter that you are happy to help. Take his or her name and number and say that a representative will return the call promptly.
- Immediately call the Health Alliance Communications Department for guidance.
Accessibility of doctors' offices, clinics, and other health care providers is essential in providing medical care to people with disabilities. Due to barriers, individuals with disabilities are less likely to get routine preventive medical care than people without disabilities. Accessibility is not only legally required, it is important medically so that minor problems can be detected and treated before turning into major and possibly life-threatening problems.

The Americans with Disabilities Act of 1990 (ADA) is a federal civil rights law that prohibits discrimination against individuals with disabilities in everyday activities, including medical services. Section 504 of the Rehabilitation Act of 1973 (Section 504) is a civil rights law that prohibits discrimination against individuals with disabilities on the basis of their disability in programs or activities that receive federal financial assistance, including health programs and services. These statutes require medical care providers to make their services available in an accessible manner. This technical assistance publication provides guidance for medical care providers on the requirements of the ADA in medical settings with respect to people with mobility disabilities, which include, for example, those who use wheelchairs, scooters, walkers, crutches, or no mobility devices at all.

The ADA requires access to medical care services and the facilities where the services are provided. Private hospitals or medical offices are covered by Title III of the ADA as places of public accommodation. Public hospitals and clinics and medical offices operated by state and local governments are covered by Title II of the ADA as programs of the public entities. Section 504 covers any of these that receive federal financial assistance, which can include Medicare and Medicaid reimbursements. The standards adopted under the ADA to ensure equal access to individuals with disabilities are generally the same as those required under Section 504.

Health Alliance will provide information and training to physician offices, agencies and other providers on the importance of ADA-compliant facilities for members who have disabilities. As a resource, Health Alliance Provider Services can provide the Health and Human Services publication “Access to Medical Care for Individuals with Mobility Disabilities.” The publication provides recommendations, including office, exam, furnishings and transfer techniques.
Health Alliance requires all contracted providers meet our Office and Medical Record Requirements. If a member registers a complaint about one of the criteria listed below, a Provider Relations Specialist will visit your office within 45 calendar days and complete an Office Site Inspection. Offices failing to score 90 percent on the inspection will be resurveyed until the 90 percent threshold is reached. Office sites that fail to reach the 90 percent threshold may be terminated.

**Goals and criteria for provider sites include:**
- Physical accessibility (see checklist, p. 2.8)
- Physical appearance/safety—professional, safe, clean and pleasant environment
- Access to care
- Limited or barred access to medications and medical records
- Equipment licensure and appropriate maintenance
- Confidentiality policy
- Medical record maintenance, availability and documentation of service rendered (see policy and procedure p. 2.10)

Each provider office will maintain a secured separate medical record for each patient. All medical information shall be maintained in a confidential manner except as required for medical treatment and care. Medical record keeping must meet Ambulatory Review criteria (see Ambulatory Review process p. 2.12) and focus on the following six critical elements:

1. Significant illnesses and medical conditions are indicated on the problem list.
2. Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
3. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
4. Working diagnoses are consistent with findings.
5. Treatment plans are consistent with diagnoses.
6. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
# Provider's Office Site Inspection

**[MAKE HEAVY DARK MARKS][ERASE CLEANLY TO CHANGE][USE #2 PENCIL OR BLACK PEN][EXAMPLE: □ □]**

<table>
<thead>
<tr>
<th>Name of Provider/Applicant:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Location of Site:</td>
<td>Specialty:</td>
</tr>
<tr>
<td>Date of visit:</td>
<td>Service Area:</td>
</tr>
</tbody>
</table>

Check Yes, No, or N/A for the following:

### I. Physical Accessibility:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Is there adequate parking?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Is there a ramp for handicapped access?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Are there designated handicapped parking space(s)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Is there a handicapped accessible toilet or are facility employees available to assist handicapped patients in restroom if needed?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### II. Physical Appearance/Safety:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Is the exterior of facility presentable and the grounds well maintained?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Is the floor or carpet in good repair?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Is the waiting room clean and free of unnecessary clutter?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Is there adequate space and seating available in the waiting room?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Are the examination rooms clean and free of unnecessary clutter?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Are prescription pads kept away from the public?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Are there appropriate disposal containers available for sharps?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Are the medical instruments, hazardous substances and other potentially dangerous materials kept out of patient areas when not being used/monitored by the physician or medical staff?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Are autoclaves used and properly maintained for sterilization of medical equipment?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### III. Access to Care:(Medical Services)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Is a routine appointment available for a new patient within 10 working days?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Is a routine appointment available for an established patient within 10-14 days?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Can a new patient be seen for an urgent problem within 24 hours (same day or next day)?&lt;br&gt;  If not, can the patient be seen elsewhere within 24 hours?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Can an established patient be seen for an urgent problem within 24 hours (same day or next day)?&lt;br&gt;  If not, can the patient be seen elsewhere within 24 hours?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Can a new patient be seen for an emergent need immediately?&lt;br&gt;  If not, can the patient be seen elsewhere immediately?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Can an established patient be seen for an emergent need immediately?&lt;br&gt;  If not, can the patient be seen elsewhere immediately?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. If the average wait time in the office is more than 15 minutes, are patients advised of the potential wait time?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Are there an adequate number of examination rooms available per physician?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### IV. Access to Care:(Behavioral Health)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Is a routine appointment available for a new patient within 10 working days?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Can a patient be seen for an urgent problem within 48 hours?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Can a patient with a non-life threatening emergency be seen within 6 hours?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Is a patient with a life-threatening emergency seen immediately?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**2.9**
<table>
<thead>
<tr>
<th>V. Medical Records:</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Are medical records easy to access by staff?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>B. Are medical records stored away from patient access?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>C. Is there a single medical record for each patient with the following:</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Is the medical record secured within the chart?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Are all pages within the chart secured?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Does each member of the family have his/her own medical record?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>D. Are there designated sections in the medical record for notes, reports, diagnostic studies, correspondence, etc?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>E. Is a current complete personal/biographical data sheet easily accessible in the medical record?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>F. Is a current complete diagnostic/problem list easily accessible in the medical record?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>G. Is there a Policy and Procedure that ensures the confidentiality of medical records?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>H. If your Policy and Procedure is written, please attach a copy. If it is oral, briefly explain it below:</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VI. Medications:</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Are drugs, including manufacturer samples, stored away from patient access?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>B. Are drugs maintained in original manufacturer packaging?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>C. If a crash cart is maintained, is the cart checked periodically for expiration dates and completeness?</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>D. Are all Schedule II drugs stored in a locked area?</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>E. Are any medications stored in a refrigerator?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>F. Is the refrigerator with the medications free from food?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

TOTALS:

| VIII. Additional Comments: | ☐  | ☐  | ☐  |

| Percent Compliance: | ☐  | ☐  | ☐  |

Signature of Reviewer: ____________________________
Date: __________

Signature of Provider/Office Representative: ____________________________
Date: __________

Please note: deficiencies of any safety issue addressed in Section II (E-I) and Section V (A,B, & D) may result in cessation of the credentialing process. The practitioner must provide written substantiation that safety issues have been corrected within 30 days of the site visit date in order to reactivate processing of the Participating Provider application.
Policy and Procedure: Medical Records Maintenance

PURPOSE OF THE POLICY

To provide guidelines for the maintenance of well-documented medical records at provider sites to facilitate communication, coordination and continuity of care and promote efficiency, safety and effectiveness of treatment, leading to better health outcomes.

STATEMENT OF THE POLICY

The medical records, whether electronic or on paper, communicate the member’s past medical treatment, family history, past and current health status, and treatment plans for their health care.

PROCEDURES

1. Contents and Organization

1.1 A single medical record should exist for each patient.
1.2 Attempts should be made to have all aspects of patient care reflected in the medical record. If some care options, i.e., home care, ambulance records, are not available for inclusion within the record, communication should exist as to the location of those specific care records.
1.3 Contents of the medical record should be secured-fastened.
1.4 Each entry should be indelibly added to the medical record.
1.5 Records should be organized for easy access by filing appropriate information together, i.e., biographical information, progress note, diagnostic studies, past medical history, etc.
   - Contents should include, but are not limited to, the following:
     - All services provided directly by the PCP
     - All ancillary services and diagnostic tests ordered by the practitioner
     - All diagnostic and therapeutic services for which a member was referred
     - History and physical
     - Allergies and adverse reactions
     - Problem list
     - Current Medications
     - Documentation of clinical findings and evaluation for each visit
     - Preventive services/risk screening
     - BMI percentile or value
     - Family History
     - Smoking Status (exposure to second-hand smoke for children)
Policy and Procedure:  
Medical Records Maintenance, continued

- Alcohol Status (for those over 14 years of age)

1.6 Information should be kept in chronological order within each section.

1.7 Documentation on whether or not a member has executed an advance directive is included in the medical record.

1.8 Documentation of advance directives is placed in prominent part of a member’s medical record.

1.9 All clinical information filed into a patient’s chart should be signed by that patient’s provider in order to note that it has been reviewed prior to filing. For an electronic chart, a time/date stamp of the review date is sufficient.

2. Storage, Availability and Confidentiality

2.1 Each provider site determined and maintains a tracking system for medical record storage and retrieval for various routing needs, such as:
   - Scheduled appointments prior to time of service
   - Same-day scheduled appointments as soon as possible

2.2 In the event a medical record is not available at the time of service, there should be a mechanism to include any related documentation of a visit into the medical record in a timely manner.

2.3 Medical record organization and storage should allow for easy retrieval. Records should be stored on site, in a secure area away from patient/visitor access to ensure confidentiality of PHI.

2.4 Offices must ensure that staff receives periodic training in confidentiality of member information.

3. Follows standards as outlined in:

3.1 *Ambulatory Review for Primary Care Practitioners* policy and Ambulatory Review For that support:
   - Specific medical record documentation criteria
   - Performance Goals
WHAT is an ambulatory review?
An ambulatory review is a medical record review conducted by Health Alliance to ensure quality care is provided to our members. It is a process for evaluating a Primary Care Physician’s (PCP) documentation of member visits.

WHY do we conduct ambulatory reviews?
The Illinois Department of Public Health (IDPH), per the Health Maintenance Organization Act, requires Health Alliance to have a program for the review and evaluation of medical record documentation of primary care physicians once every two years. In an effort to ensure quality care is provided to our members, Health Alliance scores each ambulatory review, and includes that score as part of the recredentialing process conducted every three years.

WHO conducts an ambulatory review?
Ambulatory reviews are conducted by our medical record review staff from the Quality Management Department. The medical record reviewer will contact the primary care physician’s office to coordinate a review date, which will include confirmation of the appointment and a list of charts identified for review.

If there are any questions or concerns at any time during the review process, feel free to contact your medical record reviewer at 217-337-8112 or qualitymanagement@healthalliance.org.

WHEN is an ambulatory review conducted?
New Primary Care Physicians are reviewed within their second year of affiliation with Health Alliance, as long as they have 50 or more members on their panel. Subsequent reviews are completed according to the following schedule:

<table>
<thead>
<tr>
<th>Compliance Rating</th>
<th>Next Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>90-100%</td>
<td>Two Years</td>
</tr>
<tr>
<td>≤ 89%*</td>
<td>6 months</td>
</tr>
</tbody>
</table>

*If a compliance rating is ≤ 89%, a corrective action plan must be submitted to Health Alliance by the Primary Care Physician within 10 working days of receiving their compliance rating.

HOW is the criteria applied?
Our medical record reviewers utilize specific criteria based on record keeping, confidentiality and quality of care to evaluate 10–12 member visits for each Primary Care Physician. Some of the criteria may not be applicable for a review based upon the member’s age, gender and/or medical history. If the criteria are not applicable, it will not be factored into the compliance rate.

Health Alliance reviews criteria for ambulatory reviews each year to ensure the best quality of care is being provided to our members. Any changes to the ambulatory review, including new, deleted or modified criteria, will be communicated at least 30 days in advance in writing to the providers.

The following pages provide an overview of the categories.

** Indicated the following: For monitoring purposes only. Questions will not be scored.
Health Alliance Ambulatory Review Process, continued

Section I – Record Keeping/Confidentiality

- Does staff receive annual training on confidentiality? - The primary care physician office is responsible for providing proof of a written policy regarding confidentiality to the reviewer.
- Does provider have a policy for record retention/retirement? - The primary care office is responsible for providing proof of a written policy regarding record retention and retirement of member records.
- Is Biographical data in the record? - Current biographical data such as member name, address, DOB, etc. is recorded in a designated area.
- Electronic Medical Record?**
- Provider maintains an active record for each member? - A separate medical record should be maintained for each member.
- Are records organized/stored for easy retrieval?
- Are records stored securely and allows access to authorized personnel only?
- Are records current and complete, containing services by PCP?
- Are records legible?
- Is each entry permanently added to medical records? - Information should not be entered in any method that can be removed, washed away or erased.

Section II – Information Specific to Date of Service

- Entry is dated? - The date of selected visit should be documented.
- Chief Complaint? - The reason the member sought care should be clearly documented.
- Was a blood pressure performed (≥ 18 years of age)? - A blood pressure ready for member who sought care should be clearly documented.
- Assessment noted? - Objective and subjective information regarding the member’s presenting complaint should be recorded.
- Current diagnosis present and consistent with findings? - Diagnosis for date of visit should be clearly documented and consistent with findings.
- Plan of treatment, including health education, documented? - The plan of treatment should be consistent with the diagnosis of visit. Health education should be noted for visit, including discussion of treatment, disease processes, diet, exercise, medication side effects, anticipatory guidance, and distribution of informational pamphlets. Follow up correspondence will also be reviewed.
- Results of diagnostic tests, services, therapeutic & ancillary services and referrals ordered at this visit are filed and signed/initialed by PCP?
- Is each entry signed/initialed by Primary Care Physician? - All entries, including results of diagnostic tests and services, therapeutic and ancillary services and referrals, should be signed or initialed by the provider. This includes both manual and electronic entries.

Section III – Preventative Care – Other

- Are allergies or NDKA documented? - Notation of allergies and the specific reactions should be noted. If there are no allergies, “NKA” or “NDKA” should be noted.
- Medical history, including any relative to current episode of care documented? - Notation of current, failed and past medications should be documented.
- Is current problem list documented? - Problem list for date of visit should be clearly documented.
- Are physicals documented? - Notation of routine physicals should be documented.
- Are medications documented? - Notation of pertinent medical history such as chronic conditions, malignancies, surgeries.
- Is family history documented? - Notation of pertinent family history of all established members should be on a history form during a recent physical or routine visit. If there is not significant history, a notation should be made.
- For members age 65+, advanced care planning included?** - For members age 65+, evidence in the medical record of a living will or power of attorney should be present.
- If advanced care planning is included, is it in a prominent part of the member's record? ** - Evidence in the medical record of a living will or power of attorney should be in a prominent part of member record.
Preventative Care – Preventative Services/Risk Screenings

• Notification of the use of tobacco? – The use of tobacco should be assessed on all members regardless of age. Because of the effects of second-hand smoke, infants and children should be assessed for the presence of a smoker in the home.
• Notation of smoking cessation counseling/referral?
• For members age 20–74, is BMI documented?
  • If BMI is documented, is it < 25%?**
• For members age 2–19, is BMI percentage documented?
• For members age 2–17, is counseling for nutrition and physical activity documented?
• For members age 50–80, did member have a discussion/counseling with physician regarding colorectal cancer screening?
  • If Y, did member have colorectal cancer test?**
  • If N, did member refuse colorectal cancer test?**
• For female patients age 50+, did member have a discussion/counseling with physician regarding mammogram screening?**
  • If Y, did member have mammogram?**
  • If N, did member refuse mammogram?**
• Immunization Records – Providers should maintain an age-appropriate immunization record for all members.
  • For patients two years old:
    • Appropriate immunizations completed by 2nd birthday – four DTap, three IPV, one MMR, three HiB, three HepB, one VZV, one Hepatitis A, four PVC, three rotavirus and two influenza vaccinations.
    • If all immunizations are not present, were they refused?**
  • For patients 13 years old:
    • Appropriate immunizations completed by 13th birthday – one meningococcal, one Tdap, three hpv.
    • If all immunizations are not present, were they refused?**
  • For patients ≥ 65 years old:
    • Appropriate immunizations to be completed? – one influenza within the past 12 months and pneumococcal (PVC13 and PPSV23) per ACIP recommendations for adults 65 years and older.
• For female patients age 16–25, was sexual activity assessed? – For females age 16–25, the chart should contain documentation that sexual activity is assessed, and if the patient is sexually active, a test for Chlamydia is conducted and/or discussed.
  • If Y and sexually active, test for Chlamydia was discussed?**
  • If Y and test was discussed, was it refused?**
• For patients age 65+, did the member have discussion/counseling with physician to exercise regularly?**
• For patients age 65+, did the member have discussion with physician if they had problems with balance or had fallen within the past 12 months?**
  • If Y, did the physician offer suggestions on how to prevent falls?**
• For patients age 65+, did the physician ask if the member experienced leaking of urine?**
  • If Y, were treatment options discussed?**
**Policy and Procedure: Ambulatory Review for Primary Care Practitioners**

### HEADER INFORMATION

<table>
<thead>
<tr>
<th>Owner Department:</th>
<th>Quality Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject:</td>
<td>Ambulatory Review for Primary Care Practitioners</td>
</tr>
<tr>
<td>Owner:</td>
<td>Executive Director of Quality Management</td>
</tr>
<tr>
<td>Affected Departments:</td>
<td>CPS, HA Connect, Quality Management</td>
</tr>
<tr>
<td>Effective Date:</td>
<td>05/31/95</td>
</tr>
<tr>
<td>Revision Date:</td>
<td>12/28/15</td>
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<td>Review Date:</td>
<td>10/14/17</td>
</tr>
<tr>
<td>Policy #:</td>
<td>159</td>
</tr>
<tr>
<td>Policy Applies To:</td>
<td>All Primary Care Practitioners with a panel size ≥50 members.</td>
</tr>
</tbody>
</table>

### PURPOSE OF THE POLICY

To evaluate medical record documentation by Primary Care Practitioners (PCP) as required by both the Illinois Department of Public Health (IDPH).

### STATEMENT OF THE POLICY

Initial ambulatory reviews are conducted within the second year of a practitioner’s affiliation with Health Alliance if an appropriate panel of ≥ 50 members exists. Subsequent reviews are completed according to the schedule defined in the scoring section in the procedure. Practitioners include Pediatrics, Adult/Internal Medicine, Family/General Practice and Specialists designated as PCP’s. Practitioners with a panel size of less than 50 members are not reviewed. Ambulatory Review scores are included as part of the re-credentialing process.

### PROCEDURES

1. **HEDIS Supervisor**
   1.1 Generates monthly report for each in the Ambulatory Review database to obtain a list of due and overdue reviews, updated member panel size per provider, as well as a terminated provider listing, for each Medical Record Reviewer.
   1.2 Sends copy of the report to assigned Medical Record Reviewer indicating new, overdue and terminated providers that need ambulatory review.

2. **QMM Medical Record Reviewer**
   2.1 Coordinates date for review with practitioner office 3-4 weeks prior to review date.
   2.2 Notifies HEDIS Coordinator of appointment date.
   2.3 Generates a query of medical records to be reviewed from provider claims history in the Crystal Enterprise software.
   2.4 Randomly selects visits/claims from the query report including acute illnesses, complete physical exams, and chronic disease visits for pediatric, adult and geriatric patients. If the query report does not list at least 10 visits (even with a query of visits for the past 12-24 months), request a new query from HEDIS Reporting Manager.
   2.5 Prepares Ambulatory Review database input file prior to review and sends to HEDIS Coordinator to be loaded into database.
Policy and Procedure: Ambulatory Review for Primary Care Practitioners, continued

3. **HEDIS Coordinator**

3.1 Maintains Ambulatory Review database and makes changes to database structure, forms, programming and reports to reflect changes to Ambulatory Review criteria.

3.2 Upon notification that a database input file is prepared, examine file to validate data and verify that it was entered appropriately.

3.3 Imports data from input file into a database file. Verify that data imported correctly and run any data manipulations necessary (e.g. age calculation).

3.4 Place database file on J drive and notifies the Medical Record Reviewer that it is available.

4. **Medical Record Reviewer**

4.1 Sends a confirmation letter via fax or mail to physician office with an attached list of medical records with date of birth to be reviewed.

4.2 On the day of the review, Medical Record Reviewer shall review database for completeness prior to leaving a practitioner’s office.

4.3 Takes query report to the review. If any of the pre-requested medical records are not available at the time of the review, a different member/visit may be randomly selected and reviewed from the query report.

4.4 For those physicians with a small number of members assigned, it is critical the sample consist of all the visits requested. If the physician’s office cannot provide documentation to support evidence of a visit for which they billed Health Alliance, this should be noted on the Ambulatory Review form and a report will be made to the Credentialing Committee and included in the Provider Notification Letter.

4.5 If reviewer has any concerns that come to light during the review at the provider’s office, they should fill out the provider site concern form and forward form to the Credentialing Manager.

4.6 Provides feedback and preliminary score to the physician’s office prior to leaving.

4.7 Notifies HEDIS Supervisor and HEDIS Coordinator of any scores that fall below passing, upon return from the visit.

4.8 Forwards the completed database reviews to the HEDIS Coordinator following completion of the review.

4.9 When the HEDIS Coordinator sends a report indicating the provider name, score and date, the Medical Record reviewer should review and approve the Provider Notification Letters being sent out.

5. **HEDIS Coordinator**

5.1 Upon notification that Record Reviewer has completed reviews, retrieves database file and cleans data by removing extra records and ensuring that the required number of records are completed and scored appropriately.

5.2 Creates and stores provider reports (PDFs) for each provider contained in the database file.

5.3 Updates main Ambulatory Review database by adding data from database file into the main database and entering provider scores and review information into the score tracking table.

5.4 Backs up files by exporting data in main Ambulatory Review database to storage files.

5.5 A report is sent to the Medical Record Reviewer indicating the provider name, date of review and score. The Medical Record Reviewer should approve prior to sending out the Provider Notification Letters.
Policy and Procedure: Ambulatory Review for Primary Care Practitioners, continued

6. HEDIS Coordinator

6.1 Formats result letter for each practitioner based upon compliance score upon receipt of provider reports.

6.2 Upon completion, files a copy of the letter and distributes letters with the Ambulatory Review Result Sheet to:
   - Practitioner
   - Medical Record Reviewer – Notified that letters are filed, and they can go to that file to review the result letters. A report is also sent to the Medical Record Reviewer indicating the provider name, date and score.
   - Credentialing Department to be filed in the practitioners credentialing file.

6.3 Scoring
   - New Primary Care Practitioners meeting minimum panel size requirements are reviewed within their second year of affiliation with Health Alliance. Subsequent reviews are completed according to the following review schedule:
     Compliance rating:
     - 90%-100% - Next review date 2 years
     - ≤89% - Next review date 6 months in conjunction with a corrective action plan from the practitioner.

6.4 If a practitioner receives <89%, sends memo to appropriate regional medical director with copy of practitioner letter and results.
   - Letter sent to practitioner via Certified Mail.
   - Coordinates communication to the appropriate regional Medical Director, via e-mail, if the practitioner has not submitted a response/action plan within ten (10) working days.
   - Forwards action plan to Credentialing to file.

7. Regional Medical Director

7.1 Contacts practitioner if action plan/response is not received within 10 working days from date of notification letter. An email will be generated from the HEDIS Coordinator if this is necessary.

8. Credentialing Committee

8.1 Reviews scores at six (6) month re-review results if prior scores ≤ 89% does not improve.

8.2 If problem cannot be corrected and the score does not improve, the Credentialing Committee will evaluate termination of the practitioner’s contract.
The credentialing process applies to all participating practitioners licensed in the states in which Health Alliance is qualified to do business.

The credentialing process is performed at the Health Alliance office in Urbana. Our internal goal is to complete the credentialing process in 6–12 weeks depending on licensure, standing, medical malpractice history, board certification status, responses from references, affiliations, and the Credentialing Committee’s review.

All participating practitioners are required by NCQA to complete the credentialing process before being added to the provider network. MDs, DOs and DCs in the state of Illinois will be recredentialed in accordance with the Illinois Department of Public Health regulations on recredentialing. All other providers will be recredentialed every 36 months.

Health Alliance adheres to standards set by the National Committee for Quality Assurance (NCQA), Centers for Medicare and Medicaid Services (CMS) and the State of Illinois to ensure the quality of our provider network. Legal and accreditation requirements mandate a thorough credentialing process for all managed care plans.

The following credentialing policies and procedures provide an overview of the process.
Policy and Procedure:
Application, Credentialing and Recredentialing of Participating Practitioners

PURPOSE OF THE POLICY

The purpose of this policy is to establish the procedures which the Company staff will follow in:
1. processing initial applications from applicants to become Participating Practitioners, and reapplications by former Participating Practitioners and applicants who have either withdrawn prior applications or whose applications to become Participating Practitioners have been denied by the Company;
2. conducting credentialing activities of applicants referred to in Section 1;
3. conducting recredentialing activities required by the Company;
4. ensuring that the Company maintains the highest credentialing standards possible;
5. establishing the procedures to be followed by the Company’s staff in notifying applicants who fail to meet the Company’s criteria to become a Participating Practitioner; and
6. meeting the requirements of applicable NCQA Credentialing Standards, CMS Standards, and by applicable State law.

STATEMENT OF THE POLICY

It is the policy of the Company that:
1. formal procedures and criteria be established for the application, credentialing, and recredentialing of Participating Practitioners;
2. all applicants be treated in a courteous, professional manner, including individuals who do not meet the Company’s criteria to become a Participating Practitioner;
3. approval by the respective Departments of Public Health, or their equivalent, (in all states) in which the Company is qualified to do business, as required for primary care physicians be obtained when required;
4. recredentialing of Participating Practitioners be conducted, not more than once every 24 months unless indicated by quality of care concern(s) and at least every 36 months; and e) to implement procedures to ensure these policies comply, at all times, with all applicable state and federal laws and regulations relating to credentialing of Participating Practitioners.

APPLICABILITY

This policy applies to all physicians (Medical Doctors and Doctors of Osteopathy), podiatrists, dental practitioners who perform services under medical benefits, optometrists, chiropractors, licensed behavioral health practitioners, nurse practitioners and any other independent healthcare professionals subject to credentialing (NCQA).
Policy and Procedure: Application, Credentialing and Recredentialing of Participating Practitioners, continued

practitioners licensed in the states in which the Company is qualified to do business who are invited by the Company to complete and submit an application to the Company to become a Participating Practitioner, regardless of the product for which the provider is contracted.

PROCEDURES

1. The Credentialing Committee

1.1 The Credentialing Committee (Committee) will:

- Be composed of participating practitioners.
- Evaluate potential applicants and make decisions regarding credentialing of applicants and Participating Practitioners.
- Review and evaluate information received during the credentialing process to determine if the applicant possesses the skills, training, ethics and background necessary to provide care to members.
- Determine if there is insufficient information on which to base a decision regarding an application, and request additional information from the applicant or other parties if needed.
- Withhold processing of applications from applicants who do not provide requested information until information is received, or, in the event of substantial delay and after repeated requests, remove the application from further consideration.
- Require a new application from any applicant who was removed from consideration prior to reconsideration.
- Annually review and revise, if necessary, all credentialing applications, policies and procedures, and all other credentialing documentation.

1.2 The Committee shall have the final authority to approve applicants as new Participating Practitioners, and to renew, terminate, or suspend Participating Practitioners as a result of the credentialing process. The Committee’s authority to approve an application, or to renew or terminate a Participating Practitioner is limited to those applicants the Chief Executive Officer of the Company, or his or her designee, has determined applications should be extended to or renewed. The Committee shall hold bimonthly meetings, unless no applications are awaiting review and consideration. The Committee Chairman may call a special meeting of the Committee to review pending applications when the number of applications cannot be reasonably and timely considered by the Committee at its regularly scheduled meetings.

2. Initial Credentialing Process

2.1 The Credentialing process will begin when a complete application has been received. A complete application must contain:

- A completed credentialing application, either the Illinois Health Care Professional Credentialing and Business Data Gathering form for MD/DO/DC’s in Illinois or the Health Alliance application or the application designated by the state in which the provider practices;
- Languages (other than English), including American Sign Language, spoken by the applicant or office staff.
- A complete educational and work history, broken down by month and year, with any gaps in excess of six (6) months explained in writing;
- Copy of current, valid Drug Enforcement Administration (DEA) registration from all states in which the applicant currently practices;
- Copy of current, valid certificate of insurance and
- Written explanations of all malpractices actions.
Policy and Procedure: Application, Credentialing and Recredentialing of Participating Practitioners, continued

2.2 The Committee, or its designee(s), will obtain and review verification of the following information from a primary source:
- A valid license to practice in all states in which the applicant sees members. Company staff will verify with the appropriate state licensing agencies that the license is active and in good standing via the agency website, phone call, or facsimile. (Please refer to *Inquiry of Adverse Action Against Applicants and Participating Practitioners Documented by State Regulatory Agencies* policy).
- If applicable, clinical privileges in good standing at the hospital designated by the applicant as his or her primary admitting facility. Company staff will verify Clinical privileges with the facility via signed/dated letter, via telephone or via website designated by the hospital.
- A valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) certificate, from all states in which the applicant sees members. The applicant must provide a photocopy of licenses. Company staff will verify one of the above-mentioned licenses with the appropriate licensing agency via the agency website, phone call, or facsimile.
- Completion of residency, graduation from medical school or graduation from professional school, as applicable. Education is verified via the school’s designated verification service, the educational facility directly, the AMA Masterfile, or the AOA.

2.3 Board certification status shall be verified for the following specialties. No other board certifications are recognized by the Company. The following sources are acceptable:
- MDs – Certifacts Online, AMA or the issuing board
- DOs – American Osteopathic Association Website or Certifacts Online
- Podiatrists – American Board of Podiatric Surgery
- Oral Surgeons – American Board of Oral and Maxillofacial Surgery or ABMS

2.4 If the applicant’s Board Certification is verified, Education is not verified.

2.5 Current malpractice insurance in accordance with the amounts established by the Committee. A copy of the applicant’s current malpractice insurance policy facesheet must clearly state the name of the company, coverage dates and amount(s) of coverage, and the covered entity.

2.6 Professional liability claims history. Applicants must provide detailed written information regarding past or pending claims for malpractice, whether or not submitted to their insurance carrier.

2.7 If requested by the Committee, the applicant must provide at least one reference from a peer who is not related to or in practice with the applicant.

2.8 The application shall also include statement by the applicant regarding:
- Reason for any inability to perform the essential function of the position, with or without accommodation
- Lack of present illegal drug use
- History of suspension and/or revocation of any license
- History of felony convictions
- History of loss or limitations of privileges or disciplinary activity
- Complete work history with any gaps of six months or more explained, in writing

2.9 The applicant must attest to the correctness and completeness of the information set forth in the application. Attestations must contain an original handwritten signature by the applicant. Signatures that are affixed by stamp, photocopied or electronically or mechanically produced will not be accepted.

2.10 The Committee, or its designee(s), will document requests for information and responses regarding the applicant from recognized monitoring organizations.
Policy and Procedure: 
Application, Credentialing and 
Recredentialing of Participating Practitioners, 
continued

2.11 The Committee, or its designee(s), will query the National Practitioner Data Bank (NPDB) for all providers subject to credentialing.

2.12 The Committee, or its designee(s), will request information regarding sanctions or limitations on licensure from the appropriate state licensing agencies or other appropriate verification service(s). This information is to be obtained by Company staff from the appropriate state board of medicine at the time the applicant’s medical license is verified.

2.13 For applicants potentially providing care to Medicare members, documentation received from the NPDB also serves as confirmation that the applicant has no Medicare or Medicaid sanctions.

2.14 Applicants have the right to review information submitted by third parties in support of their credentialing applications, including, but not limited to: malpractice insurance carriers, state licensing boards. Documents available for review do not include references, recommendations, peer review reports or other peer review-related materials and information. Applicants shall be notified of this right in the cover letter accompanying the credentialing application.

2.15 Information obtained during processing of the application that varies substantially from information provided to the Company by the applicant will be fully investigated. The Committee or its designee(s) may contact any other sources it deems necessary, in its sole judgment, to verify the applicant’s response.

2.16 The Committee, or its designee(s), will contact the applicant regarding the conflicting information received. The applicant will be asked to substantiate the information received and will be allowed to make corrections to erroneous information (refer to the Notification of, and Process for, Applicants to Correct Erroneous Information Discovered in Credentialing Process policy). Applicants shall be notified of this right in the cover letter accompanying the credentialing application.

2.17 The Committee may consider any other factors or information it deems, in its sole judgment, relevant (such as membership in good standing in professional societies, complaints to professional societies, etc.) in making their decision.

2.18 The Application, and all information and materials submitted by the applicant with it, together with all information and materials received in response to requests for information by the Committee, or its designee(s), will be maintained in strictest confidence. All paper information and materials relating to each applicant shall be maintained in a confidential locked file. Access to this file will be restricted to the Committee, or its designee(s). Access to the Credentialing Database and electronic credentialing files are restricted and entered only by pass code.

2.19 The Credentialing Department staff has the option, on a daily basis, to consult with a Health Alliance Medical Director if questions arise.

