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Introduction

Welcome
Welcome to CountyCare. We thank you for being part of CountyCare’s network of participating physicians, hospitals, and other healthcare professionals. Our number one priority is the promotion of healthy lifestyles through preventive healthcare. CountyCare works to accomplish this goal by partnering with the providers who oversee the healthcare of CountyCare members, such as you.

ABOUT US
Operated by the Cook County Health and Hospitals System, CountyCare is a Managed Care Community Network (MCCN) contracted with the Illinois Department of Healthcare and Family Services (HFS) to serve Cook County Medicaid recipients through the Family Health Plan, ACA Adult and Integrated Care Programs. CountyCare has the expertise to work with our members to improve their health status and quality of life.

CountyCare focuses on improving health status, successful outcomes, and member and provider satisfaction in a coordinated care environment. Our Plan has been designed to achieve the following goals:

• Ensure access to primary and preventive care services
• Ensure care is delivered in the best setting to achieve an optimal outcome
• Improve access to all necessary healthcare services
• Encourage quality, continuity, and appropriateness of medical care
• Provide medical coverage in a cost-effective manner

All of our programs, policies and procedures are designed with these goals in mind. We hope that you will assist CountyCare in reaching these goals and look forward to your active participation.

How To Use This Manual
CountyCare is committed to working with our provider community and members to provide a high level of satisfaction in delivering quality healthcare benefits. We are committed to providing comprehensive information through this Provider Manual as it relates to CountyCare operations, benefits, and policies and procedures to providers. Please contact the Provider Services department (“Provider Services”) at 312-864-8200 / 855-444-1661 if you need further explanation on any topics discussed in the manual. You may also access this manual through our web site at www.countycare.com.

www.countycare.com
The following chart includes several important telephone and fax numbers available to your office. When calling CountyCare, please have the following information available:

- NPI (National Provider Identifier) number
- Tax ID Number (“TIN”) number
- Member’s ID number or Medicaid ID number

<table>
<thead>
<tr>
<th>DEPARTMENT</th>
<th>PHONE</th>
<th>FAX</th>
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<tbody>
<tr>
<td>CountyCare Health Plan</td>
<td>312-864-8200</td>
<td>312-548-9940</td>
</tr>
<tr>
<td>1900 W Polk Street, #220-C</td>
<td>855-444-1661</td>
<td></td>
</tr>
<tr>
<td>Chicago, Illinois  60612</td>
<td></td>
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<tr>
<td>Provider Services</td>
<td>312-864-8200</td>
<td>312-548-9940</td>
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<td></td>
<td>855-444-1661</td>
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<tr>
<td>Member Services</td>
<td>312-864-8200</td>
<td>312-548-9940</td>
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<td></td>
<td>855-444-1661</td>
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<tr>
<td>Authorization Request, Discharge Planning, Case</td>
<td>312-864-8200</td>
<td>312-548-9940</td>
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<td>Management</td>
<td>855-444-1661</td>
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<td></td>
<td>(TDD/TTY) 711</td>
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<tr>
<td>Inpatient Admissions</td>
<td>312-864-8200</td>
<td>312-548-9940</td>
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<tr>
<td></td>
<td>855-444-1661</td>
<td></td>
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<td>CountyCare 24-hour Nurse Hotline</td>
<td>312-864-8200</td>
<td>312-548-9940</td>
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<tr>
<td></td>
<td>855-444-1661</td>
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<tr>
<td>Illinois Department of Healthcare &amp; Family</td>
<td>217-782-1200</td>
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<tr>
<td>Services</td>
<td>800-526-5812 TDD/TYY</td>
<td></td>
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<tr>
<td>201 South Grand Ave</td>
<td><a href="http://www.hfs.illinois.gov">www.hfs.illinois.gov</a></td>
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<tr>
<td>East Springfield, IL 62763-0001</td>
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<tr>
<td>Dental Preauthorization</td>
<td>800-508-6780</td>
<td>262-241-7150</td>
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<tr>
<td>Vision Preauthorization</td>
<td>844-254-9491</td>
<td>888-696-9552</td>
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<tr>
<td>Pharmacy Preauthorization</td>
<td>877-235-1981</td>
<td>866-511-2202</td>
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<tr>
<td>Specialty Pharmacy Preauthorization</td>
<td>855-427-4682</td>
<td>877-342-4596</td>
</tr>
<tr>
<td>Transportation Scheduling</td>
<td>630-403-3210</td>
<td>NA</td>
</tr>
</tbody>
</table>
ELECTRONIC MEDICAL & BEHAVIORAL HEALTH
CLAIMS SUBMISSION
Clearinghouse: Change Healthcare
(formerly Emdeon)
Payer ID: 06541

If you have any questions on submission of
medical or behavioral health claims, please
contact: Provider Services at 312-864-8200
or 855-444-1661

PROVIDER CLAIMS AND EFT/ERA INFORMATION
www.countycare.com

PAPER CLAIMS SUBMISSION, REQUESTS FOR
RECONSIDERATION, AND CORRECTED CLAIMS
CountyCare
Attn: Claims
PO Box 3727
Corpus Christi, Texas 78463

MEDICAL CLAIMS DISPUTE
CountyCare
Attn: Claim Disputes
PO Box 3727
Corpus Christi, Texas 78463

MEDICAL AUTHORIZATION APPEALS
CountyCare
Attn: Medical Management
PO Box 803758
Chicago, IL 60680

PHARMACY PAPER CLAIMS SUBMISSION
OptumRx
PO Box 968022
Schaumburg, IL 60196
877-235-1981

VISION
EyeQuest
PO BOX 527
Thiensville, WI 53092
844-254-9491

DENTAL
DentaQuest
12121 N. Corporate Parkway
Mequon, WI 53092
800-508-6780

TRANSPORTATION
FirstTransit
799 Roosevelt Road
Building 4, Suite 200
Glen Ellyn, IL 60137
630-403-3210
FAMILY HEALTH PLANS & ACA ADULTS
CountyCare manages the full spectrum of Medicaid covered services through an integrated care delivery system in Cook County under the Family Health Plan and ACA Expansion Programs. This includes doctor visits and dental care, well-child care, immunizations for children, mental health and substance abuse services, hospital care, emergency services, prescription drugs and medical equipment and supplies. CountyCare improves members’ health and social outcomes and access to care by integrating service delivery through Care Coordination. Care coordination encompasses acute care, community based and institutional long-term care, behavioral health, disease management and non-covered services.

INTEGRATED CARE PROGRAM (ICP)
The Integrated Care Program (ICP) is a program for older adults, and adults with disabilities, who are eligible for Medicaid, but not eligible for Medicare. The Integrated Care Program brings together local primary care providers (PCPs), specialists, hospitals, nursing homes and other providers to organize care around a patient’s needs. It will keep enrollees healthy through more coordinated medical care, helping prevent unnecessary healthcare costs.

HOME AND COMMUNITY BASED WAIVER SERVICES (HCBS)
CountyCare manages home and community based waiver services for its eligible members. These services are provided to members to assist them in remaining out of nursing homes and living independently in the community. CountyCare is responsible for managing the following waivers:

- **Aging Waiver**: For individuals 60 years and older that live in the community.
- **Individuals with Disabilities Waiver**: For individuals that have a physical disability, that are between the ages of 19-59.
- **HIV/AIDS Waiver**: For individuals that have been diagnosed with HIV or AIDS.
- **Individuals with Brain Injury Waiver**: For individuals with an injury to the brain.
- **Supportive Living Facilities**: This is for individuals that need assistance with the activities of daily living, but do not need the care of a nursing facility.

LONG TERM CARE
CountyCare also manages room and board for members within the Integrated Care Program and the ACA and Family Health Plan Programs that reside in Long Term Care facilities. This also includes managing their medical, behavioral health, dental, and vision and pharmacy benefits.
Members should present their ID at the time of service, but an ID card in and of itself is not a guarantee of eligibility; therefore, providers must verify a member’s eligibility on each date of service. Information such as member ID number, effective date, 24-hour phone number for health plan, and PCP information is included on the card. A new card is issued only when the information on the card changes, if a member loses a card, or if a member requests an additional card. If you are not familiar with the person seeking care, please ask to see photo identification. If you suspect fraud, please contact the Fraud hotline at 844-509-4669 immediately.

To verify member eligibility, please use one of the following methods:

1. **Online.** Log on to the secure provider portal at [www.countycare.com](http://www.countycare.com) where, you can check member eligibility. You can search by date of service plus any one of the following: member name and date of birth, Medicaid ID number; or CountyCare member ID number. You can submit multiple member ID numbers in a single request.

2. **Call our automated member eligibility interactive voice response (IVR) system.** Call 312-864-8200 / 855-444-1661 from any touch tone phone and follow the appropriate menu options to reach our automated member eligibility-verification system 24 hours a day. The automated system will prompt you to enter the member ID number, the member date of birth and the month of service to check eligibility.
3 Call CountyCare Provider Services. If you cannot confirm a member’s eligibility using the methods above, call our toll-free number at 312-864-8200 / 855-444-1661. Follow the menu prompts to speak to a Provider Services representative to verify eligibility before rendering services. Provider Services will need the member name or member ID number and the member date of birth to verify eligibility.

4 Utilize the state MEDI system online at www.myhfs.illinois.gov

5 Provider Panel Lists. Through CountyCare’s secure provider web portal, primary care providers (PCP) are able to access their panel lists (a list of eligible members who have selected the PCP or have been assigned to the PCP for services (Panel). The list is posted as of the first day of the month. The list also provides other important information including date of birth and indicators for patients who are due for an Early Periodic Screening, Diagnosis and Treatment (EPSDT) exam. Since eligibility changes can occur throughout the month and the member list does not prove eligibility for benefits or guarantee coverage, please use one of the methods described above to verify member eligibility on the date of service.

ELIGIBILITY FOR HCBS WAIVERS, SLFS AND LTC
CountyCare members may qualify for home and community-based services waiver (HCBS), supportive living facility (SLF) or long term care (LTC). Eligibility for these programs is determined by the state of Illinois through the Determination of Need (DON) assessment tool. The member will be asked a series of questions, and given an overall score. Based on the member’s DON score, the state will determine if the member is eligible for a waiver service or to reside in a supportive living facility or long term care facility. To confirm if a member is eligible for these services, contact CountyCare’s Provider Services. They will be able to verify if a member is eligible for these types of services.
INTERACTIVE VOICE RESPONSE (IVR)
What’s great about the IVR system? It’s free and easy to use! The IVR provides you with greater access to information. Through the IVR you can:
• Check member eligibility
• Check claims status
• Access 24 hours a day, seven days a week, 365 days a year

COUNTYCARE WEBSITE
Utilizing CountyCare’s website can significantly reduce the number of telephone calls providers need to make to the health plan which enables CountyCare staff to effectively and efficiently perform daily tasks. CountyCare’s website is located at www.countycare.com. Providers can find the following information on the website.
• Member benefits
• CountyCare news
• Clinical guidelines
• Wellness information
• Provider Manual and Forms
• Provider newsletters
• Provider Directory

SECURE WEBSITE
CountyCare web portal service allows providers to check member eligibility and benefits, submit and check status of claims, request authorizations, and send/receive messages to communicate with CountyCare staff. CountyCare’s contracted providers and their office staff have the opportunity to register for our secure provider website in just four easy steps. Here, we offer tools which make obtaining and sharing information easy! It's simple and secure! Go to www.countycare.com to register. On the home page, select the Log on link to start the registration process.

Through the secure site, you can
• View the PCP panel (patient list)
• View and submit authorizations
• View payment history
• Check member eligibility
• Contact us securely and confidentially
• View the provider director

We are continually updating our website with the latest news and information, so save www.countycare.com to your Internet “Favorites” list and check our site often. Please contact a Provider Relations representative for a tutorial on the secure site.
PRIMARY CARE PROVIDER (PCP) RESPONSIBILITIES AND THE MEDICAL HOME

The PCP is the cornerstone of CountyCare’s service delivery model. The PCP serves as the “medical home” for the member. The “medical home” concept assists in establishing a member-provider relationship, supports continuity of care, eliminates redundant services and ultimately improves outcomes in a more cost-effective way. This is accomplished through Wellness Programs, preventive care, management of Chronic Health Conditions, and coordination and continuity of care to integrate all aspects of each Enrollee’s care.

PROVIDER TYPES THAT MAY SERVE AS PCPs

CountyCare offers a robust network of PCPs to ensure every member has access to a PCP within reasonable travel distance standards. Physicians who may serve as PCPs include Internists, Pediatricians, Obstetrician/Gynecologists, and Family and General Practitioners. Non-physicians who may serve as PCPs include physician assistants and nurse practitioners. Physicians, physician assistants, and nurse practitioners in an FQHC, RHC or Health Department setting may also serve as PCPs.

CountyCare offers pregnant Enrollees, or Enrollees with chronic illnesses, disabilities, or special healthcare needs the option of selecting a specialist as their PCP. An Enrollee, family member, caregiver or Provider may request a specialist as a PCP at any time. A member of our Integrated Care Team (ICT) will contact the Enrollee, caretaker or medical consenter to schedule an assessment. In most cases, our Chief Medical Officer will review assessment results and approve requests after determining that the Enrollee meets criteria and that the specialist is willing to fulfill the PCP role, which includes, but is not limited to, provision of routine well care and immunization service. The ICT member will work with the Enrollee and previous PCP if necessary, to safely transfer care to the specialist.

PCP REQUIREMENTS

The PCP must:

- Cooperate with CountyCare’s quality improvement activities and participate in the CountyCare QI Program. Cooperation with the QI Program includes, but is not limited to:
  - Facilitating access to member’s medical records, including electronic medical records, for QAPI Program reporting and other CountyCare quality improvement initiatives and activities related to appropriateness of service and quality of care.
  - Cooperating with quality activities including, but not limited to, participating in Patient Centered Medical Home (PCMH) Self-Surveys and responding timely to quality of care complaints and concerns.
  - Adhering to access and availability requirements to include cultural competency, linguistic and physical accessibility requirements, appointment availability and 24 hour coverage.
  - Complying with CountyCare’s credentialing and recredentialing requirements.
  - Permitting CountyCare to publish results related to Provider/Practitioner clinical performance.
  - Assisting CountyCare staff in scheduling and conducting Provider/Practitioner onsite visits.
• Be enrolled as a qualified provider in the HFS Medical Program.
• Be available for or provide on-call coverage through other source 24-hours a day for management of member care. After-hours access to the Health Home or covering CountyCare provider can be via answering service, pager, or phone transfer to another location; recorded message instructing the Enrollee to call another number; or nurse helpline. In each case, all calls must be returned within 30 minutes.
• Work in partnership with their patient’s health plan-assigned care coordinator/care manager.
• Educate members on how to maintain healthy lifestyles and prevent serious illness.
• Provide culturally competent care.
• Obtain authorizations for selected inpatient and outpatient services as listed on the current prior authorization list, except for emergency services up to the point of stabilization.
• Provide screening, well care, and referrals to community health departments and other agencies in accordance with HFS (Health and Family Services) provider requirements and public health initiatives.
• Agree to practice according to generally accepted minimum standards of care and nationally recognized clinical practice guidelines as documented on CountyCare’s website.
• Accommodate the physical access and flexible scheduling needs of their enrollees.
• Agree to communicate with enrollees in a manner that accommodates the enrollee’s individual needs and work with CountyCare to coordinate specialized services (e.g. interpreters for those who are deaf or hard of hearing and accommodations for enrollees with cognitive limitations).
• PCPs and providers delivering care to CountyCare members agree that they shall communicate all appropriate treatment options to CountyCare members, regardless of cost or benefit coverage for such options.
• Agree to CountyCare’s Fraud, Waste, and Abuse policies and procedures.

CountyCare PCPs should refer to their Provider Agreement for complete information regarding providers’ obligations and mode of reimbursement.

TERMINATING CARE OF A MEMBER
A Primary Care Provider may terminate the care of a member in his/her panel if the member:
• Repeatedly breaks appointments
• Repeatedly fails to keep scheduled appointments
• Is abusive to the provider or the office staff (physically or verbally)
• Fails to comply with the treatment plan

The provider may discontinue seeing the member after the following steps have been taken:
• The incidents have been properly documented in the member’s chart
• A certified letter has been sent to the member documenting the reason for the termination, indicating the date for the termination, informing the member that the provider will be available for emergency care for the next 30 days from the date of the letter, and instructing the member to call CountyCare’s member services department for assistance in selecting a new primary care provider
• A copy of the letter must be sent to CountyCare and a copy must be kept in the member’s medical record.

ASSIGNMENT TO PRIMARY CARE PROVIDER (PCP)
For members who have not selected a PCP within 30 days of their enrollment date through the Illinois Client Enrollment Broker, CountyCare will use an auto-assignment algorithm to assign an initial PCP by the 45th day. The algorithm assigns members to a PCP according to the following criteria, and in the sequence presented below:
Member history with a PCP. The algorithm will first look for a previous relationship with a provider.

Family history with a PCP. If the member him or herself has no previous relationship with a PCP, the algorithm will look for a PCP to which someone in the member’s family, such as a sibling, is or has been assigned.

Appropriate PCP type. The algorithm will use age, gender, and other criteria to ensure an appropriate match, such as children assigned to pediatricians and pregnant moms assigned to OB/GYNs.

Geographic proximity of PCP to member residence. The auto-assignment logic will ensure members travel no more than 30 minutes or 30 miles.

Voluntarily leaving the network & continuity of care requirements
Providers must give CountyCare notice of voluntary termination following the terms of their participating agreement with our health plan. In order for a termination to be considered valid, providers are required to send termination notices via certified mail (return receipt requested) or overnight courier. In addition, providers must supply copies of medical records to the member’s new provider upon request and facilitate the member’s transfer of care at no charge to CountyCare or the member.

CountyCare will notify affected members in writing of a provider’s termination. If the terminating provider is a PCP, CountyCare will request that the member select a new PCP. If a member does not select a PCP prior to the provider’s termination date, CountyCare will automatically assign one to the member.

Providers must continue to render covered services to members who are existing patients at the time of termination until the later of 60 calendar days or until CountyCare can arrange for appropriate healthcare for the member with a participating provider.

