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Purpose

This Practitioner and Provider Manual (Manual) serves as a guide to the policies and procedures governing the administration of Family Health Network (FHN) plans and is an extension of and supplements the Provider Agreement (Agreement) between FHN and contracted practitioners and providers delivering health care service(s) to FHN members enrolled in a FHN plan.

FHN retains the right to add to, delete from and otherwise modify this Manual. Revisions to this Manual reflect changes made to FHN’s policies and procedures and updated at least annually. Revisions shall be binding thirty (30) days after notice if provided by mail or electronic means, or such other period of time as necessary for FHN to comply with any statutory, regulatory, contractual and/or accreditation requirements. As policies and procedures change, updates will be issued by FHN in the Practitioner and Provider Newsletter, and posted to the Practitioner and Provider Manual section of www.fhnchicago.com/providers and will be incorporated into subsequent versions of this Manual.

Practitioners and Providers must acknowledge this Manual and any other written materials provided by FHN as proprietary and confidential in accordance with Section 3.11 of the Agreement. If there is a conflict with the Manual and the Agreement, your Agreement supersedes, with the exception of required changes to comply with any state and/or federal laws, statutory, regulatory, and contractual and/or accreditation requirements.

We are always looking to improve the usefulness of the tools and information we make available to our practitioners and providers and we welcome your comments and feedback. You may email comments and suggestions to info@myfhn.com.

Introduction

Family Health Network (FHN) is a not-for-profit Managed Care Organization (MCO) contracted with the Illinois Department of Healthcare and Family Services (HFS) to arrange for the provision of medical services to Medicaid members who enroll in our Plan.

FHN was certified as an MCCN in 1995 under the sponsorship of community hospitals. It is locally based and governed by a Board of Directors comprised of hospital business leaders. FHN remains focused on serving Medicaid beneficiaries. FHN elected to also apply for an HMO license which is regulated by the Illinois Department of Insurance. In June 2015, FHN became an Illinois licensed HMO and is a provider-sponsored 501c3 organization.

Current Illinois managed care organization enrollment figures can be found at: www.illinois.gov/hfs/MedicalProviders/cc/Pages/TotalCCEnrollmentforAllPrograms.aspx
Our Mission
We provide access to cost effective quality health care for people who could not otherwise afford it.

Our Vision
To be the health plan of choice in our market and the leader in improving health outcomes.

Our Values
Respect ~ Integrity ~ Teamwork ~ Service ~ Stewardship

Our Services
We help coordinate physical and behavioral health care, and offer education and disease management programs.

Our Members
As a leader in managed health care services for the public sector, FHN helps low-income families, children and pregnant women, including the Family Health Plan (FHP) population and Affordable Care Act (ACA) expansion population living in Chicago, Cook County and Northern Illinois, to get the health care they need.
Terminology

**Appeal:** a request for an organization to change a medical decision

**Complaint:** an oral or written expression of dissatisfaction same as Grievance in HFS contract

**Complex Case Management:** a program of coordinated care and services for organization members who have experienced a critical event or diagnosis that requires extensive use of resources

**Delegation:** an organization gives an entity the authority to perform certain functions on its behalf. Although the organization may delegate the authority to perform a function, it may not delegate the responsibility for ensuring that the function is performed appropriately

**Denial:** the non-authorization of care or service based on either medical appropriateness or benefit coverage. Partial approvals and care terminations when the practitioner does not agree are also considered denials

**Disease Management:** a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions. Disease management supports the practitioner-patient relationship and plan of care, and emphasizes prevention of complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies such as self-management.

**Grievance:** an oral or written expression of dissatisfaction. See complaint.

**Health Appraisal (HA):** a self-reported survey to collect member information regarding their perception of their personal health. It will identify potential lifestyle changes, provide educational materials and allow the member to track health related actives. FHN encourages our members to visit our website and participate in the Health Appraisal.

**Health Risk Survey (HRS):** a survey completed by the members that is designed to capture essential aspects of the member’s health status and risk stratify the member for timely initiation of healthcare services

**Practitioners:** a licensed or certified professional who provides medical care or behavioral healthcare services

**Providers:** an institution or organization that provides services, such as a hospital, residential treatment center, home health agency or rehabilitation facility

**Vendor relationship:** a relationship between a client organization and another entity, where the organization obtains a product or service from the entity and maintains authority, including control over the implementation and manner and use of the entity’s product or services to perform the function.
## Quick Reference Guide

### Important Key Contacts

<table>
<thead>
<tr>
<th>Service/Department</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider/Member Services:</td>
<td>888-346-4968</td>
</tr>
<tr>
<td>• Health Information Line</td>
<td></td>
</tr>
<tr>
<td>• ATT Language Line</td>
<td></td>
</tr>
<tr>
<td>• Benefits and Eligibility Determination</td>
<td></td>
</tr>
<tr>
<td>• Eligibility Verification</td>
<td></td>
</tr>
<tr>
<td>Confidential Compliance Reporting Line</td>
<td>312-880-1635</td>
</tr>
<tr>
<td>Precertification Line</td>
<td>888-346-4968 option 5</td>
</tr>
<tr>
<td>Claim Inquiry (All IP/OP Surgery/Observation or Out Of Area)</td>
<td>888-346-4968 option 5</td>
</tr>
<tr>
<td>TTY/TDD</td>
<td>711</td>
</tr>
<tr>
<td>CVS Caremark (pharmacy benefit manager)</td>
<td>888-346-4968 opt 6</td>
</tr>
<tr>
<td>Behavioral Health Line</td>
<td>888-346-4968 option 4</td>
</tr>
<tr>
<td>Transportation</td>
<td>888-346-4968 option 1</td>
</tr>
<tr>
<td>Vision</td>
<td>888-346-4968 option 3</td>
</tr>
<tr>
<td>Dental</td>
<td>888-346-4968 option 2</td>
</tr>
<tr>
<td>Member Appeals</td>
<td></td>
</tr>
<tr>
<td>Provider Claims Disputes</td>
<td>FAX 312-257-2069</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>TBD</td>
</tr>
<tr>
<td>• 8am to 5pm Monday – Friday</td>
<td></td>
</tr>
<tr>
<td>• 9am to 1pm Saturdays</td>
<td>888-346-4968</td>
</tr>
<tr>
<td>• All other UM issues can be communicated via fax (312-416-4538) or by leaving a confidential voicemail by calling 1-866-346-4968 during non-business hours</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Utilization Management</td>
<td>888-211-6851</td>
</tr>
<tr>
<td>• BH Inpatient</td>
<td>Fax: 312-324-0647</td>
</tr>
<tr>
<td>• BH Outpatient</td>
<td>Fax: 312-324-0649</td>
</tr>
<tr>
<td>Behavioral Health Claims</td>
<td>800-753-5456 option 6</td>
</tr>
<tr>
<td>Behavioral Health Case Management</td>
<td>888-211-6851</td>
</tr>
</tbody>
</table>
Claims Submission, Disputes, and Inquiries

Timely filing is 120 days from the date of service or the date of discharge unless otherwise specified in the provider contract.

<table>
<thead>
<tr>
<th>Submission</th>
<th>Disputes and Inquiries</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Electronic Submissions:</strong></td>
<td><strong>Submit by mail:</strong></td>
</tr>
<tr>
<td>Clearing House: EMDEON</td>
<td>ATTN: Claim Payment Disputes</td>
</tr>
<tr>
<td>PAYOR ID: 85468</td>
<td>P.O. BOX 981731</td>
</tr>
<tr>
<td><strong>Paper Claim Submissions:</strong></td>
<td>El Paso Texas, 79998-1731</td>
</tr>
<tr>
<td>Family Health Network</td>
<td>Time Frame: 60 days from date of EOP</td>
</tr>
<tr>
<td>P.O. BOX 981731</td>
<td><strong>Paper Claim Submissions:</strong></td>
</tr>
<tr>
<td>El Paso Texas, 79998-1731</td>
<td><a href="mailto:MCPID@myfhn.com">MCPID@myfhn.com</a></td>
</tr>
</tbody>
</table>

**Submitting Corrected Claims**

<table>
<thead>
<tr>
<th>EDI Corrected Claims</th>
<th>Paper Corrected Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professional Claim Type Submission Codes:</strong></td>
<td>“Corrected Claim” must be clearly marked</td>
</tr>
<tr>
<td>7 = Replacement of Prior Claim</td>
<td>at the top of the claim with the original</td>
</tr>
<tr>
<td>8 = Void/Cancel Claim</td>
<td>claim number indicated in FLD 22 to avoid</td>
</tr>
<tr>
<td><strong>Institutional Claim Bill Types:</strong></td>
<td>duplicate claim denials</td>
</tr>
<tr>
<td>XX7 = Replacement of Prior Claim</td>
<td></td>
</tr>
<tr>
<td>XX8 = Void/Cancel Claim</td>
<td></td>
</tr>
</tbody>
</table>

**Resources Available on Our Website**

Please visit [www.fhnchicago.com](http://www.fhnchicago.com) to find information on our:

- Claim Submission portal link
- Practitioner and Provider Directory search
- Practitioner and Provider Notices and Resources
- Quality Management Program – what we do to promote quality and how we are doing in meeting our goals
- Disease Management Programs – Diabetes and Asthma. This also includes how we work with your patients to meet their goals and manage their conditions
- Clinical Practice Guidelines – new and revised for certain chronic medical and behavioral health conditions
- Preventive Health Practice Guidelines – this covers all age groups and pregnancy
- Utilization Management Criteria – what we use to make utilization decisions
- Pharmaceutical Restrictions and Preferences – what the formulary includes and excludes and how it is managed
- Pre-Certification Form
• Authorization Form
• Services and procedures that do not require an authorization
• Practitioner and Provider Change of Information Form

24 Hour Health Information Line

This telephone based health information line is available to all FHN Members. Members may call 888-346-4968 anytime they are experiencing medical or behavioral health symptoms or need health care information. Registered nurses are available 24 hours a day, seven days a week to assess symptoms and aid Members to make good health care decisions.

