Indiana University Health Plans Provider Manual

IU HEALTH Health Plans

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This manual was prepared by Indiana University Health Plans to help participating providers and their office staff administer services to plan members. The information contained in this book is proprietary and may not be disclosed to any third party without written approval from IU Health Plans.

Section 1. General details and contact information

Welcome to IU Health Plans.

As a health plan based in Indiana, IU Health Plans cares about the health and well-being of Hoosiers. Our members are not a number to us. They are our neighbors, co-workers, family members and friends. With this perspective, we strive to work closely with our providers to deliver an integrated care model that leads to better outcomes for members and healthier patients for you. We remind our members to schedule wellness visits, and our care management team proactively reaches out to help individuals who may need coordinated specialty care plans.

We're connected to IU Health, Indiana's leading healthcare system with 80% of the top doctors across the state. Additionally, our network of strategic provider partnerships allows us to make high-quality services available to our members.

Our provider website, **iuhealthplans.org/provider**, hosts our Provider Resources page and our Provider Portal, which includes helpful forms and links. Access this website when you have questions about our services, or email our provider relations team at **iuhplansproviderrep@iuhealth.org**.

Thank you for joining our network. We look forward to partnering with you to serve the health and wellness needs of Hoosiers.

About IU Health Plans

Our vision

Help our members achieve the well-being they desire by improving the way they experience healthcare.

Our products

IU Health Plans is focused on providers and the leading role you play in managing the health of our members and the community. We support healthcare providers in their efforts to keep patients healthy by encouraging a managed-care, value-based model. IU Health Plans provides coverage to a variety of Indiana residents through Commercial and Medicare Advantage plans.

What health plans does IU Health Plans offer?

IU Health Plans offers Commercial Group Plans, Commercial Self-Insured Plans and Medicare Advantage.

General plan descriptions

Commercial Group Plans:

- IU Health Plans offers fully insured products to employers with as few as two lives to very large employers with hundreds of employees. HSA and PPO plan designs are the most common offered to employers with the majority of plans offering in-network benefits only. Our in-network offering can be a stand-alone option of IU Health Select Network which gives members access to IU Health providers/facilities and select local providers that show an "IU Health Select" designation in our provider directory. Members who do not live near an IU Health facility may have access to additional in-network providers via our traditional IU Health Plans Network. Expanded network access may be available for some members at a Tier 2 in-network benefit at an increased member cost share.
- IU Health Plans also administers benefits for large employers that choose to be Self-Insured (also known as Self-Funded). This funding arrangement is one in which the employer assumes the financial risk for providing healthcare benefits. Self-insured employers pay for each out-of-pocket claim instead of paying a fixed premium. Self-insured employers can choose any type of plan design to offer to their employees.

Plans description:

- Preferred Provider Organization (PPO) members are not required to select a primary care provider (PCP) to coordinate their care; however, they are encouraged to do so.
- Members have less out-of-pocket expenses when they receive services from a participating provider.
- Members have greater out-of-pocket expenses when they receive services from a non-participating provider.
- Participating providers only refer members to other participating providers unless one is not available, and IU Health Plans pre-approves a referral to a non-participating provider.
- Prior authorization is required by IU Health Plans for some services (See Section 6 for a high level list of services that require pre-authorization.). For a more comprehensive list of services that require prior authorization, please visit our website.
- Members are not responsible for charges that exceed IU Health Plans' allowed amount when using participating providers.

Section 1. General details and contact information, continued

About IU Health Plans, continued

Commercial Self-Insured Plans:

A self-insured group health plan (also called a "self-funded" plan) is one in which the employer assumes the financial risk for providing healthcare benefits to its employees.

Medicare Advantage:

Indiana University Health Plans Medicare Advantage is the name of the coordinated health plan offered by Indiana University Health Plans, Inc., an Indiana organization licensed as a Health Maintenance Organization under state law, to meet the healthcare needs of people enrolled in Medicare and living in the IU Health Plans service area.

Indiana University Health Plans, Inc. is marketed by IU Health Plans account executives to individual Medicare beneficiaries. Medicare beneficiaries are made aware of the IU Health Plans program through print and other marketing media. Information meetings are held frequently throughout the service area. The IU Health Plans Provider Relations team can provide brochures to display in your office to increase awareness of our Medicare Advantage program.

The IU Health Plans program offers increased benefits and features beyond what is covered with Original Medicare when the member uses contracted IU Health Plans providers. The member can select from seven benefit coverage options (not all plans are available in all counties). All IU Health Plans plan options include the following benefits/features:

- Coverage to pay for all of the members' Medicare (Part A) coinsurance and deductible costs associated with hospital and skilled nursing facility services
- Coverage of physician and medical services (Part B) with low copayments, no deductibles and lower out-of-pocket costs
- $0 copay for preventive services
- Immediate coverage with no waiting period for pre-existing conditions
- Claims are filed for our members
- Affordable monthly premiums (in addition to the Medicare Part B premium that the member pays)
- Convenient, comprehensive healthcare services
- A variety of benefits for health services and wellness programs
- Out-of-network coverage is included only with the IU Health Plans Medicare Choice (HMO-POS) and IU Health Plans Medicare Flex (HMO-POS) plans.

Confidentiality

IU Health Plans employees and individuals engaged in IU Health Plans activities maintain the privacy and confidentiality of practitioner and member information, in accordance with Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH) and other applicable laws. IU Health Plans acknowledges the importance of maintaining the privacy and confidentiality of practitioner information, peer review material, facility, member-identifiable information and documents used in the course of activities associated with carrying out healthcare activities (verbal and/or written) and therefore, they will be kept confidential and comply with state and federal laws and regulations.

Section 1. General details and contact information, continued

About IU Health Plans, continued

How to contact us

Indiana University Health Plans, Inc.
Administrative Office
950 N. Meridian St., Suite 400
Indianapolis, IN 46204

Population Health Medical Management

Prior authorization services during normal business hours:
7 am – 7 pm, Monday – Friday (except federal holidays)
T 317.962.2378
T 866.492.5878 (toll free)

Completed prior authorization requests/standard requests:
F 317.962.6219

Urgent, weekend and holiday requests:
T 317.962.2378
F 317.962.6219

Communications received after normal business hours are returned on the next business day, and communications received after midnight Monday through Friday are returned on the same business day.

Prior Authorizations for Advanced Imaging Services (all products/plans)
Care to Care
iuhp.careportal.com
T 347.670.1016
Business hours: Monday – Friday, 8 am – 6 pm (EST)

IU Health Plans departments

Provider Services
T 866.895.5980 or 866.895.5835 Commercial
T 317.963.9920 Medicare Advantage
Business hours: Monday – Friday, 7 am – 7 pm

Commercial Member Services
T 866.895.5975 or 866.895.5828
Business hours: Monday – Friday, 7 am – 7 pm

Medicare Advantage Member Services
T 800.455.9776 or 317.963.9700
TTY users should call Relay Indiana: 800.743.3333
Business hours:
Oct. 1 – March 31, 8 am – 8 pm, seven days a week
April 1 – Sept. 30, 8 am – 8 pm, Monday – Friday

Provider directories

For the most recent IU Health Plans Provider Directory, please go to **iuhealthplans.org** and follow the link for "Find a Doctor or Facility." Provider directory only includes those providers who have opted to be printed in our online directory and does not include our full network of providers. Practitioners must also schedule patients at an office location to be eligible for publishing in the IU Health Plans directory.

24/7 Provider Portal

Through our Provider Portal you have 24/7 access to a variety of important tools and resources. You can access member eligibility and benefits, look up claims payment details, view important updates via our provider newsletter and access quick links to forms and websites you need for prior authorization and other procedures. In-network providers can submit prior authorization requests online via our Provider Portal.

Sign up for the Provider Portal by visiting **iuhealthplans.org/provider** and selecting "Sign up for an account" on the right side of the page.

Section 2. Provider credentialing, status and locations

Provider credentialing overview

It is the policy of IU Health Plans to credential and re-credential participating contracted providers using NCQA and CMS standards along with state and federal guidelines. IU Health Plans requires credentialing be complete for any required licensed medical practitioner (physician or non-physician) either independent or part of a group before reimbursement of any services rendered to IU Health Plans members.

The credentialing process allows IU Health Plans to contract with healthcare practitioners who demonstrate competency and a commitment to excellence in the delivery of healthcare services. The credentialing process applies to all contracted IU Health Plans providers, including MDs, DOs, DPMs, DDSs, DCs and behavioral health practitioners—psychiatrists and physicians certified in addiction medicine, doctoral-level Indiana practitioners licensed with HSPP designation, licensed clinical social workers, licensed marriage and family therapists, licensed mental health counselors, licensed psychiatric clinical nurse specialists, licensed psychiatric advanced practice nurses, other licensed independent practitioners, and practitioners who have an independent relationship with the organization. Dentists are only required to be credentialed if they provide care under the managed care organization's medical benefits.

IU Health Plans complies with the Indiana Credentialing Statute for HMOs, IC 27-13-1-10, by using the prescribed application form of the Council for Affordable Quality Healthcare (CAQH). IU Health Plans credentialing policies and procedures will incorporate NCQA and CMS requirements and will be reviewed by the IU Health Plans Credentialing Committee at least annually to maintain compliance with current standards.

The IU Health Plans Credentialing Committee renders the credentialing decision. Credentialing is generally granted for a three-year period; however, the committee may choose to grant credentialing for a shorter time.

Practitioners who must be credentialed

Practitioners who have an independent relationship with IU Health Plans:

- Medical doctors
- Specialists
- Osteopaths
- Podiatrists

Hospital-based practitioners who have an independent relationship with IU Health Plans and who have private practices such as:

- Anesthesiologists with pain-management practices
- Cardiologists

Dentists who provide care under the organizations medical benefit:

- Endodontists
- Oral surgeons
- Periodontists

Non-physician practitioners who have an independent relationship with IU Health Plans and who provide care under our benefits:

- Nurse practitioners
- Nurse midwives
- Physician assistants
- Optometrists
- Physical therapists
- Occupational therapists
- Speech and language therapists
- Behavioral health providers
- Telemedicine providers
- Genetic counselors

Practitioners excluded from credentialing include the following:

- Practitioners with exclusive practice within the inpatient setting and who provide care for members only as a result of members being directed to the facility.
- Practitioners with exclusive practice in free-standing facilities and provide care only as a result of members being directed to the facilities, such as urgent care centers, mammography centers, surgical centers, and psychiatric and addiction disorder centers.
- Practitioners with on-call coverage only.
- We credential providers going into members' homes, skilled nursing facilities and nursing homes.

Section 2. Provider credentialing, status and locations, continued

Provider credentialing overview, continued

Credentialing process

A standard credentialing application (e.g., CAQH application) must initially be completed by all providers along with submission of additional credentialing materials (e.g., DEA certificate, malpractice insurance face sheet, CV, etc.). Verification of the accuracy of the materials will be conducted by credentialing staff using data from recognized monitoring organizations. Any discrepancies between materials submitted by providers and the data viewed during verification will be conveyed to providers giving the practitioner a chance to resolve the discrepancy.

Upon completion of the initial credentialing process, an IU Health Plans-appointed committee will review the materials to determine entry into the program. At a minimum, the committee individually reviews the credentials of practitioners who do not meet IU Health Plans established criteria. An objective review will be enforced thereby omitting any committee member from making any voting decisions if he/she feels there is a conflict of interest, has been professionally involved with the practitioner, or feels his or her judgment has been compromised. Practitioners will be notified within 60 calendar days of the peer-review committee's decision.

All IU Health Plans providers have the right to request and receive information upon request regarding the status of their credentialing application. This request can be made via telephone or writing by contacting the IU Health Plans Provider Relations department. Any credentials information may be shared with you except for peer-review protected information.

Upon request, credentialing staff will notify you about the status of a completed credentialing application no more than 60 days after receiving the completed credentialing form and every 30 days after the notice until the final credentialing decision is made. For initial credentialing decisions and re-credentialing denials, providers will be notified of the credentialing decision within 60 calendar days of the peer-review committee's decision.

If there is any credentialing information obtained from an outside source that varies substantially from the information provided by the provider, IU Health Plans credentialing staff will notify the provider electronically, by telephone, fax or in writing. This may include, for example, malpractice claims history, board certification status or licensure actions. The provider has the right to correct the erroneous information by submitting written clarification to the credentialing staff within 30 or 60 days.

Minimum standards for practitioner applicant process and review by the committee include:

- Current unrestricted state license to practice medicine, dentistry, podiatry, chiropractic medicine, behavioral health, nursing and others as appropriate. The only exception is if the practitioner is on probation for alcohol or drug abuse. If the practitioner has been licensed less than 5 years in the current state, additional queries will be made to previous states of licensure or the Federation of State Medical Boards.
- Practitioner may be on probation by the licensing board for alcohol or drug abuse, provided he/she is in compliance with treatment as prescribed by the board and provides evidence of compliance and participation in board certification in specialty area. Practitioners may be considered for exception if board eligible following completion of residency/fellowship. If not board certified or eligible, a practitioner may be allowed to become a member if he/she possesses comparable competence.
- Graduation from medical school, dental school, podiatry school, chiropractic college or appropriate school, as applicable.
- Current Indiana DEA certificate, as applicable to profession
- No Medicare/Medicaid sanctions
- Not on the OIG exclusion list
- Applies only to those contracted with Medicare
- Five-year work history. A work history gap of 6 months or more is reviewed. A gap that exceeds one year requires a written explanation.
- Current evidence of professional liability insurance coverage, showing qualification as a provider in the Indiana Patient Compensation Fund or covered by the FTCA.
- Professional liability insurance coverage of a least $1,000,000/$3,000,000 if licensed and a non-eligible Indiana healthcare practitioner. For ancillary behavioral health practitioners not included in the definition of "Health Care Provider" under IC 34-18-2-14, lower professional liability insurance coverage will be considered.
- Acceptable National Practitioner Data Bank Report (NPDB)
- Malpractice claims history that includes a detailed report of occurrence of each liability claim filed, in process, or resolved in the past 10 years. Claims history is acceptable in terms of frequency, severity, patterns and trends.
- Disclosure of the reasons for any inability to perform the essential functions of the position with or without accommodation; to the lack of present illegal drug use; and history of loss of license and/or felony convictions.

Section 2. Provider credentialing, status and locations, continued

Provider credentialing overview, continued

- Disclosure of history of all past and present issues regarding the loss or limitation of clinical privileges or disciplinary action at all facilities or organizations with which the practitioner has had privileges.
- Completed CAQH application with attestation statement signed and dated by the applicant confirming the correctness and completeness of the application within 180 days of the credentialing committee decision.

Required credentialing documentation

To participate in the IU Health Plans network, practitioners must meet the following criteria:

- **Attestation:** Attested to completion and accuracy of the application
- **State license:** Current, valid and unrestricted license to practice in Indiana (or a neighboring state if not practicing in Indiana)
- **DEA:** Current, valid and unrestricted Indiana DEA certificate for prescribing controlled substances and a current Indiana Controlled Substance Certificate. Exceptions may be granted if there is a covering physician who will attest their willingness to prescribe controlled substances for provider.
- **Educational requirements:** Graduate school recognized by Indiana state boards. Satisfactorily completed a residency program in the appropriate specialty of practice.
- **Board certification:** Board certified in the specialty in which the practitioner treats IU Health Plans patients. Certification must be through a recognized board such as ABMS, AOA, APMA, etc. Exceptions may be granted if:
  - The physician is not board certified in the appropriate specialty of practice, IU Health Plans must ensure the appropriate CME documentation has been submitted that verifies the physician has received a minimum 25 Category I CMEs in the past 12 months, 50 Category I CMEs in the past 24 months, or 75 Category I CMEs in the past 36 months. Should a specialty require a different number of CMEs, we will be guided by the number of CMEs required for the specialty.
  - The practitioner possesses comparable competence
- **Privileges:** Clinical privileges in good standing at practitioner's primary admitting hospital. If the practitioner is a PCP or behavioral health practitioner and does not have admitting privileges at an in-network hospital, the practitioner must have relationship privileges with another in-network practitioner to admit an IU Health Plans member and follow the member while the member is in the hospital. Additionally, the practitioner may have a clinical appointment to an in-network hospital that designates covering practitioner relationship(s).
- **Liability coverage:** Professional liability coverage of $500,000/$1,500,000 and participation in the Indiana Patient Compensation Fund. If not under the fund, there must be coverage of $1,000,000 per occurrence; $3,000,000 aggregate; or be a covered employee or contractor of an entity that is eligible for coverage under the Federal Tort Claims Act
- **Malpractice history:** Acceptable liability history must be presented based upon pattern, frequency and type of settlement and pending claims against the practitioner. A historical report within the last 10 years of any liability claims filed must be submitted for review by the medical director or designee.

  A peer-review committee or designee will review all practitioners with:
  - Filed malpractice claims or settlement in the past 5 years
  - Any settlement for $75,001 or more in the past 5 years
  - A closed claim with a payment or settlement involving a death

  Note: *If no additional suits have been filed against the practitioner since the most recent credentials cycle or no new information arises on previous cases (e.g., settlement reached, finding of malpractice, etc.), liability history review is not required.*
- **Work history:** Comprehensive five-year professional employment and/or education history
- **Contract:** Must confirm an agreement to abide by contract terms
- **Impairment:** Attests that physical or mental impairment cannot affect ability to practice, which includes absence of chemical dependency or substance abuse
- **Sanctions:** Must report past disciplinary action or criminal indictment. Must demonstrate an absence of Medicare or Medicaid sanctions. It must be demonstrated that sanctions outside of Medicare or Medicaid will not permit future subpar performance

Section 2. Provider credentialing, status and locations, continued

Provider credentialing overview, continued

- **Providers must disclose:**
  - All past or pending sanctions under state or other licensing agencies, hospitals, DEA or other facilities
  - All past or pending disciplinary or professional committee action by a healthcare entity (e.g., hospital)
  - Information regarding past suspensions, limitations or termination from a managed care plan, hospital or insurer
  - Any felony convictions

Recredentialing process

IU Health Plans requires all practitioners participating in the IU Health Plans program to be recredentialed at least every 36 months. Approximately 3 months before the recredentialing date, the application is obtained from CAQH, but the office will be contacted if additional information is required. Recredentialing will be similar to the initial credentialing process as a standard recredentialing application (e.g., CAQH application) will be completed and verified using recognized monitoring organizations. In addition, data obtained during the provider's tenure in the plan will be evaluated for quality assurance or clinical effectiveness. Data regarding practice experience can be part of the peer-review process of recredentialing a provider. At the time of recredentialing, complaints and grievances regarding the provider are reviewed. Practitioners will be notified of any discrepancies between recredentialing applications and IU Health Plans review of the information allowing them a chance of submission of additional materials to resolve the issue. After verification of materials by IU Health Plans, the committee will comprehensively review the candidate and notify the practitioner of the decision within 60 calendar days.

