Provider Manual

Physician and Professional Providers

Last Updated: 6/3/2015

ACTIN Care Groups, LLC
973 Featherstone Road, #340
Rockford, Illinois 61107

As a provider for ACTIN Care Groups, you are obligated to be aware of Member's rights and informed of Members' responsibilities. Our health plan Members may refer to their benefit booklet for a listing of their rights and responsibilities, which are also included below: you can also access these documents on our website www.actincare.com.

RIGHTS	*RESPONSIBILITIES*
You have the right to:	***You have the responsibility to:***
Receive information about ACTIN Care Groups, its services, its functioning, it providers and your rights and responsibilities as a Member.	Provide information that your health benefit plan and provider need, in order to provide care including the completion of surveys that we use to determine your need for preventive services and to measure progress in treatment of your health conditions.
Make recommendations regarding ACTIN Care Group's rights and responsibilities policies, its service, and its functioning.	To respond to our Member satisfaction surveys about the functioning of your health plan.
Make recommendations about the specialists and other providers to whom you are referred based upon your level of satisfaction with your care.	To respond to our patient satisfaction surveys after you receive care by a specialist or at a facility.
Make recommendations about your primary care provider based upon your level of trust, access to care, and satisfaction with care	To respond to our patient satisfaction surveys about your primary care provider.
To request another primary care provider or specialist if you are dissatisfied with the care you are receiving.	To select a primary care provider who will coordinate and manage your care and to cooperate with that provider.
Freely voice complaints or appeals about the functioning of ACTIN Care Groups and the providers who care for you.	Freely voice complaints or appeals about the functioning of ACTIN Care Groups and the providers who care for you.
Expect your primary care provider, our associates and specialists to fully inform you as to the various treatment options for your health conditions.	Understand your health problems and participate in the development of mutually agreed upon treatment goals.
Expect us to fully inform you as to the qualifications and, where available, the results of care of your primary care provider and the specialists and other providers who participate in your care.	
After being fully informed, participate with providers in making decisions about your health care.	Follow the plans and instructions for the care you have agreed to with your providers.
Be treated with respect and recognition of your dignity and your right to privacy in all venues of your care.	To treat our associates and your providers and their staff with the respect and dignity that you expect to receive.

ACTIN CARE GROUPS OVERVIEW

ACTIN Care Groups is a licensed Illinois Preferred Provider Program Administrator that arranges, contracts with and administers contracts with providers under which Members are provided an incentive to use the services of the provider. ACTIN serves self-insured employers in the counties of Winnebago, Boone, and McHenry Illinois and Rock County, Wisconsin.

ACTIN contracts with a small number of selected physicians and facilities. Quality always comes first in the selection of providers. The reason for small networks is to improve communication among providers, to recruit those providers where our information indicates a high probability of patient satisfaction and quality practice, to better coordinate care, to improve our ability to monitor the quality and satisfaction with care, and to manage cost. We audit the medical records of our Members after care and call Members to elicit their satisfaction after episodes of care. This information is aggregated and used to guide our referral processes as well as define our network of providers.

Our contracted hospitals are the Alexian Brothers Hospital Network and our contracted specialists are all Alexian-affiliated specialists. Alexian hospital facilities and specialists are a 40-60 minute drive from Winnebago, Boone, and McHenry Counties where our Members reside. Renal dialysis services are provided locally. Loyola University Medical Center in Mayfield, Illinois and its medical staff provide services, such as organ and bone marrow transplantation that Alexian does not provide. ACTIN contracts for primary care, urgent care, physical therapy, occupational therapy, speech pathology, MRI/CT/Plain X-ray/ultrasound, laboratory services, durable medical equipment, hospice, home health, and skilled nursing care locally.

Care is coordinated at ACTIN's Care Coordinating Centers. All referrals to physicians and professional providers (physical therapy/occupational therapy/speech pathology, dieticians, and behavioral health providers, for example) must be made by the Member's primary care provider and authorized by the Care Coordinating Center. We will coordinate medical necessity review and verification of eligibility for these referrals so that providers need only make one call for referrals.

All requests for referrals by specialists or by Members are honored if in the judgment of the Member's primary care provider the referral is medically necessary. Primary Care Providers receive no financial incentives to limit referrals. The purposes of the referral process are: 1) to be certain that Members are referred to in-network specialists and professional providers so that Members are not subject to balanced billing 2) to select the specialist that is best for the patient based upon their results, efficiency of practice, and patient satisfaction 3) so that the Member's primary care provider can promptly follow up on the results and recommendations of the specialty physician or professional provider visit.

ACTIN's Care Coordinating Centers may be co-located with its Dedicated Primary Care Clinics. In these clinics, Members of contracted employers and insurers are seen by primary care providers who exclusively care for Members. Each Member must select a primary care provider among those who see patients in ACTIN's Dedicated Primary Care Clinics or, where the Member already has a

satisfactory primary care provider, remain with their existing provider. We find that the majority of new Members do not have a satisfactory pre-existing primary care relationship so most primary care is delivered in our Dedicated Primary Care Clinics. At our Dedicated Primary Care Clinics Members are offered as much time with their Primary Care Provider as needed, 24/7 availability to them by telephone, and appointment availability within 24 hours.

ACTIN's provider network is small and selective. The network of ACTIN facilities and professional providers with addresses and contact information is listed on our website under the provider tab at www.actincare.com. For convenience, however, we advise all specialists to call our Care Coordinating Center before ordering tests and procedures to quickly find out which providers are in network and the most convenient venue for care for the patient.

To be certain that all requests are received by us and promptly acted upon, we do not accept emailed or faxed requests for referrals. We provide telephone numbers that are backed up so that there should never be a circumstance where we cannot be reached promptly. Our phones are answered from 8 AM to 5 PM Monday through Friday, including the lunch hour except holidays, (New Years Day, New Years Eve, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Day after Thanksgiving, Christmas Eve, Christmas Day). Our standard is either to answer the telephone within 3 rings or return the call within 20 minutes so that there are no delays in ordering medical services.

Precertification of medical services for medical necessity is performed by MCM Solutions for Better Health, 200 West Monroe Street, Suite 1840, Chicago, IL. MCM bases medical necessity decisions upon Interqual criteria and physician review. The following medical services require precertification for medical necessity and in some cases continuing review but do not require authorization by the Care Coordinating Center. All inpatient Non-Emergency Hospital admissions including surgical, obstetric, and medical admissions, rehabilitation hospital, behavioral health hospital, and long term acute care), skilled nursing facility, sleep studies, spinal injections, vein ablations, MRI and CT scans and Durable Medical Equipment costing more than $500.

PROVIDER SUPPORT SERVICES

Provider Relations

Providers are encouraged to call or email Dr. Guy Clifton to provide information, address concerns and seek assistance in resolving any issues that you or your staff may have regarding the ACTIN Care Groups Plan.

Dr. Clifton may be reached at *guyc@actincare.com* or at 779-216-5525.

Credentialing & Re credentialing

ACTIN credentials and re credentials professional providers who provide specific services and credentials and re credentials organizations that provide comprehensive services. ACTIN requires each professional provider either to be credentialed by Alexian Brothers Hospital Network or Loyola University Medical Center or to submit to ACTIN's Care Coordinating Center the information in the standard form required by the State of Illinois for credentialing and re-credentialing. Re-credentialing is completed every 36 months. Forms for credentialing and re credentialing may be found at: **http://www.idph.state.il.us/about/credentialing.htm** and in the Appendix of the Physician and Professional Provider Manual.

ACTIN accepts Alexian Brothers Hospital Network and Loyola University Medical Center credentialing and re credentialing as it's credentialing for physicians with privileges at those hospitals. We audit hospital credentialing and re credentialing by random primary source verification conducted by McKesson Technologies using NCQA standards. All other physicians and professional providers are individually credentialed and re-credentialed by ACTIN. Providers who are individually credentialed or re credentialed including those who are the subject of random primary source verification must submit State of Illinois credentialing documents to ACTIN. All credentialing and re-credentialing submissions are subject to primary source verification.

Online Provider Directory

ACTIN participating physicians, professional providers, and facilities can be identified on the Participating Providers tab on the ACTIN website at www.actincare.com.

Secure Server Policy

ACTIN staff will accept and open emails from its Business Associates and other providers sent via their own Secure Server technology when the emails contain protected health information (PHI) or sensitive personal information (SPI). Any emails not containing PHI or SPI should not be sent via Secure Server technology. Rather, in order to allow for more efficient and productive exchanges with documentary email trail, ACTIN encourages external parties to send emails that do not contain PHI or SPI via regular unencrypted email. Note that all referrals require a one on one conversation by telephone with an ACTIN associate so that there can be certainty on the part of the provider and the ACTIN staff that the request was received.

Provision of Contract Copies

ACTIN will provide a copy of its contract with a participating physician, physician group or professional provider upon receipt of written request.

Provider Customer Service

Any questions can be answered by calling our Care Coordinating Center at 779-216-5522 or toll free 877-602-1288. If we cannot answer the question we will put you in touch with someone who can or get the answer and call you back. Billing questions may also be referred directly to Group Plan Solutions Benefit Administration (GPS) at 2505 Court Street, Pekin, IL 61588. GPS's telephone number is 888-301-0747. Questions about precertification for medical necessity can also be directly addressed by calling MCM at 800-367-9938

	Telephone Numbers	*Hours*	*Website*
ACTIN Care Coordinating Center (eligibility, billing, payment, physician referrals, referrals to any professional provider, home health, hospice, SNF and any questions.)	779-216-5522 Or toll free 877-602-1288	M-F 8 AM-5 PM CST except New Years Day, New Years Eve, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Day after Thanksgiving, Christmas Eve, Christmas Day	http://www.actincare.com
MCM (precertification for all hospital admissions, MRI/CT, sleep apnea, spinal injections, vein ablations)	888-367-9938 or FAX 312-236-8547	7:30 AM-6 PM M-F CST except holidays	http://www.medicalcost.com/

PRE AUTHORIZATIONS FOR INPATIENT ADMISSIONS

Inpatient Admission

Preadmission, Admission and Continued Stay Review will be performed by MCM to determine that the hospital admission and continued stay are medically necessary and appropriate. MCM uses Interqual criteria for reviews. All elective, urgent and emergency admissions will be reviewed. The covered person, or physician shall be notified, verbally of all review determinations. The hospital may also receive notice.