Credentialing and Recredentialing

FHN credentials and recredentials practitioners and organizational providers in accordance with the Agreement and the National Committee for Quality Assurance (NCQA) standards for review. Until the credentialing process is completed, practitioners should not see FHN members who are seeking in-network care from FHN practitioners or providers. FHN will accept credentialing information from the Council for Affordable Quality Healthcare (CAQH) for all practitioner and provider types or as a paper application (see below for additional information). The Health Care Professional Credentials Data Collection Act [410 ILCS 517] requires that the Health Care Professional Credentialing and Business Data Gathering Form be used to collect information for credentialing. A completed form includes required documents and attachments with a signed and current date Affirmation of Information.

Plan credentials the following types of organizational providers: Hospitals, Home Health Agencies, Skilled Nursing Facilities; (Nursing Homes), Free-Standing Surgical Centers.

Council for Affordable Quality Healthcare (CAQH)

CAQH allows practitioners to fill out one set of credentialing information for health plans and healthcare organizations to access. There is no cost to the practitioner. Completing an application online with CAQH can be done by registering at proview.caqh.org/Login/. Please make sure to allow access to Family Health Network if you do not grant global access to your CAQH application.

Incomplete Applications cannot be accessed on CAQH by FHN. Please work with CAQH to complete.
Paper Application

The Health Care Professional Credentialing and Business Data Gathering Forms – initial and re-credentialing are available in Word and PDF versions at: www.idph.state.il.us/about/credentialing.htm

If you submit a paper credentialing application please make sure to provide complete responses, provide attachments which contain all of the information requested in the relevant section and provide copies of all documents listed under CONFIDENTIAL INFORMATION before signing and dating the Affirmation of Information on page 2 of the form.

Incomplete paper applications received by FHN will be assigned to a Credentialing Coordinator who will notify the applicant of missing information. Three attempts will be made over a 60-day period to obtain the requested information. Failure to submit the information after that period will be considered a voluntary withdrawal of the application and the practitioner will not be considered for the FHN network.

Primary Source Verification

Upon receipt of a completed application, FHN will obtain primary source verification of the following information within the prescribed time limits:

1. A current valid license to practice is present
2. Hospital Privileges
3. A valid DEA or CDS certificate, if applicable
4. Education and training
5. Board Certification if the practitioner states on the application that he/she is board certified
6. Work history
7. History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner
8. Accreditation status, as applicable to non-individuals
9. CLIA Certificate of Waiver

Initial Credentialing

All contracted health professionals are required to be credentialed by Family Health Network, including practitioners joining an existing participating practice with FHN, must complete the credentialing process and be approved by the Credentialing Committee.
Recredentialing

We re-credential established practitioners at least every three (3) years to ensure they continue to meet FHN standards of care along with legislative/regulatory and NCQA requirements.

FHN re-verifies the information that is subject to change overtime. The intent is to identify any changes in licensure, certification, clinical privileges, health status, sanctions status, clinical competence or any other area that may affect the practitioner’s ability to render quality healthcare services to FHN Members.

In addition, the re-credentialing process incorporates an assessment of prior performance with FHN, including but not limited to member complaints, member satisfaction, and information from quality, peer review and medical management activities. In addition, FHN quality staff will conduct a medical record review and a practitioner and provider site visit.

Between re-credentialing cycles FHN performs on-going monitoring for adverse events, sanctions or member complaints.

Practitioner Rights

You can exercise the following rights by calling 888-346-4968 to be directed to your assigned Network Management Specialist to assist with your request.

You have the right to:

1. Review information submitted that is obtained from outside sources to support their credentialing application.
   a. You have the right, upon request, to evaluate information received through primary source verification. Upon request, you are sent copies of the item(s) in question via a confidential email. The document(s) are scanned or printed as a PDF and sent as an attachment.

2. Correct erroneous information.
   a. Email correspondence will be sent to you when the application is incomplete or if information obtained from other sources varies from that provided by the practitioner. The correspondence will identify the missing item(s). You have a 30 day time frame for submission of the missing or erroneous items. It is stated in the email the submission that response can be provided via email, fax or by mail, attention to the Credentialing Staff that has made the request.
   b. If all required information is received in the timeframe provided, the Credentialing Staff will notify you via email confirmation indicating acceptance of the information provided. The results are recorded in the Credentialing Database.
3. Receive the status of your credentialing and recredentialing application upon request:

   a. At any time from the time you submit the application to the Credentialing Committee’s decision, you have the right, upon request, to be informed of the status of your credentialing application.

   b. Telephone inquiries are also accepted by the Credentialing Staff of Network Management Staff for providing application status. Answers to the inquiries are sent via fax, email or a written response within two business days of the inquiry. The response indicates that FHN or CCAI is in receipt of the application and the 60-day timeframe for completion of the credentialing process.

Responsibilities of a Participating Practitioners and Providers

Network Participation Requirements

All practitioners participating with FHN undergo a review of their qualifications, including education and training, licensure status, board certification, hospital privileges and malpractice history. The Peer Review Committee is responsible for making decisions regarding provider credentialing. In order to participate with the FHN network, a practitioner must:

   • Be enrolled in the Illinois Medical Assistance Program
   • Be a qualified practitioner in their respective discipline – Primary Care Physicians (PCP’s) should be licensed and practicing Family/General Medicine, Internal Medicine, Pediatrics, Obstetrics/Gynecology, Nurse Practitioner or Certified Nurse Midwife or Physician Assistant.
   • Maintain active admitting privileges or demonstrate adequate admitting arrangements at one or more participating FHN network hospitals;
   • Be willing to collaborate and cooperate with FHN to coordinate the delivery of quality care to FHN members;
   • Comply with all Federal, State and local regulations and requirements, including those defined in the Contract for Furnishing Health Services by a Managed Care Organization between HFS and FHN Meet the credentialing requirements of FHN; and
   • Have an executed participation agreement or participate in a group with an executed participation agreement with FHN or an authorized affiliate.

Interested practitioners not already enrolled must complete a Provider Enrollment Application. Requests for an enrollment application may be made by visiting the IMPACT (Illinois Medicare Program Advanced Cloud Technology) website at: www.illinois.gov/hfs/impact/
Adherence to the Practitioner and Provider Agreement

Contracted practitioners and providers must abide by all applicable terms of the Contracted Provider Agreement, including all requirements in this manual. Contracted practitioners and providers must also comply with all federal and State requirements governing FHN and practitioners and providers.

Maintain Medical Records

Practitioner and providers must document and maintain in the member’s medical record all office visits, referrals, contacts, patient education, Advance Directives, family planning counseling, and follow up with members, including referrals for behavioral health and dental services. Notations regarding follow-up of canceled and missed appointments should also be evident. Records must be signed, dated and legible. It is recommended that records be maintained for a minimum of 10 years in compliance with federal regulatory agencies, including CMS (Center for Medicare and Medicaid).

On request, practitioner and providers must make all FHN member medical records available in a timely manner. We conduct audits of medical records to ensure that documentation meets standard requirements in response to an identified quality issue, and as part of the practitioner and provider recredentialing process detailed below.

Changes to Staff, Demographic Information

To notify FHN of changes in your address, staff, tax ID number, or if you are opening or closing to new patients, please follow these steps:

1. 60 days or more before the change takes effect, complete and print a Change of Information Form.
   a. Change of Information Form (PDF link). It must contain:
      • What is changing? (Name change, change of address, etc.)
      • The effective date of the change
      • Entity or tax ID number (EIN or TIN)
      • W-9, as applicable
      • NPI number and taxonomy designation (specialty type) that you will be using for billing

2. Email the form to Network Management at Net.Mgmt@myfhn.com, or fax to (312) 491-1175.

Reporting Retirement

1. At least 90 days prior to your retirement, fax or email us a letter signed by the contract holder notifying us of the change. Fax: (312) 491-1175
Access and Availability

Onsite Access

Contracted FHN practitioners and providers are responsible to adhere to the following standards to ensure access to care for our members:

- Offer 24-hour-a-day, 7-day-a-week telephone access for members. After-hours care - A professional answering service that contacts you or the practitioner covering for you.
- Be available to provide medically necessary services.
- Follow the referral/precertification guidelines. This is a requirement for covering physicians.

It is not acceptable to automatically direct the member to the emergency room when the PCP is not available or to utilize an answering machine.

Availability

Contracted FHN practitioners and providers are responsible to adhere to the appointment availability standards. Practitioners and providers must monitor the adequacy of their appointment processes and reduce unnecessary emergency room visits.

<table>
<thead>
<tr>
<th>TYPE OF CARE</th>
<th>STANDARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine/Preventive appointments</td>
<td>Within 5 weeks</td>
</tr>
<tr>
<td>Routine/Preventive appointments for Infants under 6 months old</td>
<td>Within 2 weeks</td>
</tr>
<tr>
<td>Non-urgent problem appointments</td>
<td>Within 3 weeks</td>
</tr>
<tr>
<td>Initial Prenatal Visits without Expressed Problems:</td>
<td></td>
</tr>
<tr>
<td>Member in first trimester</td>
<td>Within 2 weeks</td>
</tr>
<tr>
<td>Member in second trimester</td>
<td>Within 1 week</td>
</tr>
<tr>
<td>Member in third trimester</td>
<td>Within 3 days</td>
</tr>
<tr>
<td>Specialists referral appointments</td>
<td>Within 2 weeks</td>
</tr>
<tr>
<td>Urgent/non-life threatening illness appointments</td>
<td>Triaged and seen within 24 hours, if necessary</td>
</tr>
<tr>
<td>Emergent/life threatening appointments</td>
<td>Immediately</td>
</tr>
<tr>
<td>Patient encounters</td>
<td>Not to exceed 6 per hour</td>
</tr>
<tr>
<td>Telephone response to after-hours non-emergent issues</td>
<td>Not to exceed one hour</td>
</tr>
<tr>
<td>Patient wait time in physician office for scheduled appointments</td>
<td>Not to exceed one hour</td>
</tr>
</tbody>
</table>
We will routinely monitor practitioner and providers’ adherence to access-to-care standards and appointment wait times. You are expected to meet federal and state accessibility standards and those standards defined in the Americans with Disabilities Act of 1990. Health care services provided through FHN must be accessible to all members. This includes ensuring that individuals with disabilities have physical access to practitioner offices (Physical accessibility is not limited to entry to a provider site, but also includes access to services within the site, e.g. exam tables and medical equipment).