Providers who fail to submit required credentialing documents in a timely manner may be terminated from the network and no longer eligible to see members.

Monitoring of sanctions, complaints and quality issues

IU Health Plans is committed to providing its members with consistent, high-quality healthcare. To maintain its commitment, ongoing monitoring of sanctions, member complaints and quality issues is conducted by the credentialing staff. Between recredentialing cycles the credentialing staff will strive to identify any significant quality or safety issues in a timely manner so that an improvement plan can be implemented. Monitoring can include, but is not limited to, reviewing Medicare or Medicaid sanctions, limitations on licensures, member complaints and information regarding adverse events or quality issues.

Disciplinary action

IU Health Plans may take disciplinary action against a provider as a result of any adverse quality of care, utilization, licensure or credentialing issues. Potential issues may be identified through a number of sources, including but not limited to, medical record reviews, complaint investigation, credentialing issues, quality improvement studies and review of over- and underutilization practices. As required by applicable law, issues are investigated through the peer review process. If after investigation, the peer review committee believes a quality issue exists, it may impose the following types of sanctions:

- Monitoring of performance
- Education
- Counsel
- Focused oversight
- Termination

If the committee believes a quality-of-care issues exists, the provider will be notified in writing. The letter will contain:

- The determination of the committee
- A general description of the basis for the determination
- Specific actions the provider must take to correct the problem
- A description of the process that will be used to evaluate the effectiveness of the intervention
- The provider's appeal rights

IU Health Plans will report any decision to reduce, suspend or terminate a provider's participation in the network as required by applicable law and regulation. IU Health Plans will help a member locate another participating provider as needed.

Section 2. Provider credentialing, status and locations, continued

Disciplinary action, continued

Issues that are not related to clinical competency may also be reviewed by the committee, and action taken, if necessary. Such issues may include:

- Failure to participate in quality management or peer review activities
- Failure to meet other contractual requirements not related to clinical competency
- Unethical conduct
- Failure to cooperate with the IU Health Plans quality improvement program
- Failure to cooperate with the IU Health Plans utilization management program
- Failure to respond to an investigational request
- Failure to respond to or comply with a corrective action plan

Any of these failures may result in corrective action by IU Health Plans, including, but not limited to, termination. Termination based on grounds not related to clinical competency shall not constitute grounds for a peer review committee hearing.

Appeals process

In accordance with the Health Care Quality Improvement Act of 1986, an appeals process is available to practitioners in the event he or she should be denied participation, suspended or terminated from the program due to a credentialing review or quality issues. At the time of notice of an adverse credentialing/recredentialing decision, the provider will be notified of appeal rights and procedures, including but not limited to:

- Written notification will be issued when a professional review action has been brought against the provider; the reasons for the action; and a summary of the appeal rights and process.
- Provider may request a hearing and the specific time period for submitting the request.
- Allow 30 calendar days after the notification for provider to request a hearing.
- Allow provider to be represented by an attorney or another person of his/her choice.
- Allow a hearing officer or a panel of individuals to review the appeal.
- Written notification of the appeal decision that contains specific reasons for the decision.

Except for the following reasons, termination from the program will not occur until the appeals process is exhausted by the provider or the provider chooses not to appeal in the required time period. In addition to the termination provisions contained in the Provider's Agreement with the Health Plan, providers are terminated immediately from the IU Health Plans network for any of the following confirmed reasons:

- Loss or surrender of license
- Loss of sufficient liability coverage
- Exclusion or suspension from Medicare or Medicaid program

IU Health Plans is responsible for reporting provider quality deficiencies that affect network participation to the appropriate state and/or federal organizations. Reportable deficiencies may be related to professional competence or conduct as well as quality of care.

Section 2. Provider credentialing, status and locations, continued

Confidentiality

A credentials file is maintained on each provider. IU Health Plans maintains credentialing files in a confidential manner and uses all information collected solely for the purpose of credentialing. In adherence to state and federal regulations, IU Health Plans and IU Health Plans subcontractors maintain confidentiality of all information collected, developed or presented as part of the credentialing process. Committee minutes and discussions are confidential and protected under I.C. 34-30-15. Credentialing files and written records of quality deficiencies and improvement plans are kept in a secure location. Access to information is restricted only to individuals who are necessary to attain credentialing process objectives. Dissemination of any confidential information shall only be made (1) where expressly required by law or (2) with permission of the provider applicant.

Verification sources used:

Council for Affordable Quality Healthcare (CAQH) – **proview.caqh.org**

Indiana Professional Licensing Agency

National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank – **iqrs.npdb.hrsa.gov/**

Office of Inspector General – **exclusions.oig.hhs.gov/**

Indiana Patient's Compensation Fund – **indianapcf.com/index.aspx**

DEA – **deanumber.com**

ABMS – **certifacts.abms.org**

Timely notice of demographic changes

Providers are asked to notify Provider Data Management and Provider Relations (applicable contracting area/IU Health) of changes to demographic information that differs from the information reported with their executed participation agreement with IU Health Plans, including, but not limited to, name, phone numbers, hospital affiliations, panel position (open or closed to new patients), languages spoken by the physician or clinical staff, board certification, specialty, TIN changes, address change, additions or departures of healthcare providers from their practice, and new service locations. Please provide changes at least 30 calendar days before they become effective to prevent issues with member access, claims payment and provider directory listing.

Required notice for termination will be determined by the IU Health and provider agreement, but at no time will the notice period be less than 30 calendar days unless the requirements of Termination with Cause are met.

Section 3. Role of the provider

Provider rights and responsibilities

Responsibilities of all participating providers

Each participating provider has entered into an agreement with IU Health Plans. This agreement contains important information about the responsibilities of participating providers. Questions about these responsibilities should be directed to Provider Relations.

At a minimum, participating providers agree to:

- Accept members from all IU Health Plans and notify Provider Relations in writing 30 calendar days prior to limiting or closing their practice to members.
- Provide services during normal business hours with emergency, after-hours coverage available 24 hours, seven days a week.
- Only refer members to participating providers unless one is not available and IU Health Plans pre-approves a referral to a non-participating provider.
- Submit claims for services provided to members.
- Accept IU Health Plans' reimbursement as payment in full for covered services except for applicable co-pays, deductibles and coinsurance.
- Not seek payments from members for services determined by IU Health Plans to be medically unnecessary unless the member understood prior to receiving the services that they were not covered and agreed in writing to accept financial responsibility.
- Provide consultation to other participating providers as reasonably requested.
- Make members aware of all available care options, including clinical care management through IU Health Plans.
- Treat IU Health Plans members as equals to all other patients.
- Be active participants in discharge planning and/or other coordination of care activities.
- Maintain all required licenses, certifications, credentials and liability insurance.
- Comply with IU Health Plans' quality improvement and utilization management programs, policies and procedures.
- Conduct all on-site reviews and medical records reviewed by IU Health Plans (or its representative organization) upon reasonable notice.
- Comply with patient access standards as defined within this manual.
- Remain in good standing with local and/or federal agencies.
- Be responsive to cultural, linguistic and other needs of patients.
- Maintain the confidentiality of IU Health Plans members.
- When applicable, inform members of advanced directives concurrent with appropriate medical records documentation.
- Coordinate care with other providers through notification of findings, transfer of medical records, etc., to enhance continuity of care and optimal health. Report findings to local agencies as mandated and to IU Health Plans when appropriate.
- Promptly notify IU Health Plans of changes in their contact proprietary information address, panel status, accepting new patient status and other relevant provider enrollment information.
- Per the Appropriations Act of 2021 (No Surprises Act), health plans must verify a provider's published provider data every 90 days or remove it from the patient-facing provider directory. Providers are required to attest and/or correct any data inaccuracies via the plan's validation process to ensure their information on the plan's provider directory is accurate and up to date. This task is to be completed by the provider on a quarterly basis. Currently, IU Health Plans partners with Better Doctor, a division of Quest Analytics, for these types of validations.
- Providers are required to submit all the necessary information for a provider to be loaded in our systems based upon IU Health Plans data requirement to meet CMS/NCQA requirements.
- Respect and support IU Health Plans member rights and responsibilities.

Section 3. Role of the provider, continued

Provider rights and responsibilities, continued

- Of equal importance, IU Health Plans providers have the right to:
  - Receive written notice of network participation decisions.
  - Exercise their rights and other options as defined within this manual and/or the IU Health Plans Provider Agreement.
  - Communicate openly with patients about diagnostic and treatment options.
  - Expect IU Health Plans adherence to credentialing decisions as defined in a later section of the manual.
  - Review information submitted to support their credentialing application and correct erroneous information.
  - Receive the status of their credentialing or recredentialing application.

Please refer to your IU Health Plans provider agreement for more complete information about provider responsibilities. The list above is only a summary of some of your responsibilities for reminder purposes only. It is not intended to replace or redefine the responsibilities in your agreement.

Provider responsibility for protected health information

Provider acknowledges that protected health information (PHI) within its possession is subject to protection in accordance with applicable law. Provider agrees to abide by applicable laws regarding the privacy, confidentiality, security, integrity, use and disclosure of member information and medical records and other PHI and enrollment information, and to safeguard the privacy, confidentiality and security of any such information. Safeguarding shall include measures to protect the security of PHI when it is in use, in transit, stored or destroyed. Provider shall follow IU Health Plans policies specifying the purposes for which PHI will be used and disclosed.

- Patient medical records privacy. Provider shall safeguard the privacy of all information that identifies a particular member and abide by all applicable federal and state laws and regulations regarding confidentiality and disclosure of mental health records, medical records, other health information, and enrollment and member information. Information from, or copies of, medical, enrollment and other records may be released only to authorized individuals in accordance with applicable federal and state laws and regulations. Plans shall secure a signed release from a member prior to disclosure of the member's medical records and health information. IU Health Plans and provider shall take precautions to ensure that unauthorized individuals cannot gain access to or alter patient records.
- Subcontractor access to records. Provider and IU Health Plans agree to require all subcontractors and agents to comply with applicable laws regarding privacy of medical information, including signing business associate agreements as required. Provider agrees to ensure that all downstream entities and their agents with access to PHI agree in writing to protect PHI that is handled outside of U.S. or the U.S. Territories. Such written agreements shall specifically govern the use and disclosure of PHI and shall comply with HIPAA's business associate agreement requirements. Nothing in this section shall limit IU Health Plans' right to approve subcontracts or assignments as provided elsewhere in this agreement.

Role of the primary care provider (PCP)

The primary care provider (PCP) is the manager and medical home of a member's total healthcare needs. This includes providing primary care services and authorizing referrals for consultation, specialty and hospital services, when needed. If required or needed to authorize a referral, the PCP specifies the nature of the services that are authorized and the name of the authorized referral provider.

Role of the specialist/referral provider

Specialist/referral providers provide consultation and/or specialty services for members who have been referred by their PCP (or have self-referred in accordance with his/her benefits). They are responsible for promptly communicating their findings and treatment recommendations/outcome to the PCP, as applicable. If the specialist/referral provider determines a need to provide services not authorized by the PCP, the specialist/referral provider must obtain the PCP's approval prior to rendering these services (as applicable) except in the case of a medical emergency.

Section 3. Role of the provider, continued

Guidelines for physicians' availability

The selection of a primary care physician by the member identifies an intended doctor-patient relationship. While it is appropriate for the physician to establish protocols by which the member is integrated into the practice, the newly selected primary care physician must be available to see new IU Health Plans patients for acute care, until they can be seen under the established protocols. Primary care physicians may access the IU Health Plans web portal to verify patient eligibility, etc. at **iuhealthplans.org/provider**.

All IU Health Plans members should be able to reach their primary care physician or his/her designated covering physician by telephone, for emergencies, within 30 minutes, 24 hours a day, and 7 days a week. For routine messages, a return call should be made to the patient within one working day. IU Health Plans requires the following standards are maintained regarding appointment availability.

Primary care physicians appointment standards	
Type of appointment	**Maximum waiting time for an appointment**
Emergency	Immediate
Urgent or emergent	Within 24 hours
Routine, but in need of attention, for symptomatic but non-urgent	Within 5 business days
Routine and well/preventive care	Within 30 calendar days
Access to after-hours care	Office number answered 24 hours/7 days a week by answering service or instructional message on how to reach a physician

If PCP has more than one office participating with IU Health Plans, then the PCP must have a minimum of 20 regularly scheduled office hours over at least a week to treat patients in each location in order to be published in the provider directory.

On-call coverage: The covering physician, as well as the primary care physician, must be a credentialed provider by the network and according to IU Health Plans standards.

Specialty care physicians appointment standards	
Type of appointment	**Maximum waiting time for an appointment**
Emergency	Immediate
Urgent	Within 48 hours
Non-urgent symptomatic	Within 2 – 4 weeks
Access to after-hours care	Office number answered 24 hours/7 days a week by answering service or instructional message on how to reach a physician

Specialist physicians will be available at least an average of eight hours a week for scheduling office appointments in order to be published in the provider directory.

Behavioral health providers appointment standards	
Type of appointment	**Maximum waiting time for an appointment**
Emergency	Immediate
Urgent or emergent	Within 48 hours
Routine	Within 10 business days
Non-emergency	Within 6 hours
Access to after-hours care	Office number answered 24 hours/7 days a week by answering service or instructional message on how to reach a physician/ licensed behavioral health practitioner

Section 4. Claims inquiry, eligibility and benefits contacts

Eligibility and benefits

Commercial
T 866.895.5975 (toll free)
F 317.963.9800
T 800.743.3333 (TTY, Indiana Relay)

Medicare
T 317.963.9920
T 800.455.9776 (toll free)
F 317.963.9801
T 800.743.3333 (TTY, Indiana Relay)

Claims

Send claims, including all corrected claims to:

Commercial claims:
IU Health Plans
PO Box 11196
Portland, ME 04104-7196
EDI Payer ID: Varies with clearinghouse

Medicare:
Government Products Claims
PO Box 4287
Scranton, PA 18505
EDI Payer: 95444

EDI help desk:

Commercial
T 800.527.8133

Medicare Advantage
T 800.527.8133

Interpretation services

IU Health Plans contracted providers must provide interpreting services free of charge when necessary or appropriate, including phone communication to members with limited English proficiency or those who are hearing impaired. If interpretive services are not available onsite, the provider should contact IU Health Plans Provider Services at **317.816.5170**. TTY users should call Relay Indiana at **800.743.3333**.

IU Health Plans complies with all applicable state and federal mandates, the Office for Civil Rights (OCR) of the United States Department of Health and Human Services (HHS), Indiana Department of Insurance, and the Office of Minority Health and National Committee for Quality Assurance (NCQA).

Fraud, waste and abuse detection

IU Health Plans is committed to protecting the integrity of its healthcare programs and the effectiveness of operations by preventing, detecting and investigating fraud, waste and abuse (FWA). Combating FWA begins with knowledge and awareness.

Fraud: Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it—or any other person.

Waste: Includes overusing services or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.

Abuse: Occurs when healthcare providers or suppliers do not follow good medical practices, resulting in excessive costs, incorrect payment, misuse of codes or services that are not medically necessary.

One of the most important steps to help prevent member fraud is reviewing the member identification card to ensure that the individual seeking services is the same as the member listed on the card. It is the first line of defense against possible fraud.

Section 4. Claims inquiry, eligibility and benefits contacts, continued

Reporting healthcare fraud, waste and abuse

Providers/Facilities who suspect healthcare fraud should report any suspicions or concerns. Below is a list of ways to report your concerns to IU Health Plans. Suspicions or concerns involving an IU Health Plans member or another provider can be reported in writing, by secure email or telephone.

Examples of member FWA

- Forging, altering or selling prescriptions
- Letting someone else use the member's ID (identification) card
- Obtaining controlled substances from multiple providers

When reporting concerns involving a member, please include:

- The member's name
- The member's date of birth, member ID
- The city where the member resides
- Specific details describing the fraud, waste or abuse

Examples of provider/facility FWA:

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling – when multiple procedure codes are billed individually for a group of procedures that should be covered by a single comprehensive procedure code
- Upcoding – when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a provider (a doctor, dentist, counselor, medical supply company, etc.), please include:

- Name, address and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Provider or facility tax ID number (TIN) and National Provider Identifier (NPI), if available
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

To report directly to the IU Health Plans FWA department:

Email: vbcfwa@iuhealth.org or iuhealth.ethicspoint.com
T 888.878.7836 (Trust Line)
F 317.968.1301

Section 4. Claims inquiry, eligibility and benefits contacts, continued

Reporting healthcare fraud, waste and abuse, continued

To report to IU Health Plans Compliance Office:
Indiana University Health Plans
Executive Director, Compliance
950 N. Meridian St., Suite 400
Indianapolis, IN 46204
T 317.963.9773
T 317.963.9800

To report to IU Health Corporate Affairs:
Compliance Services
340 W. 10th St.
Fairbanks Hall, Third Floor
Indianapolis, IN 46202
T 317.962.1425
T 317.963.5548

To report anonymously to the IU Health Trust Line: 888.878.7836
The Trust Line is the confidential hotline at IU Health. IU Health personnel may use it to report (anonymously if they choose) knowledge or suspicion of unethical or illegal actions. It is available 24 hours a day, seven days a week. You cannot be punished for reporting legitimate concerns. Compliance services team members investigate Trust Line reports confidentially and attempt to maintain callers' anonymity. However, because of the nature of compliance investigations, it's not guaranteed that a caller's identity will never become known. If a caller's identity becomes known, the policy at IU Health still protects the caller from retaliation. Callers who believe that someone is retaliating against them for reporting legitimate compliance concerns should contact the IU Health Compliance Services department.

To report to the Joint Commission on Accreditation of Healthcare Organizations:
Joint Commission on Accreditation of Healthcare Organizations
Office of Quality and Patient Safety
One Renaissance Blvd.
Oakbrook Terrace, IL 60181
T 630.792.5000
F 630.792.5636
T 800.994.6610 (complaint hotline)
Online: jointcommission.org
Email: patientsafetyreport@jointcommission.org

To report to the Centers for Medicare & Medicaid Services (CMS):
If you have concerns about the safety or quality of care provided at any IU Health facility, you may report these concerns to CMS:
Centers for Medicare & Medicaid Services
Chicago Regional Office
233 N. Michigan Ave., Suite 600
Chicago, IL 60601-5519
T 312.353.9810

IU Health Plans Provider Relations

Contact Provider Relations by calling **317.963.9931** to leave a message or by emailing **iuhplansproviderrep@iuhealth.org**. You can also visit **iuhealthplans.org/provider/provider-resources** to view an up-to-date provider relations territory map to find your designated provider representative.