Upon request from a member undergoing active treatment related to a chronic or acute medical condition, CountyCare will reimburse the provider for the provision of covered services for up to 90 calendar days from the termination date. In addition, CountyCare will reimburse providers for the provision of covered services to members who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery. Exceptions may include:
- Members requiring only routine monitoring
- Providers unwilling to continue to treat the member or accept payment from CountyCare

Advance directives
PCPs and providers delivering care to CountyCare members must ensure adult members 19 years of age and older receive information on advance directives and are informed of their right to execute advance directives. Providers must document such information in the permanent medical record.

CountyCare recommends to its participating providers that they inquire about advance directives and document the member’s response in the medical record, and, for members who have executed advance directives, that a copy of the advance directive be included in the member’s medical record inclusive of mental health directives.

If an advance directive exists, the physician should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. Any such discussion should be documented in the medical record.

More information, as well as legal forms can be found at the Illinois Department of Public Health website under ‘Nursing Homes/Advance Directives’ or by clicking here.
SPECIALIST PROVIDER RESPONSIBILITIES AND THE PCP
The PCP is responsible for coordinating the members’ healthcare services and making referrals to specialty providers when care is needed that is beyond the scope of the PCP. The specialty physician may order diagnostic tests without PCP involvement by following CountyCare referral guidelines. The specialty physician must abide by the prior authorization requirements when ordering diagnostic tests; however, the specialist may not refer to other specialists or admit to the hospital without the approval of a PCP, except in a true emergency situation.

SPECIALIST REQUIREMENTS
The specialist provider must:

- Be enrolled as a qualified provider in the HFS Medical Program
- Complete credentialing initially, and re-credentialing every three years with CountyCare
- Maintain contact with the PCP
- Obtain referral or authorization from the member’s PCP and/or CountyCare Medical Management department (Medical Management) as needed before providing services
- Coordinate the member’s care with the PCP
- Work in partnership with their patient’s health plan-assigned care coordinator/care manager
- Provide the PCP with consult reports and other appropriate records within five business days
- Be available for or provide on-call coverage through another source 24-hours a day for management of member care. After-hours access can be via answering service, pager, or phone transfer to another location; recorded message instructing the member to call another number; or nurse helpline. In each case, all calls must be returned within 30 minutes
- Agree to practice according to generally accepted minimum standards of care and nationally recognized clinical practice guidelines as documented on CountyCare’s website
- Maintain the confidentiality of medical information
- Accommodate the physical access and flexible scheduling needs of CountyCare members
- Agree to communicate with enrollees in a manner that accommodates the enrollee’s individual needs and work with CountyCare to coordinate specialized services (e.g., interpreters for those who are deaf or hard of hearing and accommodations for enrollees with cognitive limitations)
- Agree to CountyCare’s Fraud, Waste, and Abuse policy and procedures

CountyCare specialty providers should refer to their provider agreement for complete information regarding providers’ obligations and mode of reimbursement.
VOLUNTARILY LEAVING THE NETWORK & CONTINUITY OF CARE REQUIREMENTS

Providers must give CountyCare notice of voluntary termination following the terms of their participating agreement with our health plan. In order for a termination to be considered valid, providers are required to send termination notices via certified mail (return receipt requested) or overnight courier. In addition, providers must supply copies of medical records to the member’s new provider upon request and facilitate the member’s transfer of care at no charge to CountyCare or the member.

CountyCare will notify affected members in writing of a provider’s termination. If the terminating provider is a PCP, CountyCare will request that the member select a new PCP. If a member does not select a PCP prior to the provider’s termination date, CountyCare will automatically assign one to the member.

Providers must continue to render covered services to members who are existing patients at the time of termination until the later of 60 calendar days or until CountyCare can arrange for appropriate healthcare for the member with a participating provider.

Upon request from a member undergoing active treatment related to a chronic or acute medical condition, CountyCare will reimburse the provider for the provision of covered services for up to 90 calendar days from the termination date. In addition, CountyCare will reimburse providers for the provision of covered services to members who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery.

Exceptions may include:

- Members requiring only routine monitoring
- Providers unwilling to continue to treat the member or accept payment from CountyCare

ADVANCE DIRECTIVES

PCPs and providers delivering care to CountyCare members must ensure adult members 19 years of age and older receive information on advance directives and are informed of their right to execute advance directives. Providers must document such information in the permanent medical record.

CountyCare recommends to its participating providers that they inquire about advance directives and document the member’s response in the medical record, and, for members who have executed advance directives, that a copy of the advance directive be included in the member’s medical record inclusive of mental health directives.

If an advance directive exists, the physician should discuss potential medical emergencies with the member and/or designated family member/ significant other (if named in the advance directive and if available) and with the referring physician, if applicable. Any such discussion should be documented in the medical record.

More information, as well as legal forms can be found at the Illinois Department of Public Health website under ‘Nursing Homes/ Advance Directives’ or by clicking here.
WAIVER PROVIDER RESPONSIBILITIES
Waiver providers must:

• Work collaboratively with CountyCare’s care coordination team to provide services according to the care plan
• Provide only the services as outlined in the care plan. If you believe a change is necessary for the member’s well-being, contact CountyCare’s Integrated Care Team to discuss the change
• Provide culturally competent care
• Maintain confidentiality of medical information
• Maintain contact with the PCP
• Obtain authorization from a CountyCare Care Coordinator as needed before providing services
• Must allow member freedom of choice and access to all willing and qualified providers
• Report any instances of alleged fraud, abuse, neglect or exploitation within required reporting parameters
• Obtain authorizations for selected inpatient and outpatient services as listed on the current prior authorization list, except for emergency services up to the point of stabilization

SUPPORTIVE LIVING FACILITIES AND LONG TERM CARE FACILITY RESPONSIBILITIES:
SLF & LTC providers must:

• Work in partnership with their patient’s health plan-assigned care coordinator/care manager
• Notify CountyCare’s Medical Management department of emergency hospital admissions, elective hospital admissions within 24-48 hours of the admission
• Notify the PCP, when possible, within 24-48 hours after the member’s visit to the emergency department
• Notify CountyCare’s Medical Management department of CountyCare member emergency room visits for the previous business day via fax or electronic file. The notification should include member’s name, Medicaid ID, presenting symptoms, diagnosis, date of service, and member phone number, if available.

MEMBER FREEDOM OF CHOICE AND ACCESS TO ALL WILLING AND QUALIFIED PROVIDERS
CountyCare ensures that members have freedom of choice of the providers they utilize for waiver services and long term care. CountyCare members have the option to choose their providers, which includes all willing and qualified providers. Subject to the member’s care plan, member access to in-network non-medical providers offering waivered services will not be limited or denied except when quality, reliability or similar threats pose potential hazards to the well-being of our members. Freedom of choice with network providers will not be limited for plan participants, nor will providers of qualified services be stopped from providing such service as long as the goal of high quality, cost efficient care is met or exceeded and providers adhere to the contractual standards outlined in the CountyCare contract with the state of Illinois. We encourage our providers to share this information with members as well.
SUSPENDING SERVICES OF A MEMBER
A home and community-based services provider may suspend the services of a member if the member or authorized representative causes a barrier to care or unsafe conditions. Any incidents of barriers to care and/or unsafe conditions should be reported to the CountyCare Care Coordinator by calling 312-864-8200 / 855-444-1661. The Care Coordinator will work directly with the provider to resolve any potential issues, and if necessary, temporarily suspend services.

VOLUNTARILY LEAVING THE NETWORK & CONTINUITY OF CARE REQUIREMENTS
Providers must give CountyCare notice of voluntary termination following the terms of their participating agreement with our health plan. In order for a termination to be considered valid, providers are required to send termination notices via certified mail (return receipt requested) or overnight courier. In addition, providers must supply copies of medical records to the member’s new provider upon request and facilitate the member’s transfer of care at no charge to CountyCare or the member.

CountyCare will notify affected members in writing of a provider’s termination. If the terminating provider is a PCP, CountyCare will request that the member select a new PCP. If a member does not select a PCP prior to the provider’s termination date, CountyCare will automatically assign one to the member.

Providers must continue to render covered services to members who are existing patients at the time of termination until the later of 60 calendar days or until CountyCare can arrange for appropriate healthcare for the member with a participating provider.

Upon request from a member undergoing active treatment related to a chronic or acute medical condition, CountyCare will reimburse the provider for the provision of covered services for up to 90 calendar days from the termination date. In addition, CountyCare will reimburse providers for the provision of covered services to members who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery.

Exceptions may include:
- Members requiring only routine monitoring
- Providers unwilling to continue to treat the member or accept payment from CountyCare

ADVANCE DIRECTIVES
PCPs and providers delivering care to CountyCare members must ensure adult members 19 years of age and older receive information on advance directives and are informed of their right to execute advance directives. Providers must document such information in the permanent medical record.

CountyCare recommends to its participating providers that they inquire about advance directives and document the member’s response in the medical record, and, for members who have executed advance directives, that a copy of the advance directive be included in the member’s medical record inclusive of mental health directives.

If an advance directive exists, the physician should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. Any such discussion should be documented in the medical record.

More information, as well as legal forms can be found at the Illinois Department of Public Health website under ‘Nursing Homes/Advance Directives’ or by clicking here.
Hospital Responsibilities

CountyCare utilizes a network of hospitals to provide services to CountyCare members.

Hospitals must:

- Obtain authorizations for selected inpatient and outpatient services as listed on the current prior authorization list. Emergency Room care does not require prior authorization
- Notify CountyCare’s Medical Management department of emergency hospital admissions, elective hospital admissions and new born deliveries within 24-48 hours of the admission
- Notify the PCP, when possible, within 24-48 hours after the member’s visit to the emergency department
- Notify CountyCare’s Medical Management department of members who may benefit from care coordination services – such as members who may have frequent visit to the emergency room
- Notify CountyCare’s Medical Management department of CountyCare member emergency room visits for the previous business day via fax or electronic file. The notification should include member’s name, Medicaid ID, presenting symptoms, diagnosis, date of service, and member phone number, if available.

CountyCare hospitals should refer to their Provider Agreement for complete information regarding the hospitals’ obligations and reimbursement.

ADVANCE DIRECTIVES

PCPs and providers delivering care to CountyCare members must ensure adult members 19 years of age and older receive information on advance directives and are informed of their right to execute advance directives. Providers must document such information in the permanent medical record.

CountyCare recommends to its participating providers that they inquire about advance directives and document the member’s response in the medical record, and, for members who have executed advance directives, that a copy of the advance directive be included in the member’s medical record inclusive of mental health directives.

If an advance directive exists, the physician should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. Any such discussion should be documented in the medical record.

More information, as well as legal forms can be found at the Illinois Department of Public Health website under ‘Nursing Homes/Advance Directives’ or by clicking here.
CountyCare network providers must:

- Answer the member’s telephone inquiries on a timely basis
- Prioritize appointments
- Schedule a series of appointments and follow-up appointments as needed by a member
- Identify and reschedule no-show appointments
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments)

- Adhere to the following response time for telephone call-back waiting times:
  - After-hours telephone care for non-emergent, symptomatic issues within 30 minutes
  - Same day for non-symptomatic concerns
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider’s absence.

CountyCare follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. CountyCare monitors compliance with these standards on an annual basis. Providers must offer hours of operation no less than those hours offered to commercial enrollees or Medicaid fee-for-service enrollees. Below is a table detailing the type of service and the scheduling time frame that must be followed by all providers:

<table>
<thead>
<tr>
<th>TYPE OF SERVICE</th>
<th>ACCESS REQUIREMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent Care</td>
<td>Immediate</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Non-urgent symptomatic</td>
<td>Within three weeks</td>
</tr>
<tr>
<td>Routine - preventive care</td>
<td>Within five weeks</td>
</tr>
<tr>
<td>Initial Visit - pregnant women</td>
<td>1st trimester – 2 weeks, 2nd trimester - 1 week, 3rd trimester - 3 days</td>
</tr>
<tr>
<td>Average office wait time</td>
<td>Equal to or less than one hour</td>
</tr>
<tr>
<td>Provider appointments</td>
<td>No more than six scheduled per hour</td>
</tr>
<tr>
<td>After Hours</td>
<td>24/7 coverage (voicemail only not acceptable)</td>
</tr>
</tbody>
</table>

CountyCare follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. CountyCare monitors compliance with these standards on an annual basis. Providers must offer hours of operation no less than those hours offered to commercial enrollees or Medicaid fee-for-service enrollees. Below is a table detailing the type of service and the scheduling time frame that must be followed by all providers:
• After-hours calls should be documented in a written format in either an after-hour call log or some other method, and then transferred to the member’s medical record

CountyCare will monitor appointment and after hours availability on an on-going basis through its Quality Improvement Program (“QIP”).

COVERING PROVIDERS
PCPs and specialty physicians must arrange for coverage with another CountyCare network provider during scheduled or unscheduled time off. The covering provider must have an active Illinois Medicaid ID number and an active NPI number in order to receive payment. The covering physician is compensated in accordance with the terms of his/ her contractual agreement.

24-HOUR ACCESS
CountyCare’s PCPs and specialty physicians are required to maintain sufficient access to facilities and personnel to provide covered physician services and shall ensure that such services are accessible to members as needed 24-hours a day, 365 days a year as follows:
• A provider’s office phone must be answered during normal business hours
• During after-hours, a provider must have arrangements for:
  o Access to a covering physician,
  o An answering service,
  o Triage service, or
  o A voice message that provides a second phone number that is answered
  o Any recorded message must be provided in English and Spanish

The selected method of 24-hour coverage chosen by the member must connect the caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision. The PCP, specialty physician, or covering medical professional must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the medical office’s daytime telephone number.

PCP MEMBER PANEL CAPACITY
Primary Care Physicians will be allowed to carry a membership panel of 1,800 member lives. Mid-level providers (e.g. APNs, NPs, PAs) will be allowed to carry a membership panel of 900 member lives.

All PCPs reserve the right to limit the number of members they are willing to accept into their panel as allowed by HFS. CountyCare DOES NOT guarantee that any provider will receive a certain number of members.

If a PCP declares a specific capacity for their practice and wants to make a change to that capacity, the PCP must contact CountyCare Provider Services at 312-864-8200 / 855-444-1661. A PCP shall not refuse to treat members as long as the provider has not reached their requested panel size.

Providers shall notify CountyCare in writing at least 45 calendar days in advance of their inability to accept additional Medicaid covered persons under CountyCare agreements. In no event shall any established patient who becomes a covered person be considered a new patient. CountyCare prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-Medicaid members.

www.countycare.com
OVERVIEW
CountyCare is committed to having all CountyCare network providers fully recognize and care for the culturally diverse needs of the members they serve. To accomplish this aim, CountyCare has established a Cultural Competency Plan to help guide and monitor efforts to ensure cultural competency, building on CountyCare partner experience and established relationships in the communities served.

CountyCare’s Cultural Competency Plan is based on the adoption of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care published by the US Department of Health and Human Services’ Office of Minority Health in 2000. Culturally and linguistically appropriate services (CLAS) are health care services provided that are respectful of, and responsive to, cultural and linguistic needs. The care provided is designed to be effective, understandable and respectful:

- ‘Effective care’ is care that successfully restores the client to the desired health status and takes steps to protect future health by incorporating health promotion, disease prevention, and wellness interventions. In order for health services to be effective, the clinician must accurately diagnose the illness, discern the correct treatment for that individual, and negotiate the treatment plan successfully with the enrollee.
- ‘Understandable care’ that focuses on the need for patients to fully comprehend questions, instructions, and explanations from clinical, administrative, and other staff. To be understandable, the concepts must “make sense” in the cultural framework of the enrollee.
- ‘Respectful care’ that includes taking into consideration the values, preferences, and expressed needs of the enrollee and to help create an environment whereby patients from diverse backgrounds feel comfortable discussing their specific needs with any staff member.

It is equally important to maintain “Disability Awareness”. The Americans with Disabilities Act (ADA) defines a person with a disability as a person who has a physical or mental impairment that substantially limits one or more major life activities, and includes people who have a record of impairment, even if they do not currently have a disability, and individuals who do not have a disability, but are regarded as having a disability.

It is unlawful to discriminate against persons with disabilities or to discriminate against a person based on that person’s association with a person with a disability. Accommodations for people with disabilities include:

- Physical accessibility
- Effective communication
- Policy modification, and
- Accessible medical equipment.

To successfully meet the demands for ‘disability awareness,’ providers should capture information about accommodations that may be required in the patient’s medical record, and when making referrals to other providers, communicate with the receiving
provider regarding any necessary accommodations that may be required.

TRAINING GOALS & REQUIREMENTS
CountyCare network providers and their staff have an obligation to deliver culturally competent health care and services by possessing attitudes, skills, and policies that enable effective work in cross-cultural settings. Trainings are available to support providers meet goals that include but are not limited to:

- Being educated about the linguistic needs and cultural differences of enrollees
- Having an understanding of the population that they serve
- Being responsive and sensitive to the enrollee’s needs
- Having the ability to communicate effectively with enrollees

During the credentialing and recredentialing process, CountyCare will confirm the languages used by providers, including American Sign Language, and physical access to provider office locations. Additionally, CountyCare will facilitate annual cultural sensitivity training to all CountyCare staff and to provider offices. For provider offices that have their own cultural sensitivity and competency training, CountyCare staff will assess the training to ensure it covers all required topics.

