Consumers’ Choice Health Plan was established to build a member-focused, Consumer Oriented and Operated Plan (CO-OP) health insurance company. Under the auspices of the Patient Protection and Affordable Care Act of 2010, Section 1322, Consumers’ Choice was awarded a federal loan to establish and operate a health insurance organization that would offer new health insurance options for the people of South Carolina, including providing individuals and small groups with multiple insurance options via the Federally Facilitated Marketplace (FFM).

Consumers’ Choice is committed to serving the population of South Carolina to building collaborative relationships with providers/practitioners. Our Mission: To provide high quality, affordable, consumer-friendly healthcare by engaging consumers and promoting provider/practitioner innovation.

This Provider/Practitioner Manual is an extension of the Provider/Practitioner contract and may be updated at any time and is available on the Consumers’ Choice website. Providers/Practitioners will be notified of any significant or material changes in advance of the changes. The Provider/Practitioner Manual may be provided in another language if requested and/or required.
NATIONAL PROVIDER IDENTIFIER (NPI) ................................................................. 55
PAPER CLAIMS SUBMISSION ............................................................................. 55
IMAGING REQUIREMENTS .................................................................................. 56
CLEAN CLAIM DEFINITION ............................................................................... 56
NON-CLEAN CLAIM DEFINITION .................................................................. 56
WHAT IS A CLAIM? ............................................................................................ 57
PROCEDURES FOR FILING A CLAIM .............................................................. 57
COMMON BILLING ERRORS .......................................................................... 58
CODE AUDITING AND EDITING ..................................................................... 58
CODE EDITING ASSISTANT ........................................................................... 68
BILLING CODES ................................................................................................. 68
CLAIM PAYMENT .............................................................................................. 69
UNSATISFACTORY CLAIM PAYMENT ............................................................ 69
BILLING FORMS ............................................................................................... 69
THIRD PARTY LIABILITY ................................................................................... 70
COMPLETING A CMS 1500 FORM ................................................................. 70
CMS 1500 STANDARD PLACE OF SERVICE CODES ..................................... 71
COMPLETING A UB-04 CLAIM FORM ......................................................... 72
UB-04 HOSPITAL OUTPATIENT CLAIMS ...................................................... 72
BILLING THE MEMBER ................................................................................... 72
STATEMENT MEMBER ACKNOWLEDGEMENT .......................................... 72
PROVIDER VERIFICATION OF MEMBER ELIGIBILITY ................................ 73
CREDENTIALING REQUIREMENTS ............................................................. 73
CREDENTIALING OF ORGANIZATIONAL PROVIDERS ............................. 75
PRACTITIONER RIGHTS .................................................................................. 75
PATIENT SAFETY COMMITTEE ...................................................................... 76
FEEDBACK ON PHYSICIAN SPECIFIC PERFORMANCE ............................. 76
RE-CREDENTIALING ....................................................................................... 76
CERTIFICATION AND LICENSING REQUIREMENTS .................................. 77
RIGHT TO REVIEW AND CORRECT INFORMATION .................................... 78
RIGHT OF RECONSIDERATION AND APPEAL ............................................ 79
Consumers’ Choice is committed to providing clear, accurate, and timely communications to our affiliated provider/practitioner network. The Consumers’ Choice Provider/Practitioner Manual is available online at www.cchpsc.org or contact Customer Service at 1-800-580-8736 for information about how to obtain a printed copy of the Provider/Practitioner Manual.

For your ease, we have included this reference guide to assist you in the day-to-day operations of your office:

<table>
<thead>
<tr>
<th>Department</th>
<th>Telephone</th>
<th>Fax</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider/Practitioner Services</td>
<td>1-800-580-8736</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Customer Service</td>
<td>1-800-580-8576</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Case Management</td>
<td>1-800-580-8576</td>
<td>1-855-260-2886</td>
<td>NA</td>
</tr>
<tr>
<td>Prior Authorization</td>
<td>1-800-580-8576</td>
<td>1-855-260-2886</td>
<td>NA</td>
</tr>
<tr>
<td>Catamaran Rx (Pharmacy)</td>
<td>1-855-577-6547</td>
<td>1-866-511-2202</td>
<td>Catamaranrx.com</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>1-855-577-6547</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>MedSolutions</td>
<td>1-855-414-2345</td>
<td>NA</td>
<td>Medsolutions.com</td>
</tr>
</tbody>
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PROGRAMS AND SERVICES

PRIMARY CARE PHYSICIANS/PRACTITIONERS (PCPs)

Consumers’ Choice endorses the Medical Homes concept and strongly encourages its Members to enroll with a PCP. Consumers’ Choice will assign Members who do not choose a PCP. The PCP serves as the medical home for the Member. PCP specialties include Family Practice, General Practice, General Medicine, Internal Medicine, and Pediatricians.

Primary care physicians contracted with Consumers’ Choice are expected to accept the responsibilities outlined below.

COVERED PCP SERVICES AND CARE COORDINATION

The PCP is responsible for supervising, coordinating, and providing all primary care to Members. In addition, the PCP is responsible for coordinating and/or initiating referrals for specialty care, taking care to refer to in-network providers in all situations where the Member’s needs may be met by in-network providers. Where, in the opinion of the PCP, the Member may best be served by a referral out-of-network, prior authorization should be obtained from Consumers’ Choice using the website or by phone except in case of emergency. Members are allowed to self-refer for certain services (see below), but need to contact their assigned PCP prior to obtaining specialty services for coordination of care. PCPs are encouraged to refer a Member to specialists when medically necessary care is needed that is beyond the scope of practice of the PCP.

SELF-REFERRALS

The following services do not require PCP authorization or referral:

- Non-PCP practitioners do not require PCP referrals to write prescriptions
- Emergency services including emergency ambulance transportation
- OB/GYN services, including those of a Certified Nurse Midwife (CNM)
- Women’s health services provided by a Federally Qualified Health Center (FQHC) or Certified Nurse Practitioner (CNP)

Except for emergencies, any services must be obtained through network providers or prior authorized out-of-network providers/practitioners.

In compliance with the Stark Law, http://www.gthm.com/index/pdfs/medfraud.pdf, PCPs are prohibited from making referrals for designated health services to healthcare entities with which the PCP or a Member of the PCP’s family has a financial relationship. Further, inducements or rewards for referrals of federal health care program business are prohibited pursuant to the federal Anti-Kickback Law, http://www.ssa.gov. The PCP maintains continuity of each Member’s healthcare and maintains the
The PCP will be responsible for providing timely access to continuing primary care following hospital discharge and communicating with the Consumers’ Choice health support team to facilitate care coordination and medication reconciliation. The PCP will be responsible, when applicable, for attending Member beneficiaries nearing end-of-life and communicating the care plan and the Member’s end-of-life wishes previously approved by the patient (or designated representative) and the attending physician.

Covered PCP services include:

- Professional medical services, including visits documented electronically and providing medical assessment and advice for both inpatient and outpatient services provided by the PCP, nurses, and other personnel employed by the PCP. These services include the administration of immunizations.
- Periodic health assessments and routine physical examinations (performed at the discretion of the PCP, and consistent with nationally recognized standards recommended for the age and sex of the covered person).
- Previously authorized injectable biologics and specialty drugs approved by Consumers’ Choice.
- Selected tests routinely performed in a physician’s office during an office visit. (See Resources/Forms section)
- The collection of laboratory specimens.
- Voluntary family planning services such as examinations, counseling, and pregnancy testing.
- Referral to specialty care physicians and other health providers/practitioners with coordination of care, follow-up after referral and oversight of Member’s entire drug regimen.
- PCP’s supervision of home care and home infusion regimens involving ancillary health professionals provided by licensed nursing agencies.
• Any other outpatient services and routine office supplies normally within the scope of the PCP’s practice (PA may apply).
• Health Risk Assessment and measurement of biometrics.
• PCP’s supervision of home care and home infusion regimens involving ancillary health professionals provided by licensed nursing agencies. These services are subject to Prior Authorization by the Plan by calling 1-800-580-8736.
• Any other outpatient services and routine office supplies normally within the scope of the PCP’s practice (PA may apply).
• Well-child exams performed according to the recommendations of the American Academy of Pediatrics (AAP), and immunizations according to the Advisory Committee on Immunization Practices (ACIP) guidelines, and in keeping with procedures outlined in this Provider/Practitioner Manual.
• A care plan developed collaboratively with Consumers’ Choice, the Member and the specialist, as appropriate, for all Members who need an extended or complex course of treatment or regular care monitoring.
• Certain professional services performed and interpreted by specialists such as nerve conduction velocities, radio-isotope studies, electromyography studies and other technical procedures are not covered PCP services when they require specialist interpretations and recommendations for optimal outcomes.
• eDoc4u
  ✓ NCQA Certified Health Risk Assessment
  ✓ Wellness Programs
  ✓ Health Education Materials and Tools

**CLINICAL PRACTICE GUIDELINES**

The organization adopts evidence-based preventive health guidelines for perinatal care, care for children up to 24 months old, care for children 2–19 years old, care for adults 20–64 years old, and care for adults 65 years and older by establishing the scientific basis for the guidelines. The established clinical guides that have been adopted and approved by the Provider Advisory Committee include those listed below. These guidelines will be reviewed and updated at a minimum of every two (2) years. These guidelines will be updated in the Provider/Practitioner Manual and the physicians will be notified that there is a change in the Provider/Practitioner Manual. If the practitioner does not have access to the Internet, the practitioner may call 1-800-580-8736 and request a hard copy be delivered by mail. For more information visit: http://www.ccchpsc.org/providers/useful-documents/clinical-practice-guidelines/.
Consumers’ Choice has currently adopted the following clinical practice guidelines:

**Diabetes**


**Coronary Artery Disease**

- AHA/ACCF Guidelines for Secondary Prevention for Patients with Coronary and Other Atherosclerotic Vascular Disease: 2011 Update. Endorsed by the National Heart, Lung, and Blood Institute. Sidney C. Smith Jr, MD; Jerilyn Allen, RN, ScD; Steven N. Blair, PED; Robert O. Bonow, MD; Lawrence M. Brass, MD; Gregg C. Fonarow, MD; Scott M. Grundy, MD, PhD; Loren Hiratzka, MD; Daniel Jones, MD; Harlan M. Krumholz, MD; Lori Mosca, MD, PhD, MPH; Richard C. Pasternak, MD; Thomas Pearson, MD, MPH, PhD; Marc A. Pfeffer, MD, PhD; Kathryn A. Taubert, PhD. Circulation 2011; 58(23):2432-2446.

**Depression**

- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorders. JAACAP. 2007;46(11):1503-1526

**Attention-Deficit/Hyperactivity Disorder**

- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorders. JAACAP. 2007;46(11):1503-1526
Preventive Health Guidelines

- The ACOG Guidelines for Perinatal Care, 2013 seventh edition Editors Laura E. Riley, MD, FACOG and Ann R. Stark, MD, FAAP.

Consumers’ Choice uses adopted clinical practice guidelines as the clinical basis for its disease management programs. The content for the Consumers’ Choice Diabetes Disease Management Program and Coronary Artery Disease Management Program are based on the American Diabetes Association Standards of Medical Care in Diabetes--2012 and the AHA/ACC Guidelines for Secondary Prevention for Patients with Coronary and Other Atherosclerotic Vascular Disease: 2006 Update endorsed by the National Heart, Lung, and Blood Institute, respectively.

The Plan will collate information from pharmacy claims and specialist notification to support evidence that patients are complying with recommended treatments, and specialists are responsive to PCPs. Extra payments may be awarded for exceptional achievement of disease control compared to peers. This program targets Consumers’ Choice Members who have been diagnosed and treated for diabetes mellitus. Members are then stratified based on the severity of their illness so that interventions can be targeted to the appropriate population. Through this program, Consumers’ Choice Members can receive additional education, case management, and support from the medical management team to enhance positive clinical outcomes. Practitioners are to refer Members to the Disease Management programs by calling 1-800-580-8736.

PCP AVAILABILITY

Availability is defined as the extent to which Consumers’ Choice contracts with the appropriate type and number of PCPs necessary to meet the needs of its Members within defined geographical areas. PCP availability is analyzed annually by the Consumers’ Choice Provider Relations Department. Availability includes but is not limited to the number of practitioners open for new Members, number of Member complaints regarding access, and other data such as appointment availability. Availability will be routinely monitored to determine the need for increasing the Consumers’ Choice practitioner network capacity.
PCP ACCESSIBILITY

Accessibility is the extent to which a Member can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment, if applicable. Consumers’ Choice monitors access to services by performing access audits, tracking applicable results of the Healthcare Effectiveness Data and Information Set/Consumer Assessment of Health Plans Survey (HEDIS/CAHPS), and analyzing Member complaints regarding access, and reviewing telephone access.

24-HOUR ACCESS

Each PCP is responsible to maintain sufficient facilities and personnel to provide covered physician services and shall ensure that such services are available as needed 24 hours a day, 365 days a year. PCPs must provide Members with an after-hours telephone number. The after-hours number must connect the Member to an answering service, a call center system, a recording that directs the caller to another number to reach the PCP or PCP authorized medical practitioner, or a system that automatically transfers the call to another telephone line that is answered by a person who will contact the PCP or PCP authorized medical practitioner.

A hospital may be used for the 24-hour telephone coverage requirement if the 24-hour access is not answered by the emergency department staff. The PCP must establish a communication and reporting system with the hospital and the PCP must review the results of all hospital authorized services.

Consumers’ Choice will monitor physicians’ offices through scheduled and unscheduled visits and call coverage verification through our Provider Relations staff.

CPT codes 99050 and 99051 will be reimbursed upon provider request (after hours coverage for services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service.

PCP TRANSFERS

In order to maintain continuity of care, Consumers’ Choice encourages Members to build collaborative relationships with their PCP. Members may request to change their PCP at any time by notifying our Customer Services Department at 1-800-580-8736 or by completing the PCP Change Request located on our website (www.cchpsc.org) in the Member Section. PCP change requests will be processed generally on the same business day or by the next business day.

If a practitioner's contract is discontinued, the organization allows affected Members continued access to the practitioner, as follows:

- Continuation of treatment through 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.
- Continuation of care through the postpartum period for Members in their second or third trimester of pregnancy.
PCP COVERAGE

In absence of the PCP, the PCP shall arrange for coverage with another participating physician who is licensed and qualified to perform necessary medical services for Consumers’ Choice Members.

APPOINTMENT ACCESS STANDARDS

The following schedule should be followed regarding appointment availability:

- **Routine visits** should be scheduled within four (4) to six (6) weeks
- **Urgent non-emergent** visits should be scheduled within 48 hours
- **Urgent or emergency** visits should be performed immediately upon presentation at the delivery site
- **Follow-up** on emergency care should be scheduled within 14 days

OFFICE WAIT TIMES

PCPs must adhere to the following standards for office wait times:

- Waiting times should not exceed 45 minutes for scheduled appointment of a routine nature.
- Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.
- Walk-in patients with urgent needs should be seen immediately.

TELEPHONE ARRANGEMENTS

PCPs are required to develop and use telephone protocol for all of the following situations:

- Answering the Members’ telephone inquiries on a timely basis.
  - Response time for telephone call-back waiting times:
    - After hours telephone care for non-emergent, symptomatic issues within one (1) hour
    - Same day for non-symptomatic concerns
- Crisis situations should be directed to the nearest emergency room
- Prioritizing appointments.
- Scheduling a series of appointments and follow-up appointments as needed by a Member.
- Identifying and rescheduling broken and no-show appointments. Members that continually do not show for scheduled appointments should be referred to Consumers’ Choice via the website or through the Provider Relations Manager to address the issue.
- Identifying special Member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, or for non-compliant Members or those Members with cognitive impairments). Noncompliance is defined as a Member with repeated documented refusal to adhere to medically sound recommendations for improving their health without explanation.
• Scheduling continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours; protocols shall be in place to provide coverage in the event of a PCP’s absence.
• After-hour calls should be documented in a written format in either an after-hour call log (or some other satisfactory method) and then transferred to the Member’s medical record.
• Notify Members within 2 business days of receipt their test results.

**Note:** If after-hour urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care center or emergency department in order to notify the facility.

✓ *Consumers’ Choice* will monitor appointment and after-hours availability on an ongoing basis through its QI Program. The process for measurement may include Member surveys, monitoring patient complaints, and the provider office site tool documentation. In addition, the Health Plan periodically verifies appointment access standards are maintained using valid methodology to collect and perform an annual analysis of data to measure performance against standards for access to regular and routine care appointments, urgent care appointments, after-hour care, and customer service by telephone.

**OTHER PROVIDER RESPONSIBILITIES**

• Educate Members on how to maintain healthy lifestyles and prevent serious illness.
• Provide culturally competent care.
• Provide follow-up on emergency care within 14 days.
• Maintain confidentiality by using safeguards to guard information, such as internal protections of oral, written, and electronic information, protections for physical facility access, protections for electronic access, controls on media and devices, and physical safeguards for workstations;
• Obtain authorizations for all inpatient and selected outpatient services as listed on the current PA List, except for emergency services up to the point of stabilization.
• Comply with the *Consumers’ Choice* request for medical records as referenced in the Quality Improvement and Utilization Management Policies.
• Cooperation with QI activities, such as providing access to medical records for HEDIS data collection and quality of care investigations, cooperation in implementing health initiatives to improve the quality of care and service member experience, participation in the collection and evaluation of health plan quality programs when appropriate, allowing the Plan to use practitioner data, and participation in *Consumers’ Choice* quality improvement programs.

*Consumers’ Choice* PCPs should refer to their contract for complete information regarding their PCP obligations and reimbursement.
SPECIALIST RESPONSIBILITIES

The specialist may order diagnostic tests consistent with answering the reasons for referral by the patient’s primary care physician. The specialist must abide by the prior authorization requirements when ordering diagnostic tests. All non-emergency inpatient admissions require notification to Consumers’ Choice and the PCP to ensure continuity of care and the Medical Management Criteria for admissions.

The specialist practitioner must:

- Maintain contact with the PCP.
- Obtain authorization, if non-participating, through the Utilization Management Department by contacting 1-800-580-8736 before providing services in order to be compensated for their services by Consumers’ Choice.
- Coordinate the Member’s care with the PCP.
- Inform the Member (and/or the Member’s next of kin if the Member is incapacitated) of the specialist’s findings and recommendations.
- Provide the PCP with findings and recommendations, and other appropriate records within five (5) business days of providing care.
- Be available for, or provide on-call coverage through another source 24 hours a day for management of Member care, and to answer questions from the attending PCP and patient or designated family Member.
- Maintain the confidentiality of medical information and adhere to HIPAA Policies and Procedures.
- Notify Members within two (2) business days of their test results.

Specialists may be identified as the managing physician under certain circumstances designated by the PCP for specific diagnosis(s) for certain patients. Consumers’ Choice providers/practitioners should refer to their contract for complete information regarding providers’/practitioners’ obligations and mode of reimbursement.

HOSPITAL RESPONSIBILITIES

Consumers’ Choice utilizes a network of hospitals to provide services to its Members.

Hospitals must:

- Notify the PCP immediately or within 24 hours after the Member’s attendance in the Emergency Department.
- Obtain authorization for all inpatient and selected outpatient services from Consumers’ Choice as listed on the current PA List, except for emergency stabilization services.
- Notify the *Consumers’ Choice* Medical Management Department of all maternity admits upon admission and all other admissions by close of the second business day.
- Notify the *Consumers’ Choice* Medical Management Department of all newborns by the next business day.
- Maintain confidentiality by using safeguards to guard information such as internal protections of oral, written, and electronic information, protections for physical facility access, protections for electronic access, controls on media and devices, and physical safeguards for workstations;
- Cooperation in providing access to medical records for HEDIS data collection and quality of care investigations, cooperation in implementing health initiatives to improve the quality of care and service member experience, participation in the collection and evaluation of health plan quality programs when appropriate, allowing the Plan to use their performance data, and participation in *Consumers’ Choice* quality improvement programs.

Hospitals contracted with *Consumers’ Choice* should refer to their contract for complete information regarding the hospitals’ obligations and reimbursement. See also “Medical Management” and “Prior Authorization” below.

**ONSITE QUALITY ASSESSMENTS**

If an organizational practitioner has not been reviewed and accredited by an acceptable accrediting body, the Plan will conduct an onsite quality assessment which includes a process for insuring that the organizational provider credentials its practitioners. The organizational provider must achieve a passing score of 80%.

A CMS or state review may be substituted in lieu of the required on-site assessment, if the review is not greater than three (3) years old at the time of the credentialing decision. The organizational provider must provide the report to verify that the review has been performed and the report must meet *Consumers’ Choice* standards. A letter from CMS or the applicable state agency which shows that the organizational provider was reviewed and indicates that it passed inspection is acceptable in lieu of the survey report, if *Consumers’ Choice* reviewed and approved CMS or state criteria as meeting *Consumers’ Choice* standards.

Site visits of unaccredited organizational providers are not required if:

- The state or CMS has not conducted a site review of the provider, AND
- The organizational provider is in a rural area, as defined by the U.S. Census Bureau. (Rural areas are defined as open country and settlements with fewer than 2,500 residents.)
CRITERIA AND THRESHOLDS FOR CREDENTIALING FILE REVIEW

Consumers’ Choice has established and uses criteria to assign each practitioner to a category that indicates whether or not the practitioner meets all participation criteria for initial or continued participation in the Consumers’ Choice network, or if significant findings were discovered during the credentialing process.