2.20 Providers who do not meet the Company’s criteria are reviewed by the Committee and either pended for additional information, approved for affiliation as a Participating Practitioner or denied as a Participating Practitioner. The Committee has final authority regarding the acceptance or rejection of all applications for providers subject to Credentialing. Applicants who are approved for affiliation will be notified in accordance with the CPS New Provider Education policy.

2.21 No members shall be assigned to a provider until their credentialing is complete.

2.22 Health Alliance shall notify the Department of Healthcare and Family Services (HFS) when the credentialing process is completed and provide the results of the process.

2.23 The following shall apply to all applicants who do not meet the criteria to become a Participating Practitioner:

• Any applicant who does not initially meet the criteria for approval as a Participating Practitioner may, in the Committee’s sole discretion, be reevaluated by the Committee according to this policy before notice is given to the applicant that he or she has not been accepted as a Participating Practitioner.
Policy and Procedure:
Application, Credentialing and Recredentialing of Participating Practitioners, continued

- In conducting its reevaluation of an application under this part, the Committee may consider any factors it deems relevant in making its recommendation regarding final approval or disapproval of an applicant.
- All additional information gathered by the Committee in this process will be maintained in the confidential file.
- The Committee will make a decision regarding the reevaluation of the applicant.
- Applicants who, after the reevaluation, do not meet criteria and are not accepted for affiliation as a Participating Practitioner are to be notified in writing by the Chairman of the Committee within five (5) business days following the Committee’s final decision.

2.24 If a provider marks “yes” to Practice and Health History, question Q, “Have you ever been convicted of a felony?” the Credentialing Department will perform a criminal background check.

2.25 Applicants have the right to be informed of the status of their application. This information may be requested via phone, fax, email or postal mail and will be responded to within three days by a Credentialing Coordinator in the same manner in which it was received. The Credentialing Coordinator may disclose the date the application was received by the Credentialing Department, any information needed to complete the application, any verifications requested but not yet received, and the date the provider’s application is scheduled to be reviewed. No information regarding peer reviews may be disclosed. Applicants shall be notified of this right in the cover letter accompanying the credentialing application.

3. Recredentialing Process

3.1 Four (4) months prior to the triennial anniversary date of all Participating Practitioners the Committee will recredential each Participating Practitioner. This applies to all practitioners except MD/DO/DCs, in Illinois. These providers will be recredentialed in accordance with the State of Illinois single recredentialing cycle.
- The Credentialing Coordinator will request a Health Care Professional Recredentialing and Business Data Gathering Form from all MD/DO/DCs, in Illinois and will send a renewal application to all other Participating Practitioners.

3.2 The Committee, or its designee(s), will obtain and review the following information from a primary source:
- A valid state license to practice in all states in which the provider sees members. Company staff will verify with the appropriate state licensing agencies that the license is active and in good standing.
- If applicable, Clinical privileges in good standing at the hospital designated by the practitioner as his or her primary admitting facility. Company Staff will verify clinical privileges via the hospital’s designated web service, signed/dated letter or telephone.
- A valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) certificate, from all states in which the provider sees members. The Participating Provider must provide a photocopy of licensure. Company staff will verify that one of the above is active and in good standing with the appropriate state licensing agencies, or appropriate verification service.
- Board certification, as applicable. Board certification status may be verified using one of the sources listed in Section 2.3.

3.3 Changes to languages, other than English and including American Sign Language, spoken by the practitioner or office staff

3.4 Current malpractice insurance in accordance with the amounts established by the Committee. A copy of the provider’s current malpractice insurance policy facesheet is to
be submitted. The facesheet must clearly state the name of the company, coverage dates and amount(s) of coverage, and covered entity.

3.5 Professional liability claims history. Participating Practitioner must submit written detailed information regarding past or pending claims for malpractice, whether or not submitted to their insurance carrier.

3.6 In addition, the Committee shall obtain a new statement from the Participating Practitioner regarding:
- Reason for any inability to perform the essential function of the position, with or without accommodation
- Lack of present illegal drug use
- History of suspension and/or revocation of any license
- History of felony convictions
- History of loss or limitations of privileges or disciplinary activity
- The Participating Practitioner must attest to the correctness and completeness of the information set forth in the application. Attestations must contain an original handwritten signature by the applicant. Signatures that are affixed by stamp, scanned or electronically or mechanically produced will not be accepted.

3.7 The Committee will document triennial requests for information and responses regarding the Participating Practitioner from recognized monitoring organizations.
- The Committee, or its designee(s), will query the National Practitioner Data Bank (NPDB).
- The Committee, or its designee(s), will request information regarding sanctions or limitations on licensure from the appropriate state licensing agencies or other appropriate verification service.
- NPDB also serves as confirmation that the Participating Practitioner has no Medicare or Medicaid Sanctions.

3.8 During the recredentialing or performance appraisal process for Primary Care Physicians (PCPs) the Committee will review data as described in the *Coordinate the Use of Quality Monitoring Information During the Recredentialing Process* policy.

3.9 Recredentialing files are available to the Committee if additional information is needed for review.

3.10 The renewal application and all information and materials submitted by the Participating Practitioner with the application, together with all information and materials received in response to requests for information by the Committee, or its designee(s) will be maintained in the strictest confidence. All information and materials relating to each applicant and his or her application shall be maintained in a confidential file for each Participating Practitioner. Access to this file will be restricted to the Committee, or individuals with the express approval of the Committee.

3.11 The Committee has final authority regarding the acceptance or rejection of all renewal applications. Denied applicants will be notified of the Committee’s decision in writing within 14 business days. Approved applicants will be notified via US mail within 5 business days of approval.

3.12 If a provider marks “yes” to Practice and Health History, question Q, “Have you ever been convicted of a felony?” the credentialing department will perform a criminal background check.

3.13 Recredentialing applicants are entitled to the rights outlined in Sections 2.14, 2.16 and 2.25. They are notified of these rights in the Provider Manual.
Policy and Procedure:
Application, Credentialing and Recredentialing of Participating Practitioners, continued

4. Documentation

4.1 In documenting verifications obtained during the credentialing and recredentialing processes, the following information is required:
   - Oral verifications – verifications taken over the phone must include a note stating the date the verification was completed, the first name or title of the person giving the verification, the information verified, and the initials of the Company staff member taking the verification.
   - Fax verifications – verifications accepted via facsimile must include the date the facsimile was received, the name or title of the person giving the verification, the information verified, and the initials of the Company staff member who received the verification.
   - Internet verifications – verifications obtained via website will include a print out of the verification screen and will be dated and initialed by the staff member who obtained it. If the verification is too large to print, the company staff member will note, on the document being verified, the date the verification was obtained, the status and expiration date, if applicable, of the document being verified, and the initials of the staff member. If the verification is not printed, the staff member will save the web page as an Adobe Acrobat document and affix a stamp to the document indicating time, date and recipient of the document.
   - Mailed verifications – verifications sent to the Company via mail will be initialed and dated by the person receiving the information.

4.2 All notations on documents must be completed either by computer generated date stamp or ink. Use of pencil on verifications is not permitted.

4.3 All information regarding provider demographics, education, licensure, specialty, and hospital affiliations is housed in a Visual Cactus database. Individual provider summaries and reports relating to credentialing providers are generated from this system. Visual Cactus is housed on a server in the Urbana office and technical support is provided by the Health Alliance Information Technology department with assistance from technical staff at Visual Cactus when needed.

4.4 Verification of applicable credentialing information should not occur, or be dated, more than 180 days prior to the Credentialing Committee’s decision.

5. Preparing Provider Files for Presentation to Credentialing Committee or Credentialing Committee Chair

5.1 After the steps outlined in Section 2 have been completed, the Credentialing Coordinator shall determine if the applicant meets Company criteria as defined in Criteria for Approval as a Participating Practitioner policy. If the applicant does meet Company criteria, the Credentialing Coordinator will print a Credentialing profile sheet and present it to the Credentialing Committee Chair, or his/her designee, for approval.

5.2 If the Applicant does not meet Company criteria, the Credentialing Coordinator will print a Credentialing profile sheet and copy all documentation relating to licensure actions, malpractice cases, hospital affiliation action, criminal history, or any other infractions. This documentation will be submitted to the Credentialing Committee for review at its bimonthly meeting.

5.3 After the steps outlined in Section 3 have been completed for a provider undergoing recredentialing, the Credentialing Coordinator adds the provider to the Recredentialing Checklist. The Recredentialing Checklist contains a summary of a provider’s board certification, malpractice history and quality program information. Any documentation related to the Checklist present in the provider file is copied and placed with the
Recredentialing Checklist. The Checklist and supporting documentation are submitted to the Credentialing Committee for review at the bimonthly meeting.

6. Credentialing Providers Who Have Terminated Participation

6.1 A provider who has terminated participation and is otherwise eligible to re-affiliate must complete the initial credentialing process unless they rejoin within thirty (30) days of the effective date of their termination.

6.2 If there are data elements in the provider’s original credentialing/recredentialing file that are less than six (6) months old and can be presented to the Committee prior to expiration, company staff does not have to recollect or re-verify those elements.

7. Updating Provider Information

7.1 When provider information stored in the Credentialing database (Visual Cactus) changes, the database must be updated within thirty (30) days of receipt.

7.2 Updates to provider demographic information that are received by the Credentialing Department are forwarded to Contracting and Provider Services.

7.3 Contracting and Provider Services generates an electronic update.

7.4 Credentialing receives the electronic update and amends the information in the Credentialing Database.

7.5 Information to be updated includes:
- provider demographic information
- hospital affiliation
- board status
- licenses
- specialties
Policy and Procedure: Criteria for Approval as a Participating Practitioner

PURPOSE OF THE POLICY
The purpose of this policy is to establish the procedures and professional criteria, which are to be followed in processing requests from practitioners to become Participating Practitioners and ensure that applications are complete, accurate and the process is completed in a timely manner.

STATEMENT OF THE POLICY
It is the policy of Health Alliance to maintain standardized, formal criteria for approval as a Participating Practitioner and to provide guidance to the Credentialing Committee (the Committee) in the exercise of its authority to accept or reject application of practitioners to become Participating Practitioners as delegated by Health Alliance Board of Directors.

APPLICABILITY
All practitioners seeking to become Participating Practitioners of Health Alliance in the state of Illinois and all other states in which Health Alliance is qualified to do business.

PROCEDURES
1. Applicants

1.1 Applicants will have (as applicable):
• Successfully completed professional education and training;
• A current, valid license;
• Clinical privileges in good standing at the hospital designated as the primary admitting facility or a referring relationship with an affiliated provider in the same or similar specialty
• Current, adequate malpractice insurance in amounts determined by the Company;
• A current, valid DEA certificate; and
• A current, valid Controlled Substances license.

1.2 Applicants must meet the following criteria. In the event that an applicant does not meet any or all of the following criteria, the Committee may consider other information or factors that it, in its sole discretion, considers pertinent in making its determination to accept the applicant as a Participating Practitioner.
Policy and Procedure: Criteria for Approval as a Participating Practitioner, continued

- Applicants will have had minimal professional liability claims or suits filed against him or her. The Committee will consider:
  - The number of cases (open and closed).
  - The nature of the cases (open and closed).
- Applicants will be physically and mentally able to practice in their profession, with or without accommodation, and have no impairment due to chemical dependency or substance abuse.
- Applicants will have no restrictions on any license to practice, no current disciplinary activity, or current loss or limitation of clinical/hospital privileges.
- Attainment of Board Certification is not itself a criterion, but may be taken into consideration by the Committee.
- Applicants will have no evidence of significant legal difficulties outside of the practice of medicine that may interfere with the ability of the Participating Practitioner to perform his or her duties under the agreement with Company (felony convictions, extensive civil litigation, etc.).
- Applicants must have no history of previous sanction activity by Medicare or Medicaid (if applicable).

1.3 The Committee may consider any other information and factors it deems relevant (such as membership in good standing of professional societies, complaints to professional societies, etc.) in making its decision.

1.4 The Committee has the right to approve new Participating Practitioners and sites. Subject to the Company’s general right to decide whether or not to renew a contract with any Participating Practitioner, the Committee has the duty to investigate matters brought to its attention it believes are relevant to a Participating Practitioner’s ability to perform his or her duties under the terms of their contract with the Company. In the event the Committee determines such facts exist with respect to a particular Participating Practitioner, the Committee may recommend to the Chief Executive Officer and the Chief Medical Officer that the contract between the Participating Practitioner and the Company not be renewed, be terminated, or the Participating Practitioner’s right to serve the Company’s members be suspended for a recommended period of time.

1.5 The Company does not make credentialing/recredentialing decisions based solely on an applicant’s race, ethnic/national identity, gender, age, sexual orientation, type of procedures the applicant specializes in, or types of patients the applicant specializes in. To ensure credentialing and recredentialing are conducted in a non-discriminatory manner, the Credentialing Committee will:
  - Submit a biannual report of all providers denied or terminated to the Quality Improvement Committee. The report will include demographic information and basic academic information about the provider and the reason for denial. If QIC determines a pattern of discrimination may exist, a referral will be made to the Compliance department.
  - Ensure that all members of the Committee have signed a non-discrimination statement.

1.6 Applicants that meet all of the Company’s criteria, have no history of malpractice or alleged malpractice, have no history of discipline on any license, have no history of discipline by any educational program, have no criminal history or alleged criminal history, have admitting privileges at an affiliated hospital, and meet the criteria for specialty designation, may be approved for affiliation by review of the Credentialing Committee Chair. In the absence of the Credentialing Committee chair, any physician member of the Credentialing Committee may approve providers for affiliation.

1.7 Company will not credential providers for participation in Federal health care programs if excluded pursuant to section 1128 or section 1128A of the Act.
Policy and Procedure: Criteria for Approval as a Participating Practitioner, continued

2. Specialty Designation

2.1 Applicants requesting specialty designation in the provider directory must hold board certification in that specialty or have completed a residency or fellowship in that specialty. Education / Board certification will be verified.

- Providers who respond on the credentialing application that they hold are qualified in multiple specialties may choose any of the specialties to be listed under in the Provider Directory. Board certification or education will be verified.

2.2 Primary Care Practitioner Designation

- Primary Care Practitioners are defined as physicians who provide primary care services (including family practice, general practice/medicine, internal/adult medicine, adolescent medicine and pediatrics) and manage routine health care needs. For women, an obstetrician/gynecologist may be considered a PCP.
- Nurse Practitioners and Physician Assistants may be designated as Primary Care Practitioners in limited situations. Those include:
  - Participation in government programs where medical midlevels are designated as PCP’s (i.e. Medicaid) and/or
  - Practice location in a medically underserved area.
- General Medicine / General Practice. Applicants who are not board certified or otherwise qualified to be listed in a specialty must be listed in the credentialing database and Provider Directory under General Medicine / General Practice if they are approved to become a participating provider.

2.3 Requested change of status from specialist to PCP

- If a practitioner has been previously credentialed as a specialist and requests a change in designation to that of PCP they must demonstrate the following:
  - Applicable education to support request, or;
  - Adequate coursework/CME hours to support request, or;
  - Document that greater than 50 percent of their practice is in providing PCP related services.
- Final determination for requested change is at the discretion of the Credentialing Committee.

2.4 PCP with specialty request

- Primary Care Physician who request to be listed also as a medical sub specialist, must provide one of the following sources of information to support the request:
  - Documentation of completion of fellowship in requested subspecialty;
  - Documentation of board certification
  - Documentation of completion of residency in requested subspecialty;
- Surgical specialties are not eligible to be PCPs
- Final determination for requested change is at the discretion of the Credentialing Committee

2.5 No credentialed provider may be designated in a provider directory in a specialty that has not been approved by the Credentialing Committee. In order to ensure accuracy between the specialty designation in the provider directory data and Visual Cactus (credentialing data), the Credentialing Manager will perform a monthly audit of new providers in the provider directory data. Credentialing Manager will confirm that specialty designation is correct. Any inconsistencies will be referred to the Regional Operations Manager for correction. Other data used in the online provider directory is pulled directly from the system of record. All systems that house provider directory data are subject to monthly audit processes established by the department responsible for data entry into the system.

2.6 No member shall be assigned to a PCP until credentialing process is completed.
3. **Use of Practitioner Performance Data**

3.1 Participating providers allow the plan to use practitioner performance data, including but not limited to, quality improvement activities and public reporting to consumers.

4. **Office Location Change**

4.1 A physician who has passed credentialing may change his/her office location within the Health Alliance networks subject to the approval by the Chairperson.

5. **Board Certification**

5.1 The Credentialing Committee encourages all participating providers to attain and maintain board certification in their specialty. For those providers who elect not to become board certified within five years of completion of residency training or let their board certification lapse, the following is required:
   - Completion of 50 hours of CME annually, in the area of the provider’s specialty.

5.2 The Credentialing Committee, or its designee, will request this information during processing of credentialing/credentialing application.

6. **High Volume & High Impact Specialty Determination**

6.1 Data regarding high volume specialists and high volume behavioral health practitioners is used by the Quality Management Department for a variety of activities. Annually, the Credentialing Manager requests a report to determine which specialists are high volume based on data from the preceding year.

6.2 The methodology used is based on claims data by volume for all provider types for a 12-month period.
   - High volume specialists for the most recent time period are: Cardiology, OB/GYN, and Orthopedics.
   - High volume Behavioral Health Providers are: Social Work, Psychiatry, and Psychology.

6.3 High impact specialists are defined as providers who treat specific conditions that have serious consequences for the member and require significant resources. High impact specialists are identified by Medical Directors annually.
   - High Impact Specialties are: Oncology.

7. **Assessment of Availability of Primary Care, High Volume Specialty Care, High Impact Specialty Care and High Volume Behavioral Healthcare Providers**

7.1 Annually, the Quality Improvement Committee assesses the supply of primary care, high volume specialty care and high volume behavioral healthcare providers in the network against geographic data and national physician supply numbers.

7.2 The goal for physician supply numbers is to exceed the minimum supply needed based on a data set supplied by a national vendor. The data set currently in use is from Solucient and federal mental health shortage designation criteria for mental health counselors.

7.3 The goal for geographic distribution is for no member to have to travel more than 30 miles or 30 minutes to see a primary care provider. The goal for high volume specialty and behavioral health care is for no member to travel more than 60 miles or 60 minutes to see a provider.

7.4 To assess the supply numbers, the Credentialing Manager requests a report from the Health Alliance Market Intelligence department. An analyst from this department collects
Policy and Procedure:
Criteria for Approval as a Participating Practitioner, continued

Health Alliance physician supply data from the Provider Directory and prepares the report comparing it against the national benchmarks.

7.5 To assess geographic distribution, the Contracting & Provider Services Director uses GeoAccess to map the distribution of Health Alliance providers.

7.6 All data is sent to the Credentialing Manager. The Credentialing Manager prepares a report summarizing all data to present to Quality Improvement Committee.

7.7 QIC reviews the data and makes recommendations to Contracting & Provider Services.
Midlevel Information

To ensure accurate and prompt claim reimbursements, Health Alliance requires all practitioner offices to submit information about certain midlevel providers in their practice (see list, page 2.34). Please complete and return the Midlevel Provider Data Form (located in Section 8 of this manual) for each new midlevel practitioner employed by your practice, and be sure to include copies of the:
  - midlevel practitioner’s state license
  - state controlled substance license
  - DEA registration certificate.

This information will be used by Health Alliance to verify the midlevel practitioner’s license. Please use the Provider Addition/Change Form (located in Section 8) to notify Health Alliance when a midlevel practitioner terminates employment.

Proper notification of midlevel practitioners will ensure timely payment of claims.

Midlevel supervision: By contracting with a physician, Health Alliance assumes the physician is the primary provider of medical care for members and therefore, should be present to see patients in the office at least 50% of the time the office is open. The Credentialing Committee must review exceptions to this requirement.

If you have any questions about requirements for midlevel credentialing, please contact a Health Alliance contract coordinator at 1-800-851-3379, extension 3445.

Proper Credentials Ensure Quality Health Care
Midlevel providers play an important role in providing care for our members, and we want Health Alliance members to receive appropriate, high-quality health care from certified or licensed midlevels.

We only reimburse claims submitted by contracted midlevel providers with valid and current state licensure. If you are a member of a contracted group practice, and a claim reimbursement is disallowed because these requirements are not met, by contract you cannot bill an HMO member.

Midlevel Service Billing Clarification
When billing for services provided by a midlevel, please use his or her provider number. Health Alliance does not need the supervising physician’s provider number as long as the midlevel’s provider number is given. When a new midlevel joins your office, please be sure to complete and return the Provider Addition/Change Form and Midlevel Provider Data Form located in Section 8. Billing for services provided by an individual delivering care outside their scope of practice is considered fraudulent billing and subject to recovery, termination of contract and prosecution to the full extent of the law.

If the midlevel type is not listed on page 2.34, then it’s necessary to complete the credentialing process outlined in the policies and procedures included in this section.
PURPOSE OF THE POLICY

To define which midlevel provider types Health Alliance recognizes for network participation.

STATEMENT OF THE POLICY

It is the policy of Health Alliance to only allow midlevel providers who hold a valid license or certification in their profession to provide services to members. The Credentialing department verifies such licensure or certification in accordance with Verification of Licensure of Midlevel Providers policy and procedure.

PROCEDURES

1. Mental Health Midlevel Provider (must be credentialed)

1.1 Clinical Professional Counselor
   - LCPC, Licensed Clinical Prof. Counselor
   - LPC, Licensed Professional Counselor
   - LC, Licensed Counselor
   - LMHC, Licensed Mental Health Counselor (IA)
   - LP, Licensed Psychologist (IA)
   - LCPC, Licensed Clinical Professional Counselor

1.2 Social Worker
   - LCSW, Licensed Clinical Social Worker
   - LSW, Licensed Social Worker
   - LISW, Licensed Independent S.W. (Iowa)
   - LMSW, Licensed Masters S.W. (Iowa)
   - LBSW, Licensed Bachelors S.W. (Iowa)

1.3 Marriage/Family Therapist
   - LMFT, Licensed Marriage Family Therapist
   - LMFC, Licensed Marriage Family Counselor
   - NP, PA, APN, PA-C with a specialty in mental health

1.4 Autism
   - BCBA Board Certified Behavioral Analyst (must have Master’s Degree, be certified by the Behavioral Analysts Certification Board and have completed 225 graduate classroom hours.)
Midlevel Information, continued

- BCaBA – Board Certified Assistant Behavioral Analyst (must have Bachelor’s Degree, be certified by The Behavioral Analysts Certification Board and have completed 135 classroom hours)

1.5 For those Behavioral Health mid-levels that do not have a Medicaid ID#, the following must be completed:
- Complete Medicaid Application
- Submit completed application to Provider Relations Specialist with copy of Behavioral Health license.
- Provider Relations Specialist forwards application to RPNM or CPS Director to submit application to HFS for processing.

2. Medical Midlevel Provider

2.1 Nurse Practitioner/Physician Assistant
- PA, PA-C, Physician Assistant
- APN, Advanced Practice Nurse
- APRN, Advanced Practice Registered Nurse
- ARNP, Advanced Registered Nurse Practitioner
- CFNP, Certified Family Nurse Practitioner
- CGNP, Certified Geriatric Nurse Practitioner
- CNP, Certified Nurse Practitioner
- CNS, Clinical Nurse Specialist
- CPNP, Certified Pediatric Nurse Practitioner
- CRNA, Certified Registered Nurse Anesthetist
- FNP, Family Nurse Practitioner
- FNPC, Family Nurse Practitioner, Certified

2.2 Nurse Practitioner
- NP, Nurse Practitioner
- RNFA, Registered Nurse First Assistant
- RNP, Registered Nurse Practitioner

2.3 Nurse Midwife
- CNM, Nurse Midwife

3. Ancillary Midlevel Providers

3.1 Physical Therapist
- PT, Physical Therapist
- RPT, Registered Physical Therapist
- LPT, Licensed Physical Therapist

3.2 Occupational Therapist
- OT, Occupational Therapist
- OTRL, Occupational Therapy, Registered License

3.3 Speech Therapist
- ST, Speech Therapist
- SP, Speech Pathologist
- SLP-CCC, Speech Language Pathologist

3.4 Audiologist
- CCC-A

3.5 Dietitian
- RD, Registered Dietitian
- LD, Licensed Dietitian
- LNC, Licensed Nutrition Counselor
Policy and Procedure: Provider Administrative Complaint and Grievance Procedure

PURPOSE OF THE POLICY

Health Alliance is committed to promoting satisfaction among its participating providers in the delivery of covered services to members pursuant to the terms of the Participating Provider Agreement. It is the purpose of this policy to describe the means through which participating providers can file a complaint and, if necessary, a grievance with Health Alliance regarding an administrative issue.

A separate Policy and Procedure currently exists for provider grievances related to medical necessity determination made by Health Alliance Quality Management Department. (That process is found in the Provider Manual under Complaints and Appeals procedure.)

STATEMENT OF THE POLICY

- This Policy describes the exclusive method for resolving claim disputes, contract disputes, or other administrative issues related to the Provider’s participation with Health Alliance.
- This Policy shall only apply to the resolution of complaints that are subject to the Plan’s control.
- Any inquiry concerning a complaint must be commenced within (30) thirty days from the date of the action causing the complaint.

DEFINITIONS

- **Complaint** – any written expression of concern or dissatisfaction from a provider regarding the administration of a Plan service. This does not include complaints and appeals, which are related to medical necessity determination, which are handled by the Plan’s Quality Management Department.
- **Grievance** – any complaint which cannot be resolved to the Provider’s satisfaction within the complaint system, and which has been brought to the grievance level for further action.
- **Provider Administrative Review Committee (PARC)** – the Committee made up of the Executive Director of CPS, the VP of Operations, the COO, the CMO, the Vice President of Legal and the CFO of Health Alliance. This Committee reviews any Provider Administrative grievances, and communicates a final decision to the Provider.
**Policy and Procedure:**

**Provider Administrative Complaint and Grievance Procedure, continued**

**PROCEDURES**

1. **Inquiry**

   1.1 The Provider should call the Contracting and Provider Services Department (CPS) or Customer Service (CS) to discuss any question or concerns with a Provider Relations Specialist (PRS), a Customer Service Representative (CS), or a Provider Service Coordinator (PSC). The PRS, CS, or PSC can respond to most routine inquiries during the discussion or soon thereafter. If they cannot respond immediately, they will investigate and respond to the inquiry within (5) five working days after the date of the inquiry.

2. **Complaint**

   2.1 If not satisfied with the response to an inquiry, Provider may submit a written complaint using the **Provider Greivance Form**, or submit a letter addressing the complaint to the Provider Relations Specialists within (30) thirty calendar days after the date of that response. The PRS will respond in writing to the Provider within (30) thirty working days from the date of the receipt of the written complaint. The Provider may bypass the inquiry, and submit a written complaint directly.

3. **Grievance**

   3.1 If the Provider is not satisfied with the response to a Complaint, Providers may request that it now be considered a Grievance, and be acted upon by the Provider Administrative Review Committee (PARC). A written request for Provider Administrative Review Committee consideration should be submitted to the Director of Provider Services (CPS) within (15) working days after the Provider receives a response on their Complaint. The Grievance should include all necessary documentation for the PARC to render a decision. The Director of Provider Services will convene a meeting of the PARC. (If the nature of the grievance has to do with Medicare Advantage, the Executive Director of CPS may include the Director of Medicare in all discussions). This Committee will meet and render a decision on the Provider Grievance within (30) thirty days of the receipt of the Grievance. The Director of Provider Services will communicate the Committee’s decision in writing to the Provider within (10) ten days of the Committee’s decision.

4. **Arbitration**

   4.1 If a Provider is dissatisfied with the decision of the PARC, the next step would be the Arbitration Process, as described in the Provider Agreement.
Provider Grievance Form

I. Name of Provider: _____________________________________________________________
   A. Provider Address: __________________________________________________________
   B. Provider Phone #: __________________________________________________________

II. Procedure: By signing this form, I represent that I have discussed my Complaint with the Plan’s Provider Relations Specialist, and have been unable to resolve the Complaint. I hereby request that the attached Grievance be submitted to the Director of Client and Provider Services for prompt consideration. I understand that I can expect a response within 45 days.

III. Nature of the Grievance:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Director of Contracting and Provider Services

__________________________________________________________________________

Provider Signature

__________________________________________________________________________

Date
Resolution of Disputes

Disputes between Health Alliance and a provider about actual terms of contracts that are not resolved within 90 days, the period of good faith dispute resolution, can be settled through binding arbitration.

Both parties have 120 days after the written notice of arbitration to gather all information needed to resolve the issue. This information includes the business records, patient care and billing records or depositions relevant to the dispute. The arbitration proceedings will be completed no more than 180 days after written notice of arbitration. The arbitration will be held in Urbana, Illinois, or other location as long as all other parties agree. Once the arbitrator reaches a decision, no punitive damages will be awarded and the losing party will be responsible for all costs and fees of the arbitration proceeding.
Risk Adjustment Coding and Documentation

Health Alliance is participating in the Illinois Insurance Marketplace, overseen by the U.S. Health and Human Services Department (HHS). Payment from the State to Health Alliance for members covered under private and public exchange plans is based on risk adjustment methodology that reimburses health plans based on the health status of the individual enrollee. The risk of the individual enrollee is determined by the diagnosis codes included on the claims submitted to Health Alliance from risk adjustment-approved providers and facilities throughout the calendar year and then passed to the State.

The risk adjustment model will closely match that of the Medicare model, with the addition of diagnosis classifications for enrollees of non-Medicare age. The conditions in the HHS Hierarchical Condition Categories (HHS-HCC) will represent conditions that are classifiable as higher-cost conditions in the disease burden among the population in the exchanges. HHS sees the member with International Classification of Disease, Tenth Revision, Clinical Modification (ICD-10-CM) codes in the HHS-HCC model as sicker than the “average” member, resulting in higher reimbursement from CMS. In this program, we are reimbursed by diagnosis code, not Current Procedural Terminology (CPT) codes.

The Provider role in this process is to submit medical record documentation that is clear, concise, consistent, complete and legible. All diagnoses, supported in the medical record documentation for each encounter, must be submitted on the claim. To that end, Health Alliance is placing an increased emphasis on provider education and recommendations related to HHS-HCCs, diagnosis coding and documentation regulations.

HHS-HCCs are given a severity ranking, the higher the medical risk to the patient, the higher the ranking. It is important to follow normal coding practices, but specificity is of utmost importance, and all diagnosis codes that apply to a particular visit must be documented. The medical record documentation must support the diagnosis that was assigned within the correct data collection period by an appropriate provider type (provider visit, hospital inpatient or hospital outpatient) and an acceptable physician data source as defined in the HHS instructions. In addition, the diagnosis must be coded according to ICD-10-CM Guidelines for Coding and Reporting.
Risk adjustment data validation (RADV) is a process of verifying that diagnosis codes submitted for payment by the health plan are supported by participating provider medical record documentation for an enrollee. The primary goals of HHS through RADV are to identify discrepancies, measure accuracy and the impact of potential discrepancies, improve and inform plans of the quality of their risk adjustment process. HHS instated a six-stage annual data validation process for the Commercial Marketplaces on behalf of the States.

**Step 1:** A sample selection of Members will be reviewed by an Independent Data Validation Auditor (IVA) engaged by Health Plan.

**Step 2:** The initial validation audit is performed.

**Step 3:** A second validation audit is performed by data validation Contractors engaged by CMS.

**Step 4:** An error estimation is done.

**Step 5:** Health plans have the opportunity to appeal.

**Step 6:** Payments and adjustments.

Health Alliance is required to retrieve and provide medical records to the IVA in a short window of time. As a participating provider it is mandatory that your staff provides medical records as request by the deadline provided in our correspondence to accomplish step 1 in the process above.
As a local health plan providing coverage to enrollees in our community, Health Alliance is committed to maintaining affordable premiums and quality care. Correct diagnosis coding is critical to ensure we have an accurate assessment of the health status of and expected level of care for our membership. Our Risk Adjustment Revenue efforts include financial accounting, reconciliation and analysis, certified coding consulting and analytics, advanced practitioner visits and complex case management to monitor ongoing issues related to our members’ needs where their chronic conditions are concerned.

In a sense, Health Alliance has brought the return of the house call for targeted members by sending mid-level practitioners into members’ homes for comprehensive Health Risk Assessment (HRA) and complex case management. These assessments are then provided to the primary care physicians and Health Alliance’s Medical Management Department to assist in care coordination.