MONITORING & REPORTING
CountyCare will perform Quality Assurance evaluations of provider practices, which will include monitoring of Enrollee accessibility to ensure linguistic and physical accessibility. CountyCare will report the following indicators towards achieving cultural competence:

Language:
- Percent of enrollees who speak Spanish or other prevalent languages
- Percent of CountyCare staff who speak Spanish or other prevalent languages
- Percent of provider offices with self-designated prevalent languages speaking staff

Gender:
- Availability of female and male primary care and obstetrician/gynecological services through the geographic area (100% within set standards)

Training:
- Percent of provider offices who have participated in annual cultural competency training
- Percent of CountyCare staff who have participated in annual cultural competency training

Education:
- In-service sessions for CountyCare staff from a local organization to increase effectiveness of culturally competent service delivery

Satisfaction/Complaints
- Satisfaction results on cultural competence indicating “good,” “very good,” or “excellent”
- Assessment and resolution of complaints regarding cultural competence in a timely manner

Communication Materials
- Materials developed for presentation in a layout and manner that enhances Enrollees’ understanding in a culturally competent manner and meet a sixth grade reading level.
- Translation of all materials at the appropriate reading level and found to be culturally appropriate.
- Assessment and resolution of complaints regarding cultural competence completed in a timely manner
COUNTYCARE BENEFITS
CountyCare network providers deliver a variety of medical benefits and services some of which are outlined on the following pages. For specific information not covered in this provider manual, please contact Provider Services at 312-864-8200 from 8:30 a.m. to 8:00 p.m. Central, Monday through Friday (excluding holidays). A Provider Services Representative will assist you in understanding the benefits. Providers can also reference the CountyCare website for the most recent benefit updates at: www.countycare.com

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>PRIOR AUTHORIZATION</th>
<th>COMMENTS</th>
<th>BENEFIT LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiology - consults and testing</td>
<td>Not required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audiology - hearing aids</td>
<td>Not required</td>
<td></td>
<td>Limited to 1 every three years</td>
</tr>
<tr>
<td>Dental care - extractions and dentures for persons with diabetes</td>
<td>Required</td>
<td>As necessary for a diabetic patient to receive proper nutrition</td>
<td></td>
</tr>
<tr>
<td>Dental care - emergencies</td>
<td>Not required</td>
<td>Definition: a situation deemed medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury that can be treated by extraction only.</td>
<td></td>
</tr>
<tr>
<td>Dental care - emergent medical conditions</td>
<td>Required</td>
<td>Medically necessary dental services requested by the patient’s physician prior to receiving medical treatment such as, but not limited to, cancer treatment, joint replacement, organ transplants, or other emergent medical conditions requiring good oral health to continue medical treatment will be considered after prior authorization.</td>
<td></td>
</tr>
<tr>
<td>SERVICE</td>
<td>PRIOR AUTHORIZATION</td>
<td>COMMENTS</td>
<td>BENEFIT LIMITS</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>---------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Dental care - persons 19-20</td>
<td>Not required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td>Not required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (DME) &lt; $500</td>
<td>Not required</td>
<td>Including but not limited to: orthotics, prosthetics, insulin pumps, oxygen, BIPAP, CPAP, O2 concentrator, ventilator, wound vac, bone growth stimulators, custom wheelchairs, neuro-stimulators, beds</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (DME) &gt; $500</td>
<td>Required</td>
<td>If available for rental, standard 3 month initial rental and re-submit for continued rental or purchase</td>
<td></td>
</tr>
<tr>
<td>Emergency room services</td>
<td>Not required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care - infusions</td>
<td>Required</td>
<td>enteral or parental nutrition, IV medications</td>
<td></td>
</tr>
<tr>
<td>Family planning</td>
<td>Not required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genetic counseling and testing</td>
<td>Required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care - professional services</td>
<td>Required</td>
<td>Including but not limited to: skilled nursing services, therapies, and wound therapy</td>
<td></td>
</tr>
<tr>
<td>Home health care - hospice care</td>
<td>Required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital inpatient service</td>
<td>Required</td>
<td>Planned services pre-authorized; acute/emergent services submitted for authorizations within XX hours</td>
<td></td>
</tr>
<tr>
<td>Laboratory services (non-genetic testing)</td>
<td>Not required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental/behavioral health services - provided at FQHCs and CCHHS</td>
<td>Not required</td>
<td>CountyCare - refer to provider manual</td>
<td></td>
</tr>
<tr>
<td>Mental/behavioral health services - all other</td>
<td>May be required</td>
<td>CountyCare - refer to provider manual</td>
<td></td>
</tr>
<tr>
<td>SERVICE</td>
<td>PRIOR AUTHORIZATION</td>
<td>COMMENTS</td>
<td>BENEFIT LIMITS</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>----------------------</td>
<td>-------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Out-of-network physician/ facility/ service</td>
<td>Required</td>
<td>Except ED services and family planning service</td>
<td></td>
</tr>
<tr>
<td>Outpatient therapy — PT, OT, ST evaluation and first six visits</td>
<td>Not required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient therapy - PT &gt; 6 visits, OT, ST, cardiac and pulmonary rehabilitation</td>
<td>Required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care providers - all providers at medical home site</td>
<td>Not required</td>
<td>Includes APNs and PAs; includes EPSDT services</td>
<td></td>
</tr>
<tr>
<td>Radiology service – non–high tech imaging</td>
<td>Not required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology service – high tech imaging</td>
<td>Required</td>
<td>• CT</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• MRI/MRA</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• PET Scan</td>
<td></td>
</tr>
<tr>
<td>Sleep study</td>
<td>Not required</td>
<td>Sleep study required prior to approval for CPAP for sleep apnea</td>
<td></td>
</tr>
<tr>
<td>Specialist physicians - all other outpatient office visits</td>
<td>Not required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist physicians - pain management</td>
<td>Required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist physicians - plastic surgery</td>
<td>Required</td>
<td>All services in office setting. Services that are for cosmetic purposes only are not a covered benefit</td>
<td></td>
</tr>
<tr>
<td>Specialist physicians - podiatry for all persons</td>
<td>Required</td>
<td>Podiatry services require authorization after the third visit</td>
<td></td>
</tr>
<tr>
<td>Surgery - hysterectomy</td>
<td>Required</td>
<td>HFS requires form 2360 accompanied by written consent to perform sterilization. HFS 1977 with claim</td>
<td></td>
</tr>
<tr>
<td>Surgery - nonemergency</td>
<td>Required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SERVICE</td>
<td>PRIOR AUTHORIZATION</td>
<td>COMMENTS</td>
<td>BENEFIT LIMITS</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------</td>
<td>----------------------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Surgery - plastic</td>
<td>Required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery - sterilization</td>
<td>HFS form 2189</td>
<td>HFS requires form 2189 with claim</td>
<td></td>
</tr>
<tr>
<td>procedures</td>
<td>required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery - transplant</td>
<td>Required</td>
<td>Authorized by Innovative Risk Management/PartnerRe</td>
<td></td>
</tr>
<tr>
<td>Termination of Pregnancy</td>
<td>HFS form 2390</td>
<td>HFS requires form 2390 with claim</td>
<td></td>
</tr>
<tr>
<td></td>
<td>required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation - air ambulance, fixed wing</td>
<td>Required</td>
<td>Single case agreement only</td>
<td></td>
</tr>
<tr>
<td>Transportation - ground ambulance service, scheduled</td>
<td>Required</td>
<td>Single case agreement only</td>
<td></td>
</tr>
<tr>
<td>Transportation - ground ambulance service, emergent</td>
<td>Not required</td>
<td>Emergency only - covered through medical benefit</td>
<td></td>
</tr>
<tr>
<td>Transportation - van or public transportation</td>
<td>Not required</td>
<td>Arranged by member’s PCP medical home</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** Out of Network Services are not covered services except for Emergency Services or when the health plan provides prior authorization.

Please contact CountyCare with questions regarding pre-authorization requirements if service is not listed at 312-864-8200. For an up to date list, please visit our website, www.countycare.com
ADDITIONAL BENEFITS
The table below outlines additional benefits offered to CountyCare members.

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Copays</td>
<td>No copays for medical visits or prescriptions.</td>
</tr>
<tr>
<td>Dental Services</td>
<td>• Annual dental cleaning for adults</td>
</tr>
<tr>
<td></td>
<td>• Additional time for dental visits</td>
</tr>
<tr>
<td></td>
<td>• “Practice visits” if needed</td>
</tr>
<tr>
<td>Gynecologic Visits</td>
<td>“Practice visits” for enrollees with developmental disabilities or serious</td>
</tr>
<tr>
<td></td>
<td>mental illness if needed</td>
</tr>
<tr>
<td>Vision Services</td>
<td>• Annual eye exam</td>
</tr>
<tr>
<td></td>
<td>• Pair of eyeglasses every two years (calendar year)</td>
</tr>
<tr>
<td></td>
<td>• Additional options include:</td>
</tr>
<tr>
<td></td>
<td>o Option to receive contacts in lieu of glasses, and receive $80 allowance</td>
</tr>
<tr>
<td></td>
<td>toward contact purchase. Any cost above $80 is member’s responsibility.</td>
</tr>
<tr>
<td></td>
<td>o Opt-out of formulary frame selection and receive $100 toward purchase</td>
</tr>
<tr>
<td></td>
<td>of frames. Member responsible for any costs above $100 allowance.</td>
</tr>
<tr>
<td></td>
<td>o Contact fitting is covered at no cost to the member.</td>
</tr>
</tbody>
</table>

ADDITIONAL COVERED SERVICES FOR WAIVER RECIPIENTS
CountyCare network providers supply a variety of additional benefits and services for those who qualify for waiver service. Each of the services below must be a part of the member’s approved care plan in order for the service to be rendered.

For specific information not covered in this provider manual, please contact Provider Services at 312-864-8200 / 855-444-1661 from 8:30 a.m. to 8:00 p.m. Central, Monday through Friday (excluding holidays). A Provider Services Representative will assist you in understanding the benefits.

Key facts to remember about HCBS services:
• Verify eligibility and benefits prior to rendering services for all members. Payment, regardless of authorization, is contingent on member’s eligibility at the time service is rendered.
• Non-par providers and facilities require authorization for all services except where indicated.
• Waiver services will be authorized by the health plan case manager based on member waiver eligibility.
• Please notify CountyCare of all Custodial admissions to Nursing Homes or Skilled Nursing Facilities.
## HCBS Covered Services by Waiver Type

<table>
<thead>
<tr>
<th>Services</th>
<th>Aging Waiver</th>
<th>Disability Waiver</th>
<th>HIV/AIDS Waiver</th>
<th>Brain Injury Waiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Equipment</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Adult Day Service</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Adult Day Service Transportation</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Behavioral Services</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Day Habilitation</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Home Delivered Meals</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Home Health Aide</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Home/Car Adoptions</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Homemaker</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Nursing, Intermittent</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Nursing, Skilled</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Personal Assistant</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Personal Emergency Response System</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Physical Therapy</td>
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<td>Prevocational Services</td>
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<td>Respite</td>
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<td>Speech Therapy</td>
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<tr>
<td>Supported Employment</td>
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ADDITIONAL COVERED SERVICES FOR MEMBERS LIVING IN LONG TERM CARE FACILITIES (LTC)
For Long Term Care Facilities, CountyCare covers room and board for qualified members.

ADDITIONAL COVERED SERVICES FOR MEMBERS LIVING IN SUPPORTIVE LIVING FACILITIES (SLFS)
The following services are included in the global rate, and should be provided to CountyCare members:

- Nursing Services
- Personal Care
- Medication administration, oversight and assistance in self-administration
- Laundry
- Housekeeping
- Maintenance
- Social and recreational programming
- Ancillary Services
- 24 hour response/security staff
- Health promotion and exercise
- Emergency call system
- Daily checks
- Quality assurance plan
- Management of resident funds, if applicable.

NON-COVERED SERVICES
The table below outlines CountyCare’s non-covered services.

<table>
<thead>
<tr>
<th>NON-COVERED SERVICE</th>
<th>COMMENT(S)</th>
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</thead>
<tbody>
<tr>
<td>Medical/surgical procedures solely for cosmetic purposes</td>
<td></td>
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<tr>
<td>Diagnostic and/or therapeutic procedures related to infertility/sterility</td>
<td></td>
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<tr>
<td>Services that are experimental and/or investigational in nature</td>
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</tr>
<tr>
<td>Intermediate Care Facility for Mentally Retarded/Developmentally Disabled (ICF/DD/MR Facility)</td>
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<tr>
<td>Nursing Facility beginning on ninety-first (91st) day</td>
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<tr>
<td>Services provided by an out-of-network provider and not prior-authorized by CountyCare</td>
<td>Except Family Planning services in the State and ER services (in/out of State).</td>
</tr>
<tr>
<td>Services that are provided without first obtaining a required referral or prior-authorization as per CountyCare policy.</td>
<td>All waiver services require prior authorization.</td>
</tr>
</tbody>
</table>
OVERVIEW AND MEDICAL NECESSITY
CountyCare’s Medical Management department hours of operation are Monday through Friday from 8:30 a.m. to 8:00 p.m., Central (excluding holidays). Medical Management services include the areas of utilization management, care coordination/case management, disease management, pharmacy management, and quality review.

REFERRALS, PRIOR AUTHORIZATIONS AND NOTIFICATIONS
REFERRALS
As promoted by the Medical Home concept, PCPs should coordinate most of the healthcare services for CountyCare members. PCPs can refer a member to a specialist when care is needed that is beyond the scope of the PCP’s training or practice parameters; however, paper referrals are not required. To better coordinate a member’s healthcare, CountyCare encourages specialists to communicate to the PCP the need for a referral to another specialist rather than making such a referral themselves.

NOTIFICATIONS
A provider is required to promptly notify CountyCare when prenatal care is rendered. Early notification of pregnancy allows the health plan to assist the member with prenatal care coordination of services.

PRIOR AUTHORIZATIONS
Some services require prior authorization from CountyCare in order for reimbursement to be issued to the provider. All out-of-network services require prior authorization. To verify whether a prior authorization is necessary or to obtain a prior authorization, call:

CountyCare Medical Management/Authorization Department
Telephone 312-864-8200 / 855-444-1661
Fax: 866-209-3703

Prior Authorization requests may be submitted electronically through the secure provider portal.

AUTHORIZATION TIMELINES
Prior authorization should be requested at least 14 calendar days before the requested service delivery date. CountyCare decisions for requests for standard services will be made within 14 calendar days of the request with a possible extension of up to 14 calendar days. “Necessary information” includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that may be required. The provider and member will be notified of the decision within one business day of the determination. Failure to submit necessary clinical information can result in an administrative denial of the requested service. For urgent/expedited requests, a decision is made within 72 hours of receipt of all necessary information. The provider and member will be notified of the decision within one business day of the determination.
NOTIFICATION OF PREGNANCY
CountyCare provides care coordination for pregnant members. It is critical to identify members as early in their pregnancy as possible. CountyCare asks that managing physician notify the CountyCare prenatal team by completing the Notification of Pregnancy (NOP) within five days of the first prenatal visit. Providers are expected to identify the estimated date of confinement and delivery facility.

UTILIZATION MANAGEMENT
The CountyCare Utilization Management Program (UMP) is designed to ensure members of CountyCare receive access to the right care at the right place and right time. Our program is comprehensive and applies to all eligible members across all product types, age categories, and range of diagnoses. The UMP incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, long term care, and ancillary care services.

CountyCare’s UMP seeks to optimize a member’s health status, sense of well-being, productivity, and access to quality healthcare, while at the same time actively managing cost trends. The UMP aims to provide services that are a covered benefit, medically necessary, appropriate to the patient’s condition, rendered in the appropriate setting and meet professionally recognized standards of care.

SECOND OPINION
Members or a healthcare professional with the member’s consent may request and receive a second opinion from a qualified professional within the CountyCare network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider at no cost to the member. Out-of-network providers will require prior authorization by CountyCare.

ASSISTANT SURGEON
Reimbursement for an assistant surgeon’s service is based on the medical necessity of the procedure itself and the assistant surgeon’s presence at the time of the procedure. CountyCare follows the guidelines for assistant surgeons set forth in the State of Illinois Medicaid fee schedule. Hospital medical staff by-laws that require an assistant surgeon be present for a designated procedure are not in and of themselves grounds for reimbursement as they may not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests that an assistant surgeon be present for the surgery, unless medical necessity is indicated.

CLINICAL INFORMATION
Authorization requests may be submitted by fax, phone or secure web portal. A referral specialist will enter the demographic information and transfer the information to a CountyCare nurse for the completion of medical necessity screening. For all services on the prior authorization list, documentation supporting medical necessity will be required.

CountyCare clinical staff will request clinical information that is minimally necessary for clinical decision making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), CountyCare is entitled to request and receive protected health information (PHI) for purposes of treatment, payment and healthcare operations.

Information necessary for authorization of covered services may include but is not limited to:
- Member’s name, Member ID number
- Provider’s name and telephone number
- Provider location if the request is for an ambulatory or office procedure
• Reason for the authorization request (e.g., primary and secondary diagnoses, planned surgical procedures, surgery date)
• Relevant clinical information (e.g., past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
• Discharge plans

Notification of newborn deliveries should include the mother’s name, date of delivery, method of delivery, and weight.

If additional clinical information is required, a CountyCare nurse or medical management representative will notify the caller of the specific information needed to complete the authorization process.

CLINICAL DECISIONS
CountyCare affirms that utilization management decision making is based only on appropriateness of care and service and the existence of coverage. CountyCare does not specifically reward practitioners or other individuals for issuing denials of service or care.

The treating physician, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The PCP, in consultation with the CountyCare Medical Director and other clinical staff, is responsible for making utilization management (UM) decisions in accordance with the member’s plan of covered benefits and established medical necessity criteria. Failure to obtain authorization for services that require plan approval may result in payment denials.

MEDICAL NECESSITY
Medical necessity is defined for CountyCare members as healthcare services, supplies or equipment provided by a licensed healthcare professional that are:
• Appropriate and consistent with the diagnosis or treatment of the patient’s condition, illness, or injury
• In accordance with the standards of good medical practice consistent with evidence based and CountyCare’s clinical practice guidelines as found on our website at www.countycare.com
• Not primarily for the personal comfort or convenience of the member, family, or provider
• The most appropriate services, supplies, equipment, or level of care that can be safely and efficiently provided to the member
• Furnished in a setting appropriate to the patient’s medical need and condition and, when supplied to the care of an inpatient, further mean that the member’s medical symptoms or conditions require that the services cannot be safely provided to the member as an outpatient service
• Not experimental or investigational or for research or education

REVIEW CRITERIA
CountyCare has adopted utilization review criteria developed by McKesson InterQual® products to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual is utilized as a screening guide and is not intended to be a
substitute for practitioner judgment. The Medical Director reviews all potential medical necessity denials and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department at 312-864-8200 / 855-444-1661. Practitioners also have the opportunity to discuss any medical or pharmaceutical utilization management adverse determination with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. The Medical Director may be contacted by calling CountyCare’s main toll-free phone number and asking for the Medical Director. A medical management nurse may also coordinate communication between the Medical Director and requesting practitioner.

Members or healthcare professionals with the member’s consent may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to:

**CountyCare**  
Provider Appeals  
P.O. Box 803758  
Chicago, IL 60680

**NEW TECHNOLOGY**
CountyCare evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and/or Medical Management staff may identify relevant topics for review pertinent to the CountyCare population. CountyCare’s Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

If you need a new technology benefit determination or have an individual case review for new technology, please contact the Medical Management department 312-864-8200 / 855-444-1661.