Only those days and services determined to be medically necessary and appropriate shall be recommended for certification. Days and services, which are not recommended for certification, shall follow non-certification and appeal procedures. Final certification shall not be made before the entire Utilization Review process is complete. This includes the performance of any required physician advisor review.

Who Requests Precertification

Hospitals are not required to perform precertification but must require precertification for medical necessity and eligibility determination to have been completed before non-emergency admissions, or payment is not guaranteed.

Member not Responsible for Pre Certification

The physician or professional provider who orders a medical service or requests a referral is ultimately responsible for precertification. ACTIN will educate its Members on how the plan works but Members are not held finally responsible for precertification. That function rests with licensed medical professionals.

Notification of Hospitalization

To ensure that all hospital admissions are identified in a timely manner Members are required to notify MCM of all planned or actual hospital admissions. MCM shall accept notification from any party, hospital, patient or physician. The patient is ultimately responsible for precertification.

Hospital Preadmission & Admission Review

Hospital preadmission and admission review include inpatient settings in which daily physician interaction takes place including acute inpatient hospital, long-term acute care hospital, inpatient rehabilitation, inpatient mental health facility, and inpatient substance abuse facilities.

Initiating Preadmission Review

Preadmission Review (PAR) and Admission Review can be initiated by simply phoning MCM via its toll-free 800-phone number or via our secure website. The covered person, hospital, attending physician, or physician representative is requested to call MCM at least 5 working days prior to a non-emergency (elective) admission.

Emergency Admissions

When an emergency admission occurs any of the above parties are requested to call MCM within 48 hours of hospital admission.

Preadmission Certification

Preadmission Certification requests will be reviewed initially by an MCM Review Specialist using Severity of Illness/Intensity of Service Screening Criteria. The Review Specialist will obtain from the hospital and physician the medical information necessary to conduct the review. The Review Specialist will compare the furnished medical information with the screening criteria.

The process includes a review to determine if:

a. The procedure proposed is appropriate to outpatient performance.
b. The diagnosis/problem is appropriate to outpatient treatment.
c. The proposed procedure requires a pre-surgical review.
d. The diagnosis or procedure indicates a potential for large case management.
e. The diagnosis indicates the need for discharge assistance.

Continued next page …

If the admission criteria are met, the Review Specialist will certify the medical necessity of the admission and assign the appropriate initial length of stay. The length of stay assignment takes into consideration the patient's age, single vs. multiple diagnoses, and surgical vs. non-surgical hospitalizations. The length of stay norms are based on national average days of care statistics compiled from individual patient discharge records provided by Solucient (formerly by the Professional Activity Study of the Commission on Professional and Hospital Activities). The length of stay norms are divided by both diagnoses and procedures.

Notification

The Review Specialist will provide the attending physician and covered person with verbal notification within one working day of the review determination if the admission is scheduled to occur in less than one day from the time of review and schedule the next continued stay review. For any non-certification determination the Review Specialist will issue a written notice to the attending physician, covered person and ACTIN. Notice may also be provided to the hospital.

Non-Certification

If admission criteria are not met the Review Specialist shall refer the furnished information to the Physician Advisor for review. The PA shall review the initial information submitted by the attending physician and shall make a determination on the medical necessity and appropriateness of the hospitalization. If the Physician Advisor has questions after reviewing the information or intends to recommend non-certification, at least two attempts shall be made to contact the attending physician within 24 hours. Any non-certification shall be conducted in accordance with URAC, DOL/ERISA and appropriate state requirements.

Emergency Admission Procedures

Cases admitted on an emergency basis shall not require a review prior to admission. The hospital, physician or covered person shall be requested to notify MCM by phone of emergency admissions within 48 hours of the admission or the time frame specified in the covered persons health plan. If the admission criteria are met, the covered person, hospital, and attending physician shall receive notification of the review determination and the length of stay recommended for the admission.

Non Confirmed Emergency Admissions

Medically necessary admissions that are not confirmed as emergency shall be subject to the following:

a. MCM's review determination shall properly classify the admission as elective or urgent;
b. Significant patterns of cases inappropriately classified as emergencies shall be referred to the MCM Medical Director for further evaluation;
c. Additional action may include involvement of the hospital UR committee or the local medical society.
d. Emergency admissions that do not meet criteria for admission shall follow non-certification and appeal procedures.

23 Hour Observation

23 hour observation does not require preauthorization. However, if patient converts from 23 hour observation to inpatient, this will require preauthorization.

HOSPITAL CONTINUED STAY REVIEW

Hospital Continued Stay Review & Discharge Assistance

MCM's Preadmission and Admission Review program includes a length of stay assignment. The attending physician, covered person or family member may contact MCM to obtain approval for additional days when it appears that a patient's hospital stay shall exceed the number of approved inpatient care days. Even if MCM is not notified of the need for additional days, a follow-up continued stay review shall automatically be conducted by the Review Specialist to determine if the patient's continued stay is medically necessary and appropriate. The continued Stay Review Program shall be conducted for all admissions subject to Preadmission Review.

Initiating Continued Stay Review

The continued stay review process may be initiated by a telephone request for recertification of additional inpatient care days. The attending physician, covered person or family member may make the request. When no request is made, the Review Specialist shall initiate review no later than one day prior to the end of the length of stay assignment.

Patient or Physician Initiated Review Process

If the attending physician requests additional days, the Review Specialist shall ascertain the medical reason for continued hospitalization and the number of additional inpatient care days needed. The Review Specialist shall follow the review procedures as outlined in the Hospital Preadmission and Admission Review Section.

MCM-Initiated Review Process

The Review Specialist shall contact the hospital to determine if the covered person ~~is~~ still hospitalized. If the covered person is still hospitalized, the RS shall contact the attending physician to:

a. Remind the attending physician that the covered person's certification ends on the specified date.

b. Determine whether the covered person shall be discharged;

Continued next page ...

c. Determine if the covered person's condition requires additional inpatient care days, discharge planning assistance or large case management.

The covered person, attending physician and Group shall be notified of the recertification determination. When continued hospital stay is approved, the recertification determination shall include a new length of stay assignment. The continued stay review and recertification process shall continue until the patient is discharged or non-certification is recommended.

Inpatient Pre-Surgical Review

All elective inpatient surgical procedures shall be subject to pre surgical review as part of the Inpatient Hospital Review Program. The goal of the Pre-Surgical Review Program is to provide assurance to the covered person and claim payer that the performance of elective inpatient surgical procedures is medically necessary and appropriate. The program determines medical necessity and appropriateness for an inpatient elective surgical procedure by review of accepted surgical criteria. When medically indicated, the program shall also provide covered persons with a waiver of plan pre-surgical or second opinion requirements.

Pre-Surgical Program Procedures

When non-emergency inpatient surgery is proposed, the covered person is requested to call MCM. All calls shall be handled by MCM Review Specialist's (RN's). MCM's Review Specialist or Physician Advisor shall contact the attending physician/surgeon to discuss the proposed surgery. MCM's Review Specialist or Physician Advisor shall review the provided information to determine if the surgery meets criteria and is going to be performed in the appropriate setting. If the surgery is recommended as medically necessary and appropriate the covered person, and or provider and Group shall be notified of the review determination. If the surgery does not meet criteria, non-certification and appeal procedures shall be followed.

PREAUTHORIZATION FOR OUTPATIENT TESTS AND PROCEDURES

Sleep Studies Vein Ablation, And Spinal Injections

The goal is to provide assurance to the covered person and Plan Sponsor that the performance of specific elective outpatient tests procedures are medically necessary and appropriate. The program determines medical necessity and appropriateness for an outpatient elective surgical procedure by review of accepted surgical criteria. The covered person is requested to call MCM. All calls shall be handled by MCM Review Specialist's (RN's). MCM's Review Specialist or Physician Advisor shall contact the attending physician/surgeon to discuss the proposed surgery. MCM's Review Specialist or Physician Advisor shall review the provided information to determine if the procedure meets criteria and is going to be performed in the appropriate setting. If the procedure is recommended as medically necessary and appropriate the covered person and or provider and Group shall be notified. If the procedure does not meet criteria, non-certification and appeal procedures shall be followed. The following outpatient procedures require precertification:

Sleep studies to determine:

- Whether the initial sleep study is indicated and ordered by a pulmonologist (only pulmonologists can order sleep studies).
- Appropriate Setting (Home vs. Lab)
- Whether follow-up sleep studies are indicated

Cervical, lumbar, and thoracic injections and Destruction by Neurolytic Agents to determine:

- Whether the initial injection is indicated
- Whether follow up injections are indicated
- Whether injections comply with Plan limits

Ablation of Veins of extremities to determine whether the procedure is indicated.

MRI and CT

All non-emergency outpatient MRI and CT scans shall be subject to precertification review. The goal of the review program is to provide assurance to the covered person and Plan Sponsor that the performance of elective scanning procedures is medically necessary and appropriate. The program determines medical necessity and appropriateness for elective imaging by review of accepted criteria. When MRIs and CTs are proposed on a non-emergency basis, the covered person is requested to call MCM. All calls shall be handled by MCM Review Specialist's (RN's). MCM's Review Specialist or Physician Advisor shall contact the attending physician/surgeon to discuss the proposed-imaging and/or high tech imaging procedure. MCM's Review Specialist or Medical Director shall review the provided information to determine if the imaging and/or high tech imaging procedures meet criteria and are going to be performed in the appropriate setting. If it is recommended as medically necessary and appropriate the covered member and or provider and Group shall be notified. If it does not meet criteria, non-certification and appeal procedures shall be followed.