Health Alliance regularly performs provider medical record reviews to ensure correct diagnosis coding compared to codes submitted on claims. As such, our coding team requests electronic or paper copies of medical records for our members that can be provided on a flash drive, CD, via secured email, remote or on-site access to EMR systems, paper for pick up, delivery, or through fax. Coding analysts may also need onsite visits to review members’ medical records. The information provided should include, but should not be limited to:

- Face sheet
- History and physical exams
- Physician orders
- Progress notes
- Operative and pathology reports
- Consultation reports
- Diagnostic reports
- Discharge summaries


Please note: claims data found to not be supported by medical records could be subject to a delay in reimbursement, as applicable.
Section 3

Members’ Rights and Responsibilities
Members’ Rights and Responsibilities

Rights
- A right to receive information about Health Alliance, its services, its contracted providers and members’ rights and responsibilities
- A right to be treated with respect and recognition of your dignity and right to privacy
- A right to participate with contracted providers in making decisions about your health care
- A right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage
- A right to voice complaints or appeals about Health Alliance or the care provided
- A right to make recommendations regarding Health Alliance members’ rights and responsibilities policy
- A right to reasonable access to health care

Responsibilities
- A responsibility to supply information (to the extent possible) that Health Alliance and its contracted providers need in order to provide care
- A responsibility to follow plans and instructions for care that you have agreed on with your providers
- A responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible
- A responsibility to read and understand your Subscription Certificate or Policy and any attached riders or amendments and follow the rules of membership
- A responsibility to know the providers in your network
- A responsibility to notify Health Alliance in a timely manner of any changes in your status as a member or that of any of your covered dependents
Complaints and Appeals Procedure

Health Alliance is committed to promoting member satisfaction. Members in the HMO, PPO, POS and self-funded plans/products have specific complaint and appeal procedures which they may follow should they encounter a problem or concern which is not resolved to their satisfaction through routine contact with providers or Health Alliance staff.

There may be instances when it is necessary for Health Alliance to contact physicians or other providers to investigate member concerns. It is essential that any requests for information are responded to quickly and accurately to ensure response to members within the required time frames.

If a member has a complaint or concern regarding their health benefits, please encourage the member to contact the Health Alliance Customer Service Department.

COMPLAINTS
If you have a question or complaint regarding any administrative process, benefit or claims payment, call your Provider Relations Specialist at 1-800-851-3379 or write:

Provider Relations
Health Alliance Medical Plans, Inc.
301 S. Vine St.
Urbana, IL 61801

Your Provider Relations Specialist will respond to your question or complaint expeditiously.

APPEALS
With permission from your Health Alliance covered patient, you may appeal a decision made by Health Alliance on any issue with respect to this member. The appeals process varies by type of appeal—medically related versus non-medically related. Medically related appeals concern a prospective or retrospective denial of coverage due to the treatment or service not meeting the Health Alliance medical necessity requirements. Non-medically related appeals encompass eligibility, benefit coverage and/or procedural issues.

MEDICALLY RELATED APPEALS

Internal Review: Medically related appeals have two levels of review. The first is an internal review by a clinical peer not involved in the original denial of a coverage decision. Once we have obtained all the information necessary to review an appeal, we have 30 days for preservice and 60 days post-service to make a decision. Information used in the internal review may include medical records, a written statement from you supporting the treatment or service for the member and, if applicable, copies of research articles or references you are using to recommend treatment. You and the member will be notified of the results of the internal review by mail and by phone.

External Review: If you or the member are not satisfied with the outcome of the internal clinical peer review, either party may request the second level of review—review by an external review organization (ERO) within four months after receipt of written notice of the adverse determination. This request is made to Health Alliance or the Illinois Department of Insurance, depending on the type of plan. All parties involved in the appeal will be given the external review process and how to file in the adverse appeal letter. The cost of the review is free to the member or provider. Upon notice of decision from the ERO, all parties will be informed of the outcome. If approved, coverage will be immediately provided.

Expedited Review: If you feel a review is urgent, please contact Member Relations at 1-800-500-3373. A decision will be rendered within 24–72 hours depending on the member’s plan type.

NON-MEDICALLY RELATED APPEALS
Non-medically related appeals will be reviewed by the administrative personnel who are trained to assess coverage of benefit issues within 30 days for pre-service and 60 days for post-service. You will be notified of the decision of this review by mail. These appeals are not reviewed by external review organizations.
Complaints and Appeals Procedure, continued

**NON-RETAIATION**
We will not retaliate against you for advocating appropriate health care services for your patients. Your participation in the appeals process fosters good physician-patient relationships — a partnership we encourage.

Please call your Provider Relations Specialist or the Health Alliance Member Relations Department at 1-800-500-3373 with any questions about the appeals process.
Section 4

Medical Management
Medical Management Department

STRUCTURE AND ACCOUNTABILITY
Health Alliance has a comprehensive Medical Management Program administered by the Medical Management Department. The Health Alliance Utilization Management Coordinators and Case Managers are accountable for the activities outlined in the Program Scope and Processes. These individuals work directly with Primary Care Physicians, Specialists and other providers in the Health Alliance provider network who are responsible for coordinating the care of our members. The Chief Medical Officer (CMO) is the senior physician responsible for the activities of the Medical Management Department. Selected physician Medical Directors provide direct utilization management as well as oversight for utilization and case management plan-wide. Local physician Medical Directors conduct utilization management activities including preauthorization, inpatient care management and medical necessity reviews pertinent to their service areas. All Medical Directors report to the CMO. Utilization activities are reviewed and discussed at the Medical Directors’ Committee.

PURPOSE
The Medical Management Department is committed to ensuring that the care delivered to our members is of the highest value (Value = (Quality + Service)/Cost). Health Alliance is committed to providing members with efficient, cost-effective and quality health care coverage. Health Alliance employees never encourage decisions that result in underutilization of care. We do not give financial inducements or set quotas for issuing denials of coverage or care; nor do we keep statistics identifying individual providers and their denial rates. Utilization decisions made by our Medical Directors, Utilization Management Nurses, Pharmacy Coordinators and Pharmacists are based only on appropriateness of care and service and the existence of coverage. There are no incentives, financial or otherwise, to encourage barriers to care and services.

CRITERIA
The Utilization Management Coordinators respond to coverage requests by obtaining all necessary clinical information, researching benefit plan descriptions and applying established medical necessity criteria. The MMD uses clinical guidelines from nationally respected vendors, such as InterQual, which are based on best practice, clinical data and medical literature. Where vendor guidelines are incomplete or absent, internal medical policies are developed by the Medical Directors Committee. Medical Technology reviews are performed on new technologies to ensure we are staying current with the latest standards of care. Interqual and Health Alliance medical policies are available on our website at at YourHealthAlliance.org for providers. You may request a paper copy of any Health Alliance medical or behavioral health criteria by calling your Provider Relations Specialist.

Medical necessity reviews beyond the scope of current coverage criteria are referred to a Medical Director, who is then accountable for review and determination of coverage. Decisions made using any criteria are based on each member’s clinical status and assessment of the local delivery system.

PROGRAM SCOPE AND PROCESSES
The following are the Medical Management activities and processes that encompass the Utilization Management and Personal Health Coordination Programs. Each case is evaluated, and the established medical criteria appropriate to each case are applied. Individual patient circumstances and the capacity of the practitioner and provider delivery systems are considered. This includes the consideration of alternate settings when needed. Factors such as age, co-morbidities, complications, progress of treatment, psychosocial situations, and home environment (when applicable) are factors that are reviewed when applying criteria.
A. Preauthorization Review

Preauthorization is a screening review process to ensure the medical necessity of selected services. This review provides for an enhanced matching of patient need with medical necessity and the appropriateness of the location of service. Medical Management Coordinators perform the preauthorization function, and any request that falls outside the approved guidelines is forwarded to a Medical Director for review and coverage determination. Preauthorization occurs prior to the delivery of service, and is subdivided into four categories:

- Screening of selected elective services (e.g., inpatient rehabilitation facility or a skilled nursing facility);
- Screening of selected procedures/diagnostic testing based on internal and external data showing significant practice variation;
- Screening of all physician referral requests to out of network and tertiary specialists, based on patient need and availability of service in the primary network for plans with only in-network benefits; and for plans with out of network benefits if the member is requesting in-network coverage.
- Screening of requests for other medical services, such as home care, durable medical equipment, or other specified services, to ensure clinical appropriateness.

For patients admitted and discharged during non-business hours, retrospective review will be performed if notification and clinical information are received within 10 business days post discharge. Please note the following:

- If no medical information is received after admission notification is received or through concurrent review efforts, the Inpatient Case Manager (ICM) will make two good-faith calls to the facility. Upon the second call, the ICM will advise that no coverage will be granted for continued stay until clinical information is received.
- If a claim is submitted for an inpatient stay in which no admission notification was received, the claim will be disallowed. You can submit an appeal provided inaccurate insurance information was presented by the member upon admission along with medical documentation for review. Retrospective review will not be granted for any other reason.
- Members will be held harmless in all instances in which the facility/provider did not comply with the Health Alliance policy and procedures outlined in facility/provider contract.

B. Inpatient Care Review (ICR) for Medical, Surgical, and Behavioral Health Care Admissions

Inpatient Care Review is a process conducted by assigned Inpatient Case Managers and Medical Directors to assess the need for continued inpatient care for a member who has been admitted to a hospital, skilled nursing facility (SNF), acute inpatient stay in behavioral health care facility, or physical rehabilitation facility. A medical review is required each business day for inpatient hospital stays. This review is performed to determine if the level of care continues to be medically appropriate or if care can be transitioned to a lower level of care.

Inpatient Care Review is conducted within one (1) business day of being notified of the admission so the necessity of an admission can be determined and concurrent review can be initiated. Notification of admission is required within 24 hours or the next business day.

Inpatient Care Review is a process conducted by assigned Inpatient Case Managers and Medical Directors to assess the need for continued inpatient care for a member who has been admitted to a hospital, skilled nursing facility (SNF), acute inpatient stay in behavioral health care facility, or physical rehabilitation facility. A medical review is required each business day for inpatient hospital stays. This review is performed to determine if the level of care continues to be medically appropriate or if care can be transitioned to a lower level of care.

Coordinators provide Inpatient Case Management through a variety of activities. They meet with assigned Health Alliance Medical Directors daily to discuss hospitalized patients. This is done formally in census meetings and informally as needed. During these meetings, complex cases are discussed, potential referrals to Personal Health Coordination are identified and variances (medically unnecessary days) are assigned by the Medical Director.

When indicated, the Medical Director contacts the attending physician to discuss the medical necessity of an inpatient stay, and/or the appropriate disposition, i.e., transfers, SNF, sub-acute care, and home care. Questionable Behavioral Health inpatient reviews are reviewed by a Medical Director that is a board certified adolescent and adult psychiatrist. Health Alliance also has a contract with an external review company, Prest & Associates. Prest offers immediate access to Behavioral Health providers who are able to perform clinical reviews and provide an opinion regarding medical necessity. When Prest is consulted, a Local Medical Director makes the final coverage decision after reviewing the recommendations of the Prest reviewer. Potential medical quality of care issues and sentinel events are identified and forwarded to the Quality Management Department.
Discharge Planning and coordination of care by the Inpatient Case Manager begins upon admission. Individual reviews are performed to analyze each case for special needs and to consider availability of local health care resources. The Nurse Coordinator and the facility discharge planner work with the attending physician to ensure the member receives care at the most appropriate level. When warranted, the Inpatient Case Manager meets with the patient and family members as early in the hospital stay as appropriate to discuss potential health care needs and coverage (this may not be indicated for short uncomplicated hospitalizations). If the member has complex issues or health care needs, they are referred for Personal Health Coordination for evaluation and potential enrollment.

In circumstances where the member’s benefits have been exhausted but medical needs still exist, the Case Manager will assist the member by providing information about other resources. This may mean informing the member or family about ways to obtain continued care through other sources such as community and government agencies. A referral to Personal Health Coordination is also made.

C. Behavioral Health
The behavioral health components of the UM program are limited to inpatient review, out-of-network referral review, and selecting and updating medical necessity criteria. Behavioral health practitioners are involved in the UM program in a variety of ways. Practitioner involvement includes a Medical Director that is board certified in adolescent and adult psychiatry, consultation with practicing psychiatrists and addiction medicine physicians associated with Carle Physician Group and with Prest & Associates’ affiliated Behavioral Health practitioners.

Input from behavioral health physicians is solicited and considered when new behavioral health criteria are selected, as well as when substantive changes to existing criteria have been made. A psychiatrist is also a member of the Medical Policy Committee, a committee comprised of actively practicing practitioners that reviews all of Health Alliance’s UM criteria, annual updates to the criteria, policies for applying the criteria and technology assessments.

DENIAL OF CERTIFICATION AND APPEAL PROCEDURE
If the requested or received service does not fall within the scope of the approved Medical Management Department criteria, the case is referred to a Medical Director for review. The Medical Director reviews all the medical information to make a coverage determination; additional information is requested if needed. The Medical Director may contact the requesting physician to discuss the case further. When necessary, the Medical Director confers with a specialist. After review of the case facts, the Medical Director makes a coverage determination of approval or denial, using his/her medical judgment, experience, and skill, as well as professionally recognized medical standards for treatment.

For all denials the member, the member’s representative and the requesting practitioner are notified in writing of the determination. The denial notice includes the rationale for the denial, the criteria used to make the determination, the appeal process and instructions on how the practitioner can contact the Medical Director to discuss the denial. The practitioner may also contact (217) 337-8061.

Requests for benefits that clearly fall outside the member’s benefit package may be denied by the Utilization Management Coordinator. Any denial decisions for services that are, or that could be considered, covered benefits are determined by the Medical Director as previously described.

All appeals are forwarded to the Member Relations Staff for processing and resolution. (See Complaints and Appeals in Section 3 of this manual.)

TURNAROUND TIME FRAMES FOR COVERAGE REQUESTS
The time frames explained below are our goals for notifying you of coverage decisions. Medical Management adheres to the Department of Labor (DOL) and DOI/state regulatory requirements and takes into account the medical urgency of each member’s condition. Please note that additional time (within DOL and DOI/state maximum time frames) will be taken if needed to perform a comprehensive review. DOL and DOI/state requirements are listed at the end of this section.

Standard (nonurgent) preservice requests: Our goal is to provide coverage decisions within five (5) business days of receiving a complete request that contains all the necessary medical documentation. Requests received after 4 p.m. Monday through Friday or on weekends or holidays are considered received on the next business day.
**Medical Management Department, continued**

**Urgent preservice requests:** Our goal is to provide coverage decisions within one (1) business day of receiving a complete request. Please mark requests “urgent” only when there is an urgent medical need to receive the services within the shortened time frame. “Urgent” should not be used for scheduling conveniences. Marking requests “urgent” that are not truly urgent results in processing delays for all requests. Urgent care is defined as any request for care or treatment with respect to which the application of the nonurgent time period for making a determination could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function, based on a prudent layperson’s judgment, OR in the opinion of a practitioner with knowledge of the member’s medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. Emergency services are reviewed retrospectively for medical necessity.

**Please submit complete requests.** A complete request includes an online Health Alliance request form with all pertinent sections filled in and a completed Clear Coverage Request and supporting documentation from the medical record. Please refer to the preauthorization list for the member’s plan to determine which requests always require supporting documentation. Supporting documentation is always helpful and necessary in making coverage decisions. If you submit inadequate information, the review will take longer to complete and your answer will be delayed. In some cases, we may have to initiate a review extension by sending you a letter explaining what specific information is needed and the time frame for the extension; the Health Alliance member will also receive a copy of this letter. Once the information is received or the extension period is exhausted (whichever occurs first), we will complete the review and notify you of the coverage decision within 15 days (standard request) or 48 hours (urgent request).

You can greatly impact the time it takes for a review to be completed by supplying complete medical information when submitting a request for coverage and by promptly responding to requests for additional information should the original request be missing something.

**DEPARTMENT OF LABOR MAXIMUM TIME FRAMES**

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>Initial Time frame (starts from date of initial request)</th>
<th>Extension Period</th>
<th>Second Time frame (starts when information received or extension expires)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preservice (nonurgent)</td>
<td>15 calendar days</td>
<td>45 calendar days</td>
<td>15 calendar days</td>
</tr>
<tr>
<td>Preservice (urgent)</td>
<td>72 hours</td>
<td>48 hours</td>
<td>48 hours</td>
</tr>
<tr>
<td>Retrospective</td>
<td>30 calendar days</td>
<td>45 calendar days</td>
<td>15 calendar days</td>
</tr>
</tbody>
</table>

**CASE MANAGEMENT PROGRAM**

The Case Management program is telephonic and conducted on an outpatient basis. Case Management integrates the health team by including the member, the family, physician and ancillary providers in conjunction with the Health Plan. A team effort between all the involved parties allows for better continuity, consistent treatment plan and transition of care from one level to another when indicated. Case Managers assess, coordinate and authorize services for identified high-risk members. This coordination of care includes efforts to identify opportunities for cost-effective treatment while maintaining or improving the quality of services available under the member’s plan. The careful monitoring of these members alerts the Case Manager to changes in health status and allows for proactive communication with the primary care physician or treating physician to provide early intervention, if warranted.

Potential candidates for Case Management are identified in various ways, including predictive modeling software reports, referral from a disease management program, the inpatient care review process and other utilization management activities. Case Management referrals are also accepted from members, their families, discharge planners, practitioners, providers involved in a member’s care and telephone advisory lines. Once identified, members are contacted and given the opportunity to participate in the program.

Case Managers use evidence-based clinical assessment tools to identify gaps and barriers to care and develop a plan of care specific to the member’s health status, taking into account the individual’s specific needs and goals.
A. Case Managers

The Case Management program focuses on assisting with coordination of services to ensure the member is receiving the right care, at the right time and right place. This includes acting as a liaison with multiple care providers, members and family. Another focus is educating members on their disease process and lifestyle changes that could impact or slow down the progression of their disease. The Case Management program includes, but is not limited to, the following conditions, diseases or high-risk groups:

- Acute myocardial infarction
- Cancer
- Diabetes
- Transplants
- Cardiac and/or lung disease
- Congestive heart failure
- Kidney failure/end-stage renal disease
- Multiple/repeat admissions
- Multiple chronic illnesses or chronic illnesses that result in high utilization
- Neurological syndromes
- Pediatric anomalies
- Traumas
- Wounds

Case Managers work with the member to develop an individualized Case Management plan including:

- Prioritized goals
- Identification of barriers to meeting goals, participating in or complying with the plan
- The development and communication of member self-management plans
- The development of a schedule for member follow-up and re-evaluation timeframes
- An assessment of the member’s progress toward overcoming barriers to care and meeting treatment goals
- Elicit the involvement of the member, family member, caregiver and/or providers in problem identification and prioritization, as needed
- Provide education related to specific conditions or disease states, health maintenance and prevention
- Explore community resources available to the member
- Encourage member to communicate changes in condition with the attending physician
- Provide guidance to members and families in phases of adjustment to acute, chronic or terminal illness
- Maintain communication with the member and/or family to assure that the member understands, and is benefiting from, the care being received
- Advise attending physician(s) of any significant status changes

B. Quality Program

The Medical Management Department collects and analyzes data in support of the Quality Management Program for the following initiatives: Case Management outcomes, continuity and coordination of care, quality of care and patient safety.

SATISFACTION SURVEY

On an annual basis, Health Alliance surveys a sample of our providers to evaluate your satisfaction with our Medical Management processes such as inpatient care coordination, case management, preauthorization, referral review, timeliness of decision making and communication. The results are analyzed for ways we can improve provider satisfaction. Your participation is greatly appreciated.

HOW TO GET MORE INFORMATION

If you have questions about the status of a review or other Medical Management processes or would like to refer a member to our program, call Health Alliance Monday-Friday, 8 a.m. to 5 p.m., at 1-800-851-3379. After normal business hours, you may leave a message at this number, and it will be returned the next business day. You can also send questions via fax at any time to (217) 337-8440.

Please see Section 8, Forms, for samples of required medical management forms.
Request Preauthorization through YourHealthAlliance.org

You can request preauthorization on YourHealthAlliance.org for providers.

1. Log in and click the Request Preauthorizations tab.
2. Check to see if your procedure requires preauthorization and if you should submit it through Clear Coverage or the forms on YourHealthAlliance.org.
3. If you should submit your preauthorization through Clear Coverage, continue to their website.
4. If you should submit your preauthorization through our online forms, choose the type of procedure it is: durable medical supplies, pharmacy or medical.
5. Fill out that form and attach any necessary documentation, and submit.

Instructions for using Clear Coverage and these forms are posted on YourHealthAlliance.org’s Forms and Resources section under “YourHealthAlliance.org Provider and Office Personnel Guide.”

Requests that don’t qualify for immediate approval are pended for review. If the request is for urgent care*, the review is completed within 24 hours if all requested information is received. All other types of requests and submission are processed within five to seven days if all information is received with the request. If you prefer, you can continue to send preauthorization requests via fax.

- Urgent care means medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the patient’s life/health or the patient’s ability to regain maximum function, or in the opinion of the attending or consulting physician, would subject the patient to severe pain that could not be adequately managed without the requested care or treatment.

You can request access to YourHealthAlliance.org for providers and office personnel by visiting YourHealthAlliance.org and creating an account for your role.

You can always request preauthorization over the phone by calling the Health Alliance quality medical management department at 1-800-851-3379, extension 8061.

If you have questions about the preauthorization process or any of the methods available to submit a preauthorization request, please contact your provider relations specialist.
Section 5

Quality Management
Quality Management

The Quality and Medical Management (QMM) Program integrates the primary functions of Quality, Medical Management and Pharmacy. These departments work in tandem to establish, coordinate and execute a structure to support Health Alliance members/enrollees as they work to improve their health and assess and evaluate the care and service provided. Note: the following are used interchangeably throughout the document; Health Alliance and Health Alliance Medical Plans; and case and care management.

DEFINITION OF QUALITY

- Clinical quality is defined as minimum variation from evidence-based practice or expert consensus.
- Service quality is defined as meeting or exceeding the valid service requirements of our customers.

PURPOSE

Quality Improvement (QI) at Health Alliance is an integrative process of continuous assessment and monitoring that strives to improve care and service provided to Health Alliance members/enrollees for all products. Activities are monitored according to a variety of quality indicators and regulatory requirements as outlined in the annual QI Plan. These indicators assess the healthcare programs delivered within the Health Alliance system. Based on quality indicator measurements and continuous evaluation of the program components, opportunities for improvement are identified. These opportunities enhance the quality of care and service provided to our members/enrollees by improving efficiency, increasing the span of healthy life and reducing disparities in the healthcare provided. Components of the QMM Program include all products and plan types for Commercial HMO/POS, Commercial PPO, Qualified Health Plans and Medicare HMO unless otherwise specified. The Quality and Medical Management Department is committed to ensuring that the care delivered to our members/enrollees is of the highest “value.”

Value = Quality + Service/Cost.

GOALS

The goals of the Health Alliance QMM program include:

A. Identify special needs of the target populations served through annual population assessment data.
B. Establish standards of clinical care and service for the target populations and measure performance outcomes adhering to NCQA, HPMS, CMS, and State and health plan requirements.
C. Identify opportunities to enhance clinical care and service for the target populations.
D. Respond with appropriate interventions to prioritized opportunities to improve clinical care and service.
E. Measure the effectiveness of interventions and implement actions as needed to improve.

OBJECTIVES

The objectives of the Health Alliance QMM program include:

A. Utilize a population-based approach to measuring and addressing continuous quality improvement for clinical care and service for the target populations.
B. Develop, refine, and maintain data systems capable of providing systematic, reliable, and meaningful structure and process measures in the QMM program.
C. Facilitate a partnership between practitioners, providers, members/enrollees, and Health Alliance for the purpose of maintaining and improving plan-wide services.
D. Annually measure access, availability, and trends in member/enrollee satisfaction for improving service.
E. Develop and maintain approaches to providing high-quality clinical care, including disease management, practice guidelines, utilization criteria and guidelines, complex case management, peer review, medical technology review, pharmaceutical management procedures, medical record criteria, and processes to enhance communication and continuity of care between practitioners and providers.
F. Involvement of designated behavioral health care practitioners to address behavioral health issues, including continuity and coordination of care, preventive health, clinical practice guidelines, appropriate triage and referral, customer service, clinical care including pharmaceutical management and all aspects of the QMM program. Health Alliance does not have a centralized triage and referral process for behavioral health services.
G. Develop and maintain a utilization management (UM) program that incorporates nationally recognized criteria, use of appropriate clinical professionals, risk management, member/enrollee and practitioner appeal rights, and appropriate handling of denials of service. Through the UM process, each case is evaluated against established medical criteria to determine medical necessity. In the case of Medicare plans, the reviewer complies with national coverage decisions, general Medicare coverage guidelines and written coverage decisions of local Medicare contractors. Individual patient circumstances and the capacity of the practitioner and provider delivery systems are considered. Factors such as age, co-morbidities, complications, progress of treatment, psychosocial situations and home environment (when applicable) are reviewed when applying criteria. Department policies and procedures further define these processes in detail.
H. Measurement of the effectiveness of the model of care for designated populations.
I. Develop and maintain a pharmaceutical management program that includes the development of policies and procedures, processes for restrictions and preferences, patient safety including medication therapy management data, review and update of procedures, participation of pharmacists and physicians, notification to practitioners, and prior authorization processes including denials and appeals.
J. Develop and maintain a credentialing and recredentialing program for individual practitioners and provider organizations that adhere to federal and state regulations, as well as standards for accreditation.
K. Provide access to information about patient safety to members/enrollees and practitioners through our website while encouraging accountability for patient safety with contracted providers through our Adverse Events and Quality of Care processes.
L. Assess cultural and linguistic needs of member/enrollee population at least annually and report findings to the Members Rights and Responsibilities/Quality Improvement Committee. Annual assessment includes evaluation of CAHPS® and new member/enrollee survey demographic data, Language Line translation requests for oral translation services, complaint data, CACTUS credentialing system data for provider language spoken, CCMS case management cultural need responses, and data provided by Health Alliance’s four major provider systems. Health Alliance also monitors CMS CLAS County Data report based on American Community Survey (ACS) data published by the U.S. Census Bureau which provides notification to health plans meeting the 10% or more threshold of the same non-English language by county.
M. Provide members/enrollees with information regarding rights and responsibilities, health plan policies and procedures, benefit and coverage information, and ensure appropriate oversight of procedures that protects the privacy and confidentiality of member/enrollee information and records.
N. Develop and promote preventive health standards, family planning services and programs to encourage members/enrollees and practitioners to utilize appropriate guidelines and early detection services for prevention of illness.
O. Provide an appeals process designed to protect the rights of the member/enrollee, physician and hospital as fully as possible. Ensure that any member/enrollee, provider or practitioner who is affected by an adverse determination is given the opportunity to appeal through a verbal or written request for medical and administrative review.
P. Establish standards and processes for maintenance and oversight of delegated activities, if applicable.
Q. Establish an annual QMM Plan that describes specific activities undertaken each year to address the components of the QMM program.
R. Annually review the program activities to determine effectiveness and focused priorities for the coming year. The QMM department prepares an annual evaluation that is reviewed and approved by the Health Alliance Vice President and Senior Medical Director of Medical Management and Quality, Executive Director of Quality and Medical Management and the Quality Improvement Committee. The annual evaluation contains a summary of the year’s program activities, an assessment of the effectiveness of the various components of the program as well as recommended program modifications and activities planned for the coming year. The annual assessment of effectiveness includes a review of the Integrated Care Team model and Model of Care. The annual evaluation highlights significant changes in the operation of the Quality Management, Medical Management, Pharmacy and Case and Utilization Management Programs based on review and recommendations from QMM leadership. Member/Enrollee and practitioner satisfaction with program activities is assessed as part of the evaluation. The impact of activities is reviewed by using the program evaluation to identify opportunities for improvement and to revise the programs as needed.
Quality Management, continued

8. discharge planning
9. preauthorization review for medical necessity
10. case management, including complex case management

B. Service
1. Member/enrollee complaints and appeals
2. trends in member/enrollee dissatisfaction/satisfaction (including CAHPS®* surveys)
3. appointment and afterhours access monitoring
4. practitioner availability monitoring
5. telephone access
6. written and verbal communications with members/enrollees
7. concurrent review

C. Behavioral Health Services
1. preventive health
2. mental health and substance abuse quality improvement activities
3. behavioral management criteria and guidelines
4. telephone and appointment access monitoring
5. credentialing and recredentialing
6. utilization management
7. care transitions

D. Patient Safety
1. continuity and coordination of care between practitioners and providers
2. tracking and trending of adverse events
3. evaluation of clinical care against aspects of evidence based guidelines that improve safe practices by
detecting under- and over-utilization
4. implementation of health management systems that support timely delivery of care
5. medication management evaluation through case management program

STRUCTURE OF PROGRAM
The Quality and Medical Management Program provides a comprehensive structure to identify, evaluate and improve
clinical care and service provided to members/enrollees individually and collectively. The Health Alliance Board has
designated the day-to-day accountability of the quality and medical management program to the Health Alliance Vice
President and Senior Medical Director of Medical Management and Quality and Executive Director of Quality and
Medical Management with reporting accountability to the Quality Improvement Committee (QIC). Subcommittees,
workgroups and operational teams of the QIC provide a focus on initiatives involving quality improvement such as
members’ rights and responsibilities, credentialing and pharmacy. In addition to committees, multiple departments
and individual staff members/enrollees have key roles and responsibilities in the QMM program.

MEDICARE ADVANTAGE
In addition to objectives, scope and program structure previously described, the following are specific to the Health
Alliance Medicare Advantage members:
1. Implement chronic care improvement programs (CCIP) through methods that identify enrollees with multiple
or sufficiently severe chronic conditions that would benefit from participating in the program. In addition,
establish mechanisms for monitoring these enrollees that are participating in the chronic care improvement
program. The program also addresses additional populations identified by CMS based on a review of current
quality performance.
2. Quality improvement projects (QIP) that can be expected to improve health outcomes, enrollee satisfaction,
and addresses areas identified by CMS.
   a. The projects are specific initiatives that address clinical and non-clinical areas and involve measurement
      of performance, system interventions including the establishment or alteration of practice guidelines,
improving performance and systematic and periodic follow-up on the effect of the intervention.
   b. The projects assess performance under the plan use quality indicators that are objective, clearly and
      unambiguously defined, and are based on current clinical knowledge or health services research.
   c. The performance assessments on the selected indicators are based on systematic ongoing collection and
      analysis of valid and reliable data.
   d. Interventions identified in the annual work plan strive to achieve demonstrable improvement and
      improvement is documented in the annual evaluation.
   e. Each QIP project status and results of each project are reported to CMS as requested.

* CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
3. Encourages providers to participate in CMS and Health and Human Service (HHS) QI initiatives.
4. Contracts with approved Medicare CAHPS® vendor to conduct the Medicare CAHPS® survey.
5. Complies with and monitors the activities reflected in the Medicare Star Rating strategy to be consistent with the six priorities in the National Quality Strategy including making care safer by reducing harm caused by the delivery of care; ensuring that each person and family are engaged as partners in their care; promoting effective communication and coordination of care; promoting the most effective prevention and treatment practices for the leading causes of mortality; working with communities to promote wide use of best practices to enable healthy living; and making quality care more affordable for individuals, families, employers and governments by developing and spreading new health care delivery models.
6. Complies with CMS requirements for Medication Therapy Management programs. The goal is to optimize therapeutic treatment of specified chronic disease states by increasing compliance and providing education to enrollees and prescribers.
   a. Health Alliance contracts with Medication Management Systems, Inc. to perform the Medication Therapy Management functions.
   b. Health Alliance policy 1233 – Medicare D Medication Therapy Management Program outlines the identification of beneficiaries, intervention and reporting processes and policy 1753 for Medicare D Reporting Requirements-Medication Therapy Management further outlines reporting.
   c. Health Alliance provides Medication Management Systems, Inc. eligibility data files as well as beneficiary plan start/end dates. Members are selected based on criteria identified within the policy. All eligible members are included unless the member chooses to opt out of participation.
   d. Medication Management Systems, Inc. provides services including determination of eligibility, telephonic CMR, medication action plan, personal medication list, targeted medication review and other interventions identified in the policy. Health Alliance reviews all interventions and provides feedback and further education/assistance as necessary
   e. Health Alliance stratifies members selected for MTMP into case management per chronic disease state.
   f. CMS data validation standards are used to validate accuracy of reporting data. Data is uploaded to CMS annually via HPMS.

To support CMS regulations, Health Alliance maintains a health information system that collects, integrates, analyzes and reports data necessary to implement its QI program:
• Health Alliance has policies and procedures in place on the requirements for reporting data to CMS. Updates to the Reporting Requirements are reviewed upon publication and updates to policies, procedures and systems are completed.
• Health Alliance collects data on the following:
  a. Provider characteristics – via Visual CACTUS Credentialing System for provider and the MC400 as the primary member system of record for member characteristics.
  b. Services furnished to members – via McKesson Compliance Reporter and Risk Manager (HEDIS®**), CAHPS® survey process, McKesson Vitals Platform for case management services, MC400 for medical claims, MedImpact for pharmacy data.
  c. Data to guide the selection of quality improvement project topics and meet the data collection requirements for quality improvement projects – via McKesson Compliance Reporter and Risk Manager (HEDIS®**), CAHPS® survey process, McKesson Vitals Platform for case management services, MC400 for medical claims, MedImpact for pharmacy data.
• Health Alliance ensures that information and data received from providers are accurate, timely and complete – via MC400 Claims processing system and MedImpact PBM.
• Health Alliance has information systems that integrate data from various sources, including member concerns and complaints – via Salesforce.
• Health Alliance has a formalized process to analyze data – via McKesson Compliance Reporter and Risk Manager (HEDIS®**), Statistical package for Social Sciences (SPSS), and Access data bases as needed, as reported to QIC.
  o Health Alliance addresses identified deficiencies in reported data through provider feedback or other corrective action – via QMM Program through McKesson Compliance Reporter (HEDIS®**) and Risk Manager, ambulatory and inpatient reviews.
  o Health Alliance complies with HIPAA and privacy laws and professional standards of health information management through the Compliance Committee.
• Health Alliance conducts a pre-assessment on the Part C measures and has checks and balances in place for data submission. Corrective actions are put into place for all findings from the data validation audit or CMS notification.

* CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
** HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
**Quality Management, continued**

Formal evidence of the impact and effectiveness of the QI program is documented in the quality and medical management annual evaluation. The evaluation includes measurement tools required by CMS and is made available to CMS to enable beneficiaries to compare health coverage options and select among them based on quality and outcomes measures.

The process of integrating the quality improvement initiatives with various Health Alliance departments and committees is accomplished, in part, through appointment of representatives to the committees listed in the structure of the quality improvement program with a diversity of knowledge and skills. These individuals support the development and continuous evaluation of the QMM Program, through the plan, do, study and act cycle. It is the primary responsibility of the QMM Department to diffuse quality initiatives throughout the organization.

**TECHNICAL RESOURCES/SYSTEMS**

There are a number of technical resources/systems available to support and implement the QI program:

a. **McKesson Vitals Platform** is a McKesson system that provides, condition identification, program identification/work list, risk levels/risk profile, identification of gaps in care, system alerts and messaging capabilities to support medical management services including utilization management, case management, disease management, management of members/enrollees at risk (complex case management) and documentation of appeals. The system allows evaluation of care management by tracking and measuring goals, interventions and outcomes. Health Alliance migrated to the McKesson Vitals platform from the McKesson CCMS system in the fall of 2013.

b. **InterQual®** is embedded in CCMS and is an industry-leading evidence-based tool for determining the appropriateness of health care interventions and levels of care across the continuum. This program supports preauthorization, concurrent review and retrospective analysis of clinical appropriateness. The following guidelines are used:

- **Inpatient Services**
  - InterQual® Level of Care: Acute Criteria, Adult
  - InterQual® Level of Care: Acute Criteria, Pediatric
  - Prest & Associates, Inc. Review Criteria – Mental Health

- **Outpatient Services**
  - InterQual® Care Planning: Procedures Criteria, Adult and Pediatric
  - InterQual® Care Planning: Imaging Criteria, Adult and Pediatric
  - InterQual® Care Planning: Molecular Diagnostics

**InterQual®** is a nationally respected vendor with clinical criteria based on best practice, clinical data and medical literature. Prest & Associates, Inc. is a nationally respected independent review organization that provides behavioral health criteria along with consultation and review services with board certified physicians in mental health and substance abuse. ASAM guidelines are a nationally accepted standard of care for the treatment of substance abuse disorders.

Where vendor guidelines are incomplete or absent, internal medical policies that reflect current standards or medical practice are developed by the Medical Director Committee and reviewed by the Medical Policy Committee. All Health Alliance criteria and medical policies are reviewed annually to determine whether updates/revisions are warranted. The designated Senior Medical Director and the medical management project coordinator receive and research all requests for policy revisions and for new policy development. Annual criteria reviews are conducted through the Medical Directors Committee and Medical Policy Committee as indicated. Coordinators utilize the medical policies to evaluate medical necessity and authorize services if appropriate. Medical Technology reviews are performed on new technologies to ensure that the Health Plan is staying current with the latest standards of care. Medical necessity reviews beyond the scope of current coverage criteria are referred to a Medical Director, who is then accountable for review and determination of coverage. Decisions made using any criteria are based on each member’s clinical status and assessment of the local delivery system. Clinical Peers are used as needed. Medical Directors and Coordinators are evaluated at least annually for consistency of applying criteria, and corrective actions are implemented when needed.

c. **McKesson Risk Manager** is an integrated performance platform that enables better management to reduce medical management costs and improve physician efficiency and quality profiling.

d. **McKesson Compliance Reporter** is used to gather and report HEDIS®. This includes data reported annually to NCQA, as well as at the provider and employer levels annually and quarterly. The system integrates with VITAL and Risk Manager.

**HEDIS®** is a registered trademark of the National Committee for Quality Assurance (NCQA).
Quality Management, continued

e. **MC400 - Managed Care 400** is a claim processing system from OAO Healthcare Solutions retains member/enrollee eligibility information, applies provider contract and payment terms and adjudicates claims based on specific rules established for employer benefit packages.

f. **PBM - Pharmacy Benefit Manager** MedImpact for Medicare Advantage and OptumRx for the Commercial and SPD/MMAI populations offers customized products and uses an evidence-based approach to manage costs.

g. **Visual CACTUS** - houses all data for credentialed providers and drives the recredentialing process.

h. **Ambulatory Review Database** - an Access based system developed by Health Alliance staff that enables tracking, documentation and reporting of ambulatory review criteria and results.

i. **Adverse Events Database** - an Access based system developed by Health Alliance staff enables to tracking, documentation and reporting of adverse events (never events and sentinel events).

j. **Wellness Vendor (Rally)** - available to all Health Alliance member/enrollees and providers free of charge via the Health Alliance website. Rally offers web-based wellness programs using current technologies to engage members in improving their health.

k. **SPSS - Statistical Package for the Social Sciences** allows users to sample, manipulate, and analyze data including statistical testing, correlations, and regression analysis.

l. **SQL Query Analyzer** - Allows users to query data from the data warehouse for reporting or producing mailing lists.

m. **Crystal Reports** - Allows users to query data from the data warehouse for reporting or producing mailing lists.

n. **MCNet** - pulls member/enrollee information for the customer service representative from the member/enrollee number entered into the Cisco Systems IVR by the caller or when accessed manually by the representative. MCNet combines access to a call tracking process from another system by Onyx called Customer Center with data housed in the MC400. Calabrio’s Work Force Management and Quality Management software are used for staff scheduling, call recording, and call monitoring. They are fully integrated with the phones by Cisco Systems.

o. **Cisco Systems** - phone system that provides reporting on telephone utilization.

p. **Onyx Customer Center** - tracks complaints and feeds into our data warehouse. Reports are run using Crystal Enterprises.

q. **Salesforce** - a customer relationship management (CRM) service. Broadly, this CRM service is used to manage our customer service, provider relations and member services. Salesforce also provides easy access to complete member information that is used to ensure more “one and done” service calls. The Custom Cloud allows the creation of powerful custom functionality in Salesforce, which works along with other services like Docusign, Conga, etc. to automate many of our manual processes.

r. **CMS** - Medicare coverage guidelines. For Medicare plans, national coverage decisions, general Medicare coverage guidelines and written coverage decisions of local Medicare contracts is used. Individual patient circumstances and the capacity of the practitioner and provider delivery system are considered. This includes the consideration of alternate settings when needed. Factors such as age, co-morbidities, complications, progress of treatment psychosocial situations, and home environment (when applicable) are reviewed when applying criteria.

s. **Storan** - software used for Medicare Advantage quality and risk management within Health Alliance.

Descriptions for committees related to the Quality and Medical Management process are available upon request.
National Committee for Quality Assurance (NCQA) and HEDIS®

In support of our commitment to quality, Health Alliance has voluntarily submitted to reviews by the National Committee for Quality Assurance (NCQA). The NCQA is an independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral health care organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations and disease management and other health-related programs. The mission of the NCQA is to improve the quality of health care delivered to people everywhere. NCQA accreditation evaluates how well a health plan manages all parts of its delivery system—physicians, hospitals, other providers and administrative services—to continuously improve health care for its members. At the health plan’s request, NCQA sends a team of trained health care experts to conduct a rigorous on-site survey of the health plan. NCQA uses information from health plan records, consumer surveys, interviews with health plan staff and performance on selected HEDIS® (Healthcare Effectiveness Data and Information Set) measures. In December 2013, the Health Alliance commercial HMO/POS plan received an Excellent three-year accreditation and the commercial PPO plan received a Commendable three-year accreditation.

NCQA’s accreditation standards are publicly reported in five categories:

- **Access and Service**: Do health plan members have access to the care and services they need?
- **Qualified Providers**: Does the health plan assess each doctor’s qualifications and what health plan members say about its providers?
- **Staying Healthy**: Does the health plan help members maintain good health and detect illness early?
- **Getting Better**: How well does the health plan care for members when they become sick?
- **Living with Illness**: How well does the health plan care for members when they have chronic conditions?

Consumers can easily access health plans’ NCQA Accreditation statuses and other information on health care quality at ReportCard.NCQA.org or by calling NCQA’s Customer Support at 1-888-275-7585.

Health Alliance has identified three major benefits of NCQA Accreditation:

- Preparation for the survey results in a strengthening of Health Alliance’s internal management systems.
- NCQA Accreditation strengthens Health Alliance’s position in the marketplace.
- NCQA Accreditation status is widely accepted and eliminates repetitive state and federal reviews.

**HEDIS**

HEDIS is the measurement tool used by the nation’s health plans to evaluate their performance in terms of clinical quality and customer service. It is a set of standardized performance measures designed to ensure purchasers and consumers have the information they need to reliably compare health care quality.

The HEDIS expert panel, the Committee on Performance Measurement, has identified the following “domains” or categories of care for reporting HEDIS:

- **Effectiveness of Care**: Measures surrounding prevention, screening and clinical conditions
- **Access/Availability of Care**: Timeliness of prenatal and postpartum care, availability of primary care providers and specialists
- **Satisfaction with the Experience of Care**: CAHPS®** survey results.
- **Use of Services**: Frequency of selected procedures, inpatient utilization, etc.
- **Health Plan Stability**: Total membership
- **Health Plan Descriptive Information**: Board certification, enrollment information, etc.
- **Cost of Care**: Relative resource measures for diabetes, asthma, low back pain, etc.

* HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
** CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
Audit Requirements
The HEDIS Compliance Audit™*** is a two-part program that consists of an overall information system capability assessment coupled with an evaluation of the MCO’s ability to comply with HEDIS specifications. Auditors who are certified by NCQA use standard audit methodologies designed to help purchasers make more reliable comparisons between health plans.

Hybrid Reviews
Plans reporting HEDIS data may draw information from three sources – administrative (i.e., claims), hybrid (combination of claims and medical record review) and survey (direct feedback from the member). The use of hybrid methodology is very time consuming and resource intensive. However, in measures where the specifications and exclusions are complicated, hybrid review often results in improved rates, despite the amount of work involved.

Hybrid review requires the cooperation of a plan’s practitioners. Health Alliance, or its designee, may request an appointment to visit the practitioner’s office to review and copy medical records for members who are part of the sample population for a specific measure. Health Alliance may also contact practitioner’s offices and ask to have specific portions of the medical record sent to our office as proof of compliance with specific measures (i.e., immunization records, proof of a colonoscopy, etc.)

Access to Services
Health Alliance is committed to providing members with efficient, cost-effective and quality health care coverage. Health Alliance employees never encourage underutilization of care. We do not give financial inducements or set quotas for denying care or coverage; nor do we keep statistics identifying individual providers and their denial rates. Utilization decisions made by our medical directors, nurse coordinators, pharmacy coordinators and pharmacists are based only on appropriateness of care and service and the existence of coverage. There are no incentives, financial or otherwise, to deny access to services.

As a member of the medical community, Health Alliance understands and respects the need to meet HIPAA requirements and keep medical information regarding patients confidential. As part of the HEDIS review process, we may ask to copy specific portions of the medical record. This is necessary to provide proof of compliance for the measure in question to our auditors. Health Alliance keeps all medical information in confidential files accessible only on a “need to know” basis. No information is released to another party outside of the audit process. If you have any questions or concerns regarding the confidentiality of any documentation provided to our office for quality review purposes, please feel free to contact the Quality Management Director at (217) 337-8129.

HEDIS specifications for the Effectiveness of Care Measures are very explicit. Each measure specifies the ages involved for the measure as well as specific requirements each patient must meet in order to attain compliance. The following pages describe some of the measures Health Alliance reviews and what indicators are required.

HEDIS is an effective tool that enables us to compare our health plan with other plans across the country. However, our success depends upon your cooperation. Please feel free to contact our Quality Management Department with questions/concerns about HEDIS, the audit and/or medical record reviews.

Summary of Specifications for HEDIS Effectiveness of Care Measures
Health Alliance participates in the Healthcare Effectiveness Data and Information Set (HEDIS) audit annually. The following briefly describes some of the HEDIS measures that are included in the annual HEDIS audit for Commercial members. This information is taken from the HEDIS 2014 Narrative and Technical Specifications manual provided by the National Committee for Quality Assurance (NCQA). Additional information can be requested by contacting NCQA at NCQA.org, or by contacting the Health Alliance Quality Management Department at 1-800-851-3379, extension 8112.

*** HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).
Remember: As a contracted provider you are expected to cooperate fully with Health Alliance Medical and Quality Management programs, which include access to medical records for these purposes. For example, you may receive requests for medical information related to quality assurance audits from the Quality Management Department annually during HEDIS or other times during the year. Please contact the Quality Management Department with any questions or concerns at 1-800-851-3379, extension 8112.
## Prevention and Screening

### 1. Adult BMI Assessment

<table>
<thead>
<tr>
<th>Product</th>
<th>Age Group &amp; Sex (if indicated)</th>
<th>Indicators</th>
<th>Notes</th>
</tr>
</thead>
</table>
| Commercial | 18 to 74 years | Documented at least every two years in medical record:  
1. BMI Value for 20 and older (date and value)  
2. BMI Percentile for 19 and younger (date and percentile)  
3. Weight (date and value)  
4. Height for 19 and younger (date and value) | Acceptable documentation:  
- Adults 20 and older-BMI value and weight.  
- Younger than 20 (on the date of service) BMI percentile documented as a value (i.e. 85th percentile), with height and weight. BMI plotted on an age-growth chart also meets criteria. Weight and height must also be documented.  
Documentation must occur during the measurement year or the year prior to the measurement year. |

### 2. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

<table>
<thead>
<tr>
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<th>Age Group &amp; Sex (if indicated)</th>
<th>Indicators</th>
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</thead>
</table>
| Commercial | 3 to 17 years | Documented annually in the medical record:  
1. BMI percentile  
2. Height  
3. Weight  
4. Counseling for nutrition or referral to nutrition education  
5. Counseling for physical activity or referral for physical activity | Acceptable documentation:  
- BMI percentile documented (i.e. 85th percentile) or BMI percentile plotted on an age-growth chart. Height and weight must also be documented. Counseling for nutrition and physical activity can include:  
1. Discussion of nutrition/physical activity behaviors  
2. Checklist indicating nutrition/physical activity discussed  
3. Counseling or referral for nutrition/physical activity  
4. Provision of educational materials for nutrition or physical activity during face-to-face visit  
5. Weight or obesity counseling  
Documentation must occur during the measurement year. |

### 3. Childhood Immunization

<table>
<thead>
<tr>
<th>Product</th>
<th>Age Group &amp; Sex (if indicated)</th>
<th>Indicators</th>
<th>Notes</th>
</tr>
</thead>
</table>
| Commercial | Birth to 2 years | 1. 4 DTaP  
2. 3 IPV  
3. 1 MMR  
4. 3 Hib  
5. 3 HepB  
6. 1 VZV (or hx of chix pox)  
7. 4 Pneumococcal  
8. 1 HepA (or hx hep A illness)  
9. 2 or 3 dose Rotavirus  
10. 2 Influenza | 1. All vaccines should be administered on or before child’s 2nd birthday  
2. DTaP, IPV, Hib, Rotavirus & Pneumococcal cannot be administered prior to 42 days after birth  
3. Influenza – do not count any vaccination given prior to 6 months of age.  
4. Providers should request complete vaccination history from previous physicians, including vaccinations administered at public health departments and I-Care-Illinois immunization records. |
### Measure

<table>
<thead>
<tr>
<th>Measure</th>
<th>Product</th>
<th>Age Group &amp; Sex (if indicated)</th>
<th>Indicators</th>
<th>Notes</th>
</tr>
</thead>
</table>
| 4.      | Adolescent      | Commercial                     | 13 years                                                                                                                                   | 1. Meningococcal – between 11<sup>th</sup> & 13<sup>th</sup> birthday  
2. 1 Tdap – between 10<sup>th</sup> & 13<sup>th</sup> birthday  
3. 3 HPV vaccines                                                                 | 1. Women with bilateral mastectomy are excluded. Biopsy, ultrasound or MRI are not acceptable tests.                                                                                             |
| 5.      | Breast Cancer   | Commercial                     | 50 to 74 years - women                                                                                                                    | At least one mammogram between October 1, 2014 to December 31, 2016                                                                                                                                |                                                                                                                                                                                                      |
| 6.      | Cervical Cancer | Commercial                     | Women -  
• 21 to 64 years -or-  
• 30 to 64 years                                                                                                                                  | Women who had one of the following:  
• At least one cervical cytology test every three years -or-  
• One cervical cytology test/HPV co-testing every five years                                                                                       | Women with hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix are excluded. Documentation of ‘vaginal’ pap smear in conjunction with documentation of ‘hysterectomy’ meets exclusion criteria but documentation of hysterectomy alone does not since it does not indicate that the cervix was removed. Please document history of hysterectomy clearly in the medical record, indicating if ‘complete’, ‘total’ or ‘radical’ abdominal or vaginal hysterectomy. |
| 7.      | Colorectal      | Commercial                     | 50 to 75 years                                                                                                                               | One of the following:  
• Fecal occult blood test annually – OR -  
• Flexible sigmoidoscopy every 5 years –OR -  
• Colonoscopy every 10 years                                                                                                                  | 1. Digital rectal exam does not count toward compliance  
2. Patients with a diagnosis of colorectal cancer or total colectomy are excluded                                                                                                                     |
| 8.      | Chlamydia       | Commercial                     | Females - 16 to 24 years                                                                                                                   | Sexually active women should receive an annual Chlamydia test                                                                                                                                      | Patients who had a pregnancy test followed w/in 7 days by either an Rx for isotretinoin or an x-ray may be excluded.                                                                                     |

### Respiratory Conditions

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>9.</td>
<td>Treatment</td>
<td>Commercial</td>
<td>2 to 18 years</td>
<td>A Group A strep test is performed for all encounters where patient is diagnosed with pharyngitis and given an antibiotic.</td>
</tr>
<tr>
<td>10.</td>
<td>Spirometry</td>
<td>Commercial</td>
<td>40+ years</td>
<td>Members with new diagnosis or newly active diagnosis of COPD who received spirometry to confirm the diagnosis.</td>
</tr>
</tbody>
</table>
| 11.     | Management      | Commercial                     | 40+ years                                                                                                                                  | Members with COPD exacerbation with acute inpatient discharge or ED visit who were given:  
• Systemic corticosteroid w/in 14 days  
• Bronchodilator w/in 30 days                                                                                                                    | COPD exacerbation is defined as an acute inpatient discharge or ED encounter with a principal diagnosis of COPD.                                                                                         |
| 12.     | Medication      | Commercial                     | 5 to 85 (Commercial)                                                                                                                       | Persistent asthmatics (as defined above) who remained on appropriate medications during the treatment period:  
1. % of members who were compliant with medications at least 50% of the treatment period  
2. % of members who were compliant with medications at least 75% of the treatment period                                                                 | Members with emphysema, COPD, obstructive chronic bronchitis, chronic respiratory conditions due to fumes/vapors, cystic fibrosis and acute respiratory failure may be excluded in addition to members with no asthma controller medications dispensed during the measurement year. Please request specific information from Health Alliance. |
<p>| 13.     | Medication Ratio| Commercial                     | 5 to 85 (Commercial)                                                                                                                       | Persistent asthmatics with a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.                                                                |                                                                                                                                                                                                      |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Cardiovascular Conditions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Controlling High Blood Pressure</td>
<td>Commercial</td>
<td>18 to 85 years</td>
<td>Patients with diagnosed hypertension. Of the denominator, members with a diagnosis of diabetes in the measurement year or year prior are flagged. Metrics are as follows: o Age 18-59, BP &lt;140/90 mm Hg  o Age 60-85 with diabetes, BP &lt;140/90 mm Hg  o Age 60-85, no diabetes, BP &lt;150/90 mm Hg</td>
<td>Patient is considered hypertensive if they have at least one outpatient visit with a hypertension diagnosis in the first six months of the measurement year.  MOST RECENT BP level in the measurement year is used as long as it occurs after the diagnosis of hypertension.  No blood pressure during the measurement year is considered ‘not controlled’.  Exclusions include diagnosis of pregnancy, ESRD or kidney transplant documented prior to December 31 of the measurement year.</td>
</tr>
<tr>
<td>15. Persistence of Beta Blocker Treatment</td>
<td>Commercial</td>
<td>18+ years</td>
<td>Patients hospitalized with diagnosis of AMI who received persistent beta-blocker treatment for six months after discharge.</td>
<td>Adverse reaction to beta blocker therapy is reason for exclusion. In addition, members with diagnosis of Asthma, COPD, obstructive chronic bronchitis, chronic respiratory conditions due to fumes/vapors, hypotension, heart block &gt;1 degree or sinus bradycardia may be excluded.</td>
</tr>
</tbody>
</table>
| 16. Statin Therapy for Patients with Cardiovascular Disease | Commercial | Males 21-75 and females 40-75 years of age | 1. Members dispensed at least 1 high or moderate-intensity statin medication during the measurement year.  
2. Members who remain on high or moderate-intensity statin medication for at least 80% of the treatment period.                                                                                   | Population identified by event or diagnosis: Event in year prior to measurement year: MI, CAGB, PCI or other revascularization Dx in both year prior and measurement year: IVD (outpatient or inpatient)  Exclusions include Pregnancy, IVF, ESRD, cirrhosis, myalgia, myositis, myopathy or rhabdomyolysis |
| **Diabetes**                                 |          |                                |                                                                                                                                                                                                          |                                                                                                                                                                                                       |
| 17. Comprehensive Diabetes                  | Commercial | 18 to 75 years                | Exclude members with diagnosis of gestational or steroid-induced diabetes and no diagnosis of diabetes in measurement year or year prior.                                                                       |                                                                                                                                                                                                       |
| • HbA1c Screening                            | Commercial | (A1c<8, A1c>9, Eye Exam, Nephropathy and BP control are all accreditation measures) | • Annual HbA1c test                                                                                                                              | MOST RECENT level during the measurement year must be used.                                                                                                                                               |
| • HbA1c Level                                | Commercial |                                | • HbA1c <7%  
• HbA1c <8%  
• HbA1c >9% (poor control)                                                                                                                |                                                                                                                                                                                                       |
| • Retinal Eye Exam                            | Commercial |                                | Retinal or dilated eye exam by an eye care professional at least every two years. If patient has diagnosis of retinopathy, then annual retinal or dilated eye exam.                                              | Eye exams results should be recorded in the medical record. Please request that all eye care providers send the PCP a copy of the results or a letter indicating the testing date, testing done and results. |
| • Monitor Nephropathy                         | Commercial |                                | 1. Annual nephropathy screening documented:  
• 24-hour urine for albumin or protein  
• Timed urine for albumin or protein  
• Spot urine for albumin or protein  
• Urine for microalbumin/creatinine ratio | Documentation must occur during the measurement year. Evidence of nephropathy may include documentation of visit to a nephrologist, documentation of renal transplant, and documentation of medical attention for: diabetic nephropathy, ESRD, CRF, CKD, renal insufficiency, |
<table>
<thead>
<tr>
<th>Measure</th>
<th>Product</th>
<th>Age Group &amp; Sex (if indicated)</th>
<th>Indicators</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Blood Pressure Control</td>
<td>MOST RECENT blood pressure level in the measurement year. Blood pressure should be documented at least annually in the medical record:</td>
<td>1. Members dispensed at least 1 statin medication, any intensity, during the measurement year 2. Members who stayed on the statin medication, any intensity, for at least 80% of the treatment period.</td>
<td>proteinuria, albuminuria, renal dysfunction, acute renal failure or dialysis, hemodialysis or peritoneal dialysis</td>
<td></td>
</tr>
<tr>
<td>18. Statin Therapy for Patients with Diabetes</td>
<td>Commercial</td>
<td>40-75 years of age with NO dx ASCVD</td>
<td>Patients with a diagnosis of rheumatoid arthritis who received at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD) in the measurement year.</td>
<td>Patients with HIV diagnosis or members with a diagnosis of pregnancy during the measurement year may be excluded.</td>
</tr>
<tr>
<td>Musculoskeletal Conditions</td>
<td></td>
<td></td>
<td>Patients with a diagnosis of rheumatoid arthritis who received at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD) in the measurement year.</td>
<td>Patients with HIV diagnosis or members with a diagnosis of pregnancy during the measurement year may be excluded.</td>
</tr>
<tr>
<td>24. Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis</td>
<td>Commercial</td>
<td>No age specification</td>
<td>Patients with a diagnosis of rheumatoid arthritis who received at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD) in the measurement year.</td>
<td>Patients with HIV diagnosis or members with a diagnosis of pregnancy during the measurement year may be excluded.</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Antidepressant Medication Management</td>
<td>Commercial</td>
<td>18+ years</td>
<td>Patients diagnosed with major depression and were newly treated with antidepressant medications and who stayed on the medication treatment.</td>
<td></td>
</tr>
<tr>
<td>• Effective Acute Phase Treatment</td>
<td></td>
<td></td>
<td>Patients identified as above who remained on medication for at least 84 days</td>
<td></td>
</tr>
<tr>
<td>• Effective Continuous Phase Treatment</td>
<td></td>
<td></td>
<td>Patients identified as above who remained on medication for at least 180 days</td>
<td></td>
</tr>
<tr>
<td>26. Follow-Up Care for Children Prescribed ADHD Medication</td>
<td>Commercial</td>
<td>6 to 12 years</td>
<td>Children with new prescription of ADHD medication who have at least three follow-up visits within a ten month period.</td>
<td></td>
</tr>
<tr>
<td>• Initiation Phase</td>
<td></td>
<td></td>
<td>Children identified as above with one follow-up visit within 30 days with a provider with prescribing authority</td>
<td></td>
</tr>
</tbody>
</table>
## HEALTH ALLIANCE MEDICAL PLANS

<table>
<thead>
<tr>
<th>Measure</th>
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<th>Age Group &amp; Sex (if indicated)</th>
<th>Indicators</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuation/Maintenance</td>
<td>Commercial</td>
<td>6+ years</td>
<td>Children identified as above who remained on medication for at least 210 days and have had two follow-up visits with a practitioner within 270 days (after the initiation phase)</td>
<td>Mental health diagnoses include: Other psychoses, Obsessive-compulsive disorder, Dysthymic Disorder, Personality Disorders, Acute reaction to stress, Adjustment reacting, Depressive Disorder, Disturbance of Conduct, NEC, Disturbance of Emotions, Hyperkinetic Syndrome of Childhood</td>
</tr>
<tr>
<td>27. Follow-up After Hospitalization for Mental Illness</td>
<td>Commercial</td>
<td>6+ years</td>
<td>Patients discharged after hospitalization for mental illness that had an outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported and described below:</td>
<td>Mental health diagnoses include: Other psychoses, Obsessive-compulsive disorder, Dysthymic Disorder, Personality Disorders, Acute reaction to stress, Adjustment reacting, Depressive Disorder, Disturbance of Conduct, NEC, Disturbance of Emotions, Hyperkinetic Syndrome of Childhood</td>
</tr>
<tr>
<td>8 Days</td>
<td>Children identified as above who remained on medication for at least 210 days and have had two follow-up visits with a practitioner within 270 days (after the initiation phase)</td>
<td>Mental health diagnoses include: Other psychoses, Obsessive-compulsive disorder, Dysthymic Disorder, Personality Disorders, Acute reaction to stress, Adjustment reacting, Depressive Disorder, Disturbance of Conduct, NEC, Disturbance of Emotions, Hyperkinetic Syndrome of Childhood</td>
<td></td>
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</tr>
<tr>
<td>30 Days</td>
<td>Children identified as above who remained on medication for at least 210 days and have had two follow-up visits with a practitioner within 270 days (after the initiation phase)</td>
<td>Mental health diagnoses include: Other psychoses, Obsessive-compulsive disorder, Dysthymic Disorder, Personality Disorders, Acute reaction to stress, Adjustment reacting, Depressive Disorder, Disturbance of Conduct, NEC, Disturbance of Emotions, Hyperkinetic Syndrome of Childhood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Follow-up After Emergency Department Visit for Mental Illness</td>
<td>Commercial</td>
<td>6+ years</td>
<td>Patients with ED visit with primary DX of mental illness that had an outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported and described below:</td>
<td>Mental health diagnoses include: Other psychoses, Obsessive-compulsive disorder, Dysthymic Disorder, Personality Disorders, Acute reaction to stress, Adjustment reacting, Depressive Disorder, Disturbance of Conduct, NEC, Disturbance of Emotions, Hyperkinetic Syndrome of Childhood</td>
</tr>
<tr>
<td>7 Days</td>
<td>Patients who received follow-up visit with a mental health provider within 7 days of discharge</td>
<td>Mental health diagnoses include: Other psychoses, Obsessive-compulsive disorder, Dysthymic Disorder, Personality Disorders, Acute reaction to stress, Adjustment reacting, Depressive Disorder, Disturbance of Conduct, NEC, Disturbance of Emotions, Hyperkinetic Syndrome of Childhood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Days</td>
<td>Patients who received follow-up visit with a mental health provider within 30 days of discharge</td>
<td>Mental health diagnoses include: Other psychoses, Obsessive-compulsive disorder, Dysthymic Disorder, Personality Disorders, Acute reaction to stress, Adjustment reacting, Depressive Disorder, Disturbance of Conduct, NEC, Disturbance of Emotions, Hyperkinetic Syndrome of Childhood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence</td>
<td>Commercial</td>
<td>13+ years</td>
<td>Patients with ED visit with primary DX of alcohol or other drug dependence (AOD) that had a follow up visit for AOD. Two rates are reported and described below:</td>
<td>Mental health diagnoses include: Other psychoses, Obsessive-compulsive disorder, Dysthymic Disorder, Personality Disorders, Acute reaction to stress, Adjustment reacting, Depressive Disorder, Disturbance of Conduct, NEC, Disturbance of Emotions, Hyperkinetic Syndrome of Childhood</td>
</tr>
<tr>
<td>7 Days</td>
<td>Patients who received follow-up visit with a primary DX of AOD within 7 days of ED visit</td>
<td>Mental health diagnoses include: Other psychoses, Obsessive-compulsive disorder, Dysthymic Disorder, Personality Disorders, Acute reaction to stress, Adjustment reacting, Depressive Disorder, Disturbance of Conduct, NEC, Disturbance of Emotions, Hyperkinetic Syndrome of Childhood</td>
<td></td>
<td></td>
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<tr>
<td>30 Days</td>
<td>Patients who received follow-up visit with a primary DX of AOD within 30 days of ED visit</td>
<td>Mental health diagnoses include: Other psychoses, Obsessive-compulsive disorder, Dysthymic Disorder, Personality Disorders, Acute reaction to stress, Adjustment reacting, Depressive Disorder, Disturbance of Conduct, NEC, Disturbance of Emotions, Hyperkinetic Syndrome of Childhood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Metabolic Monitoring for Children and Adolescents on Antipsychotics</td>
<td>Commercial</td>
<td>1-17 years</td>
<td>Children and adolescents with two or more antipsychotic prescriptions and both blood glucose or HbA1c and LDL-C or cholesterol test.</td>
<td>Mental health diagnoses include: Other psychoses, Obsessive-compulsive disorder, Dysthymic Disorder, Personality Disorders, Acute reaction to stress, Adjustment reacting, Depressive Disorder, Disturbance of Conduct, NEC, Disturbance of Emotions, Hyperkinetic Syndrome of Childhood</td>
</tr>
<tr>
<td>Medication Management</td>
<td></td>
<td></td>
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<tr>
<td>31. Annual Monitoring for Patients on Persistent Medications</td>
<td>Commercial</td>
<td>18+ years</td>
<td>Patients who receive a 180 day supply of ambulatory medication and at least one therapeutic monitoring event</td>
<td>Patients who have had an inpatient stay for any condition are excluded.</td>
</tr>
<tr>
<td>Measure</td>
<td>Product</td>
<td>Age Group &amp; Sex (if indicated)</td>
<td>Indicators</td>
<td>Notes</td>
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<tr>
<td>• ACE or ARBs</td>
<td></td>
<td>annually for the following:</td>
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<tr>
<td></td>
<td></td>
<td>• ACE/ARBs –</td>
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<td></td>
<td></td>
<td>o A serum potassium and a serum creatinine test annually*</td>
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<tr>
<td></td>
<td></td>
<td>o A lab panel test</td>
<td></td>
<td></td>
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<tr>
<td>• Digoxin</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Digoxin –</td>
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<tr>
<td></td>
<td></td>
<td>o A serum potassium and a serum creatinine and a serum digoxin test annually*</td>
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<tr>
<td></td>
<td></td>
<td>o A lab panel test and a serum digoxin test</td>
<td></td>
<td></td>
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<tr>
<td>• Diuretics</td>
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<td></td>
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<td></td>
<td></td>
<td>• Diuretics –</td>
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<tr>
<td></td>
<td></td>
<td>o A serum potassium and a serum creatinine test annually*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>o A lab panel test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Combined</td>
<td></td>
<td></td>
<td>Combined rate (sum of 3 numerators divided by sum of 3 denominators)</td>
<td></td>
</tr>
</tbody>
</table>