**DISCHARGE PLANNING**
The CountyCare UM staff will coordinate the discharge planning efforts with the member/member’s family or guardian, the hospital’s UM and discharge planning departments and the member’s attending physician/PCP in order to ensure that CountyCare members receive appropriate post hospital discharge care.

**RETROSPECTIVE REVIEW**
Retrospective review is an initial review of services provided to a member, but for which authorization and/or timely notification to CountyCare was not obtained due to extenuating circumstances related to the member. Requests for retrospective review, for services that require authorization by CountyCare, must be submitted promptly upon identification but no later than 90 days from the first date of service. A decision will be made within 30 calendar days following receipt of all necessary information for any qualifying service cases.
CountyCare is committed to providing appropriate, high quality, and cost effective drug therapy to all CountyCare members. CountyCare works with providers and pharmacists to ensure that medications used to treat a variety of conditions and diseases are covered. CountyCare covers prescription drugs and certain over-the-counter (OTC) drugs when ordered by a CountyCare physician/clinician. The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage and/or maximum quantities.

This section provides an overview of CountyCare pharmacy program. For more detailed information, please visit our website at www.countycare.com.

PREFERRED DRUG LIST (PDL)
The CountyCare PDL describes the circumstances under which contracted pharmacy providers will be reimbursed for medications dispensed to members covered under the program. The PDL does not:

- Require or prohibit the prescribing or dispensing of any medication
- Substitute for the independent professional judgment of the physician/clinician or pharmacist, or
- Relieve the physician/clinician or pharmacist of any obligation to the patient or others

CountyCare’s Pharmacy and Therapeutics (P&T) Committee has reviewed and approved, with input from its members and in consideration of medical evidence, the list of drugs requiring prior authorization (PA). The PDL attempts to provide appropriate and cost-effective drug therapy to all participants covered under the CountyCare pharmacy program. If a patient requires medication that does not appear on the PDL, the clinician can submit a PA request for a non-preferred medication. It is anticipated that such exceptions will be rare and that currently available PDL medications will be appropriate to treat the vast majority of medical conditions encountered by CountyCare providers. A copy of CountyCare’s PDL may be found on the health plan website under the Provider section.

PDL EXCLUSIONS
The following drug categories are not part of the CountyCare PDL:

- Fertility enhancing drugs
- Anorexia, weight loss, or weight gain drugs
- Experimental or investigational drugs
- Immunizations and vaccines (except flu vaccine)
- Drug Efficacy Study Implementation (DESI) and Identical, Related and Similar (IRS) drugs that are classified as ineffective
- Infusion therapy and supplies
- Oral vitamins and minerals (except those listed in the PDL)
- Drugs and other agents used for cosmetic purposes or for hair growth
- Erectile dysfunction drugs prescribed to treat impotence
- OTC drugs (except those listed in the PDL)
- Over-the-Counter Medications

The CountyCare pharmacy program covers a variety of OTC medications. All covered OTC medications
appear in the PDL. All OTC medications must be written on a valid prescription, by a licensed provider.

PHARMACY PRIOR AUTHORIZATION (PA) PROCESS
The CountyCare PDL includes a broad spectrum of generic and brand name drugs. Clinicians are encouraged to prescribe from the CountyCare PDL for their patients who are members of CountyCare. Some preferred drugs require PA. Medications requiring PA are listed with a “PA” notation throughout the PDL.

CountyCare works with OptumRx to administer pharmacy benefits, including the PA process. Certain drugs require PA to be approved for payment by CountyCare. These include all medications not listed on the Preferred Drug List (PDL) and some CountyCare preferred drugs (designated PA on the PDL).

Follow these guidelines for efficient processing of your PA requests:

1. Complete the CountyCare form: Medication Prior Authorization Request Form.
2. Fax to OptumRx at 866-511-2202.
3. Once approved, OptumRx notifies the prescriber by fax.
4. If the clinical information provided does not explain the reason for the requested PA medication, OptumRx responds to the prescriber by fax, offering PDL alternatives.
5. For urgent or after-hours requests, a pharmacy can provide up to a 72-hour supply of most medications by calling the OptumRx Pharmacy Help Desk at: 877-235-1981.
6. All prior authorization requests, Medicaid and Medicare Part D, should be submitted to OptumRx.

A phone or fax-in process is available for PA requests. When calling, please have patient information, including the member ID number, complete diagnosis, medication history, and current medications readily available.

- If the request is approved, information in the online pharmacy claims processing system will be changed to allow the specific members to receive this specific drug.
- If the request is denied, information about the denial and appeal rights will be provided to the clinician.

Clinicians are requested to utilize the PDL when prescribing medication for those patients covered by the CountyCare pharmacy program. If a pharmacist receives a prescription for a drug that requires a PA request, the pharmacist should attempt to contact the clinician to request a change to a product included in the CountyCare PDL.

WORKING WITH COUNTYCARE’S SPECIALTY PHARMACY PROVIDER
Certain medications are only covered when supplied by CountyCare’s preferred specialty pharmacy provider, OptumRx Specialty Pharmacy. These products are listed on the OptumRx Supplied Biopharmaceutical document available on the CountyCare website.

Providers can request that OptumRx deliver the specialty drug to the office/member. If you would like OptumRx to deliver the specialty drug to the office/member call OptumRx at 866-511-2202 or fax the OptumRx prior authorization form to 866-511-2202 for prior authorization. If approved, OptumRx will contact the provider or member for delivery confirmation. Specialty medication PA forms are available on the CountyCare website under the provider section.
MAINTENANCE MEDICATIONS
CountyCare offers a 90-day supply (3-month supply) of maintenance medications at many retail pharmacies or through CountyCare’s mail order pharmacy, OptumRx. Please visit our website at www.countycare.com for a listing of products considered maintenance medications. Contact a CountyCare Provider Service Representative if you have any additional questions regarding this program. To transfer a current prescription to mail order you may call OptumRx at 877-235-1981.

QUANTITY LIMITATIONS
Quantity limitations have been implemented on certain medications to ensure the safe and appropriate use of the medications. Quantity limitations are approved by the CountyCare P&T Committee and noted throughout the PDL.

STEP THERAPY
Medications requiring Step Therapy are listed with an “ST” notation throughout the preferred drug list. The US Script claims system will automatically check the member profile for evidence of prior or current usage of the required agent. If there is evidence of the required agent on the member’s profile, the claim will automatically process. If not, the claims system will notify the pharmacist that a PA is required.

AGE LIMITS
Some medications on the CountyCare PDL may have age limits. These are set for certain drugs based on FDA approved labeling and for safety concerns and quality standards of care. Age limits align with current FDA alerts for the appropriate use of pharmaceuticals.

NEWLY APPROVED PRODUCTS
Newly approved drug products will not normally be placed on the PDL during their first six months on the market. During this period, access to these medications will be considered through the PA review process.

UNAPPROVED USE OF PREFERRED MEDICATION
Medication coverage under this program is limited to non-experimental indications as approved by the FDA. Other indications may also be covered if they are accepted as safe and effective using current medical and pharmaceutical reference texts and evidence-based medicine. Reimbursement decisions for specific non-approved indications will be made by CountyCare. Experimental drugs, investigational drugs and drugs used for cosmetic purposes are excluded from coverage.

GENERIC SUBSTITUTION
CountyCare requires that generic substitution be made when a generic equivalent is available. All branded products that have an A-rated generic equivalent will be reimbursed at the maximum allowable cost (MAC) where there is not a therapeutic contraindication.

EXCEPTION REQUESTS
In the event that a clinician or member disagrees with the decision regarding coverage of a medication, the clinician may request an appeal by submitting additional information to CountyCare. The additional information may be provided verbally or in writing. A decision will be rendered and the clinician will be notified with a faxed response. If the request is denied, the clinician will be notified of the appeals process at that time.

An expedited appeal may be requested at any time the provider believes the adverse determination might seriously jeopardize the life or health of a patient by calling the CountyCare complaint and grievance coordinator at 312-864-8200 / 855-444-1661. A response will be rendered within 24 hours of receipt of complete information. In circumstances that require research, a 24 hour response may not be possible.
CountyCare offers our members access to all covered, and medically necessary behavioral health services.

CountyCare members seeking mental health or substance abuse services may self-refer to a network provider for five (5) standard outpatient sessions per member but prior authorization is required for subsequent visits. For assistance in identifying a behavioral health provider or for prior authorization for inpatient or outpatient services, contact CountyCare at 312-864-8200 / 855-444-1661.

In the event that the physician or practitioner is unable to provide timely access for a member, CountyCare will assist in securing authorization to a physician or practitioner to meet the member’s needs in a timely manner.

BEHAVIORAL HEALTH SERVICES ACCESSIBILITY
To ensure members have access to care, behavioral health providers are required to comply with the following appointment standards:

- Urgent Care - within 24 hours
- Non-urgent - (symptomatic) within 30 days
- Well Care - 3 months
- Emergent Care – immediately (24 hours per day, 7 days per week)
- Post Discharge Follow Up - within 7 days
- Office Wait Times - not to exceed 1 hour

CONTINUITY OF CARE COORDINATION
When Members are newly enrolled and have been previously receiving Behavioral Health Services, CountyCare will make best efforts to maximize the transition of members care through providing for the transfer of pending prior authorization information; and work with the Member’s CountyCare Provider to honor those existing prior authorizations.

COORDINATION AND COMMUNICATION BETWEEN BEHAVIORAL HEALTH PROVIDERS AND PCP
CountyCare encourages PCPs to consult with their Members’ mental health and substance use treatment Practitioners. In many cases the PCP has extensive knowledge about the Member’s medical condition, mental status, psychosocial functioning, and family situation. Communication of this information at the point of referral or during the course of treatment is encouraged with Member consent, when required. We encourage all service providers to coordinate care with a member’s entire treatment team, including but not limited to PCPs and mental health and/or substance use treatment Practitioners.

Network Practitioners should communicate and coordinate with the Member’s PCP and with any other behavioral health service providers whenever there is a behavioral health problem or treatment plan that can affect the Member’s medical condition or the treatment being rendered to the Member. Examples of some of the items to be communicated include:
• Prescription medication.
• Results of health risk screenings.
• The Member is known to abuse over-the-counter, prescription or illegal substances in a manner that can adversely affect medical or behavioral health treatment.
• The Member is receiving treatment for a behavioral health diagnosis that can be misdiagnosed as a physical disorder (such as panic disorder being confused with mitral valve prolapse).
• The Member’s progress toward meeting the goals established in their treatment plan.

CountyCare requires that Network Practitioners report specific clinical information to the Member’s PCP in order to preserve the continuity of the treatment process. With appropriate written consent from the Member, it is the Network Practitioner’s responsibility to keep the member’s PCP abreast of the Member’s treatment status and progress in a consistent and reliable manner.

The following information should be included in the report to the PCP:

• A copy or summary of the intake assessment;
• Written notification of Member’s noncompliance with treatment plan (if applicable);
• Member’s completion of treatment;
• The results of an initial psychiatric evaluation, and initiation of and major changes in psychotropic medication(s) within fourteen (14) days of the visit or medication order; and
• The results of functional assessments.

PRIOR AUTHORIZATION REQUIREMENTS
For each of the services listed below, provider should seek a prior authorization from CountyCare’s UM Department by calling 312-864-8200, 8:30 a.m. – 8:00 p.m. Central, Monday-Friday and 9:00 a.m. – 1:00 p.m. Saturday’s.

Behavioral health services, including substance use disorder
• Inpatient Psychiatric
• Partial Hospitalization
• Intensive Outpatient Therapy
• Psychological Testing
• Neuropsychological Testing
• Electroconvulsive Therapy (ECT) - Substance Use Disorder Treatment/Rehabilitation

Community support services/behavioral health:
• Psychological Testing
• Community Support: Prior Authorization required after 200 units
• Case Management: Prior Authorization required after 200 units.
• Psychological Rehabilitation: Prior Authorization required after 800 units.

Illinois Division of Alcohol and Substance Abuse Services DASA):
• Detoxification
• Residential Rehabilitation • Day Treatment

Authorization is not required for outpatient therapy services.
EPSDT service is Medicaid’s comprehensive and preventive child health program for individuals under the age of 21, provision of which is mandated by state and federal law. EPSDT services include periodic screening, vision, dental and hearing services.

CountyCare provides coverage for the full range of EPSDT services as defined in, and in accordance with, HFS policies and procedures for EPSDT services. Such services shall include, without limitation, periodic health screenings and appropriate up to date immunization using the Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule and the American Academy of Pediatrics periodicity schedule for pediatric preventative care. The following minimum elements are to be included in the periodic health screening assessment:

- Comprehensive health and development history (including assessment of both physical and mental development)
- Comprehensive unclothed physical examination
- Immunizations appropriate to age and health history
- Assessment of nutritional status
- Laboratory tests (including finger stick hematocrit, urinalysis (dip-stick)
- Sickle cell screen, TB skin testing and RPR serology if not previously performed); Blood lead levels must be tested pursuant to the EPSDT provider manual
- Developmental assessment
- Vision screening and services, including at a minimum, diagnosis and treatment for defects in vision, including eyeglasses
- Dental screening and services, including at a minimum, relief of pain and infections, restoration of teeth and maintenance of dental health. Although an oral screening may be part of a physician examination, it does not substitute for examination through direct referral to a dentist
- Hearing screening and services, including at a minimum, diagnosis and treatment for defects in hearing, including hearing aids
- Health education and anticipatory guidance

Provision of all components of the EPSDT service must be clearly documented in the PCP's medical record for each Member.

CountyCare requires that providers cooperate to the maximum extent possible with efforts to improve the health status of CountyCare members, and to actively participate in the increase of percentage of eligible members obtaining EPSDT services in accordance with the adopted periodicity schedules. CountyCare will cooperate and assist providers to identify and immunize all Members whose medical records do not indicate up-to-date immunizations.

Provider shall participate in the Vaccines for Children (VFC) program. Vaccines from VFC should be billed with the specific antigen codes for administrative reimbursement. No payment will be made on the administration codes alone.
CountyCare’s care coordination model consists of an integrated team of registered nurses, licensed mental health professionals, social workers and non-clinical staff. The model is designed to help your CountyCare members obtain needed services and assist them in coordination of their healthcare needs. Our model supports our provider network whether you work in an individual practice, large multi-specialty group setting, long term care facility, supportive living facility or a home and community-based service provider.

The program is based upon a coordinated care model that uses a multi-disciplinary care coordination team in recognition that multiple co-morbidities will be common among our membership. The goal of our program is to collaborate with the member and the member’s PCP to achieve the highest possible levels of wellness, functioning, and quality of life.

The program includes a systematic approach for early identification of members, assessment of their needs, and development and implementation of an individualized care plan for high risk members that includes member/family education and links the member to providers and support services as well as outcome monitoring. The PCP is included in the creation of the care plan as appropriate to assure that the plan incorporates considerations related to the medical treatment plan and other observations made by the provider. The care plan is made available to the provider. Our care coordination team will integrate covered and non-covered services and provide a holistic approach to a member’s medical and behavioral healthcare. Our program incorporates clinical determinations of need, functional status, and barriers to care such as lack of caregiver supports, impaired cognitive abilities and transportation needs.

A care coordination team is available to help all providers improve the health of CountyCare members. Listed below are programs and components of special services that are available and can be accessed through the care coordination team. We look forward to hearing from you about any CountyCare members that you think can benefit from the addition of a CountyCare care coordination team member.

To contact a care coordinator call:

**CountyCare**
**Care Coordination Department**
**312-864-8200 / 855-444-1661**

**THE INTEGRATED CARE TEAMS**
Integrated Care Teams will be led by clinical licensed care coordinators with experience working with people with physical and/or mental health conditions. The teams will have experience with the member population, the barriers and obstacles they face, and socioeconomic impacts on their ability to access services. CountyCare will use a holistic approach by integrating referral and access to community resources, transportation, follow-up care, medication review, specialty care, and education to assist members in making better healthcare choices.
CARE PLANS
Once a member is determined high risk or to be eligible for a HCBS waiver or to be placed in a supportive living facility or long term care facility, a care plan will be developed in conjunction with the member, his or her family and caregiver, as well as other individuals part of the member’s care team.

Based on that member’s care plan, CountyCare care coordinators will work directly with home and community-based services providers in order to execute the care plan.

CountyCare’s care coordination team will guide members through the process of obtaining covered services. Each member is assigned to a care coordinator. Care coordinators responsibilities include:

- Help members to obtain services
- Visit members in their residence to assess health status, needs, and develop a care plan
- Communicate with providers on services that are authorized according to the care plan
- Discharge planning
- Support quality of life for members

Please contact the care coordination department for changes in a member’s status, questions regarding services, or other

TRANSITION OF CARE
COORDINATION FUNCTIONS
Once the appropriate state agency determines eligibility, CountyCare will be responsible for all care coordination for CountyCare members including those members part of the home and community based waiver services and residing in long term care facilities or supportive living facilities. CountyCare has processes and procedures in place to ensure smooth transitions to and from CountyCare’s care coordination to other plans/agencies such as another Managed Care Organization, the Department on Aging, the Department of Rehabilitative Services and the Department of Healthcare and Family Services. During transitions between entities, CountyCare will assure 180 days of continuity of services and will not adjust services without the member’s consent during that time frame.

TRANSPLANTS
A Transplant Coordinator will provide support and coordination for members who need organ transplants. All members considered as potential transplant candidates should be immediately referred to the CountyCare medical management department for assessment and case management services. Each candidate is evaluated for coverage requirements and will be referred to the appropriate agencies and transplant centers.
GENERAL BILLING GUIDELINES
Physicians, other licensed health professionals, facilities, and ancillary providers contract directly with CountyCare for payment of covered services.

It is important that providers ensure CountyCare has accurate billing information on file. Please confirm with our Provider Relations department that the following information is current in our files:

- Provider name (as noted on current W-9 form)
- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- Taxonomy code
- Physical location address (as noted on current W-9 form)
- Billing name and address

Providers must bill with their NPI number in box 24Jb. We encourage our providers to also bill their taxonomy code in box 24Ja to avoid possible delays in processing. Claims missing the required data will be returned, and a notice sent to the provider, creating payment delays. Such claims are not considered “clean” and therefore cannot be accepted into our system.