Occupational (OT), Speech (ST) and Physical Therapy (PT) Precertification

All non-emergency outpatient OT/ST/PT treatment shall be subject to precertification and recertification review. The goal of the OT/ST/PT Review Program is to provide assurance to the covered person and Plan Sponsor that the performance of elective OT/ST/PT treatment is medically necessary and appropriate in frequency and duration. The program determines medical necessity and appropriateness by review of accepted criteria. When the above listed treatments are proposed on an outpatient, non-emergency basis, the covered person or provider shall be requested to call MCM. All calls shall be handled by MCM Review Specialist's (RN's).MCM's Review Specialist or Physician Advisor shall contact the ordering physician to discuss the proposed treatment and determine the modalities proposed as well as the frequency and duration of each modality. MCM's Review Specialist or Physician Advisor shall review the provided information to determine if the proposed treatment meets criteria and is appropriate in frequency and duration. If the treatment is recommended as medically necessary and appropriate the covered person and or provider and Group shall be notified. If the treatment does not meet criteria, non-certification and appeal procedures shall be followed.

Durable Medical Equipment

Purchase of DME costing more than $500 and any DME rental will require precertification and review for medical necessity.

Skilled Nursing Facility, Hospice, and Home Health

Skilled Nursing Facility admission, hospice admission and initiation of home health services are subject to initial review and ongoing review to assure Member and Plan Sponsor of medical necessity and appropriateness of services provided.

Home Infusion Therapy

Members requiring Home Infusion Therapy are not required to be homebound to receive services. Home Infusion Therapy requires preauthorization prior to services being rendered.

Outpatient Behavioral Health and Substance Abuse Services

Outpatient psychiatric services and health and behavioral assessment interventions require initial and ongoing review to assure Member and Plan Sponsor of medical necessity.

Out-of-Network Services and Referrals

When a provider thinks the patient should be referred to an out-of-network physician or professional provider due to network inadequacy, continuity of care, or unique capability of a provider, as for all physician referrals, the request must be authorized by the Care Coordinating Center. All out of network medical services require authorization by the Care Coordinating Center.

REFERRALS TO A PHYSICIAN

In Network Referrals

Each Member has selected a primary care provider (PCP) who must approve all specialist referrals as medically necessary. Requests for referrals by a specialist, by the Member, or by the Member's PCP are communicated by telephone to ACTIN's Care Coordinating Center. The Care Coordinating Center then initiates the referral by whatever means the office of the specialist to whom the Member is referred prefers—telephone, via an EMR interconnection, secure email, or by written referral. The choice of specialist is made by the Member's PCP considering the preferences of the requesting Member or Provider. The Care Coordinating Center provides information to the PCP about contracted specialists such as patient satisfaction surveys and the results of audits of the specialist's practice against evidence based practice guidelines. This and other information is used to guide referrals by the PCP so that the Member is referred to the specialist most suitable for the Member. PCPs receive no financial incentives to limit referrals. The purposes of the referral process are: 1) to be certain that Members are referred to in-network specialists so that they are not subject to balanced billing 2) to select the specialist that is best for the patient based upon their results, efficiency of practice, and patient satisfaction 3) so that the Member's primary care provider can promptly follow up on the results and recommendations of the specialty visit.

Emergency Referrals to a Physician

When a patient, a physician, or a professional provider think that a patient has an emergency condition, referral processes are not required. The patient should be referred to the most appropriate venue of care for the patient's condition. When appropriate the patient should be transferred to an ACTIN contracted facility as soon as medically possible.

PROCEDURAL INFORMATION ON REFERRALS

Information Necessary for a Referral

Please have the following information readily available when calling ACTIN's Care Coordinating Center for a referral.

a. Patient's full name
b. ACTIN Member ID number
c. Group Number
d. Diagnosis (ICD-9 code)
e. Referring physician or Professional Provider name
f. Specialty Care Physician name
g. Reason for referral

Method of Requesting a Referral

Referral requests are made by telephone to the Care Coordinating Center at 779-216-5522 or toll free 877-602-1288. Faxed or emailed requests for referrals are not accepted. This number is answered 8 AM to 5 PM except holidays (New Years Day, New Years Eve, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Day after Thanksgiving, Christmas Eve, Christmas Day). The telephone is answered by a person within 3 rings or the call is returned within 20 minutes. The number is backed up by a cellular phone in case of a cable malfunction affecting telephone service.

PROCEDURAL INFORMATION ON PREAUTHORIZATION

Benefit Decision

The decision to provide treatment is between the patient, the PCP, and/or the ACTIN physician or Professional provider. ACTIN and ultimately the Plan Sponsor determines what is covered and payable under the benefit plan.

Information Necessary for Preauthorization

Please have the following information readily available when calling MCM for preauthorization.

a. Patient's full name
b. ACTIN Member ID number
c. Group number
d. Anticipated date of admission or service
e. Clinical history
f. Diagnosis (ICD 9 codes)
g. Procedure(s) or service(s) planned (CPT codes)
h. Anticipated length of stay or frequency of services
i. Type of admission (elective or emergency)
j. Plan of treatment
k. Name/phone number of admitting physician
l. Facility
m. Comorbid condition(s)
n. Caller name/phone number will be requested

Who to Contact To Initiate a Preauthorization

Preauthorization can be initiated by calling MCM at 800-367-9938 or log on to the provider website at www.medicalcost.com

When to Preauthorize

Preauthorization timeframes are listed below:

Type of Service	Time Frame
All elective inpatient admissions	A minimum of two days prior to admission and preferably seven days in advance
Urgent/emergent admissions	Within the later of 48 hours or by the end of the next business day of an emergency hospital admission
Extended Care – Home Health	A minimum of 24 hours prior to admission but as early as possible
Home Health	A minimum of 24 hours prior to admission but as early as possible
Skilled Nursing	A minimum of 24 hours prior to admission but as early as possible
CT/MRI	A minimum of 24 hours prior to admission but as early as possible
Behavioral Health/Substance Abuse	A minimum of 24 hours prior to admission but as early as possible
Sleep apnea/spinal injections/vein ablations	A minimum of 24 hours prior to admission but as early as possible

After Hours Calls

After hours calls to MCM are answered electronically and are returned within 24 hours in the order they are received.

Requesting Expedited Preauthorization

When expedited preauthorization is needed, log on to http://www.medicalcost.com and obtain web certification number. Then FAX clinical materials to 312-236-8547 with the certification number.

Faxing Preauthorization Requests

If the web application is not available, preauthorization may be initiated via fax. TO FAX, dial 312-236-8547.

Important Information about the Preauthorization Program

Preauthorization requests are reviewed using the Interqual Guidelines which promote consistent decisions based on nationally accepted, physician-created clinical criteria.

Physician Review

A case will be referred to a Physician Reviewer if the information received does not meet established criteria. In any instance where there is a question as to medical necessity, experimental/investigational nature, or appropriateness of health care services, the health care physician or professional provider who ordered the services shall be afforded a reasonable opportunity to discuss the plan of treatment with the Physician Review prior to the issuance of an adverse determination. The Physician Review will attempt to contact the servicing physician or professional provider by telephone prior to issuance of an adverse determination.

Preauthorization Not a Verification

Preauthorization is not verification and does not guarantee payment. Preauthorization merely confirms the medical necessity of the service or admission. Payment is subject to, but not limited to eligibility, contractual limitations and payment of premiums.

Accessibility of Utilization Management Criteria

Utilization management criteria are available to ACTIN participating physicians or professional providers upon request. To receive Interqual Guidelines on a specific condition please call ACTIN's Care Coordinating Center at 779-216-5522 OR toll free 877-602-1288.

Responsibility for Preauthorization

ACTIN physicians or professional providers are responsible for the completion of the preauthorization process**.** Ancillary providers are responsible for preauthorization of Extended Care and Home Infusion Therapy services.

Note: Failure to preauthorize may result in reduced payment, and physicians or professional providers cannot collect these fees from subscribers. Out-of- network services require preauthorization.

Important Information about the Preauthorization Program

The following outlines important information about ACTIN's preauthorization program administered by MCM.

Clinical Criteria — Preauthorization requests are reviewed using Interqual criteria which promote consistent decisions based on nationally accepted, physician-created clinical criteria. The criteria are customized to reflect ACTIN medical policy and local standards of medical practice.

Note: Clinical Review Criteria are available upon request for cases resulting in non-certification.

Physician Review — A case will be referred to a Physician Reviewer if the information received does not meet established criteria. In any instance where there is a question as to medical necessity, experimental/ investigational nature, or appropriateness of health care services, the health care physician or professional provider who ordered the services shall be afforded a reasonable opportunity to discuss the plan of treatment with the Physician Reviewer prior to the issuance of an adverse determination. The Physician Reviewer will attempt to contact the servicing physician or professional provider by telephone prior to issuance of an adverse determination.

Notification — Written notification letters are sent to the member, physician or professional provider and facility. The preauthorized length of stay or service and the preauthorization numbers are included. Letters of notification of benefit denial determinations include the reason for denial and an explanation of the appeal process.

Benefit Decision — The decision to provide treatment is between the patient and the physician or professional provider. Once the decision has been made, ACTIN determines what benefits are allowed under the existing health plan.

Note: Preauthorization is *not verification* and does not guarantee payment. Preauthorization merely confirms the medical necessity of the service or admission. Payment is subject to, but not limited to eligibility, contractual limitations and payment of premium on the date(s) of service.

Payment will be determined after the claim is filed and is subject to the following:

- Eligibility
- Other contractual provisions and limitations, including, but not limited to:
- Cosmetic procedures
- Pre-existing conditions
- Failure to preauthorize
- Limitations contained in riders, if any
- Claims processing guidelines

Extended Care Preauthorization Procedure

The prescribing physician or professional provider is responsible for obtaining a preauthorization by contacting M C M . A preauthorization will be given after verifying medical necessity.

Extended Care Preauthorization - Home Health Services

The following general guidelines apply to Home Health Services:

- Services ***must*** be ordered by a physician and require a physician signed treatment plan.
- The patient is certified by the physician as **homebound** under Medicare guidelines.
- The needs of the patient can only be met by intermittent, skilled care by a licensed nurse, physical, speech or occupational therapist, or medical social worker.
- The needs of the patient are not experimental, investigational or **custodial** in nature.
- All Home Health Services require preauthorization ***prior*** to service being rendered.

Extended Care Preauthorization – Hospice

Hospice benefits are available for patients with a life expectancy prognosis of six months or less. Treatment is generally palliative and non-aggressive in nature, and is provided in the home. Inpatient admissions for pain management or caregiver respite may also be available depending on current group coverage. Hospice services require preauthorization ***prior*** to services being rendered.