As part of our commitment to providing the best quality practitioner and provider networks for our members, we conduct annual written surveys to verify appointment availability, hours of operation and after-hours standards. Practitioners and providers will be asked to participate in this survey each year. Practitioners and providers not in compliance with these standards will be required to implement corrective actions set forth by FHN.

**Claims Submissions**

It is the goal of Family Health Network to pay claims timely and accurately and will process all clean claims within thirty (30) days of the date of receipt. It is important that providers bill their claims according to standard billing guidelines and that all claims include the Federal Tax ID, National Provider Identifier and Taxonomy Code of the provider. FHN recommends that any changes to the above information as well as to addresses and provider/entity names be sent to FHN at least 30 days in advance of the change to ensure there are no delays in payments.

**30-Day Readmission Review: Determination of Preventable Readmissions.**

FHN may review readmission claims on a concurrent, pre-payment or post-service basis for facility readmissions which occur within 30 days after discharge from the same hospital, and which have the same, similar, or related diagnosis as the initial admission.

We may deny payment to the facility for the subsequent admission if it meets certain criteria and is determined to have been preventable based on those criteria.

**Timely Claims Submission**

Unless otherwise stated in the provider agreement, providers must submit their claims within one hundred and twenty (120) days of the date of service or discharge date or ninety (90) days from the primary insurance payment date, whichever is later.
Claim Submission Guidelines

When billing for services rendered to FHN members, providers must use the most current Medicare-approved coding format (ICD-10, CPT, HCPCS etc.) and or State Medicaid guidelines for claims payment.

To ensure the most timely and accurate processing of claims please follow these guidelines for claims submission:

- Use standard CMS 1500 or UB-04 claims form
- Use industry standard procedures and diagnosis codes such as CPT, Revenue HCPCS and ICD-10.
- Submit claims timely. Provider should use best efforts to submit claims within 60 days of the date of service, but no later than 120 days.
- Identify the name and appropriate tax identification number of the health professional or facility that provided the service
- Correctly identify the subscriber and patient with member id, address, member last name and member first name and date of birth.
- Eligibility Matching Logic Below

<table>
<thead>
<tr>
<th></th>
<th>Insured ID</th>
<th>Pat. DOB</th>
<th>Pat. First Name</th>
<th>Pat. Last Name</th>
<th>DOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Match</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>2nd Match</td>
<td>+</td>
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<td>3rd Match</td>
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<td>4th Match</td>
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<tr>
<td>5th Match</td>
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</tr>
</tbody>
</table>

- Correctly list date of service (mm/dd/yyyy)
- Correctly identify place of service

Providers should bill electronically to the FHN Emdeon payer ID 85468

All paper claims submissions should be sent to:

**FHN**
P.O Box 981731
El Paso, Texas
79998-1731

**Behavioral Health Claims**

Management of all Mental Health and Substance Abuse services is currently contracted to a specialty vendor who is responsible for behavioral health outpatient professional services including but not limited to psychiatric evaluation and psychotherapy and professional fees relating to emergency room visits, inpatient psychiatric stays, and substance abuse.
Hysterectomy, Abortion, and Sterilization

Hysterectomy, voluntary interruption of pregnancy, and sterilization services have limitations and specific forms that must be filled out prior to rendering these services. A copy of the appropriate form must accompany the paper claim. FHN is responsible for forwarding this information to HFS. The following forms can be found on the FHN Website at: www.fhnchicago.com

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>FORM</th>
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</thead>
<tbody>
<tr>
<td>Hysterectomy</td>
<td>Hysterectomy Form Patient Acknowledgement (HFS 1977)</td>
</tr>
<tr>
<td>Abortion</td>
<td>Abortion Payment Application (HFS 2390)</td>
</tr>
<tr>
<td>Sterilization</td>
<td>Informed Consent for Voluntary Sterilization (HFS 2189)</td>
</tr>
</tbody>
</table>

Recovery and Refunds

Although FHN strives for claims payment accuracy there are sometimes overpayments that occur due to duplication of payments, non-authorized services, retroactive member termination, incorrect payments per the contract or fee schedule, and non-covered benefits. FHN has subcontracted its recovery process to a subrogation vendor to proactively identify overpayments and request a refund of the overpayment from providers. According to the Illinois Insurance Code (215 ILCS 5/368d) no recoupments or offsets may be requested after eighteen (18) months from the date of payment unless in cases where a court, government administrative agency, or other tribunal has made a formal adjudication of fraud or the provider has already been paid in full by any other payer, third party or worker’s compensation insurer. FHN’s standard practice has been to go back no further than twelve (12) months from the date of payment.

When an overpayment is identified by FHN or its subcontracted vendor a letter will be issued to the provider with information regarding the overpayment (overpayment amount, reason for recoupment, contact information and refund instructions). The provider then has sixty (60) days to send in the refund, request additional information or dispute the recovery request. Should the provider fail to respond to the recovery request within the above timeframe the request is considered accepted and will result in a future offset of payment. Notification in the form of an Explanation of Benefits will be sent to the provider indicating the offset. If there are no future payments to offset the recovery against the provider will have thirty (30) days to repay the overpayment.

If a provider identifies an overpayment, they can send a refund check with an explanation of the overpayment (member ID, date of service, claim number and reason for overpayment) to:

Family Health Network
Finance Department
322 S. Green St. Ste. 400
Chicago, IL 60607
Member Balance Billing

In accordance with the provider agreement providers accept payment from FHN for covered services as payment in full. For covered services members will be held harmless, and providers will not balance bill members any amount that exceeds the contracted amount in the provider agreement. Provider may bill members for Non-Covered services or for applicable copayments, deductibles, or coinsurances as defined by the State of Illinois. In order to bill a member for non-covered services the provider must obtain a written acknowledgement from the member prior to services being rendered.

Encounter Data

Encounter data for claims processed at the Medical Group level from the Medical Services Pool must be submitted to FHN for all services provided to a member. Encounter data includes all services provided in the PCP’s office on a capitated basis, capitated specialist services and all other services paid from the Medical Services Pool. These services include but are not limited to lab, X-ray, PT, OT, speech therapy, durable medical equipment, and transportation.

The EDI Transaction Set 837P X12N (HIPAA Professional) claim format, which captures encounter data, is the only format acceptable to HFS. FHN requires electronic submission of encounter data. FHN’s contract with HFS requires that FHN submit aggregate encounter data to HFS on a regular basis in order to demonstrate ongoing reporting compliance including quality assurance standards.

Encounter data, whether services are paid on a capitated or fee-for-service basis, serves another vital purpose as it relates to HFS payments to FHN. It is the single way HFS reports services provided by FHN to the Federal CMS.

Provider and Practitioner Disputes

If you as a provider are dissatisfied with a decision made by FHN regarding claims payment you have a right to file a claims inquiry and/or dispute.

You may submit your inquiry and/or dispute request to MCPID@myfhn.com (in a secure e-mail) or mail to:

PO Box 981731,
El Paso, TX 79998-1731

So that we may address your request please confirm one of the following and respond with the necessary documents as well as your name, contact phone number and email address.

• Emdeon Rejection
  1. A copy of the Rejection notice is required
  2. A copy of the original CMS1500/UB04
• Provider Inquiry

If after 30 days from submission you have not received an Explanation of Payment (‘EOP”) and are not able to view it on Valence (only applicable to providers with this access), submit the following details for each claim; use an excel workbook if necessary:
1. Provider Tax Identification Number (“TIN”)
2. Patient name
3. Patient date of birth
4. Patient FHN member ID
5. Date of Service
6. Total billed amount

• Provider Dispute

Within 60 days from the date on the EOP, using the “Provider Dispute Resolution” form located on the CCAI website, complete the form and submit with a copy of the claim in question and a copy of the EOP- please be specific with the reason for the dispute.

When submitting PHI electronically be sure to use a secure email to protect all supporting documents. Once all necessary documents are received a response will be provided within 30-60 days.

Verifying Member Eligibility

All practitioners and providers must verify member eligibility and benefits prior to rendering non-emergency services to avoid claim denials/rejections. Individuals who claim to be an eligible participant should have their current eligibility verified whether or not they present a HFS Medical Card.

HFS Medical Card Verification

If the individual has a Medical Card, knows their Recipient Identification Number (RIN), or can give their Social Security number and date of birth, practitioners and providers may verify eligibility through one of the following resources:

1. Medical Electronic Data Interchange (MEDI) Internet Site
   a. No charge to practitioner or providers or practitioner or provider’s authorized users to verify a participant’s eligibility.
   b. No limit on the number of participant eligibility inquiries that may be made.
   c. Participant eligibility verification available seven days a week, 24-hours a day.
d. Participant eligibility inquiries can be made by using:
e. Recipient Identification Number (RIN) or
f. A minimum of two of the following three fields: the participant’s first and last name (as it appears in the HFS database); the participant’s date of birth; or the participant’s Social Security number.

2. Automated Voice Response System (AVRS) 1-800-842-1461
   a. No charge to practitioner or providers or their authorized users to verify a participant’s eligibility.
b. A limit of six (6) participant eligibility inquiries per phone call.
c. Participant eligibility verification available seven days a week, 24-hours a day.
d. Participant eligibility inquiries may be made by using the RIN and the date of service.

3. Recipient Eligibility Verification (REV) System
   a. The REV system is available to enrolled practitioner or providers throughout the state and utilizes various clearinghouses that relay electronic transactions back and forth between a practitioner or provider and the department. These clearinghouses, known as REV vendors, have connections to HFS that allow them to execute eligibility transactions and return the results. Each REV vendor has developed a unique process of transmitting data to the practitioner or providers. REV vendors develop standardized software for practitioner and providers to use on existing personal computers and point-of-service devices, and provide programming for existing computer systems to accept and transmit data. Practitioners or providers who want access to the REV system or other services sign an agreement with one or more vendors and pay the REV vendors for whatever mix and volume of services they select. For a listing of REV vendors, please refer to the REV Web site: www.illinois.gov/hfs/MedicalProviders/rev/Pages/default.aspx

Effective Date and Term of Coverage

Coverage begins on a date determined by HFS. The FHN Identification Card and the HFS Medical card will indicate the effective date of enrollment. FHN assumes financial responsibility for treatment of medical conditions and/or existing treatment plans of each Member as of the effective date of coverage as defined in the contract. You may call Member Services to request “Transition of Care” to allow the staff to arrange for the needed transition to a FHN physician. Every Member remains enrolled until coverage is ended.
Member ID Card

All Family Health Network members receive a Family Health Network member ID card (see sample). 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.

Disenrollment (Termination of Coverage)

The basis for good quality health care is being able to build a strong relationship between the Member and their physicians. However, there are times when a Physician must terminate a relationship with a Member. After every effort is made by a Physician, such requests may be necessary when:

- Member repeatedly misses scheduled appointments;
- Member fails to comply with a treatment plan;
- Member commits fraud or other misrepresentation; or
- Member becomes abusive to the practitioner and/or their staff members (either physically or verbally).

Should one of these situations arise, a practitioner or provider must follow a few steps:

- Document the incident in the Member’s medical chart.
- Send a certified letter to the Member stating the reasons for your request to terminate the relationship. However, the practitioner must be available to provide emergency care during the 30 day transition period. The Member should be instructed to contact FHN’s Member Services department at (888) 346-4968.
- Practitioner must complete and submit to FHN a Discharge Member from Care form and a copy of the certified letter.
If a Member should become physically abusive to a practitioner or the practitioner’s staff, the police should be called immediately. A copy of the police report should be sent to your Provider Relations Representative as soon as possible.

Member disenrollment and termination of coverage is subject to HFS and are as follows:

- At such time when HFS determines that the Member is no longer eligible to be enrolled in a managed care plan.
- At such time when a Member elects to terminate coverage by so informing FHN or ICES within their first ninety (90) days or on their anniversary date which is one year from enrollment.
- At such time when an Member no longer resides in FHN’s Service Area;
- FHN may not dis-enroll a Member because of adverse change in the Member’s health or cost of medical care.
- The termination of the contract agreement between FHN and HFS will result in automatic disenrollment of all covered Member.
- No Member will be terminated from FHN on the basis of health status, race, color, national origin, ancestry, religion, age, sex, marital status, handicap, or sexual orientation.

Covered Services

Covered services are limited to those that are medically necessary and appropriate, and which conform to professionally accepted standards of care. FHN will implement changes to coverage guidelines pursuant to any new guidance issued by HFS. For a complete list of covered services or to verify prior authorization requirements, please visit our website at www.fhnchicago.com.

The following services and benefits are included as covered services and will be provided to Members whenever medically necessary:

- Advanced Practice Nurse services;
- Ambulatory Surgical Treatment Center services;
- Assistive/augmentative communication devices;
- Audiology services;
- Blood, blood components and administration thereof;
- Chiropractic services for Members under age twenty-one (21)
- Dental services, including oral surgeons
- EPSDT services for Members under age twenty-one (21) pursuant to 89 Ill. Admin. Code Section 140.485; excluding shift nursing for Members in the MFTD HCBS Waiver for individuals who are medically fragile and technology dependent (MFTD);
- Family Planning Services and supplies;
• FQHCs, RHCs and other Encounter rate clinic visits;
• Home health agency visits;
• Hospital emergency room visits;
• Hospital inpatient services;
• Hospital ambulatory services;
• Laboratory and x-ray services;
• Medical supplies, equipment, prostheses and orthoses, and respiratory equipment and supplies;
• Mental health services provided under the Medicaid Clinic Option, Medicaid Rehabilitation Option, and Targeted Case Management Option;
• Nursing care for Members under age twenty-one (21) not in the HCBS Waiver for individuals who are MFTD, pursuant to 89 Ill. Admin. Code Section 140.472;
• Nursing care for the purpose of transitioning children from a hospital to home placement or other appropriate setting for Members under age twenty-one (21), pursuant to 89 Ill. Admin. Code 146, Subpart D;
• Nursing facilities for the first ninety (90) days (NF services 91+ days included in Service Package II)
• Optical services and supplies;
• Optometrist services;
• Palliative and Hospice Services;
• Pharmacy Services (drugs used in the treatment of Hepatitis C are covered only if dispensed in accordance with FHN’s coverage criteria);
• Physical, Occupational and Speech Therapy services;
• Physician services;
• Podiatric services for Members under age 21;
• Podiatric services for diabetic Members age 21 and over, and, effective October 1, 2014, podiatric services for all Members age 21 and over;
• Post-Stabilization Services as detailed in Section 5.17.2 of this Contract
• Renal Dialysis services;
• Services to prevent illness and promote health in accordance with Attachment XXI;
• Subacute alcoholism and substance abuse services pursuant to 89 Ill. Admin. Code Sections 148.340 through 148.390, 77 Ill. Admin Code Part 2090, Day treatment (residential) and Day treatment (detox);
• Transplants covered under 89 Ill. Adm. Code 148.82 (using transplant providers certified by the Department, if the procedure is performed in the State); and
• Transportation to secure Covered Services.
Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

*The drawing of blood for lead screening shall take place within the FHN’s affiliated facilities or elsewhere at the FHN’s expense. All laboratory tests for children being screened for lead must be sent for analysis to the Illinois Department of Public Health’s laboratory. All laboratory testing sites providing services under this contract must possess a valid Clinical Laboratory Improvement Amendments ("CLIA") certificate and comply with the CLIA regulations found at 42 CFR Part 493

**FHN will be responsible for covering up to a maximum of ninety (90) days nursing facility care (or equivalent care provided at home because a skilled nursing facility is not available). For periods in excess of ninety (90) days the Member must receive approval from the Department of Public Aid based on the Determination of Need for the admittance to a long term care facility. Payment will be issued to the practitioner or provider once the Member is on the Patient Credit File issued to FHN by HFS

***FHN covers Post-Stabilization Services provided by an Affiliated or non-Affiliated Practitioner or Provider in any of the following situations: (i) FHN authorized such services; (ii) such services were administered to maintain the Member’s Stabilized condition within one (1) hour after a request to FHN for authorization of further Post-Stabilization Services; or (iii) FHN does not respond to a request to authorize further Post-Stabilization Services within one (1) hour, FHN could not be contacted, or FHN and the treating Practitioner or Provider cannot reach an agreement concerning the Member’s care and an Affiliated Practitioner or Provider is unavailable for a consultation, in which case the treating Practitioner must be permitted to continue the care of the Member until an Affiliated Practitioner is reached and either concurs with the treating Practitioner’s plan of care or assumes responsibility for the Member’s care.

### Quality Program

**Purpose**

FHN supports an integrated healthcare delivery system grounded in continuous demonstrated quality outcomes through an interdependence of disciplines: Quality Management, Care Management, Utilization Management, Behavioral Health, Patient Safety, Transition of Care and Peer Review. The Quality Program is comprehensive; addressing health outcomes as well as non-clinical services to achieve the “triple aim” for members of improved clinical outcomes, excellent member satisfaction with their experience of care, and decreased costs through a systematic and organized approach to performance improvement and program evaluation. The evaluation of quality will encompass the full range of providers (primary and specialty practitioners, in-patient facilities, home care, etc.) and care management across the care continuum (inpatient, ambulatory, home care, skilled nursing, rehabilitation facilities) to assure coordination for vulnerable complex patient populations supporting the Patient-Centered Medical Home Model (PCMH). Under the direction of the Chief Medical Office / Medical Director, an annual work plan will be developed reflecting cultural sensitivity and serving at-risk members with severe physical and psychological needs. The annual Quality Plan will attend to initiatives and goals/objectives in the following areas: quality of clinical care, safety of clinical care, quality of service, Member experience, and relevant financial valuation of care and service delivery. Integral to the FHN QM program is the ongoing monitoring and evaluation of systems and processes supporting service delivery for both providers and members.
Scope

The scope of the QM Program is comprehensive, addressing the quality of health care/services as well as the quality and efficacy of the processes and systems that support the delivery of services performed by FHN staff and provider groups. FHN will conduct activities to achieve the program goals through ongoing evaluation and thoughtful intervention to continuously improve and maintain:

- Member satisfaction
- Cultural and linguistic competency
- Provider/practitioner access and availability
- Credentialing and re-credentialing of healthcare practitioners and other providers
- Medical Management Programs and activities
- Review HEDIS and CAHPS data to identify opportunities for improvement

Goals and Objectives

In accordance with FHN’s mission and vision, the overarching goals of the quality program are to:

1. Ensure that members receive high quality, safe and effective health care and services.
2. Ensure that the FHN network of practitioners and providers enable adequate and timely access to care and services.
3. Facilitate integrated coordinated care and services to deliver the right care at the right time in the right setting by the right practitioner or provider.
4. Ensure consumer satisfaction with health care, services and health plan.
5. Implement the governance, leadership, programs and monitors necessary to support efficient and effective administration of the Illinois Medicaid Managed Care Program.
6. Ensure accurate and timely evaluation and ongoing improvement within all program domains.

Pay for Performance Program

Pay-for-Performance program is designed to offer financial incentives to practitioners and other health care providers to meet defined quality, efficiency, or other targets. Incentives and specifications for the Pay-for Performance program are updated annually and communicated to groups and practitioners via the FHN Medical Management and Network Management teams.
Disease Management Program

Disease Management (DM) is the multi-disciplinary, continuum-based approach to health care delivery that proactively identifies populations with preventive care needs and/or chronic medical conditions. Disease Management supports the practitioner-patient relationship and plan of care, which includes a focus on primary preventive health needs of FHN members as well as the prevention of exacerbation and complications using cost-effective, evidence-based practice guidelines and implementing member empowerment strategies including motivational interviewing, health promotion and self-management advocacy techniques.

The DM Program seeks to:

1. Identify engage members with disease states that increase health risk.
2. Engage members in evidence-based programs of care aimed to optimize health and reduce morbidity and risk of disease complications.
3. Integrate evidence-based preventive health practices to lifestyles of members living with chronic stable conditions.
4. Improve adherence to medication and care plan regimens through community based programs.
5. Enhance provider and member satisfaction through delivery of interdisciplinary patient-centered care.

The Family Health Network (FHN) Disease Management Program aims to improve the quality of care and disease outcomes for its members living with DIABETES and ASTHMA. The program uses a multi-faceted approach to help members better manage these chronic conditions. An assessment of member needs, ongoing care monitoring, evaluation and tailored interventions are utilized to help prevent and/or minimize the effects of the member’s conditions. This occurs through a multidisciplinary approach to care coordination, continuity of care, as well as supporting self-management and self-determination for members enrolled in this program. The goal of these efforts is to empower members to assume greater responsibility for their health, and to realize improvement in population health outcomes and a reduction in avoidable costs.

Goal: The goal of disease management is to help members manage a chronic disease with support from FHN, regain optimum health or improved functional capability in the right setting in a cost effective manner through:

1. Enhancement of member self-management skills with encouragement to take control of their health and make better health decisions
2. Reducing intensity and frequency of disease-related symptoms
3. Enhancement of member quality of life, satisfaction, and functional status
4. Improving member adherence to the practitioner’s treatment plan

5. Encouragement of member/caregiver’s communication with their practitioner and interdisciplinary team in order to better understand their condition

6. Facilitation of appropriate health care resource utilization

7. Reduction in avoidable hospitalizations, emergency room visits, and associated costs related to the disease; and reduce work absenteeism and medical claim costs

8. Facilitating closure of member’s condition specific gaps in care

9. Tracking and reporting episodes of illness at the member and aggregate level for the purpose of identifying trends, and measuring medical outcomes and financial impact.

10. Serving as a liaison to community resources regarding options and services not covered by the benefit plan.

The DM program is designed to help patients with diabetes and asthma live longer, healthier lives. Many members with chronic conditions often don’t follow their prescribed treatment regimen. However, consistent and personalized communication with members about their disease and how to manage it can make a difference in producing positive clinical outcomes.

It is very difficult, if not impossible, for busy practitioner’s practices to manage and sustain the level of ongoing personal outreach with their patients that this program provides. FHN’s program does not replace or change current practitioner relationships with members; rather, the care coordinator works with the practitioner to ensure that members stay healthy between their appointments and are accountable for their health.

**How it works:**

- **Telephonic Support.** A care coordinator trained in outpatient disease management provides telephonic support to your patients by regularly contacting and encouraging them to follow your instructions for medication compliance, exercise, diet and lab work, as well as office follow-ups.

- **Physician Reports.** After a member’s consent into the program and an Initial Primary Assessment is completed, the practitioner will receive an initial care plan for review with subsequent updates of a member’s progress and activity. Immediate notification will occur if the nurse notices any emergent problems that require quick attention. Diabetics, in the program, have Genesis glucometers with a micro-chip test strip that will allow the practitioner to access a member’s daily blood sugars and adherence to daily self-testing via a website portal.
Primary Care Provider (PCP) Referrals: One of the methods to enroll members to Disease Management Program is based on direct referral system from the PCPs. Care Coordination team can be contacted via email at: carecoordinationreferral@myfhn.com.

**Complex Case Management**

Under the FHN plan, Complex Care Management (CCM) is the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the health care system to facilitate effective, timely, high quality and cost efficient delivery of care, services and equipment as appropriate to health care needs. Complex Case Management is initiated by FHN as early as possible following onset or diagnosis and continues throughout the course of condition, illness or injury.

The Complex Case Management Program is facilitated by a nurse care coordinator. The care coordinator provides goal-oriented, individualized, systematic support through ongoing assessment, planning, advocacy, monitoring activities, coordination, and linkage with other health care providers and community resources. The services and activities performed in the complex case management program are reviewed, monitored, and documented to reflect the member’s progress toward individual goals.

Identification of Members for Complex Case Management:

Family Health Network is using many methods to identify members who could benefit from this program. Business Insight is using all available data like claims, pharmacy and labs to calculate risk score. Additionally the Health Risk Survey (HRS) and the Initial Primary Assessment are done as a sources of identification followed by member self-referral, provider and vendor referrals, and other sources such as nurse hotline referral, intra-departmental and inter-departmental referrals (i.e., Disease Management, Utilization Management).

Practitioners can contact FHN Care Coordination team to refer members to the program by email at: carecoordinationreferral@myfhn.com. One of the managers will respond within 24 hours with additional information and Care Coordinator assigned to follow up with the member. Practitioner engagement is an important part of the Interdisciplinary Care Team. An Interdisciplinary Care Team is available as needed to assist the care coordinator.
Case Management Program

Medical Home

FHN has a network of practitioners and providers that serve as Anchor Health Homes for our Members. These medical homes may include FQHCs, CMHCs, and multi-specialty PCP-centered medical groups, private practice PCP offices, and nurse practitioner-led clinics. Anchor Health Homes are patient-centered in approach with the capacity to provide access to a personal clinician and care team that offers individualized, high quality comprehensive primary care and coordinates specialty and other needed services. Anchor Health Homes will demonstrate competence in the following areas:

• Effective care coordination
• Family and caregiver involvement
• Health promotion and Wellness programs
• Self-management strategies
• Chronic Health Condition management

Anchor Health Homes provide all PCP services and be supported by Interdisciplinary Care Teams and Health Information Technology. FHN will support Medical Homes and the integration of behavioral and physical health care at FQHCs, CMHCs, and high volume Providers that agree to this approach.

Assessing Medical Homes

FHN provides a PCP self-assessment tool to PCP practices that do not have Patient Centered Medical Home (PCMH) accreditation under NCQA or the Joint Commission to self-assess, and ensures that all PCP practices self-assess the following:

• Organizational capacity
• Chronic Health Management approaches
• Coordination and continuity of care processes
• Community outreach, knowledge, and connections
• Data management; and
• Quality improvement/change

Ranking Medical Homes

FHN will rank PCP practices into four (4) Medical Home levels and provide incentives for those practices to become highly functioning comprehensive Medical Homes

• Level 1—Basic Medical Home
• Level 2—Intermediate Medical Home
• Level 3—Advanced Medical Home
• Level 4—Comprehensive Medical Home
Below is the care coordination criteria based by medical home ranking:

The provider or group will be considered a Level 1 Basic Medical Home until initiating the process for self-evaluation and assessment demonstrates capacity to meet the requirements of a higher level medical home.

In order for provider group to be eligible for Level 2 – Intermediate Medical Home ranking, and to receive $4 PMPM care coordination fee, all requirements below must be met.

- Staff hired by the provider site working with FHN membership in coordination with FHN’s care coordination and quality team. (i.e., outreach worker, social worker, nurse coordinator, other staff located at the provider site) Staff to member ratio 1:5,000 or FTE equivalent.

- Collaborates with interdisciplinary team to acknowledge FHN care plan via PCP signature, and reinforces care plan goals during office visits. Meets 75% compliance on PCP care plan collaboration (reported monthly by FHN).

- Identification of members with chronic stable diseases and a) implementation of guideline-based care and b) referral to care coordination as warranted. Measured by HEDIS compliance, asthma and diabetes adherence rates.

- Timely collaboration with specialists (including medical, physical medicine, surgical and behavioral health) to ensure safe effective and seamless continuum of care.

- Conduct outreach to close gaps in care identified in the HEDIS Missing Services Reports and report monthly.

- Submit medical records to FHN when requested to perform prospective or retrospective reviews of medical records for utilization management purposes.

- Completed Self-Assessment Tool.

If groups fail to meet the criteria as outlined above for at least 60 consecutive days, the care coordination fee will be reduced by $4PMPM and the group is considered Level 1 Basic.

In order for provider groups to be eligible for Level 3 Advanced Medical Home ranking and receive $6 PMPM care coordination fee, all requirements below must be met.

- Meets all requirements listed above

- Report monthly on the number of members that have a follow-up with any provider within 14 days following Emergency department visit or an inpatient discharge. Include date and reason for admission.

- Conduct outreach and schedule PCP visits for enrollees without a Health Risk Survey or Health Risk Assessment identified in the HRS/HRA monthly no contact report. Report on the # of enrollees that have been reached and have a scheduled PCP appointment.
• Perform perinatal intake, complete, and submit FHN OB notification report, documenting new diagnosis of pregnancy in FHN membership, to FHN contact on a monthly basis.

• Will provide education to pregnant members during their last trimester on the importance of adding a newborn to the mother’s case to promote timely quality care and continuity of care for the family unit.

• Use reports provided, collaborate with health plan to engage members that have been stratified to high and moderate risk categories in complex care or disease management programs.

• Completed self-assessment tool

If group fails to meet the criteria as outlined above for at least 60 consecutive days, the care coordination fee will be reduced by $2PMPM and the group is considered a Level 2 – Intermediate.

In order for provider groups to be eligible as a Level 4 Comprehensive Medical Home “Anchor Health Home” and to receive $8 PMPM care coordination fee, all requirements below must be met.

• Meets all requirements listed above

• Has medical home recognition/accreditation or as designated by FHN

• Must attend two day training on FHN’s care management system and model of care

• Perform Health Risk Surveys and document in FHN’s care management system

• Must document into FHN’s care management system and keep accurate and updated notes

• Must have a minimum membership of 2,000

If group fails to meet the criteria as outlined above for at least 60 consecutive days, the care coordination fee will be reduced by $2PMPM and the group is considered a Level 3 Advanced.

FHN reserves the right to reassess at any time.

**Medical Home Education**

FHN educates Medical Home teams on methods to improve care capacity and capabilities to provide Wellness Programs, preventive care, management of Chronic Health Conditions and coordination and continuity of care through office visits, practitioner and provider manuals, newsletters, mailings and website updates.
Medical Home Monitoring

FHN will provide oversight and monitoring and support to assess Medical Home performance based on performance metrics that align with our contract with HFS and the standard and accepted PCMH criteria. Upon request by the practitioner or provider, FHN will provide general guidance or access to resources each individual practice may choose to utilize as part of its PCMH transformation and improvement efforts.

Utilization Management

The UM Program seeks to:

1. Coordinate the delivery of care that is aligned with evidence-based standards.
2. Promote the efficient utilization of services/resources.
3. Monitor patterns of utilization over time to reduce variations in practitioner and provider practice and inconsistent use of evidence-based practice guidelines.
4. Improve continuity of care and members outcomes through effective care management.
5. Enhance practitioner and members satisfaction by facilitating access, enhancing awareness of medical necessity and appropriateness of services.

UM staff are available 24/7 for elective admissions, medical and BH inpatient notifications. All other UM issues can be communicated via fax (312-416-4538) or by leaving a confidential voicemail by calling 1-866-346-4968 to be transferred to the UM manager who can assist you further.

Medical Necessity Criteria

Utilization Management decisions are made by qualified healthcare professionals, who have the knowledge and skills to assess clinical information, evaluate working diagnoses, and evaluate proposed treatment plans. Evidence-based criteria (InterQual level of Care) is referenced by the UM/Transition of Care Coordinators (TCC) and physician reviewers to determine medical necessity and approval of service requests. If an UM/TCC is unable to apply InterQual criteria, the request is referred to the Medical Director or physician reviewer. The Medical Director/physician reviewer may reference other criteria such as those obtained from the National Guideline Clearinghouse. He/she may also refer the review to Board Certified Consultants if the request requires same or similar specialty review.

For Substance Use Disorder in accordance to Illinois State Law under HB1530 Enrolled Public Act 097-0437 Section 5, the Illinois Insurance Code Section 370c.1 (on page 7, number 3) states: “Medical necessity determinations for Substance Use Disorders shall be in accordance with appropriate patient placement criteria established by the American Society of Addiction Medicine (ASAM)” (Illinois General Assembly - Full Text of Public Act 097-0437. (n.d.)). All medical and
behavioral health criteria used by FHN, FHN delegates and sub-delegates are subject to annual review and approval by the QM/UM Committee.

For situations where nationally recognized criteria are not available FHN may utilize additional guidelines created by FHN if the guidelines are reviewed and approved by the QM/UM Committee, including any procedures for their use. The development process of the criteria includes input from appropriate specialists and scientific medical evidence.

FHN practitioners are encouraged to participate in peer to peer discussions in support of the treatment plans or services they request as the information presented in those discussions greatly contribute to the decision making process. The criteria referenced to make medical necessity decisions are available to practitioners and providers upon request by contacting FHN’s UM department. The criteria may be distributed via fax, mail or e-mail. Member and practitioner and provider notices also contain information on the availability of review criteria.

The FHN Medical Director oversees all UM activities and makes final determinations on denial of services.

Inter-rater reliability (IRR) evaluation assures the consistent application of the utilization criteria and is conducted by testing the UM staff and the Medical Director/physician reviewers. IRR results are reported to the QM/UM Committee.

**How to Receive UM Criteria**

We want to be transparent for how we make decisions and the criteria used to make those decisions, because they are evidence-based. We tell you in denial letters the specific criteria that we use to make decisions. You can get a copy of those specific criteria by calling 1-888-346-4968 to be directed to a Utilization Management staff member who can assist you with your request.

**Preservice Review**

Preservice (prior authorization or prospective) utilization review is the process by which medical/behavioral healthcare services are assessed for medical appropriateness prior to their delivery using nationally recognized criteria. To initiate a preservice request, the practitioner or provider must submit a complete FHN FHP/ACA Authorization form, available on FHN’s website, by:

- Fax
- Phone
- FTP (ability to transfer files electronically)
- Valence Health portal (Note: This option is available to certain Medical Groups)

Note: All preservice requests must be accompanied by complete supporting information for timely processing and decision making. If an incomplete FHP/ACA
Authorization form is received, FHN will ask that the provider resubmit the request with the specific information requested and advise the current request will be closed.

Concurrent Review

Concurrent review is the process that evaluates the appropriateness and medical necessity of ongoing medical care and services, usually while inpatient. Concurrent review includes evaluation of the following:

- The medical necessity of services being rendered;
- The patient’s condition;
- The place of service and/or level of care;
- The quality of services being provided;
- Any anticipated discharge needs;
- Any changes that may necessitate modifications to the treatment plan; and,

The frequency of concurrent review is case specific. UM decisions - approved or denied- are made within twenty four (24) hours of the receipt of the request for continued hospital stays or ongoing services. The practitioner or provider may be allowed an additional forty-eight (48) hours to provide sufficient information if necessary.

FHN is responsible for gathering appropriate clinical information for all on-going services, both in the inpatient and outpatient settings. Sources of relevant clinical information utilized to make the decision, such as:

- Medical records (Note: Only the relevant sections of the medical record pertaining to the admission)
- Practitioner progress note documentation
- Diagnostic lab test results
- Imaging results
- Member feedback, or
- Other relevant information provided contributing to the review decision

Retrospective Review

Retrospective review is the process by which medical care and services are evaluated for medical necessity and appropriateness of care after the services have been rendered no later than 90 calendar days after the services and in which utilization review was not conducted. The retrospective review is completed within thirty (30) calendar days of receipt of the request. If the review results in a denial by the physician reviewer, the practitioner and/or provider is notified within thirty (30) calendar days of receipt of the request. FHN members are not held financially responsible for payment of retrospective services.
FHN is responsible for collecting all pertinent information regarding level of care, outpatient surgeries and twenty-three (23) hour observation stays upon notification and will make final determination of medical necessity and will determine final approval of services. Neither FHN nor its delegates will request the entire medical record but only the sections relevant to the retrospective review request.

**Adverse Determinations and Appeals Notifications**

All service requests that do not meet nationally recognized medical necessity criteria or are considered experimental/investigational are reviewed by the FHN Medical Director or physician reviewer. Behavioral Health adverse determinations are rendered by the delegate Behavioral Health Medical Director or physician reviewer.

For all denied requests, UM staff verbally notifies members, practitioners and providers of the appeal process. The member, practitioner and provider are issued written notification of denial and appeals rights by certified mail. Upon request, the denial notification may be given via secure fax or email. The treating practitioner is always allowed the opportunity to discuss medical and behavioral healthcare UM adverse determination decisions with a physician reviewer. Adverse determinations are never based on the receipt of any financial incentive to the health plan, health plan employees, medical groups, or providers. Adverse determinations are never based on the receipt of any financial incentive to the health plan, health plan employees, medical groups, or providers. UM decision making is based only on appropriateness of care and service and existence of coverage. FHN does not specifically reward practitioners or other individuals for issuing denials of coverage.

**Second & Third Opinions**

The FHN member has the right to request a second and third opinion through their PCP, Medical Group or by calling member services. The practitioner whom the member wishes to consult with for a second or third opinion must be a contracted FHN practitioner. If a particular specialist is not available in network, FHN will approve the consultation with that out of network specialist for the second and third opinion only.

**Out of Network Services**

Out of plan services are those services rendered by practitioners and providers that are not contracted by FHN. Utilization management functions and processes are unchanged for services requested by non-contracted practitioners and providers. If hospitalized, members are transferred to a contracted provider when the out of plan practitioner and the PCP agree the member is stable for transfer. Trending of out of plan practitioner and providers utilization help to determine need for network expansion.
Out of plan elective services, or preservice requests, are those services requested usually on an outpatient basis by non-FHN practitioners. UM review processes are unchanged for this type of service. Elective care out of the area is not a covered benefit. Urgent and emergent care out of area is a covered benefit and must be reported to FHN for UM review.

**Continuity of Care**

Prospective and new members with ongoing services provided by out of network practitioners and providers are provided continuity of care during a ninety (90)-day transition period. FHN will also provide continuity of care for those members’ whose practitioner is terminating their contract with FHN. FHN will engage the member to develop a safe transition plan to a FHN contracted practitioner and provider. The Evaluation of Continuity and Coordination of Care policy has complete details and will be provided upon request by treating practitioners and providers.