We recommend that providers notify CountyCare 30 days in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a Provider’s TIN and/or address are NOT acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

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

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

For additional information on CountyCare billing guidelines, please refer to our Billing Manual.

BILLING GUIDELINES FOR ATYPICAL PROVIDERS
Through CountyCare’s waiver services program, a variety of atypical providers contract directly with CountyCare for payment of covered services. Atypical providers include adult day service, home/car adaptations, home health agencies, day habilitation, homemaker services, home delivered meals, personal emergency response systems, respite, specialized medical equipment and supplies and supportive living facilities (SLFs).

It is important that providers ensure CountyCare has accurate billing information on file. Please confirm with our Provider Relations department that the following information is current in our files:

- Provider name (as noted on current W-9 form)
- Tax Identification Number (TIN)
• Taxonomy code
• Physical location address (as noted on current W-9 form)
• Billing name and address

Claims missing the required data will be returned, and a notice sent to the provider, creating payment delays. Such claims are not considered “clean” and therefore cannot be accepted into our system.

We recommend that providers notify CountyCare 30 days in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a Provider’s TIN and/or address are NOT acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:
• The member is effective on the date of service
• The service provided is a covered benefit under the member’s contract on the date of service, and
• Prior authorization processes were followed

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

TIMELY FILING
Providers must submit all claims and encounters within 180 calendar days of the date of service. The filing limit may be extended where the eligibility has been retroactively received by CountyCare up to a maximum of 180 days. When CountyCare is the secondary payer, claims must be received within 180 calendar days of the final determination of the primary payer.

All claim requests for reconsideration, corrected claims or claim disputes must be received within 45 calendar days from the date of notification of payment or denial is issued.

CLAIMS FOR WAIVER SERVICES AND SUPPORTIVE LIVING FACILITIES
Atypical providers and supportive living facilities will be required to submit claims to CountyCare on a CMS 1500 form. Billing guides and instructions for our online secure provider portal are available on our website at www.countycare.com.

Basic Guidelines for Completing the CMS-1500 Claim Form:
• Use one claim form for each recipient.
• Enter on procedure code and date of service per claim line.
• Enter information with a typewriter or a computer using black type.
• Enter information within the allotted spaces.
• Make sure whiteout is not used on the claim form.
• Enter information within the allotted spaces.
• Complete the form using the specific procedure or billing code for the service.
• Use the same claim form for all services provided for the same recipient, same provider, and same date of service.
• If dates of service encompass more than one month, a separate billing form must be used for each month.

CLAIMS FOR LONG TERM CARE FACILITIES
Long Term Care facilities are required to bill on a UB-04 claim form. Both short term acute stays and custodial care are covered benefits. When submitting claims for short term sub-acute stays, facilities must ensure they are utilizing the appropriate revenue codes reflecting the short term stay.
PATIENT CREDIT FILE
In order for Long Term Care facility claims to be processed, the member the facility is billing for must be on the Patient Credit File. This file is provided by the Department of Healthcare and Family Services and shows the amount the member needs to pay for residing in the facility. In certain instances, there can be a delay in the member appearing on the Patient Credit File. As a result, some LTC facility claims may be denied.

CountyCare has put a process in place to ease the administrative burden of long term care facilities in these instances. Each month when the Patient Credit File is received, CountyCare will check each member on the file against any previously denied claims. If there are claims that have been denied as a result of the member not appearing on the Patient Credit File, and all other necessary information is included in the claim, CountyCare will process and pay the previously denied claim. It is important to note, that LTC providers must still submit claims within 90 days.

ELECTRONIC CLAIMS SUBMISSION
Network providers are encouraged to participate in CountyCare’s electronic claims/encounter filing program. CountyCare can receive ANSI X12N 837, or most current version, professional, institution or encounter transactions. In addition, it can generate an ANSI X12N 835, or most current version electronic remittance advice known as an Explanation of Payment (EOP). Providers that bill electronically have the same timely filing requirements as providers filing paper claims. In addition, providers that bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

CountyCare’s Payor ID is: 06541. Our Clearinghouse vendor is Change Healthcare (Emdeon). Please visit our website for our electronic Companion Guide and our Billing Manual which offers more detailed information regarding claims billing instructions.

PAPER CLAIMS SUBMISSION
For CountyCare members, all claims and encounters should be submitted to:

CountyCare
Attention: CLAIMS
PO Box 3727
Corpus Christi, Texas 78463

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

A clean claim shall not mean a claim submitted by or on behalf of a Provider who is under investigation for Fraud or Abuse, or a claim that is under review for determining whether it was Medically Necessary. For purposes of an Enrollee’s admission to a NF, a “Clean Claim” means that the admission is reflected on the patient credit file that Contractor receives from the Department.

NON-CLEAN CLAIM DEFINITION
Non-clean claims are submitted claims that require further documentation or development beyond the information contained therein. The errors or omissions in claims result in the request for additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.
ELECTRONIC FUNDS TRANSFERS (EFT) AND ELECTRONIC REMITTANCE ADVICES (ERA)

CountyCare provides Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) to its participating providers to help them reduce costs, speed secondary billings, and improve cash flow by enabling online access of remittance information, and straightforward reconciliation of payments.

For more information on our EFT and ERA services, please contact our Provider Services Department at 312-864-8200 / 855-444-1661.

CLAIM REQUESTS FOR RECONSIDERATION, CLAIM DISPUTES, AND CORRECTED CLAIMS

All claim requests for reconsideration, corrected claims or claim disputes must be received within 45 calendar days from the date of the Explanation of Payment (EOP).

If a provider has a question or is not satisfied with the information they have received related to a claim, there are four (4) effective ways in which the provider can contact CountyCare.

1. Contact a CountyCare Provider Services Representative at 312-864-8200 / 855-444-1661. Providers may discuss questions with CountyCare Provider Services Representatives regarding amount reimbursed or denial of a particular service.

2. Submit an Adjusted or Corrected Claim to CountyCare Attn: Corrected Claim PO Box 3727 Corpus Christi, TX 78463.

The claim must clearly be marked as “RE-SUBMISSION” and must include the original claim number or the original EOP must be included with the resubmission. Failure to mark the claim as a resubmission and include the original claim number (or include the EOP) may result in the claim being denied as a duplicate, a delay in the reprocessing, or denial for exceeding the timely filing limit.

3. Submit a “Request for Reconsideration” to CountyCare Attn: Reconsideration PO Box 3727 Corpus Christi, TX 78463.

A request for reconsideration is a written communication from the provider about a disagreement in the way a claim was processed but does not require a claim to be corrected and does not require medical review. The request must include sufficient identifying information which includes, at minimum, the patient name, patient ID number, date of service, total charges and provider name. The documentation must also include a detailed description of the reason for the request.

4. Submit a “Claim Dispute Form” to CountyCare Attn: Reconsideration PO Box 3727 Corpus Christi, TX 78463.
A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration. The Claim Dispute Form can be found in the provider section of our website at www.countycare.com. If the claim dispute results in an adjusted claim, the provider will receive a revised EOP. If the original decision is upheld, the provider will receive a revised EOP or a letter detailing the decision and steps for escalated reconsideration.

CountyCare shall process, and finalize all adjusted claims, requests for reconsideration and disputed claims to a paid or denied status 45 business days of receipt of the corrected claim, request for reconsideration or claim dispute.

PROVIDER REFUNDS
When a provider sends a refund for claims processed, the refund must be sent to the following address:

CountyCare
Attention: Finance
PO BOX 3727
Corpus Christi, TX 78463

BILLING FORMS
Submit claims for professional services and durable medical equipment on a CMS 1500. Submit claims for hospital based inpatient and outpatient services as well as swing bed services on a UB 04 form.

For detailed requirements for either the CMS 1500 or the UB 04 form, see the Provider Billing Manual.

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

CountyCare, like all Medicaid programs, is always the payer of last resort. CountyCare providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to CountyCare members. If the provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third party resources, the provider shall inform CountyCare that efforts have been unsuccessful. CountyCare will make every effort to work with the provider to determine liability coverage.

If third party liability coverage is determined after services are rendered, CountyCare will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.
WHAT IS AN ENCOUNTER VERSUS A CLAIM?
An encounter is a claim which is paid at zero dollars as a result of the provider being pre-paid or capitated for the services he/she provided our members, you must file an encounter (also referred to as a “proxy claim”) on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the encounter or “proxy claim” is paid at zero dollar amounts. It is mandatory that your office submits encounter data.

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

You are required to submit either an encounter or a claim for each service that you render to a CountyCare member.

PROCEDURES FOR FILING A CLAIM/ ENCOUNTER DATA
CountyCare encourages all providers to file claims/ encounters electronically. See the Electronic Claims Submission section and the Provider Billing Manual for more information on how to initiate electronic claims/encounters.

BILLING THE MEMBER
CountyCare reimburses only services that are medically necessary and covered through the CountyCare program. Providers are not allowed to “balance bill” for covered services if the provider’s usually and customary charge for covered services is greater than our fee schedule.

Providers may bill members for services NOT covered by either Medicaid or CountyCare or for applicable copayments, deductibles or coinsurance not waived by CountyCare and at limits as defined by the State of Illinois.

In order for a provider to bill a member for services not covered under the CountyCare program, or if the service limitations have been exceeded, the provider must obtain a written acknowledgment following this language:

I understand that, in the opinion of (provider’s name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Integrated Care Program as being reasonable and medically necessary for my care. I understand that CountyCare through its contract with the Illinois Department of Healthcare and Family Services determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

For more detailed information on CountyCare billing requirements, please refer to the Billing Manual available on the website www.countycare.com
The credentialing and re-credentialing process exists to ensure that participating providers meet the criteria established by CountyCare, as well as government regulations and standards of accrediting bodies. All providers who participate in the Integrated Care Program must also be a Medicaid provider in good standing.

In order to maintain a current provider profile, providers are required to notify CountyCare of any relevant changes to their credentialing information in a timely manner.

Providers must submit at a minimum the following information when applying for participation with CountyCare:

- Complete signed and dated Illinois Standardized Credentialing application or authorize CountyCare access to the CAQH (Council for Affordable Quality Health Care) for the Illinois Standardized Credentialing application
- Signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance registration and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation
- Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider’s name, or evidence of compliance with Illinois regulations regarding malpractice coverage
- Copy of current Illinois Controlled Substance registration certificate (if applicable)
- Copy of current Drug Enforcement Administration (DEA) registration Certificate
- Copy or original of completed Internal Revenue Service Form W-9
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
- Copy of current unrestricted medical license to practice in the state of Illinois.
- Current copy of specialty/board certification certificate, if applicable
- Curriculum vitae listing, at minimum, a five (5) year work history (not required if work history is completed on the application)
- Signed and dated release of information form not older than 120 calendar days
- Proof of highest level of education – copy of certificate or letter certifying formal postgraduate training
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable
CountyCare will verify the following information submitted for credentialing and/or re-credentialing:

- Illinois license through appropriate licensing agency
- Board certification, or residency training, or medical education
- National Practitioner Data Bank-Health Integrity Practitioner Data Bank (NPDB-HIPDB) for malpractice claims and license agency actions
- Hospital privileges in good standing at a participating CountyCare hospital
- Review five year work history
- Review federal sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General and EPLS- Excluded Parties Listing)

Once the application is completed, the CountyCare Credentialing Committee (Credentialing Committee) will render a final decision on acceptance following its next regularly scheduled meeting.

Providers must be credentialed prior to accepting or treating members. PCPs cannot accept member assignments until they are fully credentialed.

**CREDENTIALING COMMITTEE**

The Credentialing Committee has the responsibility to establish and adopt as necessary, criteria for provider participation, termination, and direction of the credentialing procedures, including provider participation, denial, and termination.

Committee meetings are held at least quarterly and more often as deemed necessary.

**NOTE:** Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.

Site visits may be performed at practitioner offices within 60 calendar days of any member complaints related to physical accessibility, physical appearance, and adequacy of waiting and examining room space. If the practitioner’s site visit score is less than eighty percent (80%), the practitioner may be subject to termination and/or continued review until compliance is achieved. A site review evaluates appearance, accessibility, record-keeping practices and safety procedures.

**RE-CREDENTIALING**

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

In between credentialing cycles, CountyCare conducts ongoing sanction monitoring activities on all network providers. This includes an inquiry to the appropriate Illinois state licensing agency, board, or commission for a review of newly-disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry insures that providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, CountyCare reviews monthly reports released by the Office of Inspector General to review for any network providers who have been newly sanctioned or excluded from participation in Medicare and/or Medicaid programs.
Additionally, between credentialing cycles, a provider may be requested to supply current proof of any credentials such as Illinois licensure, malpractice insurance, DEA registration, a copy of certificate of cultural competency training, etc. that have expiration dates prior to the next review process.

A provider’s agreement may be terminated if at any time it is determined by the CountyCare’s Board of Directors (Board of Directors) or the Credentialing Committee that credentialing requirements are no longer being met.

**RIGHT TO REVIEW AND CORRECT INFORMATION**

All providers participating within the CountyCare network have the right to review information obtained by CountyCare to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and the State Licensing Agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected.

Should a provider believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, they have the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to the CountyCare credentialing department. Upon receipt of this information, the provider will have 14 calendar days to provide a written explanation detailing the error or the difference in information to the CountyCare. The CountyCare Credentialing Committee will then include this information as part of the credentialing/re-credentialing process.

**RIGHT TO BE INFORMED OF APPLICATION STATUS**

All providers who have submitted an application to join CountyCare have the right to be informed of the status of their application upon request. To obtain status, contact the CountyCare Provider Relations department at 312-864-8200 / 855-444-1661

**RIGHT TO APPEAL ADVERSE CREDENTIALING DETERMINATIONS**

Existing provider applicants who are declined for continued participation for reasons such as quality of care or liability claims issues have the right to appeal the decision in writing within 14 calendar days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant’s reconsideration for participation in the CountyCare network. Appeals will be reviewed by the Credentialing Committee at the next regularly scheduled meeting, but in no case later than 60 calendar days from the receipt of the additional documentation. The applicant will be sent a written response to his/her request within two weeks of the final decision.
Providers have the rights and responsibilities to:

1. Be treated by their patients and other healthcare workers with dignity and respect
2. Receive accurate and complete information and medical histories for members’ care
3. Have their patients act in a way that supports the care given to other patients and that helps keep the doctor’s office, hospital, or other offices running smoothly
4. Expect other network providers to act as partners in members’ treatment plans
5. Expect members to follow their directions, such as taking the right amount of medication at the right times
6. Help members or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
   a. Recommend new or experimental treatments
   b. Provide information regarding the nature of treatment options
   c. Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may be self-administered
   d. Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment
7. Make a complaint or file an appeal against CountyCare and/or a member
8. File a grievance with CountyCare on behalf of a member, with the member’s consent
9. Have access to information about CountyCare’s quality improvement programs, including program goals, processes, and outcomes that relate to member care and services. This includes information on safety issues
10. Contact CountyCare’s Provider Services with any questions, comments, or problems, including suggestions for changes in the QIP’s goals, processes, and outcomes related to member care and services
11. Treat members with fairness, dignity, and respect
12. Not discriminate against members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency
13. Maintain the confidentiality of members’ personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
14. Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider’s practice/office/facility
15. Provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA
16. Allow members to request restriction on the use and disclosure of their personal health information

17. Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records

18. Provide clear and complete information to members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process

19. Tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment

20. Allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal

21. Respect members’ advance directives and include these documents in the members’ medical record

22. Allow members to appoint a parent, guardian, family member, or other representative if they can’t fully participate in their treatment decisions

23. Allow members to obtain a second opinion, and answer members’ questions about how to access healthcare services appropriately

24. Collaborate with other healthcare professionals who are involved in the care of members

25. Obtain and report to CountyCare information regarding other insurance coverage

26. Follow all state and federal laws and regulations related to patient care and patient rights

27. Participate in CountyCare data collection initiatives, such as HEDIS and other contractual or regulatory programs

28. Review clinical practice guidelines distributed by CountyCare

29. Comply with CountyCare’s Medical Management program as outlined in this manual.

30. Notify CountyCare in writing if the provider is leaving or closing a practice

31. Contact CountyCare to verify member eligibility or coverage for services, if appropriate

32. Disclose overpayment or improper payments to CountyCare

33. Invite member participation, to the extent possible, in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible

34. Provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language

35. Provide members, upon request, with information regarding the provider’s professional qualifications, such as specialty, education, residency, and board certification status

36. Only provide members with HFS approved health plan marketing materials, including flyers and letters
Not be excluded, penalized, or terminated from participating with CountyCare for having developed or accumulated a substantial number of patients in the CountyCare with high-cost medical conditions

Object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds

Disclose to CountyCare, on an annual basis, any physician incentive plan (PIP) or risk arrangements the provider or provider group may have with physicians either within its group practice or other physicians not associated with the group practice even if there is no substantial financial risk between CountyCare and the physician or physician group

**MEMBER RIGHTS AND RESPONSIBILITIES**

Members have the rights and responsibilities:

1. To receive information about CountyCare, its benefits, its services, its practitioners and providers and member rights and responsibilities

2. To receive information on available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand

3. To be treated with respect and with due consideration for his/her dignity and the right to privacy and non-discrimination as required by law

4. To access all covered services, including certified nurse midwife services and pediatric or family nurse practitioner services

5. To participate with their providers and practitioners in making decisions regarding their healthcare, including the right to refuse treatment

6. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion

7. To receive healthcare services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid Fee-For-Service (FFS) and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished

8. To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition

9. To receive assistance from both Illinois Department of Healthcare and Family Services and CountyCare in understanding the requirements and benefits of CountyCare.