Extended Care Preauthorization – Home Infusion Therapy

ACTIN members requiring Home Infusion Therapy are not required to be homebound to receive services. Home Infusion Therapy requires preauthorization prior to services being rendered.

Extended Care Preauthorization – Skilled Nursing Facilities

All admissions to Skilled Nursing Facilities require preauthorization ***prior*** to receiving services.

Important Note

When any ACTIN member needs extended care or home infusion therapy, the ACTIN physician or professional provider must obtain preauthorization of the services prior to the delivery of services for the highest level of benefits to be received.

Preauthorization for Inpatient Care

The ACTIN physician or professional provider is required to admit the subscriber to a participating facility, except in emergencies.

The Primary Care Physician or a Specialty Care Physician or Professional Provider is responsible for preauthorizing admissions in which he/she is the admitting physician or professional provider.

A confirmation letter will be mailed to the member, facility and attending physician or professional provider.

When an admission does not meet the clinical screening criteria, the Utilization Management Department will refer the case to a Physician Reviewer. If the referring physician or professional provider disagrees with the Physician Reviewer's decision, he/she may request an appeal.

Non- Emergency Elective Medical/ Surgery Admission Guidelines

Elective admissions should be preauthorized at least seven (7) days ***prior*** to the date of admission by accessing www.medicalcost.com or contacting MCM at 800-367-9938.

Urgent/ Emergent Admissions Procedure

The admitting physician or professional provider ***must*** access www.medicalcost.com or contact MCM at 800-367-9938 within the later of 48 hours or by the end of the next business day of an emergency hospital admission.

Admission on Day of Surgery

Preoperative evaluation, testing, pre-anesthesia assessment and patient education will routinely be performed on an outpatient basis, or on the morning of surgery.

Concurrent Review

Concurrent review is performed when an extension of a previously approved inpatient length of stay is needed, or an extension of a previously approved Extended Care service is required.

Concurrent Review of Inpatient Admissions

Inpatient admissions are reviewed in order to ensure that all services are of a sufficient duration and level of care to promote optimal health outcome in the most efficient manner. Hospital admissions will be reviewed in accordance with the screening criteria approved by the Clinical Quality Improvement Committee.

Responsibility for Concurrent Review

The **ACTIN** Primary Care physician or Specialty Care physician or professional provider is responsible for obtaining an extension ***prior*** to the expiration of the previously approved length of stay or service.

Information Needed When Requesting an Extension

Please have the following information readily available when requesting an extension:

- Change of diagnosis/comorbid conditions
- Deterioration of the patient's condition
- Complication(s)
- Additional surgical intervention, if applicable
- Transfer plans to another facility or to a specialty bed/unit, if applicable
- Treatment plan necessitating inpatient stay.

Extension Review Procedure

Review will begin upon request for the extension. MCM may contact the admitting physician or professional provider or hospital Utilization Management Department for additional information. If the clinical screening criteria are not met, the case will be referred to a Physician Reviewer for a determination.

ACTIN utilizes Interqual Guidelines which promote consistent decisions based on nationally accepted, physician- created, clinical criteria. Diagnosis, procedure, comorbid conditions and age are considered when assigning the inpatient length of stay.

If information does not satisfy the criteria at any point of the admission, the case is referred to a Physician Reviewer for determination. Only a Physician Reviewer may deny a preauthorization or discontinue benefit certification. When a denial of benefits is determined, MCM notifies the admitting physician or professional provider and the hospital by telephone and letter.

The confirmation letter of the benefit determination will be mailed to the subscriber, facility and attending physician or professional provider (if other than the Primary Care Physician).

Discharge Planning

Discharge Planning is initiated as soon as the need is recognized during the hospital stay. When additional care is medically necessary following a hospital admission, ACTIN Care Coordination Center will work with the Hospital Discharge Planning Staff and the admitting physician or professional provider in coordinating necessary services within the ACTIN Network. In many cases the Member's PCP will visit the patient during admission and coordinate discharge planning with the medical staff.

Case Management Services

Case Management Services help identify appropriate physicians or professional providers and facilities through a continuum of services while ensuring that available resources are being used in a timely and cost-effective manner. ACTIN's Care Coordination Center and the Member's PCP conduct Case Management. ACTIN actively tries to identify patient where Case Management is appropriate and welcomes providers to recommend patients for Case Management that may not already be.

Case Management Examples

Cases that may be appropriate for referral to Case Management include:

- Transplants
    - solid organ
    - bone marrow
- Infectious Disease
- Internal Medicine
- Oncology
- Pulmonary
- High Risk Obstetrics
- Catastrophic Events
    - closed head injury
    - spinal cord injury
    - multi system failure

Physician or Professional Provider Involvement

Physicians or professional providers can assist the case management process by identifying and referring patients for possible Case Management Services and by providing input to alternative care recommendations identified by the Care Coordination Center.

Referrals to Case Management

Case Management referrals are accepted by telephone, fax or in writing. Contact ACTIN's Care Coordinating Center at 779-216-5522 or toll free 877-602-1288.

Evaluation of New Technology

ACTIN will evaluate new technologies, medical procedures, drugs and devices by assessing current clinical literature, appropriate government agency regulatory approvals, medical practice standards and clinical outcomes. External physician experts will be consulted in making a determination.

Physicians or professional providers may submit new technology requests for evaluation via email to the attention of Guy L. Clifton MD by calling 779-216-5525 or emailing guyc@actincare.com.

Emergency Care Services

Emergency care services are services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that failure to get immediate medical care could result in placing the patient's health in serious jeopardy, cause serious impairment to bodily function, cause serious dysfunction of any organ or part of the body, cause serious disfigurement, or in the case of a pregnant woman, cause serious jeopardy to the health of the fetus. ***Emergency room services do not require referral or preauthorization.***

Emergency Inpatient Admissions Rendered Outside the ACTIN Service Area

The attending physician or member ***must*** notify ACTIN of an emergency inpatient admission outside the **ACTIN** service area within the later of 48 hours or by the end of the next business day.

When appropriate, the physician and ACTIN will work together to arrange transportation of the member back to the service area for inpatient care at a participating facility.

Emergency Hospital Admission

Emergency hospital admissions ***do not require prior*** certification. The primary care physician ***must*** preauthorize the admission within the later of 48 hours or by the end of the next business day following the emergency hospital admission. *(Members are required to contact their primary care physician within 48 hours if not admitted by their PCP).*

If the admitting physician or professional provider is not an ACTIN physician or professional provider, the Member's PCP, in conjunction with the Care Coordinating Center, is responsible for coordinating the care of the patient upon notification of the admission.

Continuity of Care Program Criteria

Continuity of medical care is considered, based on written criteria and medical necessity, for a limited period when a physician's or professional provider's Participation Agreement is discontinued due to reasons other than quality deficiencies. Additionally, such continued care may be available when ACTIN members are required to change health plans based on an employer group change. Termination of the physician's or professional provider's Participation Agreement shall not release a physician or professional provider from the obligation to continue ongoing treatment of a member of "special circumstance" (as defined by applicable law and regulation) or Payer from its obligation to reimburse the physician for such services at the rate set forth in their agreement.

Continued next page ….

For example:

A member becomes effective with ACTIN while actively receiving health care services by physicians or professional providers not in the ACTIN network and whose current health care treatment plan cannot be interrupted without disrupting the continuity of care and/or decreasing the quality of the outcome of the care, or

A member's physician or professional provider leaves the ACTIN network and the subscriber's current health care treatment plan cannot be interrupted without disrupting the continuity of care and/or decreasing the quality of the outcome of the care.

Continuity of care may extend coverage for care with out-of- network physicians or professional providers until the course of treatment for a specific condition is completed. The physician's or professional provider's and ACTIN's obligations will continue until the earlier of the appropriate transfer of the subscriber's care to another ACTIN physician or professional provider (whichever is applicable), the expiration of 90 days from the effective date of termination of the physician or professional provider, or up to nine months in the case of a member who at the time of the termination has been diagnosed with a terminal illness. If coverage for care with an out-of-network physician or professional provider is certified due to pregnancy, it will be continued through the postpartum check-up within the first six weeks of delivery.

Continuity of care is considered when a member has special circumstances such as:

- acute or disabling conditions
- life threatening illness
- pregnancy 3rd trimester and beyond

Continuity of Care Procedure

The procedure for initiating continuity of care is as follows:

- A member, physician or professional provider may initiate a request for continuity of care by calling ACTIN's Care Coordination Center.
- The Care Coordination Center reviews all requests.
- Cases that do not meet criteria are referred to an MCM Physician Reviewer for determination.
- The Care Coordination Center notifies the physician or professional provider and member of the continuity of care decision via letter.
- If the request for continuity of care is approved, the Care Coordination Center completes an out-of-network referral and a letter is mailed to the servicing physician or professional provider.
- If continuity of care is denied, the member has the following options:
    - Continue care/treatment with his/her out-of-network physician or professional provider at the out-of-network benefit level;
    - Choose a **ACTIN** physician or professional provider *(whichever is applicable)*;
    - Receive treatment under the direction of his/her Primary Care Physician *(if applicable)*; or
    - File a formal complaint by contacting ACTIN's Care Coordination Center.

Summary of Preauthorization, Notification, and Referral Requirements

Preauthorization, Notification, Referral Requirement	***Preauthorization***	***Who to Call***
Inpatient Facility Admissions: • Hospital • Rehabilitation • Skilled Nursing • Long Term Acute Care • Behavioral Health • Drug/Alcohol Treatment	All facility admissions require review and precertification by MCM.	MCM
Outpatient and Inpatient Hospice	Requires review and precertification by MCM.	MCM
Home Health	Requires review and precertification by MCM.	MCM
Sleep Apnea, Spinal Injections, and Vein Ablation	Require review and precertification by MCM	MCM
MRI and CT Scans	Require review and precertification by MCM	MCM
Durable Medical Equipment costing >$500 or Rental	Require review and precertification by MCM	MCM
Out-of-Network/Out-of-Plan Non-Emergency Services	Out-of-Network/Out-of –Plan Services require Review by Care Coordinating Center if requested due to network inadequacy or continuity of care.	Care Coordinating Center
Out of Network Emergency Services	MCM must be notified within the later of 48 hours or by the end of the next business day of an emergency hospital admission.	MCM
Outpatient Mental Health Services	Requires authorization by Care Coordination Center and referral by PCP	Care Coordinating Center
PT/OT/Speech Pathology/Dietician and other non-physician Professional Providers	Requires authorization by Care Coordination Center and referral by PCP	Care Coordinating Center
Referral to a Physician	Requires authorization by Care Coordination Center and referral by PCP	Care Coordinating Center

APPEAL PROCEDURES

For a Payment Dispute between Provider and Payer on a Service Already Provided

Physician Group, Professional Providers, and Facilities may appeal a denial or modification of payment for services already provided by submitting to the ACTIN within thirty (30) calendar days of the denial or modification.