**Overuse/Appropriateness**

32. Non-Recommended Cervical Cancer Screening in Adolescent Females

<table>
<thead>
<tr>
<th>Measure</th>
<th>Product</th>
<th>Age Group &amp; Sex (if indicated)</th>
<th>Indicators</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Commercial</td>
<td>Females – 16 to 20 years</td>
<td>Females who were screened unnecessarily for cervical cancer, i.e. who received a cervical cytology or HPV test during the measurement year.</td>
<td>Lower rate = better performance.</td>
</tr>
</tbody>
</table>

33. Appropriate Treatment for Children with URI

<table>
<thead>
<tr>
<th>Measure</th>
<th>Product</th>
<th>Age Group &amp; Sex (if indicated)</th>
<th>Indicators</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Commercial</td>
<td>3 months to 18 years</td>
<td>Members with diagnosis of URI who did NOT receive an antibiotic prescription</td>
<td>Higher rate = better performance.</td>
</tr>
</tbody>
</table>

34. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

<table>
<thead>
<tr>
<th>Measure</th>
<th>Product</th>
<th>Age Group &amp; Sex (if indicated)</th>
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<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Commercial</td>
<td>18 to 64 years</td>
<td>Members with diagnosis of acute bronchitis who did NOT receive an antibiotic prescription</td>
<td>Higher rate = better performance.</td>
</tr>
</tbody>
</table>

35. Use of Imaging Studies for Low Back Pain

<table>
<thead>
<tr>
<th>Measure</th>
<th>Product</th>
<th>Age Group &amp; Sex (if indicated)</th>
<th>Indicators</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Commercial</td>
<td>18 to 50 years</td>
<td>Patients who did not receive an imaging study (plain x-ray, MRI or CT scan) to assess acute low back pain. This measure is reported as an inverted rate. A high score reflects appropriate treatment (i.e. members not receiving imaging studies)</td>
<td>Patients with diagnosis of cancer or recent trauma, IV drug abuse or neurological impairment, HIV, spinal infection, major organ transplant, prolonged use of corticosteroids may be excluded. Higher rate = better performance.</td>
</tr>
</tbody>
</table>

36. Use of Multiple Concurrent Antipsychotics in Children and Adolescents

<table>
<thead>
<tr>
<th>Measure</th>
<th>Product</th>
<th>Age Group &amp; Sex (if indicated)</th>
<th>Indicators</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Commercial</td>
<td>1-17 years</td>
<td>Children and adolescents on two or more concurrent antipsychotic medications in the measurement year.</td>
<td></td>
</tr>
</tbody>
</table>

**Access/Availability of Care**

37. Initiation of Alcohol and Other Drug Dependence Treatment

<table>
<thead>
<tr>
<th>Measure</th>
<th>Product</th>
<th>Age Group &amp; Sex (if indicated)</th>
<th>Indicators</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Commercial</td>
<td>Adolescent and adult</td>
<td>Patients with a new episode of alcohol or other drug dependence who receive treatment within 14 days of diagnosis through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization.</td>
<td>If the earliest diagnosis is found with an inpatient discharge, the inpatient stay is considered initiation treatment – or – if the earliest diagnosis is found with a detox, ED visit or outpatient visit, there must be a subsequent service within 14 days for compliance.</td>
</tr>
</tbody>
</table>

38. Engagement of Alcohol and Other Drug Dependence Treatment

<table>
<thead>
<tr>
<th>Measure</th>
<th>Product</th>
<th>Age Group &amp; Sex (if indicated)</th>
<th>Indicators</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Commercial</td>
<td>No age specification</td>
<td>Patients who initiated treatment (as described above) and who had 2 or more additional services with an AOD diagnosis within 30 days of the initiation visit.</td>
<td>If treatment is initiated through an inpatient stay, the 30 days starts at the date of discharge.</td>
</tr>
</tbody>
</table>
### HEALTH ALLIANCE MEDICAL PLANS

<table>
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<th>Notes</th>
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</thead>
</table>
| 39.     | Commercial  | No age specification          | Pregnant women who receive prenatal care visits in the first trimester or within 42 days of enrollment in the health plan. Prenatal care includes ONE of the following:  
  - Basic OB exam including fetal heart tones, or pelvic exam with OB observations or measurement of fundus height  
    - OR -  
      - OB panel – or – TORCH antibody panel alone - or – rubella antibody test/titer with an Rh incompatibility blood typing – or – Echography of pregnant uterus.  
    - OR -  
      - Documentation of LMP or EDD with either prenatal risk assessment and counseling/education – or - complete OB history | Pre- and Postpartum visits include providers such as:  
  - Physician assistant  
  - Nurse practitioners  
  - Midwives |
| 40.     | Commercial  | No age specification          | Delivered women who had a postpartum visit on or between 21 and 56 days after delivery. Postpartum visit includes:  
  - Pelvic exam  
  - OR -  
    - Evaluation of weight, breasts, abdomen and blood pressure (notation of breastfeeding meets breast exam)  
    - OR - Notation of 'postpartum care' | Pre- and Postpartum visits include providers such as:  
  - Physician assistant  
  - Nurse practitioners  
  - Midwives |
| 41.     | Commercial  | 1-17 years                    | Children and adolescents with a new antipsychotic medication prescription with documentation of psychosocial care as first-line treatment                                                                 |                                                                                             |
| 42.     | Commercial  | 18-64 years                   | Number of acute inpatient stays during the measurement year followed by an unplanned readmission for any diagnosis within 30 days and the predicted probability of an acute readmission:  
  - Count of index hospital stays (denominator)  
  - Count of 30-day readmissions (numerator)  
  - Average adjusted probability of readmission |                                                                                             |

**Utilization and Risk Adjusted Utilization**

**Measures below are assessed through the annual CAHPS® satisfaction survey**

<table>
<thead>
<tr>
<th>Measure</th>
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<th>Age Group &amp; Sex (if indicated)</th>
<th>Indicators</th>
<th>Notes</th>
</tr>
</thead>
</table>
| 1.      | Commercial  | See Indicators                | Aspirin Use:  
  - Women 56-79 years with at least 2 risk factors for cardiovascular disease  
  - Men 46-65 years with at least 1 risk factor for cardiovascular disease  
  - Men 66-79 years of age | The CAHPS® survey is mailed to a sample of members each Spring. |
<table>
<thead>
<tr>
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<th>Indicators</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Flu Vaccinations for Adults Ages 18-64</td>
<td>Commercial</td>
<td>18 - 64</td>
<td>Members who received an influenza vaccination between July 1 of the measurement year and the date when the CAHPS® survey is completed.</td>
<td>The CAHPS® survey is mailed to a sample of members each Spring.</td>
</tr>
<tr>
<td>3. Medical Assistance with Smoking and Tobacco Use Cessation</td>
<td>Commercial</td>
<td>18+</td>
<td>Three indicators:</td>
<td>The CAHPS® survey is mailed to a sample of members each Spring.</td>
</tr>
<tr>
<td></td>
<td>(Accreditation measure is Advising Smokers to Quit indicator)</td>
<td></td>
<td>• Advising Smokers/Tobacco Users to Quit - current smokers/tobacco users who received advice to quit during the measurement year</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Discussing Cessation Medications – current smokers/tobacco users who discussed/were recommended medication during the measurement year</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Discussing Cessation Strategies – current smokers/tobacco users who discussed to were given cessation strategies during the measurement year</td>
<td></td>
</tr>
</tbody>
</table>
Health Alliance places a strong emphasis on providing a highly developed preventive care services program for its members.

One specific activity involves the implementation of preventive care guidelines to ensure members are properly screened and educated regarding a wide range of conditions. With the input of multiple physician teams and a review of national recommendations, Health Alliance uses three resources for prevention: Institute for Clinical Improvement (ICSI), the United States Preventive Services Task Force (USPSTF) and the Center for Disease Control. To view the guidelines online, log in to YourHealthAlliance.org for providers and choose Clinical Guidelines from the resources at the bottom of the page.

These parameters are not inclusive of all proper methods of care. The ultimate judgment regarding the propriety of any preventive health care recommendation must be made by the physician in light of the individual circumstances presented by the patient.

Please feel free to convey your recommendations to the Health Alliance Quality Management Department at 1-800-851-3379, extension 8112.
Clinical Guidelines at a Glance

Health Alliance Clinical Guidelines are available on YourHealthAlliance.org for providers and office personnel by choosing Clinical Guidelines from the resources at the bottom of the page. If you have questions or would like a paper copy of the guidelines, please call the Health Alliance Quality Management Department at 1-800-851-3379, extension 8112. While clinical practice guidelines are useful aids in determining appropriate care practices for patients with specific clinical problems or prevention issues, the guidelines are not meant to replace the clinical judgment of the individual physician or establish a standard of care.

Clinical Guidelines are based on the best practice standards using national guidelines as seed guidelines. The content is reviewed annually, and updated to reflect any new updates and evidence.

Examples of Clinical Guidelines include:

- The Institute for Clinical Systems Improvement (ICSI), an independent, not-for-profit collaboration of health care organizations, works toward implementation of best clinical practices. Visit ICSI.org, choose “Guidelines & More,” then search by keyword, type/condition or alphabetically by name. Multiple guidelines are available. Those pertinent to current Health Alliance initiatives include:
  - ADHD: Attention Deficit Hyperactivity Disorder in Primary Care for School-Age Children and Adolescents – endorsed with qualifications from the American Academy of Pediatrics guideline, ADHD: Clinical Practice Guideline, and Supplement (behavioral health)
  - Diagnosis and Management of Asthma (respiratory disease)
  - Adult Depression in Primary Care (behavioral health)
  - Diagnosis and Treatment of Headache (other healthcare conditions)
  - Diagnosis and Management of Chronic Obstructive Pulmonary Disease (COPD) (respiratory disease)
  - Osteoporosis, Diagnosis and Treatment (women’s health)
  - Obesity for Children and Adolescents, Prevention and Management of
  - Obesity for Adults, Prevention and Management of (preventive & health maintenance)
  - Tobacco Use – see Healthy Lifestyles, Preventive Services for Adults

- 2016 Standards of Medical Care in Diabetes
  Log in to YourHealthAlliance.org and choose Clinical Guidelines from the resources at the bottom of the page.

  www.nhlbi.nih.gov/guidelines/asthma/index.htm

- 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults
  circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437738.63853.7a

- 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults, Report from the Panel Members Appointed to the Eighth Joint National Committee (JNC 8)

- Global Initiative for Chronic Obstructive Lung Disease (GOLD)
  goldcopd.org, and click on “GOLD documents/2014 versions”

- NIAAA National Institute of Alcohol Abuse and Alcoholism “Helping Patients Who Drink Too Much”

Immunization Schedules
The Centers for Disease Control website provides immunization schedules and updates them throughout the year. Please visit CDC.gov/Vaccines to find the most current immunization schedules for children, adolescents and adults.
PURPOSE OF THE POLICY

The purpose of this policy is to ensure clinical guidelines promoted by the plan are based on reasonable medical evidence, made available to appropriate practitioners, and reviewed/updated at least once every two years.

STATEMENT OF THE POLICY

It is the policy of Health Alliance to adopt and disseminate practice guidelines for the provision of prevention, acute, chronic and behavioral health care services that are relevant to its enrolled membership. Practice guidelines are defined as "statements that include recommendations intended to optimize patient care. They are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.” (source: Institute of Medicine).

PROCEDURES

1. Designated Quality Management Coordinator

1.1 Supports the guideline process by:

- Facilitating guideline implementation, measurement and review/approval for their designated area and Disease Management Program
- Maintaining the Health Alliance and Carle web sites.
  - Check web sites quarterly for appropriate links and updates.
  - Problems with the website links and updates shall be corrected by the Communications Coordinator responsible for the website
- Ensuring guidelines are consistent with Health Alliance UM criteria, member education materials and disease/case management programs.

1.2 Practitioners assess the National Guidelines Clearinghouse as the main resource available for new guidelines and updates, which includes but is not limited to, the Centers of Disease Control and Prevention (CDC), and American Congress of Obstetricians and Gynecologists (ACOG).
Policy and Procedure: Clinical Guidelines, continued

2. Approval

2.1 Guidelines are reviewed and approved at least once every two years. If not reviewed and approved at least every two years, then the guideline is void.

2.2 Guidelines are adopted for at least two medical conditions and at least two behavioral conditions. At least one behavioral guideline must address children and adolescents.

2.3 At least two of the guidelines provide the clinical basis for disease management programs for medical conditions.

2.4 The Quality and Medical Management Director or designee oversees review of the guidelines and makes these changes available to the Quality Improvement Committee.

2.5 Guidelines are sent to the Quality Improvement Committee (QIC) for review and approval annually.

2.6 QIC prioritizes guideline development, as needed, and is the Health Alliance approval body.

3. Distribution

3.1 After annual review of the guidelines, they are made available on the Health Alliance website.

3.2 Written notification of their availability is sent to all participating practitioners via an article in inforMED. The article includes instructions for obtaining a paper copy of the guidelines.

4. Measurement

4.1 The effectiveness of practice guidelines are “determined by scientific evidence; or by professional standards, in the absence of scientific evidence; or by expert option, in the absence of professional standards” (source: NCQA)

4.2 Health Alliance measures performance against two important aspects of at least four clinical guidelines annually to determine practitioner adherence.

4.3 Two of the four guidelines must focus on behavioral health care.
Serious Reportable Events

**Adverse Events**
It is the policy of Health Alliance Medical Plans to have a formal procedure to provide structure and guidance regarding the review of adverse events for any potential injury that occurs while a member is receiving health care services from a participating practitioner/provider.

**Sentinel Events**
Sentinel Events are quality of care concerns or occurrences that can be submitted orally, in writing or identified through the concurrent review process. Health Alliance employs a Member Relations Quality Improvement Coordinator, a registered nurse that works closely with a medical director to provide a review of the concerns and take action, if needed.
Claims Filing Procedures

A. All claims are processed at the Health Alliance office in Urbana, Illinois. The mailing address for submission of paper claims is:

Health Alliance Medical Plans, Inc.
Attn: Claims Department
301 S. Vine St.
Urbana, IL 61801-3347

B. Inquiries regarding claims payment should be directed to Health Alliance Customer Service Department in Urbana at 1-800-851-3379.

C. Claim requirements are as follows:

- If you are filing a paper copy of your claim, the following services must be detailed on a HCFA 1500 or UB04 billing form. Minimum data requirements include:
  1. Provider Name, Address, Telephone Number and NPI
  2. Referring Provider Name, Address, Telephone Number and NPI
  3. Type of Bill or Frequency Code
  4. Federal Tax ID Number (employer identification number)
  5. Statement Covers Period (beginning and ending service dates of the period included on the bill)
  6. Patient Name, Member Number, Address, Birthdate and Sex
  7. Place of Service
  8. Admission Date, Admission Hour, Type of Admission, Source of Admission
  9. Discharge Hour
  10. Patient Status
  11. Condition Codes, if applicable
  12. Occurrence Codes and Dates, if applicable
  13. Occurrence Span Code and Dates, if applicable
  14. Responsible Party Name and Address
  15. Value Codes and Amounts, if applicable
  16. Revenue Codes
  17. Revenue Description
  18. HCPCS Codes and Modifiers/Rates
  19. CPT/HCPCS Codes and Modifiers
  20. Service Date required on outpatient series bills
  21. Units of Service
  22. Total Charges (by Revenue Code Category); includes covered and non-covered charges
  23. Non-Covered Charges, if known
  24. Payer Identification (primary/secondary)
  25. Release of Information Certification Indicator
  26. Prior Payment Information
  27. Insured’s Name, Health Alliance Member Number (11 digits), and Insured Group Name
  28. Principal, other, admitting/patient’s reason for visit, and E-code ICD-9-CM (or ICD-10 after October 2014) Diagnosis Codes (diagnosis codes must be coded to the highest degree of specificity)
  29. DRG Code
  30. Procedure Code(s)-ICD-9-CM and Date
  31. Attending Physician
  32. Other Physician
  33. Provider Representative Signature
  34. Date Bill Submitted
  35. Present on Admission Indicator
  36. Ambulance Pick-Up and Drop-Off Info, if applicable

D. Full charges are to be included on the claim form. Health Alliance will process claims according to member’s benefit plan and provider payment terms. Adjustments will be detailed on the paper Remittance Advice or electronic HIPAA 835.

E. Claims for members with other primary coverage should be filed to the primary carrier first. Remaining balances should be filed to Health Alliance with the claim form and primary payer’s Explanation of Benefits. Claims filed to Health Alliance without the primary payer’s Explanation of Benefits will be returned to the provider for resubmission. Secondary claims can also be submitted electronically with appropriate HIPAA 837 COB loops and segments populated.
F. Every member is issued a plastic, wallet-size identification card. As indicated, the face of the card includes the member’s preferred provider physician office visit copayment, specialty visit copayment and emergency room copayment or coinsurance.

G. The Provider’s Remittance Advice includes an explanation of payments, denials and adjustments for each detail charge, and is also included in this section.

H. Explanation of Benefits (EOB) are available to members via the Health Alliance Web portal. A sample of Health Alliance’s EOB is included, as well as an explanation of the EOB.

I. Claim adjustments (i.e., for duplicate payments, overpayments, etc.) are deducted from the provider’s next claim payment. The Remittance Advice report will provide detail of all claims being paid and will also indicate any claims being adjusted.

J. Health Alliance utilizes a claims analysis software program called CES. This system provides an extensive set of base rules that will utilize historical data to audit claims for appropriate coding guidelines.

CES identifies coding errors related to unbundling, modifier appropriateness, mutually exclusive and incidental procedures, inappropriate billing and questionable coding relationships. The system does this by utilizing a knowledge base containing more than 9 million government and industry rules, regulations and policies governing health care claims. The editing rules are built upon nationally recognized and accepted sources, including American Medical Association CPT guidelines, CMS guidelines, specialty society recommendations, the National Correct Coding Initiative and current medical practice standards.

Per your Participating Provider Agreement with Health Alliance, you may not charge Health Alliance members for covered services except standard copayments, coinsurance and deductibles.

K. Following are standard coding practices observed by Health Alliance:

Modifiers application: Health Alliance accepts all current CPT and HCPCS modifiers for physicians and facilities.

Most commonly used modifiers:

- **-51 Multiple procedures by the same physician performed the same day.** The highest level procedure is paid at 100 percent of fee schedule or contracted rate. All subsequent procedures are paid at 50 percent (this applies to facility charges as well). Exception: Multiple Scopes. Health Alliance follows the same guidelines as Medicare for payment of multiple scopes.
- **-50 Bilateral procedures, this modifier is used when unilateral procedures are performed bilaterally. Payment will be 150 percent.**
- **-80 Assistant surgeon, Health Alliance reimburses for assistant per CMS guidelines indicating procedures where an assistant is necessary. Reimbursement is 20 percent.**
- **-62 Two surgeons, under certain circumstances the skills of two surgeons may be required. Both surgeons will report the indicated code with the –62 modifier. Reimbursement will be 62.5 percent to each surgeon.**

Descriptive modifiers such as LT and RT will facilitate claims processing and often negate requests for additional documentation.

L. **R1422OTN – Specific Modifiers for Distinct Procedural Services**

Summary of Changes: CMS is establishing four new HCPCS modifiers to define subsets of the –59 modifier, a modifier used to define a “Distinct Procedural Service.”

**Effective Date:** January 1, 2015
*Unless otherwise specified, the effective date is the date of service.

**Implementation Date:** January 5, 2015
Claims Filing Procedures, continued

CMS has defined four HCPCS modifiers to selectively identify subsets of Distinct Procedural Services (–59 modifier) as follows:

- XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter
- XS Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
- XP Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner
- XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

These modifiers, collectively referred to as –X {EPSU} modifiers, define specific subsets of the –59 modifier. CMS will not stop recognizing the –59 modifier but notes that CPT instructions state that the –59 modifier should not be used when a more descriptive modifier is available. CMS will continue to recognize the –59 modifier in many instances but may selectively require a more specific –X {EPSU} modifier for billing certain codes at high risk for incorrect billing. For example, a particular NCCI PTP code pair may be identified as payable only with the –XE separate encounter modifier but not the –59 or other –X {EPSU} modifiers. The –X {EPSU} modifiers are more selective versions of the –59 modifier, so it would be incorrect to include both modifiers on the same line.

The combination of alternative specific modifiers with a general less specific modifier creates additional discrimination in both reporting and editing. As a default, at this time CMS will initially accept either a –59 modifier or a more selective –X {EPSU} modifier as correct coding, although the rapid migration of providers to the more selective modifiers is encouraged. However, these modifiers are valid modifiers even before national edits are in place, so contractors are not prohibited from requiring the use of selective modifiers in lieu of the general –59 modifiers when necessitated by local program integrity and compliance needs.

Anesthesia Payment

Health Alliance uses Medicare guidelines in regards to the base units. Anesthesia services are calculated in fifteen (15) minute time units. Time is rounded to the nearest fifteen (15) minute time unit. If less then five (5) minutes no time unit will apply; five (5) minutes to fourteen point nine (14.9) minutes, one time unit will apply. In addition our calculator takes the base, time, modifiers and qualifying circumstances into consideration when calculating payments.

In addition to the time units calculation noted above, the National Coverage Provisions for Anesthesia Services established unique modifiers for anesthesia services that tell the payer if the services performed were medically supervised by a physician or performed without medical direction by or assistance from a physician. Those modifiers indicating services were provided by both anesthesiologist and Certified Registered Nurse Anesthetist (CRNA) will be entered in the modifier schedule at a 50 percent reduction (similar to modifier 51). The system will take the appropriate reductions at the time of service.

The four modifiers that are updated to 50 percent are:

- AD – Medically supervised by a physician for more than four concurrent procedures
- QK – Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
- QX – CRNA with medical direction by a physician
- QY – Medical direction by one CRNA or by an anesthesiologist

Multiple Scope Billing

We follow the same guidelines as Medicare for multiple scope billing reimbursement. This applies different logic than a multiple procedure reduction with the 51 modifier.

Health Alliance refers to endoscopic Base code and Secondary codes when determining the correct allowable for multiple scopes performed during same session.

Medicare has created a list of the base codes used for paying secondary endoscopic procedures related to the primary scope.

The Base code has assigned secondary codes (family of codes).

When billing, each procedure would be reported. But because the value of the base code is included in each code in that particular “family of codes”, a different reduction logic is applied. All of this is outlined in Medicare guidelines.
Claims Filing Procedures, continued

If two unrelated endoscopic procedures are performed in the same session, but not within the same family of codes, then modifier 51 multiple procedure logic would apply. This is when the highest level procedure is paid at 100% of fee schedule or contracted rate, and all subsequent procedures as paid at 50%.

Some websites which may be helpful:

CMS.HHS.gov/manuals - Medicare Claims Processing Manual Chapter 12 Physician Billing
CMS.HHS.gov/FeeScheduleGenInfo/ - physician fee schedule; PFS relative value files

Reimbursement for supplies billed in addition to a surgical procedure are considered to be inherent in the procedure.

*When reporting supplies, the appropriate HCPCS code must be indicated. Unlisted procedures/services; as industry standards, Health Alliance requires documentation for clarification.

Annual Coding Changes

ICD-10 CM: effective October 1, 2015 Health Alliance began accepting new ICD-10 diagnosis and procedure codes.

CPT-HCPCS: effective January 1 of each year Health Alliance begins accepting new/revised procedure codes. To be compliant with HIPAA standards, there is no longer a 90-day grace period for discontinued codes. Resubmission of a new/more appropriate code will be required.

Global surgery billing includes all necessary services normally furnished by the surgeon beginning with the day before surgery, the day of surgery, and the designated post-op period. Health Alliance follows the same guidelines as CMS. To indicate a service is not part of the global package, appropriate modifiers must be used (i.e., -24, -25, -57, -78, -79.)

Global obstetrical billing normally requires one global copayment to cover all physician visits for routine prenatal care and post-partum check-up. Specialty visits during pregnancy, and services provided by a perinatologist outside the scope of routine prenatal care, do have an additional office copayment.

Health Alliance Specific reimbursement policy:

Venipunctures: Health Alliance considers the collection of venous blood to be incidental to performing the laboratory test. However, Health Alliance will reimburse for the venipuncture if the laboratory test is not performed in-house but sent to a reference lab. In that event, the laboratory test code(s) must be appended with the 90 modifier.

Timely Payment Act (Illinois):

This Act was effective December 16, 1999, for Individual Plans was passed in June, 2000, for group plans. The components of the Act that directly affect claim payments are:

Clean Claims—Payments are to be made within 30 days of receipt of a claim.
Non-Clean Claims—Request for information is to be made within 30 days of receipt of a claim. Claims are to be paid within 30 days of receipt of requested information.
Interest Payments—Failure to make claim payments for fully insured members within the time periods will entitle the provider to interest at the rate of 9 percent per year from the date payment was required to be made to the date of the payments. Interest payments are to be made within 30 days after payment. Interest amounting to less than $1 does not have to be paid. The interest payment will not be on the same remittance advice as the original claim. It will be identified separately on the remittance advice.

Timely Payment Act (Iowa):

This Act was effective July 1, 2002, for all fully insured plans (individual and group). The components of the Act that directly affect claim payments are:

Clean Claims—Payments are to be made within 30 days of receipt of a claim.
Non-Clean Claims—Request for information is to be made within 30 days of receipt of a claim. Claims are to be paid within 30 days of receipt of requested information.
Interest Payment—Failure to make payments within the time periods will entitle the provider to interest at the rate of 10 percent per year beginning on the 31st day after receipt of all the information. The interest payment will not be on the same remittance advice as the original claim. It will be identified separately on the remittance.
Claims Filing Procedures, continued

Health Care Prompt Payment Act (Nebraska):
This Act was effective in 2005. The components of the Act that directly affect claim payments are:

- **Clean Claims**: Payments are to be made within 30 days of receipt of a claim if submitted electronically and forty five days after receipt if submitted in a form other than electronically.
- **Non-Clean Claims**: Request for information is to be made within 30 days of receipt of a claim. Claims are to be paid within 30 days of receipt of requested information. The responsible party to submit the additional information requested should submit this information within thirty calendar days of the request.
- **Interest Payments**: Failure to make claim payments for fully insured members within the time periods will entitle the provider to interest at the rate of 12 percent per year from the date payment was required to be made to the date of the payments. Interest payments are to be made within 30 days after payment, or on a basis when aggregate interest for a health care provider exceeds ten dollars. The interest payment will not be on the same remittance advice as the original claim. It will be identified separately on the remittance advice.

Note: Reimbursement inquiries should be submitted using the Claims Submission Inquiry tool on YourHealthAlliance.org for providers.

Process for Invalid Claims
You may have seen some changes with your critical error reports. Before March 2013, Relay Health would submit claims to Health Alliance, and if the claim hit a critical error due to an invalid member number or date of birth, Relay Health would return the critical error to the provider or clearing house that originally sent it to them.

With the current process, the claim does not hit a critical error report; it loads the claim into our claims system under a bogus member number (999981111-01) and the remittance advice states the claim was denied due to invalid member information. Please correct the information and resubmit electronically.
### Sample Member Identification Cards

#### Fully Insured IL PPO ID card

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<tr>
<th>Member Name:</th>
<th>RxBIN: 005947</th>
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<tbody>
<tr>
<td>Member Number:</td>
<td>Cards Iss ID: 80840</td>
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<tr>
<td>Subscriber Name:</td>
<td>Group: A12345</td>
</tr>
<tr>
<td>In-Network Copay/Coinsurance:</td>
<td>* Office Visit: Specialty Visit: Emergency:</td>
</tr>
</tbody>
</table>

* Copayments apply to office visits with physicians, physician assistants, nurses and other mid-level providers.

**Date Card Printed:**

#### Fully Insured State of Illinois ID card

<table>
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<tr>
<th>Member Name:</th>
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</thead>
<tbody>
<tr>
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<td>Subscriber Name:</td>
<td>Group: A12345</td>
</tr>
<tr>
<td>In-Network Copay/Coinsurance:</td>
<td>* Office Visit: Specialty Visit: Emergency:</td>
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* Copayments apply to office visits with physicians, physician assistants, nurses and other mid-level providers.

**Date Card Printed:**

#### Standard Self-Funded ID card

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**Date Card Printed:**
Electronic Filing/Express Line

Speed, accuracy and ease of processing are just a few of the reasons filing electronic claims is so popular. Health Alliance accepts both physician and hospital claims electronically. Medical offices and hospitals that use electronic filing also save money. All our multi-specialty groups and facilities are taking advantage of this technology. Isn’t it time you did the same?

Electronic filing eliminates double data entry – your staff are the only ones who enter claim information. Once the claim reaches Health Alliance, it is automatically loaded in our system, eliminating days of hand processing, sorting and scanning. Ensure the most accurate, rapid claims filing turn around times by using an electronic filing system to file your Health Alliance claims. Please contact your billing system vendor and request they file your claims through RelayHealth under payer ID 77950 to make sure claims reach Health Alliance. You can also call RelayHealth directly at 1-877-411-7271 to discuss options for submitting your claims electronically to Health Alliance. A no-cost option is also available with MD On-line at 1-888-499-5465 or MDON-LINE.com.

Health Alliance requires your ten-digit National Provider Identifier (NPI) for electronic claims.

All electronic claims must comply with the HIPAA 5010 transaction set as required by the Centers for Medicare and Medicaid Services (CMS).

If you have questions, please have your office staff call the Health Alliance System Configuration Department at 1-800-851-3379, extension 8566.

Electronic Claim Critical Error Message

Please note that if a claim has a critical error, it is not stored in our system. You have 90 days to resubmit a claim. The following is a summary of the most common critical errors you may receive when attempting to submit claims electronically:

**Admitting Provider not on file or not submitted.**
- This error message is limited to inpatient claims because admitting provider is a required field. Often times these errors can be fixed internally after admitting provider record has been reviewed to determine UPIN and/or license number. However, if the information is unable to be verified, the claim will reject and have to be submitted on paper.

**DRG Code not submitted or is invalid.**
- The submission of the DRG is required even if the provider is not reimbursed by DRG. This error message is limited to inpatient claims because the DRG is a required field. This error indicates the DRG field was either blank or invalid (i.e., miss key, old code).

**Provider not on file.**
- Health Alliance requires your NPI for electronic claims. If this number is not submitted or doesn’t find a valid match in our system, you will receive this error message. Please note, it is extremely important that your NPI is submitted in it’s entirety and is accurate, because an invalid submission may result in a match on another provider’s identification number. In addition, every provider location with a unique provider number must be submitted under their respective identification number.

**Vendor not on file.**
- This error message indicates the vendor number (tax ID) submitted does not match our system.

**Group and/or member is not eligible.**
- **Member not eligible—coverage group contract date error.**
  - This error message indicates the group coverage record or the member record is no longer effective.

**Contract history record not found.**
- This error message occurs when a provider has multiple records and the system is trying to read a record that has been terminated or marked as DO NOT USE. These errors can often be corrected internally so that resubmission is not required by removing the NPI and the tax ID from the header of the terminated records.

**G/L distribution code DEF not found.**
- This error message is completely an internal system issue at Health Alliance. These claims should be submitted in paper format for manual processing.

**Modifier not on file.**
- The two-digit modifier submitted on the claim is either miss keyed or invalid. The correct modifier must be submitted for the claim to load into the production system.
Price Category Record not found.
- This often means procedure code is not found in the fee schedule for pricing and claim must be resubmitted.

Express Line–Your Quick Link to Information
We have priorities at Health Alliance—and superb customer service is at the top of the list. To enhance our ability to serve both members and providers better, Health Alliance offers Express Line. Using a touch-tone phone, you can call this virtually “round-the-clock” system to check patient eligibility. Express Line is not replacing the Customer Service Department. Callers will always have the option of speaking directly with a Customer Service representative.

Simply dial 1-800-851-3379 to be connected to the system. Express Line is available 24 hours on the weekend and all day Monday-Friday except from 10 p.m. to 2 a.m. This secure and easy-to-use system can be accessed using your provider number. If you call regarding a patient, you will need the patient’s member number and date of birth. Members also will be able to request an ID card and check eligibility.

Or log in to YourHealthAlliance.org for providers and attach to a member to see the details of their plan’s coverage.

Electronic Funds Transfer
Health Alliance offers electronic funds transfer (EFT) through Emdeon. EFT can reduce postal delays and may reduce administrative steps associated with issuing or depositing payments. To enroll, you can either call Emdeon at 1-866-506-2830 and select Option 1 or download the enrollment form from the Emdeon website:


By enrolling in Emdeon’s EFT program, providers are signing up to receive electronic payment distribution for all payers participating in Emdeon’s EFT program. No additional EFT agreements are required with the participating payers.