10. To receive family planning services from any participating Medicaid doctor without prior authorization

11. To a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage

12. To receive information on the Grievance, Appeal and Medicaid Fair Hearing procedures.

13. To voice grievances or file appeals about CountyCare decisions that affect their privacy, benefits or the care provided

14. To request and receive a copy of your medical record • To make recommendations regarding CountyCare’s member rights and responsibilities policy

15. To request that your medical record be corrected
16 To expect their medical records and care be kept confidential as required by law.
17 To receive CountyCare’s policy on referrals for specialty care and other benefits not provided by the member’s PCP.
18 To privacy of healthcare needs and information as required by federal law (Standards for Privacy of Individually Identifiable Health Information).
19 To exercise his or her rights, and that the exercise of these rights does not adversely affect the way CountyCare and its providers treat the members.
20 To allow or refuse their personal information be sent to another party for other uses unless the release of information is required by law.
21 To choose a PCP and to change to another PCP in CountyCare’s network.
22 To receive timely access to care, including referrals to specialists when medically necessary without barriers.
23 To file for a Medicaid Fair Hearing.
24 To receive materials – including enrollment notices, information materials, instructional materials, available treatment options and alternatives, etc. - in a manner and format that may be easily understood.
25 To make an advance directive, such as a living will.
26 To choose a person to represent them for the use of their information by CountyCare if they are unable to.
27 To make suggestions about their rights and responsibilities.
28 To get a second opinion from a qualified healthcare professional.
29 To information about your rights and responsibilities, as well as the CountyCare providers and services.
30 To receive oral interpretation services free of charge for all non-English languages.
31 To be notified that oral interpretation is available and how to access those services.
32 As a potential member, to receive information about the basic features of managed care; which populations may or may not enroll in the program and CountyCare responsibilities for coordination of care in a timely manner in order to make an informed choice.
33 To receive information on the following:
   a. Benefits covered.
   b. Procedures for obtaining benefits, including any authorization requirements.
   c. Cost sharing requirements.
   d. Service area.
   e. Names, locations, telephone numbers of and non-English language spoken by current CountyCare providers, including at a minimum, PCPs, specialists and hospitals.
   f. Any restrictions on member’s freedom of choice among network providers.
   g. Providers not accepting new patients.
   h. Benefits not offered by CountyCare but available to members and how to obtain those benefits, including how transportation is provided.
34 To receive a complete description of disenrollment rights at least annually.
35 To receive notice of any significant changes in the Benefits Package at least 30 days before the intended effective date of the change.
To receive detailed information on emergency and after-hours coverage, to include, but not limited to:

a. What constitutes an emergency medical condition, emergency services, and post stabilization services?

b. Emergency services do not require prior authorization

c. The process and procedures for obtaining emergency services

d. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post stabilization services covered under the contract

e. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post stabilization services covered under the contract

f. Member’s right to use any hospital or other setting for emergency care

g. Post-stabilization care services rules in accordance with Federal guidelines

To inform CountyCare of the loss or theft of their ID card

To present their ID card when using healthcare services

To be familiar with CountyCare procedures to the best of their ability

To call or contact CountyCare to obtain information and have questions clarified

To provide information (to the extent possible) that CountyCare and its practitioners and providers need in order to provide care

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

To inform your provider on reasons you cannot follow the prescribed treatment of care recommended by your provider

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

To keep your medical appointments and follow-up appointments

To access preventive care services

To follow the policies and procedures of CountyCare and the State Medicaid program

To be honest with providers and treat them with respect and kindness

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

To follow the steps of the appeal process

To notify CountyCare, Illinois and your providers of any changes that may affect your membership, healthcare needs or access to benefits. Some examples may include:

a. If you have a baby

b. If your address changes

c. If your telephone number changes

d. If you or one of your children are covered by another plan

e. If you have a special medical concern

f. If your family size changes

To keep all your scheduled appointments; be on time for those appointments, and cancel twenty-four (24) hours in advance if you cannot keep an appointment
If you access care without following CountyCare rules, you may be responsible for the charges.

Members that are part of the Disability, HIV/AIDS or Brain Injury waivers have specific rights and responsibilities, which include:

1. Apply or reapply for waiver services
2. Receive a timely decision on eligibility for waiver services based on a complete assessment of member’s disability
3. Receive an explanation in writing, should they be determined ineligible for waiver services, telling the member why services were denied
4. Receive an explanation about waiver services that the member may receive
5. Partner with care coordinator in making informed choices for waiver services care plan
6. Be assured of the complete confidentiality of case records
7. Review rehabilitation case record with a staff member present
8. Participate with care coordinator in any decision to close member’s case
9. Appeal any decision which the member does not agree
10. Be informed of the Client Assistance Program (CAP)
11. Be provided with a form of communication appropriate to accommodate the member’s disability
12. Fully participate in the waiver services care plan
13. Set realistic goals and participate in writing waiver services care plan with care coordinator
14. Follow through with member’s plan for rehabilitation

Communicate with care coordinator and ask questions when member does not understand services
Keep a copy of waiver services plan and any amendments related to the plan
Notify care coordinator of any change in personal condition or work status
Be aware of financial eligibility requirements for some services
Keep original documents and send only copies to care coordinator’s office

Members that are part of the Aging waiver have specific rights and responsibilities, which include:

1. To not be discriminated against because of race, color, national origin, religion, sex, ancestry, marital status, physical or mental disability, unfavorable military discharge or age.
2. All information about the member and his or her case is confidential, and may be used only for purposes directly related to the administration of his or her aging waiver services as follows:
   a. Finding and making needed services and resources available
   b. Assuring the health and safety of the member
3. Information about the member and his or her case cannot be used for any other purpose as indicated above, unless the member has given his or her consent to release that information.
4. Freedom of choice of member’s providers for waiver services.
5. The right to choose not to receive waiver services.
6. The right to transfer from one provider to another provider.
The right to request a provider to furnish more services than are allowed by the member’s care plan. The member will be required to pay 100% of the cost for any additional services not included in his or her care plan.

The right to report instances to his or her provider’s supervisor or an CountyCare care coordination when the member does not believe his or her personal care worker:
   a. Is following the care plan
   b. Does not come to the member’s home as scheduled
   c. Is always late

To not discriminate against the member’s personal care worker because of race, color, national origin, religion, sex, ancestry, marital status, physical or mental disability, unfavorable military discharge or age. To do so is a Federal offense.

The member must report changes that affect him or her. This includes:
   a. Change of address, even if temporary.
   b. Change in number of family members.
   c. Changes needed in waiver services.

To notify the member’s CountyCare care coordinator if the member is entering a hospital, nursing home or other institution for any reason. The member’s services will be temporarily suspended until he or she returns home.

Notify the member’s care coordinator in advance of his or her return home.

If the member is hospitalized or in a nursing home or other institution for more than 60 calendar days, the member’s services will be terminated.

If the member returns home after such termination and need services, he or she must contact the Illinois Department of Human Services to reapply.

Notify the member’s CountyCare care coordinator if the member is away from his or her home, for any reason, for over 60 calendar days. Services cannot be provided if the member is not at home. If this is the case, services will be terminated.

Must notify the provider and the member’s CountyCare care coordinator if the member intends to be absent from his or her home when scheduled services are to be provided. The member must notify the provider when you are leaving and when the member is expected to return. The provider will resume services upon the member’s return.

Must cooperate in the delivery of services. The member must:
   a. Notify the provider agency at least one day in advance if the member will be away from home on the day services are to be rendered.
   b. Allow the authorized worker into the home.
   c. Allow the worker to provide the services included in the care plan.
   d. Do not require the worker to do more or less than what is in the care plan.
   e. If the member wants to change the care plan, he or she must contact a CountyCare care coordinator. The worker is unable to change it.
   f. The member or other persons in his or her home must not harm or threaten to harm the worker or other participants, or display any weapon.
Members that reside in supportive living facilities have specific rights, which include:

1. Be free from mental, emotional, social and physical abuse, neglect and exploitation.
2. All housing and services for which the member has contracted and paid.
3. Have member records kept confidential and released only with the member’s consent or in accordance with applicable law.
4. Have access to member records with 48 hours’ notice (excluding weekends and holidays).
5. Have member’s privacy respected.
6. Refuse to receive or participate in any service or activity once the potential consequences of such refusal have been explained to the member and a negotiated risk agreement has been reached between the member, his or her designated representative and the service provider, so long as others are not harmed by the refusal.
7. Remain in the supportive living facility, forgoing recommended or needed services from the facility or available from others.
8. Arrange and receive non-Medicaid covered services not available from the contracted facility service provider at the member’s own expense so long as he or she does not violate conditions specified in the resident contract.
9. Be free of physical restraints.
10. Control time, space and lifestyle to the extent the health, safety and well-being of others is not disturbed.
11. Consume alcohol and use tobacco in accordance with the facility’s policy specified in the resident contract and any applicable statutes.
12. Have visitors of the member’s choice to the extent the health, safety and well-being of others is not disturbed and the provisions of the resident contracts are upheld.
13. Have roommates only by the member’s choice.
14. Be treated at all times with courtesy, respect and full recognition of personal dignity and individuality.
15. Make and act upon decisions (except those decisions delegated to a legal guardian) so long as the health, safety and well-being of others is not endangered by your actions.
16. Participate in the development, implementation and review of their own service plans.
17. Maintain personal possessions to the extent they do not pose a danger to the health, safety and well-being of themselves and others.
18. Store and prepare food in the member’s apartment to the extent the health, safety and well-being of the member and others is not endangered and provisions of the resident contract are not violated.
19. Design or accept a representative to act on the member’s behalf.
20. Not be required to purchase additional services that are not part of the resident contract; and not be charged for additional services unless prior written notice is given to the member of the amount of the charge.
21. Be free to file grievances according to supportive living facility policy and be free from retaliation from the facility.
MEMBER GRIEVANCES AND PROVIDER COMPLAINTS
CountyCare Grievance System includes an informal complaints process and a formally structured grievance and appeals process. CountyCare’s Grievance System is compliant with Section 45 of the Managed Care Reform and Patient Rights Act and 42 CFR Section 438 Subpart F, including procedures to ensure expedited decision making when a member’s health so necessitates. The filing of a grievance will not preclude the member from filing a complaint with the Illinois Department of Insurance (DOI), nor will it preclude DOI from investigating a complaint pursuant to its authority under Section 4-6 of the Health Maintenance Organization Act.

A member grievance is defined as any expression of dissatisfaction by a member about any matter other than an Action. The grievance process allows the member, or the member’s appointed representative (guardian, caretaker, relative, PCP or other treating physician) acting on behalf of the member, to file a grievance either verbally or in writing or an appeal or request a State Fair Hearing. CountyCare values its providers and will not take punitive action, including and up to termination of a provider agreement or other contractual arrangements, for providers who file a grievance on a member’s behalf.

ACKNOWLEDGEMENT
CountyCare shall acknowledge receipt of each grievance in writing, unless the grievance was received telephonically or the member requests an expedited resolution. The CountyCare staff member will document the substance of an oral grievance, and attempt to resolve it immediately. For informal complaints, defined as those received verbally and resolved immediately to the satisfaction of the member or appointed representative, the staff will document the resolution details. The Grievance and Appeals Coordinator will date stamp written grievances upon initial receipt and send an acknowledgment letter, which includes a description of the grievance procedures and resolution time frames, within five (5) business days for non-clinical grievances. The GAC will send an acknowledgement letter within two (2) business days or receipt of grievances that involve a Clinical Quality of Care investigation.

TIMEFRAME AND NOTICE OF RESOLUTION
Grievance investigation and review by the Grievance Committee (for those grievances not resolved informally) will occur as expeditiously as the member’s health condition requires, within sixty (60) calendar days of the request. The determination may be extended by up to thirty (30) days if additional records are required for Resolution. Members have the right to attend and participate in the formal grievance proceedings and may be represented by a designated representative of his or her choice. Resolution is determined by majority vote. Any individuals who make a decision on grievances
will not be involved in any previous level of review or decision making. In any case where the reason for the grievance involves clinical issues or relates to denial of expedited resolution of an appeal, CountyCare shall ensure that the decision makers are healthcare professionals with the appropriate clinical expertise in treating the member’s condition or disease [see 42 CFR § 438.406].

Written notification of the grievance resolution will be made within five (5) days after the determination and will include the resolution and HFS requirements, including but not be limited to the names of the Grievance Committee Members completing the review, the decision reached by CountyCare, and a statement of the reviewers’ understanding of the grievance.

Grievances may be submitted verbally or in writing to:

CountyCare
Attention: Grievances
P.O. Box 803758
Chicago, IL 60680
312-864-8200 / 855-444-1661

APPEALS
An appeal is the request for review of a “Notice of Adverse Action”. A Notice of Adverse Action is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service excluding technical reasons; the failure to render a decision within the required timeframes; or the denial of a member’s request to exercise his/her right under 42 CFR 438.52(b)(2)(ii) to obtain services outside the CountyCare network. The review may be requested in writing or verbally within sixty (60) days of the Notice of Adverse Action, however verbal requests for appeals must be followed by a written request. All appeals must be registered initially with CountyCare and may be appealed to the Department of Healthcare and Family Services when CountyCare’s process has been exhausted.

Upon submission of a standard appeal, CountyCare will notify the filing party, within three (3) business days of receipt, of any additional information required to evaluate the appeal request. Appeals will be fully investigated without deference to the denial decision. The appeal will be reviewed by an appropriately licensed clinical peer who was not involved in any previous level of decision making regarding the request. CountyCare will render a decision and provide written notification within fifteen (15) business days after receipt of required information. A member or an authorized representative may request a standard or expedited External Independent Review (EIR) of a final adverse determination.

EXPEDITED APPEALS
Expedited appeals may be filed when either CountyCare or the member’s provider determines that the time expended in a standard resolution could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expedited resolution or supports a member’s appeal. In instances where the member’s request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.
CountyCare will notify the filing party, within 24 hours of receipt, of any additional information required to evaluate the appeal request. CountyCare will render a decision and provide notification within 24 hours after receipt of required information, not to exceed 72 hours of receipt of the initial request. CountyCare will make reasonable efforts to provide the member, PCP and any healthcare provider who recommended the service with prompt verbal notice of the decision followed by written notice within two (2) calendar days after the initial verbal notification.

NOTICE OF APPEAL RESOLUTION
Written appeal resolution notice shall include the following information:

- The decision reached by CountyCare
- The date of decision
- For appeals not resolved wholly in favor of the member the right to request a State fair hearing and information as to how to do so; and
- The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the member may be held liable for the cost of those services if the hearing decision upholds the CountyCare decision.

Appeals may be submitted verbally or in writing to:

CountyCare
Attention: Complaints
P.O. Box 803758
Chicago, IL 60607
312-864-8200 / 855-444-1661

STATE FAIR HEARING PROCESS
Any adverse action or appeal that is not resolved wholly in favor of the member by CountyCare may be appealed by the member or the member’s authorized representative to HFS for a Fair Hearing conducted in accordance with 42 CFR § 431 Subpart E. Please contact:

HFS Bureau of Administrative Hearings
401 South Clinton, 6th Floor
Chicago, IL 60607
1-800-435-0774
(TTY) 1-877-734-7429

CountyCare is responsible for providing to the HFS an appeal summary describing the basis for the denial. CountyCare will comply with HSM’s fair hearing decision.

REVERSED APPEAL RESOLUTION
In accordance with 42 CFR §438.424, if CountyCare or the state fair hearing decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, CountyCare will authorize the disputed services promptly and as expeditiously as the member’s health condition requires. Additionally, in the event that services were continued while the appeal was pending, CountyCare will provide reimbursement for those services in accordance with the terms of the final decision rendered by HFS and applicable regulations.
PROVIDER COMPLAINTS
CountyCare has established a provider complaint system that allows a provider to dispute the policies, procedures, or any aspect of the administrative function, including the proposed action.

NOTE: The process for appeals of medical necessity decisions (actions) is outlined above in the Member Appeals Section of this Manual.

Providers may submit a complaint via telephone, written mail, electronic mail or in person.

CountyCare has designated a Provider Complaints Coordinator (PCC) to process provider complaints. Provider complaints will be thoroughly investigated using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying the complete review of the provider complaint, the PCC will provide a written notice of resolution to the Provider within thirty (30) days from the date of the decision.

Provider Complaints may be submitted verbally or in writing to:

CountyCare
Attention: Complaints
PO BOX 803758
Chicago, IL 60680
312-864-8200 / 855-444-1661

In addition to communicating the provider complaint process through this Manual, CountyCare communicates the provider complaint process during provider orientation and on its website.
CountyCare takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a Fraud, Waste, and Abuse (FWA) program that complies with Illinois and federal laws. CountyCare, in conjunction with its third party administrator, Valence, successfully operates the FWA program.

**OBLIGATION TO REPORT**
A provider who becomes aware of suspected FWA shall report the activity to CountyCare. If you suspect or witness a provider inappropriately billing for Medicaid services or a member receiving inappropriate services, please call our anonymous and confidential hotline at 844-509-4669. CountyCare takes all reports of potential fraud, waste and/or abuse very seriously and will investigate all reported issues.

**FWA EDUCATION AND TRAINING**
All CountyCare providers are required to complete FWA training for preventing, detecting and reporting fraud, waste and abuse.

**FWA PLAN UPDATES AND REVISIONS**
CountyCare will review, update and communicate the FWA requirements at least annually, and as needed, incorporate changes to previously enacted law(s), new law(s), changes in the healthcare industry, and changes in CountyCare’s FWA contract requirements.

**CONFIDENTIALITY**
Reviews are considered confidential regardless of how the issue under review was identified. CountyCare and the staff will only discuss a review with individuals who may have direct knowledge of the potential area of concern or those individuals with FWA oversight responsibility.

**LINES OF COMMUNICATION**
CountyCare has systems in place to receive, record, and respond to FWA inquiries or reports of potential or suspected FWA by employees and vendors. The key aspects of Valence’s Lines of Communication are outlined below:

- All concerns are handled and investigated in a confidential and anonymous manner and to the fullest extent allowed by law.
- Retaliation against employees, Delegates and Providers for good faith reporting of FWA concerns is prohibited. Any attempted retaliation will result in disciplinary action.

**PREVENTION AND DETECTION PRACTICES**
CountyCare regularly audits to ensure fraudulent activity is recognized and performs front and back end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this process, please review the Billing and Claims section of this manual.
Also, CountyCare utilizes a Special Investigation Unit (SIU) performs back end audits which, in some cases, may result in taking the appropriate actions against those who, individually or as a practice, commit Fraud, Waste and/or Abuse, including but not limited to:

- Remedial education and/or training to attempt to eliminate the egregious action
- Increasingly stringent utilization review
- Recoupment of previously paid monies from a provider/practice
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Any other remedies available to rectify the issue identified
- Some of the most common fraud, waste and abuse issues identified are:
  - Unbundling of codes
  - Up-coding
  - Add-on codes without primary CPT
  - Diagnosis and/or procedure code not consistent with the member’s age/gender
  - Use of exclusion codes
  - Excessive use of units
  - Misuse of Benefits
  - Claims for services not rendered

REQUESTS FOR MEDICAL RECORDS
Where providers receive a document/medical records request from the CountyCare, it is expected that they will respond to the request in accordance with the requested timeframe.