Procedures

If the Physician Group or its Professional Provider has a dispute concerning the authorization or payment of a claim for service provided, the Physician Group or the Professional Provider must direct an appeal in writing to ACTIN as described below.

First Level Appeal

Within thirty (30) days of the denial or modification, the Physician Group or Professional Provider may initiate an appeal by submitting pertinent information to ACTIN. This information must be in writing and it must identify the claim or service provided which specifically describes the disputed action. This constitutes a first level appeal.

First-level appeals are to be addressed to:
Guy Clifton MD
ACTIN Care Groups
973 Featherstone Road, Suite 340
Rockford, IL 60117

ACTIN shall acknowledge receipt of the appeal in writing within fifteen (15) days. This acknowledgment letter shall inform the Physician Group or the Professional Provider that it or his/her appeal has been forwarded to ACTIN for a decision and a response will be made within sixty (60) calendar days of the appeal. The letter shall also inform the Physician Group or the Professional Provider that if the claim is denied, he/she has the right to a second level appeal.

Second Level Appeal

If the Physician Group or Professional Provider is dissatisfied with the outcome of the first level appeal, the Physician Group or the Professional Provider may apply for a second level appeal. The Physician Group or the Professional Provider must comply with the first level appeal process described above before submitting a second level appeal. The Physician Group or Professional Provider must submit the second level appeal within sixty (60) calendar days of receiving notice of the outcome of the first level appeal. In addition, the Physician Group or Professional Provider may file a second level appeal if ACTIN has failed to render a decision on the first level appeal within sixty (60) calendar days of receipt of the appeal.

Second-level appeals are to be addressed to:

Guy Clifton MD
ACTIN Care Groups
973 Featherstone Road, Suite 340
Rockford, IL 60017

The Physician Group or Professional Provider is responsible for furnishing the following documentation:

1. A letter requesting arbitration of the first-level appeal
2. A copy of the letter and all attachments sent to ACTIN requesting the first-level appeal.
3. A copy of the original claim.
4. A copy of the first-level appeal response letter.
5. All other correspondence between the Payor and the Provider that will document timely submission.

ACTIN shall acknowledge receipt of the appeal within fifteen (15) days and shall review the written documents submitted by the Physician Group or the Professional Provider. ACTIN may ask for additional information and/or hold an informal meeting with the involved parties.

If the Informal Appeals Process is Unsuccessful in Resolving the Payment Dispute

Binding Arbitration

If the Payor and Provider are unable to resolve a Dispute through this dispute resolution process, the Dispute shall be settled by final and binding arbitration, upon the motion of either party, under the appropriate rules of the AAA or JAMS, as agreed by the parties. The informal dispute resolution process must have been completed before undertaking binding arbitration. The arbitration will be conducted in Cook County, Illinois by a single, neutral arbitrator who is licensed to practice law. The written demand shall contain a detailed statement of the matter and facts and include copies of all available related documents supporting the demand. Arbitration must be initiated within the applicable statute of limitations period.

The written decision of the arbitrator shall be final and binding as to each of them. Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction. The arbitrator shall have no authority to make material errors of law or to award punitive damages or to add to, modify, or refuse to enforce any agreements between the parties. The arbitrator shall make findings of fact and conclusions of law and shall have no authority to make any award that could not have been made by a court of law. The party against whom the award is rendered shall pay any monetary award and/or comply with any other order of the arbitrator within sixty (60) days of the entry of judgment on the award. The parties waive their right to a jury or court trial.

In all cases submitted to arbitration, the parties agree to share equally the administrative fee as well as the arbitrator's fee, if any, unless otherwise assessed by the arbitrator. The administrative fees shall be advanced by the initiating party subject to final apportionment by the arbitrator in this award.

Appeal Process for Non-certification of a Medical Service

Non-certification Definition

A determination not to certify proposed or ongoing treatment as medically necessary when established guidelines have not been met. The non-certification notice is provided on behalf of the Plan Administrator in compliance with the Department of Labor Regulation 29 CFR Part 2560.

Appeal Definition

A request made by the patient, patient representative, provider or facility to have the non-certified case reviewed again by a different physician (in the same or similar specialty as the treating physician) who was not involved in the initial non-certification decision.

Non-certification Process

Non-certifications shall be conducted in accordance with the American Accreditation HealthCare Commission (URAC), and when appropriate, State standards. When a non-certification is issued, each patient is entitled to the following appeals process:

Level I Expedited Appeal

Level I Expedited Appeals are available **only** when the patient remains in active (imminent and ongoing) treatment, or urgent care is needed. The patient or patient representative may request this type of appeal either verbally or in writing. The appeal determination shall be completed within 24-72 hours from receipt of the request. Level I Expedited Appeals are completed by a physician in the same or similar specialty as the treating physician, who was not previously involved in the case. The request for a Level I Expedited Appeal must be made within one hundred eighty 180 days following receipt of non-certification. The Level I Expedited Appeal determination shall be completed within 24-72 hours from receipt of the request.

Level II Standard Appeal

Level II Standard Appeals can result from 1) an expedited appeal that did not reverse the initial decision not to certify or 2) non-certification based on lack of medical necessity from a precertification or retrospective review. The patient or patient representative may request this appeal either verbally or in writing within one hundred eighty (180) days of the date of the non-certification letter. Level II Standard Appeals are completed by a physician in the same or similar specialty as the treating physician, who was not previously involved in the case. The request for a Level II Standard Appeal must be made within one hundred eighty (180) days following receipt of non-certification. The Level II Standard Appeal determination shall be completed no later than thirty (30) calendar days of receipt of request.

Level III Final Appeal

Level III Final Appeals are available when a Level II Standard Appeal does not result in a reversal of the initial non-certification. The patient or patient representative may request a Level III Final Appeal within one hundred eighty (180) days of the Level II Standard Appeal determination. Level III Final Appeals are completed by a physician in the same or similar specialty as the treating physician, who was not previously involved in the case. The request for a Level III Final Appeal must be made within one hundred eighty (180) days following receipt of Level II Standard Appeal determination. The Level III Final Appeal determination shall be completed no later than sixty (60) calendar days of receipt of request.

Appeal Rights

The patient is entitled to receive upon request, and free of charge:

1) Copies of all documents, records and other information relevant to the request for certification of care including a copy of the portion of the Plan document that was used in determining medical necessity information regarding any voluntary appeals procedures offered by the Plan.

2) A copy of the rule, guideline or protocol used in making the non-certification decision

3) Any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination;

4) Information regarding the Participant's right to an external review process.

5) An explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances.

The patient also has the right:

4) To appeal the determination at least 180 days following receipt of a notification of an initial Adverse Benefit Determination.

5) To submit written comments, documents, records, and other information relating to the claim for benefits.

6) To review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.

7) To have a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.

8) To have a review that takes into account all comments, documents, records, and other information submitted by
the Participant relating to the claim, without regard to whether such i nformation was submitted or considered in any prior benefit determination.

Continued next page ….

9) In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, for the Plan fiduciary to consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.

10)For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice.

11) That a Participant will be provided, free of charge, and sufficiently in advance of the date that the notice of final internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Participant to respond to such new evidence or rationale

Requirements for Appeal

The Participant must file the appeal in writing within 180 days following receipt of the notice of an Adverse Benefit Determination. For pre-service urgent care claims, if the Participant chooses to orally appeal, the Participant may telephone. File Appeals with:

Guy Clifton MD

ACTIN Care Groups

973 Featherstone Road, Suite 340

Rockford, IL 61107

877-602-1288

PATIENT ID CARDS

The ACTIN Member's identification card (ID card) provides information concerning eligibility and contract benefits, and is essential for successful claims filing.

Using the ID Card

Each ACTIN subscriber receives an identification card (ID card) upon enrollment. Refer to the samples shown on the following page. This card is issued for identification purposes only and does not constitute proof of eligibility. Physicians and professional providers should check to make sure the current group number is included in the subscriber's records.

To assist in ensuring that your office always has the most current information for your ACTIN subscribers, it is recommended that you copy the subscriber's ID card (front and back) for your files at each visit.

The ID card should be presented by the subscriber each time services are rendered. The ID card displays:

- The subscriber's unique identification number
- The employer group number through which coverage is obtained
- The current coverage date
- Plan number
- Applicable coinsurance, copayment, deductible and/or cost- sharing to Covered Services

Definitions:

Coinsurance means, if applicable, the specified percentage of the Allowable Amount for a Covered Service that is payable by the subscriber. The subscriber's obligation to make coinsurance payments may be subject to an annual out-of-pocket maximum.

Copayment means the amount required to be paid to a physician or other professional provider, facility, pharmacy, etc., by or on behalf of a subscriber in connection with the services rendered.

Continued next page ….

Cost Sharing is the general term used to refer to the subscriber's out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for Covered Services a subscriber receives.

Covered Services means those health services specified and defined as Covered Services under the terms of a subscriber's health Plan.

Deductible means, if applicable, the specified annual amount of payment for certain Covered Services, expressed in dollars that the subscriber is required to pay before the subscriber can receive any benefits for the Covered Services to which the Deductible applies.

The subscriber is required to report immediately to ACTIN Customer Service any loss or theft of his/her ID card. A new ID card will be issued. The subscriber is also required to notify ACTIN within 30 days of any change in name or address.

ACTIN subscribers are also required to notify ACTIN Care Coordination Center regarding changes in marital status or eligible dependents.

> **Note**: The subscriber is not allowed to let any other person use his/her **ACTIN ID** card for any purpose.