ADVANCE DIRECTIVES

Consumers’ Choice is committed to ensure that its Members know of, and are able to avail themselves of, their rights to execute advance directives. Consumers’ Choice is equally committed to ensuring that its PCPs and staff are aware of and comply with their responsibilities under federal and state law regarding advance directives.

PCPs delivering care to Consumers’ Choice Members must ensure adult Members 18 years of age and older receive information on advance directives and are informed of their right to execute advance directives. PCPs must document such information in the permanent medical record.

Consumers’ Choice recommends to its PCPs that:

- The first point of contact for the Member in the PCP’s office should ask if the Member has executed an advance directive; the Member’s response should be documented in the medical record.
- If the Member is unable to execute an advance directive and has a surrogate decision maker, documentation should include that the advance care plan was discussed with the surrogate decision maker. The surrogate decision maker’s response should be documented in the medical record.
- If the Member has executed an advance directive, the first point of contact should ask the Member to bring a copy of the advance directive to the PCP’s office and document this request in the Member’s medical record.
- An advance directive should be included as a part of the Member’s medical record
- If an advance directive exists, the physician should discuss potential medical emergencies with the Member and/or designated family Member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. Discussion should be documented in the medical record.
- If an advance directive has not been executed, the first point of contact within the office should ask the Member if they desire more information about advance directives.
- If the Member requests further information, Member advance directive education/information should be provided.
• Customer Service representatives will assist Members with questions regarding advance directives; however, no employee of Consumers’ Choice may serve as witness to an advance directive, or as a Member’s designated agent or representative.

The Consumers’ Choice QI Department will monitor compliance with this provision during medical record review.

CULTURAL COMPETENCY

Consumers’ Choice is committed to the development, strengthening and sustaining of healthy PCP/Member relationships. Members are entitled to dignified, appropriate and quality care. When healthcare services are delivered without regard for cultural differences, Members are at risk for suboptimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

Network practitioners must ensure the following:

• Members understand that they have access to medical interpreters, signers, and teletypewriter (TTY) services to facilitate communication without cost to the Member.
• Care is provided with consideration of the Members’ race/ethnicity and language and its impact/influence of the Members’ health or illness.
• Office staff that routinely come in contact with Members has access to and participate in cultural competency training and development.
• Office staff responsible for data collection makes reasonable attempts to collect race and language specific Member information. Staff will also explain race/ethnicity categories to a Member so that the Member is able to identify the race/ethnicity of themselves and their children.
• Treatment plans are developed and clinical guidelines are followed with consideration of the Members’ race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process.

Consumers’ Choice does recognize that there may be instances when a PCP may need help in managing non-adherent Members. If you should have an issue with a Member regarding a Members behavior,

NON-COMPLIANT MEMBERS

Member being disruptive, unruly, threatening, or uncooperative to the extent that the Member seriously impairs the provider’s ability to provide services to the Member or to other Members and the Member’s behavior is not caused by a physical or behavioral condition cooperation with treatment
and/or completion of treatment, and or making or presenting for appointments, please contact our Customer Services Department at 1-800-580-8736.

Other issues may include repeated documented refusal to adhere to medically sound recommendations for improving the Member’s health without explanation that threatens their health. See Member’s Rights and Responsibilities.

A PCP may request a Member be transferred to another practice for any of the following reasons:

- Repeated disregard of medical advice
- Repeated disregard of Member responsibilities
- Personality conflicts between physician and/or staff with Member

All requests to remove a Member from a panel must be made in writing, contain detailed documentation and must be directed to:

HealthSCOPE Benefits  
P.O. Box 91606  
Lubbock, TX 79490-1606

Upon receipt of such request, the Customer Service Manager may:

- Interview the provider or their staff that are requesting the disenrollment, as well as any additional relevant providers
- Interview the Member
- Review any relevant medical records
- Involve other Consumers’ Choice departments as appropriate to resolve the issue

A PCP should never request a Member be disenrolled for any of the following reasons:

- Adverse change in the Members health status or utilization of services which are medically necessary for the treatment of a Member’s condition
- On the basis of the Member’s race, color, national origin, sex, age, disability, political beliefs or religion
- Previous inability to pay medical bills or previous outstanding account balances prior to the Member’s enrollment with Consumers’ Choice.

MEDICAL RECORDS

Consumers’ Choice providers/practitioners keep accurate and complete medical records. To ensure the Member’s privacy, medical records should be kept in a secure location and adhere to HIPAA Policies and Procedures.
Consumers’ Choice requires PCPs to maintain all records for Members and time frames specific for adult patients and for minors per state law http://www.magmutual.com/risk/FAQ-answer1.html#SC. See the Member Rights section of this manual for policies on Member access to medical records.

REQUIRED MEDICAL RECORD INFORMATION

Comprehensive Member records include, but are not limited to, diagnostic images and interpretation reports, laboratory test results, examinations and notes, accessible at the site of the Member’s participating PCP, that document all medical services received by the Member, including inpatient, ambulatory, ancillary, and emergency care, signed by the medical professional rendering the services. Ancillary documents should include HIPAA compliant forms and documentation related to Advance Directives that meet the State requirements.

PCPs must maintain complete medical records for Members in accordance with the following standards:

- Member’s name, and/or medical record number on all chart pages;
- Personal, biographical data is present (i.e. address, employer, home/work telephone number, email address and fax number, preferred means for contact and related information, spouse, next of kin, responsible party, cultural/linguistic needs, physical impairments, date of birth, etc.);
- All entries must be legible and dated;
- All entries author identification, which may be a handwritten signature, unique electronic identifier or initials;
- Significant illnesses and/or medical conditions are documented on the problem list;
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented. Medication List should include instructions to the Members regarding dosage, initial date of prescription, number of refills and preferred pharmacy information;
- An up-to-date immunization record is established for pediatric Members or an appropriate history is documented in adult Members’ charts;
- Evidence that preventive screening and services are offered in accordance with evidence based practice guidelines;
- Appropriate subjective and objective information pertinent to the Member’s presenting complaints is documented in the history and physical;
- Past medical history (for Members seen three (3) or more times) is easily identified and includes any serious accidents, operations and/or illness, discharge summaries, and ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses, and a complete History and Physical (H&P)
- Working diagnosis is consistent with findings;
- Treatment plan is appropriate for diagnosis;
- Documented treatment prescribed, therapy prescribed and drug(s) administered or dispensed;
• Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns;
• Signed and dated required consent forms;
• Unresolved problems from previous visits are addressed in subsequent visits;
• Laboratory and other studies ordered as appropriate;
• Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the PCP to signify review;
• Referrals to specialists and ancillary providers/practitioners are documented including follow up of outcomes and summaries of treatment rendered elsewhere;
• Health teaching and/or counseling is documented especially related to high health risk conditions, mental health disorders, and including other chronic conditions such as obesity and tobacco use;
• For Members ten (10) years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for Members seen three (3) or more times), a substance abuse history should be queried;
• Documentation of failure to keep an appointment;
• Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed;
• Evidence that the Member is not placed at inappropriate risk by a diagnostic or therapeutic problem;
• Confidentiality of Member information and records protected;
• Evidence that an Advance Directive has been offered to adults 18 years of age and older

MEDICAL RECORDS RELEASE

All Member medical records shall be confidential and providers/practitioners must meet State law and Federal HIPAA regulations. Release of medical records shall also meet State law and Federal HIPAA regulations and the extent of the release should be based upon medical necessity or on a need to know basis.

MEDICAL RECORDS AUDITS

Medical records may be audited annually at the request of Consumers' Choice as referenced in the Quality Improvement Program Description and Utilization Management Policies to include but not limited to determining compliance with standards for documentation, quality measures, HEDIS measures, and risk adjustment. Also to validate coordination of care and services provided to Members, including over/under utilization of specialists; ensure providers/practitioners are following National and State coding guidelines; as well as the outcome of such services may be assessed during a medical record audit.
MEDICAL MANAGEMENT

OVERVIEW AND MEDICAL NECESSITY

Medical Necessity:
Medically necessary services are generally accepted by the medical community provided in light of conditions present at the time of treatment. These services are reviewed by a physician or other health care professional, as appropriate. These services are:

- Essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity of a Member;
- Provided at an appropriate facility and at the appropriate level of care for the treatment of Member's medical condition; and
- Provided in accordance with generally accepted standards of medical practice. See previously stated adopted clinical practice guidelines listed under PCP Availability.
- Consistent with medical benefits defined by the organization, including hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits.
- Consistent with decisions about pre-existing conditions when the Member has creditable coverage (i.e. history of prior health coverage) or denial based on the policy to deny pre-existing care or services.
- Consistent with care or services that could be considered either covered or non-covered, depending on the circumstances, including decisions on requests for care that may be considered experimental.
- Consistent with denials for behavioral healthcare based on non-covered services.
- Consistent with pharmacy-related denials including step-therapy or prior authorization cases.
- Consistent with decisions about dental procedures that are covered under the Member’s medical benefits. If dental and medical benefits are not differentiated in the organization’s benefits plan, the organization must identify the services or care as if there is differentiation. This means identifying only care or services associated with medically necessary medical or surgical procedures that occur within or adjacent to the oral cavity or sinuses.

Medical Necessity and Benefit Determinations:
A benefit determination is a denial of a requested service that is specifically excluded from a Member’s benefit plan. Benefit determinations include the following:

- Services that are limited by number, duration or frequency in the Member’s benefit plan.
- Denials for extension of treatments beyond the specific limitations and restrictions imposed in the Member’s benefit plan.
- Decisions about care are not dependent upon a Member’s medical need or a practitioner's order.
• UM decision making is based only on appropriateness of care and service and existence of coverage.
• The organization does not specifically reward practitioners or other individuals for issuing denials of coverage.
• Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

There must be no other effective and more conservative or substantially less costly treatment, service and setting available. Consumers’ Choice does not cover experimental, investigational or cosmetic procedures for which insufficient evidence exists to provide reasonable assurance of safety and effectiveness. A medical necessity review of such requests will be performed unless the requested service or procedure is specifically listed as excluded in the Member’s benefit plan.

**NOTIFICATION/PRIOR AUTHORIZATION**

Prior Authorizations are required for certain services/procedures/diagnostic tests that are frequently over or under-utilized, that are costly services, or which could indicate a need for case management. See the list below.

**Standard Service Authorization** – Prior Authorization decisions for non-urgent services shall be made within 14 calendar days of receipt of the request for services. An extension may be granted for an additional 7 calendar days if the Member or the practitioner requests an extension.

**Expedited Service Authorization** – In the event the practitioner indicates, or Consumers’ Choice determines, that following the standard timeframe could seriously jeopardize the Member’s life or health, Consumers’ Choice will make an expedited authorization determination and provide notice within 72 hours of receiving the request. Consumers’ Choice may extend the 72 hour time period for up to 7 calendar days if the Member or the practitioner requests an extension. All such requests must be indicated as URGENT and called in to the Utilization Management department at 1-800-580-8736.

The Consumers’ Choice Utilization Management Department may be contacted at:

**Utilization Management (UM) Department**  
Phone: 1-800-580-8736  
Consumers’ Choice Website: [www.cchpsc.org](http://www.cchpsc.org)

Information necessary for notification/authorization may include but is not limited to:

• Member’s name, ID number, DOB, Social Security Number, Demographics;
• Physician’s name and telephone number;
• Hospital or Facility name, if the request is for an inpatient admission or outpatient services;
• Reason for admission – primary and secondary diagnoses, surgical procedures, surgery date;
• Relevant clinical information – past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed;
• Admission date or proposed surgery date, if the request is for an inpatient admission;
• Anticipated length of stay, if the request is for an inpatient admission;
• Discharge plans, if the notice/request is for an inpatient admission;
• For obstetrical (OB) admissions, the date and method of delivery, estimated date of confinement, and information related to the newborn or neonate.

If more information is required, the caller will be notified of the specific information needed to complete the notification/authorization process.

Utilization Management decisions are based only on appropriateness of care and service, and the existence of coverage. Consumers’ Choice does not reward practitioners or other individuals for issuing denials of coverage or care.

Practitioners can obtain a copy of the clinical criteria specific to their appeal by calling the Utilization Management department. Criteria will be provided electronically or delivered by mail. The clinical criteria is represented by a vendor and approved by the Provider Advisory Committee. The complete copyrighted clinical criteria document is not available for general distribution per the contractual agreement with the vendor.

The organization provides the following services for Members and practitioners who have questions related to Utilization Management:

1. **Staff** is available from 8 am to 5 pm Monday through Friday for inbound collect or toll-free calls regarding UM issues.

2. **Providers** may leave telephonic messages for staff after hours, which will be retrieved the next business day. After hours staff is available to accept expedited appeals, where normal processing time would put the member’s health in jeopardy.

3. **Staff** identifies themselves by name, title and organization name when initiating or returning calls regarding UM issues.

4. If members need help to understanding their benefits, they may call Customer Service or logon to our website. Information can be provided in another language. Members with hearing loss can use their TTY machine, dial 711, or call 800-545-8279 directly.

**Failure to provide notification/obtain authorization may result in payment denials. Please refer to the appeals section.**
LIST OF SERVICES REQUIRING PRIOR AUTHORIZATION

In order to determine benefits coverage and assure medical necessity, physicians and facilities are urged to seek Prior Authorization for the following services: all inpatient admissions, non-participating practitioners, and out-of-state care, except for emergency care.

Inpatient Authorizations:

- All non-emergent, non-urgent elective or scheduled inpatient admissions require the attending physician’s office to obtain authorization from the Health Plan’s Utilization Management (UM) department via phone or fax prior to the admission date.
  - This requirement includes admission to any level of acute or sub-acute care, including long term care facilities at the skilled or intermediate level of care, and rehabilitation admissions. This requirement also includes different levels of care within, in or between facilities (i.e. transfer from acute to rehab or transfer to a different facility);
  - Pre and Post-Transplant admissions
- All emergent or urgent inpatient admissions:
  - Hospital must notify the Utilization Management Department within two (2) business day after the date of admission. Clinical admission information must be provided.
  - Notification of newborn deliveries must be received next business day following delivery.
- Services at an non-participating or out-of-network or out of state facility, vendor or practitioner (excludes emergency care) must be authorized
- Emergency admissions must be reported within 1 business day.

Consumers’ Choice requires clinical updates throughout every admission to ensure appropriate discharge planning and determine continued medical necessity and level of care for reimbursements.

Outpatient Authorizations:

Services

- All out-of-network services
- Air Ambulance (reviewed retrospectively)
- Cardiac Rehab
- Chiropractic services in excess of 10 visits
- Home Health after 3rd visit
- Hospice
- Pulmonary Rehab
- Rehabilitative Therapy (PT/OT/ST after 10th visit; benefit limit 20 visits per discipline)
- Injectables/Infusions over $1000 billed charges (per line)
Outpatient Procedures

All out-of-network services
Abortion
Chemotherapy in MD office or Infusion Center
Cosmetic Procedures
Dental/Oral Surgery requiring general anesthesia
Genetic Testing
Hyperbaric Oxygen Therapy
Hysterectomy
Implantable devices, including cochlear implants
Mastopexy for gynecomastia
Mammoplasty
OB ultrasounds in excess of 3 per pregnancy
Orthognathic Surgery
Nuclear Cardiology Stress Tests
Pain Management
Panniculectomy
Penile Prosthesis
Spinal Procedures
Treatment at infusion centers
Treatment of TMJ (except for initial evaluation)

Durable Medical Equipment

DME over $500, including prosthetics, orthotics (unless provided in a participating physician’s office with a billed amount less than $500)
All rented durable medical equipment
All wheelchair parts (manual and power)
Enteral nutritional supplements and supplies
Insulin pumps
Orthopedic footwear, shoe modifications and additions when costs exceed $300

High Tech Imaging: Contact MedSolutions at 855-414-2345

MRI
MRA
MRT
PET
SPECT
CT
CTA
Sleep Studies
Proton Beam Therapy
Transplant Related Services

Practitioners should contact the Consumers’ Choice Case Management Department for assistance with all potential or impending transplant cases. Call 1-800-580-8736 for case management assistance. Transplant services may not be reimbursed unless coordinated by the Consumers’ Choice case manager.

The following services require coordination with the Consumers’ Choice case manager:

- All organ, bone and tissue transplants
- Pre-transplant services rendered in excess of 72 hours prior to the event
- Post-transplant follow-up services
- Post-transplant pharmaceutical services

For a complete list of services requiring prior authorization, please visit www.cchpsc.org.

NOTIFICATION OF PREGNANCY

Submit completed Notification of Pregnancy Form for expectant mothers within five (5) days of first prenatal visit. Assist expectant mother to complete a Pre-birth Selection Form (see Resources/ Forms section) for her newborn/soon to be born baby. This form allows the mother to pre-select a doctor for her baby and may be found on line at www.cchpsc.org under the Practitioner resource tab.

Practitioners will also be expected to identify the estimated date of confinement and delivery facility.

INPATIENT NOTIFICATION PROCESS

Inpatient facilities are required to notify Consumers’ Choice for emergent and urgent admissions including maternity deliveries within two (2) business days following the admission. The notification process includes maternity admissions and post stabilization. Notification is required to track inpatient utilization, enable care coordination, discharge planning, and ensure timely claim payment. To provide notification and when applicable obtain prior authorization, please contact the Consumers’ Choice Medical Management Department.

Medical Management/Authorization and Referral Department

Telephone: 1-800-580-8736
Consumers’ Choice Website: www.cchpsc.org
CONCURRENT REVIEW

The Consumers’ Choice Medical Management Department performs concurrent review for inpatient confinements via the hospital’s Utilization Review and Discharge Planning Departments and when necessary, the Member’s attending physician. PCP agrees to collaborate with Consumers’ Choice concurrent review staff regarding discharge planning. Concurrent reviews will include evaluation of the Member’s current status, proposed care plan, discharge plans, and any subsequent diagnostic testing or procedures. All clinical information requested to evaluate the member’s status and support the medical necessity of continued care must be received by the date/time indicated from the concurrent review nurse. Failure of providers to cooperate in Concurrent Review could result in a denial due to Consumers’ Choice being unable to determine medical necessity.

The Consumers’ Choice Medical Management Department may contact the Member’s admitting physician’s office or PCP’s office prior to the discharge date established during the authorization process to check on the Member’s progress and to make certain the Member receives medically necessary transition care and follow up services.

DISCHARGE PLANNING

Discharge planning activities are expected to begin upon admission. The Consumers’ Choice Medical Management Department will coordinate the discharge planning efforts with the hospital’s Utilization Review and Discharge Planning Departments and when necessary the Member’s attending physician/PCP in order to ensure that Consumers’ Choice Members receive appropriate post-acute care upon discharge.

PCP agrees to collaborate with the Consumers’ Choice Concurrent Review Nurse coordinating discharge planning efforts with the hospital staff to ensure timely and effective transition along the continuum of care for Members. Proactive, effective discharge planning is essential to prevent unnecessary inpatient confinement which will result in denial.

RETROSPECTIVE REVIEW

Retrospective Review is a post-care review of services provided to the Member and may be performed routinely and/or for a specific episode of care/services. It may also be performed when there was no opportunity for concurrent review, e.g. retro eligibility and when a Member or family Member is medically unable to provide their insurance information upon admission.
OBSERVATION BED GUIDELINES

In the event that a Member’s clinical symptoms do not meet the criteria for an inpatient admission, but the treating physician believes that allowing the Member to leave the hospital would likely put the Member at serious risk, the Member may be admitted to the facility for an (48) forty-eight hour observation period. Observation Bed Services are those services furnished on a hospital’s premises, including use of a bed and periodic monitoring by a hospital’s nurse or other staff. These services are reasonable and necessary to:

- Evaluate an acutely ill Member’s condition
- Determine the need for a possible inpatient hospital admission
- Provide aggressive treatment for an acute condition

An observation may last up to a maximum of forty-eight (48) hours. In those instances that a Member begins their hospitalization in an observation status and the Member is changed to an inpatient admission, all observation charges and services will be rolled into the acute reimbursement rate and cannot be billed separately. It is the responsibility of the hospital to notify Consumers’ Choice of the inpatient admission. Providers should not substitute outpatient observation services for medically appropriate inpatient hospital admissions.

UTILIZATION MANAGEMENT CRITERIA

Consumers’ Choice has adopted utilization review criteria developed by mcg™ (formerly Milliman). The criteria are developed by specialists representing a national panel from community-based and academic practices. Criteria are established and periodically evaluated and updated with appropriate involvement from physician Members of the Consumers’ Choice Utilization Management Committee. The criteria are utilized as a screening guide and are not intended to be a substitute for practitioner judgment. Utilization review decisions are made in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. Criteria are used for the approval of medical necessity but not for the denial of services. The Medical Director reviews all service requests that may result in a denial of medical necessity.