MEMBER RELATED FWA AND “LOCK-IN” PROGRAM:
CountyCare employs data analytics to identify members who consistently utilize multiple pharmacies and/or physicians to obtain multiple medications or medical services. Members who consistently misuse their pharmacy or physician services may be enrolled in a lock-in or restriction program.

MEMBER VERIFICATION OF SERVICES RENDERED PROCESS
CountyCare will randomly select a sample of members to receive an Explanation of Benefits (EOP). The EOPs will be sent to members to help ensure that services for which CountyCare is billed are actually rendered. Any services that are billed for but not received will be referred to the CountyCare Claim Audit Department for further review and investigation to determine if fraudulent activity is occurring. Findings from the original review and investigation will be forwarded to the SIU if warranted.

INVESTIGATION
CountyCare will follow an established procedure for investigation of all potential FWA.

CORRECTIVE ACTION, SANCTIONS, PROSECUTION AND RECOVERY
CountyCare will implement the appropriate corrective action required, including prosecution and recovery.
REPORTING OF CRITICAL INCIDENTS
CountyCare has developed a systematic approach to promote the identification of any potential critical incident(s). Any concerns identified as a potential critical incident must be promptly reported, reviewed, investigated, and appropriate corrective actions must be taken as necessary. The primary focus is to identify and report instances that have the potential for harm to a member. CountyCare requires affiliated providers to be proactive in reporting critical incidents to promote the safety of members. Retaliatory action is prohibited against the reporting personnel by the affiliated provider, an employee, and/or other person affiliated with CountyCare.

Critical Incidents differ in reporting requirements depending on the Member impacted by the critical incident.

FOR ALL COUNTYCARE MEMBERS:
Critical incidents include any incident regarding Abuse, Neglect, and exploitation or any incident that has the potential to place a Member, or the Member’s services, at risk, but which does not rise to the level of Abuse, Neglect, or exploitation.

When considering incidents that do not rise to the level of Abuse, Neglect or Exploitation, providers, vendors and staff Members should report critical incidents in which the CountyCare Member’s health, safety or welfare is/was at risk and further action is/was needed to address the ongoing risk or the cause(s) of the incident. Critical incidents are unusual and not reasonably expected.

All suspected critical incidents should be reported to: CountyCare Member Services department: 312-864-8200. All information is kept private and confidential.

FOR COUNTYCARE MEMBERS IN HOME AND COMMUNITY BASED SERVICES (E.G., WAIVER PROGRAMS):
Providers, vendors and staff are required to report additional instances of critical incidents for members who are enrolled in waiver programs, such as:

- Abuse, neglect, exploitation or any incident that has the potential to place a member or a member’s services at risk including those which do not rise to the level of abuse, neglect, or exploitation
- Suicide attempts
- Willful infliction of injury
- Financial misconduct: Misuse or withholding of a person’s resources
- Failure to notify a health care professional when needed; failure to provide or arrange necessary services to avoid physical or psychological harm
- Inappropriate use of restraints in the Long term Care setting

If the incident involves a criminal act, local law enforcement must be notified immediately. For critical incidents involving Abuse, Neglect, and exploitation, the reporter is required to report to the applicable agency or agencies per below:

- Reports regarding Enrollees who are age 18 and older and living in the community are to be made to the Illinois Department on Aging by utilizing the Adult Protective Services Hotline number at 1-866-800-1409 (voice) and 1-800-206-1327 (TTY).
- Reports regarding Enrollees in nursing facilities must be made to the Department of Public Health’s Nursing Home Complaint Hotline at 1-800-252-4343.
• Reports regarding Enrollees aged 18-59 receiving mental health or Developmental Disability services in DHS operated, licensed, certified or funded programs are to be made to Illinois Department of Human Services Office of the Inspector General Hotline at 1-800-368-1463 (voice and TTY).

• Reports regarding Enrollees in Supportive Living Facilities (SLF) must be made to the Department of Healthcare and Family Services’ SLF Complaint Hotline at 1-800-226-0768.

• Reporting for all populations is mandated when the incident involves child abuse, elder abuse, law enforcement, incidents occurring at nursing facilities and fraud reports to OIG.

INDIVIDUALS REQUIRED TO REPORT CRITICAL INCIDENTS

Individuals who are required to report critical incidents include the following:

• Social Services/Care Management
• Network Providers
• Contracted Vendors
• Regulatory agencies
• Medical Management
• Member Services
• Member Appeals & Grievances
• Enrollee*
• Family or Caregiver*

*Note: These individuals are trained on signs of Abuse, Neglect, and exploitation and how to call the hotline, and may use the reporting form, but are not legally required to report cases of suspected Abuse, Neglect, and exploitation.

METHOD FOR REPORTING CRITICAL INCIDENTS

Individuals may use the Critical Incident Reporting form that is available for providers and Enrollees on the CountyCare website at www.countycare.com. Upon downloading the electronic form from the website, the reporter may complete the Reporting form electronically or may print out and complete the form manually. Upon completion, the Critical Incident Reporting form should be sent to the Member Services department via fax at 1-312-548-9940. Reports should be made within X hours/business days of becoming aware of an incident. A copy of the Critical Incident Report is found at www.countycare.com.

COUNTYCare’S INVESTIGATION OF CRITICAL INCIDENTS

CountyCare’s Quality Department will ensure:

• Timely and comprehensive response in the protection of members;
• Interventions and/or education are in place to prevent more serious or future incidents;
• Medical assessments and/or treatment has been initiated as appropriate;
• The appropriate state agencies/authorities were contacted, as applicable;
• The resolution process is documented, updated, and tracked as the investigation proceeds, indicating actions taken on behalf of the member, care coordinator and other relevant parties;
• Any proposed corrective action is documented, including proposed interventions/education;
• All corrective action and recommendations by state agencies/external authorities have been followed up on and/or implemented.
AUTHORITY AND RESPONSIBILITY
CountyCare’s Compliance Officer has overall responsibility and authority for carrying out the provisions of CountyCare’s compliance program. CountyCare is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

The CountyCare provider network will cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT
The federal regulations set forth in 42 CFR 455.105 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency certain business transactions. Failure to submit the accurate, complete information requested in a timely manner may lead to the termination or denial of enrollment into the network as specified in 42 CFR 455.416.

42 CFR 455.105 states in relevant part: “(a) Provider agreements. A Medicaid agency must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions in accordance with paragraph (b) of this section. A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about:

1. The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and
2. Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.
3. Denial of Federal financial participation (FFP). Providers should note that:
   • FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under paragraph (b) of this section or under § 420.205 of this chapter (Medicare requirements for disclosure).
   • FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the Medicaid agency and ending on the day before the date on which the information was supplied.”

The Enrollment Disclosure Statement Form (HFS form 1513 - http://www2.illinois.gov/hfs/SiteCollectionDocuments/hfs1513.pdf ) is required documentation and serves as verification of the provider’s eligibility to render services.
Quality Improvement

CountyCare culture, systems, and processes are structured around its mission to improve the health of all enrolled members. The Quality Assessment and Performance Improvement Program (QAPI Program) utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of healthcare provided to all members, including those with special needs. This system provides a continuous cycle for assessing the quality of care and service among plan initiatives including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions.

CountyCare recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, CountyCare will provide for the delivery of quality care with the primary goal of improving the health status of its members.

PROGRAM STRUCTURE
CountyCare’s Board of Directors (BOD) has the ultimate authority and accountability for the oversight of the quality of care and service provided to members. The BOD oversees the QAPI program and has established various standing and ad-hoc committees to monitor and support it.

The Quality Improvement Committee (QIC) is a senior management committee with physician representation that is directly accountable to the BOD. The purpose of the QIC is to promote a system-wide approach to Quality Assurance, provide oversight and direction in assessing the appropriateness of care and services delivered, encourage Provider participation, and to continuously enhance and improve the quality of care and services provided to members. In addition, the QIC has the responsibility for developing and implementing the QAPI program. This will be accomplished through a comprehensive, plan wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems; the identification of opportunities to improve member outcomes; and the education of the member, Providers and staff regarding the QA, UM, and Credentialing programs.

The following sub-committees report directly to the QIC:
- Credentialing Committee
- Pharmacy and Therapeutics Committee
- Utilization Management Committee
- Performance Improvement Team
- Grievance and Appeal Committee
- Delegation Oversight Committee
- Peer Review Committee (Ad Hoc Committee)
- The Enrollee Advisory Committee, Community
Stakeholder Committees and Physician Advisory Committee report indirectly to the QIC through the Performance Improvement Team.

**PRACTITIONER INVOLVEMENT**
CountyCare, recognizing the integral role practitioner involvement plays in the success of its quality improvement program, encourages provider representation in various levels of the process. The QIC consists of a cross representation of all types of Providers, including PCPs, specialists, dentists and long term care representatives from CountyCare network and across the service area. CountyCare encourages PCP, behavioral health, specialty, and OB/GYN representation on key quality committees such as, but not limited to, the QIC, Credentialing Committee, Pharmacy and Therapeutics Committee, and select ad-hoc committees.

**QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT PROGRAM (QAPI) SCOPE AND GOALS**
The scope of CountyCare’s QAPI Program addresses both the quality of clinical care and the quality of services provided to Enrollees and Providers. CountyCare QA activities encompass all demographic groups, benefits and care settings; and, address all services, including medical and behavioral healthcare, preventive, emergency, primary, and specialty care; as well, as acute care, short-term care, long-term care, home care, pharmacy and ancillary services. Areas subject to quality oversight include:

- Acute and chronic care management and disease management
- Adoption and compliance with preventive health and clinical practice guidelines
- Behavioral healthcare management and coordination with medical practitioners
- Continuity and coordination of care
- Delegated entity oversight
- Department performance and service
- Employee and Provider cultural competency, including monitoring of Enrollee accessibility to ensure linguistic and physical accessibility.
- Disparities in Care
- Enrollee Grievance and Appeals
- Enrollee satisfaction
- Health education and promotion
- Network accessibility and appointment availability, including specialty practitioners
- Patient safety including appropriateness and quality of healthcare services
- Provider satisfaction
- Selection and retention of skilled, quality-oriented practitioners and facilities (credentialing and re-credentialing)
- Utilization Management, including under and over utilization
- Compliance with preventive health and practice guidelines

**PERFORMANCE IMPROVEMENT PROCESS**
CountyCare QIC reviews and adopts an annual QAPI program and QAPI work plan based on managed care Medicaid appropriate industry standards. The QAPI adopts traditional quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area, and includes targeted interventions that have the greatest potential for improving health outcomes or the service.
Performance improvement projects, focused studies and other quality improvement initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each quality improvement initiative is also designed to allow CountyCare to monitor improvement over time.

Annually, CountyCare develops a Quality Assessment Performance Improvement (QAPI) Work Plan for the upcoming year. The QAPI work plan serves as a working document to guide quality improvement efforts on a continuous basis. The work plan integrates quality improvement activities, reporting and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QIC as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI work plan.

CountyCare communicates activities and outcomes of its quality improvement program to both members and providers through avenues such as the member newsletter, provider newsletter and the CountyCare web portal. At any time, CountyCare providers may request additional information on the health plan programs including a description of the QAPI program and a report on the CountyCare progress in meeting the QAPI program goals by contacting CountyCare Quality Improvement department.

**HEALTH EMPLOYER DATA INFORMATION SET (HEDIS)**

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of NCQA Health Plan Accreditation and CountyCare’s contract with the Department of Healthcare and Family Services for the provision of coordinated care services within the Integrated Care Program.

HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider as well. CountyCare purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a Health Insurance Company’s ability to demonstrate an improvement in preventive health outreach to its members.

**HOW ARE HEDIS RATES CALCULATED?**

HEDIS rates may be calculated using two methodologies: administrative data methodology or hybrid methodology. Administrative data methodology is calculated from claims or encounter data submitted to the health plan. Measures typically calculated using administrative data methodology include: annual mammogram, annual chlamydia screening, annual pap test appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

Hybrid methodology consists of both administrative data and a sample of medical records. Hybrid methodology requires review of a random sample of member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data and submission of appropriate CPT II codes can reduce the necessity of medical record reviews. Measures typically requiring medical record review include: diabetic HgA1c, LDL, eye exam and nephropathy, controlling high-blood pressure, and prenatal care and postpartum care.
WHO WILL BE CONDUCTING THE MEDICAL RECORD REVIEWS (MRR) FOR HEDIS?
CountyCare will contract with a national medical record review vendor to conduct the HEDIS medical record reviews on its behalf. Medical record review audits for HEDIS are usually conducted March through May each year. At that time, providers may receive a call from a medical record reviewer representative if any of your patients are selected into HEDIS samples for CountyCare. Prompt cooperation with these requests is greatly needed and appreciated.

The medical record review vendor will sign a HIPAA compliant Business Associate Agreement with CountyCare which allows them to collect PHI on our behalf.

WHAT CAN BE DONE TO IMPROVE HEDIS SCORES?
- Understand the specifications established for each HEDIS measure
- Submit claim/encounter data for each and every service rendered. All providers must bill (or report by encounter submission) for services delivered, regardless of contract status. Claim/encounter data is the most clean and efficient way to report HEDIS. If services are not billed or not billed accurately they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation
- Ensure chart documentation reflects all services provided
- Bill CPT codes related to HEDIS measures such as diabetes, eye exam, and blood pressure

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the CountyCare Quality Improvement department at 312-864-8200 / 855-444-1661.

PROVIDER SATISFACTION SURVEY
At least annually, CountyCare conducts a provider satisfaction survey which includes questions to evaluate provider satisfaction with our services such as claims, communications, utilization management, and provider services. The survey is conducted by an external vendor. Participants are randomly selected by the vendor, meeting specific requirements outlined by CountyCare, and the participants are kept anonymous. We encourage you to respond timely to the survey as the results of the survey are analyzed and used as a basis for forming provider related quality improvement initiatives.

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDER SYSTEMS (CAHPS) SURVEY
The CAHPS survey is a member satisfaction survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to members by an NCQA certified survey vendor. The survey provides information on the experiences of CountyCare members with the health plan and practitioner services and gives a general indication of how well we are meeting the members’ expectations. Member responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability.
PROVIDER PROFILING
In recent years, it has been nationally recognized that pay-for-performance and other incentive and/or bonus programs, which include provider profiling, have emerged as a promising strategy to improve the quality and cost-effectiveness of care. CountyCare has implemented a physician profiling as a tool to encourage providers to promote appropriate care and services for CountyCare members which have been shown to lead to better health outcomes.

Provider profiling promotes efforts that are consistent with the Institute of Medicine’s aims for advancing quality (safe, beneficial, timely, patient-centered, efficient and equitable) as well as recommendations from other national agencies such as the CMS-AMA Physician Consortium, NCQA, and NQF. Additionally, that the program encourages accurate and timely submission of preventive health and disease monitoring services in accordance with evidence-based clinical practice guidelines. Physicians, who meet a minimum panel threshold will receive a quarterly profile report with an individual score for each measure. Scores will be benchmarked per individual measure and compositely to the CountyCare network average and as applicable, to the then available NCQA Medicaid mean. Provider profile indicator data is not risk adjusted and scoring is based on provider performance within the service area range.

PCPs who meet or exceed established performance goals and who demonstrate continued excellence or significant improvement over time may be recognized by CountyCare in publications such as newsletters, bulletins, press releases, and recognition in our provider directories.
WHAT IS THE MODEL OF CARE?
Model of Care defines the management, procedures and operational systems that provide access, coordination and structure needed to provide services and care to CountyCare members.

CountyCare’s Model of Care includes the following elements:

- Measurable goals
- Staff structure and care management roles
- Interdisciplinary care team
- Provider network having special expertise and use of clinical practice guidelines
- Model of care training
- Health risk assessment
- Individualized Care Plan
- Communication network
- Care Management
- Performance and health outcome measurements

CountyCare ensures all of our members have:

- Access to essential available services such as medical, behavioral and social services
- Access to affordable care
- Care coordination through an identified point of contact
- Seamless transitions of care
- Improved access to preventive health services
- Appropriate utilization of healthcare services
- Overall improved health outcomes

HEALTH RISK SCREENING (HRS) - COMPLETED WITH NEW MEMBERS WITHIN 30 DAYS TO IDENTIFY THOSE WITH UNMET OR ONGOING NEEDS.
Work with the member to assess:

- Functional Abilities
- Physical and Behavioral Health Conditions • Social, Environmental, and Cultural Issues
- Ability to Live Independently
- Mobility
- Economic Self-sufficiency
- Medications
- And Other Needs that Form the Basis of Our Integrated, Holistic Care Plan

Member Outreach is Critical to our Model

- Explain benefits, provide health education, including how to access care (ex. appropriate Emergency Room utilization)
- Participate in community events and establish partnerships with local community agencies, churches, and high volume provider offices to promote healthy living and preventive care
- Influence consumers’ beliefs and behaviors because they are hired from within the community
- Identify and engage high-risk consumers
- Facilitate communication across medical and behavioral health specialties
MEDICAL RECORDS
CountyCare providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to members. To ensure the member’s privacy, medical records should be kept in a secure location.

REQUIRED INFORMATION
Medical record is defined as the complete, comprehensive member records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the member’s participating primary care physician or provider, that document all medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Providers must maintain complete medical records for members in accordance with the following standards:

- Member’s name, and/or medical record number on all chart pages
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.)
- Prominent notation of any spoken language translation or communication assistance
- All entries must be legible and maintained in detail
- All entries must be dated and signed, or dictated by the provider rendering the care
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented
- An up-to-date immunization record is established for pediatric members or an appropriate history is made in chart for adults
- Evidence that preventive screening and services are offered in accordance with CountyCare’s practice guidelines
- Appropriate subjective and objective information pertinent to the member’s presenting complaints is documented in the history and physical
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and
- ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses
- Working diagnosis is consistent with findings
- Treatment plan is appropriate for diagnosis
- Documented treatment prescribed, therapy prescribed and drug administered or dispensed including instructions to the member
• Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns
• Signed and dated required consent forms
• Unresolved problems from previous visits are addressed in subsequent visits
• Laboratory and other studies ordered as appropriate
• Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the primary care provider (PCP) to signify review
• Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services and services for the treatment of sexually transmitted diseases
• Health teaching and/or counseling is documented
• For members ten (10) years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for members seen three or more times substance abuse history should be queried)
• Documentation of failure to keep an appointment
• Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed
• Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem
• Confidentiality of member information and records protected
• Evidence that an advance directive has been offered to adults 18 years of age and older

MEDICAL RECORDS RELEASE
All member medical records shall be confidential and shall not be released without the written authorization of the covered person or a responsible covered person’s legal guardian. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis.