Section 5. Members, eligibility and benefits

IU Health Plans Member Services believes it is critical to provide consistent and accurate responses to all members and to actively monitor member feedback concerning its physicians. Consequently, IU Health Plans Member Services is responsible for:

- Having a dedicated Member Services department with a toll free 800 phone number and Indiana Relay telephone number for the hearing impaired.
- Following IU Health Plans policies and procedures and Indiana Department of Insurance and Centers for Medicare & Medicaid Services (CMS) requirements for resolution of member concerns, appeals and grievances.
- Processing of reconsiderations and expedited appeals per IU Health Plans guidelines and Indiana Department of Insurance and CMS guidelines.

Please direct all IU Health Plans member inquiries concerning plan benefits or procedures to IU Health Plans Member Services:

Commercial
T 866.895.5975 (toll free),
Business hours: Monday – Friday, 7 am – 7 pm

Medicare
T 317.963.9700
T 800.455.9776 (toll free)
Business hours: Monday – Friday, 8 am – 8 pm

Member assignment

Commercial primary care physician

All commercial IU Health Plans members are required to select a primary care physician (PCP) who falls under the categories of family practice, general practice, internal medicine or pediatrics. The member can currently choose a physician from the IU Health Plans Physician Directory or contact IU Health Plans Member Services at **866.895.5975**.

Medicare primary care physician

All IU Health Plans members are required to select a primary care physician (PCP). The member can currently choose a physician from the IU Health Plans Physician Directory or contact IU Health Plans Member Services at **800.455.9776**.

Eligibility

How to identify IU Health Plans members

Membership cards

We encourage you to verify eligibility and obtain benefit information before rendering services. The member ID card is not an authorization for services or a guarantee of payment.

All IU Health Plans members receive a white membership card when their enrollment is confirmed. The card includes the member's plan name, the member's name, and in some cases, the member's PCP and any other dependents on the plan. Providers are encouraged to verify eligibility or call member services to verify and confirm eligibility.

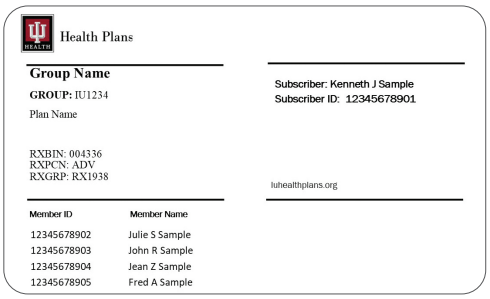
The IU Health Plans member is instructed to present the card at each visit. Depending on the member's benefit plan, the card may list copayment information for PCP, specialist, emergency room, and urgent care visits, maximum deductible amount or out of pocket maximum. The members may present a copy of their enrollment application or acknowledgment letter in lieu of their membership card if the IU Health Plans card has not been received. This occasionally happens when the member has recently enrolled in IU Health Plans.

The card has a unique 11-digit IU Health Plans member number; please refer to this 11-digit member number when making inquiries. The IU Health Plans group number is the policy number indicated on the card.

Section 5. Members, eligibility and benefits, continued

Eligibility, continued

Commercial member sample ID card


Health Plans

Group Name

GROUP: IU1234

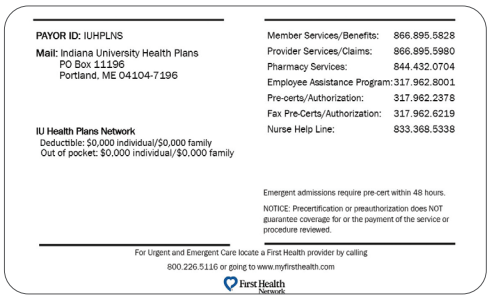
Plan Name

RXBIN: 004336
RXPCN: ADV
RXGRP: RX1938

Subscriber: Kenneth J Sample
Subscriber ID: 12345678901

luhealthplans.org

Member ID	Member Name
12345678902	Julie S Sample
12345678903	John R Sample
12345678904	Jean Z Sample
12345678905	Fred A Sample


PAYOR ID: IUHPLNS

Mail: Indiana University Health Plans
PO Box 11196
Portland, ME 04104-7196

IU Health Plans Network
Deductible: $0,000 individual/$0,000 family
Out of pocket: $0,000 individual/$0,000 family

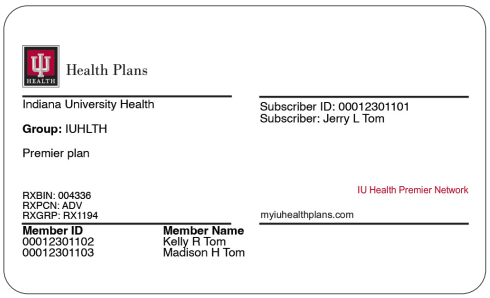
Member Services/Benefits:	866.895.5828
Provider Services/Claims:	866.895.5980
Pharmacy Services:	844.432.0704
Employee Assistance Program:	317.962.8001
Pre-certs/Authorization:	317.962.2378
Fax Pre-Certs/Authorization:	317.962.6219
Nurse Help Line:	833.368.5338

Emergent admissions require pre-cert within 48 hours.

NOTICE: Precertification or preauthorization does NOT guarantee coverage for or the payment of the service or procedure reviewed.

For Urgent and Emergent Care locate a First Health provider by calling
800.226.5116 or going to www.myfirsthealth.com
First Health Network

IU Health Premier Plan member sample ID card


Health Plans

Indiana University Health

Group: IUHLTH

Premier plan

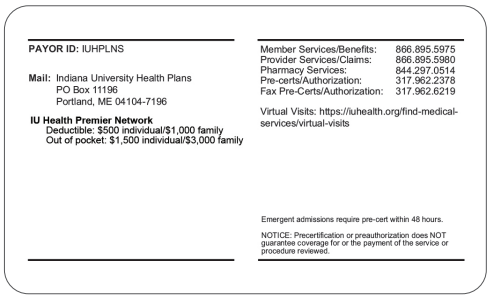
RXBIN: 004336
RXPCN: ADV
RXGRP: RX1194

IU Health Premier Network

Subscriber ID: 00012301101
Subscriber: Jerry L Tom

myiuhealthplans.com

Member ID	Member Name
00012301102	Kelly R Tom
00012301103	Madison H Tom


PAYOR ID: IUHPLNS

Mail: Indiana University Health Plans
PO Box 11196
Portland, ME 04104-7196

IU Health Premier Network
Deductible: $500 individual/$1,000 family
Out of pocket: $1,500 individual/$3,000 family

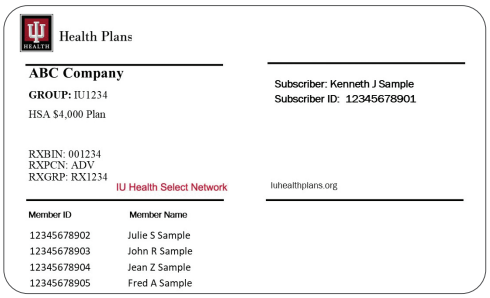
Member Services/Benefits:	866.895.5975
Provider Services/Claims:	866.895.5980
Pharmacy Services:	844.297.0514
Pre-certs/Authorization:	317.962.2378
Fax Pre-Certs/Authorization:	317.962.6219

Virtual Visits: https://iuhealth.org/find-medical-services/virtual-visits

Emergent admissions require pre-cert within 48 hours.

NOTICE: Precertification or preauthorization does NOT guarantee coverage for or the payment of the service or procedure reviewed.

IU Health Select member sample ID card


Health Plans

ABC Company

GROUP: IU1234

HSA $4,000 Plan

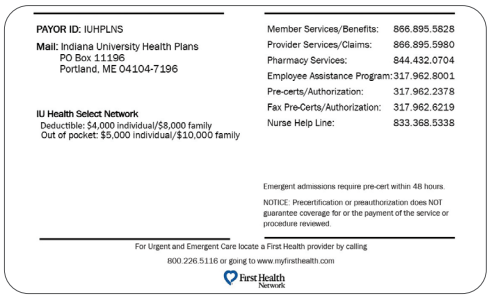
RXBIN: 001234
RXPCN: ADV
RXGRP: RX1234

IU Health Select Network

Subscriber: Kenneth J Sample
Subscriber ID: 12345678901

luhealthplans.org

Member ID	Member Name
12345678902	Julie S Sample
12345678903	John R Sample
12345678904	Jean Z Sample
12345678905	Fred A Sample


PAYOR ID: IUHPLNS

Mail: Indiana University Health Plans
PO Box 11196
Portland, ME 04104-7196

IU Health Select Network
Deductible: $4,000 individual/$8,000 family
Out of pocket: $5,000 individual/$10,000 family

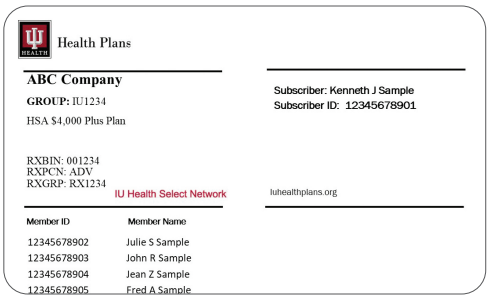
Member Services/Benefits:	866.895.5828
Provider Services/Claims:	866.895.5980
Pharmacy Services:	844.432.0704
Employee Assistance Program:	317.962.8001
Pre-certs/Authorization:	317.962.2378
Fax Pre-Certs/Authorization:	317.962.6219
Nurse Help Line:	833.368.5338

Emergent admissions require pre-cert within 48 hours.

NOTICE: Precertification or preauthorization does NOT guarantee coverage for or the payment of the service or procedure reviewed.

For Urgent and Emergent Care locate a First Health provider by calling
800.226.5116 or going to www.myfirsthealth.com
First Health Network

IU Health Select Plus member sample


Health Plans

ABC Company

GROUP: IU1234

HSA $4,000 Plus Plan

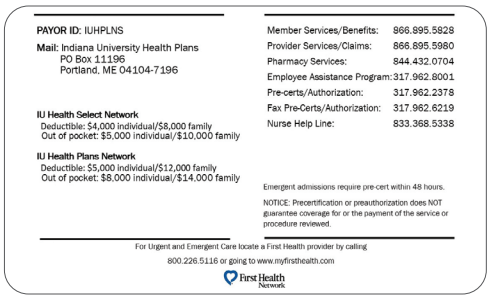
RXBIN: 001234
RXPCN: ADV
RXGRP: RX1234

IU Health Select Network

Subscriber: Kenneth J Sample
Subscriber ID: 12345678901

luhealthplans.org

Member ID	Member Name
12345678902	Julie S Sample
12345678903	John R Sample
12345678904	Jean Z Sample
12345678905	Fred A Sample


PAYOR ID: IUHPLNS

Mail: Indiana University Health Plans
PO Box 11196
Portland, ME 04104-7196

IU Health Select Network
Deductible: $4,000 individual/$8,000 family
Out of pocket: $5,000 individual/$10,000 family

IU Health Plans Network
Deductible: $5,000 individual/$12,000 family
Out of pocket: $8,000 individual/$14,000 family

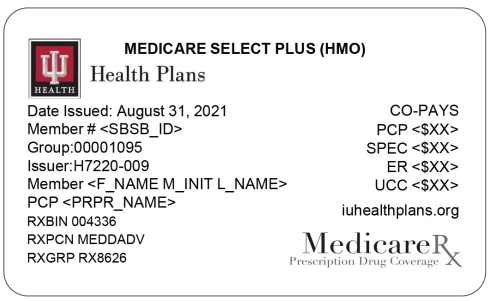
Member Services/Benefits:	866.895.5828
Provider Services/Claims:	866.895.5980
Pharmacy Services:	844.432.0704
Employee Assistance Program:	317.962.8001
Pre-certs/Authorization:	317.962.2378
Fax Pre-Certs/Authorization:	317.962.6219
Nurse Help Line:	833.368.5338

Emergent admissions require pre-cert within 48 hours.

NOTICE: Precertification or preauthorization does NOT guarantee coverage for or the payment of the service or procedure reviewed.

For Urgent and Emergent Care locate a First Health provider by calling
800.226.5116 or going to www.myfirsthealth.com
First Health Network

Medicare member sample ID card


MEDICARE SELECT PLUS (HMO)

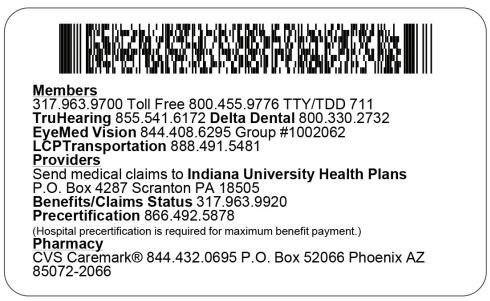
Health Plans

Date Issued: August 31, 2021
Member # <SBSB_ID>
Group:00001095
Issuer:H7220-009
Member <F_NAME M_INIT L_NAME>
PCP <PRPR_NAME>
RXBIN 004336
RXPCN MEDDADV
RXGRP RX8626

CO-PAYS
PCP <$XX>
SPEC <$XX>
ER <$XX>
UCC <$XX>

iuhealthplans.org

MedicareRx
Prescription Drug Coverage

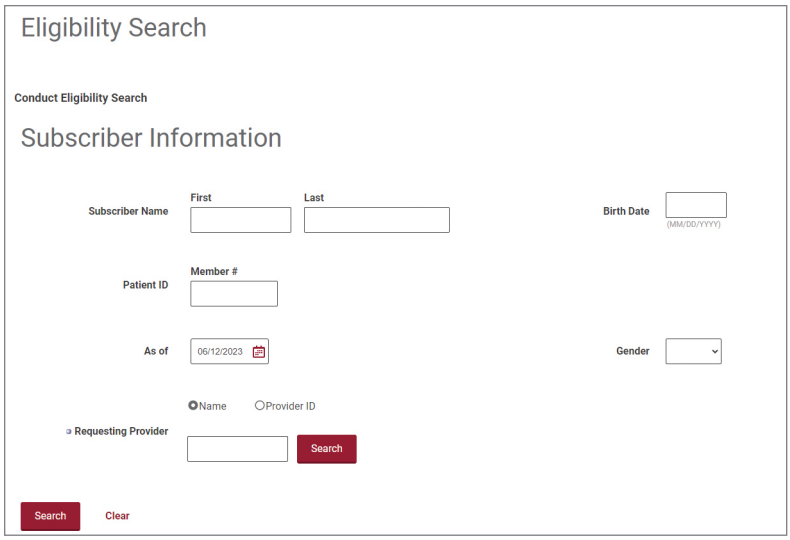

Members
317.963.9700 Toll Free 800.455.9776 TTY/TDD 711
TruHearing 855.541.6172 **Delta Dental** 800.330.2732
EyeMed Vision 844.408.6295 Group #1002062
LCPTransportation 888.491.5481
Providers
Send medical claims to **Indiana University Health Plans**
P.O. Box 4287 Scranton PA 18505
Benefits/Claims Status 317.963.9920
Precertification 866.492.5878
(Hospital precertification is required for maximum benefit payment.)
Pharmacy
CVS Caremark® 844.432.0695 P.O. Box 52066 Phoenix AZ 85072-2066

Section 5. Members, eligibility and benefits, continued

Eligibility, continued

How to verify eligibility and benefits

Verify eligibility by logging into your Provider Portal account and selecting **Eligibility Search** from the **Office Management** tab. Select the appropriate line of business and enter member information to perform the search. Don't have a Provider Portal account yet, visit our website at **iuhealthplans.org/provider** and follow the steps to create one.



Primary care physician selection and transfers

IU Health Plans requires most members to select a participating PCP to coordinate their healthcare. Exceptions are PPO and POS plan members. In order for POS members to receive the highest level of benefits, the member must select a PCP and get referrals from that PCP to coordinate his/her healthcare.

Members select a PCP from our provider directory. Generally, members can request a transfer to another PCP once each year or more often if there is reasonable cause. Transfers can be made by calling IU Health Plans Member Services.

A PCP can also request a transfer of a member to another PCP if problems arise. To request a transfer of a member to another PCP, IU Health Plans Member Services or send a written request and explanation to member services.

Medicare member disenrollment and dismissal

A provider may not request that an IU Health Plans member be disenrolled from the plan. IU Health Plans may request disenrollment for cause and with permission from the Centers for Medicare & Medicaid Services (CMS). Examples of "cause" include failure to pay required charges, a move outside the plan's geographic service area, fraud or abuse with the membership card, or disruptive behavior. If providers believe there is just cause for such disenrollment, they should notify IU Health Plans Provider Relations in writing with specific details. The member must be given a 30-day notice before disenrollment.

If a physician no longer wants to see a Medicare patient with IU Health Plans coverage, he or she must notify the IU Health Plans Managed Care department to initiate medical director approval. The physician will also notify the patient 30 days before discontinuing to see the patient. The member can obtain a disenrollment form by calling IU Health Plans Member Services at **800.455.9776**. The member can also call **800.MEDICARE (800.633.4227)**, which is the national help line.

IU Health Plans will then send a letter to the member confirming when the membership will end. This is the disenrollment date. The disenrollment date will be the first day of the month that comes after the month IU Health Plans received the request to leave, or at the member's request, a later date of up to three months after the request is received. (CMS does not allow retroactive disenrollment.)

Even though members request disenrollment, they must continue to receive all covered medical services from participating providers of IU Health Plans until the effective date of disenrollment in order for IU Health Plans to be financially responsible. If members elect to receive non-urgent or non-emergency care that is not provided or authorized by their IU Health Plans PCP prior to the effective date of disenrollment, the member will be responsible for all charges. IU Health Plans will not be obligated to process any claims related to services so obtained.

Section 5. Members, eligibility and benefits, continued

Eligibility, continued

Involuntary disenrollment

A member may be involuntarily disenrolled from IU Health Plans by IU Health Plans only for the following reasons:

- A member moves out of the IU Health Plans geographic service area or live outside the plan's service area for more than six months at a time.
- A member does not stay continuously enrolled in Medicare Part A and Part B.
- A member gives IU Health Plans information on the enrollment form that he/she knows is false or deliberately misleading, and it affects whether or not the member can enroll in IU Health Plans.
- A member behaves in a way that is unruly, uncooperative, disruptive or abusive, and this behavior seriously affects IU Health Plans' ability to arrange or provide medical care for the member or for others who are members of IU Health Plans. IU Health Plans cannot make a member leave the plan for this reason unless the plan obtains permission from the Centers for Medicare & Medicaid Services.
- A member allows someone else to use his/her plan membership card to get medical care. Before IU Health Plans asks the member to leave the plan for this reason, the plan must refer the case to the Inspector General, which may result in criminal prosecution.
- A member does not pay the plan premiums or cost sharing. IU Health Plans will notify the member in writing before he/she is required to leave the plans.
- The contract between IU Health Plans, Inc. and CMS is terminated.

Please note: The PCP should notify IU Health Plans as soon as possible when a member is deceased.