Practitioners may obtain the criteria used to make a specific decision by contacting the Medical Management Department at 1-800-580-8736. Practitioners also have the opportunity to discuss any medical UM denial decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. The Consumers’ Choice Medical Director may be contacted by calling the Plan’s main toll-free phone number and asking for the Medical Director. A Plan case manager may also coordinate communication between the Medical Director and the requesting practitioner.
Members, a Member’s representative or healthcare professional with Member’s consent may request an appeal related to a medical necessity decision made during the authorization, pre-certification or concurrent review process orally or in writing to:

Consumers’ Choice  
Attention: Appeals  
PO Box 80486  
Charleston, SC 29416

SECOND OPINION

Members, a Member's representative or healthcare professional with Member’s consent may request and receive a second opinion from a qualified professional within the Consumers’ Choice network. If there is not an appropriate practitioner to render the second opinion within the network, the Member may obtain the second opinion from an out-of-network practitioner at in-network cost to the Member. All out-of-network practitioners and select in-network practitioners, dependent on practitioner type, (see current PA list) will require PA.

ASSISTANT SURGEON

Reimbursement is provided to Assistant surgeons when medically necessary. Consumers’ Choice utilizes guidelines for Assistant surgeons as set forth by the American College of Surgeons.

Hospital medical staff by-laws that require an Assistant Surgeon to be present for a designated procedure are not grounds for reimbursement. Medical staff by-laws alone do not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests an Assistant Surgeon be present for the surgery. Coverage and subsequent reimbursement for an Assistant Surgeon’s service is based on the medical necessity of the procedure itself and the Assistant Surgeon’s presence at the time of the procedure.

CASE MANAGEMENT SERVICES

Medical case management is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services to meet an individual’s health needs, using communication and available resources to promote quality, cost effective outcomes. Care coordination/management is a Member-centered, goal-oriented, culturally relevant and logically managed process to help ensure that a Member receives needed services in a supportive, effective, efficient, timely and cost-effective manner.
A Consumers’ Choice case manager supports the physician by tracking compliance with the case management plan, and facilitating communication between the PCP, Member, managing physician, and the case management team. The case manager also facilitates referrals and links to community providers, such as local health departments and school-based clinics. The managing physician maintains responsibility for the patient’s ongoing care needs. The Consumers’ Choice case manager will contact the PCP and/or managing physician if the Member is not following the plan of care or requires additional services.

Consumers’ Choice will provide individual case management services for Members who have high-risk, high-cost, complex or catastrophic conditions. The Consumers’ Choice case manager will work with all involved practitioners to coordinate care, provide referral assistance and other care coordination as required. The Consumers’ Choice case manager may also assist with a Member’s transition to other care, as indicated, when Consumers’ Choice benefits end.

**CASE MANAGEMENT PROCESS**

Consumers’ Choice will work with the Member’s PCP and attending specialists to coordinate case management services. Case Management services are defined as those services necessary to coordinate an optimum life style for the Member population. The services include monitoring the patient’s needs and referring them to providers/practitioners for medical, educational, legal and rehabilitative services, with documented follow-up, and assisting with self-sufficiency of the Member and act as a deterrent to institutional care by facilitating service delivery. No counseling services will be delivered by the case manager.

Consumers’ Choice case management for high-risk, complex or catastrophic conditions contains but is not limited to the following key elements:

- Screen and identify Members who potentially meet the criteria for high risk case management
- Assess the Member’s risk factors to determine the need for case management
- Obtain acceptance from the Member to participate in case management
- Notify the Member’s PCP of the Member’s enrollment in the Consumers’ Choice case management program
- Develop and implement a treatment plan in collaboration with the patient’s PCP that accommodates the specific cultural and linguistic needs of the Member
- Establish treatment objectives and monitoring of outcomes
- Refer and assist the Member in ensuring timely access to practitioners
- Coordinate medical, residential, social and other support services
- Monitor care/services and periodically update the PCP on progress and status changes
- Revise the treatment plan as necessary in conjunction with the PCP
- Track plan outcomes and report to the PCP
Follow-up post discharge from case management and record and report the case summary to the PCP.

Work with Members who have a positive PHQ9.

Work with Members who are deemed noncompliant by their PCP by providing education as needed and assisting in removing barriers to care.

Case Management objectives can be met through the following:

- Distributing information to Members to improve their knowledge about clinical safety in their own care.
- Collaborating with network providers and practitioners.
- Focusing on existing quality improvement activities on improving patient safety.
- Distributing information to Members that facilitates informed decisions based on safety

**CHRONIC AND COMPLEX CONDITIONS**

*Consumers’ Choice* provides individual case management services for Members who have chronic, complex, high-risk, high-cost or other catastrophic conditions. Members with special healthcare needs are included in the chronic and complex case management-care coordination program. The *Consumers’ Choice* case manager will work with all involved practitioners to coordinate care, provide referral assistance, and other support as required. *Consumers’ Choice* also uses disease management programs and associated practice guidelines and protocols for Members with chronic conditions, including conditions such as coronary artery disease and diabetes. *Consumers’ Choice* will review the Member population to assess the characteristics and needs of the population and subpopulations for updates to the complex case management processes to address member needs and will survey the effectiveness of the program and the satisfaction of Members.

Case managers will also work with Members at high risk for complications of pregnancy and poor neonatal outcomes. The goals of the program are to identify and coordinate care for pregnant Members who are at high-risk for complications of pregnancy and assure that all Members have access to appropriate care for diagnosis, monitoring and treatment of pregnancy.

*Consumers’ Choice* will provide educational opportunities to inform our Members about the benefits and risks associated with behaviors that may affect the outcome of their pregnancy and facilitate transitions to home when outcomes are less than ideal. We will provide educational opportunity and support for pregnant women and their partners about appropriate care of newborns as well as identifying pediatric practitioners and access to care for their newborn.

When an event occurs resulting in an early delivery and resultant admission to a Neonatal Intensive Care Unit, our case manager will work with the hospital neonatal providers, discharge planners, and managing pediatric practitioner to ensure a smooth transition to home and coordination of ongoing follow-up care as needed.
The Consumers’ Choice case manager will coordinate care needs, assist in identifying and obtaining supportive community resources, and arrange for long-term referral services as needed. The case manager may identify (and a Member may request) a specialist with whom a Member with a chronic condition has an ongoing relationship who may serve as the PCP and coordinate services on the Member’s behalf.

Members determined to need a course of treatment or regular care monitoring may have direct access to a specialist as appropriate for the Member’s condition and identified needs, such as through a standing referral or an approved number of visits. A Member’s PCP will develop a treatment plan with the Member’s participation and in consultation with any specialists caring for the Member. The Consumers’ Choice Medical Director oversees these processes in accordance with state standards.

Consumers’ Choice encourages all PCP’s and physicians to notify Consumers’ Choice Case Management when a Member is identified that meets the criteria for a chronic or complex condition.

Examples of Members with complex health needs might include the following:

- Members who have had an organ transplant
- Members with HIV/AIDS, progressive degenerative disorders and metastatic cancers
- Members requiring improvement in their access to primary and specialty care ensuring that Members with complex health conditions receive appropriate services
- Coordinating care for Members who receive multiple services
- Identifying and reducing barriers to services for Members with complex conditions
- Members with physical or developmental disabilities, serious mental illness, multiple chronic conditions or severe injuries
- Members requiring assessments for activities of daily living, mental health status, life planning, clinical history, health status, culture, linguistic, visual and hearing needs, preferences or limitations, caregiver resources, benefits, general resources, plans and prioritized goals, barriers, or self-management plans

The following sources will be included in identifying members for Chronic Case Management programs:

- Health information line referral, if applicable
- Disease Management program referral
- Discharge planner referral
- UM referral, if applicable
- Member or caregiver referral
- Practitioner referral

Practitioners are to refer Members to the Case Management programs by calling 1-800-580-8736.

Medical Management/Case Management Department
Telephone: 1-800-580-8736
Consumers’ Choice Website: www.cchpsc.org
DISEASE MANAGEMENT PROGRAMS

As a part of the Consumers’ Choice medical management quality improvement efforts, disease management programs are offered to Members. The program will be provided as an opt-out program. Disease management is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, chronic medical conditions. Disease management supports the practitioner-patient relationship and plan of care, emphasizes the prevention of exacerbation and complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies such as self-management. It continuously evaluates clinical, humanistic and economic outcomes with the goal of improving overall health.

As a part of the Consumers’ Choice medical management quality improvement efforts, disease management programs are offered to Members. Components of the programs available include but are not limited to:

- Increasing coordination between the medical, social and educational communities
- Assuring that referrals are made to proper practitioners, including dental practitioners
- Improving levels of screening and more consistent referrals to and from Early Intervention Programs
- Appropriate medications, follow-up care and laboratory testing
- Ensuring active and coordinated physician/specialist participation
- Identifying modes of delivery for coordinated care services such as: home visits, clinic visits, and phone contacts depending on the circumstances and needs of the Member and his/her family
- Increasing the Member’s and Member’s caregiver ability to self-manage chronic conditions

The following sources will be included in identifying members for Disease Management programs:

- Claim or encounter data
- Pharmacy data, if applicable
- Health appraisal results
- Laboratory results, if applicable
- Data collected from the UM process, case management
- Data from health management, wellness or health coaching programs
- Information from EHRs
- Member and practitioner referrals

Components of the programs available include but are not limited to:

- Increasing coordination between the medical, social and educational communities
- Referrals are made to proper practitioners (including dental, medical, and behavioral health)
- Ensuring active and coordinated physician/specialist participation
- Identifying modes of delivery for coordinated care services such as: home visits, clinic visits, and phone contacts depending on the circumstances and needs of the Member and his/her family
Increasing the Member's and Member's caregiver ability to self-manage chronic conditions
Condition monitoring including self-monitoring and medical testing
Adherence to treatment plans including medication adherence as appropriate
Medical and behavioral health comorbidities and other health conditions such as cognitive deficits and physical limitations
Health behaviors
Psychosocial issues
Depression screening
Information about the patient’s condition provided to caregivers who have the patient’s consent
Encouraging patients to communicate with their practitioners about their health conditions and treatment
Additional resources external to the organization, as appropriate
Focusing on diseases will include Diabetes, Coronary Artery Disease, Attention Deficit with Hyperactivity Disorder, and Depression

Members will be stratified for severity of their disease process and types of Interventions may include the following and will be based on the program delivery by severity:

- Educational mailings
- Telephone calls to check progress or offer coaching
- Secure email reminders if applicable
- Written or electronic tools to record progress
- Transmitting biometric results if applicable

The program will be evaluated by Member feedback, surveys, complaints and inquiries. Other evaluations will include measuring effectiveness by analyzing data and producing quantitative results.

**NEW TECHNOLOGY**

*Consumers’ Choice* has established a formal process to evaluate new developments in technology and new application of existing technology prior to inclusion in its benefits plan or approval on a case-by-case basis. The assessment of new technology is done to determine if the technology improves the quality of life and health outcomes and if it is applied in a manner that considers the individual health care needs of the member. The purpose of this process is to promote health and safety, keep pace with changes, and ensure members have equitable access to safe and effective care.

This new medical technology evaluation process includes identified decision criteria, a review of information from government regulatory bodies and published scientific evidence, and input from relevant specialists and professionals who have expertise in the technology being evaluated.
SCOPE

The Consumers’ Choice new medical technology evaluation process addresses:

- Medical procedures
- Behavioral healthcare procedures
- Pharmaceuticals
- Devices

DECISION CRITERIA

Consumers’ Choice uses the following objective criteria, as appropriate, to evaluate new technologies or new application of existing technology for inclusion in a benefits plan or approval on a case-by-case basis:

- The technology must have final approval from the appropriate regulatory body with authority to regulate the technology (e.g., the Food and Drug Administration). This applies to drugs, biological products, devices, or other products that must have final approval to market the technology.
- The scientific evidence must support the technology utilizing well-conducted investigations published in peer-reviewed literature and evaluations by national medical associations must permit conclusions based on medical facts concerning the effect of the technology on health outcomes.
- The technology must demonstrate measurable improvement in health outcomes or health risks. The beneficial effects must outweigh any harmful effects on health outcomes. It must improve the length or quality of life or ability to function.
- The technology must be as beneficial as any established alternatives. It should improve the net health outcome as much, or more than, established alternatives.
- Improvement must be attainable outside the investigational setting.
- The technology must be generally accepted as safe and effective by the medical community.
- The technology must be furnished in a manner consistent with community standards of care and in a setting (place of service) consistent with the patient’s medical needs and condition.
- The technology must be furnished at a level, duration, dosage or frequency appropriate for the patient or clinical condition.
- Opinions and evaluations of professional organizations, panels or technology assessment bodies are evaluated based on the scientific quality of the supporting evidence.
RESOURCES FOR EVALUATION

Resources that Consumers’ Choice uses to conduct new medical technology evaluations included, but are not limited to policies, position statements, consensus reports and standards of private and governmental agencies as well as peer reviewed medical literature and journals.

Government Regulatory Bodies
- National Institutes of Health (NIH)
- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Medicare & Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Other appropriate regulatory bodies

Published Scientific Sources
- Review of peer reviewed medical literature and journals from professional medical associations and health organizations, such as:
  - National Comprehensive Cancer Network
  - Humana Medical and Pharmacy Coverage Policies
  - Aetna Clinical Policy Bulletins
  - Cigna Coverage Policies and Criteria
  - National Institute for Health and Care Excellence
  - American Medical Association
  - American Association for Cancer Research (AACR)
  - American College of Clinical Pharmacy (ACCP)
  - American Diabetes Association
  - American Institute for Cancer Research (AICR)
- Hayes Knowledge Center, including:
  - Medical Technology Directory
  - Health Technology Briefs
  - Genetic Test Evaluation
  - Search and Summary Reports
  - New Service

AHRQ’s Evidence Based Practice Centers and Other Sources
- Blue Cross Blue Association’s Technology Evaluation Center (TEC)
- Brown University, Center for Evidence-based Medicine
- ECRI Institute–Penn Medicine Evidence-based Practice Center
- Johns Hopkins University
- Kaiser Permanente Research Affiliates
- Pacific Northwest Evidence-based Practice Center—Oregon Health & Science University
- RTI International—University of North Carolina (UNC) at Chapel Hill
- Southern California Evidence-based Practice Center—RAND Corporation
SPECIALISTS AND PROFESSIONALS

During the new medical technology evaluation process, Consumers’ Choice solicits and obtains opinions and input from medical specialists and professionals who have expertise in the technology that is being evaluated. These may include, but are not limited to physicians, doctoral level practitioners, and pharmacists.

EVALUATION PROCEDURES

New medical technology assessments may be handled as either standard evaluations or as expedited evaluations as described below.

Standard Evaluation
1. A practitioner or member submits a request for the review of a new medical technology or new application of an existing technology to the Medical Director. The requester is asked to supply literature that supports the therapy requested.
2. The Medical Director conducts an in-depth review of the literature provided by the requesting party. If appropriate, the Medical Director performs additional literature searches, governmental regulatory searches, or searches using other resources as described above. Professionals or specialists with expertise related to the technology are utilized, as appropriate, to assist in evaluating the information.
3. The Medical Director reviews the information supplied in conjunction with the decision criteria for evaluation and prepares a summary assessment report.
4. The Medical Director places the new medical technology request on the agenda for the next Provider Advisory Committee meeting.
5. The Medical Director presents the request, the information that has been collected, and his/her summary assessment report of the new medical technology to the Provider Advisory Committee at the next meeting.
6. The Provider Advisory Committee reviews and discusses the evaluation of the new medical technology using the decision criteria defined above and makes a recommendation as to whether or not the request should be denied, granted on a case-by-case basis, or included in the plan’s benefit package.
7. The recommendation of the Provider Advisory Committee is forwarded to the Quality Improvement Committee.
8. The Quality Improvement Committee makes a final decision at its next meeting.
9. The Medical Director notifies the requestor of the final decision either verbally or in writing.
**Expedited Evaluation**

In cases where the request may affect/delay active treatment of a member, the request is handled in an expedited process. Expedited procedures are available to all practitioners and members if health, life, or ability to repair maximum function may be jeopardized. The Medical Director has the authority to approve/deny an expedited request on an as needed basis.

1. The Medical Director conducts an in-depth review of the literature provided by the requesting party. If appropriate, the Medical Director performs additional literature searches, governmental regulatory searches, or searches using other resources as described above. Professionals or specialists with expertise related to the technology are utilized, as appropriate, to assist in evaluating the information.
2. The Medical Director reviews the information supplied in conjunction with the decision criteria for evaluation and makes a determination to deny or approve for the case in question.
3. The Medical Director verbally notifies the requesting party of the decision.
4. If the request is approved, the Medical Director places the new medical technology case on the agenda for the next Provider Advisory Committee meeting.
5. The Medical Director presents the request, the information that has been collected, and his/her rationale for approving the request to the Provider Advisory Committee at the next meeting.
6. The Provider Advisory Committee reviews and discusses the evaluation of the new medical technology using the decision criteria defined above and makes a recommendation as to whether or not the technology should be continue to be granted on a case-by-case basis or included in the Plan’s benefit package.
7. If the recommendation is to include the new technology in the Plan’s benefit package, the recommendation of the Provider Advisory Committee is forwarded to the Quality Improvement Committee.
8. The Quality Improvement Committee makes a final decision at its next meeting.

**UM Decision-Making Criteria**

If the final decision is to either grant approval for the technology on a case-by-case basis or include the technology in the Plan’s benefit package, the Medical Director leads the development of formal policy and UM decision-making criteria for is application. The criteria are developed according to UM policy.
ROUTINE, URGENT AND EMERGENCY SERVICES

ROUTINE, URGENT AND EMERGENCY CARE SERVICES DEFINED

Members are encouraged to contact their PCP prior to seeking care, although it is not required in an emergency.

EMERGENCY ROOM VISITS

The services described in Consumers’ Choice policies are subject to the terms, conditions and limitations of the Member’s Certificate of Coverage or Summary of Benefits policy. This policy applies to the Consumers’ Choice product lines. Consumers’ Choice reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Consumers’ Choice administrative procedures or applicable state law.

Certain policies may not be applicable to certain insured products. Refer to the Member’s Certificate of Coverage or Summary of Benefits policy to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies.

The purpose of this policy is to describe the Consumers’ Choice policy for emergency room visits as indicated in the Member’s Certificate of Coverage or Summary of Benefits policy. Consumers’ Choice covers emergency services necessary to screen and stabilize Members without prior approval or notification in cases where a prudent layperson would have believed that an emergency medical condition existed or an authorized representative, acting for Consumers’ Choice, has authorized the provision of emergency services.

Emergency: A medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to:

A. Place an individual’s health in serious jeopardy;
B. Result in a serious impairment to the individual’s bodily function; or
C. Result in serious dysfunction of a bodily organ or part of the individual.

Prudent Layperson: A prudent layperson is a person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek emergency medical treatment. A prudent layperson is considered to have acted “reasonably” if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that emergency medical treatment was necessary. Severe pain and other symptoms may constitute such emergency cases. (Source: NCQA)
Authorized representative: An authorized representative may be an employee or contractor of Consumers’ Choice who directs the Member to seek services. For example, an advice nurse, network physician, physician assistant or a Customer Service representative may act as the Consumers’ Choice authorized representative. An ER practitioner may be an authorized representative of Consumers’ Choice if they participate in the Consumers’ Choice practitioner network.

PROCEDURES AND RESPONSIBILITIES

Emergency room treat and release services are covered both in and out of the service area and are payable upon claim submission, minus the Member's applicable emergency room cost share as determined by their Member Certificate of Coverage or Summary of Benefits policy.

Policy Statements

All Members will be afforded benefits for emergency services in accordance with the applicable Plan Documents.

- Emergency services may be obtained from participating or non-participating hospitals, in-area or out-or-area providers, without the prior authorization of the Plan or the Member’s Primary Care Physicians or Primary Care Medical Office. While the Member should seek care at the closest emergency facility for emergency services, his/her failure to seek care at a plan facility cannot be used as the sole reason to deny coverage.

- If a hospital admission occurs following the ER visit, the ER visit will be approved. If the Member requires continued outpatient care, Consumers’ Choice may, at its sole option, elect to transfer the patient, at Consumers’ Choice expense, to the care of a participating practitioner/provider, subject to the condition that such transfer does not jeopardize the Member's health and be coordinated by the Member’s PCP or network physician.

- All claims are payable for emergency services which meet the criteria as delineated in accordance with criteria defining prudent layperson. Emergency services that did not meet the Consumers’ Choice auto-pay criteria will be retrospectively reviewed by a prudent layperson and the Medical Director or other designated physician as needed to determine if an emergency existed as defined above. The physician reviewer will determine if a claim is to be denied due to lack of medical necessity or the presence of a non-emergent condition.

- Emergency room treatment that leads to an approved inpatient stay will only cover the inpatient stay.
Procedure

- The claim for services will be submitted by the ER facility to the claims department. The claims department will apply the Plan-accepted auto-pay criteria for emergency coverage.

- If the condition meets the auto-pay criteria based on the presenting symptoms and discharge diagnosis submitted from the provider, the claim is entered for payment irrespective of where (i.e., in-area or out-of-area; plan facility or non-plan facility) the Member received care.

- If the claim does not meet the emergency auto-pay criteria, the ER facility claim is forwarded to Medical Management for review.

- If the medical documentation does not meet the prudent layperson’s review criteria (care was not emergent), the claim and the accompanying medical record are forwarded to the Medical Director or physician reviewer.