Emdeon’s EFT program is HIPAA compliant and confidential. Once enrolled, it usually takes 2-3 weeks for payments to begin. If you have questions about enrolling, please contact Emdeon at 1-866-506-2830 and select Option 2.
Health Alliance
301 South Vine Street
Urbana, IL 61801

Return Service Requested

ALL FOR AADC 617

Busey Bank

CHECK NO:

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<th>MO</th>
<th>DAY</th>
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PAY *****Two Hundred Seventy One & 98/100 Dollars
PAY TO THE ORDER OF

VOID

Jeffrey

VOID AFTER 180 DAYS
### Remittance Advice

**Check #:**
Check Date: 11/02/2006  
Check Amount: 271.98

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**Claim #:**  
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<tr>
<td>EYE EXAM, ESTABLISHED PATIENT</td>
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**Claim Comments:**

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**DUPLICATE CLAIM/SUBMISSION**

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<th>ADJUST</th>
<th>ADJ CODE</th>
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<td>06/29/2006</td>
<td>97.00</td>
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<td>97.00</td>
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**CLAIM TOTALS:**

<table>
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<tr>
<th>DATES OF SERVICE</th>
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<th>NCV RSN</th>
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<tbody>
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**Provider:**

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**OFFICE CONSULTATION**

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<th>ADJUST</th>
<th>ADJ CODE</th>
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<td>10/23/2006</td>
<td>186.00</td>
<td>148.80</td>
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<td>COA2</td>
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**CLAIM TOTALS:**

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**PAYER TOTALS:**

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<td>707.00</td>
<td>443.28</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>271.98</td>
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</table>

**Code:**

- **COA2**  Contractual Adjustment
- **OA18**  Duplicate claim/service.
- **OA23**  Payment adjusted because charges have been paid by another payer.
Section 1—Vendor Information Block
Includes Vendor (same as Federal Tax ID #), Vendor Name, amount of check and check number.

Section 2—Title Line for Claim Data
This line describes each data element printed per claim detail. The corresponding data for this line is found under the Patient Identification Line.

Section 3—Patient Identification Line
The claim data is sorted in alphabetical order by Patient Name. This line provides the patient’s name (last name, first name and middle initial) and the patient’s Health Alliance member number. Following the patient line is the detailed claim information.

Section 4—Claim Data Lines
This section provides claim data under the title lines described in each patient identification line. Claim data is entered in detail; therefore, multiple lines per invoice will be shown.

A. Provider Name
B. Provider Account #
C. Admission Data/1st Date of Service on Invoice
D. Form #
   ♦ Health Alliance assigned claim
E. Proc Code
   ♦ Each Revenue Code, CPT4 Code, or HCPCS Code on the Invoice will be listed in this column.
F. Description
   ♦ A description of each Procedure Code will appear here.
G. Billed $
   ♦ The charge corresponding to each procedure code
H. Allowed $
   ♦ The Allowed $ for each detail line. Provider discounts, charges over usual and customary, etc. are deducted from Billed $ to arrive at Allowed $.
I. Adjust $
   ♦ This is the difference between Billed $ and Allowed $.
J. Adj. Rsn
   ♦ Adjustment Reason codes appear to define the difference between Billed $ and Allowed $. A legend of the codes prints with each remittance.
K. Not Cov $
   ♦ This amount field includes charges and payments made by other carriers (Medicare, commercial, etc.)
L. Not Covered Rsn
   ♦ This code defines the reason why dollars are in the not covered column. A legend of the codes prints with each remittance.
M. Copay + Deduct
   ♦ This amount field includes copayments, coinsurance and deductibles.
N. Withheld $
   ♦ This field contains $ withheld as part of the provider payment terms.
O. Paid $
   ♦ This is the amount paid for this line.

The remittance report provides totals for each claim/invoices and provides grand totals at the end of the report for balancing with the check.
**Health Alliance**  
301 South Vine Street  
Urbana, IL 61801  

**Return Service Requested**  

---

**EXPLANATION OF BENEFITS**  

**THIS IS NOT A BILL**  
**RETAIN COPY FOR YOUR RECORDS**

<table>
<thead>
<tr>
<th>Date:</th>
<th>10/07/2006</th>
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<tbody>
<tr>
<td>Subscriber:</td>
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<td>Member #:</td>
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</tr>
<tr>
<td>Claim #:</td>
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<tr>
<td>Group:</td>
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<tr>
<td>Processed Date:</td>
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<tr>
<td>Check to be Issued To:</td>
<td>Provider</td>
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**PROVIDER:**

<table>
<thead>
<tr>
<th>Date of Service / Procedure Code/Description</th>
<th>Total Charges</th>
<th>Provider Discount / Adjust</th>
<th>Deductible</th>
<th>Copay / Coins</th>
<th>Non-Covered Charges</th>
<th>Other Insurance Paid</th>
<th>Paid by Health Alliance</th>
<th>Non-Covered Reason</th>
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<td>09/27/2006 J1055 - MEDROXYPROGESTERON ACETATE, CONTRACEPTIVE USE</td>
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<td>09/27/2006 90772 - THERAPEUTIC INJECTION, SUBCU</td>
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<td>$9.90</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$23.10</td>
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<td><strong>TOTALS:</strong></td>
<td><strong>$116.00</strong></td>
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**MEMBER RESPONSIBILITY**

<table>
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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>30</td>
<td>Services Provided Are Not Covered By The Plan</td>
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</tbody>
</table>

- Individual Deductible Remaining For Current Benefit Year: $0.00
- Family Deductible Remaining For Current Benefit Year: $68.00
- Individual Copay/Coinsurance Remaining For Current Benefit Year: $0.00
- Family Copay/Coinsurance Remaining For Current Benefit Year: $1,487.12

Some services may not apply to your benefit year deductible and/or your out-of-pocket maximum. Please refer to your Description of Coverage Worksheet or your Summary Plan Description for specific information, or call Customer Service for assistance.

---

**VOID**

Si usted necesita un intérprete para traducir esta información, por favor llamar al teléfono gratis 1-800-322-7451 y pregunte pro la "Language Line."

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6.14
**Explanation of Benefits**

| **Subscriber/Participant:** | Subscriber/Participant Name (Policyholder)  
<table>
<thead>
<tr>
<th></th>
<th>Subscriber/Participant Address</th>
</tr>
</thead>
</table>
| **Member/Beneficiary:**    | Member/Beneficiary Name  
|                           | Health Plan ID # |
| **Provider:**              | Provider of service  
|                           | Provider address |
| **Form #:**                | Assigned claim # |
| **Group:**                 | Name of employer group providing coverage |
| **Service Date:**          | Date services were rendered  
|                           | Service description is listed below service date |
| **Billed Amount:**         | Amount billed by provider |
| **Provider Adjust:**       | Amount that billed charges was discounted according to provider contract amounts and other amounts to be adjusted by provider. Examples of the latter include: a duplicate claim filed and a fee reduction applied to a procedure modifier. |
| **Plan Paid:**             | Amount paid by Plan |
| **Patient Responsibility:**| Charges applied to patient’s deductible.  
|                           | Portion of charges due by the patient due to policy copayments/coinsurance.  
|                           | Charges not covered by the patient’s policy. This column also includes amounts paid by Medicare and/or other primary payers as noted in the Non-covered Reasons. |

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**6.15**
Billing for Services

Health Alliance requires all claims to be submitted within the timeframe stated in the provider contract. Outpatient services for Health Alliance members must be billed within 90 calendar days from the date of service, and inpatient services must be billed within 90 calendar days of the date of discharge. If the member has a different primary insurance or third-party payor, then Health Alliance must be billed within 90 calendar days of receipt of an explanation of benefits from the primary payor.

“Date of Service” (DOS) refers to the actual day you perform a service for your patient. The Health Alliance standard timely filing limit is 90 days. Self-funded plans may have their own timely filing limits that are different from the Health Alliance standard. This is not reflected in the provider contract. Contact your Provider Relations Specialist should you have any questions. Health Alliance uses the DOS for claims purposes. When submitting claims for any service you provide, it must be within 90 calendar days of the DOS. If not, the claim will be disallowed. For example, if you provide services to your patient on August 1, 2016, the claim must be received at Health Alliance before November 1, 2016.

Also, please use the standard HCFA 1500 or UB04 claim form and include standard code submissions (both principal and secondary), complete coding and CPT Modifiers. Failure to submit complete information may result in delayed or loss of reimbursement.

If you have any questions about this process or the timeframes, please consult your provider relations specialist.

Submitting Workmans’ Compensation Claims
To ensure payment for possible compensation (WC) claims, please follow the preauthorization process including services on the preauthorization list, as well as all referrals for secondary, tertiary and out-of-network providers.

To increase efficiency, you can bill both WC (as primary) and Health Alliance (as secondary) at the same time. Health Alliance will then pend the claim until WC pays or denies. If the claim is paid or denied, send this documentation to Health Alliance within 90 calendar days, and we will proceed with processing the claim. Please call your provider relations specialist with questions.

Timely Follow-up on Claims
If you have not received payment or notification from Health Alliance about a claim within 30 days of the submission date, please follow up with Health Alliance to check the status. You can check the status of a claim on our website, www.healthalliance.org. If you have received a request for more information about a claim, please follow up with Health Alliance within 90 calendar days of request to avoid denial of the claim.

Recoupment Appeals Limit: Effective January 1, 2012, the State of Illinois set a time limit on recoupment appeals from providers. Providers/billing offices have 60 days after the receipt of a paper or electronic remittance advice to appeal recoupments or offsets.

Submitting Refunds
When sending Health Alliance a refund, please make sure you provide the information needed to properly account for it. If Health Alliance has requested the refund, please make sure you include the information requested in the letter. If you are sending a refund for a claim Health Alliance has not yet contacted your office about, please include the following information:

- Member name
- Health Alliance ID (if available)
- Date of service
- Provider of services
- Detailed explanation of why you are sending a refund.

Please send all correspondence regarding refunds to:
Health Alliance Medical Plans
Attn: Recovery Department
301 S. Vine St.
Urbana, IL 61801
Claims Submission Exceptions

Liable Third-Party Claims:
The submission timeframe will begin later when a third-party payor is involved (i.e., workers’ compensation, other commercial insurance, etc.). Once the provider receives notification from the third party of payment or denial of the submitted claim, the provider then has 90 days to submit the appropriate information to Health Alliance for processing.

(Example: Member has other primary coverage and receives care from a Health Alliance contracted provider on January 1, 2016. The claim is received at Health Alliance on May 1, 2016; the other insurance EOB is dated March 1, 2016. Claim would typically be denied based on the 90-day timeframe; however, because another carrier is primary and its EOB is dated March 1, 2016, the provider has until June 1, 2016, to submit its claim to Health Alliance.)

Difficulty Obtaining Member Insurance Information:
The provider must have supporting documentation to show effort to collect this information and will be given 90 days from the date it obtains the information, but no longer than 180 days from the date of service.

Prenatal Visits:
Claims that normally would have been billed as part of a global OB charge but are being billed separately due to a change in physician or member condition must be submitted no later than 90 days following the date of delivery.

New or Additional Information:
Any information that would require a claim to be reprocessed must be submitted within the 90-day period following the receipt of the new information or within the 90-day period following the request for additional information made by Health Alliance.

Resubmission Due to an Error:
Claims being resubmitted as a result of an error on the part of Health Alliance can be resubmitted up to one year following the date of the initial payment or denial (provider remittance advice).

In Advance Request:
When a provider has contacted Health Alliance in advance requesting a temporary extension of the filing limit for just cause as determined by Health Alliance.
Health Alliance administers pharmacy benefits in conjunction with OptumRx, a pharmacy benefit management company. This function is coordinated by the Pharmacy Department at Health Alliance. Activities of this department include:

- Pharmacy network development and maintenance
  - Contracting
  - Monitoring/auditing
- Third-party claims processor relations, contract development and management
- Manufacturer discount contracting
- Pharmacy & Therapeutics Committee support
- Drug formulary coordination and management
- Medical Management Department clinical support
- Medical Directors Committee and Administrative support
- Quality Improvement Committee support
- Pharmacy utilization reporting and physician support
- Customer Service Department and Claims Department support
- Medicare Part D Formulary coordination and management
The Health Alliance drug formulary has been created to assist in the management of ever-increasing costs of prescription medications. The use of formularies to provide physicians with a reference for cost-effective medical treatment has been used successfully in health insurance organizations throughout the country.

The drug formulary has been created under the guidance of physicians and pharmacists representing most specialties. The Pharmacy and Therapeutics Committee (P&T) evaluates the needs for most patients, use of products, and cost-effectiveness as factors to determine the formulary choices. In all cases, available bioequivalency data supply and therapeutic activity are considered.

The P&T Committee meets on a regular basis to evaluate the changing needs of physicians and patients. We urge you to provide recommendations for improvement of the drug formulary and its contents. It is our belief that the Drug Formulary can enhance your ability to provide quality, cost-effective care to your Health Alliance patients.

The use of products on the drug formulary is encouraged as a method to provide quality care at a lesser cost. If a pharmacist receives a prescription for a Tier 3 drug, the prescription will not be covered or may be assessed at the highest copayment tier, e.g. $25-$70 up to 50 percent of the cost of the medication.

The use of generic and over-the-counter (OTC) products is highly recommended where applicable.

To view our formulary online, visit HealthAlliance.org/Pharmacy and then select the formulary you wish to see. To search within the PDF document, choose the search function (the picture of binoculars), enter a drug name and click “search.” If you need a paper copy of the current formulary, please contact your provider relations specialist.

To reach the Health Alliance Pharmacy Department, please call 1-800-851-3379, option 4.
Pharmacy Copayments

A member will pay applicable deductible and/or copayments/coinsurance unless one of the following conditions applies:

In most cases, a prescription written for a product with an OTC equivalent will not be covered. The pharmacy will direct the member to the OTC product. There are some exceptions to this policy. Members should be referred to the Health Alliance Customer Service Department for quotation of benefits.

For fully insured plans, the member’s pharmacy benefit design charges a Dispense as Written (DAW) difference when a brand name drug is chosen over the more cost-effective generic for a majority of therapeutic classes. Criteria for coverage to override the Mandatory Generic Drug language policy requires documented allergic reaction to the generic drug. Reactions can include, but are not limited to: rash, shortness of breath, shock. Normal side effects or lack of efficacy for the medication in question are not considered allergic reactions. Generic substitution requirements may vary slightly for self-funded plans. Members should be referred to the Health Alliance Customer Service Department for quotation of benefits.

The Drug Formulary does not apply to medication administered in the physician’s office or used in inpatient settings.

Unless otherwise noted, all dosage forms of the listed drug products are covered. Please review those classes that you frequently use to determine which product formulations offer the best treatment choices. Some products listed also have other limitations to their use.

Members have a medical exception policy which allows a request to have a Tier 3 drug covered at the Tier 2 copayment based on the following criteria. Criteria for coverage requires documentation of trial and failure of every formulary agent in the same therapeutic class or documentation of allergic reactions or contradictions to every formulary agent in the same therapeutic class. Agents that are the only drug entity in a therapeutic class are not eligible for reduction in copayment.
Excluded or Non-Reimbursable Products

Member certificates of coverage state that drug products will be covered only for indicated use. Approved indications include the labeled indications (FDA approved) and other indications that are unequivocally accepted as standard for practice in the medical community as determined by physicians on the Pharmacy and Therapeutics (P&T) Committee.

Excluded Products (but not limited to):
- Non-prescription drugs (i.e., over-the-counter [OTC] medications), except for insulin and insulin syringes
- Drugs which are not considered to be medically necessary, including but not limited to: psoralens, tretinoin and oral anti-fungals for cosmetic use; weight loss
- Products classified as a Prescription Medical Device by the FDA including but not limited to: therapeutic devices, artificial appliances, support garments, bandages, etc.
- Products classified as Medical Food or supplements, including but not limited to Deplin®, Neocate®, Pediasure®, Ensure®, etc.
- Prescription strength benzoyl peroxide and combination products
- Non-sedating antihistamines and combinations, including but not limited to: Claritin®, Claritin®-D, Clarinex®, Allegra®, Allegra®-D, Zyrtec®, Xyzal®
- Dermatologic formulations of existing covered generic products that offer no additional benefit or clinical benefit (cosmetically pleasing formulations), including but not limited to: Clobex® lotion/shampoo (clobetasol), Vanos® (fluocinonide), Capex®, Luxiq® (betamethasone), Olux® (clobetasol), Olux-E (clobetasol emulsion), Verdeso Aer® (desonide foam)
- Replacement of lost/stolen/damaged medication(s)
- Any drug determined to be abused or otherwise misused by a member

Restricted Formulary (requires preauthorization)
- Specialty Prescription Drugs
- Biotechnology products, biologicals and treatment for uncommon or rare diseases (Human growth hormone, erythropoetin, Interferon, etc.)
- Newly FDA approved medications for the first six months or as determined by the P&T Committee.
- Cyclooxygenase–2 inhibitors, thiazolidinediones, etc.
- The table below lists the most common drugs that require preauthorization. Other drugs may also require preauthorization. For the most updated list, please view the drug formulary at HealthAlliance.org.

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<td>Advair® (fluticasone-salmeterol)</td>
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<tr>
<td></td>
<td>Arnuity™ Ellipta® (fluticasone-salmeterol)</td>
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<tr>
<td></td>
<td>Breo™ Ellipta® (fluticasone-vilanterol)</td>
<td>See Breo Ellipta policy</td>
</tr>
<tr>
<td></td>
<td>Flovent® (fluticasone)</td>
<td>See Flovent policy</td>
</tr>
<tr>
<td>BEHAVIORAL HEALTH: ADHD</td>
<td>Dyanavel™ XR (amphetamine suspension)</td>
<td>Preauthorization required for age 13 years and older</td>
</tr>
<tr>
<td></td>
<td>Quillichew® ER (methylphenidate ER)</td>
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<tr>
<td></td>
<td>Quillivant XR® (methylphenidate suspension)</td>
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<tr>
<td>BEHAVIORAL HEALTH: Antidepressants</td>
<td>Trintellix® (vortioxetine)</td>
<td>See Behavioral Health policy; two Tier 1 SSRIs and two Tier 1 SNRIs (duloxetine and venlafaxine)</td>
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<tr>
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<td>Fetzima™ (levomilnacipran ER)</td>
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<td>Pristiq® (desvenlafaxine)</td>
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<td>Viibryd® (vilazodone)</td>
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# Excluded or Non-Reimbursable Products, continued

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<td><strong>BEHAVIORAL HEALTH:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atypical Antipsychotics</td>
<td>aripiprazole</td>
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<tr>
<td></td>
<td>Rexulti® (brexpiprazole)</td>
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<tr>
<td></td>
<td>Fanapt® (iloperidone)</td>
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<tr>
<td></td>
<td>Latuda® (lurasidone)</td>
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<tr>
<td></td>
<td>paliperidone</td>
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<tr>
<td></td>
<td>quetiapine ER</td>
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<tr>
<td></td>
<td>Saphris® (asenapine)</td>
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<tr>
<td></td>
<td>Vraylar™ (caripiprazine)</td>
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<tr>
<td></td>
<td>See Behavioral Health policy; as adjunct therapy for Major Depressive Disorder: TWO Tier 1 SSRIs, AND TWO Tier 1 SNRIs; for Bipolar Disorder and Schizophrenia: TWO of the following: olanzapine, quetiapine, risperidone or ziprasidone.</td>
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<tr>
<td><strong>BEHAVIORAL HEALTH:</strong></td>
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<tr>
<td>Parkinson’s Disease Psychosis</td>
<td>Nuplazid™</td>
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<tr>
<td></td>
<td>See Nuplazid policy</td>
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<tr>
<td><strong>CARDIOVASCULAR:</strong></td>
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<tr>
<td>ARNI</td>
<td>Entresto™ (sacubitril/valsartan)</td>
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<tr>
<td></td>
<td>See Entresto policy</td>
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<tr>
<td>Lipotropics</td>
<td>omega-3-acid ethyl esters</td>
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<td></td>
<td>Vascepa® (icosapent ethyl)</td>
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<td>See Fish Oil (Lovaza and Vascepa) policy</td>
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<tr>
<td>Statins</td>
<td>Advicor® (lovastatin/niacin)</td>
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<td>Altoprev® (lovastatin ER)</td>
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<td>Lescol® XL (fluvastatin)</td>
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<td></td>
<td>Livalo® (pitavastatin)</td>
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<td>See Brand Name Statin policy</td>
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<td><strong>CENTRAL NERVOUS SYSTEM:</strong></td>
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<tr>
<td>Anticonvulsants</td>
<td>Qudexy™ XR (topiramate ER)</td>
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<td>Trokendi™ XR (topiramate ER)</td>
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<td>See Qudexy XR and Trokendi policy</td>
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<td><strong>DERMATOLOGY:</strong></td>
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<tr>
<td>Miscellaneous Agents</td>
<td>Aczone® (dapsone)</td>
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<td></td>
<td>Azelex® (azelaic acid)</td>
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<td></td>
<td>Finacea® (azelaic acid)</td>
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<td></td>
<td>Picato® (ingenol mebutate)</td>
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<td></td>
<td>Tazorac® (tazarotene)</td>
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<td></td>
<td>Soolantra® (ivermectin)</td>
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<td></td>
<td>Documentation of a non-cosmetic diagnosis (acne, actinic keratosis, etc.); trial of two Tier 1 agents</td>
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<td><strong>DIABETES:</strong></td>
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<tr>
<td>GLP-1 (Glucagon-like peptide-1)</td>
<td>Bydureon® (exenatide)</td>
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<td>Byetta® (exenatide)</td>
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<td>Tanzeum™ (albiglutide)</td>
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<td>Trulicity™ (dulaglutide)</td>
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<td></td>
<td>Victoza® (liraglutide)</td>
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<td></td>
<td>See Diabetes Drug Therapies policy</td>
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<td><strong>DIABETES, MISC.</strong></td>
<td>Regranex® (becaplermin)</td>
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<tr>
<td></td>
<td>Diagnosis of diabetic ulcers with failure on conventional (dressings, soaks, debridement, etc.)</td>
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<tr>
<td><strong>ENDOCRINE:</strong></td>
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<tr>
<td>Estrogen Replacement Therapy</td>
<td>All estrogen and estrogen-containing medications</td>
<td>Use in males requires prior authorization; see Hormone Replacement Therapy in Gender Reassignment policy</td>
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<tr>
<td><strong>ENDOCRINE:</strong></td>
<td>All testosterone and testosterone-containing medications</td>
<td>Use in females requires prior authorization; see Hormone Replacement Therapy in Gender Reassignment policy</td>
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## Excluded or Non-Reimbursable Products, continued

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<thead>
<tr>
<th>Drug Class</th>
<th>Drug Name</th>
<th>Comments</th>
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<tbody>
<tr>
<td><strong>ENDOCRINE: Testosterone Replacement</strong></td>
<td>Androderm® (testosterone transdermal)</td>
<td>See Testosterone (Implantable, Topical, Oral, and Nasal) policy</td>
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<tr>
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<td>Androgel® (testosterone gel)</td>
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<td>Axiron® (testosterone topical)</td>
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<td>Fortesta® (testosterone gel)</td>
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<td>Natesto™ (testosterone nasal)</td>
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<td></td>
<td>Striant® (testosterone buccal)</td>
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<td></td>
<td>Testim® (testosterone gel)</td>
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<tr>
<td><strong>INFECTIOUS DISEASE: Antibacterial, Misc</strong></td>
<td>Xifaxan® (rifaximin)</td>
<td>See Xifaxan policy</td>
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<tr>
<td><strong>LOWER GI DISORDERS: Narcotic antagonists</strong></td>
<td>Movantik™ (naloxegol)</td>
<td>See Movantik policy for opioid induced constipation</td>
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<tr>
<td></td>
<td>Relistor® (methylaltrexone)</td>
<td>See Relistor policy for opioid induced constipation</td>
</tr>
<tr>
<td><strong>LOWER GI DISORDERS: other</strong></td>
<td>Fulyzaq™ (crofelemer)</td>
<td>See Fulyzaq policy</td>
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<tr>
<td><strong>NEUROLOGY: Botulinum toxins</strong></td>
<td>Botox® (onabotulinumtoxinA)</td>
<td>See Botox policy</td>
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<td></td>
<td>Myobloc® (rimabotulinumtoxinB)</td>
<td>See Myobloc policy</td>
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<tr>
<td></td>
<td>Xeomin® (incobotulinumtoxinA)</td>
<td>See Xeomin policy</td>
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<tr>
<td><strong>NEUROLOGY: GABA analogs</strong></td>
<td>Gralise® (gabapentin ER)</td>
<td>See Gabapentin Coverage Requirement policy; FDA label diagnosis specific to product, and trial of Gabapentin</td>
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<tr>
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<td>Horizant® (gabapentin ER)</td>
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<td>Lyrica® (pregabalin)</td>
<td>See Lyrica policy</td>
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<tr>
<td><strong>NEUROLOGY: Fibromyalgia agents</strong></td>
<td>Savella® (milnacipran)</td>
<td>Trial of TCA, muscle relaxant, gabapentin, duloxetine, and non-pharmacologic therapy</td>
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<tr>
<td><strong>NEUROLOGY: Narcolepsy</strong></td>
<td>modafinil</td>
<td>See Provigil and Nuvigil policy, only medically necessary FDA label diagnosis covered</td>
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<td></td>
<td>Nuvigil® (armodafinil)</td>
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<tr>
<td><strong>ONCOLOGY</strong></td>
<td>capecitabine</td>
<td>See Oncology Agents policy</td>
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<td></td>
<td>Hycamtin® (topotecan)</td>
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<tr>
<td><strong>PAIN MANAGEMENT: Analgesics, Narcotics</strong></td>
<td>Abstral® (fentanyl sublingual tablet)</td>
<td>See Fentanyl® Oral Dosage Formulation policy; limited to cancer diagnosis and inability to swallow and concurrent long acting agent requiring breakthrough agent</td>
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<tr>
<td></td>
<td>fentanyl citrate lozenge</td>
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<td></td>
<td>Fentora® (fentanyl citrate)</td>
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<tr>
<td></td>
<td>Onsolis® (fentanyl buccal film)</td>
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<tr>
<td></td>
<td>Subsys® (fentanyl sublingual spray)</td>
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<tr>
<td><strong>UPPER GI DISORDERS: Anti-ulcer preparations</strong></td>
<td>Dexilant® (dexlansoprazole)</td>
<td>See PPI policy; trial of three generic PPIs and Nexium® 24HR OTC (at least 14 days in duration) in addition to qualifying diagnosis</td>
</tr>
<tr>
<td></td>
<td>esomeprazole</td>
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</table>
### Step-Therapy

Step-therapy is a tool used to lower pharmacy costs by requiring, in select categories, the use of the most cost-effective drugs on the formulary prior to coverage of other alternatives. Health Alliance requires for all new prescriptions in the following categories that there be a claim documenting use (and presumed failure) of the cost-effective drug before any other drug in that category is covered:

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Step-Therapy (ST) Medication</th>
<th>Prerequisite Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>BEHAVIORAL HEALTH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-anxiety</td>
<td>alprazolam ODT</td>
<td>alprazolam tablet</td>
</tr>
<tr>
<td>BEHAVIORAL HEALTH</td>
<td>Aplenzin® (bupropion)</td>
<td>bupropion</td>
</tr>
<tr>
<td>Antidepressants NDRI</td>
<td>Oleptro™ (trazodone)</td>
<td>trazodone</td>
</tr>
<tr>
<td>BEHAVIORAL HEALTH</td>
<td>olanzapine/ fluoxetine</td>
<td>olanzapine and fluoxetine</td>
</tr>
<tr>
<td>Antidepressants SARI</td>
<td>Suboxone® Film (buprenorphine and naloxone)</td>
<td>generic buprenorphine/naloxone tablets</td>
</tr>
<tr>
<td>BEHAVIORAL HEALTH</td>
<td>Aptiom® (eslicarbazepine acetate)</td>
<td>oxcarbazepine</td>
</tr>
<tr>
<td>Atypical Antipsychotics</td>
<td>Briviact®, Spritam® ODT</td>
<td>levetiracetam solution, tablets or capsules</td>
</tr>
<tr>
<td>Opioid dependence</td>
<td>Corlanor® (ivabradine)</td>
<td>Tier 1 ACE-I or ARB, AND Tier 1 beta blocker</td>
</tr>
<tr>
<td>CENTRAL NERVOUS SYSTEM</td>
<td>Anoro™ Ellipta™ (umeclidinium/ vilanterol)</td>
<td>Incruse Ellipta®, Serevent®, Spiriva®, Striverdi® or Tudorza®</td>
</tr>
<tr>
<td>Anticonvulsant</td>
<td>Bevespi Aerosphere™ (glycopyrrolate/ formoterol fumarate)</td>
<td>ICS (inhaled corticosteroid) or ICS combo, Asmanex®, QVar®, Aerobid®, Aerobid-M®, Alvesco®, Azmacort®, Pulmicort® or Symbicort®</td>
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<tr>
<td>COPD (Chronic Obstructive Pulmonary Disease)</td>
<td>Stiolto™ Neohaler® (indacaterol/ glycopyrrolate)</td>
<td>Daliresp® (roflumilast)</td>
</tr>
<tr>
<td>DERMATOLOGY</td>
<td>Denavir® (penciclovir)</td>
<td>acyclovir</td>
</tr>
<tr>
<td>Topical anti-infective</td>
<td>Mirvaso® (brimonidine)</td>
<td>metronidazole cream, lotion, or gel</td>
</tr>
<tr>
<td>DERMATOLOGY</td>
<td>Flector® patch (diclofenac)</td>
<td>Voltaren® gel</td>
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<tr>
<td>Topical anti-inflammatory</td>
<td>Pennsaid® (diclofenac)</td>
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<tr>
<td>DERMATOLOGY</td>
<td>Eurax® (crotamiton)</td>
<td>two prescription fills of permethrin</td>
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<tr>
<td>Other</td>
<td>Sklice® (ivermectin)</td>
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<tr>
<td>DIABETES</td>
<td>Avandia® (rosiglitazone)</td>
<td>metformin or a sulfonylurea</td>
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<tr>
<td>TZDs (Thiazolidinedione)</td>
<td>Avandaryl®</td>
<td>(glipezide, chlorpropamide, glipizide, glyburide, tolbutamide, tolazamide)</td>
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<tr>
<td></td>
<td>Avandamet®</td>
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</table>
# Excluded or Non-Reimbursable Products, continued

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Step-Therapy (ST) Medication</th>
<th>Prerequisite Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DIABETES DPP4 (Dipeptidyl/Peptidase IV)</strong></td>
<td>Jentadueto® (linagliptin/metformin)</td>
<td>metformin or a sulfonylurea</td>
</tr>
<tr>
<td></td>
<td>Kazano™ (alogliptin/metformin)</td>
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<tr>
<td></td>
<td>Nesina™ (alogliptin)</td>
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<td></td>
<td>Oseni™ (alogliptin/pioglitazone)</td>
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<tr>
<td></td>
<td>Tradjenta® (linagliptin)</td>
<td></td>
</tr>
<tr>
<td><strong>DIABETES DPP4 (Dipeptidyl/Peptidase IV)</strong></td>
<td>Janumet® (sitagliptin/metformin)</td>
<td>metformin or a sulfonylurea AND Tradjenta, Jentadueto, Nesina, Oseni, or Kazano</td>
</tr>
<tr>
<td></td>
<td>Januvia® (sitagliptin)</td>
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<td></td>
<td>Juvisync™ (simvastatin/sitagliptin)</td>
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<tr>
<td></td>
<td>Kombiglyze™ (saxagliptin/metformin)</td>
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<td></td>
<td>Kombiglyze™ XR (saxagliptin/metformin ER)</td>
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<tr>
<td></td>
<td>Onglyza® (saxagliptin)</td>
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<tr>
<td><strong>DIABETES SGLT-2 (Sodium glucose co-transporter 2 inhibitor)</strong></td>
<td>Farxiga™ (dapagliflozin)</td>
<td>metformin or a sulfonylurea</td>
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<tr>
<td></td>
<td>Invokana® (canagliflozin)</td>
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<td>Jardiance® (empagliflozin)</td>
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<td></td>
<td>Synjardy® (empagliflozin/metformin)</td>
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<td></td>
<td>Xigduo™ XR (dapagliflozin/metformin)</td>
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<tr>
<td><strong>DIABETES SGLT-2/DPP4 (Sodium glucose co-transporter 2 inhibitor/ Dipeptidyl/Peptidase IV)</strong></td>
<td>Glyxambi® (empagliflozin/linagliptin)</td>
<td>metformin or a sulfonylurea, AND an SGLT-2 (Farxiga, Invokana or Jardiance) OR a DPP-4 (Nesina or Tradjenta)</td>
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<tr>
<td><strong>ENDOCRINE Bone</strong></td>
<td>risedronate</td>
<td>alendronate or ibandronate</td>
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<td>Binosto™ (alendronate)</td>
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<tr>
<td><strong>HEMATOLOGICAL DISORDER Anti-Platelet</strong></td>
<td>Effient® (prasugrel)</td>
<td>New start prescriptions are restricted to cardiologists</td>
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<td></td>
<td>Plavix® (clopidogrel)</td>
<td>clopidogrel</td>
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<tr>
<td><strong>HEMATOLOGICAL DISORDER Thrombin Inhibitors</strong></td>
<td>Savaysa™ (edoxaban)</td>
<td>Eliquis® and Xarelto®</td>
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<td><strong>HYPERPARATHYROID AGENT</strong></td>
<td>paricalcitol</td>
<td>calcitriol or Vitamin D</td>
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<tr>
<td><strong>INFECTIOUS DISEASE Antibiotic</strong></td>
<td>Dificid® (fidaxomicin)</td>
<td>metronidazole or vancomycin</td>
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<tr>
<td><strong>INFECTIOUS DISEASE Antiviral</strong></td>
<td>Tybost® (cobicistat)</td>
<td>Requires concurrent treatment with Reyataz® or Prezista®</td>
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<tr>
<td>Excluded or Non-Reimbursable Products, continued</td>
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<td>-----------------------------------------------</td>
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<td><strong>PAIN MANAGEMENT</strong></td>
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<td><strong>Long Acting Opioid</strong></td>
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<td>Avinza® (morphine ER)</td>
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<td>Belbuca™ (buprenorphine)</td>
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<td>Butrans® (buprenorphine)</td>
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<td>Embeda® (morphine/ naltrexone)</td>
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<td>hydromorphone ER</td>
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<td>Hysingla® ER (hydrocodone ER)</td>
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<td>morphine sulfate ER (Kadian®)</td>
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<td>Nucynta® ER (tapentadol ER)</td>
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<td>Opana® ER (oxymorphone ER)</td>
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<td>Oxycontin® (oxycodone)</td>
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<td>Xartemis™ XR (oxycodone/ acetaminophen)</td>
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<td>Xtampza™ ER (oxycodone)</td>
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<td>Zohydro™ ER (hydrocodone ER)</td>
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<td>morphine sulfate ER or fentanyl</td>
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<td><strong>PAIN MANAGEMENT</strong></td>
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<td><strong>Short Acting Opioid</strong></td>
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<td>Nucynta® (tapentadol)</td>
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<td>Tier 1 opioid</td>
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<td>Ryzolt® (tramadol)</td>
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<td>tramadol ER</td>
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<td>SEDATIVE-HYPNOTICS</td>
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<td>Belsomra® (suvorexant)</td>
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<td>Zolpimist™ (zolpidem)</td>
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<td>Silenor® (doxepin)</td>
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<tr>
<td>zolpidem/zolpidem ER and zaleplon</td>
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<td>SKELETAL MUSCLE DISORDER</td>
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<td>cyclobenzaprine 7.5mg</td>
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<td>BPH (Benign Prostatic Hypertrophy)</td>
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<tr>
<td>Cialis® (tadalafil) once daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>tamsulosin, alfuzosin, Rapaflo®</td>
<td></td>
<td></td>
</tr>
<tr>
<td>finasteride, Avodart® or Jalyn®</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(dutasteride/tamsulosin)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Changes to the Commercial Formulary

There are currently several thousand medications, combinations of medications and dosage forms available in the United States. Inclusion of all of the products would compromise the ability of the formulary to control cost and optimize patient care.

