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G. Notice of Medicare Non-Coverage Instructions
H. Detailed Explanation of Non-Coverage
I. Detailed Explanation of Non-Coverage Instructions
J. Notice of Denial of Medical Coverage
K. Notice of Denial of Medical Coverage Instructions
L. List of Approved Indiana Counties-Service Areas
M. Clinical Editing Provider Information
N. Clinical Editing Dispute/Appeal Form
O. An Important Message from Medicare
Indiana University Health Plans, Inc. Administrative Office
950 N. Meridian Street, Suite 200
Indianapolis, IN 46204
(317) 963.9920

Utilization/Medical Management Department
Clarian Ambulatory Care Management
950 N. Meridian Street
Suite 600
Indianapolis, IN 46204

Ambulatory Utilization Pre-certification  (317) 962.2378
FAX  (317) 962.6219
FAX  (317) 963.9949

Indiana University Health Plans Departments:
Customer Solutions Center  (317) 963.9700
Toll free  (800) 455.9776
Business hours are Monday through Friday, 8:00 a.m. to 5 p.m.

Sales
Account Executives –William Trout -Indianapolis  (317) 963.9790
Linda Rullman- Lafayette  (765) 448.8348
Toll Free  (800) 455.9776
Business hours are Monday through Friday, 8:00 a.m. to 5 p.m.

Claims Inquiry, Eligibility and Benefits
Provider Services Department  (317) 963.9920
Toll free  (866) 218.1524
FAX number  (317) 963.9801
TTY, Indiana Relay  (800) 743.3333

Provider Relations  (317) 963.9930
Toll Free  (877) 793.8361
FAX  (317) 962.2551
Send claims, including all corrected claims to:

Government Products Claims
PO Box 4287
Scranton, PA 18505
EDI Payor: 95444

Send all refund checks (please include appropriate supporting documentation) to:

IU Health Plans
2432 Reliable Parkway
Chicago, IL 60686-0024

Additionally, claims inquiries may be faxed to Indiana University Health Plans at (317) 963.9800 by using the form in Appendix D, Standard Claim Inquiry Form.
Indiana University Health Plans, Inc. Medicare Advantage Program
Description

Indiana University Health Plans Medicare Advantage (IU Health Plans) is the name of the coordinated health plan offer by Indiana University Health Plans, Inc., an Indiana organization licensed as a Health Maintenance Organization under state law, to meet the health care needs of people enrolled in Medicare and living in the IU Health Plans service area which includes the counties listed on the attached Service Area Map.

The Indiana University Health Plans, Inc. is marketed by IU Health Plans Account Executives to individual Medicare beneficiaries. Medicare beneficiaries are made aware of the IU Health Plans program through print and other marketing media. Information meetings are held routinely throughout the service area. The IU Health Plans Provider Relations staff can supply IU Health Plans brochures for display in your office so Medicare eligible patients can be aware of the program (See Section 5- Plan Benefits).

The Indiana University Health Plans program offers increased benefits and features to current Medicare coverage when a member uses contracted IU Health Plans providers. The member can select the three benefit coverage options. All IU Health Plans include the following benefits/features:

- Coverage to pay for all of the members’ Medicare (Part A) coinsurance and deductible costs associated with hospital and skilled nursing facility services.
- Coverage of physician and medical services (Part B) with low copayments, no deductibles and less out-of-pocket costs.
- Coverage for check-ups and preventive services.
- Immediate coverage with no waiting period for pre-existing conditions.
- Claims are filed for our members.
- Very affordable monthly premiums, in addition to members’ payment of the Medicare Part B premium.
- Convenient, comprehensive health care services.
- A variety of discounts on health services and wellness programs including a Fitness Club reimbursement of up to $150.00 for 2013.

The following additional services are covered only with the IU Health Plans Medicare Choice HMO-POS benefit plan:

- POS Coverage//Out of Network ($10,000 yearly limit)
Indiana University Health Plans, Inc. has entered into a contract with the Centers for Medicare and Medicaid Services (CMS), and under this contract IU Health Plans is allowed to administer Medicare benefits to its enrolled Medicare Advantage members. When Indiana University Health Plans, Inc. was granted this contract and on an ongoing basis, it must demonstrate experience, financial stability and proven ability to work with health care providers.

As a result of the IU Health Plans government contract, and as good managers and health care experts, IU Health Plans has the important job of coordinating members’ Medicare benefits. By doing a good job, IU Health Plans will serve members needs better, save the government money, and cover expenses related to providing quality health care coverage. IU Health Plans has contracted with well established hospitals and physicians to care for our members.