B. A Member's claim will be paid without prior authorization:

1. If authorized by an authorized representative acting for the Plan.

2. If an individual is acting as a prudent layperson. Determining whether a Member has acted as a prudent layperson is based on presentation to the ER, and not the final diagnosis documented. Prior to rendering a denial decision, the review must be done using a complete emergency room record that includes triage notes, nursing notes, physician history and exam notes, medications given, and lab and test results. The following examples include but are not limited to conditions that shall be approved for payment. A Member seeks emergency care for the acute onset or acute exacerbation (within the immediate past four (4) hours) of symptoms, (which are documented in the complete emergency record) such as:

   a. Severe pain that is treated with IV or IM pain medication, excluding recurrent migraine headaches;
   
   b. Dizziness with inability to ambulate; and/or with severe headache; and/or with nausea; and/or with vomiting;
   
   c. Syncope with confusion; and/or with visual disturbance;
   
   d. Fall or acute injury which causes the Member to think he/she has broken a bone (does not include fingers and/or toes) due to symptoms of pain, inability to move the body part, swelling, inability to bear weight, and decreased function of the affected part;
   
   e. Fever $\geq 103$ for a child $\leq 2$ years old or $\geq 100.5$ for children $< 8$ weeks old;
   
   f. Respiratory distress;
   
   g. A head injury with LOC; and/or with dizziness; and/or with nausea; and/or with vomiting; and/or confusion; or
   
   h. Pain consistent with cardiac etiology and the work-up includes EKG and troponin level;
i. A third party called for ambulance transport because the Member was incapacitated;

j. A clinician, including but not limited to LPN, RN, NP, EMT, PA or MD, referred the Member for emergency care in response to an acute injury, syncope, convulsion or severe, acute pain, etc. which inhibits the Member from taking care of his/her needs;

k. Acute abdominal pain ≥ 8 out of 10 on the pain scale;

When a Member is admitted to any facility (par or non-par) from the emergency room, either as an observation or inpatient admission, notification of the admission and supporting clinical information (medical records) are required within two (2) business days of the admission. See the Inpatient Notification Process section of this manual.

**COVERED SERVICES AND BENEFITS**

**Inpatient Hospital Services** - *Consumers’ Choice* will pay for medically necessary inpatient hospital care.

**Outpatient Hospital Services** - *Consumers’ Choice* will pay for medically necessary outpatient hospital visits and emergency room visits.

**Physicians Services** - *Consumers’ Choice* will pay for medically necessary physicians’ services. All symptomatic visits to physicians or physician extenders within the scope of their licenses are covered benefits. Physician services including services while admitted in the hospital, outpatient hospital department, in a clinic setting or in a physician's office are covered benefits.

**Inpatient Physician Visits** - *Consumers’ Choice* will also pay for a physician to visit patients in the hospital. If the patient has to be seen by more than one (1) physician while in the hospital, *Consumers’ Choice* also pays for those visits.

**Audiological Services** - *Consumers’ Choice* will pay for Audiological Services including diagnostic, screening, preventive, and/or corrective services provided to individuals with hearing disorders or for the purpose of determining the existence of a hearing disorder by or under the direction of an Audiologist. A physician or other Licensed Practitioner of the Healing Arts (LPHA), within the scope of his or her practice under state law, must refer individuals to receive these services. Audiological Services involve testing and evaluation of hearing-impaired children less than 21 years of age who may or may not be improved with medication or surgical treatment. This includes services related to hearing aid use.

**Chiropractic Services** - Chiropractic services are available to all recipients. Chiropractic services are limited to manual manipulation of the spine to correct a subluxation. Chiropractic visits are counted separately from the ambulatory visit limit. This service has a limit of six (6) visits per year.

**Family Planning Services** - This program pays for counseling, diagnosis, treatment, and birth control drugs and supplies prescribed or furnished by a physician. All Family Planning services should be provided on a voluntary and confidential basis to all Members including those that are less than 18 years of age.
Laboratory Services - Consumers’ Choice will pay for laboratory tests in a physician’s office that are provided for a Member. LabCorp and Quest Diagnostics Laboratories are our preferred clinical laboratory services provider.

Durable Medical Equipment - Durable medical equipment (DME) provides either therapeutic benefits or enables a recipient to perform certain tasks that the Member would be unable to undertake otherwise due to certain medical conditions and/or illnesses. Durable medical equipment can withstand repeated use and is primarily and customarily used for medical reasons and is appropriate and suitable for use in the home. Included are medical supply products, surgical supplies, traction equipment, walkers, canes, crutches, kidney machines, ventilators, oxygen, and other items when ordered by a physician as medically necessary in the treatment of a specific medical condition. The attending physician has the responsibility of determining the type or model of equipment and length of time the equipment is needed through a written necessity statement. Approval for Consumers’ Choice coverage of products requiring prior authorization is patient-specific and is determined according to certain established criteria. Luxury and deluxe models are restricted if standard models would be appropriate. Repairs to medical equipment are covered if reasonable. Consumers’ Choice also covers certain prosthetic and orthotic devices when ordered by a physician and determined to be medically necessary. Consumers’ Choice covers hearing aids and hearing aid accessories for Members under age twenty-one. DME, home supplies, orthotics and prosthetics provided in a PCP’s office with a billed amount less than $500 is exempt from the PA requirement. Items billed $500.00 or above require a PA obtained from Consumers’ Choice by calling 1-800-580-8736.

Ambulance Transportation - Consumers’ Choice will pay for emergency transportation services provided via ambulance for an emergent situation.

Podiatry Services - Members may receive podiatry care from an in-network PCP or a Podiatrist. Diabetic Members will be allowed to receive their annual foot exams from a Podiatrist.

Institutional Long Term Care Facilities - Consumers’ Choice covers 30 days of a confinement in a long term care facility. Services include nursing facility and rehabilitative services at the skilled or intermediary level of care. Services must be authorized by Consumers’ Choice by calling 1-800-580-8736.

Home Health Services - These services are provided at the patient’s home, with a physician prescription, to people who are unable to leave their homes due to illness or disability. These services include skilled nursing, home health aide, physical, occupational and speech therapy services and physician ordered supplies.

Physical, Occupational and Speech Therapies - Therapy can be provided in the following situations as ordered by a physician and is deemed a covered service:

Covered Therapy Services - Reimbursement is allowed for physical, occupational and speech therapies performed under the following guidelines. The Member’s record must substantiate at least ONE of the following requirements for therapy:
The attending physician prescribes therapy in the plan of treatment during an inpatient hospital stay and therapy continues on an outpatient basis until that plan of treatment is concluded;
The attending physician prescribes therapy as a direct result of outpatient surgery;
The attending physician prescribes therapy to avoid an inpatient hospital admission.
  a) In a long term care facility;
  b) As a Home Health Service;
  c) As an inpatient in a hospital with a certified therapy department, and therapy may be continued at the hospital as an outpatient if ordered by the doctor;
  d) Therapy may be continued at the hospital as an outpatient if ordered by a doctor;
  e) By an independent therapist for Members under age 21.

Mental Health Clinic Services (Behavioral Health) - Consumers’ Choice covers behavioral health and substance abuse treatment, including prescription drugs rehabilitative and habilitative services.

COVERED PHARMACY SERVICES

Covered Pharmacy Services
Prescription drug benefits are managed through Consumers’ Choice and are administered by the Consumers’ Choice prescription benefit manager, (PBM), Catamaran. Consumers’ Choice uses a formulary. This is a list of prescription drugs approved by Consumers’ Choice for use by our Members. All generic drugs and certain brand name drugs listed in the formulary are covered. Some drugs, even though they are listed on the formulary, may have special limitations such as quantity limits and age restrictions. Others may require the Member to try and fail other preferred medications first. Non formulary drugs may be requested through the Prior Authorization process. Some drugs are excluded from the pharmacy benefits such as those for weight loss, infertility and cosmetic purposes. The formulary is available to practitioners on the Consumers’ Choice website at www.cchpsc.org.

Pharmacy Policy
The Consumers’ Choice pharmacy benefit provides access to a broad range of approved medications using a formulary. The formulary does not:

- Require or prohibit the prescribing or dispensing of any medication;
- Substitute for the independent professional judgment of the physician or pharmacist; or
- Relieve the physician or pharmacist of any legal or medical obligation to the patient or others.

The formulary is administered by the Pharmacy and Therapeutics (P&T) Committee, composed of the Medical Director, Pharmacy Director and community based primary care physicians and specialists. Alternatively, Consumers’ Choice may utilize the services of the PBM’s P&T Committee. If this option is utilized, recommendations of the PBM’s committee will be reviewed and approved by the Consumers’ Choice Provider Advisory Committee prior to adoption. The primary function of the committee is to assist with the maintenance of the Consumers’ Choice formulary and to establish
programs and procedures for promoting positive patient outcomes. The DUR program of South Carolina must approve inclusion and exclusion of drugs on the Consumers’ Choice formulary.

Generic substitution is mandatory when a generic equivalent is available. All branded products that have three or more A-rated generic equivalents will be reimbursed at the maximum allowable cost (MAC).

PHARMACY PRIOR AUTHORIZATION

The formulary attempts to provide appropriate and cost effective drug therapy to all participants covered by the Consumers’ Choice pharmacy program. If a patient requires medication that does not appear on the formulary, the physician can make a request for a non-covered medication. It is anticipated that such expectations will be rare and that formulary medications will be appropriate to treat the vast majority of medical conditions. Prior Authorization criteria have been established by the Pharmacy and Therapeutic (P&T) Committee. In order for a Member to receive coverage for a medication requiring prior authorization, the physician, Member or Member’s representative must submit a “Prior Authorization Request Form”. All relevant clinical information and previous drug history should be included and the form request made via:

Catamaran
Phone: 1-855-577-6547
Fax: 1-866-511-2202
www.cchpsc.org

A. Exception Procedure

a. A practitioner, member, or member’s representative may request a coverage exception. A request may be made for a Prior Authorization, Quantity Limit exception, Step Therapy exception, Gender Limit exception and a drug coverage exception. The procedures for making a request are found in the Plan’s Prior Authorization and Appeals Procedure document, which is incorporated as part of this document.

i. The Plan, or its delegate, will consider a Utilization Management exception request based on medical necessity for a Prior Authorization exception, Quantity Limit exception, Step Therapy exception, or a Gender Limit exception, requested by the practitioner, member, or member’s representative. The request may be made to the PBM by several methods:

1. The practitioner may complete the form found on www.cchpsc.org and fax the information to 1-866-511-2202
2. The practitioner may call provider services at 1-855-577-6546
3. The member may call member services at 1-800-580-8736
4. The member or practitioner may complete a request form found at www.cchpsc.org and submit the form electronically.
ii. A drug coverage exception will be considered by the Plan upon receipt of a request of the member, practitioner, or member’s representative. The Plan will render a decision based on approved plan criteria and documentation provided to the Plan. The request may be made by several methods:

1. The member or practitioner may call member services at 1-800-580-8736
2. The member or practitioner may complete a request form found at www.cchpsc.org and submit the form electronically.

iii. The Plan will accept any medical documentation, including chart notes, member history, lab values, and test results. This information may be submitted along with the request. If a request is made, but a completed form is not received, the PBM or the Plan will initiate contact with the prescriber to request the necessary information. The Plan will provide a decision no later than 15 days after the request is received. When a member is suffering from a serious health condition, the Plan will provide a decision no later than 72 hours after receiving the request. The Plan will provide its decision verbally and in writing no later than 72 hours after receiving an expedited request and no later than 15 days after receiving a standard request. The Plan will also advise the member about his or her ability to request an appeal.

iv. The Exception review must be conducted by a physician who is currently licensed to practice without restriction and has obtained appropriate education, training, or professional experience or a registered pharmacist who is currently licensed to practice without restriction and has obtained appropriate education, training, or professional experience. Documentation of this review must be contained in the file, including the name of the reviewer, and clinical rationale for the decision.

v. The written denial letter to the practitioner shall include a statement stating that the practitioner may contact the physician or pharmacist reviewer to discuss the denial. The letter shall include contact information for the practitioner to contact the Plan. If the Plan makes the initial denial via phone to the practitioner’s office, the Plan shall also verbally inform the office that a physician or pharmacist reviewer is available to discuss the denial.

vi. The Plan shall inform the member and the practitioner in writing the specific reasons for the denial. The notification shall also include reference to the specific criteria that the decision is based upon and also that the member may obtain a copy of this criteria upon request. The denial notification shall also include an explanation of the appeal process.

B. Appeal rights of the member
   a. A member, member’s representative, or practitioner may request an appeal of a denied exception request. The pharmacy appeal request shall be conducted in accordance to the Plan’s Prior Authorization and Appeals Procedure document, which is incorporated into this document.
C. Availability and Distribution of the Formulary
   a. The Plan will utilize a closed formulary which will be available on the Plan’s website at www.cchpsc.org. The information available will include relative copayment requirements of each agent and tier, listing of preferred agents, prior authorization criteria (PA), step-therapy criteria (ST), quantity limits placed on specific agents (QL), gender limits placed on specific agents (GL) how prescribers must provide information to support an exception request, the Plan’s process for generic substitution, therapeutic interchange, and any other relevant criteria.
   b. The formulary and the pharmaceutical management information in D(a) is distributed to Members by the Member Services Department upon enrollment and to Providers by the Provider Relations Department upon contracting.
   c. Acute medications and certain maintenance medications are limited to a 30-day in a retail pharmacy, certain specialty medications are limited to a 30-day supply from the specialty pharmacy, and certain maintenance medications may be filled for up to a 90-day supply at either a retail pharmacy or from the mail order pharmacy.
   d. Preferred agents will have lower copay than non-preferred agents. Agents with a Prior Authorization requirement are not covered unless prior approval is obtained. Agents with Step Therapy criteria are only covered if other agents are used prior to the ST agent. Agents with Quantity limits are only covered if quantity requested is at or below the QL. Agents with a Gender Limitation are only covered for members of a specific sex. Specific requirements for these agents are listed in the formulary available on the Plan’s website.
   e. The Plan has developed step therapy programs to encourage appropriate use of lower-cost or safer medication alternatives before stepping up to less cost-effective or more risky alternatives. Step therapy is a pharmaceutical utilization management tool that requires using one or more drugs in a step-wise approach. It typically involves using generics or other cost-effective alternatives as the first choice of drug before progressing to more costly alternatives. A trial with a preferred first-line drug is usually the prerequisite for coverage. When the member requires the step therapy drug as a first-line option, supporting documentation is requested from the prescriber. If a member tries and fails a first-line drug, the prescriber may request a prior authorization for the member by utilizing the exception procedure of the Plan.
   f. The Plan utilizes mandatory generic substitution. A brand name with an equivalent generic available will not be covered by the Plan. A prescriber or member may request a brand name be covered through the Prior Authorization process.
   g. The formulary is distributed in its entirety in hard copy or via the website at least annually, thus providing practitioners and member’s access to the most up-to-date formulary information at all times. Practitioners are notified of formulary changes monthly via e-mail blast, or fax blast, or US Mail during the month prior to the effective date of the change. If the notification regarding the annual distribution or any formulary changes is via the website, practitioners are notified either via email, or fax, or US Mail that they may also request a copy by calling the Provider Relations Department if they do not have access to the Internet. Affected members are notified of negative changes to the formulary or negative changes to UM criteria at least 60 days prior to the effective date of the change via the website and US Mail at their last known address on file with Member Services. The quarterly newsletter for members will include a statement of formulary changes and instructions for how a member may access them from the website. If the notification regarding annual distribution or any formulary changes is via the website, members are
notified either in member newsletters or by US Mail that they may also request a copy of
the change by contacting Member Services at the phone number listed on their ID Card if
they do not have access to the Internet.

D. Pharmacy Benefit Updates

a. The updates to the PBM website shall be delegated to the PBM and be available to
members at the PBM’s website, www.mycatamaranrx.com. Updates include, but may not
be limited to, those related to formulary tiers, copays, limitations and exclusions, new drugs
made available or drugs that have been recalled. The content to be hosted on the PBM’s will
be determined by the PBM. Customer service telephone representatives will utilize the
same information available on the website. The telephone representatives will have real-
time access to this information as it is updated. Information will be made available via
various internal PBM departments and communicated to the PBM’s internal IT staff to
update their website. The PBM’s internal IT staff will have the responsibility for updating the
information as it becomes available.

b. Updates made to the Plan’s Internal Member portal and Provider portal shall be the
responsibility of the Plan. Content to be hosted on the Plan’s portals shall be determined by
the Plan. This may include documents such as Prior Authorization forms, network pharmacy
listings, drug formulary, and other pertinent information. The Pharmacy Director, or his/her
designee, shall notify the Plan’s IT department to make the necessary updates to
www.cchpsc.org
   i. The clinical account team of the PBM shall forward an updated formulary document
      containing any revisions from the P&T Committee
   ii. The Provider Advisory Committee will then review the updated formulary
   iii. Once approved, the Pharmacy Director will forward the formulary document to the
      Plan’s internal IT team to post to the website
   iv. Additionally, once other documents have been reviewed by the Pharmacy Director
      and/or the Provider Advisory Committee, they will be forwarded to the Plan’s
      internal IT team to post to the website

c. All updates, including updates to the formulary and UM criteria must be made no later than
the effective date of the change. Updates relating to drug recalls are made as soon as
possible.

d. The Pharmacy Director, or his/her designee, shall review the accuracy of the updates made
to the formulary or to any UM criteria or for any recalled drugs posted on the website prior
to the effective date of the change. This includes visiting the appropriate portion of the
website to ensure the change has been completed. Additionally, materials utilized by
Member Services will also be reviewed for accuracy. Screen shots and actual documents will
be captured as evidence of compliance.

e. Documentation of these reviews will be kept in the pharmacy department.
**SPECIALTY PHARMACY**

**Injectable and Oral Anti-Cancer Drugs**

Some injectable drugs and oral cancer drugs that can be self-administered by the patient or family Member, and are listed in the formulary, are covered under the pharmacy benefit. The majority of self-administered injectable drugs, and several oral anti-cancer drugs, will require a prior authorization from the Consumers’ Choice Specialty Pharmacy, BriovaRX prior to dispensing. A listing of self-administered injectable drugs, and those oral anti-cancer drugs requiring prior authorization, are listed in the formulary. Specialty injectables, such as Avonex, Nutropin, Enbrel, PEG Intron, Synagis, etc. should be prior authorized through:

**Prior Authorization Phone:**
1-855-577-6547

**Prior Authorization Website:**

**Fax:**
866-511-2202


**Over the Counter Medications**

Many over-the-counter (OTC) medications are available to our Members on the formulary. Most Over the Counter (OTC) medications do not appear on the formulary and therefore are not a covered benefit. However, there may be a few exceptions. If an OTC does appear on the formulary as a covered benefit, then the OTC medications must be written on a valid prescription, by a licensed prescriber, in order to be filled by the pharmacy.

**Five (5) Day Supply Policy**

State and federal law require that a pharmacy dispense a five (5) day supply of medication to any Member awaiting a prior authorization (PA) or medical necessity (MN) determination. The purpose is to avoid interruption of current therapy or delay in the initiation of therapy for medications not included in the formulary. All participating pharmacies are authorized to provide a five (5) day supply of medication and will be reimbursed for the ingredient cost and dispensing fee of the five (5) day supply of medication whether or not the prior authorization (PA) or medical necessity (MN) request is ultimately approved or denied. The pharmacy must call 1-855-577-6547 for a prescription override to submit the five (5) day supply of medication for payment.
Exclusions

Prescriptions are limited to a 30-day supply per fill. Select maintenance medications may be filled for a 90-day supply, either at an in-network pharmacy or from the Consumers’ Choice Mail Order pharmacy. Prescriptions are only a covered benefit for the member if they are filled at an in-network pharmacy provider. A listing of in-network pharmacy providers may be found at www.cchpsc.org

The following drug categories are not part of the Consumers’ Choice formulary and are not covered regardless of circumstance:

- Weight control products (except lipase inhibitors)
- Investigational pharmaceuticals or products
- Pharmaceuticals identified by CMS as less than effective and identical, related or similar drugs
  - (DESI drugs)
- Injectable pharmaceuticals (except those listed in the formulary)
- Fertility products
- Investigational pharmaceuticals or products
- Pharmaceuticals used for cosmetic purposes or hair growth
- Erectile dysfunction products prescribed to treat impotence

SERVICES NOT COVERED BY CONSUMERS’ CHOICE

Some services are not covered by Consumers’ Choice. These services include:

- Care or supplies that are not medically necessary
- Routine dental services for adults above the age of 18
- Routine vision services including corrective glasses for adults over the age of 18
- Experimental care, such as drugs, procedures, technologies or supplies that are not FDA approved or approved by Centers for Medicare and Medicaid Services (CMS)
- Infertility care for men or women includes services or supplies that are designed to create a pregnancy, enhance fertility or improve conception quality, including but not limited to: (1) artificial insemination; (2) in vitro fertilization; (3) fallopian tube reconstruction; (4) uterine reconstruction; (5) assisted reproductive technology (ART) including but not limited to GIFT and ZIFT; (6) fertility injections; (7) fertility drugs, (8) services for follow-up care related to infertility treatments
- Cosmetic surgery/procedures
- Immunizations to travel outside of the country
- Bariatric Surgery is not covered
- Sex change surgery and similar care
- Sex or marriage therapy
- Court ordered testing
- Acupuncture and biofeedback services
- Services to find cause of death
- Comfort items in the hospital (for example, TV or phone)
- Father/child paternity testing
- Care provided by any providers/practitioners when insured has other primary coverage at the time of the episode of care.
- Temporomandibular Joint Dysfunction (TMJ) under medical benefits.