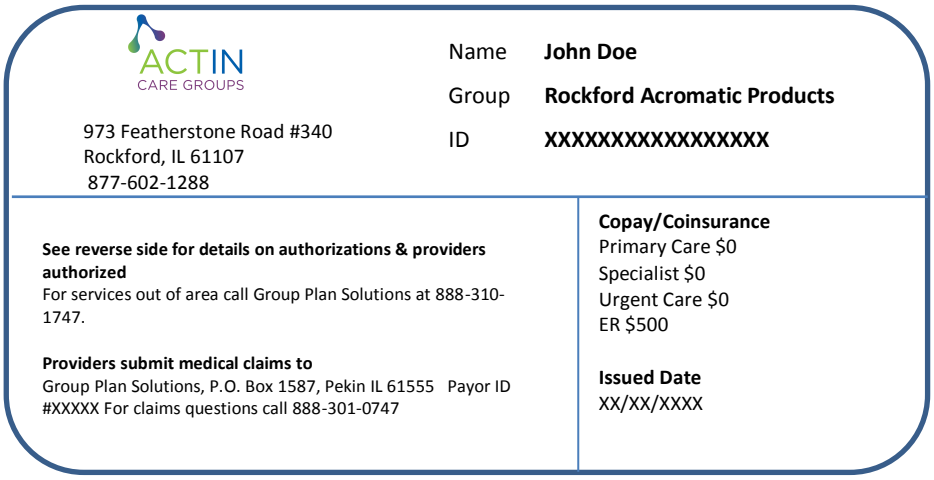
Other Information

Much of the information you will need is printed on the face and reverse side of your patient's ID card. Please note the copayment amount is usually indicated on the face of the ID card. Please call ACTIN Care Coordination Center to verify a subscriber's applicable coinsurance, copayment, and/or deductible or if you have questions.

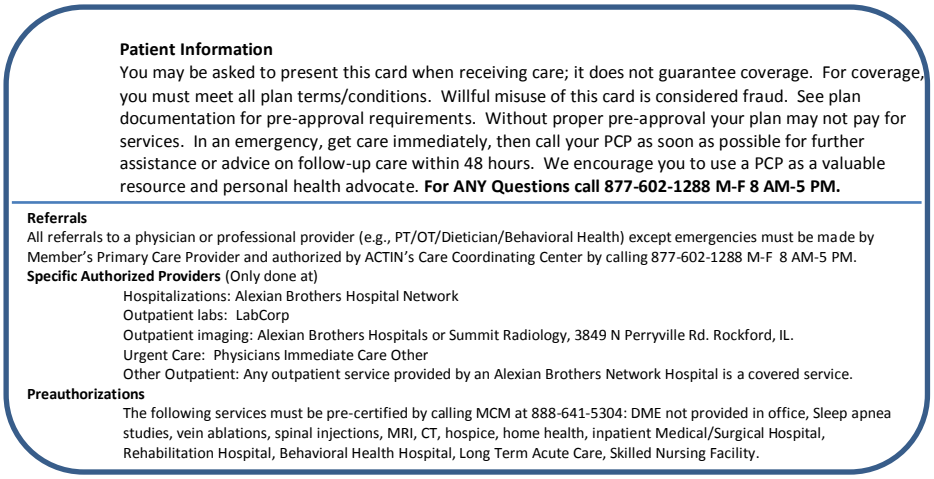
ACTIN ID Card Sample

The subscriber's identification card (ID card) provides information concerning eligibility and contract benefits, and is essential for successful claims filing.

FRONT SIDE



BACK SIDE



ADDITIONAL FEES AND NON-COVERED SERVICES

Additional Fees Charged By Participating Physicians and Participating Professional Providers beyond Copayments and Coinsurance

ACTIN prohibits the practice of participating physicians and professional providers charging subscribers additional fees beyond required copayments and coinsurance.

Notification of Beneficiary of Financial Responsibility for Non Covered Services

Professional providers must clearly identify non-covered services and notify Members of their financial obligation to pay for non-covered services before their provision.

SERVICE LOCATIONS AND FACILITIES

Where Services can be obtained

Unlike traditional plans, ACTIN contracts with only a few handpicked medical facilities for services. These are discussed below:

Hospitalization and Hospital Outpatient Services

Alexian Brothers Hospital Network comprised of Alexian Brothers Behavioral Health Hospital, Alexian Rehabilitation Hospital, St. Alexius Medical Center, Alexian Brothers Women and Children's Hospital and Alexian Brothers Medical Center are ACTIN's base hospital service providers. Services that cannot be offered at Alexian Brothers Hospital Network are provided by Loyola University Health System, 2160 S. First Ave.,Maywood, IL 60153. Any inpatient or outpatient service that Alexian Brothers Hospital Network provides is a covered service.

Laboratory Services

An ACTIN participating physician or professional provider may order any necessary outpatient laboratory test at any LabCorp Facility.

Radiology Services

CT, MRI, plain x-ray and ultrasounds may be ordered at any Alexian facility or at Summit Radiology, 3849 N Perryville Rd. Rockford, IL 61107. Summit does not perform nuclear medicine studies and some cardiac MRI/CT procedures. The decision of which venue to order imaging is primarily based on patient convenience.

Urgent Care

ACTIN has contracted with Physician's Immediate Care for urgent care services in the Winnebago and Boone County areas. Members are able to reach their PCP 24/7 but should a specialist receive a patient call that requires urgent evaluation please refer patients to a Physicians Immediate

Care facility in Rockford or Belvidere.

Hospice

Hospice Care of America is ACTIN's hospice and palliative care provider. Hospice Care of America is located at 3815 N. Mulford Rd. Rockford, IL 61114 and can be reached at (815) 316-2700 or 888-206-9972.

Home Health

Able Home Health is ACTIN's home health provider for Winnebago, Boone, and McHenry Counties. Able's corporate address is 1946 Daimler Road, Rockford, IL 61112 and can be reached at 800-979-2253.

Physical Therapy

Forest City Physical Therapy provides physical therapy services for Members who reside in Winnebago and Boone Counties. Forest City's address is 3920 N Mulford Rd #2200, Rockford, IL 61114 and can be reached at 815-639-0764.

Durable Medical Equipment

Integrated HomeCare Services, 5027 Harrison Ave, Rockford, IL 61108 is ACTIN's DME supplier for all DME except respiratory-related services and negative wound therapy and can be reached at (815) 965-9454

Respiratory Services

Apria HealthCare will provide home respiratory services. Their Winnebago County location is 10910 N 2nd St. Machesney Park IL, 61115 and Apria can be reached at 815-633-7778.

Pharmaceuticals

Benecard is ACTIN's Pharmacy Benefits Manager. ACTIN's formulary is in Appendix B. About 85% of medications in the formulary are generics. Branded medications are included where there is no generic substitute. Preauthorization is required for any medication, generic or branded, that costs more than $200 for a 3 month supply.

PHYSICIAN AND PROFESSIONAL PROVIDER ROLES AND RESPONSIBILITIES

Role of the Specialty Care Physician or Professional Provider

An **ACTIN** participating physician or professional provider who provides services as a Specialty Care physician or professional provider is expected to:

- Provide the same level of care to ACTIN patients as provided to all other patients.
- Provide urgent care and emergency care or coverage for care 24 hours a day, seven days a week. Specialty Care physicians or professional providers will have a verifiable mechanism in place, for immediate response, for directing patients to alternative after hours care based on the urgency of the patient's need. Acceptable mechanisms may include: an answering service that offers to call or page the physician or on-call physician; a recorded message that directs the patient to call the answering service and the phone number is provided; or a recorded message that directs the patient to call or page the physician or on-call physician and the phone number is provided.
- Make his/her own arrangements for patient coverage when out of town or unavailable.
- Meet required Patient Appointment Access Standards (appointment within 2 weeks)
- Emergency Care - perform immediate triage during office hours and have a method for directing patients to alternative care after hours.
    - Urgent Care - within 24 hours.
    - Symptomatic Non-Urgent Care (Routine) - within 5 days.
    - Initial New Patient Visit - within 30 days.
    - In-Office Wait Time - within 30 minutes.
    - After Hours Access – immediate.
- Keep central record of the subscriber’s health and health care that is complete and accurate.
- Provide inpatient consultation within 24 hours of receipt of request. Emergency consultation to be provided as soon as possible.

- Provide ACTIN, upon request and at no charge, copies of medical records within 5 business days when requested by ACTIN for the purpose of claims review or auditing.
- Cooperate with ACTIN for the proper coordination of benefits involving covered services and in the collection of third party payments including workers' compensation, third party liens and other third party liability. ACTIN contracted physicians and professional providers agree to file claims even if the physician or professional provider believes or knows there is a third party liability.
- Only bill for copayments, cost share (coinsurance) and deductibles, where applicable. Specialty Care physician or professional provider will not offer to waive or accept lower copayments or cost share or otherwise provide financial incentives to Member's, including lower rates in lieu of the subscriber's coverage.

Role of Primary Care Provider

- An **ACTIN** participating physician or professional provider who provides services as a Primary Care physician or professional provider including woman's principal health care providers are expected to provide 24 hours per day 7 days per week immediate response for directing patients to alternative after hours care based on the urgency of the patient's needs. Acceptable mechanisms may include: an answering service that offers to call or page the physician or on-call physician. Recorded message that directs the patient to call the answering service and the phone number is provided; or a recorded message that directs the patient to call or page the physician or on-call physician and the phone number is provided.

Failure to Establish Physician or Professional Provider Patient Relationship

Reasons a physician or professional provider may terminate his/her professional relationship with a subscriber/patient include, but are not limited to, the following:

- Fraudulent use of services or benefits;
- Threats of physical harm to a physician or professional provider or office staff;
- Non-payment of required copayment for services rendered or applicable coinsurance and/or deductible;
- Evidence of receipt of prescription medications or health services in a quantity or manner that is not medically beneficial or necessary;
- Refusal to accept a treatment or procedure recommended by the physician or professional provider, if such refusal is incompatible with the continuation of the physician or professional provider subscriber/patient relationship (physician or professional provider should also indicate if he/she believes that no professionally acceptable alternative treatment or procedure exists);
- Repeated refusal to comply with office procedure in accordance with acceptable community standards;
- Other behavior resulting in serious disruption of the physician or professional provider subscriber/patient relationship.