When Medicare beneficiaries choose IU Health Plans, they are selecting a health plan that will bring them peace of mind – no surprises in health care costs. They will have a health plan that delivers better benefits, maximum convenience, and value unavailable in other plans designed to replace or supplement Medicare coverage.

In order for members to receive full IU Health Plans coverage, all of their medical care, except urgently needed care (out-of-area) and emergency care, must be provided or coordinated by the Indiana University Health Plans Medicare Advantage Contracted Primary Care Physician.

Note: The Medicare Choice HMO-POS Plan does include a POS option/out of network for medical services. Maximum out of network coverage for the Choice HMO-POS is $10,000 per year.

If members should receive non-urgent or non-emergency care that is not provided by or authorized by their IU Health Plans Primary Care Physician, or an IU Health Plans Specialty Care Physician, the member will be responsible for all charges. Traditional Medicare will not pay for services to any provider as IU Health Medicare Advantage plan replaces the payment part of traditional Medicare. IU Health Care Medicare Advantage Plan members must use the IU Health Medicare Advantage participating providers in order for benefits to be allowed. Exception to this as mentioned above is a member who is on the Medicare Choice HMO-POS Plan which has a POS option. Maximum out of network coverage for the Choice HMO-POS is $10,000 per year.

IU Health Plans coverage is based on Medicare guidelines. Except for those items specifically excluded by Medicare, IU Health Plans covers all of the hospital, medical, and skilled nursing care benefits as long as members are referred within the IU Health Plans network. In addition, all of our benefit plans allow added coverage for routine vision and preventative dental care. It provides the protection members want and deserve.
**SECTION 3  General Physician Office Information**

**Primary Care Physician**

All Indiana University Health Plans members are required to select a Primary Care Physician (PCP). The member can currently choose a physician from the participating primary care physicians, as detailed in the IU Health Plans Physician Directory or by contacting IU Health Plans Member Services.

**Health Assessment – Personal Wellness Profile**

As a quality initiative to enhance the continuity of care for new members, IU Health Plans has developed a Health Assessment to be completed by each new member. The health assessment provides the Primary Care Physician with historical and current medical information, health behaviors, a brief member depression screening and most importantly, the patient’s perception of his or her own health status.

The Health Assessment will be sent in their New Member packet along with a postage paid envelope to be completed and mailed back in to the IU Health Plans Quality Improvement Department.

The IU Health Plans Quality Improvement Department will forward the completed assessments to the Primary Care Physician (PCP). IU Health Plan’s hope is the information will reach the PCP’s office prior to the patient’s first appointment. The Health Assessment will be sent to the PCP’s office in a blue envelope designated “IU Health Plan Assessment.” IU Health Plans asks that the PCP’s office have a system to link the Health Assessment with the new IU Health Plans patient (See Appendix E- Member Health Assessment Form).

A form for authorization of medical record transfer from the member’s previous physician to the new PCP is also provided to the member for completion at the time of enrollment.

**Guidelines for Physician Availability**

**Patient – Primary Care Physician Relationship** Selection of a primary care physician by the member identifies an intended doctor-patient relationship. While it is appropriate for the physician to establish protocols by which the member is integrated into the practice, the newly selected Primary Care Physicians must be available to see new IU Health Plans patients for acute care, until they can be seen under the established protocols. Primary Care Physicians may access CHP Access to verify patient eligibility, authorizations, etc.

Providers may obtain access and/or instructions regarding on-line verification of eligibility, authorizations, etc. at [www.iuhealthplansmedicare.org](http://www.iuhealthplansmedicare.org) or by contacting IU Health Plans at 317.963.9920 or 317.866.218.1524 for more details regarding access.

**Access for Members**

**Member Access** All IU Health Plans, Inc. members should be able to reach their attending physician or his/her designated covering physician by telephone, for emergencies, within 30 minutes, 24 hours a day, and 7 days a week. For routine messages, a return call should be made
to the patient within one working day. IU Health Plans requires the following standards are maintained regarding appointment availability.

Appointment Standards for Primary Care Physicians are as follows:

<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Maximum Waiting Time for an Appointment</th>
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<tbody>
<tr>
<td>Emergency Imm</td>
<td>ediate</td>
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<tr>
<td>Urgent or Emergent</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Routine, but in need of attention, for symptomatic but non-urgent</td>
<td>Within 5 business</td>
</tr>
<tr>
<td>Routine and Well/preventive care</td>
<td>Within 30 days</td>
</tr>
<tr>
<td>Access to afterhours care</td>
<td>Office number answered 24 hrs/7 days/wk by answering service or instructional message on how to reach a physician.</td>
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On Call Coverage: The covering physician, as well as the Primary Care Physician, must be a credentialed provider by the network and according to IU Health Plans standards.

Appointment Standards for Specialty Care Physicians are as follows:

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<th>Type of Appointment</th>
<th>Maximum Waiting Time for an Appointment</th>
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<tr>
<td>Emergency Imm</td>
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<tr>
<td>Urgent</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Non-Urgent symptomatic</td>
<td>Within 2-4 weeks</td>
</tr>
<tr>
<td>Access to afterhours care</td>
<td>Office number answered 24 hrs/7 days/wk by answering service or instructional message on how to reach a physician.</td>
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Appointment Standards for Behavioral Health Providers

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<th>Type of Appointment</th>
<th>Maximum Waiting Time for an Appointment</th>
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<tr>
<td>Emergency Imm</td>
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<tr>
<td>Urgent or Emergent</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Routine</td>
<td>Within 10 business</td>
</tr>
<tr>
<td>Non life threatening emergency</td>
<td>Within 6 hours</td>
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<tr>
<td>Access to afterhours care</td>
<td>Office number answered 24 hrs/7 days/wk by answering service or instructional message on how to reach a physician.</td>
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</table>
**Interpretive Services**

These Services must be made available for non-English speaking or hearing impaired members at no cost. If resources are not available on site then provider should contact IU Health Plans Customer Service at 317-963-9700 or 1-800-455-9776. TTY users call Relay Indiana at 1-800-743-3333.

**Services Not Covered by Medicare or Not Medically Necessary**

Use of the appropriate form is essential when communicating to members that services are not covered, are not medically necessary, etc. It is important that members receiving such services are informed of potential financial responsibility as an outcome.

- Notice of Medicare Non-Coverage: NMNC - See Appendix-H, I
- Notice of Denial of Medical Coverage: NDMC - See Appendix-L, M
- Detailed Explanation of Non-Coverage: DENC - See Appendix- J, K

**Billing**

The IU Health Plans provider is reimbursed, per their provider agreement. **The member should not be balance billed**, except for uncollected copays or non-covered services. Members can be billed for non-covered services but must be made aware of their financial obligation prior to the services being rendered.

**Charging IU Health Plans Members for Failed Appointments**

IU Health Plans follows policy which states that a failed appointment is defined as a scheduled appointment with an IU Health Plans provider which has been made by an IU Health Plans member, in which the member fails to keep such appointment and does not notify the provider's office of cancellation prior to the appointment. IU Health Plans providers may bill our members for failed appointments contingent upon the following conditions:

- It is the provider's office policy to charge for a failed appointment and it is applicable to all the provider's patients regardless of insurance carrier.
- Patients must be given adequate advance notice of such policy and what the applicable charge will be.
- The charge for the failed appointment must be reasonable, (i.e., not to exceed 50% of the normal office visit charge or the Medicare allowable).

**Copayments**

The only payment required by a member, at the time of a covered service, is the applicable copay. Please refer to the member’s membership card for current copay information or to the IU Health Plans Summary of Benefits. (See Section 5 –Benefits.)

The copayment is to be collected for an office visit when the member has a face-to-face encounter with a professional that can make an independent decision regarding patient care. In addition to physicians, this would include mid-level providers (physician assistants, advanced
practice nurses), optometrists, podiatrists, occupational, speech and physical therapists. If members only see one of the following, a copayment should not be collected: dietitians, Certified Medical Assistants, Licensed Practical Nurses, Registered Nurses, certified diabetes educators and certified health educators.

Copayments should be collected at the time of the visit. However, if the member does not come prepared to pay the copayment, the provider’s office can bill the member. A billing fee limited to $5.00 can be added to the bill as long as the member is given notice of the additional amount.

**Referral Process**

A Primary Care Physician or subcontracted primary care physician may refer to any of the participating IU Health Plans specialists.

No written referral forms and/or referral log is required for members who are referred to in-plan specialists. Pertinent medical information should be provided to the specialist to assist in the consultation.

Network prior authorization is not required for the members to seek care from most participating specialists for most services provided during or in conjunction with an office visit. (See Appendix- A, Quick Reference Guide.)

Our members will receive written notification from the network on all denied services.

**Initial Requests for Health Care Services**

See Section 9 Member Appeals and Grievances.

**Out-of-Plan Referrals**

Any coverage for out of plan routine services requires pre-authorization. For Urgent and Emergent Care see Section 6 – Emergent and Urgent Services.

**Pre-authorization Process**

For specific information, please reference (See Appendix F, G - for applicable Referral Forms and Appendix-A, Quick Reference Guide) or contact the network utilization/medical management department.

**Nursing Home Coverage**

If an IU Health Plans member is in a custodial nursing home, the primary care physician is responsible for the member’s care on a 24 hour, seven day a week basis, just as he or she would be with any established patient in that primary care physician’s practice. The member, if able, should be seen in the PCP’s office for routine care. If transportation from the custodial setting is unavailable or not feasible, the PCP is to see the member on rounds or may designate another in
plan provider to conduct the rounds. The custodial rounds are covered services for our members as long as they meet Medicare guidelines.

**Patient Self Determination Act - Advanced Directives**

IU Health Plans members receive information regarding the Patient Self Determination Act permitting the member to make some written instructions for the health care providers to use should the member become unable to communicate. The member is given forms to complete to accomplish this goal. The member can change any of these forms at any time. Indiana law permits the member to make advanced directive on one of the following forms which the member receives at the time of enrollment:

- **Appointment of Health Care Representative.** This form allows a member to appoint another adult to make decisions about his or her health care, if the member is unable. That person is expected to act according to the member’s opinions and desires. If the member does not appoint someone, Indiana law says that the member’s spouse, parents, adult siblings, and adult children may make these decisions. Because all of these people have the same authority, the member may want to appoint one person to avoid disagreements. (Note: Someone with “power of attorney” does not have the power to make health care decisions unless this is specifically written in the document.)

- **The Living Will.** If the member becomes “terminally ill” and is expected to die within a short period of time, this completed form tells the physician that the member does not want to be given artificial treatments to prolong life.

- **Life-Prolonging Procedures Declaration.** This form permits the member to request the use of life-prolonging procedures that would extend the member’s life, without regard to his or her condition or chances of recovery.

**Member Disenrollment**

A provider may not request a Indiana University Health Plans member disenroll from the plan. The plan may request Disenrollment for cause and with Centers for Medicare and Medicaid Healthcare Services (CMS) permission (e.g., the enrollee fails to pay required charges, moves out of the geographic service area, commits fraud or abuse with the membership card, or engages in disruptive behavior). If providers believe there is just cause for such disenrollment, they should notify IU Health Plans Provider Relations Department in writing with the specific details. The member must be given thirty (30) day notice prior to the time the provider would cease to see the patient.

If a physician no longer wants to continue to see a patient with our coverage, he or she must notify the IU Health Managed Care Department who will then send to the Medical Director for approval. The physician will also notify the patient 30-days prior to the time the provider would cease to see the patient as well as notifying the Plan so that the member can be assigned a new PCP.
Determining Eligibility
A person is eligible for IU Health Plans Medicare Advantage plans if:

- The person is enrolled in Medicare Part A and Part B.
- The person lives in the service area which includes Benton, Blackford, Boone, Brown, Carroll, Clay, Clinton, Delaware, Grant, Greene, Hamilton, Hancock, Hendricks, Henry, Howard, Jay, Johnson, Lawrence, Marion, Monroe, Morgan, Orange, Owen, Parke, Putnam, Randolph, Shelby, Tippecanoe, Tipton, Vermillion, Vigo, and White Counties. (See Appendix– N, List of Approved Indiana Counties-Service Areas)
- The person does not have End Stage Renal Disease (ESRD). A person with ESRD who has received a kidney transplant and is no longer in dialysis may enroll.

Verifying Eligibility
Eligibility can be verified by the member’s membership card, or if the member does not have a membership card, the provider can call the IU Health Plans Provider Services department at (317) 963-9920, or toll free (866) 218-1524 to verify eligibility.

Customer Solutions Center
IU Health Plans believes it is critical to provide consistent and accurate responses to all IU Health Plans members and to actively monitor member feedback concerning their physicians. Consequently, the IU Health Plans Customer Solutions Center is responsible for:

- Having a dedicated Member Service Department with an “800” telephone number, (800) 455-9776 and TTY telephone number, (800)743-3333 (Relay Indiana)
- Documenting member concerns in a call tracking system
- Following the Centers for Medicare and Medicaid Services (CMS) requirements for resolution of member concerns, appeals and grievances
- Processing of reconsiderations and expedited appeals per CMS guidelines
- Developing systems for trend analysis of member concerns based on system identification of plan and physician.

Please direct all IU Health Plans member inquiries concerning plan benefits or procedures to IU Health Plans Customer Solutions Center at (317) 963-9700 or (800) 455-9776. Business hours are Monday through Friday, 8:00 a.m. to 5 p.m.

Enrollment
IU Health Plans Medicare Advantage members have specific open enrollment periods. Qualified Medicare beneficiaries must complete and submit a IU Health Plans application, in a valid election period, by the end of the month prior to the requested effective date of coverage.
• Annual Election Period (AEP) – October 15 through December 7 every year – Beneficiaries may make any change in the way they receive Medicare and will have a January 1 effective date

• Medicare Advantage Disenrollment Period (MADP) – Beneficiaries may make one change to return to Original Medicare. Beneficiaries may also elect a Medicare Prescription Drug Plan in addition to Original Medicare. Beneficiaries may NOT change from one Medicare Advantage plan to another during this election period.

• Other special enrollment periods could apply – contact IU Health Plans Customer Solutions Center if more information is needed

All IU Health Plans members are effective on the first day of the month. An IU Health Plans application must be in our office by the last day of the previous month for processing, per the guidelines of the Centers for Medicare and Medicaid Services (CMS). Applications will be taken up to three months in advance.

When an application is received at the IU Health Plans office, it must first be submitted to the Centers for Medicare and Medicaid Services (CMS) office for approval for enrollment into the IU Health Plans program. If the application has been submitted with the incorrect information and CMS does not approve the application, membership will be denied until the information is corrected. A copy of the prospective member’s Medicare card may be made to assist in verifying the information with CMS. All IU Health Plans members are covered under individual contracts.

The member must choose a primary care physician (PCP) from a list of the IU Health Plans participating primary care physicians. (See www.iuhealthplansmedicare.org – Physician/Provider Directory.)

Membership Card

All IU Health Plans members receive a white membership card at the time of their confirmed enrollment. The IU Health Plans member is instructed to present the card at each visit.

Please note: IU Health Plans urges physicians and their staff to ask Medicare beneficiaries if they have coverage in addition to Medicare. This may help remind them to give the physician’s staff their IU Health Plans information.

The members may present a copy of their enrollment application or acknowledgement letter in lieu of their membership card if the IU Health Plans card has not been received. This occasionally happens when the member has recently enrolled in IU Health Plans.

Sample IU Health Plans Membership Card

The white membership card has the IU Health Plans logo in the upper left-hand corner of the card. The card has a unique eleven-digit IU Health Plans member number. Please refer to this eleven digit member number when making inquiries. The card indicates the member name, the PCP name, and the PCP’s telephone number.

The card also indicates the copayments for an office visit (PCP), specialist (SPEC), emergency room (ER), and urgent care center (UCC). To obtain the members effective date, you may contact IU Health Plans Provider Services by calling (317) 963-9920.
The IU Health Plans group number is the Policy # as indicated on the card. See SAMPLE CARDS for differences based on PCP selection and appropriate contact information regarding preauthorization, Dental and Vision information which is listed on the back of the card.

**SAMPLE CARD**

**IU Health Plans Primary Care Membership Cards:**

Members that selected a **IU Health Plans Primary Care Physician** will have ID Cards with the following information:

---

**Front of card**

**MEDICARE SELECT PLUS**

**CO-PAYS**

<table>
<thead>
<tr>
<th>Service</th>
<th>Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>$10</td>
</tr>
<tr>
<td>SPEC</td>
<td>$40</td>
</tr>
<tr>
<td>ER</td>
<td>$65</td>
</tr>
<tr>
<td>UCC</td>
<td>$50</td>
</tr>
</tbody>
</table>

**www.iuhealthplansmedicare.org**

**Back of card**

**Members**

Monday - Friday
8 am - 5 pm
317-963-9700
toll free: 800-455-9776
TTY (Relay Indiana):
800-743-3333
1776 N Meridian St
Indianapolis, IN 46202

**Guardian Dental** | Group #00480261 | 800-541-7846
**Eye Med Vision** | Group #9855115 | 866-723-0514

**Providers**

Send medical claims, coinsurance and deductible claims to:
Government Products Claims,
Indiana University Health Plans
PO Box 4287, Scranton, PA 18505

PreCert: 317-962-2378 or 866-492-5878
Benefits/Claim Status: 317-963-9920
(Hospital precertification is required for maximum benefit payments)

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IU Health Plans members receive their membership cards and a IU Health Plans Membership Kit of information, per federal guidelines, that apprises them of their rights, benefits, and explains the details of the IU Health Plans option that was selected.
Disenrollment – Voluntary

If a member wishes to disenroll from IU Health Plans, he or she, or their legal representative, can write or fax a letter to IU Health Plans or fill out a disenrollment form and send it to IU Health Plans Enrollment Department at 1776 N. Meridian Street, Suite 300, Indianapolis, IN 46202 or to the fax number (317) 963-9800. The member can obtain a disenrollment form by calling the Customer Solutions Center at (317) 963-9700 or (800) 455-9776. The member can also call 1-800 MEDICARE (1-800-633-4227), which is the national help line.

IU Health Plans will then send a letter to the member to confirm when the membership will end. This will be the disenrollment date. The disenrollment date will be the first day of the month that comes after the month IU Health Plans received the request to leave, or, at the member’s request, a later date of up to three months after the request is received. (CMS does not allow retroactive disenrollments.)

Even though members request disenrollment, they must continue to receive all covered medical services from participating providers of IU Health Plans until the effective date of disenrollment in order for IU Health Plans to be financially responsible. If members elect to receive non-urgent or non-emergency care that is not provided or authorized by their IU Health Plans PCP prior to the effective date of disenrollment, the member will be responsible for all charges. IU Health Plans will not be obligated to process any claims related to services so obtained.

Disenrollment - Involuntary

Members may be involuntary disenrolled from IU Health Plans by The Plan only for the following reasons:

1. Members move out of the IU Health Plans geographic service area or live outside the plan’s service area for more than 6 months at a time.

2. If members do not stay continuously enrolled in Medicare Part A and Part B.

3. If members give IU Health Plans information on the enrollment form that they know is false or deliberately misleading, and it affects whether or not they can enroll in IU Health Plans.

4. If members behave in a way that is unruly, uncooperative, disruptive or abusive, and this behavior seriously affects IU Health Plans’ ability to arrange or provide medical care for the member or for others who are members of IU Health Plans. IU Health Plans cannot make members leave the Plan for this reason unless we get permission first from the Centers for Medicare & Medicaid, the government agency that runs Medicare.

5. If members let someone else use their plan membership card to get medical care. Before IU Health Plans asks the member to leave the Plan for this reason, we must refer the case to the Inspector General, and this may result in criminal prosecution.

6. If members do not pay the plan premiums or cost sharing, IU Health Plans will notify them in writing before they are required to leave the Plan.

7. The contract between IU Health Plans, Inc. and CMS is terminated.

Please note: The PCP is to notify IU Health Plans as soon as possible when a member is deceased. Enclosed is the form to be used to notify the plan.
Members Change of Primary Care Physician
If members wish to change their PCP, they can call the IU Health Plans Customer Solutions Center to do so. The change can be effective in 24 hours. Members may not receive their new membership card for ten to fourteen days.

Financial Assistance for Medicare Premium
There is help available to people with Medicare who need financial assistance with Medicare premium costs. This assistance, provided through Indiana’s Medicaid program, consists of three levels:

- Qualified Medicare Beneficiary (QMB)
  
  **QMB:** Medicaid is responsible for deductibles and coinsurance for all Medicare covered services and the Medicare program premium through the “Buy-In” program. A QMB is not eligible for non-Medicare covered benefits, such as dental or pharmacy services.

  **QMB Also:** An individual who is eligible for Medicaid because of the ‘spend down’ program. Medicaid pays the deductibles and coinsurance for all Medicare covered services and will pay for services covered by Medicaid after the spend-down is met.

- Special Low Income Beneficiary (SLMB)
  
  **SLMB:** Medicaid pays the Medicare Part B premium.

Please note: Medicaid payment of HMO premium is not an option in Indiana at this time. If the Medicare Beneficiary should need more information they can call the state’s Senior Health Insurance Information Programs (SHIIP) at (800) 452-4800 or (317) 233-3475.
Indiana University Health Plans, Inc. - Medicare Advantage Plan Benefits

IU Health Plans Medicare Advantage (MA) Summary of Benefits for each plan can be found on our website www.iuhealthplansmedicare.org on the Plan Benefit page www.iuhealth.org/medicare/plan-options/plan-benefits/
SECTION 6  Emergent and Urgent Services

What is a “medical emergency”?  
A “medical emergency” is when the member reasonably believes that his or her health is in serious danger when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting worse.

What should members do if they have a medical emergency?  
If members have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room. It is not necessary for members to get permission first from the Primary Care Physician (PCP) or other plan providers.

- Members need to make sure that the PCP knows about their emergency because the PCP will need to be involved in following up on the emergency care. The member or someone else should call to tell the PCP about the emergency care as soon as possible, preferably within 48 hours. The PCP’s phone number is on the front of the ID membership card.

The PCP will help manage and follow up on the member’s emergency care
The PCP will talk with the doctors who are giving the emergency care to help manage and follow up on the care. When the doctors who are giving the emergency care say that the patient’s condition is stable and the medical emergency is over, what happens next is call “post-stabilization care.” Follow up care (post-stabilization care) will be covered according to Medicare guidelines. In general, the PCP will try to arrange for plan providers to take over the member’s care as soon as the medical condition and the circumstances allow.

What is covered if a member has a medical emergency?  
- Members can get covered emergency medical care whenever it is needed, anywhere in the world for members with the Choice Plan and anywhere in the United States for members with the Select and Select Plus Plans.

- Ambulance services are covered worldwide in situations where other means or transportation would endanger the member’s health for members with the Choice Plan and anywhere in the United States for members with the Select and Select Plus Plans.

Please note: There is an applicable copay per emergent visit for members for services that do not result in an admission to a hospital. See Section 5 for member benefits.

What if it wasn’t really a medical emergency?  
Sometimes it can be difficult for members to know if they have a real medical emergency. For example, members might go in for emergency care thinking that their health is in serious danger and the doctor may say that it was not a medical emergency after all. If this happens, members
are still covered for the care they received to determine what was wrong, (as long as members thought their health was in serious danger, as explained under “medical emergency” above.). However, please note:

- If the member gets any additional care after the doctor says it was not a medical emergency, IU Health Plans will only pay our portion of the covered additional care if the member gets it from a plan provider.

- If the member gets any additional care from a non-plan provider, after the doctor says it was not a medical emergency, the member would normally have to pay Original Medical out-of-pocket amounts. There is an exception: IU Health Plans will pay our portion of the covered additional care from a non-plan provider if the member is out of the service area, as long as the additional care the member gets meets the definition of “urgently needed care” that is given below.

What is “urgently needed care”?

“Urgently needed care” is when members are temporarily out of the service area and they need medical attention right away for an unforeseen illness or injury, and it is not reasonable given the situation for members to get medical care from the PCP or other plan providers. In this case, the member’s health is not in serious danger.

What is the difference between a “medical emergency” and “urgently needed care”?

The main difference between an urgent need for care and a medical emergency is in the danger to the member’s health. “Urgently needed care” is if members need medical help immediately, but their health is not in serious danger. A “medical emergency” is if members believe that there is serious danger.

How to get urgently needed care

IU Health Plans covers urgently needed care that members get from non-plan providers when they are outside the plan’s service, IU Health Plans prefers that members call the PCP first, whenever possible. If members are treated for an urgent care condition while out of the services area, IU Health Plans prefers that they return to the service area to get follow-up care through the PCP. However, IU Health Plans will cover follow-up care that members get from non-plan providers outside the plan’s service area as long as the care they are getting still meets the definition of “urgently needed care”.

Please note: There is an applicable copay per urgent visit for all IU Health Plans members. See Section 5 for member benefits.
Quality Improvement Program

IU Health Plans, Inc. established and maintains an on-going program of quality improvement to facilitate continuous improvement of health care, clinical education, safety, and services in order to meet customer needs and expectations and to enhance or improve the health status of IU Medicare members, thus, supporting our mission of providing cost-effective, appropriate, quality healthcare and responsive customer service to members. Components of the QI program may include, but are not limited to:

- retrospective review and investigation of complaints about quality of care
- share findings with other peer review committees, such as the Credentialing Committee
- Credentialing of providers

The Centers for Medicare & Medicaid Services (CMS) requires Medicare plans to report HEDIS™ measures, as detailed in the HEDIS Volume 2: Technical Specifications manual. Annually, HEDIS™ data may be collected through a contracted vendor or by IU Health Plans clinical staff under the direction of the Quality Management Department. IU Health Plans will collect as much of the data as possible from claims and encounter data; however, chart review is required when claims/encounter data need verification or the data is not available. Providers shall allow the IU Health Plans vendor or staff to access member medical records for HEDIS™, or any other data collection purposes.