**OUT-OF-NETWORK SERVICES AND PROVIDERS/PRACTITIONERS**

*Consumers’ Choice* realizes that there may be times when a Member needs care from a practitioner or provider who is not in the *Consumers’ Choice* network. *Consumers’ Choice* will approve medical services to an out-of-network practitioner or provider if these services are not available in-network and are medically necessary, as determined by Member’s practitioner and *Consumers’ Choice* (prior authorization must be obtained).

Our Members have many questions about their health, their primary care provider and access to emergency care.

Members may use www.cchpsc.org to request information about providers/practitioners and services available in their community after the Plan is closed. PCP’s can use it to verify eligibility any time of the day. The Customer Service staff is conversant in both English and Spanish and can offer the Language Line for additional translation services.

We provide this service to support your practice and offer our Members access to a Registered Nurse (RN) every day. If you have any additional questions, please notify Customer Services at 1-800-580-8736 and ask for a Health Coach.

**IMMUNIZATIONS**


**DOMESTIC VIOLENCE**

*Consumers’ Choice* Membership may include individuals at risk for becoming victims of domestic violence. Thus, it is especially important that providers/practitioners are vigilant in identifying these
Members. Customer Service can help Members identify resources to protect them from further
domestic violence.

South Carolina residents who are victims of domestic violence may be referred to the National Domestic
Violence Network hotline, at 1-800-799-SAFE (7233) for information about local domestic violence
programs and shelters within the state of South Carolina.

Providers/Practitioners should report all suspected domestic violence as described. State law
requires reporting by any person if he or she has “reasonable cause to believe that a child has been
subjected to child abuse or acts of child abuse”. Such reporting can be done anonymously. Report
any injuries from firearms and other weapons to the police. Report any suspected child abuse or
neglect immediately to Children’s Services in the appropriate county.
BILLING AND CLAIMS

GENERAL BILLING GUIDELINES

Physicians, other licensed health professionals, facilities, and ancillary provider’s contract directly with Consumers’ Choice for payment of covered services.

It is important that practitioners ensure Consumers’ Choice has accurate billing information on file. Please confirm with your Office Manager that the following information is current in our files:

- **Practitioner Name** (as noted on his/her current W-9 form)
- **Provider National Provider Identifier (NPI)**
- Physical location address (as noted on current W-9 form)
- Billing name and address (if different)
- **Tax Identification Number**

Practitioners must bill with their NPI number in box 24J. Consumers’ Choice will return claims when billing information does not match the information that is currently in our files. **Claims missing the requirements noted in bold above will be returned**, and a notice sent to the practitioner, creating payment delays. Such claims are not considered “clean” and therefore cannot be entered into the system.

We recommend that practitioners notify Consumers’ Choice in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a Practitioner’s Tax Identification Number and/or address are NOT acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

- The Member is effective on the date of service
- The service provided is a covered benefit under the Member’s contract on the date of service
- Referral and prior authorization processes were followed

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

Providers/Practitioners must submit all claims and encounters within 120 days from the date of service, unless Consumers’ Choice or its vendors created the error. The filing limit may be extended for newborn claims, claims where Consumers’ Choice is the secondary payer and where the eligibility has been retroactively received by Consumers’ Choice, up to a maximum of 365 days.

**All requests for reconsideration or adjustment to paid claims must be received within 60 calendar days from the date the notification of payment or denial is received.**
ELECTRONIC CLAIMS SUBMISSION

Network providers/practitioners are encouraged to participate in the Consumers’ Choice Electronic Claims/Encounter Filing Program. The Plan has the capability to receive an ANSI X12N 837 professional, institution or encounter transaction. In addition, it has the ability to generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP). For more information on electronic filing, contact:

HealthSCOPE Benefits
P.O. Box 91606
Lubbock, TX 79490-1606
1-800-580-8736

Providers/Practitioners that bill electronically are responsible for filing claims within the same filing deadlines as providers/practitioners filing paper claims.

Providers/Practitioners that bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers/Practitioners are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

NATIONAL PROVIDER IDENTIFIER (NPI)

Consumers’ Choice requires all claims to be submitted with a practitioner’s National Provider Identifier (NPI). Consumers’ Choice will require this on all electronic and paper claim submissions. Practitioners must send a copy of the confirmation letter from the Enumerator to Consumers’ Choice to ensure that the NPI is loaded correctly into our claims payment database.

Practitioners may register for an NPI at https://nppes.cms.hhs.gov/NPPES/

Practitioners may download forms at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/

A PAPER CLAIMS SUBMISSION

For Consumers’ Choice Members, all claims and encounters should be submitted to:

HealthSCOPE Benefits
P.O. Box 91606
Lubbock, TX 79490-1606
ATTN: CLAIMS DEPARTMENT
IMAGING REQUIREMENTS

Consumers’ Choice uses an imaging process for claims retrieval. To ensure accurate and timely claims capture, please observe the following claims submission rules:

Do’s
- Do use the correct address
- Do submit all claims in a 9” x 12”, or larger envelope
- Do type all fields completely and correctly
- Do use black or blue ink only
- Do submit on a proper form . . . CMS 1500 or UB-04

Don’ts
- Don’t submit handwritten claim forms
- Don’t use red ink on claim forms
- Don’t circle any data on claim forms
- Don’t add extraneous information to any claim form field
- Don’t use highlighter on any claim form field
- Don’t submit photocopied claim forms
- Don’t submit carbon copied claim forms
- Don’t submit claim forms via fax

CLEAN CLAIM DEFINITION

A clean claim means a claim received by Consumers’ Choice for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment or alteration by the provider/practitioner of the services in order to be processed and paid by Consumers’ Choice.

NON-CLEAN CLAIM DEFINITION

Non-clean claims are submitted claims that require further investigation or development beyond the information contained therein. The errors or omissions in claims result in the request for additional information from the provider/practitioner or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.
WHAT IS A CLAIM?

You are required to submit a claim for each service that you render to a Consumers’ Choice Member.

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

PROCEDURES FOR FILING A CLAIM

Consumers’ Choice encourages all providers/practitioners to file claims electronically. See “Electronic Claims Submission” for more information on how to initiate electronic claims/encounters. Please remember the following when filing your claim:

- All documentation **must** be legible.
- PCP’s and all participating providers must submit claims data for every Member visit, even though they may receive a monthly capitation payment.
- Providers/Practitioners must ensure that all data and documents submitted to Consumers’ Choice, to the best of your knowledge, information and belief, are accurate, complete and truthful.
- All claims and encounter data must be submitted on either form CMS 1500, UB 04, or by electronic media in an approved format.
- Review and retain a copy of the error report that is received for claims that have been submitted electronically, then correct any errors and resubmit with your next batch of claims.
- Providers/Practitioners must submit all claims and encounters within 120 days of the date of service, unless Consumers’ Choice or its vendors created the error.
- All requests for reconsideration or adjustment to paid claims must be received within 60 days from the date the notification of payment or denial is received.
- When submitting claims where other insurance is involved, a copy of the EOB or rejection letter from the other insurance carrier must be attached to the claim.
- Consumers’ Choice Members must **never** be billed by any provider/practitioner for covered services
- Unless the criteria listed under “Billing the Member” is met.
- In a Worker’s Compensation case for which Consumers’ Choice is not financially responsible, the provider should directly bill the employer’s Worker’s Compensation carrier for payment.
COMMON BILLING ERRORS

In order to avoid rejected claims or encounters always remember to:

- Bill the primary diagnosis in the first field
- Use SPECIFIC CPT-4 or HCPCS codes. Avoid the use of non-specific or “catch-all” codes (i.e. 99070)
- Use the most current CPT-4 and HCPCS codes. Out-of-date codes will be denied
- Use the 4th or 5th digit when required for all ICD-9 codes
- Submit all claims/encounters with the proper provider number
- Submit all claims/encounters with the Member’s complete Medicaid number
- Verify other insurance information entered on claim

CODE AUDITING AND EDITING

Consumers’ Choice utilizes National Correct Coding Initiative Guidelines (NCCI) software for automated claims coding verification and to ensure that Consumers’ Choice is processing claims in compliance with general industry standards.

NCCI code auditing software takes into consideration the conventions set forth in the healthcare insurance industry, such as Center for Medicare and Medicaid Services (CMS) policies, current health insurance and specialty society guidelines, and the American Medical Association’s CPT Assistant Newsletter.

Using a comprehensive set of rules, the code auditing software provides consistent and objective claims review by:

- Accurately applying coding criteria for the clinical areas of medicine, surgery, laboratory, pathology, radiology and anesthesiology as outlined by the American Medical Association’s (AMA) CPT-4 manual;
- Evaluating the CPT-4 and HCPCS codes submitted by detecting, correcting and documenting coding inaccuracies including, but not limited to, unbundling, upcoding, fragmentation, duplicate coding, invalid codes, and mutually exclusive procedures;
- Incorporating Historical Claims Auditing (HCA) functionality which links multiple claims found in a Member’s claims history to current claims to ensure consistent review across all dates of service.

The following provides conditions where code-auditing software will make a change on submitted codes:
**Age/Gender** – submitting codes inappropriate for the Member’s age or gender because of the nature of the procedure.

**Example:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>99382</td>
<td>Initial preventive medicine evaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures, new Member; early childhood (age 1 through 4 years)</td>
<td>Allow (1-4yrs) Review (over 4yrs)</td>
</tr>
</tbody>
</table>

**Explanation:**
- Procedure code 99382 is appropriate for a Member who is 1-4 years of age
- Procedure code 99382 is recommended for review for a Member whose age exceeds four (4) years

**Duplicate services** – submitting the same procedure more than once on the same date for services that cannot or are normally not performed more than once on the same date.

**Example: excluding a duplicate CPT:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>72010</td>
<td>Radiologic exam, spine, entire, survey study, anteroposterior &amp; lateral</td>
<td>Allow</td>
</tr>
<tr>
<td>72010</td>
<td>Radiologic exam, spine, entire, survey study, anteroposterior &amp; lateral</td>
<td>Disallow</td>
</tr>
</tbody>
</table>

**Explanation:**
- Procedure code 72010 includes radiologic examination of the lateral and anteroposterior views of the entire spine that allow views of the upper cervical vertebrae, the lower cervical vertebrae, the thoracic vertebrae, the lumbar vertebrae, the sacrum, and the coccyx
- It is clinically unlikely that this procedure would be performed twice on the same date of service

**Example: recommended replacement**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>22114</td>
<td>Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; lumbar</td>
<td>Allow</td>
</tr>
</tbody>
</table>
Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; lumbar

Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; each additional vertebral segment (list separately in addition to code for primary procedure)

Explanation:
- Procedure code 22114 is used to report a single vertebral segment excision
- When submitted twice on a single date of service, the second submission of procedure code 22114 is not recommended for separate reporting and procedure code 22116 is recommended as an alternate code to be added to the claim to indicate the excision of additional vertebral segments

Evaluation and Management Services – submission of an evaluation and management (E/M) service either within a global surgery period or on the same date of service of another E/M service.

Global Surgery

Procedures that are assigned a 90-day global surgery period are designated as major surgical procedures. Procedures that are assigned a 10-day or 0-day global surgery period are designated as minor surgical procedures.

- Evaluation and management services, submitted with major surgical procedures (90-day) and minor surgical procedures (10-day), are not recommended for separate reporting because they are part of the global service
- Effective for service dates in 2003, evaluation and management services, submitted with minor surgical procedures (0-day), are not recommended for separate reporting or reimbursement because these services are part of the global service

Example: evaluation and management service submitted with minor surgical procedures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>11000</td>
<td>Debridement of extensive eczematous or infected skin; up to 10% of body surface</td>
<td>Allow</td>
</tr>
</tbody>
</table>
Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two (2) of these three (3) key components:
1. an expanded problem focused history;
2. an expanded problem focused examination;
3. medical decision making of low complexity.
Counseling and coordination of care with other practitioners or agencies are provided consistent with nature of problem(s) and the Member's and/or family's needs. Problem(s) are low/moderate severity. Physicians spend 15 minutes face-to-face with Member and/or family.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>27447</td>
<td>Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)</td>
<td>Allow</td>
</tr>
<tr>
<td>99213</td>
<td>Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two (2) of these three (3) key components: 1. an expanded problem focused history; 2. an expanded problem focused examination; 3. medical decision making of low complexity. Counseling and coordination of care with other practitioners or agencies are provided consistent with nature of problem(s) and the Member's and/or family's needs. Problem(s) are low/moderate severity. Physician spends 15 minutes face-to-face with member and/or family.</td>
<td>Disallow</td>
</tr>
</tbody>
</table>

**Explanation:**
- Procedure code 11000 (0-day global surgery period) is identified as a minor procedure
- Procedure code 99213 is submitted with the same date of service
- When a minor procedure is performed, the evaluation and management service is considered part of the global service

**Example: global surgery period**

**Explanation:**
- Procedure code 27447 has a global surgery period of 90 days
- Procedure code 99213 is submitted with a date of service that is within the 90-day global period
- When a substantial diagnostic or therapeutic procedure is performed, the evaluation and management service is included in the global surgical period
**Same Date of Service**

One (1) evaluation and management service is recommended for reporting on a single date of service.

**Example: same date of service**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
</table>
| 99215 | Office or other outpatient visit for the evaluation and management of an established Member, which requires at least two (2) of these three (3) key components:  
  1. a comprehensive history;  
  2. a comprehensive examination;  
  3. medical decision making of high complexity.  
  Counseling and/or coordination of care with other practitioners or agencies are provided consistent with nature of problem(s) and Member's and/or family's needs. Usually, problem(s) are moderate/high severity. Physicians spend 40 minutes face-to-face with Member and/or family. | Allow  |
| 99242 | Office consultation for a new or established Member, which requires these three (3) key components:  
  1. an expanded problem focused history;  
  2. an expanded problem focused examination;  
  3. straightforward medical decision making.  
  Counseling/coordination of care with other practitioners or agencies is provided consistent with nature of problem(s) and Member's/family's needs. Presenting problem(s) are low severity. Physicians spend 30 minutes face- to-face with Member/family. | Disallow |

**Explanation:**

- Procedure code 99215 is used to report an evaluation and management service provided to an established Member during a visit.
- Procedure code 99242 is used to report an office consultation for a new or established Member.
- Separate reporting of an evaluation and management service with an office consultation by a single practitioner indicates a duplicate submission of services. Interventions, provided during an evaluation and management service, typically include the components of an office consultation.

**NOTE:**

*Modifier - 24 is used to report an unrelated evaluation and management service by the same physician during a post-operative period.*

*Modifier - 25 is used to report a significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure.*
Modifier - 79 is used to report an unrelated procedure or service by the same physician during the post-operative period.

When modifiers -24 and -25 are submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, the evaluation and management service is questioned and a review of additional information may be required.

When modifier - 79 is submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, separate reporting of the evaluation and management service is allowed.

Modifiers - Modifiers are added to the main service or procedure code to indicate that the service has been altered in some way by a specific circumstance.

**Modifier -26 (professional component)**

**Definition:** Modifier -26 identifies the professional component of a test or study.

- If modifier - 26 is not valid for the submitted procedure code, the procedure code is not recommended for separate reporting.
- When the place of service is an inpatient setting, modifier -26 will be recommended to be appended to valid procedure codes submitted without modifier -26.
- When the place of service is an outpatient setting, procedure codes submitted with modifier -26 are recommended for separate reporting.

**Example:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>78278</td>
<td>Acute gastrointestinal blood loss imaging</td>
<td>Disallow and Replace</td>
</tr>
<tr>
<td>POS=Inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>78278-26</td>
<td>Acute gastrointestinal blood loss imaging</td>
<td>Add and Allow</td>
</tr>
<tr>
<td>POS=Inpatient</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Explanation:**
- Procedure code 78278 is valid with modifier -26.
- Modifier -26 will be added to procedure code 78278 when submitted without modifier -26.
**Modifier - 50 (bilateral procedures)**

**Definition:** Modifier - 50 edit applies to bilateral procedures submitted with or without a modifier - 50 and should be billed with a count of one. (Bilateral procedures are those that can be performed on both sides of the Member in the same operative session.)

**Example:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>69436</td>
<td>Tympanostomy (requiring insertion of ventilating tube), general anesthesia</td>
<td>Allow</td>
</tr>
<tr>
<td>69436</td>
<td>Tympanostomy (requiring insertion of ventilating tube), general anesthesia</td>
<td>Disallow and Replace</td>
</tr>
<tr>
<td>69436-50</td>
<td>Tympanostomy (requiring insertion of ventilating tube), general anesthesia</td>
<td>Add and Allow</td>
</tr>
</tbody>
</table>

**Explanation:**
- Procedure code 69436 was performed bilaterally and submitted twice without modifier -50
- The second submission of procedure code 69436 is not recommended for separate reporting, but modifier -50 is recommended to be added to this procedure code to indicate a bilateral performance of the procedure

**Modifier - 51 (multiple procedures)**

**Definition:** Modifier - 51 edit identifies a secondary procedure code when more than one (1) surgical procedure is performed.

**Example:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>51820</td>
<td>Cystourethroplasty with unilateral or bilateral ureteroneocystostomy</td>
<td>Allow</td>
</tr>
<tr>
<td>51840-51</td>
<td>Anterior vesicourethropexy, or urethropexy (e.g., Marshall-Marchetti- Krantz, Burch); simple</td>
<td>Allow</td>
</tr>
<tr>
<td>51920-51</td>
<td>Closure of vesicouterine fistula;</td>
<td>Allow</td>
</tr>
<tr>
<td>58140-51</td>
<td>Myomectomy, excision of leiomyomata of uterus, single or multiple (separate procedure code); abdominal approach</td>
<td>Allow</td>
</tr>
</tbody>
</table>
Explanation:
- Procedure code 51820 is determined to be the primary procedure performed because it is the most clinically intensive procedure for this clinical scenario
- Procedure codes 51840, 58140, and 51920 are determined to be secondary procedure codes and modifier -51 is recommended to be appended to each

**Modifier - 80, - 81, - 82, and -AS (Assistant Surgeon)**

**Definition:** The Assistant Surgeon edit identifies procedures not requiring an assistant-at-surgery.

Many surgical procedures require aid in prepping and draping the Member, monitoring visualization, keeping the wound clear of blood, holding and positioning the Member, assisting with wound closure, and/or casting (if required). This assistance does not require the expertise of a surgeon. A qualified nurse, orthopedic technician, or resident physician can provide the necessary assistance.

**Example:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>42820-81</td>
<td>Tonsillectomy and adenoidectomy; under age 12</td>
<td>Disallow</td>
</tr>
</tbody>
</table>

Explanation:
- Procedure code 42820 is not recommended for Assistant Surgeon reporting because a skilled nurse or surgical technician can function as the assistant in the performance of this procedure

**Modifier -LT and -RT (left, right)**

**Definition:** Modifiers -LT and -RT, when submitted with a procedure code, identify procedures that are performed on the left and right side of the body. When a valid bilateral procedure is submitted more than one (1) time and either -LT or -RT is appended to of the codes, the modifier -50 will be added to the remaining procedure code to indicate bilateral performance of the procedure.

**Example:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>28400-LT</td>
<td>Closed treatment of calcaneal fracture; without manipulation</td>
<td>Allow</td>
</tr>
<tr>
<td>28400</td>
<td>Closed treatment of calcaneal fracture; without manipulation</td>
<td>Disallow and Replace</td>
</tr>
<tr>
<td>28400-50</td>
<td>Closed treatment of calcaneal fracture; without manipulation</td>
<td>Add and Allow</td>
</tr>
</tbody>
</table>
Explanation:

- The first submission of procedure code 28400 is submitted with modifier -LT, indicating performance of the procedure on the left side of the body.
- The second submission of procedure code 28400 does not include a modifier indicating which side of the body the procedure was performed; As a result of this omission, modifier -50 is added to procedure code 28400 to indicate bilateral performance of the procedure.

**Place-of-service** – services billed with an incorrect place of service for the procedure billed.

**Example:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>96410</td>
<td>Chemotherapy administration, intravenous; infusion technique, up to one (1)hour</td>
<td>Disallow for POS=Inpatient</td>
</tr>
</tbody>
</table>

Explanation:

- Procedure code 96410 is not routinely administered by a physician in an inpatient setting and is not recommended for separate reporting.
- Provision of this service in an office or outpatient facility place of service is recommended for separate reporting.

Global edit - procedure(s) submitted that are performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure.

**Example:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>47562</td>
<td>Laparoscopy, surgical; cholecystectomy</td>
<td>Allow</td>
</tr>
<tr>
<td>49000</td>
<td>Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure)</td>
<td>Disallow</td>
</tr>
</tbody>
</table>

Explanation:

- Procedure code 49000 is routinely performed for most abdominal procedures and is considered clinically integral to performing the primary surgical procedure 47562.