Copays and deductibles

Most IU Health Plans benefit plans require copays for non-preventive care visits.

If a copay is required, it will be indicated on the member's ID card. You may also call IU Health Plans Member Services to obtain copay information.

Copays should be collected at the time of service. It is your responsibility to collect copays, and IU Health Plans will not reimburse you for copay amounts.

Preventive care exceptions

Preventive care is generally not subject to copays or deductibles. These services include:

- Preventive screening and assessment office visits
- Well-child and immunization visits
- Prenatal care visits

If you have questions about what services are considered by IU Health Plans as preventive care, please call Member Services.

Neighborhood pharmacies

IU Health Plans wants the health plan to be easy to use, so members are offered a selection of convenient pharmacies for filling prescriptions. Eligible members, enrolled in applicable plans, may have prescriptions filled at IU Health Plans participating pharmacies.

Section 5. Members, eligibility and benefits, continued

Eligibility, continued

Members should direct questions to IU Health Plans Member Services:

Commercial employer-provided
T 866.895.5975
Monday – Friday, 7 am – 7 pm (ET)

Medicare Advantage
T 800.455.9776
T 800.743.3333 (TTY, call Relay Indiana)
Oct. 1 – March 31: seven days a week, 8 am – 8 pm (ET)
April 1 – Sept. 30: Monday – Friday, 8 am – 8 pm

Providers may call IU Health Plans Provider Services at **866.895.5980**.

Using mail order

- Prescriptions filled by the IU Health Plans mail-order service must be written for a 90-day supply.
- A nominal dispensing fee is also charged per prescription.
- For information about filling prescriptions by mail, providers should direct members to IU Health Plans Member Services at **800.455.9776** (toll free within Indiana).

Medicare nursing home coverage

If an IU Health Plans member is in a custodial nursing home, the primary care physician is responsible for the member's care on a 24-hour, seven day a week basis, just as he or she would be with any established patient in that primary care physician's practice. The member, if able, should be seen in the PCP's office for routine care. If transportation from the custodial setting is unavailable or not feasible, the PCP is to see the member on rounds or may designate another in-plan provider to conduct the rounds. The custodial rounds are covered services for IU Health Plans members as long as members meet Medicare guidelines.

Medicare health assessment – Personal wellness profile

To enhance the continuity of care for new members, IU Health Plans has developed a health assessment to be completed by each new member. The health assessment provides the primary care physician with historic and current medical information, health behaviors, a brief member depression screening and most importantly, the patient's perception of his or her own health status.

The health assessment will be included in the new member packet along with a postage-paid envelope for returning the completed form to the IU Health Plans Quality Improvement department.

IU Health Plans Quality Improvement will forward the completed assessments to the primary care physician. IU Health Plans strives to ensure the information reaches the PCP's office prior to the patient's first appointment. The health assessment will be sent to the PCP's office in a blue envelope designated "IU Health Plans Assessment." IU Health Plans requests that the PCP's office have a system to link the health assessment with the new IU Health Plans patient. An authorization form for transferring medical records from the member's previous physician to the new PCP is also provided to the member for completion at the time of enrollment.

Section 6. Referrals and prior authorizations

Affirmative incentives

All utilization review decisions are based only on appropriateness of care, service, existence of coverage and setting of the covered service. Please note:

- We do not use financial incentives in conjunction with our Utilization Management program.
- We do not reward doctors who conduct utilization review for issuing denials of coverage or service.
- We do not offer financial incentives to Utilization Management decision-makers that encourage decisions resulting in underutilization.

Retroactive authorizations

Prior authorization should be obtained prior to services being rendered to a member. We understand there may be circumstances where a prior authorization is not obtained prior to delivering to meet the needs of a patient.

IU Health Plans will consider an authorization request up to thirty (30) calendar days from the date that services were rendered. Post-service (retroactive) authorizations are subject to UM review and must meet benefit and medical necessity. If you request a retroactive authorization, ensure to provide all supporting documentation to support the medical necessity of the services provided.

Extenuating circumstances include, but are not limited to:

- Member presents unconscious
- Provider received incorrect insurance or lack of
- Member's ID number is not available at time of admission
- Newborns with extended stay (example NICU)
- Proof from provider submitting authorization, but health plan did not receive the authorization

The Utilization Management Department will notify the requesting provider and member of the determination to authorize or deny services. If services are denied, both provider and member will be informed of the rational for the denial and how to appeal the UM decision.

In-network referral process

IU Health Plans members are allowed to use in-network providers without a referral from their PCP. A primary care physician or subcontracted primary care physician may refer to any of the participating IU Health Plans specialists. No written referral forms and/or referral log are required for members who are referred to in-plan specialists. Network prior authorization is not required for members to seek care from most participating specialists for most services provided during or in conjunction with an office visit.

Primary care physicians are encouraged to communicate with specialists when they do refer for a particular service.

Pertinent medical information should be provided to the specialist to assist in the consultation. All services should be verified for coverage under the member's benefit plan prior to rendering services if a referral was made by the member's PCP. To facilitate continuity and coordination of care, the referring PCP should provide timely communication of clinical information to the specialist. Likewise, the specialist should communicate with the member's PCP, providing a description of health services rendered to the member at the referrals visit(s).

IU Health Plans encourages all providers to make referrals to in-network specialists and to contact Population Health Medical Management at 317.962.2378 or 866.492.5878 (toll free) to determine medical necessity or other out-of-network options, if necessary.

Members will receive written notification from Population Health Medical Management on all denied services.

Though medical services may not require a prior authorization, services ordered must be medically necessary in frequency, duration, and quantities ordered. All services provided are subject to post service review and a denial for payment or payment recoupment may take place if services rendered are not medically necessary.

Section 6. Referrals and prior authorizations

Out-of-network referrals

An out-of-network (OON) referral requires a written authorization by IU Health Plans. OON referrals must be requested by the member's treating physician. If an OON referral is obtained, services received from a non-participating provider are covered at an in-network level of benefits under the member's benefit plan. An OON referral is needed only when services are not available from an IU Health Plans network provider. To determine whether an OON referral is necessary under a member's benefit plan, contact IU Health Plans Member Services at the number on the back of the member's IU Health Plans ID card.

Please note that a referral does not guarantee payment of a claim, and all services by an OON provider require prior authorization before services are rendered.

Emergency care

What is a "medical emergency"?
A "medical emergency" is when the member reasonably believes that his or her health is in serious danger when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness or a medical condition that is quickly getting worse.

Notification of emergency inpatient admissions

If an emergency or unplanned inpatient admission occurs, the admitting physician or PCP must notify IU Health Plans within 48 hours of admission.

Medical and behavioral health authorizations

If services require IU Health Plans' prior approval, the online prior authorization portal is a secure way to submit Prior Authorization requests. Log in to your IU Health Plans provider portal account and click the "Authorizations" tab on the navigation bar. Authorizations can also be faxed to IU Health Population Health Medical Management at **317.962.6219**. If you have questions regarding prior authorizations call **317.962.2378**.

For urgent, weekend and holiday requests, call **317.962.2378** or fax 317.962.6219; Prior authorization (PA) forms can be found at **iuhealthplans.org/provider/prior-authorization.**

- Standard requests may take up to 14 calendar days; expedited requests may take up to 72 hours.
- Provide the requesting provider information, including contact numbers and address. Ensure member's information is complete on the form and that the member ID number is accurate.
- Attach any supporting documentation that is applicable to expedite the process.
- Request may be closed if clinical documentation is not provided within the specified time.

Medication

Provider determines that patient needs one of the drugs on the Prior Authorization List
(See Prior Authorization List at **iuhealthplans.org/provider/prior-authorization**.)

- Formulary information and prior authorization (PA) forms can be found under the provider tab at **iuhealthplans.org**.
- Complete PA form and fax to **317.962.6219**.
- Pharmacist will review the request and notify provider's office of the results by fax within the turn-around time requested by the provider.
- Some drug treatments are designated as "Step Therapy" drug therapies that will be approved upon evidence of use of a preferred agent. Such Step Therapy drugs are typically generic or biosimilar agents that can be interchanged with the brand drug product and considered therapeutically equivalent.
- Standard requests may take up to 48 hours.
- Expedited requests may take up to 24 hours.

Medicare members: With questions or urgent needs, call Pharmacy Services at **866.823.1016**, Monday – Friday, 8 am – 8 pm.

Commercial and Family Plans members: With questions or urgent needs, call Pharmacy Provider Services at **866.822.6504**, Monday – Friday, 8 am – 8 pm.

Section 6. Referrals and prior authorizations, continued

Out-of-network referrals, continued

Medication authorization request tips

- Provide the prescriber information, including contact numbers and address.
- Ensure member's information is completed on the form and the ID number is accurate.
- Attach any supporting documentation that is applicable to expedite the process, such as laboratory results, diagnostic test results and peer-reviewed medical literature for off-label indications.
- Complete the authorization form in its entirety and put applicable information in the comments section:
  - Drugs previously tried or failed
  - Patient medical conditions that favor requested drug over an alternative
  - Special circumstances or medical opinion necessitating requested drug
  - Consider whether the drug therapy is a Step Therapy drug treatment that has a preferred alternative drug

This information helps expedite request processing and avoids unnecessary follow up and appeals later.

What services require prior authorization?

Prior authorization is required for certain planned services for medical necessity determination. The list of services and the process for prior authorizations may include cardiology and radiology notifications.

- Protocols related to inpatient admission notification continue to be the responsibility of the hospital.
- Services that require prior authorization and notification may also require a referral to the specialist performing the service.
- The responsibility for obtaining prior authorization resides with the ordering/rendering physician whether it is the PCP or a specialist with an active referral.

The following services require prior authorization before the member receives services. **For a complete list see the Prior Authorization list at iuhealthplans.org/provider/prior-authorization**.

Commercial services requiring Prior Authorization include but are not limited to:

- All services provided by out-of-network providers
- ABA therapy
- Home health services
- Inpatient
- Behavioral health services
- Genetic testing

Medicare services requiring prior authorization include but are not limited to:

- All services provided by out-of-network providers
- Home health services
- Inpatient
- Behavioral health services – inpatient and outpatient
- Genetic testing
- Transplants
- Radiology
- Cosmetic and reconstructive surgeries
- Durable medical equipment (DME) requires a prior authorization for any item with charges in excess of $500 billed rates or any item or rental that is a capped rental by CMS policy

Notification of emergency inpatient admissions

If an emergency or unplanned inpatient admission occurs, the admitting physician or PCP must notify IU Health Plans within 48 hours of admission.

Section 7. Medicare Advantage specialty vendors

Benefit	Benefits description
Dental (Delta Dental®)	Two exams, two cleanings and two X-rays, plus $1,000 of embedded coverage
Vision (EyeMed®)	Annual routine eye exam and material allowance for glasses or contacts
Hearing (TruHearing®)	Annual routine hearing exam and copays for hearing aids
Over-the-Counter Items (OTC Health Solutions)	$100 quarterly allowance for purchases through the OTC Health Solutions catalog
Transportation (LCP Transportation)	24 one-way rides to plan approved, health-related locations
BrainHQ	Online, evidence-based memory fitness program
myStrength	Digital self-care tool designed to help you feel better and stay mentally strong
Fitness Benefit (Silver&Fit®)	$0 copay for fitness center memberships at any participating fitness center and more through the Silver&Fit Healthy Aging and Exercise program
Meals (Mom's Meals®)	42 healthy, refrigerated, home-delivered meals following an inpatient hospital stay
Health Coaching (Healthy Results®)	Health coaching through our Healthy Results program
Healthy Rewards	Earn $25 – $50 on a limited Visa© card for receiving eligible preventive care

Section 8. Claims and billing

Claims policy

IU Health Plans provides enrolled beneficiaries with benefit coverage for Medicare Advantage (Parts A, B, C, and D), Commercial, including fully and self-insured groups products. IU Health Plans is responsible for the accurate adjudication of medical claims submitted by providers rendering services for beneficiaries. IU Health Plans covers medically necessary emergency services in and out of the service area and for out of area urgently needed services in accordance with plan benefits. The goal is to ensure timely and accurate adjudication of IU Health Plans claims as outlined by plan benefits and state and federal regulations, including CMS, the Indiana Department of Insurance and ERISA. It is the responsibility of the provider and/or beneficiary to follow IU Health Plans prior authorization requirements for medical, pharmacy, out-of-network services, and exceptions as outlined in the beneficiary's benefit summary.

- Clean claims must be processed within 30 days if submitted electronically and 45 days if submitted via paper. Clean claims must be submitted for accurate and timely adjudication.
- For Medicare Advantage, Non-clean claims are to be adjudicated within 60 days of receipt. For the Commercial lines of business, the provider filing non clean claims must be notified as to additional information necessary to process the claim within 30 calendar days of receipt if filed electronically and 45 days if filed on paper.
- Upon whole or partial adverse determination of a claim, the member is issued an Explanation of Benefits (EOB) and a right to appeal notice.
- Claims adjustments are completed within 60 days of receipt/acknowledgment of required adjustment.
- The contracted adjustment timeframe limit shall not apply in cases of fraud, waste, or abuse by the Provider or Health Plan with respect to the claim on which the overpayment or underpayment was made.

Billing

Providers and hospitals are to submit claims data in accordance with appropriate Medicare billing and National Correct Coding Initiatives (NCCI) and in accordance to their current provider contract based on the reimbursement methodology agreed upon. All methods of billing for services must include current and applicable CPT-4, DRG, ICD-10 or successor, HCPCS, revenue codes and appropriate modifiers. Claims submitted without such information will be returned to the submitting entity for resubmission. It is required that providers maintain documentation to support the level of service performed/billed and maintain an accurate medical record. Please be aware of the following billing criteria:

- Members cannot be billed for covered services except for uncollected copays, coinsurance and deductibles.
- A physician, healthcare practitioner, hospital or facility may not bill members for non-professional services including, but not limited to, charges for overhead, administration fees, malpractice surcharges, membership fees, fees for referrals, or fees for completing claim forms or submitting additional information. If IU Health Plans rejects or denies a claim because a physician, healthcare practitioner, hospital or facility failed to follow policies and procedures, the member may not be billed.
- For all covered services, except for workers' compensation-related services, the member is responsible for payment of copayments, deductibles or coinsurance as described in the member's health benefit plan. Providers are required to accept the IU Health Plans contracted amount as payment in full for covered services, with the exception of the participating provider's right to collect from the member any applicable copayment, deductible, or fee for any services that are deemed to be non-covered services under the participant's health plan. You are prohibited from balance billing IU Health Plans members for services covered by the health plan and for amounts in excess of their copayments, deductibles or coinsurances as described in their health benefit plan. For workers' compensation-related services, there are no copayments, deductibles, or coinsurances and balance billing is prohibited for all services covered by a workers' compensation benefit plan.

Members cannot be held liable for a non-covered CMS service; out-of-network emergency services; or patient visits to certain in-network health care facilities, unless notice and consent requirements are met, for certain items and services.

Interim billings

Claims for ongoing treatment or hospitalization should be submitted every 30 days with exception of maternity care, which should only be billed after delivery, termination of pregnancy or when the member is no longer receiving care from the provider.

Referral and on-call billings

Referral and on-call providers are responsible for submitting claims for services they provide to members.

Section 8. Claims and billing, continued

Clean claims

Clean claims are defined as invoices whereby the services provided were covered and/or authorized; the member was eligible at the time of service; the invoice was submitted on CMS 1500 or UB 04 and a Medicare Remittance Advice form with the correct codes (CPT-4, ICD-10, DRG, HCPCS or Revenue Code); and W9 is on file.

A clean claim is defined as one that includes the following:

- Full member name
- Member's date of birth
- Full IU Health Plans member identification number
- Date(s) of service
- Valid diagnosis code(s)
- Valid procedure code(s) and modifier codes(s) if applicable
- Valid place of service code(s)
- Charge information and units
- National provider identifier (NPI) group number
- National provider identifier (NPI) rendering provider number, when applicable
- Vendor name and address (including ZIP plus 4)
- Provider's federal tax identification number
- National Drug Codes, when applicable
- For corrected claims, the original IU Health Plans claim number

Non-clean claims

Non-clean claims are defined as claims missing any required documentation and/or information required for the accurate adjudication of the claim. Documentation is often required from an outside source. Such information will be requested either via a letter or EOP to the submitting/servicing provider. Failure to respond to such correspondence may result in whole or partial adverse determinations.

Corrected claims

Corrected claims for both UB04 and CMS 1500 may be sent via electronic 837 transmissions with the appropriate value displayed to ensure the claim is identified as a "corrected claim."

- UB04-Bill Type (locator 4) on claim must reflect the appropriate value for corrected claim submission (i.e., 00XX7). The original IU Health Plans claim ID must also be included in box 64A and a condition code explaining changes in boxes 18 through 28.
- CMS 1500 – A frequency code of 7 must be present on a claim for a corrected claim submission. The original IU Health Plans claim ID must also be included in box 22.

Corrected claims may also be sent on paper directly to the address below with a notation of "corrected claim" on the document and the appropriate value displayed to ensure the claim is identified as a "corrected claim.".

Medicare corrected claims
IU Health Plans
PO Box 4287
Scranton, PA 18505

Commercial corrected claims
IU Health Plans
PO Box 11196
Portland, ME 04104-7196

Section 8. Claims and billing, continued

Claims formats for submission

Provider shall submit claims in one of the following formats utilizing all appropriate segments and box/field locators to ensure a clean claim:

- HIPAA complaint
- EDI compliant format
- CMS 1500 (paper claims)
- UB04 (paper claims)

EDI Claims

IU Health Plans accepts medical claims electronically through the EDI clearinghouse Change Healthcare for both our Medicare Advantage and Commercial Plans. If you are interested in submitting claims electronically, contact your clearinghouse.

Commercial EDI Payer ID (July 1, 2017, and after): IUHPLNS

Medicare EDI Payer ID: 95444

Paper claims

Paper claims submitted to IU Health Plans must be on CMS 1500 or UB04 standard documents. Claims submitted on any form other than those mentioned will be returned to the submitting entity. All claims with attachments should be stapled when submitted.

Where to send your claims

Commercial claims
IU Health Plans
PO Box 11196
Portland, ME 04104-7196

Medicare claims
Government Products Claims
IU Health Plans
PO Box 4287
Scranton, PA 18505

Guidelines for submitted claims

National Provider Identifier(s)

The National Provider Identifier (NPI) is a 10-digit identification number for covered healthcare providers. IU Health Plans requires NPIs to be provided by all healthcare service providers, both individuals and organizations, in accordance with HIPAA Administrative Simplification rules. A healthcare services provider may apply to obtain an NPI at the National Plan & Provider Enumeration System (NPPES) website.

Individuals and organizations must obtain the proper type of NPI. Type I (individual) NPIs are for a healthcare provider that is conducting business as an individual. Type 2 (organizational) are for a healthcare provider that is conducting business as an organization or a distinct subpart of an organization, such as a group practice, a facility or a corporation (including an incorporated individual using an Employee Identification Number).