The P&T Committee can add/delete a product with a majority vote. A product may be tabled for the next meeting if more information is needed.

The addition/deletion of drugs to the formulary will be based on a comparative efficacy, pharmacoeconomic data and drug-specific parameters such as side effect profiles, pharmacokinetics and contraindications. Evaluations will be based on information from peer-reviewed medical references, primary literature and standard of practice guidelines. Cost will be considered a major factor in making additions/deletions to the formulary when little or no difference exists in comparative and drug specific parameters. Specific considerations are listed below:

Proper Indication
The medication must have an indication that would benefit patients in an ambulatory/outpatient setting.

Efficacy
The medication must be clearly proven as effective in the outpatient population. It must also offer a distinct advantage over existing products in the same therapeutic category. These advantages must include, but are not limited to:

- Distinct or unique therapeutic feature
- Greater efficacy against other products in the same therapeutic category that can be clearly shown in clinical trials
- Improved dosing schedule, decrease in adverse effects, or fewer contraindications which clearly show superiority over existing products
- Cost savings over products in the same therapeutic category

Information
Decisions from the P&T meeting will be communicated to all physicians via the inforMED. You can view the updated commercial drug formulary at HealthAlliance.org.
Voluntary Pharmacy Programs

You can help your patients save money on prescription drugs by encouraging participation in our voluntary pharmacy programs. If you have any questions, or want to verify a member’s eligibility for any of the following programs, please contact the Health Alliance Pharmacy Department at 1-800-851-3379, option 4.

Mail Order
Health Alliance offers mail order service through OptumRx Home Delivery for most members on covered maintenance medications. For your patient to take advantage of mail order services for maintenance drugs, please write a prescription for the maximum day supply for all maintenance medications. For example, for a medication taken once daily, the prescription should read, “Dispense #90 of such medication with four refills.”

Retail 90
Most members with prescription drug benefits can purchase a 90-day supply of maintenance medication from a participating retail pharmacy. As an added value, most members will receive a discount off the regular copayments charged for a 90-day supply. Members who prefer can continue purchasing the traditional 30-day supply of medication for one copayment from their pharmacy, or they can purchase a 90-day supply through mail order.
Value-Based Pharmacy Benefit
Health Alliance launched a value-based pharmacy benefit initiative that started in 2008 for most of its members. After conducting extensive research and analysis, we believe the best approach is to balance lowering the patient cost for drugs that provide the greatest value. Examples of high-value drugs include those for the treatment of diabetes and asthma (please see tables below for specifics). The goal is to increase compliance with these medications and thus, better control of the disease.

High-Value Drugs

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Drug Name</th>
<th>Formulary Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIABETES</td>
<td>All generics</td>
<td>Tier 1</td>
</tr>
<tr>
<td></td>
<td>Vials, pens and cartridges for Lilly insulins</td>
<td>Tier 2 w/ max of $20.00*</td>
</tr>
<tr>
<td>ASTHMA</td>
<td>All generics</td>
<td>Tier 1</td>
</tr>
<tr>
<td></td>
<td>Ventolin® HFA</td>
<td>Tier 1</td>
</tr>
</tbody>
</table>

* $20.00 maximum copay applies up to each 30-day supply of medication. Coverage may differ depending on plan.
Voluntary Pharmacy Programs, continued

Rxtra
Fully insured Health Alliance members with prescription coverage can save money—and even get some medications free—based on where they have their prescriptions filled. Pharmacies are placed at levels based on their preferred status with Health Alliance. The higher the level a pharmacy is, the more savings members receive.

Rxtra is composed of three levels:
- Primary—the current Health Alliance network pharmacies. When Health Alliance members go to these locations, they continue to pay for prescriptions based in their current copayment structure.
- Preferred—$0 copayment on hundreds of commonly used medications.
- Preferred Plus—in addition to the free medications offered at the Preferred level, members also receive Simvastatin, Pravastatin Sodium and Ventolin HFA for free. Preferred Plus pharmacies include:
  - Walmart
  - Sam’s Club
  - Kmart
  - Osco
  - Shop ‘n Save
  - Dierbergs
  - Kroger

A listing of drugs available for $0 and Preferred pharmacies can be found at HealthAlliance.org/Pharmacy.
Notification of Provider Changes

Please remember to notify Health Alliance if your office has any provider-related changes, including the addition of a National Provider Identification (NPI) number, a mid-level provider, address change, fax number change, tax I.D. number change, practice name change or opening or closing of primary care panels. Timely notification of any pertinent changes to your practice allows us to update the information in our claims payment system for proper and speedy reimbursement and is also a contractual requirement. This information is also necessary to update the Provider Directory.

Please remember to notify Health Alliance of the termination of any provider from your practice, including the effective date of termination and the reason for termination.

The Provider Addition/Change Form (see form in this section) should be used for the above types of changes.

In addition, please remember to notify Health Alliance if a new physician is joining your practice. This provider will need to be credentialed and a Prospective Provider Request Form (located on the Health Alliance website) will be required.
Contracted Provider Information Change/Update Form

This form is for contracted Health Alliance providers to notify Health Alliance of any new information or changes to their current practice structure. Completed form(s) can be emailed to PSC@healthalliance.org.

The fields marked with an asterisk (*) under this section are required for all changes/updates. Failure to complete all required sections will cause form to be returned.

Contracted Provider Information:

*Contact Name: ____________________________________________________________________________
*Contact Phone: ____________________________________________________________________________
*Contact Email: ____________________________________________________________________________
*Contact Tax ID: ____________________________________________________________________________

*Type of Change/Update (please also complete corresponding section below):

☐ Address (any type) ☐ New Clinic Name ☐ Add New Provider Information
☐ Add New Location ☐ Tax ID Changes (please include new W-9) ☐ Phone Number (any type)
☐ Provider NPI ☐ Provider TIN: ___________________ ☐ PCP Status Change
☐ Provider Termination ☐ Provider Panel Closed

*Effective Date of Change: __________________________________

Please describe the changes being requested and indicate in comments if changes apply to all providers under the Tax ID Number.

Comments: ________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Office Location Address/Provider NPI/Provider Termination/Add New Provider

<table>
<thead>
<tr>
<th>Current Information:</th>
<th>Remove (Yes or No):</th>
<th>New Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Clinic/Provider Name</td>
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<tr>
<td>Tax ID Number</td>
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<tr>
<td>Provider Specialty</td>
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<tr>
<td>Office Hours</td>
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<tr>
<td>Office Contact Email</td>
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</table>

8.3
## Correspondence Address

<table>
<thead>
<tr>
<th>Current Information:</th>
<th>Remove (Yes or No):</th>
<th>New Information:</th>
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<tbody>
<tr>
<td>Current Clinic/Provider Name</td>
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<td>Address</td>
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<td>Provider NPI</td>
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<td>Fax</td>
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<td>Office Hours</td>
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<td>Office Contact Email</td>
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</table>

## Remit/Pay To Address

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<tr>
<th>Current Information:</th>
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<th>New Information:</th>
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<tbody>
<tr>
<td>Current Clinic/Provider Name</td>
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<td>Address</td>
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<td>Zip</td>
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<tr>
<td>Phone</td>
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<tr>
<td>Pay To NPI</td>
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</tbody>
</table>

## Tax ID Changes (include new W-9)

Applicable to All Providers? ☐ Yes ☐ No If No, please complete a form for each affected provider.

<table>
<thead>
<tr>
<th>Current Information:</th>
<th>Remove (Yes or No):</th>
<th>New Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax ID Number</td>
<td></td>
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<tr>
<td>Current Clinic/Provider Name</td>
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<td>Address</td>
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<td>Phone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay To NPI</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please email completed form(s) to [PSC@healthalliance.org](mailto:PSC@healthalliance.org).

If you need to add a new practitioner, please complete the [Prospective Provider Request Form](#).
Health & Wellness

Health Alliance provides the resources your patients need to help prevent and control illness, avoid emergencies and improve their quality of life. We encourage your patients to take an active role in their health with the following health and wellness programs and by receiving regular wellness newsletters. These Health Alliance programs are available to members free of charge to help them attain and maintain the best possible health. To sign up or learn more about any of the available programs, members can call Customer Service for more information or our Quality and Medical Management Department, at 1-800-851-3379, extension 8112.

Hypertension Disease Management Program
Members with high blood pressure receive educational materials, including a welcome letter and a blood pressure tracking card. Health Alliance also mails “best practice” guidelines to physicians.

Asthma Disease Management Program
Members receive general education about asthma and its treatment. In an effort to reduce inpatient admissions, Health Alliance notifies primary physicians about emergency room visits, hospital admissions and respiratory medication use. We also have a respiratory therapist on staff to answer questions. Adults and parents of children with asthma receive materials to help improve self-management skills.

Diabetes Disease Management Program
In a survey mailed to these program members, 81 percent of respondents reported making positive lifestyle changes, including eating better, exercising more and receiving important routine screenings. Program participants receive, a welcome letter and information about diabetes. Members and physicians also receive reminders about gaps in recommended care.

Immunization Program
Health Alliance mailings remind parents and children of the importance of vaccination. Children and adolescents who are up-to-date on their immunizations receive a free gift. Members 65 years and older receive annual reminders about the importance of pneumococcal and influenza immunization.

Quit For Life® smoking cessation program
Quit For Life helps our members become smoke-free for life. The program includes one-on-one coaching, a personalized quit plan and access to an online support community. Quit For Life members may also be able to use nicotine replacement therapy, like patches, gum or medicine, at reduced copayments*.

*copayment is subject to individual plan agreements

Fitness and Weight-Loss Center Discounts
Health Alliance members can gain discounted memberships to select gyms and weight-loss centers. There are also helpful nutrition and exercise resources on the Wellness section of HealthAlliance.org.

Case Management (1-800-851-3379, extension 8112)
Health Alliance connects members who need additional help for health conditions with a case manager, an experienced registered nurse or social worker, who can assist in getting the care needed to lead a healthier, more productive life. Our case managers provide support and education to members with diabetes, COPD, heart failure, asthma, cardiac disease (heart attack), high blood pressure and end-stage renal (kidney) disease/dialysis. We also offer Case Management to members who either have or have had:
- a high-risk pregnancy
- a transplant
- a major illness or accident
- a high-risk infant or child
- behavioral health needs
Rally
Our newest benefit partnership, Rally, is an easy-to-use digital health experience that engages and motivates members in a new way through intuitive online tools, personalized plans and rewards. Whether members are ready to eat better, move more, be more informed or just feel good in general, Rally gives them personalized missions and the support they need to get healthier.

Anytime Nurse Line
Health Alliance members have access to a nurse 24 hours a day with the Anytime Nurse Line at 1-855-802-4612. It can help members find the health care resources they need or decide if they need to see a doctor right away or set up an appointment. The Anytime Nurse Line is not for benefit questions. Members should call the number on the back of their ID card for benefit questions.
Section 10

Compliance Program
Guidance for Business Partners

Health Alliance Business Partners are expected to:

- Maintain a compliance plan, which includes policies and procedures addressing prevention, detection and correction of fraud, waste and abuse.
- Act with integrity.
- Operate in compliance with all applicable laws and regulations.
- Protect the physical and intellectual property of Health Alliance and any assets entrusted in your care against loss, theft, destruction, misappropriation and misuse.
- Protect the confidentiality of member information. Do not use or disclose member information other than for services provided for in the contract between you and Health Alliance.
- Never offer or accept any bribes, kickbacks or inducements in connection with performing duties for Health Alliance. Gifts of money or cash equivalents are never permissible.
- Never pursue a business opportunity or relationship that would compromise Health Alliance ethical standards or violate a law or regulations.
- Respect the rights and dignity of our employees and members. Health Alliance does not tolerate any form of discrimination, abuse, harassment or intimidation in the workplace or with our members.
- Never use for personal gain any information obtained as a business partner of Health Alliance.
- Comply with all relevant government requirements regarding record, document and data retention.
- Report all suspected misconduct, compliance violations, privacy or security incidents and potential fraud or abuse situations.
- Be free of inappropriate conflicts of interest.

A copy of the Ethics and Compliance in the Workplace: A Guide to Employee Conduct is available to you upon request by calling 1-800-851-3379.
Reporting a Compliance Violation, Suspected Misconduct, Privacy or Security Incident or a Potential Fraud or Abuse Situation

If you suspect misconduct or fraud or abuse activity or become aware of a possible violation of federal or state laws, you must report it.

Scott McAdams, Vice President, Chief Compliance and Risk Officer  
1-800-851-3379 ext 3238 or 217-365-3238

Traci Jensen, Compliance Programs Manager and Privacy Officer  
1-800-851-3379 ext 3418 or 217-337-3418

Wyatt Scheiding, HIPAA Security Officer  
1-800-851-3379 ext 3493 or 217-337-3493

Health Alliance Compliance Line (this avenue can be anonymous)  
217-383-8304 or 1-855-371-4640

The Office of the Inspector General  
1-800-HHS-TIPS (1-800-447-8477)  
TTY: 1-800-377-4950
Compliance and Fraud, Waste and Abuse Training

Commitment to Compliance

Health Alliance is committed to maintaining a reputation for excellence by establishing the highest ethical principles and professional standards and ensuring compliance with applicable state and federal laws. These principles and standards apply to our relationship with members, providers, employer groups, vendors, consultants and regulatory agencies and coworkers.

In support of this commitment, and in conformance with the standards set forth in the U.S. Federal Sentencing Guidelines and the compliance program guidance for Medicare Advantage Organizations (MAO), Part D Plan Sponsors and Medicare-Medicaid plans published by the Center for Medicare and Medicaid Services, and applicable state requirements Health Alliance established a Corporate Compliance Program.

This Program includes an Employee Guide to Conduct and policies and procedures designed to assist Health Alliance employees achieve and maintain compliance.

Health Alliance fosters an environment in which compliance with laws, regulations and sound business practices are woven into the corporate culture.
Compliance and Fraud, Waste and Abuse Training, continued

Commitment to Compliance

The Compliance Program focuses on the prevention and detection of violations of federal and state laws as well as corporate policies and procedures and promotes reporting of suspected misconduct, compliance violations, privacy and security incidents and potential fraud or abuse situations.

There is no retribution for asking questions, raising concerns or reporting possible violations in good faith.

Commitment to Compliance

Your understanding of this commitment and your willingness to partner with Health Alliance in adhering to these principles and standards are essential to the well-being of our members and to the success of the business partnership.

A copy of the Health Alliance Ethics and Compliance in the Workplace: A Guide to Employee Conduct accompanies this education and is also available to you upon request by calling 1-800-851-3379, ext 3418.

Guidance for Business Partners

Health Alliance Business Partners are expected to:

- Maintain a compliance plan which includes policies and procedures addressing prevention, detection and correction of fraud, waste and abuse.
- Act with integrity.
- Operate in compliance with all applicable laws and regulations.
- Protect the physical and intellectual property of Health Alliance and any assets entrusted in your care against loss, theft, destruction, misappropriation and misuse.
- Protect the confidentiality of member information. Do not use or disclose member information other than for services provided for in the contract between you and Health Alliance.
- Never offer or accept any bribes, kickbacks or inducements in connection with performing duties for Health Alliance. Medicare guidelines allow nominal giveaways of no more than $15. Gifts of money or cash equivalents are never permissible.
- Never pursue a business opportunity or relationship that would compromise Health Alliance ethical standards or violate a law or regulations.
- Respect the rights and dignity of our employees and members. Health Alliance does not tolerate any form of discrimination, abuse, harassment or intimidation in the workplace or with our members.
- Never use for personal gain any information obtained as a business partner of Health Alliance.
- Comply with all relevant government requirements regarding record, document and data retention.
- Report all suspected misconduct, compliance violations, privacy or security incidents and potential fraud or abuse situations to Health Alliance.
- Be free of inappropriate conflicts of interest.
The Center for Medicare and Medicaid Services (CMS) requires MAOs, Part D Sponsors and Medicare-Medicaid plans to provide Compliance and Fraud, Waste and Abuse (FWA) training to all entities and individuals who meet the definition of first tier, downstream or related entity. First tier, downstream and related entities that have met the FWA certifications through enrollment in the fee for service Medicare program or accredited as a DMEPOS suppliers are deemed to have met the FWA training and education requirement.

Citation: F.R. Vol. 72, No. 233, December 5, 2007
F.R. Vol. 75 No 19678 effective June 7, 2010

Key Terms and Definitions

• First Tier entity means any party that enters into a written arrangement, acceptable to CMS, with an MAO to provide administrative services or health care services for a Medicare eligible individual under the Medicare Advantage (MA) program.

• Downstream entity means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between the MAO and the first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

• Related entity means any entity that is related to the MAO by common ownership or control and (1) performs some of the MAO management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MAO at the cost of more than $2,500 during a contract period.

Fraud is knowingly and willfully executing or attempting to execute a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representation or promises) any of the money or property owned by or under control of any health care program.

Waste is the over-utilization of services or other practices that directly or indirectly result in unnecessary costs; misuse of resources.
Compliance and Fraud, Waste and Abuse Training, continued

Key Terms and Definitions
Abuse includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between “fraud” and “abuse” depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Health care fraud is a major reason why the cost of health care in the United States continues to rise at an alarming rate. Individuals who participate in fraud schemes and those who fail to report health care fraud contribute to those rising costs. Schemes and fraudulent billing practices not only cost taxpayers, they put beneficiaries health and welfare at risk. For example: Two patients died because of a scan that involved recruiting homeless and other vulnerable adults for unnecessary heart catheterizations and angioplasties. The doctors and administrators behind the scheme were caught and prosecuted.

Fraud is a criminal act, abuse is not
Fraud is distinguished from abuse in that, in the case of fraudulent acts, there is clear evidence that the acts were committed knowingly, willfully and intentionally or with reckless disregard. If fraud occurs, a crime has been committed and criminal prosecution may take place. In most cases of abuse a crime has not been committed.

The major difference is the intent of deception from the person.
Compliance and Fraud, Waste and Abuse Training, continued

Fraud, Waste and Abuse

Fraud and Abuse Opportunities
There are many ways fraud and abuse can occur. Examples include:

- Identity Swapping
- Identity Theft
- Kickbacks
- Marketing Schemes
- False Claims
- Duplicate Billing
- Abuse of the System

Fraud, Waste and Abuse

Who can commit fraud and abuse?

- Beneficiaries/members
- Providers, pharmacies and billing companies
- Pharmacy benefit management companies (PBMs)
- Insurance Companies
- Employees
- Brokers/Agents
- Employer groups

Fraud, Waste and Abuse

The following slides are some examples of potential fraud and abuse under the Medicare program.

This is not intended as a comprehensive listing of all possible fraud and abuse schemes.
Compliance and Fraud, Waste and Abuse Training, continued

Fraud, Waste and Abuse

**Beneficiary / Member**
- Use of another’s insurance card to obtain prescription drug benefits or medical services
- Loaning one’s ID card to someone else to obtain prescription drug benefits
- Adding ineligible dependents to the plan
- Falsifying information on the application
- Excessive trips to the emergency room to obtain controlled substances
- Submitting prescription drug receipts that are forged or altered for reimbursement
- Resale of drugs on the black market
- Identity theft

**Provider or billing company – Medical Services**
- Intentionally not giving the member the amount of drugs prescribed
- Intentionally dispensing a different drug than the doctor prescribed, for purposes of saving money (prescription drug switching)
- Billing for drugs that a member did not receive
- Billing under another provider’s Tax Identification Number (TIN) to obtain reimbursement for services
- Duplicate billing
- Billing for services performed by non-licensed persons
- Regularly prescribing unnecessary drugs
- Illegal remuneration schemes such as selling prescriptions
- Script mills
- Theft of prescribers prescription pads

**Pharmacy Benefits Manager (PBM)**
- Prescription drug switching
- Unlawful remuneration, such as remuneration for steering a beneficiary toward a certain plan or drug
- Inappropriate formulary decisions
- Prescription drug splitting or shorting
- Failure to offer negotiated prices
Compliance and Fraud, Waste and Abuse Training, continued

Fraud, Waste and Abuse

Insurance Company
- Discriminating against an individual, including not allowing the individual to enroll in a plan because of age, health, race, religion or income
- Charging a member more than once for premium costs
- Not paying for covered medical services or drugs
- Making false statements in advertising materials that influence consumers to make buying decisions

Employee or Broker
- Encouraging an individual to enroll in a richer benefit plan to receive a higher commission and, once the individual is on the plan, switching him or her to a reduced benefit plan without the member being fully aware of the implications (bait and switch)
- Encouraging a member to disenroll from a plan
- Offering cash to enroll in a MA or Prescription Drug plan
- Offering a gift worth more than $15 to sign up for MA or Prescription Drug plan
- Making false statements to an individual or member
- Altering claims or medical records for a service to be covered that is not normally covered
- Fabricating claims

Employer
- Misrepresenting who is actually eligible for coverage by representing them as an employee of the group
- Providing false employer or group eligibility information to secure health care coverage
- Changing dates of hire or termination to expand dates of coverage
Compliance and Fraud, Waste and Abuse Training, continued

Your Role

As a business partner you must participate in compliance and FWA training on an annual basis.
Report any suspected misconduct, compliance violation, privacy or security incident or potential fraud and abuse activity.

Reporting

If you suspect misconduct or fraud or abuse activity or become aware of a possible violation of federal or state laws, you must report it.

Health Alliance Compliance Line
217-383-8304 or toll-free 855-371-4640

The Office of the Inspector General
800-HHS-TIPS (800-447-8477)

Non-Retaliation for Reporting

Good faith reporting of suspected fraud, waste and abuse is expected and accepted behavior.

Anyone who in good faith reports a violation is protected from any retaliation.

A number of laws contain whistleblower protection including the False Claims Act.
Compliance and Fraud, Waste and Abuse Training, continued

The False Claims Act

The False Claims Act establishes a law enforcement partnership between federal law enforcement officials and private citizens who learn of fraud against the government.

Those who knowingly submit or cause another person or entity to submit false claims for payment of government funds are liable for three times the government’s damages for the false bills plus civil penalties from $5,000 to $10,000 per false claim.

A private citizen or “whistleblower” with knowledge of past or present fraud on the federal government is permitted to sue on behalf of the government to recover civil penalties and damages. The whistleblower has guaranteed job protection under the Act and is entitled to a share of the government’s total recovery.

The False Claims Act Enforcement

The Federal False Claims Act/Fraud Enforcement and Recovery Act of 2009

Penalties

Civil
- Not less than $5,500 and not more than $11,000 per false claim plus three times the amount of the false claim
- Exclusion from participation in federal health care programs
- Additionally, under the Patient Protection and Affordable Care Act, the Office of Inspector General (OIG) may impose civil monetary penalties of up to $50,000 for each false record or statement and for knowingly failing to report and return an overpayment within the required timeframe.

Criminal
- Courts can impose criminal penalties against individuals and organizations for willful violations

Anti-kickback

The Federal Anti-Kickback laws make it a criminal offense to knowingly and willfully offer, pay, solicit or receive remuneration of any kind to induce or reward referrals of items or services reimbursable by a Federal health care program.

Remuneration includes anything of value, directly or indirectly, overtly or covertly, in cash or in kind.
Compliance and Fraud, Waste and Abuse Training, continued

Anti-kickback Enforcement

The Federal False Claims Act/Fraud Enforcement and Recovery Act of 2009

Penalties

Criminal:
- Violation is a felony
- Fine of up to $25,000 and/or prison for up to 5 years

Civil:
- Violation may result in civil monetary penalties of up to $50,000 for each violation of the statute plus damages of up to three times the total amount of the unlawful remuneration

Exclusion:
- Violation may result in exclusion from participation in the Medicare and Medicaid programs

Conflicts of Interest

Conflicts of interest arise when a member of the board, an officer, director, manager, Pharmacy and Therapeutics Committee member, employee or contractor is in a position to influence either directly or indirectly Health Alliance business decisions that could lead to gain for the individual, the individual's relatives or others to the detriment of Health Alliance and its mission and integrity.

Examples:
- Ownership of a significant financial interest in any outside concerns that does business with, or is a competitor of Health Alliance.
- Provision of services for compensation to any outside concern that does business with, or is a competitor of Health Alliance.

Excluded Entities or Individuals

Health Alliance may not contract with or employ entities or individuals who are excluded from doing business with the government.

Health Alliance monitors the Office of Inspector General (OIG) Exclusion List and General Service Administration (GSA) List on a monthly basis.

Non-compliance and/or fraudulent behavior is unacceptable and subject to termination of the business relationship with Health Alliance.
### Compliance and Fraud, Waste and Abuse Training, continued

#### Additional Resources

<table>
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<tr>
<th>Resource</th>
<th>Link</th>
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Audit Program

Audit Program and Corrective Action Plans

The goal of Health Alliance’s Provider Audit Program is to proactively analyze claims data and confirm that claim submissions accurately represent the services provided to Plan members, and to ensure that billing is conducted in accordance with Current Procedural Terminology (CPT) & HCPCS guidelines and other applicable standards, rules, laws, regulations, contract provisions, policies and procedures to combat potential healthcare fraud, waste and abuse.

As part of an ongoing program to monitor plan payment integrity and cost-effective medical care, and as a supplement to other Health Alliance Compliance initiatives the objective of the Provider Audit Program is to ensure that Health Alliance fulfills its responsibility to its enrollees and/or Plan sponsors by identifying and recovering inaccurate payments which are a result of inadvertent or intentional provider actions or misrepresentations.

The areas reviewed by the Provider Audit Program include, but are not limited to, the following:

• Billing for services that were not provided
• Intentional misrepresentation
• Billing services at a higher level than which was rendered
• Failure to comply with the Contract, Plan policies and procedures, and/or other relevant guidelines, regulations or laws
• Inadequate documentation to support the services billed
• The deliberate performance of unwarranted or medically unnecessary services for the purpose of financial gain

In connection with the provisions set forth in the contract with Health Alliance providers shall:

• Provide or arrange for health services for members in an economic and efficient manner consistent with professional standards of medical care generally accepted in the medical community at the time
• Provide or authorize for members only those services which are medically necessary
• Maintain complete and up-to-date medical records
• Bill in accordance with the American Medical Association’s CPT guidelines and HCPCS guidelines
• Comply with all Health Alliance payment policies

In connection with the preceding provisions, Health Alliance’s Provider Audit Program may:

• Audit providers
• Recover funds from providers who engage in improper and/or inappropriate billing practices. Although audits are usually based on claim submissions for up to a five-year period, audits and medical record requests will only be subject to a five year request. Recoupment requests will extend back no further than one year from the payment date.
• Suspend/Off-Set future claim payments once improper billing practices are suspected
• Close the provider’s panel or terminate the provider in addition to recovering overpayments if the provider intentionally engages in improper billing practices
• Access medical records of past and present Health Alliance members

Note: Providers shall mail/fax or grant Health Alliance access to review and copy member medical records within a reasonable period of time following such request. For purposes of this document, “reasonable” shall be defined as a maximum of 30 days from Health Alliance’s initial request for access, unless a different time period is mutually agreed upon by the Plan and the provider.

The provisions set forth in the foregoing description of the Provider Audit Program apply to all plans, programs, contractual arrangements and products administered by Health Alliance.
Audit Program, continued

Corrective Action Plans
A Corrective Action Plan (CAP) is a plan of action developed to address findings and observations that have been identified by the Health Alliance Special Investigations Unit and approved to request remediation on by the Compliance Officer during a desk audit or a field audit. The CAP gives a provider the opportunity to analyze and identify the root causes of the identified findings and observations, and to develop a corrective action to address the findings and observations to ensure future billing and/or documentation compliance with Health Alliance.

Upon receipt of the corrective action plan, the Health Alliance Compliance Officer or designated staff will review the submitted CAP and determine whether the specific plan for corrective action for each audit finding/observation meets the requirements for approval. Health Alliance will provide a letter of acceptance or denial to the provider based upon the submitted CAP.

Health Alliance may deny a submitted CAP if it:

- Fails to address the specific findings/observations.
- Fails to provide a specific plan for corrective action for each deficiency;
- Contains argument or refutation of findings/observations;
- Fails to identify the person(s) responsible for implementation; or
- Fails to identify target dates, including implementation and completion dates.

A follow up review may be conducted after the CAP is accepted to ensure compliance and implementation of the CAP. Any follow up reviews must show adequate corrections of the deficiencies or monetary recoupment and/or termination of your contract with referral to an appropriate government agency could occur.
HIPAA Privacy Policy for Use, Protection and Disclosure of PHI
Health Alliance (covered entity) complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules. The Privacy Rule ensures a patient’s protection of privacy without hindering his or her access to quality health care.

As a health care provider (covered entity) you are required to comply with the HIPAA Privacy and Security Rules. As a contracted provider of Health Alliance for our fully insured plans you are also required to protect member/patient PHI based on the contract provisions, such as you must safeguard the privacy of any information that identifies a particular member; take reasonable precautions to maintain the confidential nature of and to prevent the disclosure of confidential records or information, including medical records, relating to members other than to individuals authorized to receive such information pursuant to valid releases, lawful court orders, lawful subpoenas or in accordance with federal or state laws. If required by law, you are responsible for obtaining and maintaining adequate release of information authorizations from members essential for the administration of benefits under the member’s plan.

As covered entities under HIPAA, we are allowed to use members’/patients’ Protected Health Information (PHI) as allowed by the Privacy Rule and we are allowed to disclose PHI to one another for treatment, payment and certain health care operations activities.

Payment and certain health care operation activities include:
- Submission and receipt of claims for reimbursement
- Billing and claims management
- Health care data processing
- Disclosure and receipt of medical record information for review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges
- Utilization review activities, including preauthorization, concurrent and retrospective review of services
- Quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines
- Population-based activities relating to improving health or reducing health care costs
- Protocol development, case management and care coordination
- Contact with health care providers or patient/member with information regarding treatment alternatives
- Review of competence or qualifications of health care professionals and evaluate practitioner, provider or health plan performance
- Accreditation, certification, licensing or credentialing activities
- Fraud and abuse detection and compliance programs

If authorization by the member is required before releasing PHI (for example, for mental health records), Health Alliance will obtain a completed and signed form from the member (see form included on next page) and send it to you along with our request for the PHI.

We have provided a copy of our Notice of Privacy Practices which describes how we protect this information.
Even though HIPAA does not require the use of this form for medical necessity review or appeals (except when mental health information is involved), a Provider may receive a copy of this completed authorization form signed by the Member when Health Alliance requests medical records from the Provider.