**Unbundling** – submission of a comprehensive code along with incidental procedure codes that are an inherent part of performing the global procedure code. The unbundled procedure code(s) will be rebundled to the comprehensive procedure code.
**Example:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>20102</td>
<td>Exploration of penetrating wound (separate procedure); abdomen/flank/back</td>
<td>Disallow</td>
</tr>
<tr>
<td>44120</td>
<td>Enterectomy, resection of small intestine; single resection and anastomosis</td>
<td>Allow</td>
</tr>
</tbody>
</table>

**Explanation:**

- Procedure code 20102 is an exploratory procedure for a penetrating wound that when performed with procedure code 44120 represents unbundling because exploration is considered to be a component of the more comprehensive procedure code 44120.
- Unbundled procedure codes are re-bundled and paid as a single procedure.

**Fragmentation** – billing all incidental codes or itemizing the components of procedures separately when a more comprehensive code is available.

**Example:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>82465</td>
<td>Cholesterol, serum, total</td>
<td>Replaced</td>
</tr>
<tr>
<td>83718</td>
<td>Lipoprotein, direct measurement, high density cholesterol</td>
<td>Replaced</td>
</tr>
<tr>
<td>84478</td>
<td>Triglycerides</td>
<td>Replaced</td>
</tr>
<tr>
<td>80061</td>
<td>Lipid panel</td>
<td>Added</td>
</tr>
</tbody>
</table>

**Explanation:**

- Procedure code 82465, 83718 and 84478 are part of a more comprehensive code – 80061; The definition of procedure code 80061 includes procedures codes 82465, 83718 and 84478.
- Fragmented procedure codes are replaced and paid as the single comprehensive procedure.

The code auditing software is updated regularly to incorporate the most recent medical practices, coding practices, annual changes to the AMA's CPT-4 Manual and other industry standards.

**Consumers' Choice** uses only standard diagnosis and procedure codes to comply with the Health Information Portability and Accountability Act (HIPAA) Transactions and Code Sets Standards.
CODE EDITING ASSISTANT

A web-based code auditing reference tool designed to “mirror” how Consumers’ Choice code auditing product(s) evaluate code combinations during the auditing of claims is available for participating providers/practitioners. This allows Consumers’ Choice to share with our contracted providers/practitioners the claim auditing rules and clinical rationale we use to pay claims.

This tool offers many benefits:

- Prospectively access the appropriate coding and supporting clinical edit clarifications for services before claims are submitted
- Proactively determine the appropriate code/code combination representing the service for accurate billing purposes
- Retrospectively access the clinical edit clarifications on a denied claim for billed services after an Explanation of Payment (EOP) has been received

The tool will review what was entered and will determine if the code or code combinations are correct based on the age, sex, location and modifier (if applicable) or other code(s) entered.

BILLING CODES

It is important that providers/practitioners bill with codes applicable to the date of service on the claim. Billing with obsolete codes will result in a potential denial of the claim and a consequent delay in payment. Submit professional claims with current and valid CPT-4, HCPCS, or ASA codes and ICD-9 codes. Submit institutional claims with valid Revenue Codes and CPT-4 or HCPCS (when applicable), ICD-9 codes and DRG codes (when applicable).

Providers/Practitioners will also improve the efficiency of their reimbursement through proper coding of a Member’s diagnosis. We require the use of valid ICD-9 diagnosis codes, to the ultimate specificity, for all claims. This means that ICD-9 codes must be carried out to the fourth or fifth digit when indicated by the coding requirements in the ICD-9 manual (Note: not all codes require a fourth or fifth digit). The highest degree of specificity, or detail, can be determined by using the Tabular List (Volume One) of the ICD-9 coding manual in addition to the Alphabetic List (Volume Two) when locating and designating diagnosis codes. The Tabular List gives additional information such as exclusions and subdivisions of codes not found elsewhere in the manual. Any three-digit code that has subdivisions must be billed with the appropriate subdivision code(s) and be carried out to the fifth digit if appropriate. Ancillary practitioners (e.g. Labs, Radiologists, etc.) and those physicians interpreting diagnostic testing may use V72.6 for Laboratory Exam, V72.5 for Radiological Exam, NEC and V72.85 for Other Specified Exam as the principal diagnosis on the claim. Please consult your ICD-9 manual for further instruction. Failure to code diagnoses to the appropriate level of specificity will result in denial of the claim and a consequent delay in payment. In addition, written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of Consumers’ Choice.
**CLAIM PAYMENT**

Clean claims are normally adjudicated (finalized as paid or denied) within thirty (30) business days of the receipt of the claim. It is the provider’s/practitioner’s responsibility to check their audit report to verify that Consumers’ Choice has accepted their electronically submitted claim. This is also available at www.cchpsc.org. This will require you to register for the secure Provider Portal.

**UNSATISFACTORY CLAIM PAYMENT**

If a provider/practitioner has a question or is not satisfied with the information they have received related to a claim, they should contact:

- When submitting a paper claim for review or reconsideration of the claims disposition, the claim must clearly be marked as "CORRECTED CLAIM" and [include the original claim number]. Failure to mark the claim as a resubmission and include the claim number or Explanation of Payment (EOP) may result in the claim being denied as a duplicate, or for exceeding the filing limit deadline.
- Providers/practitioners may discuss questions with Consumers’ Choice Provider Relations Managers regarding amount reimbursed or denial of a particular service; providers/practitioners may also submit in writing, with all necessary documentation, including the EOP for consideration of additional reimbursement.
- Any response to approved adjustments will be provided by way of check with accompanying explanation of payment.

All requests for reconsideration or adjustment to paid claims must be received within 60 days from the date of notification of payment or denial is received.

Consumers’ Choice shall process, and finalize, all Adjusted/corrected claim requests for reconsideration to a paid or denied status normally within thirty (30) business days of receipt of the Adjusted/Corrected Claim Request. Adjusted/corrected claims are claims in which a provider/practitioner files a request for informal claims payment adjustment or a claim complaint with Consumers’ Choice.

**BILLING FORMS**

Providers/Practitioners submit claims using standardized claim forms whether filing on paper or electronically. Submit claims for professional services and durable medical equipment on a CMS 1500. The following areas of information on CMS 1500 claim forms are common submission requirements of a clean claim accepted for processing:

- Full Member name
- Member’s date of birth
- Valid Member identification number
Complete service level information:
- Date of service
- Diagnosis
- Place of service
- Procedural coding (appropriate CPT-4, ICD-9 codes)
- Charge information and units
- Servicing provider’s/practitioner’s name, address and Medicaid Number
- Provider’s National Provider Identifier (NPI)
- Provider’s/Practitioner’s federal tax identification number
- All mandatory fields must be complete and accurate

Submit claims for hospital based inpatient and outpatient services, as well as swing bed services, on a UB-04.

**THIRD PARTY LIABILITY**

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

*Consumers’ Choice* providers/practitioners shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to *Consumers’ Choice* Members. The provider/practitioner has 120 days from the date of service to submit first time claims. Claims that denied for additional information, providers/practitioners have 120 days from the date of denial to submit the additional information needed for reimbursement.

If third party liability coverage is determined after services are rendered, *Consumers’ Choice* will coordinate with the provider/practitioner to pay any claims that may have been denied for payment due to third party liability.

**COMPLETING A CMS 1500 FORM**

All medical claims are to be submitted on the CMS 1500. The CMS 1500 claim form is required for:

- All professional services “including specialists”
- Individual practitioners
- Non-hospital outpatient clinics
- Ancillary Services
- Durable Medical Equipment
- Non-institutional expenses
- Professional and/or technical components of hospital based physicians and Certified Registered
  - Nurse Anesthetists (CRNAs)
- Home Health Services
<table>
<thead>
<tr>
<th>Place of Service Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00 -10</td>
<td>Not in Use</td>
</tr>
<tr>
<td>11</td>
<td>Office</td>
</tr>
<tr>
<td>12</td>
<td>Home</td>
</tr>
<tr>
<td>13 - 20</td>
<td>Not in Use</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient Hospital</td>
</tr>
<tr>
<td>22</td>
<td>Outpatient Hospital</td>
</tr>
<tr>
<td>23</td>
<td>Emergency Room – Hospital</td>
</tr>
<tr>
<td>24</td>
<td>Ambulatory Surgical Center</td>
</tr>
<tr>
<td>25</td>
<td>Birthing Center</td>
</tr>
<tr>
<td>26</td>
<td>Military Treatment Facility</td>
</tr>
<tr>
<td>27 - 30</td>
<td>Not in Use</td>
</tr>
<tr>
<td>31</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>32</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>33</td>
<td>Custodial Care Facility</td>
</tr>
<tr>
<td>34</td>
<td>Hospice</td>
</tr>
<tr>
<td>35 - 40</td>
<td>Not in Use</td>
</tr>
<tr>
<td>41</td>
<td>Not Valid</td>
</tr>
<tr>
<td>42</td>
<td>Not Valid</td>
</tr>
<tr>
<td>43 - 50</td>
<td>Not in Use</td>
</tr>
<tr>
<td>51</td>
<td>Inpatient Psychiatric Facility</td>
</tr>
<tr>
<td>52</td>
<td>Psychiatric Facility Partial Hospitalization</td>
</tr>
<tr>
<td>53</td>
<td>Community Mental Health Center</td>
</tr>
<tr>
<td>54</td>
<td>Immediate Care Facility/Mentally Retarded</td>
</tr>
<tr>
<td>55</td>
<td>Residential Substance Abuse Treatment Facility</td>
</tr>
<tr>
<td>56</td>
<td>Psychiatric Residential Treatment Center</td>
</tr>
<tr>
<td>57 - 60</td>
<td>Not in Use</td>
</tr>
<tr>
<td>61</td>
<td>Comprehensive Inpatient Rehabilitation Facility</td>
</tr>
<tr>
<td>62</td>
<td>Comprehensive Outpatient Rehabilitation Facility</td>
</tr>
<tr>
<td>63, 64</td>
<td>Not in Use</td>
</tr>
<tr>
<td>65</td>
<td>End Stage Renal Disease Treatment Facility</td>
</tr>
<tr>
<td>66 - 70</td>
<td>Not in Use</td>
</tr>
<tr>
<td>71</td>
<td>State or Local Public Health Clinic</td>
</tr>
<tr>
<td>72</td>
<td>Rural Health Clinic</td>
</tr>
<tr>
<td>73 - 80</td>
<td>Not in Use</td>
</tr>
<tr>
<td>81</td>
<td>Independent Laboratory</td>
</tr>
<tr>
<td>82 - 98</td>
<td>Not in Use</td>
</tr>
<tr>
<td>99</td>
<td>Other Unlisted Facility</td>
</tr>
</tbody>
</table>
COMPLETING A UB-04 CLAIM FORM

A UB-04 is the only acceptable claim form for submitting inpatient or outpatient hospital (technical services only) charges for reimbursement by Consumers’ Choice. In addition, a UB-04 is required when billing for nursing home services, swing bed services with revenue and occurrence codes, Dialysis services rendered in a hospital facility can also fine on a UB-04. Additional information may be requested by Consumers’ Choice to facilitate claims payment.

Incomplete or inaccurate information will result in the claim/encounter being rejected or denied for corrections.

UB-04 HOSPITAL OUTPATIENT CLAIMS

The following information applies to outpatient claims:

- Professional fees must be billed on a CMS 1500 claim form
- Include the appropriate CPT-4 code next to each revenue code

BILLING THE MEMBER

Consumers’ Choice reimburses only services that are medically necessary and covered by the Members’ benefit plan. Providers/Practitioners may not bill a Consumers’ Choice Member for a covered service. Providers/Practitioners should obtain a written consent from the Member to bill for non-covered or non-medically necessary services.

STATEMENT MEMBER ACKNOWLEDGEMENT

A provider/practitioner may bill a Member for a claim denied as not being medically necessary, not a covered benefit, or the Member has exceeded the program limitations for a particular service only if the following condition is met:

Prior to the service being rendered, the provider/practitioner has obtained and kept a written Member Acknowledgement Statement signed by the client that states:

“I understand that, in the opinion of (provider’s/practitioner’s name), the services or items that I have requested to be provided to me on (dates of service) may not be covered by Consumers’ Choice as being reasonable and medically necessary for my care. I understand that my physician and Consumers’ Choice determine the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.”

Balance billing to any Consumers’ Choice Member is strictly prohibited.
PROVIDER VERIFICATION OF MEMBER ELIGIBILITY

To ensure Providers receive payment for Covered Services, Providers must conduct a verification of coverage eligibility prior to rendering any Covered Services to Members.

Under the terms of the Patient Protection and Affordable Care Act (PPACA), if a Member receives an Advanced Premium Tax Credit (APTC), the Member is entitled to a 3 month grace period for payment of Premium. If non-payment occurs during the first month, coverage will continue and Consumers’ Choice will provide payment for Covered Services. However, Consumers’ Choice will suspend payment of claims for any Covered Services provided during the second and third months of the grace period if no Premium payments are received. If the grace period ends, and the Member has not paid all outstanding Premiums, coverage will end pursuant to the terms of the Members’ plan. Due to the grace period available to Members, Providers should always contact Customer Service or visit www.cchpsc.org to verify eligibility prior to rendering Covered Services. If Consumers’ Choice has suspended payment of claims, the Provider will be notified when verifying eligibility.

If the Member is not entitled to receive an APTC, the Member is entitled to a grace period of 31 days for payment of Premium, except for the first Premium due. Coverage will continue during the grace period, unless the Member provides Consumers’ Choice written notice of prospective cancellation in accordance with the terms of the Members’ plan. Although payment will be continued during the grace period under these circumstances, Providers should always contact Customer Service or www.cchpsc.org to verify eligibility prior to rendering Covered Services.

Verification of coverage or benefits does not guarantee payment. A Members’ eligibility is based on the Members’ status at the time services are rendered. Final payment determinations will be made when the claims are processed.

CREDENTIALING REQUIREMENTS

The credentialing and re-credentialing process exists to ensure that participating providers/practitioners meet the criteria established by Consumers’ Choice, as well as government regulations and standards of accrediting bodies. A provider/practitioner is not considered participating with us until they are credentialed and contracted. The participation effective date will be the date the approval letter is sent to the provider/practitioner by The Plan. This letter will be sent following approval from the Patient Safety Committee or the Medical Director.

All communications regarding a provider/practitioner will be maintained in their respective credentialing files. Each Consumers’ Choice network provider/practitioner delivering care to a Consumers’ Choice member in a Consumers’ Choice network healthcare facility (organization) agrees to deliver healthcare services within the authorized scope of his/her license to practice and in accordance with the privileges authorized by the credentialing committee of that licensed and accredited healthcare facility.

Notice: In order to maintain a current practitioner profile, practitioners are required to notify Consumers’ Choice of any relevant changes to their credentialing information in a timely manner.
Physicians must submit at a minimum the following information when applying for participation with Consumers’ Choice:

- Complete signed and dated Consumers’ Choice Standardized Credentialing Form or CAQH (Council for Affordable Quality Health Care) Provider Data Form
- Signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation
- Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage with a minimum of $1M-$3M and practitioner’s name
- Copy of current State Controlled Substance certificate (if applicable)
- Copy of current Drug Enforcement Administration (DEA) Registration Certificate for SC and in the state where care is being provided
- Copy of W-9
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
- Copy of cultural competency training certificate, if applicable
- Copy of current unrestricted Medical License to practice in the state of South Carolina
- Current copy of specialty/board certification certificate, if applicable
- Curriculum vitae listing, at minimum, a five-year work history
- Signed and dated release of information form
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training
- Copy of Clinical Laboratory Improvement Amendments (CLIA) (if applicable)
- The number issued by NPPES (National Plan and Provider Enumeration System), depicting the practitioner’s unique National Provider Identifier (NPI)

Consumers’ Choice will verify the following information submitted for Credentialing and/or Re-credentialing:

- State license through appropriate licensing agency
- Board certification, residency training, or medical education
- National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Databank (HIPDB)
- Current Drug Enforcement Administration Registration
- Hospital privileges in good standing at a participating Consumers’ Choice hospital
- Review five (5) year work history
- Review sanction activity from Medicare/Medicaid, Office of Inspector General (OIG), and Excluded Parties List (EPLS)
- Current South Carolina License even if practice site is located in a border state
Once the application is completed, the Consumers' Choice Patient Safety Committee will render a final decision on acceptance following its next regularly scheduled meeting.

Providers/Practitioners must be credentialed and contracted prior to accepting or treating Members.

**CREDENTIALING OF ORGANIZATIONAL PROVIDERS**

Consumers’ Choice conducts a formal initial assessment of organizational providers before contracting with the providers and at least every three years thereafter. During the initial and subsequent assessments, Consumers’ Choice confirms that organizational providers are in good standing with state and federal regulatory bodies and have been reviewed by an accrediting body or an onsite quality assessment has been performed, as appropriate, if the organizational provider is not accredited. Consumers’ Choice may elect to contract with the CVO to collect evidence of good standing with state and federal regulatory bodies and review and approval by an accrediting body. The CVO may also collect a copy of a CMS audit report, which may be substituted in lieu of the required site visit for non-accredited organizational providers. Consumers’ Choice conducts oversight of the delegate as described in the “Delegation of Credentialing Activities” section of this Credentialing policy.

Regardless of whether or not Consumers’ Choice elects to use a CVO to collect the required organizational provider credentialing information or elects to retain the process in house, Consumers’ Choice maintains a worksheet to consolidate and document credentialing activities for organizational providers. The worksheet includes:

- Organizational provider name
- Organizational provider type
- Prior Confirmation Date/License Status
- Current Confirmation Date/License Status
- Prior Accreditation Confirmation Date/Accrediting Body/Status
- Current Accreditation Confirmation Date/Accrediting Body/Status

**PRACTITIONER RIGHTS**

Practitioners may request to review information that has been obtained to evaluate their credentialing application, attestation or CV. A review of their information includes all documents regarding the credentialing application including information obtained from any outside source such as a malpractice insurance carrier, state licensing board, but excludes references, recommendations or peer review protected information. Practitioners will be notified when their credentialing information obtained from other sources varies substantially from that provided by the practitioner, but the source may not be provided to the practitioner. The practitioner has the right to correct erroneous information submitted by another source. See Credentialing and Re-credentialing of Practitioners and Organizational Providers policy for more detailed information regarding time frames to submit changes and or corrections, how
and to whom to submit those changes, when you can expect receipt of the corrections and how you will be notified for the correction of the erroneous information. The practitioner has the right to request the status of their application and the process can be viewed in the Credentialing and Re-credentialing of Practitioners and Organizational Providers policy.

**PATIENT SAFETY COMMITTEE**

The Patient Safety Committee is a professional review committee comprised of practicing practitioners from the provider network and the Medical Director. This peer review committee reports directly and only to the QIC. The committee conducts practitioner/provider credentialing activities as well as peer review activities to investigate the medical and behavioral healthcare that has been rendered in order to determine whether accepted standards of care have been met. The committee assesses the competence and professional conduct of Consumers’ Choice practitioners. Committee meetings are 6 times per year and more often as deemed necessary.

**FEEDBACK ON PHYSICIAN SPECIFIC PERFORMANCE**

As part of the quality improvement process, performance data on each practitioner is reviewed and evaluated. This may be done by the Patient Safety Committee and/or other committees involved in the quality improvement program. This review of practitioner specific performance data may include, but is not limited to:

- Site evaluation results including medical record audit, appointment availability, afterhours access, cultural proficiency and in-office waiting time
- Preventive care, including well-child exams, immunizations, lead screening, cervical cancer screening, breast cancer screening, and screening for detection of chronic diseases such as diabetes and kidney disease
- Prenatal care
- Member complaint and appeals data
- Utilization management data including referrals/1000 and bed days/1000 reports
- Sentinel events and/or adverse outcomes
- Compliance with clinical practice guidelines

**RE-CREDENTIALING**

To comply with accreditation standards, Consumers’ Choice conducts the re-credentialing process for providers at least every three (3) years from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the practitioner’s licensure, sanctions, certification, competence or health status, which may affect the ability to perform services the provider is under contract to provide. This process includes all practitioners (including primary care providers and
specialists), ancillary providers and/or facilities previously credentialed to practice within the Consumers’ Choice network.

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

A provider’s agreement may be terminated if at any time it is determined by the Consumers’ Choice Board of Directors or the Patient Safety Committee that credentialing requirements are no longer being met.

CERTIFICATION AND LICENSING REQUIREMENTS

Consumers’ Choice has established a set of minimum level criteria which will be used to determine physicians’ and other professional providers’ participation. The minimum criteria include:

**Review and Approval by an Accrediting Body**

Consumers’ Choice confirms with selected accreditation bodies that the organizational provider has been reviewed and approved by the accrediting body. Below are the acceptable accrediting bodies for each organization provider type:

**Hospitals**
- The Joint Commission (TJC), formerly known as JCAHO
- Healthcare Facilities Accreditation Program (HFAP)
- Det Norske Veritas National Integrated Accreditation for Healthcare Organizations (DNVNIAHO)

**Home Health Agencies**
- The Joint Commission (TJC), formerly known as JCAHO
- Community Health Accreditation Program (CHAP)
- The Accreditation Commission for Health Care Inc. (ACHC)

**Skilled Nursing Facilities**
- The Joint Commission (TJC), formerly known as JCAHO
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Continuing Care Accreditation Commission (CCAC)

**Free-Standing Surgical Centers**
- The Joint Commission (TJC), formerly known as JCAHO
- American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF)
- Accreditation Association for Ambulatory Health Care (AAAHC)

**Behavioral Health Organizational Providers, including inpatient, outpatient (ambulatory), and residential**
- The Joint Commission (TJC), formerly known as JCAHO
- Commission on Accreditation or Rehabilitation Facilities (CARF)
- Healthcare Facilities Accreditation Program (HFAP), accrediting program approved by the American Osteopathic Association (AOA)
- Council on Accreditation for Children and Family Services (COA)
FAILURE OF AN APPLICANT TO ADEQUATELY RESPOND TO A REQUEST FOR ASSISTANCE MAY RESULT IN TERMINATION OF THE APPLICATION PROCESS.