Reasons a physician or professional provider may not terminate his/her professional relationship with a subscriber/patient include, but are not limited to, the following:

- Subscriber's/patient's medical condition (i.e., catastrophic disease or disabilities);
- Amount, variety, or cost of covered health services required by the subscriber/patient; patterns of over utilization, either known or experienced;
- Patterns of high utilization, either known or experienced.

Procedures

When ACTIN's Care Coordination Center receives preliminary information indicating a contracted physician or professional provider has deemed it necessary to terminate a relationship with a subscriber/patient, the ACTIN Care Coordination Center will:

1. Review with the physician or professional provider, the following important points:

    a. Refer to the Performance Standard section above – and if necessary explain why he/she may not terminate his/her relationship with a subscriber/patient.

    b. Determine the effective date of termination based on the following: The effective date must be no less than 30 calendar days from the date of the provider's notification letter to the subscriber/patient. Exception: Immediate termination may be considered if a safety issue or gross misconduct is involved – must be reviewed and approved by ACTIN.

    c. A notification letter from the physician or professional provider to the subscriber/patient is required and must include:
        i. Name of subscriber/patient– if it involves a family, list all patients affected;
        ii. Subscriber identification number(s);
        iii. Group number; and
        iv. Effective date of termination (as determined based on the above).

    d. A copy of the letter to the Member/patient must be sent simultaneously to the ACTIN Care Coordinating Center.

Note: The physician or professional provider must continue to provide medical services for the subscriber/patient until the termination date stated in the provider's letter.

Continued next page ….

When the ACTIN's Care Coordinating Center receives a copy of thee Physician's or Professional Provider's letter to the Member / patient, ACTIN will:

1. Contact the physician or professional provider to confirm receipt of the letter, review important points outlined above, and address any outstanding issues if applicable.

2. Send a letter to the Member/patient, 30 days prior to the termination date, which will include a new designated PCP, specialist or professional provider or outline steps for the Member/patient to select a new PCP, specialist or professional provider.
3. Send a follow-up resolution letter to the Physician or Professional Provider.

If the Physician or Professional Provider Agrees to Continue to See the Subscriber/Patient:

If the subscriber/patient appeals the termination directly with the physician or professional provider and the physician or professional provider agrees to continue to see the subscriber /patient, the physician or professional provider must immediately:

- Notify ACTIN in writing of his/her approval to reinstate the subscriber/patient to his/her panel (so that ACTIN can re-assign the PCP to the Member/patient if the Member/patient requests such, and/or to prevent any future miscommunication).

Change in Status or Changes Affecting Your ACTIN Provider ID

If your membership in a contracted provider group changes you may apply to ACTIN's Care Coordinating Center for a new Participating Physician Contract. You should submit all changes at least 30 days in advance of the effective date of the change.

The following information will be needed by the Care Coordination Center:

- Name
- Physical address (primary, secondary, tertiary)
- Billing address
- Email address
- Telephone number
- Tax ID or other information
- Specialty or sub-specialty
- Practice information/status
- Board certification
- NPI Number change
- TIN/SS number change
- Moving from Group to Solo practice
- Moving from Solo to Group practice
- Moving from Group to Group practice
- Back up/covering physicians or professional providers

CREDENTIALING

Credentialing Process for Office Based Physicians or Professional Providers

1. ACTIN's credentialing requirements do not apply to physicians and professional providers with Alexian or Loyola credentials unless provider is selected for random primary source verification.
2. The following professional providers (from NACQ) must be credentialed by ACTIN if they or their physician group are contracted with ACTIN unless they are credentialed by Alexian Hospital Network or Loyola University Medical Center or they are employees of an organization that provides comprehensive services:
    - Acupuncturist
    - Alcohol/Drug Counselor
    - Audiologist
    - Biofeedback Technician
    - Certified Registered Nurse Anesthetist
    - Christian Science Practitioner
    - Clinic Nurse Specialist
    - Clinical Social Worker
    - Dietician
    - Licensed Practical Nurse
    - Marriage/Family Therapist
    - Massage Therapist
    - Naturopath
    - Neuropsychologist
    - Nurse Midwife
    - Nurse Practitioner
    - Nutritionist
    - Occupational Therapist
    - Optician
    - Optometrist
    - Pharmacist

Continued next page ….

- Physical Therapist
- Physician Assistant
- Professional Counselor
- Registered Nurse
- Registered Nurse First Assistant
- Respiratory Therapist
- Speech Pathologist

3. Nurse Practitioners must submit to the Care Coordination Center the written physician protocols under which they practice in addition to the credentialing document for the State of Illinois in the Appendix A.

Additional Forms Required by ACTIN for Credentialing If you are an office based physician or professional provider that requires one of the following additional forms listed below, you must complete the form(s) and forward to **ACTIN**. Forms are available in Appendix A.

Behavioral Health Form – required to be submitted to ACTIN for all Behavioral Health providers.

APN Supplemental Questionnaire – Prescribing Authority – required for a APN who plans to prescribe controlled substances and holds a current DEA and State Controlled Substance Certificate.

PA Supplemental Questionnaire – Prescribing Authority - required for a PA who plans to prescribe controlled substances and holds a current DEA and State Controlled Substance Certificate.

PA Supervising Physician and Protocols & Duties Supplemental Questionnaire – required for Physician Assistants to provide the name of their Supervising Physician and attest to having protocol/duties.

Ophthalmologist Treatment Expertise – required for Ophthalmologists to indicate if their practice includes retinal surgery.

Recredentialing

The process of recredentialing is identical to that for credentialing, and is consistent with NCQA and State of Illinois requirements. ACTIN will notify providers prior to the 36 month period from initial credentialing to recredentialing. The recredentialing document is found in the Appendix B.

Credentialing Review Requests

Who can request review?

Any physician or professional provider may seek a review of a decision related to initial credentialing.

When to request review

Requests for review must be submitted in writing within 60 calendar days from the date of the denial/termination letter.

Addressing the request

Written requests should be addressed to Guy Clifton MD, 973 Featherstone Road #340, Rockford, IL 61107.

What to include

Requests should include any supporting documentation or facts the physical or professional provider feels would be beneficial for review.

Stages

1. The physician or professional provider submits an appeal request.
2. The appeal is submitted to the ACTIN Advisory Peer Review Panel

   Note: The committee recommendation is intended to assist Dr. Clifton. The committee's role is advisory only, and, as such, the recommendation of the committee is not binding.
3. Dr. Clifton forwards the final determination in writing to the physician or professional provider within 60 days of initial notification to the physician or professional provider or the date of request for additional information for review.

Physician or Professional Provider Termination Process

- If a physician or professional provider is being considered for ACTIN network termination for any of the following reasons, ACTIN will present the proposal for termination to a ACTIN Advisory Peer Review Panel along with all available supporting documentation:
  - Non-compliance with credentialing criteria; or
  - Loss, restriction or probation of license; or
  - Government action such as debarment from Medicare and Medicaid; or
  - Cost and utilization issues; or
  - Quality of care issues.
- ACTIN medical director may immediately terminate a physician or professional provider's network participation if he/she determines that:
  - Continued network participation by the physician or professional provider poses imminent harm to patient health; or
  - An action by a state licensing board effectively impairs the physician or professional provider of the reason(s) for termination. Physician's or professional provider's ability to provide services; or
  - There has been fraud or malfeasance.
- If network termination is initiated based on the Advisory Peer Review Panel recommendation a written explanation shall be provided to the physician or professional provider of the reason(s) for termination.
- A physician or professional provider may, within thirty (30) days of the written termination notice, request in writing that a review of the termination decision be conducted by a different Advisory Peer Review Panel to consider whether the termination action was correct under the terms of the Provider Contract/Agreement.

Continued next page ….

- ACTIN will not notify subscribers of the provider's termination until thirty (30) days prior to the effective date of such termination or the time the Advisory Peer Review Panel makes a formal recommendation. However, if a provider is terminated for reasons related to imminent harm, ACTIN may notify subscribers immediately.

- Within sixty (60) days following receipt of physician's or professional provider's written request for review, ACTIN will notify provider of its review decision.

- Upon request, ACTIN will provide physician or professional provider with a copy of the recommendation of the Advisory Peer Review Panel. The Panel's recommendation must be considered by ACTIN but is non-binding.

PRIVACY OF HEALTH INFORMATION

Privacy of Health Information Overview

The following information provides a summary of ACTIN's privacy policies.

The regulations are long and complex, but they can be grouped into five main topics:

Consent and Authorization: This refers to the permission a person must give for us to use or disclose his or her Protected Health Information (PHI). ACTIN will be dealing mostly with authorizations.

Use, Disclosure and Minimum Necessary: These rules talk about when and\ how to use or disclose PHI. In most cases, we must use or disclose only the least amount, the minimum necessary, of PHI needed to do a certain task.

Individual's Rights: The person who is the subject of PHI has five major rights.

- The right to ask for access to his/her PHI and receive a copy or view it on location
- The right to ask for an amendment to his/her PHI
- The right to receive a listing of all recorded disclosures of his/her PHI
- The right to ask for further restrictions on the use and disclosure of his/her PHI
- The right to ask that any communication with the person regarding his/her PHI be carried out through confidential means that differ from the normal methods of contact, such as mail to the home address.

Business Associates: Outside persons or entities that carry out a function on behalf of ACTIN are our business associates. They must follow the privacy regulations, too, and be allowed to access only certain PHI, as outlined in their contract.

Administrative Requirements: There are several things that ACTIN must do to oversee compliance with the privacy regulations. They include such activities as naming a privacy officer, creating a privacy office, writing privacy policies and procedures, sending out a notice of privacy practices and training its workers about its privacy policies.

ACTIN's Privacy Policies

ACTIN's Privacy Policies are listed below. .

Policy #1: Documentation of Privacy Policies and Procedures

ACTIN has written policies and procedures subject to Privacy.

Policy #2: Privacy Complaints

ACTIN shall evaluate privacy complaints and respond in writing to an individual or an individual's personal representative in a timely manner following receipt of a complete, written complaint, as required by law and in accordance with approved corporate procedures.