Imaging quality – Claims and/or requested documentation

Paper claims and/or requested documentation are to be free of add-on items or any markings that will deter the claim from meeting the criteria required for obtaining a quality image for adjudication. Some examples of these claim add-ons or items include stickers, highlighting of fields, combinations of written and keyed data, non-standard fonts and light or faded ink/toner color, etc.

Coded service identifier(s)

Coded service identifier(s) is a list of descriptive terms and identifying codes, updated occasionally by the Centers for Medicare & Medicaid Services (CMS) or other industry source, for reporting Health Services on the CMS 1500 or UB-04 claim forms or their successors. The codes include, but are not limited to, American Medical Association Current Procedural Terminology (CPT®-4), CMS Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases, 10thRevision, Clinical Modification (ICD-10-CM), National Drug Code (NDC), and ADA Current Dental Terminology (CDT), or their successors.

Section 8. Claims and billing, continued

Guidelines for submitted claims, continued

Diagnosis code and diagnosis pointers

All claims must be submitted with at least one ICD-10 diagnosis code describing the member's condition. IU Health Plans requires these diagnosis codes up to the sixth or seventh character level when applicable. On claims submitted using a CMS-1500, the diagnosis pointer is also required in field 24E. Please enter only the reference number and not the diagnosis code itself. If more than one diagnosis number is entered, IU Health Plans requires the number to be placed in descending order of importance. To ensure proper claim processing, the diagnosis codes referenced in field 24E must have a direct relationship with the CPT/HCPCS code billed and be in the proper order.

Taxonomy codes

The taxonomy code may or may not be required based on provider type and/or plan type. Therefore, IU Health Plans strongly recommends that the taxonomy code be submitted with all claims. If not submitted, the claim may deny if the information was needed for accurate claims processing.

Copayments/coinsurance/deductibles

Members are responsible for copayments, coinsurance and deductibles associated with their benefit plan. Please refer to the member's membership card for current copay information or to the IU Health Plans Summary of Benefits which can be found on the IU Health Plans Provider Portal after verifying eligibility.

Medicare copayment

The only payment required by a Medicare member at the time of a covered service is the applicable copay. Refer to the member's membership card for current copay information or to the IU Health Plans Summary of Benefits found on the IU Health Plans Provider Portal. The copayment is to be collected for an office visit when the member has a face-to-face encounter with a professional that can make an independent decision regarding patient care. In addition to physicians, this would include mid-level providers (physician assistants, advanced practice nurses), optometrists, podiatrists, and occupational, speech and physical therapists. If members only see one of the following, a copayment should not be collected: dietitians, certified medical assistants, licensed practical nurses, registered nurses, certified diabetes educators and certified health educators.

If the member does not come prepared to pay the copayment, the provider's office may bill the member.

Claim filing time limits

All physicians and healthcare professionals are required to submit clean claims for reimbursement no later than the time specified in the provider's participation agreement or the timeframe specified in the state guidelines, if applicable. The claims filing deadline is based on the date of service on the claim; it is not based on the date the claim was sent or received by IU Health Plans.

If a provider fails to submit clean claims within established time frames, IU Health Plans reserves the right to deny payment for claim(s) submitted beyond the filing limit. Claim(s) that are denied for untimely filing cannot be billed to a member. IU Health Plans is committed to paying claims for which it is financially responsible within the time frames required by state and federal law.

The claims receipt date used to determine timely/untimely submission is the date of the business day when a claim, by physical or electronic means, is first delivered to the IU Health Plans-specified claims payment office, post office box or designated claims processor.

Section 8. Claims and billing, continued

Guidelines for submitted claims, continued

Out-of-network providers (OON) – Medicare Advantage

- The claims filing limit for Medicare Advantage is 365 days from the date of service on the claim.
- An out-of-network provider submitting claims for Medicare Advantage members will be subject to claims filing time limits governed by Medicare law, which prescribes specific time limits within which claims for benefits may be submitted.
- Non-urgent or non-emergent OON services must meet medical necessity guidelines and are subject to prior authorization.
- An out-of-network provider that does not have a contract establishing the amount of payment for services furnished to a Medicare beneficiary enrolled in an MA plan must accept the amount that would have been paid under the original Medicare program as payment in full [42 C.F.R. § 422.214].
- Non-contracted providers are required to participate in Medicare to receive payment for services unless services are deemed medically necessary for the member or are approved by IU Health Plans.
- For claims covered by the No Surprises Act, non-contracted providers have 30 business days from the date of initial payment or denial to provide notification of dispute to begin the open-negotiation period to determine an alternate payment amount.

Out-of-network providers (OON) – Commercial

- The claims filing limit for Commercial is 365 days from the date of service on the claim.
- An OON provider that does not have a contract establishing the amount of payment for services furnished to an IU Health Plans' Commercial member must accept the amount as determined by their participating PPO or national network contracts, or in accordance with IU Health Plans default reimbursement policy, or an amount that is negotiated through a single case agreement (SCA) or entity negotiating discounts on behalf of IU Health Plans.
- OON services must meet medical necessity guidelines and may be subject to prior authorization.

Clinical editing

Clinical editing encompasses a comprehensive set of clinical edits that will allow for the evaluation of coding accuracy. IU Health Plans clinical editing criteria follows guidance from CPT coding instructions, the National Correct Coding Initiative (NCCI) and other medical specialty guidelines. This essential transition allows IU Health Plans to ensure consistency in coding, processing and payment of claims in accordance with NCCI practice standards for both CMS 1500 and UB04 outpatient claims. Clinical editing is designed to detect irregularities in medical billing such as:

- Incidental procedures
- Mutually exclusive/redundant procedures
- Unbundling/re-bundling

Clinical editing also checks for inconsistencies with coding in the following areas:

- Cosmetic procedures
- Invalid/outdated codes (CPT/HCPCS)
- Assistant surgeon eligible
- Investigational (experimental)/unlisted procedures
- Diagnosis codes (ICD-10/PCS)
- Same-day procedures
- Surgical follow-up days
- Appropriateness of age/gender/place of service

Additional information on NCCI can be found by visiting the CMS website link below:
cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index

When applicable, providers are encouraged to use the IU Health Plans Clinical Editing Appeals/ Provider Dispute Form when questions arise regarding the denial of a service detail line or claim. Failure to use this form appropriately will ensure the immediate denial and return of the request to the submitting provider. See the bottom of the form for submission address and contact information.

Section 8. Claims and billing, continued

Guidelines for submitted claims, continued

Submission of clinical editing appeals:

Please access our Provider Portal here: **iuhealthplans.org/provider**. To ensure there are no delays associated with your inquiries, please review prior to sending to confirm they are properly labeled for correct routing to the appropriate department.

If you do not have access to our Provider Portal, request by sending a request via the same page. Just click on "Sign up for an account".

You can use also our Clinical Edit Appeals email and mailing address:

Email: iuhpclinicaledits@iuhealth.org

Mailing address:
IU Health Plans
950 N. Meridian St., Suite 400
Indianapolis, IN 46204
Attn: CQT Clinical Editing Appeals

IU Health Plans appreciates your commitment as a participating provider to ensuring accurate claims coding and clean claims submission.

Modifiers

Unless otherwise stated in your provider agreement or a stand-alone policy, IU Health Plans will follow CMS Medicare Claims Processing manual and NCCI manual guidelines for appropriate modifier usage.

Anesthesia

Anesthesia providers are required to bill anesthesia services using the appropriate anesthesia code, applicable modifier(s) and must indicate the total anesthesia time on the claim. IU Health Plans will use 15-minute time intervals to calculate anesthesia time appropriately.

Laboratory and radiology

When applicable, laboratory and radiological services may require the use of technical – "TC" and professional – "26" modifiers. This is due to the facility renders the actual service (TC) and the provider renders the interpretation (reading) of the service (26). Under certain circumstances, the provider's office renders both the professional and technical components of laboratory and radiological services in one setting. In those circumstances, providers are to bill using the appropriate global procedure code versus the professional and technical components of the procedure code.

Laboratory handling fees are not allowed and should not be billed.

Unlisted procedures

Under certain circumstances, providers may render services that have not been assigned permanent CPT or HCPCS codes. Under those circumstances, providers are to bill those services using the most appropriate and accurate unlisted procedure code that best describes the services rendered. For billing purposes and to not further delay the processing of claims, it is strongly recommended that providers submit the appropriate documentation (i.e., operative report, lab report) with their claim to help identify the unlisted procedure rendered.

Providers are reminded to review the services requiring PA for all unlisted procedure code PA requirements listed on the provider portal at **iuhealthplans.org/provider/provider-resources**.

Maternity care

All charges for maternity care must be submitted after delivery, termination of pregnancy or when the member is no longer receiving care from the provider using global fees. This will help avoid payment adjustments should the pregnancy not continue to term, the patient leaves or the anticipated method of delivery changes.

In cases when the provider has not provided the maternity care, billings should reflect coding and charges appropriate to the level of evaluation and management services rendered.

Section 8. Claims and billing, continued

Guidelines for submitted claims, continued

Standby services

Charges for standby services are generally not allowable.

After-hours charges

Additional charges for services provided after routine office hours are generally not allowable.

Discounted fees

Submitted charges must reflect any discounts offered by the provider. For example, if a provider offers a $20 discount from a regular fee of $100, the allowable billing charge is $80.

Charges for duplication of records

IU Health Plans will reimburse providers for costs associated with the collection and photocopying of records requested by or on behalf of IU Health Plans in accordance with state regulations.

Coordination of benefits

Claims for secondary reimbursement must be submitted to IU Health Plans in the time frame required under applicable law and regulations. All explanations of payments and denials from the member's primary carrier must be provided with the claim.

You may send this information to:

Commercial
IU Health Plans
PO Box 11196
Portland, ME 04104-7196

Medicare
Government Product Claims
IU Health Plans
PO Box 4287
Scranton, PA 18505

IU Health Plans generally uses the "birthday rule" method of determining which insurance carrier is primary when more than one provides coverage for a member's dependent. Under the birthday rule, the primary insurer—the one that covers the member—is the person whose birthday occurs earliest in the year.

A program that does not provide for coordination of benefits will always be primary over a program that includes a coordination of benefits provision.

A program that covers the member as a subscriber shall be primary over the program that covers the member as a dependent.

A program that covers the member as a dependent child shall have the following rules:

- If the parents are not separated or divorced, the program of the parent whose birthday (excluding year of birth) falls earlier in the year will be primary, if that is in accord with the coordination of benefits of both programs. Otherwise, the rule set forth in the program that does not have this provision shall determine the order of benefits.
- If the parents are separated or divorced and a court decree makes one parent responsible for paying the child's healthcare costs, that parent's program will be primary. Otherwise, the program of the parent with custody will be primary, followed by the program of the spouse of the parent with custody, followed by the program of the parent who does not have custody.

If the rules above do not apply, the program that has covered the member for the longest time will be primary, except that benefits of a program that covers the subscriber as a laid-off or retired employee, or as the dependent of such an employee, shall be determined after the benefits of any program that covers the subscriber as any other laid-off or retired employee or as a dependent of such an employee. This applies, however, only when other programs involved have this provision regarding laid-off or retired employees.

If none of the rules listed above determines the order of the benefits, the program that has covered an employee or subscriber for the longest time will be primary.

Section 8. Claims and billing, continued

Guidelines for submitted claims, continued

Revenue recovery/subrogation/worker's compensation (TPL)

Revenue recovery/subrogation is based on the right of an IU Health Plans member who suffered injury/illness caused or contributed to by a third party to recover damages from that entity. IU Health Plans' recovery process is solely for the value of services rendered to or the expense incurred in treating the member for those injuries/illnesses. IU Health Plans will first adjudicate claims to ensure appropriate medical care for members in such situations and then pursue reimbursement from the appropriate third-party payer. The subrogation review/process routinely takes a considerable amount of time to resolve. In most cases, the claim for a provider's services will be paid before the subrogation process is initiated.

As with COB, providers are asked to report potential subrogation and worker's compensation cases (using the appropriate fields on the CMS 1500 Claim Form) to IU Health Plans. In addition, it is routine practice for IU Health Plans to notify the member via an Accident/Injury Inquiry Form requesting any potential third-party liability payer information should claims data depict an accident/injury. IU Health Plans retains all rights to any sums payable under such circumstances unless otherwise contractually noted.

Denied, voided and corrected claims

Claims will be denied for incorrect or incomplete information. Corrected claims must be resubmitted as instructed above. If documentation is required from an outside source, information will be requested either via a letter or EOP to the submitting/servicing provider. Failure to respond to such correspondence may result in whole or partial adverse determinations.

IU Health Plans also accepts voided claims if necessary. Please submit a frequency code of 8 to void a claim along with the original IU Health Plans claim number.

Unless otherwise documented in the Provider's Agreement with the Health Plans claims returned to the provider for additional information should be resubmitted within 10 working days to ensure accurate and timely payment.

Balance billing

Providers are reimbursed per their provider agreement. The member should not be balanced billed, except for uncollected copays, coinsurance, deductibles and non-covered services. Members may not be billed for services provided that are denied due to the provider's failure to: notify IU Health Plans, obtain Prior Authorization, file a timely claim, submit a complete claim, respond to requested information, or comply with the policy and procedures as required by the provider's agreement with IU Health Plans. Members may not be balance billed for (a) emergency services or (b) non-emergency services by out-of-network providers during patient visits to certain in-network healthcare facilities, unless notice and consent requirements are met for certain items and services, as required by the No Surprises Act. Members can be billed for non-covered services but must be made aware of their financial obligation prior to the services being rendered.

Services not covered by IU Health Plans or Medicare, or not medically necessary

Commercial

For commercial members, providers may seek and collect payment from members for services not covered under the applicable benefit plan, if the provider first obtains the member's written consent. The consent must comply with the following:

- Such consent must be signed and dated by the member prior to the provider rendering the specific service(s) in question and contain the date and time such services are to be rendered.
- Retain a copy of this consent in the member's medical record.

In those instances in which you know or have reason to know that the service may not be covered (as described below), the written consent also must: (a) include an estimate of the charges for that service; (b) include a statement of reason for your belief that the service may not be covered; and (c) in the case of a determination by us that planned services are not covered services, include a statement that IU Health Plans has determined that the service is not covered and that the member, with knowledge of IU Health Plans' determination, agrees to be responsible for those charges.

Section 8. Claims and billing, continued

Services not covered by IU Health Plans or Medicare, or not medically necessary, continued

You should know or have reason to know that a service may not be covered if:

- IU Health Plans has provided general notice through an article in a newsletter or bulletin, or information provided on iuhealthplans.org, (including clinical protocols, medical and drug policies) that we will not cover a particular service or that a particular service will be covered only under certain circumstances not present with the member; or
- IU Health Plans has made a determination that the planned services are not covered services and have communicated that determination to you on this or a previous occasion.

If the rendering provider does not obtain written consent as specified above, the rendering provider must not bill the member for the cost of care. General agreements to pay, such as those signed by the member at any time (including at admission or upon the initial office visit) are not written consent under this protocol.

If you provide the service before a coverage decision is rendered, no written consent is obtained as described above, and IU Health Plans ultimately determines that the service was not covered, IU Health Plans may deny the claim, and you must not bill the member. By proceeding prior to the final coverage determination, it is not possible for the member to make an informed decision about whether to pay for and receive the non-covered services. It is important that members receiving such services are informed of potential financial responsibility as an outcome.

Medicare

Use of the appropriate form is essential when communicating to members that services are not covered, are not medically necessary, etc. It is important that members receiving such services are informed of potential financial responsibility as an outcome.

- Notice of Medicare Non-Coverage: NMNC
- Notice of Denial of Medical Coverage: NDMC
- Detailed Explanation of Non-Coverage: DENC

Medicare national and local coverage determinations (LCD and NCD)

National Coverage Determination (NCD) is a nationwide determination of whether Medicare will pay for an item or service. Medicare coverage is limited to items and services that are considered “reasonable and necessary” for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category).

Local Coverage Determination (LCD) is contractor-developed coverage policies, pertaining to services or items not addressed in National Coverage Determinations (NCDs) or program manuals. LCDs contain coding and utilization guidelines as well as descriptive passages. LCDs sometimes contain some Centers for Medicare & Medicaid Services (CMS) language as well. LCDs are developed for various reasons, some of which are:

- To define the appropriate use of new technologies
- To address services with an abuse history or potential for abuse
- High-volume, high-dollar services

In the absence of a NCD, an item or service is covered at the discretion of the Medicare contractors based on a Local Coverage Determination (LCD) that is defined by each state’s MAC (Region and Medicare Contractor). Indiana follows WPS Medicare Part A J5 MAC/J8 MAC and WPS Medicare Part B J8 MAC LCDs.

Section 8. Claims and billing, continued

Services not covered by IU Health Plans or Medicare, or not medically necessary, continued

Charging IU Health Plans members for failed appointments

IU Health Plans follows a policy stating that a "failed appointment" is defined as a scheduled appointment with an IU Health Plans provider that has been made by an IU Health Plans member, in which the member fails to keep such appointment and does not notify the provider's office of cancellation prior to the appointment. IU Health Plans providers may bill members for failed appointments contingent upon the following conditions:

- It is the provider's office policy to charge for a failed appointment and it is applicable to all the provider's patients regardless of insurance carrier.
- Patients must be given adequate advance notice of such policy and what the applicable charge will be.
- The charge for the failed appointment must be reasonable, i.e., not to exceed 50% of the normal office visit charge or the Medicare allowable.

Medicare preventive services

IU Health Plans provides coverage for preventive and/or wellness care for its beneficiaries as outlined by CMS. Such services are provided under Part B and are determined to meet certain requirements, effective for services furnished on or after Jan. 1, 2009. These services are defined as services that identify medical conditions or risk factors and that are determined to be (1) reasonable and necessary for the prevention or early detection of an illness or disability; (2) recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and (3) appropriate for individuals entitled to benefits under Part A or enrolled under Part B. Such services are noted as the IPPE, screening mammography, colorectal cancer screening services, cardiovascular screening tests, etc. To see a complete list of such benefits, refer to the appropriate IU Health Plans Summary of Benefits link provided in Section 5, Benefits, and or the Medicare website, **medicare.gov**.

Medicare health risk assessment (HRA)

Effective Jan. 1, 2012, CMS adopted criteria for a health risk assessment (HRA) to be used as part of the annual wellness visit (AWVs). MAOs and their contracted providers are expected to incorporate this change to the AWV for CY 2012. No cost sharing will be applied to the member for such service(s).

Provider Medicare number

When billing for home heath, skilled nursing, ESRD (facility only), the provider Medicare number should be displayed in box 51 on the UB-04 to ensure timely claim adjudication and potential payment.