Site visits are performed at all practitioner offices during the initial credentialing process and at re-credentialing if new office locations exist or change in office locations has occurred. This review is conducted for all Primary Care Physicians, Pediatricians high-volume behavioral health providers. A satisfactory review (>80%) must be completed prior to finalization of the credentialing process. If the practitioner scores less than 80%, the practitioner may be subject to rejection and/or continued review until compliance is achieved. Site review evaluates appearance, accessibility, posting of office hours, record-keeping practices, and privacy and safety procedures.

RIGHT TO REVIEW AND CORRECT INFORMATION

All providers requesting participating with Consumers’ Choice have the right to review information obtained by Consumers’ Choice to evaluate their credentialing and/or re-credentialing application may do so by contacting Customer Service at 1-800-580-8736. This includes information obtained from any outside primary source such as malpractice insurance carriers and the State of South Carolina State Board of Medical Examiners and South Carolina State Board of Nursing for Nurse Practitioners. This does not allow a provider to review references, personal recommendations or other information that is peer review protected.

Should a provider believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, they have the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to the Consumers’ Choice Credentialing Department. Also, have the right to receive the status of their credentialing or recredentialing application, upon request. Upon receipt of this information, the provider will have ten (10) days to provide a written explanation detailing the error or the difference in information to Consumers’ Choice. The Consumers’ Choice Patient Safety Committee will then include this information as part of the credentialing/re-credentialing process.
RIGHT OF RECONSIDERATION AND APPEAL

New provider/practitioner applicants who are declined participation for reasons such as quality of care or liability claims issues have the right to request a reconsideration of the decision in writing within thirty (30) calendar days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant’s reconsideration for participation in Consumers’ Choice. Reconsiderations will be reviewed by the Patient Safety Committee at the next regularly scheduled meeting, but in no case later than sixty (60) calendar days from the receipt of the additional documentation. The applicant will be sent a written response to his/her request within sixty (60) calendar days or the Patient Safety Committee decision. If the original decision is upheld, the provider/practitioner will not be eligible to reapply for twelve (12) months.

QUALITY IMPROVEMENT PROGRAM

Consumers’ Choice Website: www.cchpsc.org

The culture, systems and processes of Consumers’ Choice are structured around its mission to improve the health of all enrolled Members. The Quality Improvement Program (QIP) utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of healthcare provided to all Members, including those with special needs. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and service among Plan initiatives including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. The purpose of the QIP program is to plan, implement, and monitor ongoing efforts that demonstrate improvements in Member safety, health and satisfaction.

Consumers’ Choice recognizes its legal and ethical obligation to provide Members with access to a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, Consumers’ Choice will provide for the delivery of quality care with the primary goal of improving the health status of its Members. Where the Member’s condition is not amenable to improvement, Consumers’ Choice will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the Member. This will include the identification of Members at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions. Whenever possible, the Consumers’ Choice QIP supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its Members.
PROGRAM STRUCTURE

The Consumers’ Choice Board of Directors (BOD) has the ultimate authority and accountability for the oversight of the quality of care and service provided to Members. The BOD oversees the Quality Improvement (QI) program and has established various committees to monitor and support the QI program.

The QIC is responsible for oversight of the Consumers’ Choice QI Program and is directly accountable to the Consumers’ Choice Board of Directors. The QIC sets the strategic direction for all QI activities, directs and guides the QI Program, and establishes QI goals. The QIC recommends policy decisions, analyzes and evaluates the progress and outcomes of all QI activities, institutes needed action, and ensures follow-up. The QIC is a multidisciplinary committee composed of clinical and administrative personnel.

The QIC establishes subcommittees and taskforces as necessary to take action on focused areas of care or service and receives reports from those bodies. The QIC reviews data from QI activities to ensure that performance meets standard and makes recommendations for improvements to be carried out by subcommittees, taskforces, or specific departments.

The QIC reports to the Board of Directors on a regular basis. The QIC develops and presents to the Board of Directors a QI Program Description, Annual QI Work Plan, and Annual QI Program Evaluation, as well as periodic summaries of QI activities.

QUALITY IMPROVEMENT (QI) PROGRAM SCOPE

The scope of the QI Program is comprehensive and addresses both the quality of clinical care and the quality of service provided to the Plan’s Members. The Consumers’ Choice QI program incorporates all demographic groups, care settings, and services in QI activities, including preventive care, primary care, specialty care, acute care, short-term care, long-term care (depending upon the Plan’s products), and ancillary services, and the Plan operations. To that end, the Consumers’ Choice QI program monitors:

- Compliance with preventive health guidelines and practice guidelines
- Acute and chronic care management
- Provider/Practitioner network adequacy and capacity
- Selection and retention of providers (credentialing and re-credentialing)
- Delegated entity oversight
- Continuity and coordination of care
- Utilization Management, including under and over utilization
- Compliance with Member confidentiality laws and regulation
- Employee and provider cultural competency
- Practitioner appointment availability
INTERACTION WITH FUNCTIONAL AREAS

The QI Department maintains strong working relationships with key functional areas within the Health Plan such as Informatics, Provider Relations, Customer Services, Clinical Operations, Compliance, and Appeals and Grievances. Quality is integrated throughout the Plan, and represents the strong commitment to quality of care and services for Members.

- **Informatics** and the QI Department work together to ensure that data integrity is maintained in the study design of quality initiatives and reported data is accurate, timely and validated.
- **Network Managers** and the QI Department work together to verify that clinical materials distributed to providers are understandable and useful, and that providers understand the Members’ rights and responsibilities and treat enrolled Members accordingly. These departments also coordinate efforts for appropriate access and availability through ongoing monitoring.
- **Members Services** and the QI staff collaborate in relation to Member Satisfaction survey activities, including performance improvement projects. The QI and Customer Services departments work collaboratively to maintain performance data related to Customer services functions, including call center functions, which are tracked, trended and used as a tool to identify opportunities for performance improvement, as appropriate.
- **Clinical Operations** provides utilization management, case management and disease focused services to enrolled Members. Staff identifies and refers quality concerns to the QI department for investigation, and recommends benefit enhancements and participates in QI activities and projects.
- **Compliance** and the QI Department work together so the Plan's new initiatives comply with the federal requirements for CO-OPs contract and accreditation requirements for NCQA/URAC.
- **Appeals and Grievance** and the Provider Relations Department work closely with the QI department so that: any grievance related to a quality of care issue is promptly investigated; grievances and second-level reviews of grievances and administrative reviews are handled timely; data collection and reporting is in compliance with relevant contractual and regulatory requirements; and reporting to appropriate quality committees occurs.
PRACTITIONER INVOLVEMENT

Consumers’ Choice recognizes the integral role practitioner involvement plays in the success of its quality improvement program. Licensed practitioner involvement in various levels of the process is highly encouraged through participating provider representation. Consumers’ Choice encourages PCP, Behavioral Health, Pediatrics, OB/GYN, Specialist and Allied Health Practitioner representation on key quality committees such as, but not limited to, the Quality Improvement Committee, P&T Committee, Provider Advisory Committee, Patient Safety Committee and select ad-hoc committees.

PERFORMANCE IMPROVEMENT PROCESS

The Consumers’ Choice QI Committee reviews and adopts an annual QI Program and QI Work Plan based on appropriate industry standards. The QIC adopts traditional quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. As part of this approach, the Plan’s Senior Management, and the Chief Health Officer, in conjunction with the QI Department, determine the scope and frequency of QI initiatives (clinical and non-clinical performance improvement projects, focus studies, etc.). Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area, and includes targeted interventions that have the greatest potential for improving health outcomes or the service. Other initiatives will be selected to test an innovative strategy. Once a QI topic is selected, the QI Department, in conjunction with specific functional areas as appropriate, will present the proposed QI initiative to the QIC for approval. The QIC will select those initiatives that have the greatest potential for improving health outcomes or the quality of service delivered to the Plan’s Members and network providers.

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

The development and selection of clinical performance improvement projects is the responsibility of QIC due to its clinical representation. The QIC continues to monitor progress of clinical Performance Improvement Process (PIP) as well as regular reporting. The Consumers’ Choice Quality Improvement Program allows for continuous performance of quality improvement activities through analysis, evaluation and improvement in the delivery of healthcare provided to all Members, and will establish mechanisms to track issues over time.

Quality Improvement Work Plan is developed annually. The Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The Work Plan integrates QI activities, reporting and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QI Committee as well as requirements for external reporting.
and other performance measurement activities and issues to be tracked over time are scheduled in the QI Work Plan.

The Work Plan is used by the QI Department to manage projects, and by the QI committees and subcommittees and Consumers’ Choice Board of Directors to monitor progress. The Work Plan is modified and enhanced throughout the year.

At any time, Plan providers/practitioners may request information on the Consumers’ Choice quality program including a description of the QI Program and a report on the Plan’s progress in meeting the Work Plan Program goals by contacting the Consumers’ Choice Quality Improvement Department. The organization annually makes information about the QI Program available to Members and practitioners.

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS consists of 20+ Effectiveness of Care type measures as well as Access to Care and Use of Services measures.

As both the State and Federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the Health Plan, but to the individual practitioner as well. Purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a Health Insurance Company’s ability to demonstrate an improvement in Preventive Health outreach to its Members. Physician specific scores are being used as evidence of preventive care from primary care office practices. The rates then serve as a basis for physician incentive programs such as ‘pay for performance’ and ‘quality bonus funds’. These programs pay practitioners an increased premium based on scoring of such quality indicators used in HEDIS. Individual practitioner incentives are negotiated as part of the contracting process.

How are HEDIS rates calculated?
HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim or encounter data submitted to the Health Plan. Examples of measures typically calculated using administrative data include: annual mammogram, annual Chlamydia screening, annual Pap test, treatment of pharyngitis, treatment of URI, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of Member medical records to abstract data for services rendered but that were not reported to the Health Plan through claims/encounter data. Accurate and timely claim/encounter data reduces the necessity of medical record review. Measures typically requiring medical record review include: comprehensive diabetes care, control of high-blood pressure, immunizations, prenatal care, and well-child care.
Who will be conducting the Medical Record Reviews (MRR) for HEDIS?
Medical record review audits for HEDIS are usually conducted March through May each year. At that
time, you may receive a call from a Health Plan representative if any of your patients are selected into
HEDIS samples for Consumers’ Choice. Your prompt cooperation with the Health Plan representative is
greatly needed and appreciated.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment,
payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not
require consent or authorization from the Member/patient.

What can be done to improve my HEDIS scores?
Practitioners should understand the specifications established for each HEDIS measure. They should
submit claim/encounter data for each and every service rendered. All practitioners must bill (or report
by encounter submission) for services delivered, regardless of contract status. Electronic submission of
claim/encounter data and clinical measures is the most clean and efficient way to report HEDIS
measures. If services are not billed or not billed accurately they are not included in the calculation.

Accurate and timely submission of claim/encounter data will positively reduce the number of medical
record reviews required for HEDIS rate calculation. Chart documentation, paper or electronic records
must reflect the services provided.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical
record reviews, please contact Consumers’ Choice customer service at 1-800-580-8736.

CONSUMER ASSESSMENT OF HEALTHCARE PRACTITIONERS AND SYSTEMS (CAHPS) SURVEY

This is a Member satisfaction survey that is included as a part of HEDIS and NCQA accreditation. It is a
standardized survey administered annually to Members by an NCQA certified survey vendor. The adult
CAHPS survey provides information on the experiences of Members with the Health Plan services and
gives a general indication of how well the Health Plan meets Members’ expectations. Global rating
questions reflecting overall satisfaction include rating of personal doctor and rating of specialist seen
most often. Composite scores summarize responses in key areas such as getting care quickly, getting
needed care, how well doctors communicate, and shared decision making. The child CAHPS survey looks
at the same global and composite areas but provides information on parents’ experience with
Consumers’ Choice services. Member responses to the CAHPS survey are used in various aspects of the
quality program including monitoring of practitioner access and availability.

PRACTITIONER SATISFACTION SURVEY

Consumers’ Choice conducts an annual practitioner satisfaction survey which includes questions to
evaluate practitioner satisfaction with our services such as claims, communications, utilization
management, and practitioner services. The survey is conducted by an external vendor. Participants are
randomly selected by the vendor, meeting specific requirements outlined by Consumers’ Choice, and the
participants are kept anonymous. We encourage you to respond timely to the survey as the results of the survey are analyzed and used as a basis for forming provider related quality improvement initiatives. Other surveys may be used for practitioner feedback as well.

**FEEDBACK OF AGGREGATE RESULTS**

Aggregate results of studies and guideline compliance audits are presented to the QI Committee. Participating physician Members of the QIC provide input into action plans and serve as a liaison with physicians in the community. Aggregate results are also published in the quarterly provider newsletter or a special practitioner mailing may be distributed.

At least annually, a Provider Relations Manager meets with primary care providers and high volume specialists to review policies, guidelines, indicators, medical record standards, and provide feedback of audit/study results. These sessions are also an opportunity for practitioners to suggest revisions to existing materials and recommend priorities for further initiatives. When a guideline, indicator, or standard is developed in response to a documented quality of care deficiency, Consumers’ Choice disseminates the materials through an in-service training program to upgrade practitioners' knowledge and skills. The Consumers’ Choice Medical Director and Pharmacist conduct special training and meetings to assist physicians with quality and service improvement efforts.

**FRAUD, WASTE AND ABUSE**

Consumers’ Choice takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a Fraud, Waste and Abuse Program that complies with state and federal laws. Consumers’ Choice performs front and back end audits to ensure compliance with billing regulations. If you suspect or witness a provider/practitioner inappropriately billing or a Member receiving inappropriate services, please notify Customer Services at 1-800-580-8736.

**Referrals**

A. **Internal Referrals**

 Departments within HealthSCOPE Benefits can send referrals to the Special Investigations Unit (SIU) by email, or phone call.

 Judy James, Judy.James@healthscopebenefits.com  
 (615) 695-8522  
 fraud.referrals@healthscopebenefits.com

B. **Toll Free Fraud Hotline – (800) 333-4585**

 This number is provided to Members and Providers/Practitioners on each Explanation of Benefits.
Some of the most common errors seen are:
- Unbundling of codes or Up-coding
- Add-on codes without primary CPT
- Diagnosis and/or procedure code not consistent with the Member’s age/gender
- Use of exclusion codes
- Excessive use of units
- Practitioners and Members that share the same address
- Member’s resident state is different from the practitioner’s rendering state
- Practitioners and Members share the same last name

**AUTHORITY AND RESPONSIBILITY**

The Consumers’ Choice General Counsel has overall responsibility and authority for carrying out the provisions of the compliance program.

Consumers’ Choice is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

The Consumers’ Choice provider/practitioner network must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.
MEMBER/CUSTOMER SERVICES

CUSTOMER SERVICES

Consumers’ Choice is committed to providing its Members with information about the health benefits that are available to them through the Consumers’ Choice. Members are encouraged to take responsibility for their healthcare by providing basic information to assist with making decisions about their healthcare choices.

Consumers’ Choice has developed targeted programs to address the needs of its Members. Members may attend classes; receive specific disease management bulletins and treatment updates, appointment reminder cards, and informational mailings.

As a provider/practitioner for Consumers’ Choice, please remember that it is your obligation to identify any Member who requires translation, interpretation, or sign language services. Consumers’ Choice will pay for these services whenever you need them to effectively communicate with a Consumers’ Choice Member. Consumers’ Choice Members are not to be held liable for these services. To arrange for any of the above services, please notify the Consumers’ Choice Network Department at 1-800-580-8736.

MEMBER MATERIALS

Members will receive various pieces of information from Consumers’ Choice through mailings and through face-to-face contact. The Member Handbook is printed in English and Spanish and can be requested in other languages identified by the State. These materials include:

- Quarterly Newsletters
- Targeted Disease Management Brochures
- Provider Directory
- Incentive Information
- Emergency Room Information
- Member Handbook
- Benefit Information, including pharmacy network information
- Member Rights and Responsibilities

Providers/Practitioners interested in receiving any of these materials may contact:

Customer Service Department
1-800-580-8736
www.cchpsc.org

For TTY hearing impaired, you have two options:
1. Use your TTY machine and call 711. Provide the 800 number listed on the back of your ID card.
2. Call 800-545-8279 directly.
PROVIDERS/PRACTITIONERS BILL OF RIGHTS

Consumers’ Choice Providers/Practitioners shall be assured of the following rights:

A Healthcare Professional, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a Member who is his/her patient for the following:

- The Member’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered
- Any information the Member needs in order to decide among all relevant treatment options
- The risks, benefits, and consequences of treatment or non-treatment
- The Member’s right to participate in decisions regarding his/her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.
- To receive information on the Grievance, Appeal and Fair Hearing procedures
- To have access to Consumers’ Choice policies and procedures covering the authorization of services
- To be notified of any decision by Consumers’ Choice to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested
- To challenge on behalf of Consumers’ Choice Members, the denial of coverage of, or payment for, medical assistance
- Consumers’ Choice provider/practitioner selection policies and procedures must not discriminate against particular providers/practitioners that serve high-risk populations or specialize in conditions that require costly treatment
- To be free from discrimination for the participation, reimbursement, or indemnification of any provider/practitioner who is acting within the scope of his/her license or certification under applicable State law, solely on the basis of that license or certification

NOTICE TO PROVIDERS OF THIRD PARTY PAYMENT RESTRICTION

As an anti-fraud measure, Consumers’ Choice will not accept premium payments from third party payers such as medical clinics, hospitals, healthcare providers, or other entities or individuals who are not related to the member by blood or legally by marriage, adoption, guardianship, etc. unless Consumers’ Choice is required to do so by state or federal law (for example, Ryan White HIV/AIDS Program or an Indian tribe or tribal organization). If Consumers’ Choice determines that such unacceptable third party payments have been made by an in-network or out-of-network provider, payments may be rejected or related claims may be denied.
MEMBER RIGHTS

Members are informed of their rights and responsibilities through the Member Handbook. Consumers’ Choice providers/practitioners are also expected to respect and honor Members’ rights and to post the Members’ Rights and Responsibilities in their offices. As partners in the provision of care, the Health Plan encourages its Members to understand their rights and responsibilities to access the best possible care, and to improve their overall health experience. The Health Plan provides covered services to all eligible Members regardless of age, race, religion, color or disability.

The organization distributes its member rights and responsibilities statement to the following groups:

1. New members, when they enroll.
2. Existing members, annually.
3. New practitioners, when they join the network.
4. Existing practitioners, annually.

Members Have The Right:

- To choose a primary care provider (PCP) and to change to another PCP.
- To voice grievances or file appeals about Consumers’ Choice decisions that affect their privacy, benefits or the care provided.
- To request and receive a copy of their medical record.
- To make recommendations regarding Consumers’ Choice Member Rights and Responsibilities policy.
- To request that their medical record be amended or corrected.
- To make an advance directive, such as a living will.
- To receive information about Consumers’ Choice, its benefits, its services, its practitioners, providers, Member rights and responsibilities.
- To be treated with respect and with due consideration for his/her dignity and the right to privacy and non-discrimination as required by law.
- To participate with their providers and practitioners in making decisions regarding their healthcare, including the right to refuse treatment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion.
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
- To have a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- To receive information on the Grievance, and Appeals procedure.
- To expect their medical records and care be kept confidential as required by law.
- To receive **Consumers’ Choice** policy on referrals for specialty care and other benefits not provided by the Member’s Primary Care Provider (PCP).
- To privacy of healthcare needs and information as required by federal law (Standards for Privacy of Individually Identifiable Health Information).
- To exercise these rights without adversely affecting the way **Consumers’ Choice** or its providers/practitioners treat the Members.
- To allow or refuse their personal information be sent to another party for other uses unless the release of information is required by law.
- To receive timely access to care, including referrals to specialists when medically necessary without barriers.
- To receive materials – including enrollment notices, information materials, instructional materials, available treatment options and alternatives, etc. - in a manner and format that may be easily understood.
- To get a second opinion from a qualified healthcare professional.
  - They have the right to a second opinion about their care and choose a **Consumers’ Choice** contracted practitioner to give a second opinion. There is no charge to them. Their PCP or Customer Services can help them find a practitioner. If they are unable to find a practitioner in the **Consumers’ Choice** network, we will help them find a practitioner outside the network. There is no charge to them if you need a second opinion from a practitioner outside the network which has been preapproved for this service.
  - This means talking to a different practitioner about an issue to see what they have to say. The second practitioner is able to give them their point of view. This may help them decide if certain services or methods are best for them. If they want to hear another point of view, tell their PCP.
  - Any tests that are ordered for a second opinion must be given by a practitioner in the **Consumers’ Choice** network. Their PCP will look at the second opinion and help them decide on a treatment plan that will work best for them.
- To receive oral interpretation services free of charge for all non-English languages.
- To be notified that oral interpretation is available and how to access those services.
- To receive complete description of disenrollment rights at least annually.
- To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
  - What constitutes an emergency medical condition, emergency services, and post-stabilization services
  - What emergency services do not require prior authorization.
  - The process and procedures for obtaining emergency services.
  - The locations of any emergency settings and other locations at which practitioners and hospitals furnish emergency services and post-stabilization services covered under the contract.
  - Member’s right to use any hospital or other setting for emergency care.
- Post-stabilization care services rules in accordance with Federal guidelines.
- To privacy, and to be treated with respect and dignity.
- To an interpreter to aid them in better understanding their benefits.
- To receive a Member handbook, and if requested, in another language or format.
- To ask for and receive copies of their medical records, and the right to confidentiality in the treatment of their medical records.
- To voice or file a complaint or appeal about our services, our participating providers/practitioners or about our organization or the care it provides/practitioners, without fear, discrimination, retaliation, reprisal or repercussion.
- To receive a timely response or resolution to their questions, complaints or appeals.
- To participate with practitioners in making decisions about their treatment and care, including the right to request a second opinion, and the right to refuse treatment. If a Member refuses medical care, their health care professionals should tell them what might happen.
- To have a candid discussion with their practitioners about appropriate or medically necessary treatment options for their condition, regardless of the cost or benefit coverage. We do not have any policies restricting this discussion between them and their practitioners and we do not direct practitioners to restrict information regarding treatment options.