**Discharge Follow-up**

Within three (3) days after discharge from hospital and/or ER visit the member will receive a follow-up call from the Transition of Care Coordinator (TCC). TCC communicates the needed for services with the PCP. The purpose of the call is to determine:

- All needed services are in place (e.g. ordered DME has been delivered)
- The member’s health status.
- Follow-up appointments with PCPs or specialists have been scheduled.
- This insure appropriate quality and medically necessary care in the most appropriate setting and that all FHN s receive all appropriate care in the least restrictive setting. FHN will utilize available sources to detect potential over/under utilization.

**Behavioral Health**

FHN and contracted partners will provide or manage the following behavioral health services, which are Covered Services:

- Inpatient psychiatric or substance abuse services that are provided in general hospital medical units;
- Inpatient psychiatric services provided in a hospital that is a psychiatric hospital or a distinct psychiatric unit;
- Inpatient acute alcoholism and substance abuse treatment (detoxification);
- Hospital-based organized clinic services referred to as outpatient treatment psychiatric services for Type A and Type B Psychiatric Clinic Services;
• Behavioral health services provided by FQHCs, RHCs, and Physicians, including psychiatrists; and
• Laboratory services provided on an outpatient basis for behavioral health, even if ordered by a behavioral health provider practitioner in connection with the provision of treatment that is excluded from Covered Services.

FHN contracts and maintains a behavioral health network of providers which may be contacted through FHN’s Member Services or directly at 800-753-5456 (24 hours a day). Members may self-refer or they may be referred by their PCP for assignment of a behavioral health provider.

**Pharmacy**

Drug therapy is an essential part of your patient’s comprehensive treatment program. One of the goals of Family Health Network is to provide our members with the prescription benefits that are high quality and cost effective to improve their personal outcomes.

In order to provide easy access to pharmacy products, Family Health Network (FHN) has contracted with a national Pharmacy Benefits Manager (PBM), CVS Caremark. FHN has delegated formulary management, provider contracting, compliance and quality monitoring to the PBM.

The CVS Caremark National P&T Committee is responsible for the formulary development process. The P&T Committee is an external advisory body of experts from across the United States, composed of 19 independent health care professionals including 16 physician and 3 pharmacists, all who have broad clinical backgrounds and/or academic expertise regarding prescription drugs. The CVS Caremark National P&T Committee bases decision on scientific evidence, standards of practice, peer-reviewed medical literature, accepted clinical practice guidelines and other appropriate information. The standard formulary is reviewed annually.

Updated pharmacy information can be found on the website [www.fhnchicago.com](http://www.fhnchicago.com)

The website contains the following information:

• FHN Pharmacy Formulary, including restrictions and preferences along with pharmacy management procedures
• Quick Reference List (QRL) – a summary of covered medications by category
• Pharmacy locator- an easy way to locate In-network pharmacies by name, city, state or zip code
  – The pharmacy network serving our members is very extensive and includes many clinic pharmacies, local drug stores, and hospital outpatient pharmacies as well as major chain retail stores.
• Over-the-Counter list – a list of medications normally sold over the counter but that require a prescription for coverage by the plan

• Formulary Exception Request form and instructions for submission to CVS Caremark
  – An electronic Formulary Exception request is available on-line for submission directly to CVS Caremark
  – Alternatively prescribers can call Formulary Exception request at (855) 293-4114
  – Members can submit a Formulary Exception request, but providers will be contacted for clinical information to complete this process
  – CVS Caremark will notify prescribers and members if a Formulary Exception is not approved. This will enable the prescriber to prescribe an alternative medication.

• Drug Reference and Interactions Tool that provides information regarding
  – Drug interactions
  – Side effects and risks of drugs
  – Generic substitutions available for a brand name drug

• 90-Day Medication list
  – Practitioners are encouraged to write maintenance prescriptions for 90-day supply at retail if it is likely the member will be taking the medication for an extended period of time.
  – Complete list is found on our Pharmacy Web page

• Updates and Notices – posting of formulary updates and recall notices will be posted here

Formulary Management

Formulary management is an integrated member care process that enables practitioners, pharmacists, and other allied health professionals the opportunity to work together to promote clinically sound, cost effective medication therapy.

The most current Family Health Network Formulary contains both prescription drugs and Over-the-Counter drugs. It is located on the FHN website. Formulary Medications do not require Exception Form. Family Health Network typically covers a 30 day supply of medication, however 90 day supply is covered for certain maintenance medications at retail locations. Information on medication coverage and formulary updates are shared with prescribers throughout the year both by mail and via FAX. Formulary update documents are also available on the Family Health Network website at www.fhnchicago.com under “For Provider”. The Formulary document describes limitations on drugs including
age limits, quantity limits, step therapy, and Formulary Exception requirements. Prescribers will be notified of all “negative formulary changes” via letter if any of their patients are currently prescribed a medication being removed from the formulary or are undergoing criteria changes such as quantity limits. Prescribers can complete a Formulary Exception Form if they believe the member would be adversely affected by the change in formulary. Questions regarding the formulary medication should be directed to CVS Caremark customer service at 855-293-4114.

**Generic Medications** – According to the Food and Drug Administration (FDA), a generic drug is a medication that has the same active ingredients, dosage strength, and method of administration as its brand name counterpart. Generic medications must meet the same quality standards as brand name medications. The FDA sets quality standards and reviews all generic medications before they are marketed. Many generic drugs are made by the same companies that make the brand name products. Generic forms of medications will be substituted as they become available unless otherwise designated. CVS Caremark may grant an exception to the generic substitution. If for any reason the prescriber feels a brand medication is needed, they can follow the exception process and submit a Formulary Exception request to CVS Caremark as described above.

**Formulary Medications requiring Exception Form** – These medications are most often drugs with safety concerns or with a high potential for inappropriate use and demonstrate. The member must have an adequate trial failure of a first line medication and demonstrate medical necessity before a Formulary Exception may be approved.

**Non Formulary Medications** – These medications may be considered for exception when Formulary medications are not appropriate for a particular member. Requests for Formulary exceptions may be completed by contacting FHN/Caremark Customer Service at 1-855-293-4114. Clinical evidence documentation from prescriber should be submitted, when a non-formulary medication exception request is needed.

**Quantity Limits** – Quantity limits are designed to limit the use of selected drugs for quality and safety reasons. The quantity limit for each drug is supported by drug studies and by actively practicing doctors. An exception request is required to exceed quantity limits by completing the PA process.

**Step Therapy** – Step therapy is the practice of beginning drug therapy for a medical condition with drugs considered first-line for safety and cost-effectiveness, then progressing to other drugs that may have more side effects or risks or that are more costly. You will be notified by CVS Caremark if Step therapy is indicated. The same practice is in effect for therapeutic interchange of medications.

**Specialty medication** – Drugs used to treat serious chronic conditions. Specialty medications are usually high-cost, self-administered, injectable, oral, or infused
drugs. These drugs typically require special storage and handling, and are typically not readily available at a local pharmacy. Specialty medications may also have side effects that require monitoring by a healthcare professional.

**High-Risk Medications (HRM)** – A medication that has an inherent narrow therapeutic index and/or has the potential to cause serious adverse events when not used appropriately. The Beers List is used as a guideline for health care professionals to help improve the safety of prescribing medications for older adults. It contains lists of medications that may pose potential risks while outweighing potential benefits for people ages 65 and older. By considering this information during routine care and observing safe practices, doctors can help prevent or minimize side effects.

**Transition Fill** – A transition refill, also known as a transition fill, is typically a one-time, 30-day supply of a drug that Family Health Network drug will cover when the member is new to the plan. Transition fills let the member get temporary coverage for drugs that aren’t on the formulary or that have restrictions on them. An exception request can be filled out for continues coverage.

**90 Day Medication Coverage** – To improve adherence to medication, FHN encourages prescribers to prescribe 90 Day supply of maintenance medications once the medication has proven beneficial for the member. The following categories have qualifying medications available.

- Antidiabetics
- Antihypertensives
- Cardiovascular
- Contraceptives
- Folic Acid
- Prenatal Vitamins
- Thyroid agents

**Lost Medications** – If a member reports medication has been lost and needs an early refill, the member or prescriber can submit a request for a refill override by contacting CVS Caremark Customer Service.

**Stolen Medications** – If a member reports medication has been stolen and needs an early refill, specific information will be required in order to receive approval for replacement medication.

- **Controlled Substance, i.e. Narcotics** – If the medication stolen is a controlled substance, such as oxycodone, hydrocodone, alprazolam, etc. the member will need to submit and Official Police Report along with the request for an early refill replacement. The request can be faxed to 312-257-2057, making sure to include the following information: patient’s name, patient’s ID number medication(s) requested and the official police report.
• Non Controlled Substance – If a member reports medications has been stolen and needs an early refill, the member or their physician can submit a request for early refill override

CVS Caremark Customer Service: 1-855-293-4114

CVS Caremark is available 365 days per year and 24 hours per day. The Pharmacy Authorization Provider and Practitioner help line will answer inquiries regarding claims processing; benefit coverage, claim submission and payment, and Formulary Exception.

Member Rights and Responsibilities

FHN Members have the right to:

• Be treated with respect and recognition with due consideration for the Member’s dignity and right to privacy;

• Receive information on available treatment options and alternatives, and presented in a manner appropriate to the Member’s condition and ability to understand;

• Participate in decisions with practitioners regarding the Member’s health care, including the right to refuse treatment;

• Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

• Request and receive a copy of the Member’s medical records, and to request that they be amended or corrected; and

• Exercise the Member’s rights, and that the exercise of those rights will not adversely affect the way the Member is treated.

• Receive care consistent with sound nursing and medical practices, have candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

• Share in deciding the type of care they will receive and information about the organization and its practitioners and providers need in order to provide care with persons under the age of 18 who are married, pregnant, or have a child, also having this right.

• Request information regarding MCO and health care facility licensure.