National Provider Identifier(s)

The National Provider Identifier (NPI) is a 10-digit identification number for covered healthcare providers. IU Health Plans requires NPIs to be provided by all healthcare service providers, both individuals and organizations, in accordance with HIPAA Administrative Simplification rules. A healthcare services provider may apply to obtain an NPI at the National Plan & Provider Enumeration System (NPPES) website. Individuals and organizations must obtain the proper type of NPI. Type I (individual) NPIs are for a healthcare provider that is conducting business as an individual. Type 2 NPIs (organizational) are for a healthcare provider that is conducting business as an organization or a distinct subpart of an organization, such as a group practice, a facility or a corporation (including an incorporated individual using an Employee Identification Number).

HIPAA, federal Medicare regulations and many state Medicaid agencies mandate the adoption and use of a standardized NPI for all healthcare professionals. In compliance with HIPAA, all covered healthcare providers and organizations must obtain an NPI for identification purposes in standard electronic transactions. In addition, based on state-specific regulations, an NPI may be required to be submitted on paper claims.

HIPAA defines a covered healthcare provider as any provider who transmits health information in electronic form in connection with a transaction for which standards have been adopted. These covered healthcare providers must obtain an NPI and use this number in all HIPAA transactions, in accordance with the instructions in the HIPAA electronic transaction x12N Implementation Guides.

To avoid payment delays or denials, IU Health Plans requires that a valid Billing NPI, Rendering NPI and relevant Taxonomy code(s) be submitted on both paper and electronic claims and encounters. In addition, we strongly encourage the submission of all other NPIs. In addition to the NPI, it is important that you continue to submit your TIN.

The NPI information that you report to us now and on all future claims and encounters is essential to efficiently process claims and encounters, and to avoid delays or denials.

Section 9. Provider payments and disputes

Explanation of payment (EOP)

Providers will receive a paper remittance unless otherwise designated to receive electronically via 835 transactions. The EOP will provide detailed information about submitted claims received and adjudicated by IU Health Plans.

Disputing claims and/or payment decisions

IU Health Plans will adjudicate all claims in accordance with your provider agreement and following all state and federal regulations. If a provider or facility disagrees with the adjudication of a claim by IU Health Plans, please contact the plan at the numbers below or submit your dispute with appropriate supporting documentation. Please note, the preferred methods of dispute submission are via provider portal, email or fax, as this expedites receipt & processing of the dispute.

Disputes include, but are not limited to:

- General denials
- Duplicate payment inquiries
- Additional payment requests
- Timely filing denials **(proof of timely filing includes ledgers from billing system or clearinghouse; copies of previously submitted claim forms CANNOT be accepted as proof)**
- Retro authorization denials **(retro authorization requests must be submitted within 30 days of the date of service)**

Extenuating circumstances include, but are not limited to:

- Member presents unconscious
- Provider received incorrect insurance or lack of
- Member's ID number is not available at time of admission
- Newborns with extended stay (e.g., NICU)
- Proof from provider submitting authorization, but health plan did not receive the authorization
- W-9 denials

If you need to dispute a claim or payment denial, there are several ways that you can submit them. The preferred way to submit them is through the Provider Portal, email or fax. The following link to the Provider Resources page, section 3, contains the dispute process, forms and additional information to file a claims or payment dispute.

iuhealthplans.org/provider/provider-resources

The provider and IU Health Plans shall do all that is possible to resolve the concern, to the extent possible, by informal meetings and discussion in good faith between appropriate representatives of the parties.

Medicare Advantage Provider Services
T 317.963.9920 or 866.218.1524 (toll free)

Commercial disputes

Send written correspondence to:

IU Health Plans
Attn: CQT Provider Disputes
950 N. Meridian St., Suite 400
Indianapolis, IN 46204

Email: IUHPlansProvDispute@IUHealth.org
F 317.968.1205

Commercial Customer Service Center
T 855.413.2434

Medicare dispute mailing address:
IU Health Plans
Attn: Medicare Disputes
950 N. Meridian St., Suite 400
Indianapolis, IN 46204
F 317.963.9801

Providers may also contact IU Health Plans through the Provider Portal by visiting **iuhealthplans.org** and clicking on the "I'm a Provider" link.

Providers may be able to file an appeal on behalf of the member. See Appendix A.

Section 9. Provider payments and disputes, continued

Overpayment recoveries

Overpayment recoveries will be deducted from future payments unless otherwise acknowledged in the IU Health Plans Provider Agreement. Such recoveries will be noted on the Remittance Advice for appropriate posting and may start 45 days after the claim was adjusted.

If there are questions regarding an overpayment recovery, contact IU Health Plans Provider Services:

Provider Services
T 317.963.9920 or 866.218.1524 (toll free)

Customer Service Center
T 855.413.2434

Refunds

Providers may opt to send a refund check in lieu of letting IU Health Plans recover the money from future payments. Refund checks must be received within 30 days of the notification of the overpayment. If they are not received timely there is risk of the overpayments being recovered via our auto-recoupment process.

Send all refund checks and supporting documentation to:

Commercial
IU Health Plans
PO Box 775322
Chicago, IL 60677-5322

Medicare Advantage
IU Health Plans
2432 Reliable Parkway
Chicago, IL 60686-0024

Electronic payments

Electronic 835 files will be transmitted each business day to applicable clearinghouses with claims adjudication remittance and reimbursement for registered providers. Providers need to be registered with clearinghouses to receive payments electronically. It is the responsibility of the provider to register for such reimbursement practices.

Please use the following link to our Provider Resources Page; Once there, go to Section 3 (Provider Manual, Forms, and Rep Territory Map); Then select the appropriate forms with detailed sign-up instructions for EFT/ERA for either or both of our Commercial Plan and/or Medicare Advantage Plan (Commercial EFT Request – Payment Portal Provider Sign-Up form; OR Medicare EFT Request – Change Healthcare form, AND Medicare EFT Change Healthcare - FAQ form).

iuhealthplans.org/provider/provider-resource

Missing or Late EFTs and/or ERAs

If you've enrolled to receive EFTs/ERAs through our respective vendors and are missing or routinely receiving those items late, please reach out to your assigned Provider Relations representative or email us at: **iuhplansproviderrep@iuhealth.org** for further assistance and resolution.

CAQH CORE Payment and Remittance (CCD+/835) Reassociation Rule

Healthcare providers must proactively contact their financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements necessary for successful reassociation of the EFT payment with the ERA remittance advice.

The CORE-required Minimum CCD+ Data are defined in Table 3.3-1 and Table 4.1-1 in the link below. The rule does not prohibit a healthcare provider and its financial institution from mutually agreeing to exchange more Healthcare EFT Standards data in addition to the required minimum data.

caqh.org/sites/default/files/core/Payment-Remittance-Reassociation-CCD-835-Rule.pdf

IU Health Plans tracks and audits all EFT and ERA transactions it transmits to ensure that 90% of all transactions within each calendar month are compliant with the following timing requirements.

- No sooner than three business days prior to the date identified in the Stage 1 payment initiation transmission as the date the health plan intends to provide funds to the payee via EFT (the Effective Entry Date).
- No later than three business days after the Effective Entry Date identified in the Stage 1 payment initiation.
- The rule defines a business day as "24 hours commencing with 12:00 am (Midnight or 00:00 hours) of each designated day through 11:59 pm (23:59 hours) of that same designated day."

Section 10. Medical management

Quality improvement (QI) program

IU Health Plans Quality Improvement Department is committed to evaluating the quality, appropriateness and outcome of care and services delivered to our members. Quality Improvement (QI) Program pursues opportunities for improvement and problem resolution. We establish and maintain an ongoing program of quality improvement to facilitate continuous improvement of healthcare, clinical education, safety and services in order to meet customer needs and expectations and to enhance or improve the health status of IU Health Plans members. This supports IU Health Plans' mission of providing cost-effective, appropriate, quality healthcare and responsive customer service to members. Components of the QI program may include, but are not limited to:

- To continually improve the quality, safety, accessibility, availability, and effectiveness of medical and behavioral healthcare services.
- Implement and maintain quality improvement activities/programs that focus on HEDIS®and Star measures.
- Plan, implement, monitor, and act on identified quality improvement opportunities to ensure optimal health outcomes of our membership.
- Develop and maintain quality improvement policies/procedures and documents, such as annual quality improvement program description, work plan, and program evaluation.
- Evaluate provider performance in order to improve the quality of services provided.
- Objectively measure and analyze member and provider surveys to improve member and provider satisfaction.
- Enhance member experience through evaluation of quality of care, service complaints, and appeals.
- Evaluate the population through assessment in order to ensure an adequate network that addresses the needs of membership.
- Assess and monitor the cultural and linguistic needs of our membership and initiate interventions as appropriate.
- Analyze the population to prioritize strategies that meet the complex health, disease management, and behavioral health needs of our membership. This data is used to determine and implement appropriate clinical services.
- Research and adopt nationally recognized clinical practice and preventative health guidelines. Distribute and promote the use of these guidelines to practitioners as appropriate.
- Improve the continuity of medical care between and across health settings by collecting, analyzing, and evaluating data to identify opportunities for improvement.
- Manages and coordinates the investigation, medical review, tracking, and trending of quality of care/service complaints.
- Improve collaboration between medical and behavioral health care through data collection and analysis; identify and act on opportunities for improvement.
- Assures compliance with access/availability standards.
- Ongoing monitoring of medical, behavioral, and pharmaceutical utilization management services.
- Provide delegation oversight to ensure compliance with national quality standards.
- Comply with Federal and State regulations concerning confidentiality, privacy and security of member identifiable health information.
- Ensure only the minimal necessary information is shared during quality improvement activities for internal and external initiates.
- Conducts onsite review to ensure quality of clinical care, safety and service are provided to members at physicians and facilities.
- Enforces clinical safety and HIPAA compliance regarding PHI to providers.

Performance monitoring

HEDIS (Healthcare Effectiveness and Data Information Sets)
HEDIS (Healthcare Effectiveness Data Information Set) is a set of healthcare performance measures developed by NCQA (National Committee for Quality Assurance) that have been adopted by regulatory agencies to evaluate the quality of care and services provided. IU Health Plans uses these metrics as a way to monitor the quality of care provided by the network.

Annually, additional HEDIS data is collected through a contracted vendor on behalf of IU Health Plans under the direction of the Quality Improvement Department to ensure our providers are receiving optimal credit regarding these measures. IU Health Plans will use claims and encounter data if possible; however, on-site medical record review or faxed medical records may be required. It is the expectation that providers will cooperate and provide the necessary records to an IU Health Plans vendor or team member when requested.

Section 10. Medical management, continued

Quality improvement (QI) program, continued

STARS (MEDICARE)

CMS has created a Five Star rating system to measure the quality of care provided to Medicare beneficiaries. Part of the rating system includes a set of HEDIS measures, which are included in the annual HEDIS data collection project, Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Health Outcomes Survey (HOS) questions. HEDIS consists of 71 measures across 8 domains used in the Stars program.

Quality improvement initiatives

The Quality Improvement Department develops initiatives that are designed to improve health outcomes of our members based on selected aspects of clinical care, safety, and preventive care services. Select HEDIS measures are chosen annually to focus on improvement efforts for the current calendar year.

The following HEDIS quality measures are identified for the QI Program:

Medical

- Breast Cancer Screening
- Colorectal Cancer Screening
- Controlling Blood Pressure Screening
- Comprehensive Diabetic Eye Exams
- Comprehensive Diabetic HbA1c
- Comprehensive Diabetic Nephropathy
- Transitions of Care
- Osteoporosis Management
- Statin Therapy for Patients with Cardiovascular Disease

Pharmacy

- Medication Therapy Management
- Medication Adherence to Chronic Drug regimens prescribed to treat hypertension, diabetes and hypercholesterolemia

Safety of clinical care

IU Health Plans is committed to improving safe clinical practice for its members. The Quality Improvement Department accomplishes this by:

- Focusing existing quality improvement activities on improving patient safety.
- Following up with practice sites when safety issues have been identified.
- Monitoring of clinical practices against aspects of practice guidelines that improve safe practices.
- Tracking and trending quality of care complaints and taking action when appropriate.
- Engaging in practitioner and member safety education initiatives.
- Collaborating with contracted Pharmacy Benefit Manager to implement pharmaceutical management practices that require safeguards to enhance patient safety.

Practitioners and providers are required to cooperate with IU Health Plans' quality improvement activities to improve the quality of care and services and member experience. Cooperation includes collection and evaluation of data and participation in the organization's QI programs. Practitioners and providers agree to allow IU Health Plans to use practitioner/provider performance data for quality improvement activities.

The Quality Improvement Program Description is available online through the Provider Portal.

Quality of care/service

IU Health Plans holds practitioners and healthcare offices to professionally recognized standards of healthcare by providing quality of care and service to our members. The Quality Improvement Department does ongoing monitoring of member complaints, quality of care occurrences, and quality of service occurrences. Occurrences may be reviewed by the IU Health Plans Medical Director, Quality Improvement Program, and the Credentialing Committee. Appropriate action will be initiated when indicated.

The Quality Improvement Program has the ability to impose correction actions based on substantiated quality of care/services concerns. Corrective actions are integrated within the Credentialing Committee. Practitioners and healthcare offices have a right to appeal any corrective actions applied.

Section 10. Medical management, continued

Pharmacy

Medicare Advantage
Formulary Link: IU Health Plans Comprehensive Formulary 2023
Prior authorization phone number: 866.823.1016

Understanding coverage and cost-sharing formulary

The formulary, also known as preferred drug list, is a list of prescription drugs that are covered under your plan. The inclusion of specific medications on the IU Health Plans formulary is based on the medication's effectiveness, safety and value. The formulary offers a wide selection of generic and brand name prescription drugs suggested by the Pharmacy and Therapeutics (P&T) Committee, a group of physicians and pharmacists who researches and evaluates medications. The formulary is periodically reviewed and updated throughout the year to ensure that the benefits package consistently and adequately meets member needs. When members need a prescription medication, their provider can choose from six different levels of the formulary. These are low-cost generics (Tier 1), Generics (Tier 2), Preferred brands (Tier 3), Non-preferred brands (Tier 4), Specialty (Tier 5), and Preventive medications (Tier 6). Each level has a different copayment. This gives members and doctor the freedom to choose the medication that is right, while helping members to better budget their healthcare dollars. Prescribers using e-Prescribing tools and Electronic Medical Record systems like Cerner or Epic that have e-Prescribing capabilities can review member cost and formulary coverage options for most electronic prescription therapies by using the "Real-Time-Benefit" function supported by CVS and Surescripts. This technology permits prescribers to see and discuss with patients about the costs of drug therapy options covered in the health plan's formulary.

Low-cost generics (Tier 1) – Prescription drugs with the lowest coinsurance or copayment. This tier will contain low-cost generic medications.

Generics (Tier 2) – Prescription drugs with a higher coinsurance or copayment than those in Tier 1. This tier will contain generic medications.

Preferred brands (Tier 3) – Prescription drugs with a higher coinsurance or copayment than those in Tier 2. This tier will contain preferred brand-name medications.

Non-preferred brands (Tier 4) – Prescription drugs with a higher coinsurance or copayment than those in Tier 3. This tier will contain non-preferred brand-name medications.

Specialty (Tier 5) – Prescription drugs with a higher/comparative coinsurance or copayment than those in Tier 4. This tier will contain medications that are considered specialty drugs.

Preventive medications (Tier 6) – Prescription drugs reserved for preventive medications that may be covered at a $0 coinsurance or copayment for covered persons who meet the clinical criteria in accordance with the ACA and set forth by the U.S. Preventive Services Task Force A and B recommendations.

Non-formulary medications may be covered if the formulary medications do not work. If member requires a non-formulary medication, the provider may request coverage for the Tier 4 copayment by making a request for an exception.

Prior authorization – Drugs that require prior authorization are often:

- Newer drugs for which the health plan wants to track usage.
- Prescribers using the "Real-Time-Benefit" technology using an e-Prescribing application or in Electronic Medical Records like Cerner and Epic are able to identify what drug therapy options require PA and submit their PA request electronically to the PBM call center.
- Non-formulary drugs that require the use of formulary drugs prior to coverage. These drugs are not used as a standard first option in treating a medical condition.
- Drugs with potential side effects that the health plan wants to monitor for patient safety.
- Drugs categorized as specialty medications.

Step therapy – Step therapy ensures patients are taking the most effective medication at the best cost. This means trying the least expensive medications (usually generic medications) or drugs that are considered as the standard first-line treatment.

Section 10. Medical management, continued

Pharmacy, continued

How step therapy works

Step 1: When a prescribed drug is impacted by step therapy, first try generic or first-line treatment drugs. The drug recommended will be approved by the Food and Drug Administration (FDA) as providing the same health benefit at a much lower cost.

Step 2: If the generic drug in step 1 does not work, then members will have coverage for a brand-name drug. For more information on step therapy call **866.823.1016**.

Quantity limits – The symbol "QL" next to the drugs in this formulary booklet stands for Quantity Limits. To ensure members are getting the most cost-effective dose of medication, a quantity limit or dose duration may be placed on certain drugs. These limits are based on FDA guidelines, clinical literature, and manufacturer's instructions. Quantity limits promote appropriate use of the drug, prevent waste, and help control costs. For some drugs, the dosing guidelines may recommend that patients take the drug one time a day in a larger dose instead of several times a day in smaller doses. The quantity limits follow the guidelines and cover one larger dose per day.

Prescriptions for specialty medications are limited to a 30-day supply. For more information on quantity limits or dose durations call 866.823.1016.

Commercial

Prior authorization phone number: 866.822.6504

Understanding coverage and cost-sharing formulary

The formulary, also known as preferred drug list, is a list of prescription drugs that are covered under a member's plan. The inclusion of specific medications on the IU Health Plans formulary is based on the medication's effectiveness, safety and value. The formulary offers a wide selection of generic and brand name prescription drugs suggested by the Pharmacy and Therapeutics (P&T) Committee, a group of physicians and pharmacists who researches and evaluates medications. The formulary is periodically reviewed and updated throughout the year in order to ensure that our benefits package consistently and adequately meets member needs. When members need a prescription medication, providers can choose from six different levels of the formulary. These are Low-cost generics (Tier 1), Generics (Tier 2), Preferred brands (Tier 3), Non-preferred brands (Tier 4), Specialty (Tier 5), and Preventive medications (Tier 6). Each level has a different copayment. Prescribers using e-Prescribing tools and Electronic Medical Record systems like Cerner or Epic that have e-Prescribing capabilities can review member cost and formulary coverage options for most electronic prescription therapies by using the "Real-Time-Benefit" function supported by CVS and Surescripts. This technology permits prescribers

Low-cost generics (Tier 1) – Prescription drugs with the lowest coinsurance or copayment. This tier will contain low-cost generic medications.