**MEMBER RESPONSIBILITIES**

**Members Have The Responsibility:**

- To read and understand the materials provided to them by *Consumers’ Choice* concerning their benefits, and to contact the Plan if they have any questions.
- To present their identification card to indicate that they are our Member before receiving care.
- To supply information (to the extent possible) to their practitioners and providers and the organization in order to provide care and for them to stay healthy or get healthy, and to ask questions so that they can understand their health status.
- To understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible if they become ill. This includes making and keeping appointments.
- To follow the treatment plan and instructions for care that was agreed upon by them and their practitioners.
- To notify *Consumers’ Choice* or their practitioner of any enrollment changes such as family size, address changes, or whether they have other health insurance.
- To fulfill any financial obligations as it relates to payments as stated in their policy.
- To supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- To follow plans and instructions for care that they have agreed to with their practitioners.
• To understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

• To choose a person to represent them for the use of their information by Consumers’ Choice if they are unable to.

• To inform Consumers’ Choice of the loss or theft of their ID card.

• To present their ID card when using healthcare services.

• To be familiar with Consumers’ Choice procedures to the best of their ability.

• To notify Consumers’ Choice to obtain information and have questions clarified.

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

• To inform their practitioner with reasons why they cannot follow the prescribed treatment of care recommended by their practitioner.

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

• To keep their medical appointments and follow-up appointments.

• To access preventive care services.

• To be honest with practitioners and treat them with respect and kindness.

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

• To complete an HRA and biometrics

• To be responsible for their health

• To follow the steps of the appeal process

• To keep all of their scheduled appointments; be on time for those appointments, and cancel (24) hours in advance if they cannot keep an appointment

• To notify Consumers’ Choice and their providers/practitioners of any changes that may affect their membership, healthcare needs or access to benefits. Some examples may include:
  
  o If they have a baby
  
  o If their address changes
  
  o If their telephone number changes
  
  o If they or one of their children are covered by another health plan
  
  o If they have a special medical concern
  
  o If their family size changes
MEMBER GRIEVANCES

A grievance is an expression of dissatisfaction about any matter other than an "action" with any aspect of Consumers’ Choice or a provider’s/practitioner’s operation. A grievance may become a member appeal if the member is dissatisfied with the outcome.

Examples:

- Quality of care issues
- Rudeness of a provider/practitioner or employee
- Failure to respect the Member’s rights

Who has the authority to file?

- A Member or Member’s authorized representative
- A provider/practitioner, acting on behalf of the Member

Grievances may be filed either orally or in writing with Consumers’ Choice. Members or their authorized representative may file a grievance by contacting Customer Services at 1-800-580-8736, or by submitting written notification to www.cchpsc.org.

Consumers’ Choice will respond to all issues raised by Members as soon as possible but at least within thirty (30) calendar days of receipt of the grievance. Should Consumers’ Choice or the Member request additional time to resolve the grievance, Consumers’ Choice will extend the resolution timeframe to 14 additional calendar days for resolution of the grievance.

Consumers’ Choice shall retain Grievance and Appeal records and reports for three (3) years in accordance with SC Code. If any litigation, claim negotiation, audit or other action involving the documents or records has been started before the expiration of the three (3) year period, the records shall be retained until the completion of the action and resolution of issues which arise from it or until the end of the regular five (5) year period, whichever is later.

MEMBER MEDICAL APPEALS

A medical appeal is the request for review of an “action.” Actions include:

- denial or limited authorization of a requested service, including the type or level of service;
- reduction, suspension, or termination of a previously authorized service;
- denial, in whole or part of payment for a service; or
- failure to provide services in a timely manner.

An appeal may be requested in writing or orally. Only services that were previously reviewed for medical necessity by the Medical Director will be considered for medical appeals.
Who may file an appeal?

- Consumers’ Choice Members
- Authorized representative of an Consumers’ Choice Member
- Provider/Practitioner acting on behalf of Member
- Send all medical appeal request to:

  Consumers’ Choice  
  Attention: Appeals  
  PO Box 80486  
  Charleston, SC 29416

Members have the right to request, within 10 days of the date of the Notice of Action, that benefits be continued while an appeal is pending. Consumers’ Choice will send a written decision within thirty (30) calendar days after the request for an appeal is received by Consumers’ Choice, subject to an authorized extension of up to 14 days.

The Member may be held liable for the cost of those benefits if original determination is upheld.

Consumers’ Choice will not take punitive action against a provider/practitioner who requests an expedited resolution or supports a Member’s appeal request. Consumers’ Choice will retain medical appeal records for 5 years.

MEMBER EXPEDITED RESOLUTION OF APPEALS

If a decision on an appeal is required immediately due to the Member’s health needs an expedited appeal may be requested. Consumers’ Choice decision on the expedited resolution will be provided within 72 hours of receipt of the request for the review.

If Consumers’ Choice denies a request for expedited resolution of an appeal, standard timeframes for appeal resolution (30 calendar days) will apply Consumers’ Choice will make reasonable efforts to give prompt verbal notice of the denial of expedited review and follow up within two (2) calendar days with a written notice.

Provider Adverse Determination Appeals Process

The following process should be utilized when a Provider has questions or concerns regarding benefit determinations or claims payment issues (medical necessity, appropriateness, healthcare setting, level of care or effectiveness, etc., “Adverse Determination”). All other issues or disputes should be handled pursuant to the Provider Dispute Resolution Procedure (see this section).

Prior to filing a formal Adverse Determination Appeal, contact Customer Service to determine if your questions or concerns can be resolved. If we are unable to resolve the issue, please review and follow the instructions below, for filing an Adverse Determination Appeal.
Adverse Determination Appeals

Internal Appeal

If a Provider disagrees with a benefit determination after initially contacting Customer Service, the Provider should request an Adverse Determination Appeal by providing the following information:

- The patient’s name and the identification number from the ID card;
- The date(s) of medical service(s);
- The Provider’s name;
- The reason the Provider believes the claim should be paid or adjusted; and
- Any documentation or other written information to support the appeal.

The request for appeal must be submitted to the Plan, either orally or in writing, within one hundred eighty (180) days after the date of receipt of a notice of an Adverse Determination. Within 5 days of receipt of the first level appeal, the Provider will be notified of the right to submit written documents, records and other materials relating the appeal. The Provider will also have access to copies of all documents, records and other information, free of charge, which are relevant to the appeal.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If the appeal is related to clinical matters, the review will be done with a health care professional with expertise in the field who was not involved in the prior determination. The Plan may consult with medical experts as part of the appeal resolution process. Non clinical appeals will be reviewed by an appeals committee comprised of representatives from Provider Relations, Customer Service, Community Relations, Communications, Pharmacy, and Clinical Operations.

Providers will receive written or electronic notification of the Plan’s determination within thirty (30) days of receipt of appeal.

Urgent Appeals that Require Immediate Action

A Provider’s appeal may require immediate action if it involves an Adverse Determination about admission, availability of care, continued stay, or healthcare services when a patient has received emergency services but has not yet been discharged. In these urgent situations:

- The appeal is not required to be submitted in writing. The preferred method for receipt of an expedited internal appeal is via the telephone; however, the Provider may request these types of appeals either orally or electronically.
- Provider will be provided with all documents and information being considered in the expedited appeal by phone, email, fax, or other reasonable means.
- The Plan will provide a determination as quickly as the condition requires, but not more than 72 hours following receipt of the urgent appeal request.

Provider can pursue an Expedited External Review while simultaneously pursuing an Expedited (Urgent) Internal Appeal (see below).
Standard External Review

Provider may request a standard external review if:

- Provider has exhausted the first level of the internal review process documented above under Adverse Determination Appeals or;
- The Plan has not provided a determination on Provider’s internal appeal within the applicable time frame.

The request for external review must be received within 6 months of the final internal Adverse Determination.

External review is available if the decision to deny benefits is based on:

- Lack of medical necessity
- Failure to meet requirements for appropriateness, setting, level of care, or effectiveness; or
- The exclusion for experimental, investigational or unproven services or treatment and the condition is life threatening or seriously disabling; or
- A rescission of the patient’s coverage.

The Plan will notify Provider within 3 business days whether or not Provider’s request is eligible for external review. The Plan will also advise Provider on how to submit additional documentation for the review.

If the appeal is eligible for external review, the Plan will forward Provider’s request to an Independent Review Organization (IRO) at no cost to Provider. A decision will be made on the external review within 45 days from the date of Provider’s request.

The IRO’s decision will be binding and no subsequent review will be available.

Expedited (Urgent) External Review

Provider may request an expedited external review if the denial:

- Involves a medical condition where the time frame for a standard external review would seriously jeopardize the life, health or ability to regain maximum function of the patient; or
- Was based upon a determination concerning an admission, availability of care, continued stay, or health care service for which the patient received emergency care and has not been discharged from a Facility.

All expedited external appeals should be submitted via the telephone. If the appeal is not eligible for an expedited external review, the Plan will immediately notify the Provider, and advise the Provider of his/her right to file a complaint with the Commissioner of Insurance. If the appeal is eligible for an expedited external review, the Plan will immediately send the request to an IRO at no cost to Provider.

The IRO will make a decision as quickly as the medical condition or circumstances require, but no more than 72 hours from the time of the request.

The decision made by the IRO will be binding and no subsequent review will be available.
Provider Dispute Resolution Procedure

NOTE: This Procedure is not to be followed when appealing issues regarding adverse benefit determinations (medical necessity, appropriateness, healthcare setting, level of care or effectiveness, etc.). All appeals regarding adverse benefit determinations will be handled pursuant to the Provider Adverse Determination Appeals section of this Manual.

This Procedure sets forth the exclusive process to be followed by network Providers and Consumers’ Choice in resolving any disputes, including but not limited to, administrative, medical policy or other issues related to a Provider’s participation in the Consumers’ Choice network and the Agreement between Consumers’ Choice and Provider. This procedure shall be incorporated by reference into the participation Agreement between the parties, and shall survive the termination of that Agreement.

A party must commence a dispute under this Procedure within one hundred eighty (180) days from the date the dispute arose. The parties may mutually agree to skip one or more steps of the Procedure to expedite resolution of a dispute.

I. Informal Inquiry: Providers should contact or forward their Inquiry to the Customer Service Department. If an immediate response to the Provider’s Inquiry cannot be provided, an investigation will be conducted and a written response to that Inquiry will be provided within thirty (30) days.

II. Reconsideration: If the Provider is still dissatisfied after receiving a response to their Inquiry, they may submit a written Reconsideration within 30 days of receipt of the response to the Inquiry. Providers should forward their written Reconsideration to the Customer Service Department. The statement for Reconsideration shall set forth the basis of the dispute and attach any documents that are available, that relate to the dispute. An investigation will be conducted and a written response to the Reconsideration will be provided within thirty (30) days of receipt.

III. Binding Arbitration: To the extent a dispute cannot be settled by Informal Inquiry or reconsideration, such dispute shall be resolved by binding arbitration, conducted in accordance with and subject to the Arbitration Rules of the American Health Lawyer’s Association (AHLA) then in effect. The parties will select a single arbitrator from a panel of arbitrators proposed by the AHLA. In the event the parties cannot agree on the arbitrator, then the arbitrator shall be appointed by the AHLA. The arbitration shall be conducted in South Carolina or such other location as mutually agreed upon by the parties.

Any judgment rendered in any such arbitration may be entered in any court of competent jurisdiction sitting in the state of South Carolina, or application may be made to such court for judicial acceptance and enforcement of the award, as applicable law may require or allow.

The submission of any dispute to arbitration shall not adversely affect either party’s right to seek preliminary injunctive relief with respect to an actual or threatened termination, repudiation or rescission of the Provider’s Agreement, where applicable.
The cost of any arbitration proceeding(s) hereunder shall be borne by the party initiating the arbitration. Each party shall be responsible for its own attorneys’ fees and such other costs and expenses incurred related to the proceedings. However, the costs of enforcement of the award rendered in any such arbitration in a court of competent jurisdiction shall be borne by the non-prevailing party, including reasonable attorney’s fees and court costs of the prevailing party.

Arbitration proceeding(s) hereunder shall be conducted solely between Provider and Consumers’ Choice; shall not be joined with another lawsuit, claim, dispute or arbitration commenced by any other person, and may not be maintained on behalf of any purported class.

CONTINUATION OF BENEFITS

If the Member is hospitalized on the date the Plan is terminated, benefits for Hospital Services will be provided: for 60 days; until they are covered under another plan; or until they are discharged, whichever occurs first. The provisions of this paragraph will not apply to their newborn child if an application for that child has not been made within 31 days following the child’s birth.

Depending on the Member’s situation, they may be eligible to continue participating in the Plan during a leave or disability.

Consumers’ Choice Members may continue receiving services or items until a decision is made about his/her appeal if the Member was receiving ongoing services that were suspended, reduced or terminated. To ensure continuation of currently authorized services, the Member or person acting on behalf of the Member must file a medical appeal on or before ten (10) calendar days following the mailing of the Consumers’ Choice Notice of Action or the intended effective date of the Action.

Consumers’ Choice will continue the Member’s benefits if the following conditions are met:

- The Member or the provider/practitioner files the appeal timely
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- The services were ordered by an authorized provider/practitioner
- The original period covered by the original authorization has not expired; and
- The Member request extension of benefits.
ASSISTANCE AND CONTACTING CONSUMERS’ CHOICE

The Consumers’ Choice Appeals and Grievance staff is available to assist Members who need help in filing a grievance or request for appeal or in completing any element in the grievance or appeal process. Members may seek assistance or initiate a grievance or request for appeal by calling 1-800-580-8736 for TTY hearing impaired, you have two options:

1. Use your TTY machine and call 711. You will need to provide the 800 number listed on the back of your insurance card.

2. Call 800-545-8279 directly.

SPECIAL SERVICES TO ASSIST WITH MEMBERS

Consumers’ Choice has designed its programs and trained its staff to ensure that each Member’s cultural needs are considered in carrying out Consumers’ Choice operations. Members’ needs may vary depending on their gender, ethnicity, age, beliefs, etc. We ask that you recognize these needs in serving your patients. Consumers’ Choice is always available to assist your office in providing the best care possible to the Members.

There are several services that are also available to the Members to assist with their everyday needs. Please see the description below.

INTERPRETER/TRANSLATION SERVICES

Consumers’ Choice is committed to ensuring that staff and subcontractors are educated about, remain aware of, and are sensitive to the linguistic needs and cultural differences of its Members. In order to meet this need, Consumers’ Choice is committed to the following:

PROCEDURE: VERBAL COMMUNICATION

Spanish Speaking Members:
The US Census data has identified Spanish as the predominant foreign language spoken in the United States and in South Carolina. When a member or a prospective member contacts Customer Services, the call is routed through the IVR system. The caller is immediately offered the option of continuing the call in either English or Spanish. If the caller selects Spanish, the call will be routed to an on staff Spanish bilingual customer service representative (CSR).

Other Languages (Non-Spanish)

When a CSR receives a call from a member or prospective member speaking another language that is not English or Spanish; or identifies through communication; or through a lack of understanding of the
conversation by the CSR or caller, and is unable to assist; the CSR will utilize the contracted AT&T Language Line services for further assistance. The AT&T Language Line provides translation and interpretation services for over 170 languages. The CSR will document the call in English into the Caller Inquiry Tracking System following the normal call inquiry documentation procedures. These calls will be tracked on a spreadsheet for reporting purposes.

**TTY Service**

Calls received from the hearing impaired are conducted through a relay system where the operator voices the transcribed message of the caller. The Member may use their TTY machine, dial 711 or in the event the relay service is not available, they can call 800-545-8279 directly. In the case, where the Health Plan has to initiate a phone call with a member who is hearing impaired, the CSR will engage the use of the TTY service relay operators to convey the message. The CSR will document the call in English into the Caller Inquiry Tracking System following the normal call inquiry documentation procedures.

**PROCEDURE: WRITTEN COMMUNICATION AND CORRESPONDENCE**

**Spanish Speaking Members**

To address the needs of this population, the Health Plan will print all written communication and correspondence in English as well as in Spanish to be readily available for immediate distribution to members as needed.

In addition, the Health Plan’s website will also be configured to allow Spanish speaking members the ability to view the information presented on the website in Spanish.

**Other Languages (Non Spanish)**

At the members’ request, any or all written communication or correspondence will be conveyed in the language of the Members’ choice; including but not limited to the Member Handbook, Summary of Benefits, Health and Wellness Information, Member Newsletter, Policy Exclusions and the Explanation of Benefits/Payments.

The member must contact Customer Service in writing or by telephone to request this service. The CSR will document the request and provide an effective start date for the receipt of the translated documents.
PROVIDER RELATIONS ASSISTANCE

PROVIDER RELATIONS DEPARTMENT

The Provider Relations Department at Consumers’ Choice is designed around the concept of making your experience with Consumers’ Choice a positive one by being your advocate within Consumers’ Choice. The Provider Relations Managers are responsible for providing the services listed below which include but are not limited to:

- Maintenance of existing Consumers’ Choice Provider/Practitioner Manual
- Researching of trends in claims inquiries to Consumers’ Choice
- Provider/Practitioner Education using network performance profiling to include Quality and Cost
- Physician and office staff orientation
- Hospital and ancillary staff orientation
- Ongoing provider/practitioner education, providing updates, answering questions and training to include Web Tool training, HEDIS training and education

The goal of this department is to furnish you and your staff with the necessary tools to provide the highest quality of healthcare to Consumers’ Choice enrolled Membership. To contact a Provider Relations Manager for your area contact:

Provider Relations Department: 1-800-580-8736

The Provider Relations toll free help line staff is available to you and your staff to answer questions, listen to your concerns, assist with Members, respond to your Consumers’ Choice inquiries, connect you to the Consumers’ Choice Provider Relations Manager for your area and other services as you request.

The Provider Relations Manager will serve as your advocates to ensure that you receive necessary assistance and maintain satisfaction with Consumers’ Choice.
RESOURCES AND INFORMATION

- Contact Quick Reference Guide
- Pharmacy Coverage Exception Form
- Care Plan Agreement Form
- Notice of Pregnancy Form
- Medical Prior Authorization Request Form
- Pharmacy Coverage Appeal Form
- Member Non-Routine Use and Disclosure Restriction Request Form
- Member PHI Amendment Request Form
- Prior Authorization Quick Reference List
- Medical Necessity Appeal Form
- Provider Dispute Resolution Appeal Form

DEFINITIONS

✓ PHQ9 (Patient Health Questionnaire-9) - The PHQ-9 is the nine item depression scale of the Patient Health Questionnaire*. It can be a powerful tool to assist clinicians with diagnosing depression and monitoring treatment response. The nine items of the PHQ-9 are based directly on the nine diagnostic criteria for major depressive disorder in the DSM-IV (Diagnostic and Statistical Manual Fourth Edition). This can help track a patient's overall depression severity as well as the specific symptoms that are improving or not with treatment.

✓ Practitioner - A professional who provides health care services. Practitioners are usually licensed as required by law.

✓ Provider - An institution or organization that provides services for health plan members. Examples of providers include hospitals and home health agencies. NCQA uses the term practitioner to refer to the professionals who provide health care services, but recognizes that a "provider directory" generally includes both providers and practitioners and the inclusive definition is the more common use of the word.

✓ Generally accepted standards of medical practice - means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of Physicians practicing in relevant clinical areas, and any other relevant factors.

✓ Services - A business entity that provides inpatient or outpatient testing or treatment of human disease or dysfunction; dispensing of drugs or medical devices for treating human disease or dysfunction or a procedure performed on a person for diagnosing or treating a disease.

✓ Utilization Management (UM) - Evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources.