## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO WE ARE</td>
<td>4-5</td>
</tr>
<tr>
<td>- About our Plan</td>
<td>4</td>
</tr>
<tr>
<td>- About Our Management Partner</td>
<td>4</td>
</tr>
<tr>
<td>- About this Guide</td>
<td>5</td>
</tr>
<tr>
<td>- Contact</td>
<td>5</td>
</tr>
<tr>
<td>ABOUT PROVIDER RELATIONS</td>
<td>6</td>
</tr>
<tr>
<td>PLAN ELIGIBILITY</td>
<td>6-9</td>
</tr>
<tr>
<td>- Eligibility</td>
<td>6</td>
</tr>
<tr>
<td>- Verifying Eligibility</td>
<td>7</td>
</tr>
<tr>
<td>- Service Area</td>
<td>7</td>
</tr>
<tr>
<td>- Services Covered</td>
<td>8-9</td>
</tr>
<tr>
<td>MEMBERS RIGHTS AND RESPONSIBILITIES</td>
<td>10-11</td>
</tr>
<tr>
<td>ENROLLMENT IN A MANAGED LONG TERM PLAN</td>
<td>12-15</td>
</tr>
<tr>
<td>- Enrollment Process</td>
<td>12-13</td>
</tr>
<tr>
<td>- Disenrollment Policies</td>
<td>14-15</td>
</tr>
<tr>
<td>PROVIDER RESPONSIBILITIES AND POLICIES</td>
<td>16-23</td>
</tr>
<tr>
<td>- Standard of Care</td>
<td>16</td>
</tr>
<tr>
<td>- Standards of Conduct</td>
<td>16-18</td>
</tr>
<tr>
<td>- Policies</td>
<td>19-22</td>
</tr>
<tr>
<td>- Credentialing and Termination</td>
<td>22-23</td>
</tr>
<tr>
<td>CARE MANAGEMENT</td>
<td>24-25</td>
</tr>
<tr>
<td>- Role of Care Manager</td>
<td>24</td>
</tr>
<tr>
<td>- Transportation Guidelines</td>
<td>24</td>
</tr>
<tr>
<td>- Emergency Services</td>
<td>25</td>
</tr>
<tr>
<td>SERVICE AUTHORIZATIONS</td>
<td>26-28</td>
</tr>
<tr>
<td>- Prior Authorization</td>
<td>26</td>
</tr>
<tr>
<td>- Service Authorization</td>
<td>26</td>
</tr>
<tr>
<td>- Concurrent Review and Discharge Planning Requests</td>
<td>26-27</td>
</tr>
<tr>
<td>- Retrospective Review</td>
<td>27</td>
</tr>
<tr>
<td>- Services That Require Physician Authorization</td>
<td>28</td>
</tr>
<tr>
<td>CLAIMS MANAGEMENT</td>
<td>29-31</td>
</tr>
<tr>
<td>- Provider Billing for Services</td>
<td>29</td>
</tr>
<tr>
<td>- Instructions and all information required for a clean or complete claim</td>
<td>29-31</td>
</tr>
<tr>
<td>PROVIDER APPEALS AND GRIEVANCE</td>
<td>32</td>
</tr>
<tr>
<td>- Policies and Procedures that cover the Provider Complaint System</td>
<td>32</td>
</tr>
<tr>
<td>- External Appeals</td>
<td>32</td>
</tr>
<tr>
<td>MEMBER GRIEVANCES AND APPEALS</td>
<td>32-37</td>
</tr>
<tr>
<td>- Grievances</td>
<td>32-33</td>
</tr>
<tr>
<td>- Appeals</td>
<td>34-37</td>
</tr>
<tr>
<td>UTILIZATION MANAGEMENT AND QUALITY IMPROVEMENT</td>
<td>37</td>
</tr>
</tbody>
</table>
Independent Living Systems is committed to enhancing quality of life through innovative health and support solutions that help improve health outcomes, reduce costs, and foster independence.

Redefining Healthcare Values
Through its holistic approach to long-term care, ILS helps individuals balance social and medical services, with an emphasis on delivering compassionate, supportive care to individuals as they age. Too often, the notion of “healthcare” is reduced to clinical services, medical procedures and solutions aimed at a discrete condition.

About this Guide
This guide is intended to orient iCircle Care providers of the plan specific policies and procedures. In addition, there is detailed information on ways in which our experienced care managers work with our members and providers to facilitate care, including detailed information on the authorizations process, instructions on how to submit claims and receive reimbursements for services rendered.

Contact
iCircle Care can be contacted as follows for all referrals, provider services and all general inquiries:
1-844-iCircle
TTY/TDD Dial 711
Website: http://www.icirclecarecny.org
iCircle Care Provider Relations: 631-297-0633

About Our Plan
iCircle Care was formed in collaboration with community-based service providers throughout a 22-county region in Central New York. iCircle is committed to helping those who are chronically ill or have a disability find and receive the best long-term care and treatment for their situation. As a local, community-based organization, we understand the special health needs of our community. We don’t have to answer to a large distant corporation. iCircle believes that members and their families should have accessible and open lines of communication with the MLTC plan care team and leadership right in their own community.

iCircle acts as a service portal to empower people to find and receive the best health care and treatment, while maximizing their independence, dignity and quality of life. As a non-profit, iCircle’s first priority is to provide coordinated health and social services that enrich the lives of our members.

iCircle is a comprehensive, sustainable, trusted, and compassionate system of support and service that empowers individuals and their families, and promotes members’ independence, dignity, happiness, and inclusion as productive members of our community.

iCircle is a member and provider driven managed care organization guided by individual choice, inclusion, diversity, cultural competence, respect, community, learning and empowerment. Providers and the prospective membership were involved in the development and planning for iCircle Care. We believe in transparency, collaboration, and innovation.

As a non-profit, iCircle’s first priority will always be to fulfill our mission of serving and enriching the lives of our members. As part of that mission, we treat all members with respect and compassion. Always.

iCircle Care is licensed by the NYS Department of Health to offer a Medicaid Managed Long-Term Care Plan. Our foundation was built from collaboration with leading community-based providers who believed the region deserved a higher level of quality of care, choice, and personalized care. Through a distinctly compassionate and friendly approach to service and care, iCircle Care empowers people to live independently in their homes as productive members of their communities.

iCircle Care is dedicated to addressing the needs and questions in a timely and appropriate matter. Our enrollment nurses and care managers are knowledgeable of each unique region and county we serve, because that is where they live and work. They work closely with members and their circle of support to ensure their needs are being met.

Each geographic area has a regional approach to serving our members. We offer enrollment, care management and Medicaid specialists who provide direct clinical care and assistance locally, in your neighborhood. Our tagline is – Hometown Care, Centered on You – this regional approach to care is just one way we live up to this.

About Our Management Partner
Independent Living Systems (ILS) is a health services company that provides managed long-term support services aimed at improving the aging experience for millions of America’s elderly and non-elderly, special needs and dual-eligible and non-dual-eligible individuals, while rebalancing costs for healthcare plans and providers. The company’s integrated offering provides assistance beyond the clinical realm for individuals at every stage of care, from acute hospitalization, through experiences with chronic illness, to personalized care management for the long term.
ABOUT PROVIDER RELATIONS

Welcome to Independent Living Systems Community Network, IPA LLC Network of Providers and iCircle Care. As a provider you play a very key role in the delivery of important services to the plans’ members.

The ILS IPA Provider Relations department is responsible for the recruitment, credentialing and management of the IPA’s providers. We help support the relationship of the providers and iCircle Care. We are available to answer questions, orient you and other providers on policies and procedures and serve as a single point of entry to the plan you have contracted with. We look forward to working with you.

PLAN ELIGIBILITY

Eligibility
In order to be eligible for enrollment in iCircle Care, potential enrollees must meet the New York Department of Health (NYSDOH) requirements for Managed Long Term Care (MLTC). A person who completes an enrollment agreement is eligible to enroll in iCircle Care if they meet the requirements below :

1. Meets the age requirements of 18 years of age or older.
2. Is determined eligible for New York State Medicaid as determined by New York Medicaid Choice or the Local Department of Social Services or entity designated by the NYSDOH.
3. Lives in the iCircle Care area.
4. Is determined eligible for MLTC by the plan using an eligibility assessment tool designated by the NYSDOH.
5. Is capable, at the time of enrollment, of returning to or remaining in his/her home and community without jeopardy to his/her health and safety, based upon criteria provided by NYSDOH.
6. Is expected to require at-least one of the following services and care management for more than 120 days.
   a. nursing services in the home
   b. therapies in the home
   c. home health aide services
   d. personal care services in the home
   e. adult day health care
   f. private duty nursing
   g. Consumer Directed Personal Assistance Services (CDPAS)

*Eligibility requirements vary whether enrollee dual or non-dual. In both mandatory and non-mandatory counties, the same eligibility would apply. Providers should contact iCircle Care for additional information.

Verifying Eligibility
The iCircle Care Managers will order and authorize the majority of services. Network providers will need to verify member eligibility prior to providing services. Providers are not allowed to directly bill members.

Service Area
iCircle Care’s MLTC area of service is listed below:

Broome  Oswego
Cayuga  Otsego
Chemung  Schuyler
Chenango  Seneca
Cortland  Steuben
Genesee  Tioga
Livingston  Tompkins
Madison  Wayne
Monroe  Wyoming
Onondaga  Yates
Ontario  Orleans

About Provider Relations

<table>
<thead>
<tr>
<th>Services Provided as Medically Necessary</th>
<th>Non-Covered Services; Excluded From The MLTC Benefit; Can Be Billed Fee-For Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Management</td>
<td>Inpatient Hospital Services</td>
</tr>
<tr>
<td>Nursing Home Care</td>
<td>Outpatient Hospital Services</td>
</tr>
<tr>
<td>Home Care:</td>
<td>Physician Services including services provided in an office setting, a clinic, a facility, or in the home. 3.</td>
</tr>
<tr>
<td>1. Nursing</td>
<td></td>
</tr>
<tr>
<td>2. Home Health Aide</td>
<td></td>
</tr>
<tr>
<td>3. Physical Therapy</td>
<td></td>
</tr>
<tr>
<td>4. Occupational Therapy</td>
<td></td>
</tr>
<tr>
<td>5. Speech Pathology</td>
<td></td>
</tr>
<tr>
<td>6. Medical Social Services</td>
<td></td>
</tr>
<tr>
<td>Adult Day Health Care</td>
<td>Laboratory Services</td>
</tr>
<tr>
<td>Covered Services by the MLTC Plan 1.2</td>
<td>Non-Covered Services; Excluded From The MLTC Benefit; Can Be Billed Fee-For Service</td>
</tr>
<tr>
<td>Personal Care</td>
<td>Radiology and Radioisotope Services</td>
</tr>
<tr>
<td>DME, including Medical/Surgical Supplies; Enteral and Parenteral formula and Hearing Aid batteries, Prosthetics, Orthotics and Orthopedic Footwear</td>
<td>Rural health Clinic services</td>
</tr>
<tr>
<td>Personal Emergency Response System</td>
<td>Chronic Renal Dialysis</td>
</tr>
<tr>
<td>Non-emergent Transportation</td>
<td>Mental Health Services</td>
</tr>
<tr>
<td>Podiatry</td>
<td>Alcohol and Substance Abuse Services</td>
</tr>
<tr>
<td>Dentistry</td>
<td>OPWDD Services</td>
</tr>
<tr>
<td>Optometry/Eyeglasses</td>
<td>Family Planning Services</td>
</tr>
</tbody>
</table>

1 Includes applicable Medicare coinsurance and deductibles for benefit package services
2 Includes nurse practitioners and physician assistants acting as “physician extenders”
MEMBERS RIGHTS AND RESPONSIBILITIES

All managed care enrollees are guaranteed rights under Article 44 of the Public Health Law; all contracted MLTC plans and contracted providers are expected to comply with the rights of plan members as contracted with ILS.

Member Rights
Members have the following rights and responsibilities:

• The right to receive medically necessary care
• The right to timely access to care and services
• The right to be provided with reasonable accommodation for members with disabilities.
• The right to privacy about their medical record and when treatment is received
• The right to get information on available treatment options and alternatives presented in a manner and language the member/family/guardian understands
• The right to get information, including all enrollment notices, informational materials, and instructional materials, in a language, manner, and format the member and his family/caregiver understands. Member can get oral translation services free of charge.
• The right to be free from any form of discrimination on the basis of race/ethnicity, color, national origin, gender, disability, political beliefs, religion, sexual orientation, age, medical condition (including physical and mental illness), claims experience, receipt of health care, medical history, genetic information, or evidence of insurability or disability
• The right to be free from abuse and neglect
• The right to be treated with respect and dignity

Member/Caregiver Responsibilities
Members and/or their authorized representatives are responsible for:

• The right to receive medically necessary care
• The right to timely access to care and services
• The right to be provided with reasonable accommodation for members with disabilities.
• The right to privacy about their medical record and when treatment is received
• The right to get information on available treatment options and alternatives presented in a manner and language the member/family/guardian understands
• The right to get information, including all enrollment notices, informational materials, and instructional materials, in a language, manner, and format the member and his family/caregiver understands. Member can get oral translation services free of charge.
• The right to be free from any form of discrimination on the basis of race/ethnicity, color, national origin, gender, disability, political beliefs, religion, sexual orientation, age, medical condition (including physical and mental illness), claims experience, receipt of health care, medical history, genetic information, or evidence of insurability or disability
• The right to be free from abuse and neglect
• The right to be treated with respect and dignity

• The right to contact iCircle Care when they need help or have questions.
• The right to receive all covered services through the iCircle Care Plan utilizing network providers.
• The right to follow their plan of care and request changes as needed.
• The right to obtain prior authorization for covered services, except for pre-approved services.
• The right to be seen by their physicians if a change in their health status occurs.
• The right to share complete and accurate health information with their Care Manager and health care providers.
• The right to inform their Care Managers when they go away or are out of town.

In the event we are made aware of a member being denied any of the rights identified above, we will initiate an investigation into the matter and report the findings to the Compliance Department.

Members and their authorized representatives will not be penalized or suffer any negative consequences for exercising their rights.

In the event we are made aware of a member not complying with the responsibilities outlined above, the Plan will make a good faith effort to address the issue with the member and his or her authorized representative, educate the member and his or her authorized representative about their responsibilities, and document the interaction.
Enrollment in a Managed Long Term Plan

Enrollment Policies

Eligibility for enrollment in a MLTC plan must be established through a clinical assessment process. Enrollment Coordinators will review basic eligibility criteria with potential members, help them determine if they meet the minimum eligibility requirements (Age, County of Residence, Medicaid Eligibility) to continue with the enrollment process and explain what can be expected once he or she is enrolled in iCircle Care. If he or she would like to continue with the enrollment process, the iCircle Care will schedule a home visit with an Enrollment Nurse (RN) who will complete the eligibility health assessment.

Enrollment Nurses are registered nurses who have experience and expertise in home care and community based long term care services. Enrollment Nurses will determine clinical eligibility by visiting members in their home and completing health assessment to establish the level of care needed, as well as, a social and environment assessment.

If the enrollee is interested in joining iCircle Care, he or she can sign the Enrollment Agreement & Attestation Form and a HIPPA Release of Information Form and a Medical Release of Information Form at the end of the enrollment visit. The patient will only be requested to sign a Medical Release of Information Form if the eligibility criteria are met and the decision is made to enroll in the plan.

If NY Medicaid Choice or LDSS receives notice of enrollment by Noon on the 20th of the month, membership will usually begin on the 1st day of the next month. If notices of enrollment are received after the 20th of the month, enrollment will usually begin on the 1st day of the month following the next month. For example, if the LDSS receives the enrollment notice on August 24, enrollment will usually begin on October 1st.

Denial of Enrollment

The applicant can be denied enrollment by the MLTC Program and/or Medicaid Choice or LDSS for one or more of the following reasons:

- Applicant is not at least 18 years of age
- Applicant is not Medicaid eligible.
- Applicant is not eligible for MLTC as per the eligibility assessment tool (UAS), where applicable.
- Applicant is not capable of returning to or remaining in the home without jeopardy to his/her health and safety.
- Applicant does not require community-based long term care services for more than 120 days.
- Applicant has been previously involuntarily dis-enrolled from the MLTC Program.
- Applicant is currently enrolled in another Medicaid managed care plan, a Home and Community Base Services waiver program, an OPWDD Day Treatment Program, or is receiving services from a hospice and does not wish to end his/her enrollment in one of these programs.
- Applicant is an inpatient or resident of a hospital or residential facility operated by the State Office of Mental Health, Office of Alcohol and Substance Abuse Services or the State OPWDD (applications for enrollment may be taken but enrollment may only begin upon discharge to applicant’s home in the community.)
- If the eligibility criteria for age, county of residence, and Medicaid are not met, the applicant will not be assessed for enrollment and will be so informed by letter. If the applicant chooses to pursue enrollment despite a lack of eligibility, iCircle will send this information to NY Medicaid Choice or LDSS for review and eligibility determination. If iCircle determines that the enrollment should be denied based on failure to meet the enrollment criteria, iCircle Care will recommend to NY Medicaid Choice or LDSS that the enrollment application be denied. NY Medicaid Choice or LDSS makes the final determination in the denial of enrollment and NY Medicaid Choice or LDSS will notify the applicant of his/her rights.
- If the applicant disagrees with iCircle Care regarding ineligibility due to age, county of residence or Medicaid eligibility, information that has been provided to the plan will be sent in writing to NY Medicaid Choice or LDSS with a copy to the applicant. NY Medicaid Choice or LDSS will decide if the plan was correct in informing the applicant that he/she is ineligible to enroll. If NY Medicaid Choice or LDSS agrees that the applicant is ineligible to enroll, then the applicant will be denied enrollment.
- If the applicant is determined to be clinically ineligible for enrollment, the applicant will be advised and may withdraw the application. Clinical ineligibility means that based on the in-home assessment the applicant is not eligible for MLTC using the eligibility assessment tool (UAS), where applicable and/or that the applicant does not meet health and safety criteria, and/or the applicant does not require managed community-based long term care services for at least 120 days. If the applicant does not wish to withdraw the application for clinical denial, the enrollment application will be processed as a proposed denial, pending NY Medicaid Choice or LDSS agreement.

Withdrawal of Enrollment

The applicant may withdraw the enrollment application at any time prior to enrollment. Election to withdraw the application prior to enrollment may be made by the applicant orally or in writing and the plan will confirm applicant’s request for withdrawal in writing.

Transitional Care

New iCircle Care members may continue an ongoing course of treatment for a transitional period of up to ninety (90) calendar days from the enrollment effective date with a non-network health care provider, provided that such provider: (a) accepts payment at an agreed upon rate with the iCircle; (b) adheres to the iCircle Care’s requirements for quality assurance and other policies and procedures; and (c) provides necessary medical information about the care being rendered to iCircle Care.

In addition, iCircle Care members may continue an ongoing course of treatment for a transitional period of up to ninety (90) calendar days should the member’s participating provider leave the Provider Network, provided that such provider: (a) accepts payment at an agreed upon rate with the plan; (b) adheres to the plan requirements for quality assurance and other policies and procedures; and (c) provides necessary medical information about the care being rendered.

Individuals transitioning from fee-for-service Medicaid to MLTC in mandatory counties must continue to receive services under the enrollee’s pre-existing service plan for at least 90 days after enrollment or until a care assessment has been completed by the Plan, whichever is later. In addition, the patient/worker(s) relationship must be preserved for the same 90 day period. The worker in this case is defined as both professional and paraprofessional staff of the provider agency.
Disenrollment Policies

If you live in a mandatory county and elect to disenroll from our plan and are still in need of community based long-term care services (CBLTCS), such as personal care services, you will need to transfer to another MLTC plan, managed care plan or an alternate service in order to continue to receive these services. If a member dis-enrolls orally, we will provide them with written confirmation of receipt of their oral request. The member’s Care Manager will discuss his or her decision to dis-enroll, and at the Member’s request a Nursing Supervisor can meet with the member at his or her home and attempt to resolve the circumstances leading to the disenrollment request.

Voluntary Disenrollment

A member can ask to leave the iCircle Care at any time for any reason. The member will be encouraged to sign a Disenrollment Form that will inform the member of the projected date upon which they will no longer be entitled to receive covered services through iCircle Care. It can take up to six weeks to process, depending on when the member’s request is received. For example, if the LDSS or Medicaid Choice processes the request by the tenth of the month, the effective date of the member’s disenrollment will be as of the first day of the following month. If the process is initiated later then the tenth of the month, the effective date of disenrollment will be the first day of the second month following the disenrollment request. iCircle Care will continue to provide and arrange for covered service until the effective date of disenrollment. All involuntary disenrollment’s have to be approved by the LDSS or NY Medicaid Choice.

Members Will Have to Leave iCircle Care if he or she:

If an enrollee does not request voluntary disenrollment, iCircle Care MUST initiate involuntary disenrollment within 5 business days from the date the plan knows:

• An Enrollee no longer resides in the service area
• An Enrollee has been absent from the service area for more than thirty (30) consecutive days
• An Enrollee is hospitalized or enters an OMH, OPWDD, or OASAS residential program for forty-five (45) consecutive days or longer:
• An Enrollee clinically requires nursing home care but is not eligible for such care under the Medicaid Program’s Institutional rules:
• An Enrollee is no longer-eligible to receive Medicaid benefits;
• An Enrollee is not eligible for MLTC because he/she is assessed as no longer requiring community-based long term care services or,

Involuntary Disenrollment

If iCircle Care feels that it is necessary to dis-enroll a member involuntarily, the plan must obtain authorization from the LDSS or New York Medicaid Choice. iCircle Care Program will not involuntarily dis-enroll members on the basis of adverse change in health status or the need for and/or cost of covered services. The reasons for involuntary disenrollment are listed below. Involuntarily dis-enrolled members will be notified of their fair hearing rights by LDSS or by New York Medicaid Choice. iCircle will continue to provide and arrange for covered service until the effective date of disenrollment. All involuntary disenrollment’s have to be approved by the LDSS or NY Medicaid Choice.

Members Can Ask Members to Leave the plan if:

• The plan member or a member of his or her family behaves in a way that prevents the plan from providing the care he or she needs.
• The plan member knowingly provides false information or behaves in a deceptive or fraudulent way.
• The plan member fails to complete or submit any consent form or other document that is needed to obtain services.
• The plan member fails to pay or make efforts to pay any spend down requirement payable to the MLTC Program.

Re-Enrollment Provisions

Members who voluntarily disenroll will be allowed to re-enroll in iCircle Care if he or she meets eligibility criteria for enrollment. If the member is involuntarily disenrolled, he or she may be allowed to re-enroll provided that: (a) he or she meets the eligibility requirements; and (b) that the condition or circumstance leading to the involuntary disenrollment determination has been corrected.
Appropriateness of Marketing Materials:

a) Providers shall not engage in marketing practices, nor distribute any marketing materials, that mislead, confuse or defraud eligible persons, the public or any government agency. Providers may not misrepresent the Medicaid program; the Medicaid managed long term care program or policy requirements of the State or its agents (counties).

REMINDER: Medicaid recipients may never be told by their provider that they have to join a Plan now. Recipients have to make a selection when they receive their official notice from the State or its designee or are seeking community based long term care services in mandatory counties.

b) Marketing materials must accurately reflect general information, which is applicable to the average consumer such as which plans the provider has contracts with.

c) Only marketing materials approved by NYSDOH for Plans may be used and distributed by such Plans.

Permitted/Impermissible Marketing Activities:

a) Marketing activities may not discriminate on the basis of a potential member’s health status, prior health service use, or need for future health care services.

b) Plans/Providers may not conduct “cold call” telephone solicitations. Door to door solicitation is also prohibited.

c) Providers may not provide mailing lists of their patients to Plans. Providers may not disseminate any information regarding mandatory enrollment requirements.

d) Providers may give permission to iCircle Care marketing representatives to conduct marketing activities at their facility. Plans at these activities must prominently display a list of all other Plans operating in the county or borough.

e) Neither the provider nor iCircle Care marketing representative may market in hospital emergency rooms, treatment rooms, hospital patient rooms, medical professional offices, Nursing Home or Adult Care Facility resident rooms, Adult Day Health Care Programs (ADHCP) and Social Day Care sites.

f) Plans may not require providers to distribute plan-prepared communications to their patients.

g) In the event a Provider is no longer affiliated with a particular Plan, but remains affiliated with other Plans, the Provider may notify his/her patients of the new status and the impact of such change for the patient.

h) All marketing activities shall be conducted in an orderly, non-disruptive manner and shall not interfere with the privacy of potential enrollees or the general community.

i) An approved Plan may begin to market to referral sources when the Plan has received it’s Certificate of Authority and the State Contract has been executed and completed internal Department of Health clearance.

j) Plans are not permitted to market to potential enrollees nor conduct any assessments for potential enrollment until such time as the Plan receives written Department approval.

Required Information for Potential Enrollees:

a) Plans must provide any potential enrollee not referred by New York Medicaid Choice (NYMC) with information describing managed long term care, a list of available Plans and information on how to reach NYMC. Plans must utilize managed long term care information and plan lists provided by the Department of Health’s website.

Inducements to Enroll:

a) Providers and Plans may not offer material or financial gain to Medicaid beneficiaries as an inducement to enroll. Specifically Providers and Plans may only: 1) make reference in marketing materials and activities to benefits/services offered under the program; and 2) Offer only nominal gifts, with a fair market value of no more than $5.00, with such gifts being offered regardless of beneficiary’s intent to enroll.

b) Providers shall not pay any individual, or accept in payment from a Plan, any commission, bonus, or similar compensation that uses numbers or Medicaid eligible persons enrolled in the managed long term care plan as a factor in determining compensations.

Reporting Attendance and Significant Health Events

- All Licensed Home Care Services agencies as of January 1st 2012 must comply with the daily attendance and verification requirements of the New York State Office of the Medicaid Inspector General (OMIG).

- All providers are expected to comply with the attendance and reporting requirements as stated in their provider contract.

- The provider will also report enrollee Adverse Events to the iCircle Care Manager and assist the care manager with review. Such adverse events would include the following:
  - Adverse Events related to the following:
    - Decline in management of medications
    - Significant worsening of ADLs
    - Two or more Behavioral Problems
    - Fall or Accidents (with or without injury)
    - Disaster that leaves Provider facility diminished

All Adverse Event reporting and Reviews are part of the Quality Initiatives for both Contractor and Provider. This Quality Initiative and Risk Management process anticipates the information will not be included in the discoverable elements of the enrollee file.
Incident Reporting

Provider agrees to implement a systemic process for incident reporting and notifying the appropriate iCircle Care plan staff within 48 hours of occurrence of an incident that may jeopardize the health, safety and welfare of an enrollee or impair continued service delivery.

Reportable conditions include but are not limited to:

- Closure of Provider services or facilities due to license violations
- Provider financial concerns/difficulties
- Loss or destruction of enrollee records
- Compromise of data integrity:
- Fire or natural disasters; and
- Critical issues or adverse incidents that affect the health, safety, and welfare of enrollees.

Licensed Home Care Services Agencies (Responsibilities)

License Home Care Service Agencies have the following responsibilities and requirements:

- To Coordinate services and receive appropriate authorizations from the Care Manager.
- To receive and provide services in accordance with Physician Orders when appropriate.
- To promptly update iCircle about any relevant changes in member’s health or living situation.
- To promptly inform the plan when they are unable to deliver services.
- To ensure that all direct care staff are trained and deliver services according to the regulations set by the NYSDOH and the federal government.
- To ensure that members have access to emergency services on a twenty-four (24) hour a day, seven (7) day per week basis through Provider or through covering provider(s) who are Participating Providers when Provider is not otherwise available.

Transportation Providers

All transportation providers are expected to maintain vehicle safety in accordance with criteria set by New York State Medicaid and CMS. In addition, they are expected to maintain appropriate documentation of each member trip.

Policies

Equal Opportunity Employer

iCircle Care and its management partners are Equal Provider Opportunity organizations. Provider decisions are based on merit and business needs, and not on race, color, citizenship status, national origin, ancestry, gender, sexual orientation, age, weight, religion, creed, physical or mental disability, marital status, veteran status, political affiliation, or any other factor protected by law.

Affirmative Action and Cultural Competency

iCircle Care and it’s management partners are committed to embracing diversity in the provision of services to New York’s healthcare consumer and in providing fair and equal opportunities for all qualified minority businesses. The contractor tracks and reports information to applicable agencies on utilization of certified and non-certified minority contractors and vendors for all subcontractors and vendors receiving funds pursuant to all contracts covered. The Plans wishes to accommodate religious and cultural preferences of the enrollees and will seek input from the Provider that might be useful in meeting enrollee preferences.

Americans with Disabilities Act

It is the policy of iCircle Care and its management partner to comply with all relevant and applicable provisions of the Americans with Disabilities Act [ADA]. We will not discriminate against any qualified Provider or job applicant with respect to any terms, privileges, or conditions of Provider because of a person’s disability.

Contract, Law and License Compliance

The application of Providers is contingent on verification of the candidate’s right to provide services. Every Provider will be asked to provide documents verifying compliance.

Provider Background Check

A background check may be applicable depending on the service and provider type. A comprehensive background check may consist of prior Provider verification, professional reference checks, and education confirmation.

Criminal Record Check and Criminal Allegations

Most provider licenses require a criminal record check be performed prior to issue of license. iCircle Care and it’s management partner will not duplicate such effort if possible, but reserves the right to request a criminal record check to protect our interest and that of our clients and members.

Any report that implies criminal intent on the part of Provider and is referred to a governmental or investigatory agency must be sent to the department. The Plan(s) must investigate allegations regarding falsification of client information, service records, payment requests, and other related information. If the contractor has reasons to believe that the allegations will be referred to the State Attorney, a law enforcement agency, the United States Attorney’s Office, or other governmental agency, iCircle Care is required to notify the Inspector General and the Medicaid Inspector General at the department immediately. A copy of all documents, reports, notes or other written material concerning the investigation, whether in the possession of the MLTC plan and/or a subcontractor of the plan, must be sent to the department’s Inspector General and the Medicaid Inspector General with a summary of the investigation and allegations.

New Provider Orientation

The formal welcoming process, or “Provider Orientation,” may be conducted by a Provider Relations Representative when a provider is authorized for service, and includes an overview of iCircle Care.

Information about the program and Provider Orientation is also part of the process by the Provider Relations Representative during the contracting process.

Home Care Workers Parity

Home care providers are expected to comply with the home care worker wage parity provisions of Section 3614-C of the Public Health Law which applies to New York City on and after March, 1
Change of Provider Data
Any change in a Provider’s name, address, telephone number, or change of ownership, must be reported in writing without delay to Provider Relations.

Policies on Billing
Provider agrees to comply with the following provisions pursuant to 11 NYCRR Part 101 as stated in the Provider contract, which prohibits providers from attempting to collect from members any amounts owed to the provider for covered services.

Abuse, Neglect, and Exploitation Training
Agency issued licenses will require such training and New York statutes place an affirmative duty to report suspected or confirmed elder abuse, neglect, or exploitation. All persons who examine, care for or treat vulnerable adults have this affirmative duty to report any instance of suspected or confirmed elder abuse, neglect, or exploitation.

Suspected elder abuse, neglect, or exploitation may be reported twenty four (24) hours a day seven (7) days a week by calling 1-800-342-3009 (New York State Office of Temporary and Disability Assistance) or contacting local county Department of Social Services Adult Protective Services. When reporting suspected or confirmed abuse, neglect, or exploitation, please reports the following information (if available).

- Each victim’s name, age, sex, race, and physical description
- Location of each victim alleged to have been abused, neglected, or exploited
- Name, address and telephone number of the victims’ family members
- Name, address and telephone number of each alleged perpetrator
- Name, address, and telephone number of the care giver, if this differs from the perpetrator
- Name, address, and telephone number of the person reporting the abuse, neglect, or exploitation
- Description of the physical or psychological injuries sustained
- Actions you’ve taken, such as call the police, or family of the victim
- Any information you may have regarding the cause of the abuse, neglect or exploitation

Medicaid Managed Care Organizations (MLTC Plans) are required to ensure that all direct care providers have knowledge of and attest they will maintain compliance with staff training relative to Abuse, Neglect & Exploitation.

It is your responsibility as the Provider to ensure that Abuse, Neglect and Exploitation training occurs and to maintain necessary documentation of this training for the employees who have contact with iCircle enrollees. You may be requested to make such documentation available.

For additional information please refer to the New York State Office of Children and Family Services website:
https://www.ocfs.state.ny.us/main/psa/

For further information or assistance in filing a report in New York City, you may contact the Adult Protective Services Central Intake Office at (212) 630-1853; within New York State you may contact (800) 342-3009 (New York State Office of Temporary and Disability Assistance) or contact the local county Department of Social Service Adult Protective Services.

Emergency Service Responsibilities
iCircle Care has an emergency management plan that specifies what actions the plan shall conduct to ensure the ongoing provision of covered services in a disaster or man-made emergency including, but not limited to, localized acts of nature, accidents, and technological and/or attack-related emergencies.

Weather-related and Emergency-related Closings
At times, emergencies such as severe weather, fires, or power failures can disrupt operations. In such instances, it is important that iCircle Care be kept informed of your status. This is of real significance if you have an active authorization for an enrollee.

Additional New York State information can be found at www.nyalert.gov and specifically for health care providers at:
http://www.health.ny.gov/environmental/emergency/health_care_providers/
Provider agrees to review the details and comply with the following as required by Section 6032 of the Federal Deficit Reduction Act of 2005:

a. The False Claims Act

b. The penalties for submitted false claims and statement

c. Whistleblower protections.

d. The law’s role in preventing and detecting fraud, waste and abuse, and each person’s responsibility relating to detection and prevention.

Details may be included in the State’s Medicaid Provider Manual and may be included in New York State’s Office of the Medicaid Inspector General website, http://omig.ny.gov/data/

The New York State Office of the Medicaid Inspector General audits and investigates providers suspected of overbilling and defrauding New York’s Medicaid program, recovers overpayments, issues administrative sanctions and refers cases of suspected fraud for criminal investigation.

Advance Directives

All providers are required to comply with the Patient Self Determination Act of 1990 and any state, federal laws on Advance Directives. Members can use an Advance Directive to provide directions on his or her medical care, should the member be unable to communicate or make decisions about treatment. In addition members can use an Advance Directive to appoint a proxy to make health care decisions for them if they are unable to do so.

Credentialing and Termination

Application Process

The iCircle management partner follows nationally recognized accreditation standards in the credentialing and re-credentialing of providers. The Management partner makes credentialing decisions within 30 to 90 days of receipt of a complete credentialing application. The complete credentialing application contains but is NOT limited to the following:

- Current applicable state license
- Review of Professional Liability Claims
- Review for Medicaid and Medicare Sanctions
- Verification of good standing with CMS
- Abuse, Neglect and Exploitation Training Attestations
- Professional Liability Insurance
- Appropriate and relevant accreditations and certificates

It is the policy of iCircle and its management partner and delegated organizations that information obtained in the credentialing process is kept confidential.

Provisional Credentialing

iCircle Care will grant provisional credentialing to providers whose credentialing process has exceeded 90 calendar days, and has appropriate licensing in good standing, a written application; verification of information from primary and secondary sources; confirmation of eligibility for payment under Medicare and/or Medicaid and no adverse credentialing information.

Ongoing Credentialing

The re-credentialing process will be completed every three years and will verify Medicare and Medicaid exclusions annually. The Plan will continually monitor providers as outlined in the provider contract, in accordance with state and federal laws.

Provider Termination and Disciplinary Action

Provider Terminations and Disciplinary Action will occur in compliance with the requirements of Section 4406-d of the New York Public Health Law.

(a) A health care plan shall not terminate a contract with a health care professional unless the health care plan provides to the health care professional a written explanation of the reasons for the proposed contract termination and an opportunity for a review or hearing as hereinafter provided. This section shall not apply in cases involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional’s ability to practice.

(b) The notice of the proposed contract termination provided by the health care plan to the health care professional shall include:

(i) the reasons for the proposed action;

(ii) Notice that the health care professional has the right to request a hearing or review, at the professional’s discretion, before a panel appointed by the health care plan;

(iii) a time limit of not less than thirty days within which a health care professional may request a hearing; and

(iv) a time limit for a hearing date which must be held within thirty days after the date of receipt of a request for a hearing.

(c) The hearing panel shall be comprised of three persons appointed by the health care plan. At least one person on such panel shall be a clinical peer in the same discipline and the same or similar specialty as the health care professional under review. The hearing panel may consist of more than three persons, provided however that the number of clinical peers on such panel shall constitute one-third or more of the total membership of the panel.

(d) The hearing panel shall render a decision on the proposed action in a timely manner. Such decision shall include reinstatement of the health care professional by the health care plan, provisional reinstatement subject to conditions set forth by the health care plan or termination of the health care professional. Such decision shall be provided in writing to the health care professional.

(e) A decision by the hearing panel to terminate a health care professional shall be effective not less than thirty days after the receipt by the health care professional of the hearing panel’s decision; provided, however, that the provisions of paragraph (e) of subdivision six of section four thousand four hundred three of this article shall apply to such termination.

(f) In no event shall termination be effective earlier than sixty days from the receipt of the notice of termination.

To report suspected fraud and/or abuse in New York Medicaid: Toll Free Hotline: 877-87-FRAUD (877-873-7283)

Online: www.omig.ny.gov

Email: bmf@omig.ny.gov

Telephone: (618) 402-1578

Fax: (618) 408-0480

Mail:

NYS-OMIG- Bureau of Medicaid Fraud Allegations
800 North Pearl Street
Albany, NY 12204
Emergency services means medically necessary services required to evaluate and stabilize an emergency medical condition. MLTC plans do not cover emergent transportation or emergency costs. An emergency medical condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the person affected with such condition in serious jeopardy, or in the case of a behavioral condition placing the health or such person or others in serious jeopardy; (b) serious impairment to such person’s bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

If a member has an emergency and needs immediate medical attention, they should call 911 or rush to the nearest hospital emergency room. Should the member call 911, he or she will listen to the questions carefully, answer their questions and follow their instructions. After the member’s emergency, the Care Manager should be notified within 24 hours of the emergency. The member may be in need of long-term care services that can only be provided by the iCircle Care. If the emergency results in a hospital admission, the member (if possible), a family member or informal support should contact the iCircle Care within 24 hours of the admission. The Care Manager will then cancel any scheduled services or appointments that the member may have. If the member is in the hospital, the physician or discharge planner should be asked to contact the iCircle Services MLTC Plan. We will then work with them to plan for the member’s care upon your hospital discharge.

We always encourage members to call their assigned Care Managers for any assistance. If members have an urgent need for service or assistance or have an emergent situation after normal business hours or on weekends or holidays, just call us on the toll free member care assistance line at 1-844-MY-iCare (1-844-694-2273), and our On-Call Care Managers will be available for assistance.
SERVICE AUTHORIZATIONS

Prior Authorization

A Prior Authorization is a request by the Enrollee or provider on Enrollee’s behalf for a new service (whether for a new authorization period or within an existing authorization period) or a request to change a service as determined in the plan of care for a new authorization period.

Service Authorization

When members ask for approval of a treatment or service, it is called a Service Authorization Request. To get a service authorization request, the member or his or her doctor may call the Plan. Services will be authorized in a certain amount and for a specific period of time. This is called the authorization period.

Concurrent Review and Discharge Planning Requests

A Concurrent Review is a request by an Enrollee or provider on Enrollee’s behalf for additional services (i.e., more of the same) that are currently authorized in the plan of care or for Medicaid covered home health care services following an inpatient admission.

Review Process

Any of the authorization requests specified above will be considered by a standard or expedited review process. A decision to deny a service authorization request or to approve it for an amount that is less than requested is called an action. These decisions will be made by a qualified health care professional. If the iCircle Care decides that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor, a nurse or a health care professional who typically provides the care requested. Members can request the specific medical standards, called clinical review criteria, used to make the decision for actions related to medical necessity determinations.

After iCircle Services receives the request, the plan will review it under a standard or expedited process. A member or his or her doctor may ask for an expedited review if it is believed that a delay will cause serious harm to a member’s health. If the member’s request for an expedited review is denied, the plan will inform them and the request will be handled under the standard review process. In all cases, it will be reviewed as fast as the member’s medical condition requires it to do so, but no later than mentioned below.

iCircle Services will tell the member and his or her provider both by phone and in writing if his or her request is approved or denied. The member will also be informed of the reason for the decision. The member will be informed what options he or she has for appeals or fair hearings if he or she doesn’t agree with our decision.

Timeframes for prior and service authorization requests

• Standard review: within 3 business days of receipt of necessary information, but no more than 14 days of receipt of request for services.
• Expedited review: 3 business days from request for service.

Timeframes for concurrent review requests

• Standard review: Within 1 business day of receipt of necessary information, but no more than 14 days of receipt of request for services.
• Expedited review: within 1 business day of receipt of necessary information, but no more than 3 business days of receipt of request for services.

In the case of a request for Medicaid covered home health care services following an inpatient admission, one (1) business day after receipt of necessary information; except when the day subsequent to the request for services falls on a weekend or holiday; seventy-two (72) hours after receipt of necessary information; but in any event, no more than three (3) business days after receipt of the request for services.

If the plan needs more information to make either a standard or expedited decision about the member’s service request, the timeframes above can be extended up to fourteen (14) calendar days. The plan will:

• Write and inform the member what information is needed. If the request is an expedited review, the plan will call the member immediately and send a written notice later.
• Tell the member why the delay is in his or her best interest.
• Make a decision as quickly as it can when the plan receives the necessary information, but no later than fourteen (14) calendar days from the end of the original timeframe.

The member, his or her provider, or someone the member trusts may also ask the plan to take more time to make a decision. This may be because the member has more information to give the plan to help decide the member’s case. This can be done by calling the member’s assigned Care Manager. The member or someone he or she trusts can also file a complaint with iCircle Services if he or she does not agree with the plan’s decision or to take more time to review the request. The member or someone the member trusts can also file a complaint about the review time with the New York State Department of Health MLTC by calling 1-866-712-7197. If the member is not satisfied with the plan’s answer, he or she has the right to file an action appeal with the plan.

Retrospective Review

Sometimes the plan will do a concurrent review on the care a member is receiving to see if he or she still needs the care. The plan may also review other treatments and services the member has already received. This is called a retrospective review. In this process, the plan will inform the member if it takes any of these following actions.

Timeframes for notice of other actions

• In most cases, if the plan makes a decision to reduce, suspend or terminate a service it has already approved and which the member is now receiving within an authorization period, the plan must inform the member at least ten (10) calendar days before it changes the service.
• If the plan is reviewing care that has been given in the past, the plan will make a decision about paying for it within thirty (30) calendar days of receiving necessary information for the retrospective review. If plan denies payment for a service, the plan will send a notice to the member the day payment is denied. Members will not have to pay for any care he or she received that was covered by the MLTC plan or by Medicaid even if the plan later denies payment to the provider.

In all cases, it will be reviewed as fast as the member’s medical condition requires it to do so, but no later than mentioned below.

The plan must inform the member at least ten (10) calendar days before it changes the service. The member, his or her provider, or someone the member trusts may also ask the plan to take more time to make a decision. This may be because the member has more information to give the plan to help decide the member’s case. This can be done by calling the member’s assigned Care Manager. The member or someone he or she trusts can also file a complaint with iCircle Services if he or she does not agree with the plan’s decision or to take more time to review the request. The member or someone the member trusts can also file a complaint about the review time with the New York State Department of Health MLTC by calling 1-866-712-7197. If the member is not satisfied with the plan’s answer, he or she has the right to file an action appeal with the plan.

If the plan needs more information to make either a standard or expedited decision about the member’s service request, the timeframes above can be extended up to fourteen (14) calendar days. The plan will:

• Write and inform the member what information is needed. If the request is an expedited review, the plan will call the member immediately and send a written notice later.
• Tell the member why the delay is in his or her best interest.
• Make a decision as quickly as it can when the plan receives the necessary information, but no later than fourteen (14) calendar days from the end of the original timeframe.

The member, his or her provider, or someone the member trusts may also ask the plan to take more time to make a decision. This may be because the member has more information to give the plan to help decide the member’s case. This can be done by calling the member’s assigned Care Manager. The member or someone he or she trusts can also file a complaint with iCircle Services if he or she does not agree with the plan’s decision or to take more time to review the request. The member or someone the member trusts can also file a complaint about the review time with the New York State Department of Health MLTC by calling 1-866-712-7197. If the member is not satisfied with the plan’s answer, he or she has the right to file an action appeal with the plan.
Claims Management

Provider Billing for Services

As a network provider you will receive payment and provide services and supplies according to your contract with iCircle’s management partner.

Instructions and all information required for a clean or complete claim

The provider shall routinely submit timely and clean claims. A “clean claim” is a claim that meets the requirements of 11 NYCRR Section 217.2 (if it is a paper claim), or the requirements of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), if it is an electronic claim, and which is received timely by Health Plan or delegate and has no defect, impropriety or lack of substantiating documentation from the member’s medical record regarding the covered services.

Examples of Acceptable Paper Claims Forms

iCircle requires providers to use one of the following forms when submitting claims:

- A CMS 1500 (formerly HCFA 1500) billing form is used to submit paper claims for professional services.
- Home health care, skilled nursing, and nursing home room and board must be billed on the UB-04 billing form.

Durable Medical Equipment

iCircle Services will authorize all necessary equipment, supplies and appliances for members, such as: canes, walkers, wheelchairs, commodes, oxygen and respiratory equipment, wound care supplies, colostomy and diabetic supplies, enteral and parenteral nutrition and supplies, artificial limbs, braces, and shoe inserts or orthopedic shoes. (Please discuss certain service limitations with the plan care manager). These services require a physician’s order and prior authorization by the plan.

Respiratory Therapy Services

These services provided by a licensed respiratory therapist include, but are not limited to instruction in the use of nebulizers and oxygen. These services require a physician’s order and prior authorization from the plan.

Outpatient Physical, Occupational, Speech or Other Therapies (Outside the Home)

These services will be provided in an outpatient setting by a licensed professional and require a physician’s order and prior authorization from the MLTC plan. (Please note: Medicaid coverage of outpatient PT, OT and ST provided in a setting other than a home is limited to 20 visits per calendar year, except for children under age 21 and the developmentally disabled. A MLTC plan may authorize additional visits.)

Medical Social Services

A licensed social worker will assess member needs for, and arrange for the provision of aid to assist members in dealing with social problems and maintaining members home. These services require a physician’s order and prior authorization by the plan.

Nursing Home Care

Nursing home care for short-term rehabilitative stays, which occur mainly after hospitalizations, are covered by the plan. However, an admission to a nursing home for a long-term care may occur when staying at home is no longer safe. These services require a physician’s order and prior authorization by the plan.

Services That Require Physician Authorization

For some covered services, a member may need a physician’s order in addition to prior authorization. The plan care manager is available to assist members obtaining these medically necessary services, and coordinate with the ordering physician.

Examples of Acceptable Paper Claims Forms

iCircle requires providers to use one of the following forms when submitting claims:

- A CMS 1500 (formerly HCFA 1500) billing form is used to submit paper claims for professional services.
- Home health care, skilled nursing, and nursing home room and board must be billed on the UB-04 billing form.
Completing a CMS 1500 (HCFA 1500)

The CMS 1500 billing form is used to submit paper claims for professional services. Before submitting a claim, a Provider should ascertain that all required attachments are included. All claims that involve other insurance must be accompanied by an Explanation of Benefits (EOB) or a remittance advice that clearly states how the claim was paid or the reason for denial.

Completing the UB-04

The UB-04 form is used when billing for facilities services, including nursing home room and board and ICF services.

CLAIMS SUBMISSION

Electronic Claims Submission

To submit electronic claims Providers will need to obtain the required software electronic claim submission to Emdeon*.

a. The first step is to register with Emdeon or another Clearing House.

b. Once registered Provider will be able to submit electronic claims following instructions from clearinghouse.

c. Provider will need to use the payer ID of TO BE DETERMINED when billing through the clearing house.

Providers can submit hard copy claims directly to ILS via US mail at:

c/o icircle care
PO Box 5575
Hauppauge, New York, 11788

*Emdeon Inc is a provider of revenue and payment cycle management and clinical information exchange solutions, connecting payers, providers, and patients in the U.S. healthcare system. The company operates the largest financial and administrative information exchange in the United States.

CLEAN CLAIM SUBMISSION

iCircle and its Management partner can only process clean claim submissions. A “clean claim” is defined as one that can be processed (adjudicated) without obtaining additional information from the service Provider or from a third party. It does not include claims submitted by Providers under investigation for fraud or abuse or those claims under review for medical necessity.

Claims Resubmission

For Network Providers:

• We will consider a claim for resubmission only if it is re-billed in its entirety within 180 days from date of service. Provider must include a letter outlining the reason for submission.

Claims Reconsideration

Providers have 180 days from the date of remittance to resubmit a claim or the original payment will be considered full and final for the related claims. Providers must include the nature of the request, member’s name, date of birth, member identification number, service/admission date, location of treatment, service or procedure, documentation supporting request, copy of claim, and a copy of remittance advice on which the claim was denied or incorrectly paid. Providers must additionally address the following labels on the claim when submitting a claim for reconsideration:

ATTN: Claims Dept. - Reconsideration Claim
iCircle Care
PO Box 211188
Eagan, MN 55121

Providers can also check the status of claims by contacting the Claims Department at 1-844-424-7253
MEMBER GRIEVANCES AND APPEALS

Member’s have the right to appeal decisions made about their care.

When the Plan:

- Denies or limits services requested by the member or his or her provider
- Denies a request for a referral
- Decides that a requested service is not a covered benefit
- Reduces, suspends or terminates services that we already authorized
- Denies payment for services
- Does not provide timely services
- Does not make grievance or appeal determinations within the required timeframes

These are considered plan “actions”. An action is subject to appeal.

What is a Grievance?

A grievance is any communication by the member to the plan of dissatisfaction about the care and treatment he or she has received from plan staff or providers. For example, if someone was rude to the member, or he or she is not satisfied with the quality of care or services received, he or she can file a grievance with the plan.

Grievance Procedures

The member may file a grievance orally or in writing with the plan. The person who receives the grievance will record it, and appropriate plan staff will oversee the review of the grievance. The plan will send the member a letter telling him or her that it has received the grievance and a description of the plan’s review process. The plan will review the grievance and give the member a written answer within one of the following timeframes:

- If a delay would significantly increase the risk to the member’s health, the plan will decide within 48 hours after receipt of necessary information.
- For all other types of grievances, the plan will notify the member of its decision within forty-five (45) calendar days of receipt of necessary information, but the process must be completed within sixty (60) calendar days of the receipt of the grievance. The review period can be increased up to fourteen (14) calendar days if the member requests it or if the plan needs more information and the delay is in the interest of the member.

The Plan’s written answer will describe the plan’s investigation of the grievance and its decision about the grievance.

How do I Appeal a Grievance Decision?

If a member is not satisfied with the decision concerning his or her grievance, he or she may request a second review of the issue by filing a grievance appeal. The member must file a grievance appeal in writing within sixty (60) business days of receipt of the initial decision about the grievance. Once the plan receives the member’s appeal, the plan will send the member a written acknowledgement with the name, address and telephone number of the individual designated to respond to the appeal.

All grievance appeals will be conducted by appropriate professionals, including health care professionals for grievances involving clinical matters. These professionals were not involved in the initial decision.

For standard appeals, the plan will make the appeal decision within thirty (30) business days after it receives all necessary information to make our decision. If a delay in making the decision would significantly increase the risk to the member’s health, it will use the expedited grievance appeal process. For expedited grievance appeals, the plan will make an appeal decision within two (2) business days of receipt of necessary information. For both standard and expedited grievance appeals, the plan will provide the member with a written notice of its decision. The notice will include the detailed reasons for its decision and, in cases involving clinical matters, the clinical rationale for the plan’s decision.

Grievances

Grievance Process

iCircle Services will try its best to deal with member concerns or issues as quickly as possible and to the member’s satisfaction. The member may use either the grievance process or the appeal process, depending on what kind of problem he or she may have.

There will be no change in the member’s services or the way he or she is treated by the by iCircle staff or a health care provider because he or she had filed a grievance or an appeal. iCircle Services will maintain the member’s privacy. The plan will give the member any help he or she may need to file a grievance or appeal. This includes providing the member with interpreter services or assistance if he or she has vision and/or hearing problems. The member may choose someone (such as a relative, friend, or provider) to act on his or her behalf.

When iCircle Services is contacted, it will need the member’s name, address, telephone number and the details of the problem.

External Appeals

Providers are entitled to file an external appeal if they do not agree with actions taken by contracted plans. Providers are expected prior to filing an appeal to attempt to resolve any issues with the plan informally as outlined in their provider contract.
Appeals

Timing of Notice of Action

If iCircle Care decides to deny or limit services the member has requested or decides not to pay for all or part of a covered service, the plan will send the member a notice when it makes its decision.

If the plan is proposing to reduce, suspend or terminate a service that is authorized, a letter will be sent at least ten (10) calendar days before the plan intends to change the service.

Contents of the Notice of Action

Any notice sent to a member about an action will:

• Explain the action the plan has taken or intend to take
• Cite the reasons for the action, including the clinical rationale, if any
• Describe the member’s right to file an appeal with the plan (including whether the member may also have a right to the State’s external appeal process)
• Describe how to file an internal appeal and the circumstances under which the member can request that the plan expedites its review of the member’s internal appeal.
• Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational
• Describe the information, if any, which must be provided by the member and/or his or her provider in order for the plan to render a decision on appeal

If the plan is reducing, suspending or terminating an authorized service, the notice will also inform the member about his or her right to have services continue while the plan decides on the appeal.

how to request that services be continued, and the circumstances under which the member may have to pay for services if they are continued while we were reviewing the member’s appeal.

How to file Appeal of an Action?

If the member does not agree with an action that the plan has taken, he or she may file an appeal. When the member files an appeal, it means that the plan must look again at the reason for its action to decide if it was correct. The member can file an appeal of an action with the plan orally or in writing. When the plan sends the member a letter about an action it is taking (like denying or limiting services, or not paying for services), the member must file their appeal request within forty-five (45) calendar days of the date of the plan’s letter notifying the member of the action. If the member calls the plan to file a request for an appeal, he or she must send a written request unless he or she requests for an expedited review.

If a member files an appeal he or she can contact iCircle services at the address and phone number listed in this manual or the member’s handbook. The person who receives the appeal will record it, and appropriate staff will oversee the review of the appeal. The plan will send a letter informing the member that it has received his or her appeal, and how it will be handled. The member’s appeal will be reviewed by a knowledgeable clinical staff member who was not involved in the initial decision or action that he or she is appealing.

Request to Continue Services

If the member is appealing a reduction, suspension or termination of services he or she is currently authorized to receive, he or she may request to continue to receive these services while the plan is deciding the appeal. The plan must continue the member’s service if he or she makes the request no later than ten (10) calendar days from the mailing of the notice about the plan’s intent to reduce, suspend or terminate services, or by the intended effective date of its action. The member’s services will continue until he or she withdraws the appeal, or until ten (10) days after the plan mails the member’s notice about the plan’s appeal decision if the decision is not in the member’s favor, unless he or she has requested a New York State Medicaid Fair Hearing with continuation of services.

Although a member may request a continuation of services while his or her appeal is under review, if the appeal is not decided in the members favor, the plan may require the member to pay for these services if they were provided only because the member requested to continue to receive them while the appeal was being reviewed.

How long will it take the Plan to Decide an Appeal of an Action?

Unless the member asks for an expedited review, the plan will review the appeal of the action as a standard appeal and send the member a written decision as quickly as his or her health condition requires, but no later than thirty (30) calendar days from the day the plan receives an appeal. The review period can be increased up to fourteen (14) calendar days if the member requests an extension or if the plan needs more information and the delay is in the member’s interest. During the review, the member will have a chance to present his or her case in person and in writing. The member will also have the chance to look at any of his or her records that are part of the appeal review.

The plan will send the member a notice explaining the decision rendered about his or her appeal and the date a decision was reached. If the plan reverses its decision to deny or limit requested services, or reduce, suspend or terminate services, and services were not furnished while the member’s appeal was pending, the plan will provide the member with the disputed services as quickly as his or her health condition requires.

If the Plan Denies My Appeal, What Can I Do?

If the decision about the member’s appeal is not totally in his or her favor, the notice the member receives will explain his or her right to request a Medicaid Fair Hearing from New York State, how to obtain a Fair Hearing, who can appear at the Fair Hearing on his or her behalf, and for some appeals, the right to request to receive services while the Hearing is pending and how to make such a request. If the plan denies the member’s appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an “external appeal” of the decision.

Expedited Appeal Process

If the member or his or her representative feels that taking the time for a standard appeal could result in a serious problem to the member’s health or life, he or she may ask for an expedited review of the appeal of the action. The plans will respond to the member with its decision within two (2) business days after the plan receives all necessary information. In no event will the time for issuing a decision be more than three (3) business days after the plan receives the member’s appeal. The reviews can be increased up to fourteen (14) calendar days if the member requests an extension or needs more information and the delay is in the member’s interest.

If the plan does not agree with the request to expedite the appeal, the plan will make best efforts to contact the member in person to let him or her that we have denied the request for an expedited appeal and will handle it as a standard appeal. Also, the plan will send a written notice of its decision to deny the request for an expedited appeal within two (2) business days after receiving the request.
If the plan did not decide the appeal totally in the member's favor, he or she may request a Medicaid Fair Hearing from New York State within sixty (60) calendar days of the date the plan sent the notice about its decision on the Fair Hearing.

If the member's appeal involved the reduction, suspension or termination of authorized services he or she is currently receiving, and the member has requested a Fair Hearing, he or she may also request to continue to receive these services while waiting for the Fair Hearing decision. The member must check the box on the Fair Hearing form to indicate that he or she wants the services at issue to continue. The request to continue the services must be made within ten (10) calendar days of the date the appeal decision was sent by the plan or by the intended effective date of the action to reduce, suspend or terminate services; whichever occurs later. The member's benefits will continue until he or she withdraws the Fair Hearing, or until the State Fair Hearing Officer issues a hearing decision that is not in the member's favor; whichever occurs first.

If the State Fair Hearing Officer reverses its decision, the plan/provider must make sure that the member receives the disputed services promptly and as soon as his or her health condition requires. If the member receives the disputed services while the appeal was pending, the plan will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

Although the member may request to continue services while he or she is waiting for the Fair Hearing decision, if the Fair Hearing is not decided in the member's favor, the member may be responsible for paying for the services that were subject of the Fair Hearing.

Members can use one of the following ways to request a Fair Hearing:

- By phone. Call toll free 1-800-342-3334
- By fax at 518-473-6735
- By Internet at www.otda.state.ny.us/oah/forms.asp
- By mail:
  Fair Hearing Section
  NYS Office of Temporary and Disability Assistance
  Managed Care Unit
  P.O. Box 21023
  Albany, New York 12201-2023

Remember, members can file a complaint anytime to the New York State Department of Health MLTC by calling 1-866-712-7197. Please call our Membership Services Department at 1-855-747-5483 and speak to a Membership Services Representative regarding any questions.

State External Appeals

If the plan denies an appeal because it may determine the service is not medically necessary or is experimental or investigational, the member may ask for an external appeal. If the plan upholds its decision, the member might receive a new final determination and have another chance to ask for an external appeal.

The member loses the right to an external appeal if he or she does not file an application for an external appeal on time. To ask for an external appeal, the member should fill out an application and send it to the New York State Department of Financial Services.

Members can contact the plan's member services team if help is needed filing an appeal. The member and his or her physician(s) will have to give information about the medical problem.

- The member can prove Circle Services did not follow the rules correctly when reviewing your action appeal.

When the plan makes a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, the plan will provide the member with information about how to file an external appeal, including a form on which to file the external appeal along with the decision to deny an appeal. If the member would like an external appeal, he or she must file the form with the New York State Department of Financial Services within four (4) months from the date the plan denied the appeal.

If the member had an expedited action appeal and is satisfied with the plans, he or she can choose to file a standard action appeal with the plan or ask for an external appeal. If he or she chooses to file a standard action appeal with the Plan, and the plan upholds its decision, he or she will receive a new final determination and have another chance to ask for an external appeal.

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If the member had an expedited action appeal and is satisfied with the plan, he or she can choose to file a standard action appeal with the Plan, and the plan upholds its decision, he or she will receive a new final determination and have another chance to ask for an external appeal.

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PROVIDER QUICK REFERENCE GUIDE

Provider Services
If you have any questions regarding claims status, payment or submission please dial 1-844-My-iCare (694-2273) and press 4 for claims.

Claims Submission
For Paper Submission:

(1) CMS-1500 (formerly HCFA 1500) this billing form is used for professional services. For instructions on completion of the CMS-1500 please refer to the “HCFA/CMS 1500 Tutorial” or the ILS Provider Manual.

(2) UB-04 This billing form is used when billing for home health care, skilled nursing, and nursing home room and board. For instructions on completion of the UB-04 please refer to the Centers for Medicare and Medicaid Services website at http://www.cms.gov or the iCircle Care Provider Manual.

All paper claim submissions are to be mailed to the following address:
iCircle Care
PO Box 5575
Hauppauge, New York, 11788

For Electronic Submission:
The iCircle Care Emdeon payer ID # is 33884. Emdeon supports both professional and institutional claims.

Care Management & Prior Authorization
To obtain a prior authorization, make a claim status inquiry, request a referral for additional services, and/or if you require assistance contacting a member or caregiver please contact the iCircle Coordinated Care Unit Services 1-844-My-iCare (694-2273). iCircle’s business hours are Monday through Friday 9:00 a.m. – 5:00 p.m. with 24-hour on-call assistance available.

Referrals
Providers can make referrals to iCircle Care in three ways listed below:
Call: 1-844-iCircle (424-7253)
Visit: www.icirclecarecny.org
Email: enrollment@icirclecarecny.org
Mail: 860 Hard Road, Webster, NY 14580 (Referral Form Attached)