Generics (Tier 2) – Prescription drugs with a higher coinsurance or copayment than those in Tier 1. This tier will contain generic medications.

Preferred brands (Tier 3) – Prescription drugs with will have a higher coinsurance or copayment than those in Tier 2. This tier will contain preferred brand-name medications.

Non-preferred brands (Tier 4) – Prescription drugs with a higher coinsurance or copayment than those in Tier 3. This tier will contain non-preferred brand-name medications.

Specialty (Tier 5) – Prescription drugs with a higher/comparative coinsurance or copayment than those in Tier 4. This tier will contain medications that are considered specialty drugs.

Preventive medications (Tier 6) – Prescription drugs reserved for preventive medications that may be covered at a $0 coinsurance or copayment for covered persons who meet the clinical criteria in accordance with the ACA and set forth by the U.S. Preventive Services Task Force A and B recommendations.

Non-formulary medications may be covered if the formulary medications do not work. If a member requires a non-formulary medication, providers may request coverage for the Tier 4 copayment by making a request for an exception.

Section 10. Medical management, continued

Commercial, continued

Prior authorization – Drugs that require prior authorization are often:

- Newer drugs for which the health plan wants to track usage.
- Non-formulary drugs that require the use of formulary drugs prior to coverage. These drugs are not used as a standard first option in treating a medical condition.
- Drugs with potential side effects that the health plan wants to monitor for patient safety.
- Drugs categorized as specialty medications.

Step therapy – Step therapy ensures patients are taking the most effective medication at the best cost. This means trying the least expensive medications (usually generic medications) or drugs that are considered as the standard first-line treatment.

How step therapy works

Step 1: When a prescribed drug is impacted by step therapy, first try generic or first-line treatment drugs. The drug recommended will be approved by the Food and Drug Administration (FDA) as providing the same health benefit at a much lower cost.

Step 2: If the generic drug in step 1 does not work, then members will have coverage for a brand-name drug. For more information on step therapy call **866.822.6504**.

Quantity limits – The symbol "QL" next to the drugs in this formulary booklet stands for Quantity Limits. To ensure a cost-effective dose for medication, a quantity limit or dose duration may be placed on certain drugs. These limits are based on FDA guidelines, clinical literature, and manufacturer's instructions. Quantity limits promote appropriate use of the drug, prevent waste, and help control costs. For some drugs, the dosing guidelines may recommend that patients take the drug one time a day in a larger dose instead of several times a day in smaller doses. The quantity limits follow the guidelines and cover one larger dose per day.

Prescriptions for specialty medications are limited to a 30-day supply. For more information on quantity limits or dose durations call 866.822.6504.

Utilization management

IU Health uses the MCG (formerly Milliman Care Guidelines), other approved medical policies, medical literature and national and regional guidelines/criterion for utilization management. To obtain a copy of the utilization management program, please log in to the Provider Portal to review.

To request an Prior Authorization for a service log in to your IU Health Plans provider portal account and click the "Authorizations" tab on the navigation bar.

Clinical practice guidelines

IU Health uses evidence-based best practices and care-planning tools across the continuum of care, supporting clinical decision-making and documentation and enabling efficient transitions between care settings. For more information, please log in to the Provider Portal or visit our Provider Resources page for resources and details on the clinical practice guidelines.

Section 11. Population Health

The IU Health Population Health program focuses on impacting patient populations through the Personalized Approach to Health (PATH) programs. Patients are categorized (high, moderate and low) according to their risk for adverse outcomes. The risk stratification process uses various data sources to identify patients. Programs have been developed with physician leadership to manage each category of risk. The PATH focuses on impacting a complex patient population with multiple chronic conditions and high rates of utilization of medical services. The care management team includes a regional medical director along with nurse care managers, social workers, clinical nutritionists and pharmacists. The team will provide physician office, telephonic, and when appropriate, in-home assessment and proactive intervention of patients identified for care management outreach. The care management team works with PCPs, specialists and home care agencies (including home hospice) to coordinate follow-up care and promote adherence to care and treatment plans. Where appropriate and available, care managers may be provided space at high-volume local hospitals and physician offices. Community Based health service programs are also available.

Programs available for members

- Complex care/PATH
- Transition care/HTP
- Condition care
- Behavioral Health
- Catastrophic care
- Advanced Illness Care
- Hospital to Home

For an in-depth explanation of each program, refer to the Appendix: Population health services.

How to enroll members in program

Members may be enrolled in these programs through the following actions:

- Physician referral
- Stratification
- CM referral
- Roster review
- UM rounds

PATH Complex Care Program

The PATH Complex Care Management Program's goals are to:

- Proactively identify patients who have multiple or complex medical and/or psychosocial needs or who are at risk of developing complex needs during an acute episode of illness.
- Provide early intervention and optimize chronic care management for patients appropriate for complex care management.
- Support the clinical staff focusing on the delivery of medical care that maximizes quality of life and ensures that the care is provided in the most appropriate and supportive setting.
- Improve care coordination for patients across care settings.
- Facilitate communication among the member, his or her family members, healthcare providers, the community and the health plan in an effort to enhance cooperation while planning for and meeting the healthcare needs of the member.
- Track and report episodes of illness at the member and aggregate level for the purpose of identifying trends and measuring medical outcomes and financial impact.
- Assist in the development and communication of the member's self-management care plan.
- Function as an educator of members, the healthcare team and the community regarding the care management process and specific healthcare issues.
- Partner with the patient and family in assisting the patient to reach maximum achievable medical potential and maximum independence.

Section 11. Population health, continued

PATH Complex Care Program, continued

PATH transitions program for acute discharges

The Hospital Transitional Care Program is a patient-centered, interdisciplinary process that begins with an initial assessment of the patient's potential needs at the time of admission and continues throughout the patient's stay. Ongoing consultation with the hospital care team and reassessment of the patient's changing medical, functional, social and cognitive capabilities assure that the comprehensive needs of the patient are addressed. Patients and families are encouraged to participate in all phases of the transitional care planning process, including generating an initial assessment and care plan. Referral mechanisms with community providers occur in a timely, systematic fashion for the patient to gain access to identified resources and patients/families/caretakers are apprised of the appropriate resources available. The process concludes with the coordination and implementation of services and transition to the least restrictive level of care in keeping with the individual's wishes. The interventional components of the program focus on medication self-management, primary care and specialist follow-up and patient knowledge of indicators that would suggest a condition is worsening.

The goal of transitional care is specifically designed to focus on the patient's immediate needs:

- Detailed medication education, including a reconciliation of prescribed medications pre- and post-hospitalization
- Education about the patient's specific condition, interaction with co-morbidities and "what to watch for" after discharge
- Written discharge plan
- Self-management plans, including when to contact the doctor
- Adequate caregiver support and appropriate resources at home
- Arranging follow-up appointments, including an appointment with the primary care physician within 7 days of discharge when possible
- Hand-off between the IP transitional care manager and the outpatient embedded or central care manager
- Post-discharge telephone call to the patient from the outpatient embedded or central care manager
- Home visit for the patient based on risk assessment and clinical need

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Section 12. Provider communications and available resources

Provider newsletters

Provider newsletters are released on a regular basis via the Provider Portal and email, and include important information about prior authorization, claims, and clinical guidelines. Providers should sign up for a Provider Portal account at **iuhealthplans.org/provider** so they can view current and past issues of the newsletter.

Online resources

A variety of provider resources and links are available on our website, **iuhealthplans.org/provider/provider-resources**, and through our Provider Portal. These resources include prior authorization lists, claims forms, a quick reference guide for contact information, clinical guidelines, the provider newsletter, and more.

Appendix A: Member rights, responsibilities and general information

Member's rights and responsibilities

You, your patient and other healthcare providers are partners in your patients' healthcare. There are certain rights and responsibilities that are critical to this partnership. The manner in which the member exercises these rights and responsibilities affects our ability to make appropriate medical care available to all our members. The members are entitled to these rights without regard to sex, race, culture, and economic, educational or religious background. Below is a summary of the member's rights.

The member has the right:

- To receive information about the organization, its services, its practitioners and providers and member rights and responsibilities;
- To be treated with respect and recognition of dignity and right to personal privacy;
- To have 24-hour access to a PCP, and if out of town, receive emergency care, if necessary;
- To receive prompt and appropriate treatment for physical and emotional disorders and disabilities;
- To be informed by their healthcare provider of information about their diagnosis, treatment and prognosis;
- To participate in decisions involving their medical care;
- To participate in candid discussions of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- To receive appropriate information so they may give an informed, voluntary consent to participate in any experimental research. (Experimental and investigational procedures are not covered in our plan.)
- To refuse treatment and to be informed of the probable consequences of their action.
- To have a guardian, next of kin or legally authorized person exercise their rights on their behalf;
- To have health records kept confidential except when disclosure is required by law or permitted by the patient in writing;
- To receive guidance and recommendations for additional medical care when coverage ends;
- To be provided with information about us, our providers and your rights; and
- To continue receiving active treatment from their provider even if the provider's network status changes (i.e., terminates from the network) until the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition. For pregnant members in their second or third trimester of pregnancy, continuation of care through the postpartum period.
- To voice complaints or appeals about the organization or the care it provides; and
- To make recommendations regarding the organization's member rights and responsibilities policy

The member has the responsibility to:

- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care;
- Follow plans and instructions for care that they have agreed to with their practitioners;
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Noninterference with medical care

Providers shall at all times provide treatment to Medicare members in a manner consistent with sound medical judgment and practice. IU Health Plans shall not require the provider to take any action inconsistent with his/her professional judgment concerning the medical care and treatment to be provided to Medicare members. However, IU Health Plans reserves the right to make coverage decisions when a dispute exists between the Medicare member and the network physician/provider regarding the medical necessity of a covered service. Physicians will maintain the relationship of physician and patient with Medicare members, without intervention in any manner by IU Health Plans or employees, and physician will be solely responsible for all medical advice to and treatment of his/her patients and for the performance of all medical services in accordance with accepted professional standards and practices. Providers shall be free to communicate with their patients regarding the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations and shall also be free to discuss their compensation arrangements with their patients.

Appendix A: Member rights, responsibilities and general information, continued

Member's rights and responsibilities, continued

Nondiscrimination

Providers agree to render covered services to members in accordance with prevailing community medical standards applying the same standards to members they apply to other patients and must provide covered services to all members without regard to race, color, religion, national origin, handicap, sex or age, health status or income.

IU Health Plans, Inc. privacy practices

IU Health Plans is required by law to maintain the privacy of our member's health information and to provide our members with notice of our legal duties and privacy practices. An IU Health Plans member's healthcare provider may have different policies or notices regarding the use and disclosure of medical information as it applies to the provider's office or center.

Provider shall keep such medical records for a period as required by applicable laws. Medical records must be legible, signed and dated. Medical record information must be protected by the provider as required under state and federal laws and regulations. Provider shall provide a copy of a member's medical record and other information that pertains to the member in a timely manner.

If members have any questions about IU Health Plans Privacy Practices, they should contact IU Health Plans Member Services.

How IU Health Plans may use and disclose medical information about members

The following categories describe different ways IU Health Plans uses and discloses medical information. For each category of uses or disclosures, IU Health Plans will explain what is meant and try to give some examples. Not every use or disclosure in a category will be listed; however, all of the ways IU Health Plans is permitted to use and disclose information will fall within one of the categories.

For treatment

IU Health Plans may review patient medical information to provide authorization for certain medical treatment. IU Health Plans may disclose patient medical information to healthcare providers who are involved in their care. For example, IU Health Plans may obtain medical information for services providers requested that may be considered experimental/investigational. IU Health Plans may also review medical information when members request treatment by an out-of-network provider.

For payment

IU Health Plans may use and disclose patient medical information to providers so that they can bill and receive payment for the treatment and services they provided. For example, IU Health Plans may need to give patient insurance information to providers so they can bill IU Health Plans for the treatment that the patient received.

For healthcare operations

IU Health Plans may use and disclose medical information about the patient for our business operations. These uses and disclosures are necessary to run IU Health Plans and make sure that all of our members receive quality care. For example, IU Health Plans may use the medical information to review the provider's treatment and services and to evaluate their performance. IU Health Plans may remove information that identifies the patient from this set of medical information when used to evaluate specific disease conditions.

Health-related benefits and services

IU Health Plans may use and disclose medical information to tell the patient about health-related benefits or services. For example, IU Health Plans may remind the patient that it is time for the patient's yearly mammogram or diabetic retinal exam.

Individuals involved in the care or payment for patient care

IU Health Plans may release medical information about the patient to a friend or family member who is involved in his or her medical care and who the patient has designated with the appropriate authorization on file.

Workers' compensation

IU Health Plans may release medical information about the patient for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Appendix A: Member rights, responsibilities and general information, continued

Member's rights and responsibilities, continued

Health oversight activities

IU Health Plans may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the healthcare system, government programs and compliance with civil rights laws.

Lawsuits and disputes

If members are involved in a lawsuit or a dispute, IU Health Plans may disclose medical information about the member in response to a court or administrative order. IU Health Plans may also disclose medical information about members in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

Member rights regarding medical information

Right to inspect and copy

Members have the right to inspect and copy medical information that may be used to make decisions about their care. This includes medical and billing records but does not include psychotherapy notes.

To inspect and copy medical information that may be used to make decisions, the member must submit a request in writing to IU Health Plans, Attn: Grievance & Appeal Coordinator, 950 N. Meridian St., Suite 400, Indianapolis, IN 46204. If requesting a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with the request.

IU Health Plans may deny the request to inspect and copy in certain circumstances. If members are denied access to medical information, members may request that the denial be reviewed as a grievance.

Grievances can be submitted either verbally or in writing. Members can refer to the IU Health Plans "Evidence of Coverage" for more information about requesting and processing of grievances.

Right to amend

If members feel that the medical information IU Health Plans has is incorrect, they may ask to amend the information. Members have the right to request an amendment for as long as the information is kept by the IU Health Plans. To request an amendment, a request must be made in writing by the member and submitted to IU Health Plans, Attn: Grievance and Appeal Coordinator, 950 N. Meridian St., Suite 400, Indianapolis, IN 46204.

In addition, the member must provide a reason that supports the request.

IU Health Plans may deny the request for an amendment if it is not in writing or does not include a reason to support the request. In addition, IU Health Plans may deny the request if the member asks the company to amend information that:

- Was not created by IU Health Plans, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by the IU Health Plans;
- Is not part of the information that the member would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an accounting of disclosures

Members have the right to request an "accounting of disclosures." This is a list of the disclosures IU Health Plans made of member medical information.

To request this list or accounting of disclosures, members must submit the request in writing to IU Health Plans Member Services. The request must state a time period which may not be longer than six years and may not include dates before Jan. 1, 2009. The first list requested within a 12-month period will be free. For additional lists, IU Health Plans may charge members for the cost of providing the list. IU Health Plans will notify members of the cost involved. Members may choose to withdraw or modify the request at that time before any costs are incurred.

Appendix A: Member rights, responsibilities and general information, continued

Member rights regarding medical information, continued

Right to request restrictions

Members have the right to request a restriction or limitation on the medical information IU Health Plans uses or discloses about them. Members also have the right to request a limit on the medical information IU Health Plans discloses about them to someone who is involved in their care or the payment for their care, like a family member or friend. For example, members could ask that IU Health Plans not use or disclose information about a surgery they had.

IU Health Plans is not required to agree with the request. If IU Health Plans does agree, we will comply with the request unless the information is needed to provide emergency treatment. To request restrictions, members must make a written request to IU Health Plans Member Services. In the request, members must tell IU Health Plans (1) what information they want to limit; (2) whether they want to limit IU Health Plans' use, disclosure or both; and (3) to whom they want the limits to apply, for example, disclosures to the spouse.

Right to request confidential communications

Members have the right to request that IU Health Plans communicate with them about medical matters in a certain way or at a certain location. For example, members can ask that IU Health Plans only contact them at work or by mail.

To request confidential communications, members must make a written request to IU Health Plans Member Services. IU Health Plans will not ask members the reason for the request. IU Health Plans will accommodate all reasonable requests. The request must specify how or where the member wishes to be contacted.

Other uses of medical information

Other uses and disclosures of medical information not covered by this notice or law will be made only with the member's written permission. If members provide IU Health Plans permission to use or disclose medical information, they may revoke that permission, in writing, at any time. If members revoke permission, IU Health Plans will no longer use or disclose medical information about them for the reasons covered by the written authorization. Members understand that IU Health Plans is unable to take back any disclosures we have already made pursuant to member permission, and that IU Health Plans is required to retain our records of the care that we have provided.

Inpatient member appeals rights

When members are admitted as hospital patients, they have the right to get all the hospital care covered by IU Health Plans that is necessary to diagnose and treat their illness or injury.

According to federal law, the date a patient leaves the hospital (the discharge date) must be determined solely by medical needs, not by any method of payment. This section tells members what to do if they feel they are being asked to leave the hospital too soon.

When members are admitted to the hospital, they should be given a notice called **Important Message from Medicare**. This notice explains:

- The member's right to get all medically necessary hospital services covered
- The member's right to know about any decisions the hospital, the doctor, or anyone else makes about the patient's hospital stay and who will pay for it
- That the doctor or the hospital may arrange for services members will need after they leave the hospital
- The member has the right to appeal a discharge decision

If members do not receive this notice, they should be sure to ask for it right away. When a doctor decides patients are ready to leave the hospital (to be "discharged"), members will again be shown the notice, Important Message from Medicare. At this time, the second part of this document will include information about the hospital discharge. It will tell the patient:

- Why the patient was discharged
- The date IU Health Plans will stop paying for hospital costs
- What members can do if they think they are being asked to leave the hospital too soon
- Who to contact for help

Appendix A: Member rights, responsibilities and general information, continued

Inpatient member appeals rights, continued

Members of IU Health Plans should receive this information about their discharge before they leave the hospital. They (or someone they authorize) will be asked to sign and date this document to show that the member received the notice. If members do not receive the notice when they are being told about the discharge from the hospital, they should be sure to ask for it immediately.