• Request information about practitioners of health care services, including education, board certification, and re-certification.

• Request information regarding provider and practitioners bills and payments.

• Make a “living will” to plan for the kind of care they want if they become seriously ill or injured.
• Expect their records to be treated confidentially and to not be released without their permission.
• Receive information about FHN, its services and providers and practitioners.
• Choose a family doctor from the FHN network and to switch to another FHN doctor at any time.
• Make a complaint, appeal, or file a grievance to FHN, about the organization or the care it provides.
• Not be terminated from FHN due to high utilization of services, diminished mental capacity, or uncooperative/disruptive behavior resulting from the member’s special needs.
• Make recommendation regarding the organization’s member rights and responsibilities policy.
• Have an open conversation of appropriate or necessary medical treatment choices for their conditions, regardless of the cost or benefit coverage. RR1A4

FHN Members have the responsibility to:
• Treat doctors, staff and FHN employees with dignity and respect.
• Supply information to the extent possible, that FHN and our doctors need to provide care.
• Make and keep appointments and be on time. A member will always call with as much notice as possible if they need to cancel an appointment or if they will be late.
• Get referrals from their FHN doctor before going to a specialist, hospital or another health care provider.
• Notify their FHN doctor as soon as possible after receiving emergency room services.
• Explain their health problem and symptoms to the doctor and to ask questions.
• Follow their doctor’s treatment plan and instructions for care that they have agreed to with their doctors.
• Discuss with their FHN doctor any circumstances that could prevent them from following doctor’s instructions.
• Become involved in their health care – get the information they need and take part in any treatment decisions.
• Consider the outcome of refusing treatment recommended by a doctor.
• Understand their specific health problems while being able to participate in developing a mutually agreed-upon treatment goal that is possible.
• Learn and follow the FHN policies in their Member Handbook.
  • Carry their FHN identification card with them at all times and immediately report any lost or stolen cards to one of the FHN Member Services Representatives.
• Call one of the FHN Member Services Representatives if they have a problem and need help.
• Respect the privacy of other people waiting to get health care services.
• Make a “living will” to indicate their wishes concerning the type of care they want if they become seriously ill or injured.

Fraud, Waste and Abuse

Family Health Network (FHN) is committed to ensuring that all employees (temporary and permanent), including management, and First Tier, Downstream, or Related entities (FDR) comply with all applicable federal and state laws and regulations, and other contractual requirements designed to prevent fraud, waste, and abuse (FWA).

It is a federal crime to defraud any government program. Individuals who commit fraud may be imprisoned, fined, or both. Criminal convictions typically result in restitution, fines, and possible exclusion from federal programs such as Medicaid or Medicare.

Prevention, early detection, and timely resolution are essential elements necessary to effectively discourage FWA activities. Therefore, FHN will provide to all employees, governing body members, and FDR entities, information regarding various laws, regulations, and policies established to prevent, detect, and report issues applicable to FWA.

First Tier entities are those who have contracted with FHN to provide administrative or health care services to our FHN members, respectively. They include consultants, contracted providers and practitioners delegated entities, and vendors. Downstream entities are companies that are contracted with a First Tier entity to provide administrative or health care services on behalf of FHN. A Related entity is a party that is connected to FHN by common ownership or control and performs some of the management functions or delegation.

What is Fraud, Waste, and Abuse?

Fraud is generally defined as the intentional deception, false statement, or misrepresentation in an effort to receive an unauthorized benefit. For example, fraud in the provision of health care can involve:

• Billing for medical services, procedures, and /or supplies that weren’t ordered or provided
• Billing for durable medical equipment items that weren’t ordered or provided
• Providing services or items a person doesn’t need based on his or her medical history
• Intentional misrepresentation by manipulating:
• The dates on which services and/or treatments were rendered,
• The medical record of service,
• Condition treated or diagnosed,
• Charges or reimbursement
• Identity of provider/practitioner or recipient of services
• “Unbundling” or “up coding”
• Balance billing a Medicaid member for Medicaid covered services; or asking a member to pay the difference between discounted fees, negotiated fees, and the practitioner’s and provider’s usual and customary charges.
• Concealing a patient’s misuse of Family Health Network’s identification card
• Failure to report a patient’s forgery/alteration of a prescription
• “Doctor shopping” – when a patient who may or may not have a legitimate physical ailment goes from doctor to doctor to obtain multiple prescriptions for narcotic painkillers

**Waste** is defined as the thoughtless or careless expenditure, consumption, mismanagement, use, or squandering of resources owned and operated by FHN to the detriment of FHN. Waste involving the provision of health care refers to health care that is “ineffective”. It can also include fraud and abuse.

**Abuse** is defined as practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices.

The key distinctions between fraud and abuse are intent and knowledge. Waste and abuse allegations can escalate to a fraud investigation if a pattern of intent is determined.

**Report Fraud, Waste, and Abuse**

If you suspect cases of fraud, waste, or abuse you can report it to FHN and we will investigate. No director, officer, employee, volunteer, or contractor who in good faith reports illegal, unethical, or otherwise inappropriate acts, such as violations of applicable laws and/or FHN policies shall suffer harassment, intimidation, retaliation or adverse employment consequences.

FHN maintains a zero-tolerance policy for retaliation or retribution against anyone who reports or participates in an investigation of a compliance concern. Any employee who retaliates against someone who has reported a violation in good faith is subject to disciplinary action up to and including termination of employment.

**How to Report Fraud, Waste, and Abuse**

All FDRs are required to report actual or suspected fraud, waste or abuse. To report suspected fraud, waste, or abuse, you can contact the FHN Compliance Department.

**Compliance Department Contact Information**

Confidential Compliance Reporting line 312-880-1635
E-mail: compliance@myfhn.com
Mail: Family Health Network
Attention: Chief Compliance Officer
CONFIDENTIAL
322 S. Green Street, Suite 400
Chicago, IL 60607

You may remain anonymous if you prefer. All information received or discovered by FHN will be treated as confidential, and the results of investigations will be discussed only with persons having a legitimate reason to receive the information.

Fraud, Waste, and Abuse Training and Education
To comply with the Centers for Medicare and Medicaid (CMS) requirements that all contracted entities provide fraud, waste, and abuse training to their employees, governing body members, and FDRs, FHN will provide FWA training within 90 days of their start date, as well as on an annual basis.

Health, Safety, Welfare & Monitoring- including Abuse, Neglect and Exploitation
When should you report to the hotline numbers?

- If you see someone hitting or otherwise injuring a person in a domestic setting or in a facility
- If you see someone with an injury that does not appear to be caused by an accident
- If someone tells you they have been harmed by their caregiver
- If someone appears to be neglected, emotionally abused, or financially exploited

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<th>Who to call</th>
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| Adult Protective Services  
  Adults 18 and older with disabilities or adults 60 years of age and older | 866-800-1409  
  711 (TTY)                                    |
| Family Health Network (FHN)  
  Member/Provider Services                              | 866-871-2305                  |
| Illinois Department of Public Health  
  An adult over the age of 60 years of age in a Nursing Home | 800-252-4343                  |
| Supportive Living Facility  
  Members residing in a SLF                               | 800-226-0768                  |
| Department of Children & Family Services  
  Children under the age of 18                           | 800-252-2873  
  711 (TTY)                                    |
| Office of Inspector General (OIG)                         | 800-368-1463                  |
Cultural Competency

Family Health Network has a Cultural Competency Workgroup created to promote education and awareness of the diversity in our membership. The workgroup has created a Cultural Competency Plan and policy that is reviewed on a periodic basis. We also provide cultural competency awareness training to all new hires, temporary help and consultants. Some of the metrics we measure include: practitioner demographics including secondary languages, call center requests for language interpreter and languages requested, and employee race and languages spoken.

Practitioners and subcontractors are required to ensure all members are treated with respect and awareness of their cultural needs. If you would like a copy of the Cultural Competency Work plan please contact your Network Management Specialist.

Member Grievance

A grievance is defined as any expression of dissatisfaction by a Member, including complaints and requests for disenrollment, about any matter other than a matter that is properly the subject of an Appeal.

Members have the right to file a grievance. A grievance may also be filed on the member’s behalf by an Authorized Representative (which could be a practitioner) with the member’s written consent. Grievances may be submitted verbally or in writing. If the member wishes to use a representative, then he or she must complete an Authorized Representative Form.

Grievances are reviewed by Family Health Network, and a decision will be made within 90 days of receiving the grievance.

If the member remains dissatisfied with Family Health Network’s decision on their grievance, the member may request a review by the Illinois Department of Healthcare and Family Services.

Member Appeals

An appeal is defined as a request for review of a decision made by FHN with respect to an adverse organizational determination. Members have the right to file an appeal if they are dissatisfied with a decision made by FHN to terminate, suspend, reduce or not provide covered services to a member. If you are filing on behalf of a member, you must obtain the written consent, either via letter or using the Authorized Representative form, of the member in order to act on his/her behalf. The Authorized Representative form can be found at: www.fhnchicago.com/members/member-forms
If you believe that waiting the standard time to decide the appeal could seriously risk the life, health or well-being of the member, you may request an expedited appeal.

Standard appeals must be filed within 60 days from the date of the notice, and a decision will be rendered within 15 days of receipt of the filed appeal. Expedited appeal decisions will be rendered within 24 hours.

Medical appeals can be submitted by fax to 312-257-2060 or to the address listed below.

To request and submit member medical appeals, contact:

**Family Health Network**  
Grievance and Appeals  
322 S. Green Street Suite 400  
Chicago, IL 60607  
Phone: 1-888-346-4968

To request a pharmacy appeal contact:

**CVS Caremark**  
Prescription Claim Appeals  
MC 109, P.O. Box 52084  
Phoenix, AZ 85072-2084  
Fax: 1-866-443-1172