MEDICAL RECORDS TRANSFER FOR NEW MEMBERS
All PCPs are required to document in the member’s medical record attempts to obtain historical medical records for all newly assigned CountyCare members. If the member or member’s guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers then this should also be noted in the medical record.

MEDICAL RECORDS AUDITS
CountyCare will conduct random medical record audits as part of its QAPI Program to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to members, including over/under utilization of specialists, as well as the outcome of such services also may be assessed during a medical record audit. CountyCare will provide verbal or written notice prior to conducting a medical record review.
PROVIDER RELATIONS DEPARTMENT
CountyCare’s Provider Relations department is designed around the concept of making your experience a positive one by being your advocate within CountyCare. The Provider Relations Department is responsible for providing the services listed below which include but are not limited to:

• Contracting
• Maintenance of existing CountyCare Provider Manual
• Development of alternative reimbursement strategies
• Researching of trends in claims inquiries to CountyCare
• Pool settlement updates/status
• Network performance profiling
• Individual physician performance profiling
• Physician, provider and office staff orientation
• Hospital and ancillary staff orientation
• Ongoing provider education, updates, and training

The goal of this department is to furnish you and your staff with the necessary tools to provide the highest quality of healthcare to CountyCare enrolled membership.

To contact the provider relations specialist for your area contact our Provider Services toll free help line at 312-864-8200 / 855-444-1661. Provider Services Representatives work with Provider Relations specialists to serve as your advocates to ensure that you receive necessary assistance and maintain satisfaction with CountyCare.
BENEFITS COVERED BY FAMILY HEALTH PLAN

• Enrollees under age 21 screening examinations including appropriate childhood immunizations
• Preventative medicine including a complete health history and physical exam
• Family Planning, Reproductive health
• Well woman exams
• Maternity care including Prenatal, post-natal care, high risk pregnancy care
• Screening for STD and risk counseling for STI/HIV, universal HIV testing.
• Health Maintenance promotion
• Complex and Serious Medical Condition management
• Mobile crisis services for children

PREGNANCY AND MATERNITY SERVICES

• Outpatient doctor services including routine prenatal care before and after delivery for problems or complications resulting from pregnancy or childbirth.
• Inpatient hospital services in participating hospitals and out-of-network emergency labor and delivery services.
• Care from the Comprehensive Perinatal Services Program (CPSP), including a medical/obstetrical, nutritional, psychosocial and health education assessment at the first prenatal visit, once each trimester thereafter, and at the post-partum visit.

• The newborn child’s healthcare for the month of delivery and the month after delivery. By that time, the newborn should be enrolled separately.

GENERAL PREVENTIVE CARE SERVICES

• Eye exams. We cover an eye exam every 2 years (unless our member have a medical need for more frequent exams). We cover refractions to determine a prescription for glasses.
• Health education programs including, but not limited to: diabetes education, heart health education, nutritional education, etc. Look for information on health education in our Member newsletter and on our website. CountyCare may also mail our members information.
• Child and adult immunizations are covered according to the Advisory Committee on Immunization Practices (ACIP), the Illinois Adult Immunization and the United States Preventive Services Task Force recommendations.
• Periodic check-ups. A complete history and physical exam every one to three years.
• Medical screening such as for diabetes, high cholesterol, osteoporosis and tuberculosis.
• Cancer screening for cervical, breast, BBRACA1, BRAC2, colorectal, prostate and skin.
• Any test recommended by CountyCare and medical professionals is covered.
We recommend that our members a checkup according to the following schedule:

### PREVENTIVE CARE FOR WOMEN

<table>
<thead>
<tr>
<th>Service</th>
<th>Age</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Exam</td>
<td>&lt; 21 years</td>
<td>Annually</td>
</tr>
<tr>
<td>Physical Exam</td>
<td>21-63 years</td>
<td>Every 1-3 years</td>
</tr>
<tr>
<td>Physical Exam</td>
<td>&gt; 65 years</td>
<td>Annually</td>
</tr>
</tbody>
</table>

### PREVENTIVE CARE FOR WOMEN

<table>
<thead>
<tr>
<th>Service</th>
<th>Age</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pelvic Exam</td>
<td>21-39</td>
<td>Annually</td>
</tr>
<tr>
<td>PAP Smear</td>
<td>&gt; 21</td>
<td>Dependent on risk factors</td>
</tr>
<tr>
<td>Clinical Breast Exam</td>
<td>21-40</td>
<td>Not required except when medically necessary</td>
</tr>
<tr>
<td>Clinical Breast Exam</td>
<td>&gt; 40</td>
<td>Annually</td>
</tr>
<tr>
<td>Mammogram</td>
<td>21-49</td>
<td>No required except when medically necessary</td>
</tr>
<tr>
<td>Mammogram</td>
<td>50-74</td>
<td>Annually</td>
</tr>
</tbody>
</table>

### VOLUNTARY FAMILY PLANNING SERVICES

We cover the cost of contraceptives, including the birth control device, and fitting or inserting the device (such as diaphragms, IUDs, Norplant). Our members can get services from any qualified family planning provider. He/she does not have to be a Participating Provider. Our members do not need a referral from PCP and do not have to get permission from CountyCare to get these services.

### VOLUNTARY STERILIZATION SERVICES

We cover vasectomies and tubal ligations.

### WELL-CHILD CARE

The Child Health & Disability Prevention (CHDP) program offers:

- Health history
- Medical, dental, nutritional and developmental assessment
- Immunizations
- Vision and hearing testing
- Some laboratory tests (e.g., tuberculin, sickle cell, blood and urine tests, pap smears)
- Health education, including smoking and information on second-hand smoke Care Coordination Enhancements
- Chronic Care Action Plan
- Coordination with community services such as Supplemental Nutrition Program, Head Start, Early intervention and school systems.
- Coordinating services with Family Case Management
Definitions

Abuse: (i) A manner of operation that results in excessive or unreasonable costs to the Federal or State health care programs; (ii) the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish (42 CFR Section 488.301).

Action: (i) The denial or limitation of authorization of a requested service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial of payment for a service; (iv) the failure to provide services in a timely manner; (v) the failure to respond to an Appeal in a timely manner, or (vi) solely with respect to a Health Plan that is the only Health Plan serving a rural area, the denial of an Enrollee’s request to obtain services outside of the contracting Area.

Adults with Disabilities: An individual who is 19 years of age or older, who meets the definition of blind or disabled under Section 1614(a) of the Social Security Act (42 U.S.C. 1382), and who is eligible for Medicaid.

Advanced Practice Nurse (APN): A Provider of medical and preventive services, including Certified Nurse Midwives, Certified Family Nurse Practitioners and Certified Pediatric Nurse Practitioners, who is licensed as an APN, holds a valid license in Illinois, is legally authorized under statute or rule to provide services, and is enrolled with the Department and contracted with the Health Plan.

Affiliated Provider: A Provider associated as an employee or by other legally recognizable means with a Health Plan for the purpose of providing services under the Department’s contract with the Health Plan.

Anniversary Date: the annual anniversary of an Enrollee’s initial enrollment in the Health Plan. For example, if an Enrollee became effective in an Health Plan on October 1, 2010, their Anniversary Date with that Health Plan would be each October 1st thereafter.

Appeal: A request for review of a decision made by the Health Plan with respect to an Action.

CAHPS: Consumer Assessment of Health Plans Survey is a public-private initiative to develop standardized surveys of patient’s experience with ambulatory and facility level care.

Capitation: The reimbursement arrangement in which a fixed rate of payment per Enrollee per month is made to the Health Plan for the performance of all of the Health Plan’s duties and responsibilities.

Care Coordinator: An employee of the Health Plan, together with an Enrollee and Providers, establishes an Enrollee Care Plan for the Enrollee and, through interaction with Affiliated Providers, ensures the Enrollee receives necessary services.

Care Management: Services that assist Enrollees in gaining access to needed services, including medical, social, educational and other services, regardless of the funding source for the services.
Centers for Medicare & Medicaid Services (Federal CMS): The agency within DHHS that is responsible for the administration of the Medicare program and, in partnership with the states, administers Medicaid, the State Children’s Health Insurance Program (CHIP), and the Health Insurance Portability and Accountability Act (HIPAA).

Complaint: A phone call, letter or personal contact from a Participant, Enrollee, family member, Enrollee representative or any other interested person expressing a concern related to the health, safety or well-being of an Enrollee.

Department or HFS: The Illinois Department of Healthcare and Family Services and any successor agency.

DHS: The Illinois Department of Human Services, and any successor agency.

DHS-DRS: The Division of Rehabilitation Services, and any successor agency, within DHS that operates the home services programs for persons with physical disabilities, brain injury and HIV/AIDS.

DoA: The Illinois Department on Aging, and any successor agency.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

Emergency Services: Those inpatient and outpatient health care services that are covered services, including transportation, needed to evaluate or stabilize an Emergency Medical Condition, which are furnished by a Provider qualified to furnish Emergency Services.

Encounter: An individual service or procedure provided to an Enrollee that would result in a claim if the service or procedure were to be reimbursed Fee-For-Service under the Medicaid Program.

Encounter Data: The compilation of data elements, as specified by the Department in written notice, identifying an Encounter that includes information similar to that required in a claim for Fee-For-Service payment under the Department’s Medical Program.

Enrollee: A Participant who is enrolled in a Health Plan. “Enrollee” shall include the caretaker relative or guardian where the Enrollee is an adult for whom a guardian has been named; provided, however, that the Health Plan is not obligated to cover services for any individual who is not enrolled as an Enrollee with the Health Plan.

Enrollee Care Plan: An Enrollee-centered, goal-oriented, culturally relevant, and logical, written plan of care that assures that the Enrollee receives medical and medically-related necessary services in a supportive, effective, efficient, timely and cost-effective manner that emphasizes prevention and continuity of care.

Fee-For-Service: The method of charging which bills for each service or encounter rendered.

Fraud: Knowing and willful deception, or a reckless disregard of the facts, with the intent to receive an unauthorized benefit.

Grievance: An expression of dissatisfaction by an Enrollee, including Complaints, about any matter other than a matter that is properly the subject of an Appeal.
Health Plan: A Health Maintenance Organization or a Managed Care Community Network that provides or arranges to provide covered primary, secondary, and tertiary managed health care services for Medicaid Participants under contract with the Illinois Department of Healthcare and Family Services.

Health Insurance Portability and Accountability Act (HIPAA): Also known as the Kennedy-Kassebaum Bill, the Kennedy-Kassebaum Bill, K2, or Public Law 104-191 (pdf), the federal law that makes a number of changes that have the goal of allowing persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA provides DHHS with the authority to mandate the use of standards for electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, Providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information.

Home and Community-Based Services (HCBS) Waivers: Waivers under Section 1915(c) of the Social Security Act that allow Illinois to cover home and community services and provide programs that are designed to meet the unique needs of individuals with disabilities who qualify for the level of care provided in an institution but who, with special services, may remain in their homes and communities.

ILCS: Illinois Compiled Statutes.

Illinois Participant Enrollment Services (ICES): The entity contracted by the Department to conduct enrollment activities for Potential Enrollees, including providing impartial education on health care delivery choices, providing enrollment materials, assisting with the selection of an Health Plan and PCP, and processing requests to change Health Plans.

Integrated Care Program: The program under which the Department will contract with Health Plans to provide the full spectrum of Medicaid covered services through an integrated care delivery system to Older Adults and Adults with Disabilities who are eligible for Medicaid but are not eligible for Medicare.

Long-Term Care (LTC) Facility or Nursing Facility (NF): A facility that provides Skilled Nursing or intermediate long-term care services, whether public or private and whether organized for profit or not-for-profit, that is subject to licensure by the Illinois Department of Public Health under the Nursing Home Care Act, including a county nursing home directed and maintained under Section 5-1005 of the counties code; and a part of a hospital in which skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act are provided.

Long Term Services and Supports. (LTSS): Nursing home services or Home and Community Based Service waivers (HCBS) services.

Marketing: Any written or oral communication from a healthcare delivery system or its representative that can reasonably be interpreted as intended to influence a Participant to enroll, not enroll, or to dis-enroll from a health care delivery system.

Medicaid Program: The program under Title XIX of the Social Security Act that provides medical benefits to groups of low-income people.
**Medically Necessary:** A service, supply or medicine that is appropriate and meets the standards of good medical practice in the medical community, as determined by the Provider in accordance with the Health Plan’s guidelines, policies or procedures, for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease, to assist in the Enrollee’s ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth.

**National Committee for Quality Assurance (NCQA):** A private 501(c) (3) not for profit organization dedicated to improving health care quality and has a process for providing accreditation, certification and recognition, e.g., Health Plan accreditation.

**Neglect:** A failure to notify the appropriate health care professional, to provide or arrange necessary services to avoid physical or psychological harm to a resident or to terminate the residency of a Participant whose needs can no longer be met, causing an avoidable decline in function. Neglect may be either passive (non-malicious) or willful.

**Non-Affiliated Provider:** A Provider who is not associated with a Health Plan for the purpose of providing health care services under a Medicaid managed care program pursuant to a written contract or agreement. Limited service agreements or contracts (e.g. single case agreements) do not constitute network participation.

**Nursing Facility (NF):** See Long-Term Care Facility.

**Older Adult:** An individual who is 65 years of age or older and who is eligible for the Medicaid program.

**Open Enrollment:** The specific period of time each year in which Enrollees shall have the opportunity to change from one Health Plan to another Health Plan.

**Participant:** Any individual determined to be eligible for the Medicaid Program.

**Performance Measure:** A quantifiable measure to assess how well an organization carries out a specific function or process.

**Person:** Any individual, corporation, proprietorship, firm, partnership, trust, association, governmental authority, contractor, or other legal entity whatsoever, whether acting in an individual, fiduciary, or other capacity.

**Personal Assistant:** Individuals who provide Personal Care to a Participant when it has been determined by the Care Coordinator that the Participant has the ability to supervise the Personal Care Provider.

**Personal Care:** Assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well being of a Participant.

**Personal Emergency Response System (PERS):** An electronic device that enables a Participant at high risk of institutionalization to secure help in an emergency.

**Physician:** means an individual licensed to practice medicine in all its branches in Illinois under the Medical Practice Act of 1987 or any such similar statute of the state in which the individual practices medicine.

**Post-Stabilization Services:** Medically necessary non-emergency services furnished to an Enrollee after the Enrollee is Stabilized following an Emergency Medical Condition, in order to maintain such Stabilization.

**Potential Enrollee:** A Participant who is subject to mandatory enrollment in a managed care program, but is not yet an Enrollee of a Health Plan.
Primary Care Provider (PCP): A Provider, including a WHCP, who within the Provider’s scope of practice and in accordance with State certification requirements or State licensure requirements, is responsible for providing all preventive and primary care services to assigned Enrollees in the Health Plan.

Provider: A Person enrolled with the Department to provide Covered Services to a Participant.

Quality Assurance (QA): A formal set of activities to review, monitor and improve the quality of services by a Provider or Health Plan, including quality assessment, ongoing quality improvement and corrective actions to remedy any deficiencies identified in the quality of direct Enrollee, administrative and support services.

Quality Assurance Plan (QAP): A written document developed by the Health Plan in consultation with its QAP committee and Medical Director that details the annual program goals and measurable objectives, utilization review activities, access and other Performance Measures that are to be monitored with ongoing Physician profiling and focus on quality improvement.

Quality Program: The Health Plan’s overarching mission, vision and values, which through its goals, objectives and processes committed in writing in the QAP, are demonstrated through continuous improvement and monitoring of medical care, Enrollee safety, behavioral health services, and the delivery of services to Enrollees, including ongoing assessment of program standards to determine the quality and appropriateness of care, Case Management and coordination. It is system-wide and implemented through the integration, coordination of services, and resource allocation throughout the organization, its partners, Providers, other entities delegated to provide services to Enrollees, and extended community involved with Enrollees.

Recipient Identification Number (RIN): The nine-digit identification number unique to the individual receiving coverage under one of the Department’s Medical Programs. It is vital that this number be correctly entered on billings for services rendered.

Service Plan: A plan that addresses all identified needs for services received at home.

Significant Change: A decline or improvement in a Participant’s status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, where the decline or improvement impacts more than one area of the Participant’s health status and requires revision of the Enrollee Care Plan.

Skilled Nursing: Nursing services provided within the scope of the State’s Nurse Practice Act by registered nurses, licensed practical nurses, or vocational nurses licensed to practice in the State.

Skilled Nursing Facility (SNF): A group care facility that provides Skilled Nursing care, continuous Skilled Nursing observations, restorative nursing and other services under professional direction with frequent medical supervision, during the post-acute phase of illness or during reoccurrences of symptoms in long-term illness.

Speech Therapy: A medically prescribed speech or language based service that is provided by a licensed speech therapist and identified in the Enrollee Care Plan that is used to evaluate or improve an Enrollee’s ability to communicate.

Stabilization or Stabilized: A determination with respect to an Emergency Medical Condition made by an attending emergency room Physician or other treating Provider that, within reasonable medical probability, no material deterioration of the condition is likely to result upon discharge or transfer to another facility.
**State:** The State of Illinois, as represented through any agency, department, board, or commission.

**Supportive Living Facility (SLF):** A residential apartment-style (assisted living) setting in Illinois that is certified by the Department that provides or coordinates flexible Personal Care services, twenty-four (24) hour supervision and assistance (scheduled and unscheduled), activities, and health related services with a service program and physical environment designed to minimize the need for residents to move within or from the setting to accommodate changing needs and references; has an organizational mission, service programs and physical environment designed to maximize residents’ dignity, autonomy, privacy and independence; and encourages family and community involvement.

**Third Party:** Any person other than the Department, Health Plan, or any of Health Plan’s affiliates.
Thank You for Choosing
CountyCare