If members think they are being asked to leave the hospital too soon

Patients and their doctor know more about their condition and health needs than anyone else. Decisions about medical treatment should be between the patient and the doctor. If members have questions about their medical treatment, their need for continued hospital care, their discharge or their need for possible post-hospital care, members should not hesitate to ask their doctor. IU Health Plans, the hospital's representative or social worker will also help with questions and concerns about hospital services. If patients feel they are being asked to leave the hospital too soon, they must ask IU Health Plans to give them notice of non-coverage called the Notice of Discharge & Medicare Appeal Rights, then they must act quickly and the patient has the right by law to get an outside agency called the QIO (Quality Improvement Organization), to review the discharge. QIOs are groups of doctors who are paid by the federal government to review medical necessity, appropriateness and quality of hospital treatment furnished to Medicare patients, including those enrolled in a managed care plan (or an HMO like IU Health Plans). The telephone number and address of the QIO for this area are:

Livanta
6830 W. Oquenod Road
Las Vegas, NV 89118
T 888.524.9900
F 855.236.2423
Website: livantaqio.com

- Members must ask the QIO for a "fast review" (also call a "fast appeal") of whether they are ready to leave the hospital.
- Members must request an immediate review, by telephone or in writing, by noon of the first day after the day of delivery of the NOMNC (that is, by noon of the day before the effective date on the NOMNC). The QIO will make its decision within one working day after it has received from the hospital and IU Health Plans all of the medical information it needs to make a decision. The QIO will let the member know as soon as it decides.
- If the QIO decides members should be discharged, members will not be responsible for paying the hospital charges until noon the day after the QIO gives its decision.
- If the QIO agrees with the patient, then IU Health Plans will continue to cover the hospital stay.

What if the patient does not ask the QIO for a review by the deadline?

If patients do not ask the QIO by noon on the date that is written in the Notice of Discharge and Medicare Appeal Rights, and if they stay in the hospital after the discharge date, members may be financially responsible for the cost of many of the services received. However, members can appeal any bills for hospital care received.

The other option members have is to ask IU Health Plans for a "fast appeal" of the discharge. Please see the "Fast or Expedited Appeals" section in this manual. If IU Health Plans decides, based on the fast appeal, that members need to stay in the hospital, IU Health Plans will continue to cover the hospital care. However, if IU Health Plans decides that members should not have stayed in the hospital beyond the discharge date, IU Health Plans will not cover any hospital care received if members stayed in the hospital after the original date.

Post-hospital care

When the doctor determines that the patient no longer needs all of the specialized services provided in a hospital, but members still require medical care, the doctor may discharge the member to a skilled nursing facility or home care. IU Health Plans, or the discharge planner at the hospital, will help arrange for the services the member may need after the discharge.

Medicare managed care plans, like IU Health Plans, have limited coverage for skilled nursing facility care and home healthcare. Therefore, the member should find out which services will or will not be covered and whether there are any other expenses, such as copayments. Members should consult with their doctors, IU Health Plans or hospital discharge planner, patient representative, and the family in making preparations for care after the patient leaves the hospital. Members should not hesitate to ask questions.

Appendix A: Member rights, responsibilities and general information, continued

Member appeals and grievances

IU Health Plans members or authorized member representative have a right to appeal any decision made by IU Health Plans.

Matters that are received from members and care providers are documented, tracked and analyzed. IU Health Plans acknowledges and enters all written, verbal and in-person complaints into the complaint database. IU Health Plans will not discriminate against a member based on race, color, religion, sex, sexual orientation, age, disability, genetic information, veteran status, national origin, gender identity and/or expression, marital status or any other characteristic protected by federal, state or local law.

IU Health Plans ensures that all members have access to and can fully participate in the grievance/appeal system by providing assistance for those with limited English proficiency or with visual or other communicative impairment. Such assistance shall include, but not be limited to, translation of grievance procedures, forms and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.

Documentation is utilized to measure and improve member and care provider satisfaction. On a quarterly basis, an analysis of the complaint data is conduct and presented to the Quality Improvement Committee, to identify opportunities for improvement and promote better health outcomes. Tracking data also endorses fulfilling requirements and expectations of our members and our network care providers. In addition, it supports compliance with CMS and NCQA Standards.

After a grievance is filed and received by the Grievance Analyst or Designee, the investigation is started. If the complaint involves an imminent and serious threat to the member's health, the case is then escalated for immediate action. IU Health Plans identifies and requests relevant medical records and information needed to resolve quality of care investigations. We use the results to assign severity levels and data collection codes. This helps us objectively and systemically monitor, evaluate and improve the quality and safety of clinical care and quality of service provided to our members.

Who may file a grievance/appeal?

The member, member representative, or their treating practitioner may file a grievance and/or an appeal on their behalf. The person named will be the authorized representative. In order for members to have someone else file a grievance and/or an appeal on their behalf, they must give IU Health Plans a written statement that includes:

- The member's name
- The member's Medicare number
- A statement which appoints an individual as the member's representative. An example of that statement would be:
  - "I [member's name], appoint [name of representative] to act as my representative requesting an appeal from IU Health Plans and/or the Centers for Medicare & Medicaid Services regarding IU Health Plans' denial of payment for services."
- The member's signature and written date of the statement
- The signature of the representative and the date, unless the representative is an attorney
- Include this written statement with the appeal.

For Medicare Advantage members an Authorization of Representative (AOR) must be requested. Commercial members will need to request an Appointment of Health Representative form.

Non-IU Health Plans providers may file a standard appeal for a denied claim if they complete a "waiver of payment" statement indicating they will not ask members to pay for medical services under review regardless of the outcome of the appeal.

A court-appointed guardian or an agent under a healthcare proxy to the extent provided under state law.

Appendix A: Member rights, responsibilities and general information, continued

Submission of grievance and appeal

In the event if an IU Health Plan members or authorized member representatives is dissatisfied with a service or care, a grievance/appeal can be filed through a form, letter, fax, in person, online, by calling or writing to:

Medical grievance or appeal:
IU Health Plans Office of Appeals
950 N. Meridian St., Suite 400
Indianapolis, IN 46204

T 866.895.5975 Commercial
T 800.455.7776 Medicare
F 317.963.9801
Email: IUHPMedicare@IUHealth.org
(Monday – Friday, 8 am – 5 pm)

Pharmacy grievance:
IU Health Plans Office of Appeals
950 N. Meridian St., Suite 400
Indianapolis, IN 46204

T 866.822.6504
F 317.963.9801
(Monday – Friday, 8 am – 5 pm)

Pharmacy appeal:
IU Health Plans Office of Appeals
950 N. Meridian St., Suite 600
Indianapolis, IN 46204

T 866.822.5604
F 855.397.8762
(Monday – Friday, 8 am – 5 pm)

Grievance

After a complaint is filed and is determined to be a grievance, the investigation is started. The Grievance Analyst will complete a comprehensive review and resolution of a member's dispute regarding the availability, delivery, appropriateness, medical necessity or quality of healthcare services; the payment of a claim; or matters pertaining to the contractual relationship between the enrollee and the plan. The member or authorized representative should have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

Commercial members are provided with a written acknowledgment letter within three days of receipt from a customer service representative. This letter instructs the member with the grievance process, timelines and member's rights.

All grievance records must contain: (1) the name of the member, provider and/or facility rendering service, (2) copies of all correspondence from the member, provider or facility rendering service and the organization regarding the appeal, (3) dates of appeal reviews, documentation of actions taken and final resolution, and (4) minutes or transcripts of appeal proceedings (if any).

The following is a sample list of complaint issues in which the IU Health Plans grievance procedures should be used:

- Time spent on the telephone with the doctor's office or in the waiting or exam room
- Disrespectful or rude behavior by doctors, nurses, receptionists or other staff
- Cleanliness or condition of doctor's office or hospitals
- The quality of the medical care the member received, including the quality of care during a hospital stay
- If members feel they are being encouraged to leave (disenrollment from) IU Health Plans, or feel they are being discouraged from seeking the care that members feel they need
- The quality of customer service members receive
- Involuntary disenrollment situations, though disenrollment for cause requires prior CMS approval

Appendix A: Member rights, responsibilities and general information, continued

Grievance, continued

Grievance timeliness

Non-urgent (standard) grievance are to be completed within 30 calendar days from receipt of the grievance into the health plan. A notification in writing of the status and estimated completion date of the grievance resolution will be sent to member and/or the representative.

For grievances that are identified as escalated for immediate action (urgent) for cases involving an imminent and serious threat to member's health, including but not limited to, potential life loss, severe pain, media coverage/legal action, major bodily function, cases are to be completed within 2 business days.

Additional handling of grievances by the health plan include:

- Ability to respond within 24 hours to a member's expedited grievance whenever:
  - IU Health Plans extends the time frame to make a determination or reconsideration
  - IU Health Plans refuses to grant a request for an expedited determination or reconsideration
  - Requests from IDOI or CMS
- An initial assessment is completed, and a determination is made if additional information is needed

Appeals

IU Health Plans members or authorized member representatives have a right to appeal any adverse decision about IU Health Plans' payment for or failure to provide what members believe are covered services provided with IU Health Plans. Members have the right to appeal if they do not agree with IU Health Plans' decisions about medical bills or healthcare.

When members want IU Health Plans to reconsider and change a decision that has been made about what services or benefits were covered members can file an appeal. Members may file an appeal under these conditions:

- IU Health Plans, or its plan providers, will not approve or give the member the care that IU Health Plans should cover or what we will pay
- If members think that IU Health Plans has refused to pay for services that they think are covered
- IU Health Plans has not paid a bill
- IU Health Plans has not paid a bill in full

Appeals workflow

IU Health Plans members have a right to appeal any decision about the health plan's payment for or failure to provide what members believe are Medicare-covered services provided with IU Health Plans Medicare Advantage. Members have the right to appeal if they do not agree with IU Health Plans' decisions about medical bills or healthcare. Medicare Managed Care Manual, Chapter 13, Section 70.1 states members may register claim edit disputes but not for medical necessity.

Members or representative must file a claim denial appeal request within 60 calendar days of the date they are notified of the initial decision from IU Health Plans.

IU Health Plans is responsible for processing the appeal request within 30 days from the date the request is received at IU Health Plans. Commercial Members or representative receives an Acknowledgment Letter within three business days of receipt of the Appeal.

If IU Health Plans does not rule in the member's favor, the health plan will forward the appeal request for a decision (depending the line of business) to an independent review organization.

If IU Health Plans has not paid a bill in full, Medicare Advantage members can appeal if they think they are being discharged from a hospital or coverage in a skilled nursing facility (SNF) or comprehensive outpatient rehabilitation facility (CORF) is ending too soon. These appeals should be made by members directly and immediately to Livanta at 888.524.9900. Livanta is the Quality Improvement Organization in Indiana.

Appendix A: Member rights, responsibilities and general information, continued

Appeals, continued

Commercial appeals timeliness

Commercial has two different timelines IU Health Plans follows Pre-service Appeals and Expedited. The following will provide information on how members can file an appeal under each of these processes.

Pre-service appeals
Fully insured – 20 business days
Self-funded – 30 days process appeals

Expedited
Fully insured/self-funded – 72 Hours

Pre-service appeal
A request to change an Adverse Benefit Determination made by the organization for care or service that has not been provided to the member.

- Submit an appeal to IU Health Plans by mail or deliver in person the written appeal request to the health plan
- IU Health Plans is responsible for processing the appeal request within 30 days from the date the request is received at IU Health Plans.

Expedited appeal
An urgent /expedited appeal will be provided for any appeal related to an illness, a disease, a condition, an injury or a disability that would seriously jeopardize the Covered Person's:

- Life or health;
- Ability to reach and maintain maximum function; or
- Requires medical service within 48 to 72 hours.

If members or representative ask for an urgent appeal, IU Health Plans will decide, based upon established criteria, whether an urgent appeal should be granted.

Medicare appeals timeliness
There are three appeals processes for Medicare appeals. There is a 30-day process, expedited, or 72-hour appeal process, and Standard Post Service Claim Denial. The following will provide information on how members can file an appeal under each of these processes.

Standard preservice – 30 Calendar days

Expedited or fast track preservice – 72 hours

Standard post service claim denial – 60 Calendar Days

Standard preservice
The 30-day appeals process can be used for all Medicare appeals. If members want to file an appeal that will be processed within 30 days, they can do the following:

- Submit an appeal to IU Health Plans by mail or deliver in person the written appeal request to the health plan.
- Members must file the appeal request within 60 calendar days of the date they are notified of the initial decision from IU Health Plans.
- IU Health Plans is responsible for processing the appeal request within 30 days from the date the request is received at IU Health Plans. If IU Health Plans does not rule in the member's favor, the health plan will forward the appeal request for a decision to an independent review organization contracted by the Centers for Medicare & Medicaid Services.

Appendix A: Member rights, responsibilities and general information, continued

Appeals, continued

Expedited or fast track preservice

Members may have the right to a faster 72-hour appeals process. Members can get a fast appeal if 30 days for a standard 30-day appeal could seriously harm their health. If members ask for a fast appeal, IU Health Plans will decide, based upon established criteria, whether a 72-hour/fast appeal should be granted.

If it is decided the appeal does not meet the expedited criteria, the appeal will be processed in 30 days.

Please note: The fast 72-hour appeal option does not apply to the denial of a claim payment.

If members want to file an appeal that will be processed in 72 hours, they should file an oral or written request for a 72-hour appeal. The member should specifically state, "I want a fast appeal or 72-hour appeal," or "I believe my health could be seriously harmed by waiting 30 days for a standard appeal.

Members can request a "fast decision" via phone or a written statement. Members must be sure to ask for a "fast" or "72 hour" review. Post services do not apply to fast decisions.

The 72-hour time frame will not begin until the request for an appeal is received. Members must file their request within 60 days of the date of notice that a healthcare service is not being approved or that a healthcare service is being stopped.

IU Health Plans notifies the member or representative of the decision on the appeal within 72 hours of receipt of the request. If IU Health Plans does not rule in the member's favor, the health plan will forward the appeal request for a decision to an independent review organization contracted by the Centers for Medicare & Medicaid Services.

Major areas of impacts to IU Health Plans providers regarding the 72-hour or fast appeal

- **Supporting members' appeals:** Members may ask the physician to support an appeal. If supporting documentation is required, IU Health Plans will need an immediate response from the provider to meet the 72-hour deadline.
- **Representing the member in appeals:** A physician may represent or support the member in requesting a 72-hour appeal or expedited appeal if the physician gives a written or oral statement to the effect that the standard or 30-day appeal process could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.
- If any physician asks IU Health Plans to grant them a fast appeal, it will be granted.
- **Copying medical records:** IU Health Plans is responsible for gathering all necessary medical information. It is imperative physicians and their staff be quick to respond to requests for information when a member has requested the 72-hour appeal. The 72-hour period begins when the appeal is received by IU Health Plans and is not limited to business days.

Standard post service claim denial

Standard post-service (claim) reconsiderations: Resolve and respond to member or member representative no later than 60 calendar days from the date the oral or written request is received.

Additional documentation from the provider – 14-day extension

14-day extension – An extension of up to 14 days is permitted for a 72-hour appeal, if the extension of time benefits the member. For example, an extension is permitted if the member needs time to provide IU Health Plans with additional information or if the health plan needs to have additional diagnostic tests completed.

Payment for care

For an appeal about payment for care, the independent review organization has up to 60 calendar days to make a decision.

- For a standard appeal about medical care, the independent review organization has up to 30 calendar days to make a decision. This time period can be extended by up to 10 calendar days if more information is needed, and the extension will benefit the member.
- For a fast appeal about medical care, the independent review organization has up to 72 hours to make a decision. This time period can be extended by up to 10 calendar days if more information is needed and the extension benefits the member.

Appendix A: Member rights, responsibilities and general information, continued

General information

Help with the appeal

If members decide to appeal and want help with the appeal, they may have a doctor, a friend, a lawyer or someone else help. There are several groups that can assist the member. The member may want to contact the Central Indiana Council on Aging at **800.432.2422**; the state's Senior Health Insurance Information Program (SHIP) at **800.452.4800**; or the Medicare Rights Center at **800.333.4114**.

Appealing an independent review organization decision

The independent review organization will inform members in writing about its decision and the reason for it. Members may continue the appeal by asking for a review by an administrative law judge, provided the dollar value of the medical care of the payment in the appeal meets the annual dollar requirement. (Members can contact IU Health Plans Member Services if they need the current year's dollar requirement.)

Members must make a request for review by an administrative law judge in writing within 60 calendar days after the date the member was notified of the decision by the independent review organization. Members can extend this deadline for good cause. Members must send the written request to the entity specified by the independent review organization.

- The appeal may be sent directly to the independent review organization that reviewed the appeal. It will send the request along with the appeal information to the administrative law judge who will hear the appeal or to: IU Health Plans or to the local Social Security Administration office. In these cases, it will take longer because the request must first be forwarded to the independent review organization. The independent review organization will then send the request along with the appeal information to the administrative law judge who will hear the appeal.

Administrative law judge decision

Members may request a hearing before an administrative law judge by writing to IU Health Plans, CMS, or any Social Security office within 60 days of the date of the notice of an adverse reconsideration decision. (This 60-day period may be extended for good cause.)

A hearing can be held only if the dollar value of the medical care meets the annual dollar requirement. (Members can contact IU Health Plans Member Services if they need the current year's dollar requirement.) During the review by the administrative law judge, members may present evidence, review the record and be represented by counsel.

If the administrative law judge rules for the member, IU Health Plans must pay for, authorize or provide the service the member has asked for within 60 calendar days from the date we receive notice of the decision. IU Health Plans has the right to appeal this decision by asking for a review by the Medicare Appeals Council.

Appealing an administrative law judge's decision

An administrative law judge's adverse decision can be reviewed by the Medicare Appeal Council, either by its own action or as the result of a request from the member or IU Health Plans. The council is part of the federal department that runs the Medicare program.

If the dollar value of the member's contested medical care meets the annual dollar requirement, either the member or IU Health Plans may request that a decision made by the Medicare Appeals Council or administrative law judge be reviewed by a federal district court.

An initial, revised or reconsidered determination made by IU Health Plans, the independent review organization, the administrative law judge or the Medicare Appeals Council can be reopened:

- Within 12 months;
- Within four years for just cause, or
- Any time for clerical correction or in cases of fraud

Medicare member complaints

If members believe their privacy rights have been violated, they may file a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave., SW, Washington, DC 20201 or by calling **877.696.775**. A member can also file a complaint by calling **800.MEDICARE (800.633.4227)**. Members may also contact IU Health Plans Member Services at 950 N. Meridian St., Suite 400, Indianapolis, IN 46204, or by calling toll free within Indiana at **800.455.9776**. Business hours are Monday – Friday, 8 am – 5 pm.

Members will not be penalized for filing a complaint.

Appendix A: Member rights, responsibilities and general information, continued

General information, continued

Medicare Appeals Council

The Medicare Appeals Council does not review every case it receives. When the Council receives the case, it will first decide whether to review it. If the Council decides not to review the case, then either the member or IU Health Plans may request a review by a federal court judge. The federal court judge will only review cases when the amount involved is equal to or greater than a specific dollar amount. If the dollar value is less than the specified amount, members may not appeal further.

If the Medicare Appeals Council reviews the case, it will make its decision as soon as possible. IU Health Plans must pay for, authorize or provide the medical services within 60 calendar days from the date the health plan receives notice of the decision. However, IU Health Plans has the right to appeal this decision by asking for a federal court judge to review the case provided the amount involved meets the dollar value criteria. If the dollar value criterion is not met, the Council's decision is final and no further appeal can be made.