**HEALTH ALLIANCE**
**AUTHORIZATION TO USE AND DISCLOSE**
**PROTECTED HEALTH CARE INFORMATION**

Member’s Name ___________________________ Birthdate ___________________________
Street Address ___________________________ Member Number # ______________________
City, State, Zip ___________________________ Patient # ___________________________
Maiden/Other Names ________________________
Telephone # (home) ________________________ (work) ___________________________

I. Information About the Use and Disclosure of Protected Health Information

I hereby authorize the disclosure and use of my protected health information as described below:

Person(s) or organization(s) providing the information: _________________________________

Person(s) or organization(s) receiving/using the information: _____________________________

A detailed description of the specific type of protected health information to be disclosed and/or used (include dates and type of treatment):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

The purpose for which protected health information will be disclosed and/or used:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

If information below is stated above, release is authorized. Please circle Yes or No in the column below.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Communicable disease and infection information, as defined by statute and Illinois Department of Public Health rules (which include venereal disease, &quot;VD,&quot; tuberculosis, &quot;TB,&quot; hepatitis B, human immunodeficiency virus &quot;HIV,&quot; acquired immunodeficiency &quot;AIDS,&quot; AIDS related complex &quot;ARC&quot; and specify other if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>N</td>
<td>Alcohol and/or drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations, Part 2. (See &quot;Important Notice&quot; on next page.)</td>
</tr>
<tr>
<td>Y</td>
<td>N</td>
<td>Mental health treatment records, psychological services and social services information, including communications made by me to a social wonder or mental health professional.</td>
</tr>
</tbody>
</table>

10.18
II. Important Information About Your Rights

I have read and I understand and acknowledge the following statements about my rights:

- I may revoke this authorization at any time prior to the expiration date by notifying Health Alliance in writing. However, the revocation will not have any effect on actions taken before the revocation was received.
- If the person or organization to whom this information is disclosed is not a covered entity under the federal privacy rules, the information may no longer be protected by the federal privacy rules after such disclosure is made.
- Treatment, payment, eligibility or enrollment will not be conditioned on obtaining this Authorization except as specifically authorized by law.

This Authorization expires one year after the date signed below or upon the following specific date, event or condition:_______________________________________________

III. Signature of Member or Member's Representative

I accept these terms and authorize the above use and disclosure:

____________________________________  _______________________________________
Member or Member's Legally Authorized   Witness Signature and Date
Representative's Signature and Date

______________________________________________________
Printed name of the member or Legally Authorized Representative

If signed by a Legally Authorized Representative, please indicate the relationship to the individual

If a representative signs on behalf of the member, Health Alliance must have a copy of the legal document declaring representation on file.

IMPORTANT NOTICE: Any information disclosed is protected by Federal Protection Rules (42 CFR Chapter I, Part 2) and State Mental Health Protection Laws and is prohibited from furthur disclosure unless furthur disclosure is expressly permitted by the written authorization of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient for this purpose. Federal Rules restrict use of the information to criminally investigate or prosecute any member receiving treatment for alcohol or drug abuse.
HIPAA Privacy – PHI Authorization Forms, continued

A Provider will receive a copy of this completed authorization form signed by the Member along with the letter below, when Health Alliance requests medical information from the Provider for the purpose of determining a pre-existing condition.

Member #: 
DOB: 

Dear:

Your plan has a pre-existing condition limitation for dates <<date>> to <<date>>. In order to process claims we have received, please complete the following and return both documents to us in the enclosed envelope. Health Alliance will then send a letter to the provider(s) requesting medical documentation. If we do not receive the requested medical records by <<45 days out>>, your claims will be processed according to the pre-existing condition limitation listed in your Subscription Certificate/Summary Plan Description.

1. Fill in this table with the physicians you have seen from <<DATE>> to <<DATE>>.

<table>
<thead>
<tr>
<th>Dr.</th>
<th>Dr.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Address:</td>
</tr>
</tbody>
</table>

2. To expedite the process of obtaining records from your previous provider(s), fill out the enclosed form authorizing the release of medical information to Health Alliance.

It often takes physician offices several weeks to send requested records. Therefore, we suggest that you complete the tasks above as soon as possible.

Your pre-existing condition limitation period may be reduced or eliminated by submitting a certificate of creditable coverage from your previous insurance provider. Please refer to your plan information or contact the Health Alliance Customer Service Department at 1-800-851-3379/1-800-322-7451 for assistance.

Sincerely,

Medical Management Department
Re: Member:
Member #: 
DOB:

Dear Provider:

<<NAME>> has informed us that he/she received services from you between <<DATE>> and <<DATE>>. Please send all clinical notes for the above date(s) of service to our secure fax at 217-337-8009 by <<DATE>>. If you prefer you may mail the records to:

Health Alliance Medical Plans
ATTN: Medical Management
301 S Vine Street
Urbana, IL 61801

This information will be used to determine if the member has a pre-existing condition that may affect coverage.

Thank you for your prompt attention to this matter. If this information is not received by <<DATE>>, coverage for the claims being reviewed may be reduced to the benefit level allowed by the member’s plan.

Sincerely,

Medical Management Department

enclosure

cc:

preex prov
HIPAA Privacy – PHI Authorization Forms,
continued

Member #:  
DOB: 

Dear:

Your plan has a pre-existing condition limitation for dates <<date>> to <<date>>. In order to process claims we have received, please complete the following and return both documents to us in the enclosed envelope. Health Alliance will then send a letter to the provider(s) requesting medical documentation. If we do not receive the requested medical records by <<45 days out>>, your claims will be processed according to the pre-existing condition limitation listed in your Subscription Certificate/Summary Plan Description.

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</table>

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It often takes physician offices several weeks to send requested records. Therefore, we suggest that you complete the tasks above as soon as possible.

Your pre-existing condition limitation period may be reduced or eliminated by submitting a certificate of creditable coverage from your previous insurance provider. Please refer to your plan information or contact the Health Alliance Customer Service Department at 1-800-851-3379/1-800-322-7451 for assistance.

Sincerely,

Medical Management Department
A Provider will receive a copy of this completed authorization form signed by the Member, when Health Alliance requests medical information from the Provider for the purpose of rating small or large groups.

HEALTH ALLIANCE
AUTHORIZATION TO USE AND DISCLOSE
PROTECTED HEALTH CARE INFORMATION

Member’s Name_________________________ Birthdate_________________________
Street Address________________________ Member Number #_________________
City, State, Zip________________________ Patient #_____________________
Maiden/Other Names_______________________ Telephone # (home)_________________
                                          (work)_____________________

I hereby authorize and direct Health Alliance to obtain all protected health information, including medical records from any health care provider that, either advised, treated, attended or rendered service to me or my dependents, or that has in its possession any information or records with respect to advice, treatment or services. This authorization is limited only to such protected health information, including medical records, obtained for rating determination purposes.

I have read and I understand and acknowledge the following statements about my rights:
• I may revoke this authorization at any time prior to the use of the protected health information stated above, by notifying Health Alliance in writing. Please note however, the revocation will not have any effect on actions taken before the revocation was received.
• If the person or organization to whom this information is disclosed is not a covered entity under the federal privacy rules, the information may no longer be protected by the federal privacy rules after such disclosure is made.
• I further understand that eligibility of enrollment in this plan will not be conditioned on receiving authorization to obtain protected health information, including medical records.

A copy of this authorization and release shall be valid as the original, and will remain in effect as long as I or any of my dependents are enrolled in a Health Alliance plan, or until revoked by me in writing.

Signature of Individual Applicant or Legally Authorized Representative: ____________________________

If signed by a Legally Authorized Representative, please indicate the relationship to the individual:

Please provide a copy of the legal document declaring representation.
A Provider will receive a copy of this completed authorization form signed by the Member, when Health Alliance requests medical records from the Provider for underwriting purposes for Individual Plans.

Section G: Authorization

Applicant’s Name:__________________________________ Date of Birth:_____________________

Address:_______________________________________________________________________________

Dependent’s Name(s):      Date of Birth
___________________________________________ ______________________________________
___________________________________________ ______________________________________
___________________________________________ ______________________________________
___________________________________________ ______________________________________

I hereby authorize and direct Health Alliance to obtain all protected health information, including medical records from any health care provider that, either advised, treated, attended or rendered service to me or my dependents, or that has in its possession any information or records with respect to advice, treatment or services. This authorization is limited only to such protected health information, including medical records, obtained for rating determination purposes.

I have read and I understand and acknowledge the following statements about my rights:
  • I may revoke this authorization at any time prior to the use of the protected health information stated above, by notifying Health Alliance in writing. Please note however, the revocation will not have any effect on actions taken before the revocation was received.
  • If the person or organization to whom this information is disclosed is not a covered entity under the federal privacy rules, the information may no longer be protected by the federal privacy rules after such disclosure is made.
  • I further understand that eligibility of enrollment in this plan will not be conditioned on receiving authorization to obtain protected health information, including medical records.

A copy of this authorization and release shall be valid as the original, and will remain in effect as long as I or any of my dependents are enrolled in a Health Alliance plan, or until revoked by me in writing.

Signature of Individual Applicant or Legally Authorized Representative

If signed by a Legally Authorized Representative, please indicate the relationship to the individual

Please provide a copy of the legal document declaring representation.

___________________________________________________________

Signature of Spouse and/or Child(ren) over the age of 18
Health Alliance Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date of this notice: April 14, 2003

Protecting the privacy of information about your medical conditions and health is a responsibility we take very seriously. We understand that medical information about you and your health is personal and it is important to you that we keep it confidential. We are committed to the practices and procedures we established to protect the confidential nature of information about your health.

This notice describes the way we may use and disclose information about your health to carry out treatment, payment and health care operations and for other purposes as permitted or required by law. It also describes your rights and duties regarding the use and disclosure of medical information.

INFORMATION THAT THIS NOTICE APPLIES TO
This notice applies to any information in our possession that would allow someone to identify you and learn something about your health. It does not apply to information that could only be used to identify you.

We collect such personal information as name, address, telephone number, Social Security number, age, sex and medical diagnosis to coordinate medical care. This information is obtained from member enrollment forms, member surveys and claims.

OUR LEGAL RESPONSIBILITIES
• We are required to maintain the privacy of your medical information.
• We are required to provide this notice of privacy practices and legal duties regarding medical information to anyone who asks for it.
• We are required to abide by the terms of this notice until we officially adopt a new notice.
• We will not sell your protected health information.
• We will not use or disclose genetic information for underwriting purposes.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION
The following categories describe different ways we may use and disclose protected health information without your authorization. For each category, we give some examples of uses and disclosures. Not every use or disclosure in a category is listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of these categories.

Treatment: We do not provide medical treatment or services. We may disclose information about your health to a physician or health care professional involved in making a decision that could affect your care. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription contradicts prior prescriptions.

Payment: We use and disclose information about your health to determine eligibility for benefits and payment of claims for medical treatment or services. For example, we may disclose information to your health care provider to verify coverage for medical treatment or services. Likewise, we may share medical information with a health care provider to assist in billing or filing claims for payment of treatment and services, including third party liability claims and coordination of benefits. We may also send you information about claims we pay and claims we do not pay (called an “explanation of benefits”) for you and your covered dependents. Under certain circumstances, you may request to receive this information confidentially.
Health Care Operations: We may use and disclose your medical information for activities that are necessary for our HMO and health insurance operations. These uses and disclosures are necessary for our business and to make sure you are receiving quality services. Some examples of how we may use and disclose information about your health include: case management and care coordination; conducting quality assessment and improvement activities such as outcomes evaluation and development of clinical guidelines; underwriting, premium rating and other activities relating to coverage; submitting claims for stop-loss or reinsurance coverage; conducting or arranging for medical review; fraud and abuse detection programs; business planning and development such as cost management; and business management and general administrative activities.

We may also disclose information about your health to our business associates to enable them to perform services for us or on our behalf relating to our operations. Some examples of business associates are our lawyers, auditors, accrediting agencies, consultants, pharmacy benefit managers, collection agencies and printing and mail service vendors. Our business associates are required to maintain the same high standards of safeguarding your privacy that we require of our own employees and affiliates.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use or disclose your protected health information in the following situations without your authorization or without allowing you to object or agree to the use or disclosure.

Legal Requirements: We may use and disclose your medical information when we are required to do so by law. This includes disclosing your protected health information to a government health oversight agency for activities authorized by law, including audits, investigations, inspections and licensure. For example, we may be required to disclose your medical information, and the information of others, if we are audited by the Illinois Department of Insurance. We will also disclose your medical information when we are required to do so by a court order or other judicial or administrative process.

To Report Abuse: We may disclose your medical information when the information relates to abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting or with your permission.

Law Enforcement: We may disclose your medical information for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness, missing person or in connection with suspected criminal activity. We may disclose protected health information in response to court orders or in emergency circumstances related to a crime. We may also disclose your medical information to a federal agency investigating our compliance with federal privacy regulations.

Family and Friends: Unless you object or law prohibits it, we may disclose your medical information to a member of your family or to someone else involved in your medical care or payment for care. This may include telling a family member about the status of a claim or what benefits you are eligible to receive.

To Avert a Serious Threat: We may disclose your medical information if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

Health Benefits and Services: We may use your medical information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Workers' Compensation: We may disclose medical information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs that provide benefits for work-related injuries and illnesses.
Your Employer or Organization Sponsoring your Group Health Plan (Plan Sponsor): We may disclose eligibility, enrollment and disenrollment information about you to the Plan Sponsor. We may also disclose summary health information to the Plan Sponsor for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan.

In addition, we may disclose other health information to the Plan Sponsor for plan administration upon certification from the Plan Sponsor that they have agreed to special restrictions on the use and disclosure of this information. Refer to your group health plan documents on additional health information the Plan Sponsor may receive.

ORGANIZED HEALTH CARE ARRANGEMENTS
We may share information that we have about you within our organization and with Carle and its affiliates; and with Springfield Clinic, Memorial Medical Center and their affiliates for purposes of health care operations under an organized health care arrangement. Sharing information enables us to:

- Determine our financial risk
- Resolve quality of care complaints
- Arrange for medical and clinical peer review
- Improve our methods of payment or coverage policies
- Arrange for legal services
- Perform utilization management services

YOUR RIGHTS
The following describes your rights regarding the protected health information we maintain about you. If you want to exercise your rights, please contact a member of our Customer Service Department, who will give you the necessary information and forms for you to return to the address listed under “Whom to Contact” at the end of this notice.

Authorization: We may use and disclose your medical information for any purpose that is listed in this notice without your written authorization. We will not use or disclose your medical information for any other reason without your authorization. If you authorize us to use or disclose your medical information, you have the right to revoke the authorization at any time. You may not revoke an authorization for us to use and disclose your medical information to the extent that we have taken action in reliance on the authorization. If the authorization is to permit disclosure of your information to an insurance company, as a condition of obtaining coverage, other laws may allow the insurer to continue to use your information to contest claims or your coverage, even after you have revoked the authorization. We will receive your authorization to use or disclose your information for certain marketing activities.

Request Restrictions: You have the right to request that we restrict uses and disclosures of your medical information that we use for treatment, payment and health care operations. You also have the right to request a limit on the information we disclose about your health to someone who is involved in your care or the payment of your care, like a family member. We will consider your request, however, we are not required to agree to a restriction. We cannot agree to restrict disclosures that are required by law.

Receive Confidential Communications: If our normal communication channels could endanger you, you have the right to request that we send communications that contain your medical information by alternative means or to an alternative location. We will ask you the reason for your request, and we will accommodate all reasonable requests to the extent the request specifies an alternative location and allows us to continue to pay claims.

Inspect and Copy: You have the right to inspect the medical information we maintain about you in our records and to receive a copy of it. This right is limited to information about you that is used to make decisions such as claims, payment and enrollment records. Under state and federal law, this right does not include psychotherapy notes or information about your health compiled in reasonable anticipation of litigation, administrative action or administrative proceedings. To inspect your records or to receive a copy, send your written request to the address listed under “Whom to Contact” at the end of this notice. We may charge a fee for the cost of copying and mailing the records. We will respond to your request within 30 days.
We may deny you access to certain information if it would reasonably endanger the life or physical safety of you or another person. If you are denied access to information about your health, we will explain how you may appeal the decision.

Amend: You have the right to request that we amend your medical information for as long as we maintain such information if you believe the information is incorrect or incomplete. This right is limited to information about you that is used to make decisions such as claims, payment and medical case management records. Your written request must include the reason or reasons that support your request. We will respond to your request in writing within 30 days. We may deny your request for an amendment if we determine the record that is the subject of the request was not created by us, is not available for inspection as specified by law or is accurate and complete.

Accounting of Disclosures: You have the right to receive an accounting of certain disclosures of your medical information made by us in the six years prior to the date the accounting is requested (or shorter period as requested). This does not include disclosures made to carry out treatment, payment and health care operations; disclosures made to you; disclosures made with your authorization; communications with family and friends; disclosures made for national security or intelligence purposes; disclosures to correctional institutions or law enforcement officials; or disclosures made prior to April 14, 2003. We will provide the first list of disclosures you request at no charge. A reasonable, cost-based fee may be imposed for each subsequent request. You must tell us the time period you want the list to cover. If a breach of your information occurs, we will notify you within 60 days.

Receive a Paper Copy: You have the right to obtain a paper copy of this notice at any time.

Complaints: You have a right to complain about our privacy practices, if you think your privacy has been violated. You may file your complaint with our Customer Service Department. (See “Whom to Contact” at the end of this notice.) You may also file a complaint directly with the Secretary of the U.S. Department of Health and Human Services. We will not take any retaliation against you if you file a complaint.

Maintaining Confidentiality of Member Information: The security of our members’ personal information is very important to us. Member information is never sold to anyone, for any purpose. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your privacy.

All Health Alliance employees are educated on our standards and are required to sign a confidentiality and security agreement annually. Any employee found to be in violation of our privacy practices is subject to disciplinary action. Employees are encouraged to report violations of confidentiality using the Health Alliance compliance hotline.

CHANGES TO THIS NOTICE
We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any medical information we already have, as well as to medical information we receive in the future. Before we make any change in the privacy practices described in this notice, we will mail a revised notice to you within 60 days of the effective date.

WHOM TO CONTACT
You may contact a member of our Customer Service Department by calling the number listed on the back of your Member Identification Card (TTY 1-800-526-0844 for the hearing impaired) or in writing at 301 S. Vine Street, Urbana, IL, 61801:

- For more information about this notice and/or our privacy policies
- To exercise your rights as described in this notice
- To request a copy of the current notice

Representatives are available from 8 a.m. to 5 p.m. Monday through Friday.

This notice is also available on our website at: HealthAlliance.org
The Centers for Medicare & Medicaid requires all Medicare Advantage plans to make a determined effort to prevent, detect and correct health care fraud, waste and abuse. Health Alliance has selected TC3 Health (a Change Healthcare Company) as a partner in our ongoing effort.

TC3 performs overpayment analysis on all Health Alliance claims. Provider offices may see an increase in recoupment requests (based on national coding standards) and an increase in medical record requests from Health Alliance or TC3. The requests are based on audits performed on billing errors related to unbundling, modifier appropriateness, mutually exclusive and incidental procedures, inappropriate billing and questionable coding relationships. The audits are performed following government and industry rules, regulations and policies governing health care claims. The findings within the letters are based upon nationally recognized and accepted sources, including American Medical Association CPT Guidelines, CMS guidelines, specialty society recommendations, the National Correct Coding Initiative and current medical practice standards.

Providers may appeal the findings in the recoupment requests by following the complaints and appeals process in the Members’ Rights and Responsibilities section of this manual.
Section 11

Online Services
YourHealthAlliance.org is easier for providers than ever before. Register now to connect with us anytime, anywhere, and you’ll find:

- Fast access to all your authorizations and claims
- Submit and manage claim reprocessing inquiries
- Member lookup that connects you to that member’s coverage info
- Guidance through our preauthorization process
- Helpful reminders for your pending actions
- A personalized start page to quickly get you to what you use most
- Instant access to announcements, forms and resources from Health Alliance
- Signons for office personnel and the features they need

Visit YourHealthAlliance.org to log on or register and get started today! If you have questions about YourHealthAlliance.org, please contact your Provider Relations Specialist.
Registration

Connect to provider partner resources from the home page of HealthAlliance.org or go to Provider.HealthAlliance.org, where you'll see the page below. On the side, you'll see a section about YourHealthAlliance.org. Choose the appropriate button to start a registration for your role. This will take you to the screen on page 7 of this document.

We will only approve you for a provider account if you're actually the doctor providing care. If you work in an office for a provider, you must choose office personnel, or your account won't be approved, and you'll have to start the registration process over.
You can also register by going directly to YourHealthAlliance.org and choosing Create an Account from under the Log In box.
From there, you’ll choose the type of account you’re creating. You should choose the Health Care Professional tab from the menu. Then choose your role, provider or office personnel.

We will only approve you for a provider account if you’re actually the doctor providing care. If you work in an office for a provider, you must choose office personnel, or your account won’t be approved, and you’ll have to start the registration process over.

If you’re a provider already contracted with us, you should never choose Prospective Provider Request. That is for providers interested in joining our provider network, not providers already working with us.
Follow the on-screen directions to set your contact information and password. Once you hit the Create Account button on this page, you'll be sent to the Confirm Email page.

**Health Alliance Provider Registration**

1. **Create Account**
2. **Confirm Email**
3. **Complete Profile**

Set up an account with your email address, which will be your login name/ID, and a secure password.

**Name**
- **First Name:**
- **Last Name:**

**Email Address**
- This will be Your Health Alliance login.
- This is where we'll send you notifications electronically.
- You'll have to confirm this email address to finish registering.
- **This email can only be linked to one user account.**

- **Email:**
- **Re-enter Email:**

**Set Password**
- Must be at least 8 characters long.
- Must have at least one upper-case, one lower-case, and one number or special character.
- Can't be your name, email, or contain any version of our name, Health Alliance.

- **Password:**
- **Re-enter Password:**
This page outlines the confirmation email process. When you receive the email, click Confirm (in the second image below) to finish your registration.

A confirmation email has been sent to [email address]. Make sure you get it before you close or navigate away from this page.

If you haven’t gotten it within 10 minutes:

- Check the junk or spam folders of your email account.
- Make sure you entered your email address correctly. If you made a mistake, it’s okay! Just start again with the correct email.
- Add CustomerService@HealthAlliance.org to your email account’s address book.
- Confirm your email address within 7 days, or you’ll have to start over.

Still haven’t gotten it?
Resend Confirmation

Welcome to Your Health Alliance!
Your account has been created. Please confirm your email address to finish activating your account and complete your profile.

Confirm
Then, you'll follow the on-screen directions to complete your profile with information like your National Provider ID, and submit it to us for approval. Approval should take approximately 7 business days, and you'll get an email when you've been approved.

Providers are the ones bringing patients health care, like doctors and hospitals. If this doesn't sound like you, you might need to set up a different type of account.

**Provider Information**

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<th>National Provider ID</th>
<th>Tax ID/TIN Numbers Only (No Dashes)</th>
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<th>Business Phone</th>
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**Clear Coverage Access**

Clear Coverage is a fast and easy way to file pre-authorizations online. Would you like access to Clear Coverage?

- [ ] Yes
- [ ] No

☐ I have read the Provider Agreement and agree to the terms and conditions.

Submit
Announcements

The first time you log into YourHealthAlliance.org with your new account, you’ll end up here. You can see announcements and recent InforMED newsletters from this page. From the very top menu, you can connect to Forms & Resources, your notifications, this announcements page, contact information and account settings.

From the footer menu, you can also connect to clinical guidelines, members’ rights and responsibilities and give us website feedback.
Account Settings

When you choose Account from the very top menu, you’ll come to this Account Settings page. From here, you can change your name and the first page you see when you log in, update your preferences or password and request access to add an additional type of access role to your account.
If you choose Office Management from the side menu, you'll come to this page, which lets you update the address for your office location.
Preauthorization Requests

The first tab in your main menu, Request Preauthorization, brings you here, where you can submit preauthorization requests. Use the Where Do I File? search to look up if you should file your preauthorization at Clear Coverage, eviCore or through the Health Alliance forms for Durable Medical Supplies, Pharmacy or Medical in the middle. Follow the on-screen directions to file requests with these forms.

See the Clear Coverage section on page 28 for more on using that tool.


YourHealthAlliance.org, continued

Authorizations

The Authorizations tab of the main menu lets you search for authorizations by the authorization's info, the provider's info or the member's info. Your results and their details will appear at the bottom. If you click a result's reference number, you can see more details for that authorization.
This authorization details page shows more authorization details, including provider information, procedure codes and the status of the authorization.

Details for Authorization #

Details

Member: 
Auth Type: HOSPITAL
Primary/Admit: 03/03/2017
Discharge/Through: 03/04/2017
Extended Status: APPROVED BY UR NURSE
Authorization Date: 03/03/2017
Auth. Level: 1

Provider Information

Referred by: 
Referred to: Circle Foundation Hospital (03/04/17)

Status: Approved
Claims and Claim Reprocessing Inquiries

The Claims tab of the main menu works much like the authorizations page. You can search for claims by their service dates, claim info or the member’s info. Your results and their details will appear at the bottom. If you click a result’s claim number, you can see more details for that claim.
This claim details page shows more claim details, including the status, benefit and service information and the breakdown of what we were billed and paid.

If you have a question about how a claim was processed, use the Create Reprocess Claim Inquiry button to fill out and submit a claim reprocessing inquiry form that’s prefilled with this claim’s details.
From the Claim Reprocessing Inquiries tab of the main menu you can search your claim reprocessing inquiries by date, status, reference number, claim number or member number. Your results and their details will appear at the bottom.

If you have a question or disagree with how a claim was processed, you can also request a claim be reprocessed by choosing the New Inquiry button to fill out the claim reprocessing inquiry form.
If you chose the Create Reprocess Claim Inquiry button from a claim's details, this form will be prefilled with that claim's information. If you were on the Claim Reprocessing Inquiries tab of the main menu, you'll have to fill out all of this form.

If you're asking for an inquiry of frequency, modifiers, place of service, procedure code, diagnosis code or any member information, you can't use this form, you must resubmit the corrected claim.
In the Review Inquiry section of this form, you can choose between a coding issue inquiry and a non-coding issue inquiry.

Reasons you should choose coding issue inquiry:
• Assistant, team or co-surgeon denial
• Code bundling
• Diagnosis denial
• Duplicate denial
• Global surgery
• Invalid, missing, or inappropriate modifier
• Maximum units or frequency of service
• New patient visit denial
• Non-covered procedure denial
• Place of service denial
• Qualifying service not recorded
• Unlisted code denial

Reasons you should choose non-coding issue inquiry:
• Claim not found (claim documentation required)
• COB or worker comp liability (EOB required)
• Description of unlisted
• Incorrect reimbursement
• Meets emergency room criteria
• Non-covered procedure
• Non-duplicate denial
• Proof of authorization (authorization documentation required)
• Timely filing (HA clearinghouse documentation required)

When requesting a review of a denied code, make sure you include a brief explanation and supporting documentation below.
Attach to Member

From Attach to Member in the main menu, you can look up a member by their member number or by their name and date of birth. Results will appear below the search fields for you to choose the member you want to attach to.
Once you've attached to a member, you can choose their Member Details from the blue overview at the top of the page. The Member Detail page includes their info, PCP info and plan info. From the side menu, you can also connect to their ID card, formulary, wellness benefits and provider directory.

While you're attached to a member, from this blue overview, you can also switch to one of their dependents or the policy holder from that dropdown, and you can also detach from this member there.
While you’re attached to the member, you can use all of the main menu tabs specifically for that member. You can request a preauthorization as you normally would, specifically for that member.
You can search all of that member's authorizations from the Authorizations tab of the main menu.

You can also search all of that member's claims from the Claims tab of the main menu.
You can also search all of that member's claim reprocessing inquiries from the Claim Reprocessing Inquiries tab of the main menu.
Forms & Resources

On the Forms & Resources page, found in the top menu or the footer menu, you can connect to important resources, like the provider manuals, credentialing forms, drug lists, pharmacy directories and more.
Clinical Guidelines

You can find these online anytime from the Clinical Guidelines page in the footer menu.

Alcohol Misuse

National Institute on Alcohol Abuse and Alcoholism - Helping Patients Who Drink Too Much, a Clinician’s Guide

Asthma

Institute for Clinical Systems Improvement (ICSI) - Guidelines for the Diagnosis and Management of Asthma
National Heart, Lung, and Blood Institute (NHLBI) - Guidelines for the Diagnosis and Management of Asthma

Attention Deficit Hyperactivity Disorder

ICSI - Primary Care Guidelines for Attention Deficit Hyperactivity Disorder for School-Age Children and Adolescents

Cholesterol Control

ACC/AHA - Guidelines on the Treatment of Blood Cholesterol
ACC/AHA - Pocket Card Guidelines: Cholesterol Adult Management

Chronic Obstructive Pulmonary Disease (COPD)

ICSI - Guidelines for the Diagnosis and Management of COPD
Global Initiative for Chronic Obstructive Lung Disease (GOLD) (1 free download allowed)

Congestive Heart Failure

2013 ACCF/AHA - Guideline for the Management of Heart Failure

Coronary Artery Disease

2012 ACCF/AHA/ACP/AATS/PCNA(SCAI)/STS - Guideline for the Diagnosis and Management of Patients With Stable Ischemic Heart Disease

2014 ACC/AHA/AATS/PCNA/SCAI/STS - Focused Update of the Guideline for the Diagnosis and Management of Patients With Stable Ischemic Heart Disease

2016 ACC/AHA - Guideline Focused Update on Duration of Dual Antiplatelet Therapy in Patients With Coronary Heart Disease

AHA/ACC - Pocket Card Guidelines: Stable Ischemic Heart Disease

Depression in Adults

ICSI - Guidelines for Adult Depression in Primary Cares

Diabetes

American Diabetes Association - Standards of Medical Care in Diabetes

Hypertension

Journal of the American Medical Association - 2014 Guidelines for the Management of High Blood Pressure in Adults
Clinical Guidelines, continued

Migraines and Headaches

ICSI - Guidelines for the Diagnosis and Treatment of Headache
AAN/AHA Evidence-Based Guideline Update - Pharmacologic Treatment for Episodic Migraine Prevention in Adults

Osteoporosis

ICSI - Guidelines for the Diagnosis and Treatment of Osteoporosis

Potentially Inappropriate Medication (PIM) Usage in Older Adults

American Geriatrics Society - Updated Beers Criteria

Preventive Care

ICSI - Guidelines for Preventive Services for Adults
ICSI - Guidelines for Preventive Services for Children and Adolescents

U.S. Preventive Services Task Force - Recommendations for Primary Care Practice - For perinatal care info, use the perinatal care and obstetric and gynecologic category filters on the right to narrow your results.

Health Alliance's Preventive Care Guidelines Brochure

Tobacco Use

ICSI - Guidelines for Healthy Lifestyles
ICSI - Guidelines for Preventive Services for Adults
ICSI - Guidelines for Preventive Services for Children and Adolescents

Weight Management

ICSI - Guidelines for the Prevention and Management of Obesity for Adults
ICSI - Guidelines for the Prevention and Management of Obesity for Children and Adolescents

Clinical Guidelines have been developed to assist patients and providers in choosing appropriate healthcare alternatives for specific clinical conditions. While clinical practice guidelines are useful aids to assist providers in determining appropriate care practices for many of their patients with specific clinical problems or prevention issues, the Guidelines are not meant to replace the clinical judgment of the individual physician or establish a standard of care.

The recommendations contained in the Guidelines may not be appropriate for use in all circumstances. Decisions to adopt any particular recommendation must be made by the provider in light of the circumstances presented by the individual patient. Accordingly, Health Alliance makes and receives no warranty, express nor implied, and all warranties of merchantability and fitness for a particular purpose are expressly excluded.
1. Log in to Clear Coverage.

2. Choose at the top of the main screen.

3. In the Patient Search accordion, search for a patient by entering information, then choose Search. Note: Required fields have a red asterisk (*).

4. In the Search Results, choose select next to the patient’s name.

5. Verify the patient’s information, and then Add to Request.

6. In the Requesting Information accordion, select the Date of Service and then select the Requesting Clinician from your preferred clinician list. Or, choose a provider from the Select Other Clinician link. Then choose Add to Request.

7. In the Diagnosis accordion, search for a specific billable diagnosis, then Add to Request, and then choose Next. Search by entering a diagnosis description or ICD9/10 may be entered.

8. In the Service accordion, search for the Service/Test, Add to Request, and then choose Next. Search by entering a service/test description or CPT®/HCPCS code.

9. In the Service Information accordion, complete the required information, and then choose NEXT. Note: Required fields have a red exclamation mark (!).

A. Priority — Defaults to Normal. If appropriate, you can change it.

B. Diagnosis — If you selected multiple diagnosis codes, you should select the primary diagnosis from this drop down list.

C. Service Facility — Select the appropriate servicing facility.

D. Medical Review — Complete the Medical Review.

E. Modifiers — Appears only if a modifier is required. Click to select a modifier.

F. CPT — You may be required to select a primary CPT code.

G. Details — Enables you to specify details such as: Referring provider, Place of Service, Units/Frequency/Duration. Enter this information as required.

10. In the Additional Notes accordion, add any notes or supporting documentation.

11. Verify the Authorization Request details are correct in the right pane.

12. Choose Submit in the lower right pane. If Submit is not active, move the pointer over it to see the information that’s missing.

13. Clear Coverage creates a request confirmation for each service/test.

14. Print the authorization request by selecting the View Request PDF link. Then, choose Yes to create another authorization for the same patient or No to go back to the main screen to create an authorization for a new patient.

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