Policy #3: Safeguarding Protected Health Information (PHI)

ACTIN shall develop, implement and maintain appropriate administrative, technical, and physical safeguards to prevent inappropriate use or disclosure of Protected Health Information (PHI).

Policy #4: Training of Privacy Policies and Procedures

ACTIN shall train its workforce on its Privacy Policies and Procedures, and the privacy policies and procedures of operational areas as required by law and in accordance with approved corporate procedures.

Policy #5: Disclosure Tracking

This policy addresses ACTIN as a Covered Entity (an entity that must comply with the Federal privacy regulations). ACTIN shall record and track its disclosures of PHI as required by law and in accordance with its written procedures.

Policy #6: Authorizations

ACTIN shall obtain a signed authorization form from an individual or the individual's personal representative in situations required by law and in accordance with approved corporate procedures.

Policy #7: Minimum Necessary Protected Health Information (PHI)

This policy assumes a disclosure of PHI is not as a result of an authorization, or that de-identification of the information will not provide the needed information.

ACTIN workforce and ACTIN Business Associates (BA) that have executed BA agreements shall be permitted access to and use of only the minimum PHI reasonably necessary for the performance of their duties. Unless otherwise permitted by the terms of a BA agreement, ACTIN BAs shall only be permitted access to and use of PHI in accordance with their BA agreement.

ACTIN workforce members or BAs will not use, disclose or request an entire medical record without the CEO's written approval that this is the minimum necessary PHI needed for the stated purpose.

Policy #8: Business Associates

ACTIN shall require its Business Associates to enter into a written BA agreement. Business Associates (BA) will, upon execution of the agreement, be provided with information about ACTIN's Privacy Policies.Any person or entity determined to be a BA without an executed BA agreement shall not receive PHI unless the subject of the PHI or their authorized representative signs an authorization. Any member of the ACTIN workforce who has a good faith belief that a BA has possibly violated their BA agreement shall orally report such information to their management. ACTIN shall document this report in writing. Potential violations of the terms of a BA agreement by a BA shall be resolved according to ACTIN procedures and applicable law. When ACTIN serves as a BA to another Covered Entity, ACTIN will enter into a written BA agreement with the Covered Entity. As a BA, ACTIN will use or disclose PHI as permitted by state and federal law and the BA agreement with the Covered Entity.

Policy #9: Disclosure Accounting

This policy addresses ACTIN as a Covered Entity. When ACTIN acts as a Business Associate, there may be situations in which disclosure accounting will need to be done in accordance with both the law and a specific BA agreement. ACTIN shall provide an individual or an individual's personal representative with an accounting of ACTIN's disclosures as required by law and in accordance with approved corporate procedures.

Each request for an accounting of PHI disclosures shall be entered into the ACTIN Tracking Database in a timely manner. The Privacy Office shall be responsible for implementing this policy and the associated disclosure accounting corporate procedures.

Policy #10: Requests to Receive Protected Health Information (PHI) by Alternative Confidential Means

ACTIN shall consider granting a written request from an individual or an individual's personal representative to receive PHI by alternative confidential means or at an alternative location as required by law and in accordance with ACTIN policies. Each written request to receive PHI by alternative confidential means or at an alternative location shall be documented in a timely manner. ACTIN shall update it records as required by law to reflect requests accepted by ACTIN.

Policy #11: Requests to Access Protected Health Information (PHI)

ACTIN shall consider requests from an individual or an individual's personal representative to inspect and obtain a copy of the requesting individual's PHI as permitted by state or federal law and in accordance with approved corporate procedures. ACTIN shall evaluate the request and issue a written response as required by law.

Policy #12: Personal Representatives

ACTIN will disclose appropriate PHI to personal representatives of an individual when the personal representative follows the same procedures as the individual. The designation of a person as a personal representative will be documented according to appropriate law, and corporate procedures.

Policy #13: De-Identification of PHI

Except as otherwise permitted by law, ACTIN will de-identify PHI released externally. The de-identification of PHI shall be accomplished in accordance with applicable law and approved corporate procedures. PHI that has been de-identified is health information that may be released without minimum necessary determinations. There are several ways to de-identify PHI. One way involves removing individually identifiable health information that may link the data to a specific person. This information includes, but is not limited to:

- Name
- AddresS
- Date admission/discharge
- E-mail address
- Social security number Medical record number
- Health plan beneficiary number Account number
- Vehicle identifiers Certificate/license number
- Web universal resource locator (URL) Internet protocol (IP) address number Biometric ID, such as finger or voice prints Full face or comparable photo images
- Other unique ID number, code or characteristic

Policy #14 Verification of Identity and Authority

ACTIN shall verify the identity and authority of any person requesting PHI as may be required by law and in accordance with approved corporate procedures.

Policy #16: Notice of Privacy Practices

ACTIN shall issue a Notice of Privacy Practices to persons as required by law and in accordance with approved corporate procedures.

Revisions shall be made to the Notice of Privacy Practices if there is any material change to ACTIN's legal duties with respect to its privacy practices, individuals' privacy rights or other privacy practices that would need to be reflected in the Notice. The revised Notice will be distributed to insured members as required by law and made available to any other person upon request.

Policy #17: Requests to Restrict PHI

This policy addresses ACTIN as a Covered Entity. Individuals may submit requests to restrict use or disclosure of their PHI to ACTIN. Each request to restrict PHI must be entered in the ACTIN Tracking Database in a timely manner. ACTIN shall not grant a request from an individual or a personal representative of an individual to place any additional restrictions on the use and disclosure of the individual's PHI, unless required by law or the restriction is approved by the CEO.

Policy #18: Requests to Amend PHI

This policy addresses ACTIN as a Covered Entity. ACTIN shall consider amending an individual's PHI upon receipt of a completed Amendment Request Form from the individual making the request or his/her personal as permitted by law and in accordance with approved corporate procedures. Notification of the disposition of the amendment request will be sent to the individual or his/her personal representative. ACTIN shall take reasonable steps as required by law to communicate amended PHI to appropriate BAs.

Policy #19: Privacy Practical Guidelines

The following privacy guidelines represent the philosophy and practices that ACTIN follows in its day-to-day operations:

ACTIN will not disclose PHI for the purpose of reporting abuse, neglect or domestic violence, unless required by law. Then, only the minimum necessary information will be disclosed and entered into the ACTIN Tracking Database.

PHI may be requested or disclosed for deceased persons without obtaining an authorization if it goes to persons with authority to act on behalf of the deceased or as permitted by law.

No PHI will be used for fundraising, but ACTIN may solicit its employees for charitable fundraising purposes.

Workforce members must verify identity and authority of the recipient before making such disclosure.

HOSPITAL ACQUIRED CONDITIONS AND SERIOUS REPORTABLE EVENTS

Policy

ACTIN will apply the following principles and guidelines for review and determination of **Hospital Acquired Conditions** (identified by CMS) and **Serious Reportable Events** (identified by National Quality Form), to determine whether reimbursement to a physician or professional provider should be reduced for the additional costs related to the event.

The error or event must be preventable.

The error or event must be within control of the physician or professional provider.

The error or event must be a result of a mistake by the physician or professional provider.

The error or event must result in significant harm.

Identification of non-payable events will incorporate case-by-case review and determination by a ACTIN Medical Director, except when self-reported and without dispute.

If medical records are required to complete a review of a Hospital Acquired Condition/Serious Reportable Event, the minimum defined record set will include: Discharge Summary, Admission History and Physical, Operative Reports, Consultation Reports, Physician Progress Notes, Emergency Department records (if admitted via the ER), and other documentation as determined by the Medical Director.

If adjustment of claims is determined applicable, the physician or professional provider will be notified. The physician or professional provider may appeal a decision made by ACTIN for the Hospital Acquired Condition/Serious Reportable Event and appeal instructions will be included in the notification letter.

Hospital Acquired Conditions

As defined by CMS, Hospital Acquired Conditions are those conditions that are acquired by a patient while they are in the inpatient hospital setting and were not present upon admission to the hospital.

The following Hospital Acquired Condition represents a potential area of responsibility and will be reviewed by the ACTIN Medical Director on a case by case basis:

- Foreign Object Retained After Surgery

Serious Reportable Events

As defined by the National Quality Forum (NQF), Serious Reportable Events are adverse events that are serious, but largely preventable, and of concern to both the public and health care providers for purposes of public accounting. Serious Reportable Events earned that name because these events should never happen in medical practice.

The following Serious Reportable Events represent potential areas of responsibility and will be reviewed by ACTIN Medical Director on a case by case basis:

1. Surgery performed on the wrong body part
2. Surgery performed on the wrong patient
3. The wrong surgical procedure performed on a patient

CLAIMS PROCEDURES

(This section under development)

Types of Claims

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

Pre-service Claims. A "pre-service claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A "pre-service urgent care claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the Participant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the Plan does not require the Participant to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

Concurrent Claims. A "concurrent claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

- The Plan Administrator determines that the course of treatment should be reduced or terminated; or
- The Participant requests extension of the course of treatment beyond that which the Plan Administrator has approved.

Post-service Claims. A "post-service claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed

Post-service health claims must be filed with the EDI within _____ months of the date charges for the service were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. **Claims filed later than that date shall be denied.**

- Pre-service Urgent Care Claims:

  - If the Participant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

  - If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 72 hours after receipt of the claim.

  - The Participant will be notified of a determination of benefits as soon as possible, but not later than 72 hours, taking into account the medical exigencies, after the earliest of:

    - The Plan's receipt of the specified information; or

    - The end of the period afforded the Participant to provide the information.

If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Participant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Participant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Participant may request an expedited review under the external review process.

- Pre-service Non-urgent Care Claims:

- If the Participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

- If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Participant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Participant (if additional information was requested during the extension period).

  - Concurrent Claims:

- Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.

- Request by Participant Involving Urgent Care. If the Plan Administrator receives a request from a Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, as long as the Participant makes the request at least 72 hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

- Request by Participant Involving Non-urgent Care. If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).

- Request by Participant Involving Rescission. With respect to rescissions, the following timetable applies:

  - Notification to Participant 30 days

  - Notification of Adverse Benefit Determination on appeal 30 days

- Post-service Claims:

- If the Participant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

- If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.

  - Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.

  - Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15- day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

  - Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.