RISK MANAGEMENT

The purpose of the risk management component of the Quality Management Program is to control risk due to adverse patient occurrences associated with care or service. The risk management function is integrally linked to Quality Improvement. Ongoing monitors include member complaints or appeals, quality of care occurrences, quality of service occurrences, practitioner malpractice case reviews, and medical licensing board actions. Occurrences may be reviewed by the Plan Medical Director, in-house counsel, and the Credentialing Committee and appropriate action will be initiated when indicated.

CREDENTIALING

The credentialing process allows IU Health Plans to contract with healthcare practitioners who demonstrate competency and a commitment to excellence in the delivery of healthcare services. The credentialing process applies to all contracted IU Health Plans providers including MDs, DOs, DPMs, DDSs, DCs and Behavioral Health Practitioners- psychiatrists and physicians certified in addiction medicine, doctoral level Indiana practitioners licensed with HSPP designation, licensed clinical social workers, licensed marriage and family therapists, licensed mental health counselors, licensed psychiatric clinical nurse specialists, licensed psychiatric advanced practice nurses, other licensed independent practitioners, and practitioners who have an independent relationship with the organization. DDSs are only required to be credentialed if they provide care under the managed care organization's medical benefits. Practitioners excluded from credentialing include the following:
- Practitioners with exclusive practice within the inpatient setting and who provide care for members only as a result of members being directed to the facility.
- Practitioners with exclusive practice in free-standing facilities and provide care only as a result of members being directed to the facilities, such as urgent care center, mammography centers, surgical centers, psychiatric and addiction disorder clinics.
- On-call coverage only practitioners
- Practitioners who do not provide care for members in a treatment setting, such as telemedicine.

IU Health Plans complies with the Indiana Credentialing Statute for HMOs, IC 27-13-1-10 by using the prescribed application form of the Council for Affordable Quality Healthcare (CAQH). IU Health Plans credentialing policies and procedures will incorporate NCQA and CMS requirements and will be reviewed by the CHP Credentialing Committee at least annually to maintain compliance with current standards.

Minimum standards for practitioner applicant process and review by the committee include:

- Current unrestricted state license to practice medicine, dentistry, podiatry, chiropractic medicine, behavioral health, nursing and others as appropriate. The only exception is if practitioner is on probation for alcohol or other drug abuse. If the practitioner has been licensed less than 5 years in the current state, additional queries will be made to previous states of licensure or the Federation of State Medical Boards.
- Practitioner may be on probation by the licensing board for alcohol or other drug abuse, provided they are in compliance with treatment as prescribed by the Board and provide evidence of compliance and participation.
- Board certification in specialty area. Practitioners may be considered for exception if Board Eligible following completion of residency/fellowship. If not board certified or eligible, a practitioner may be allowed to become a member if he possesses comparable competence.
- Graduation from medical school, dental school, podiatry school, or Chiropractic College, or appropriate school as applicable.
- Current DEA certificate, as applicable to profession.
- No Medicare/Medicaid sanctions.
- Not on the OIG exclusion list.
- Not on the Medicare Opt-Out list.
- Five year work history. A work history gap of 6 months or more is reviewed. A gap that exceeds one year requires a written explanation.
- Current evidence of professional liability insurance coverage, showing qualification as a provider in the Indiana Patient Compensation Fund, or are individuals covered by the FTCA.
- Professional liability insurance coverage of a least $1,000,000/$3,000,000 if licensed and an ineligible Indiana Health care practitioner. For ancillary Behavioral Health practitioners not included in the definition of Health Care Provider under IC 34-18-2-14, lower professional liability insurance coverage will be considered.
- Acceptable National Practitioner Data Bank Report (NPDB) (not applicable to DCs and DPMs) and Healthcare Integrity and Protection Data Bank Report (HIPDB).
- Malpractice claims history that includes a detailed report of occurrence of each liability claim filed, in process, or resolved in the past ten (10) years. Claim history is acceptable in terms of frequency, severity, patterns and trends.
• Disclosure of the reasons for any inability to perform the essential functions of the position, with or without accommodation; to the lack of present illegal drug use; and history of loss of license and/or felony convictions.

• Disclosure of history of all past and present issues regarding the loss or limitation of clinical privileges or disciplinary action at all facilities or organizations with which the practitioner has had privileges.

• Completed application with attestation statement signed and dated by the applicant confirming the correctness and completeness of the application within 180 days of the Credentialing Committee decision.

The IU Health Plans Credentialing Committee renders the credentialing decision. Credentialing is generally granted for a three year period; however, the Committee may choose to grant credentialing for a lesser time.

Recredentialing is conducted at least every three years or when the credentialing cycle expires. Approximately 3 months before the recredentialing date, the application is obtained from CAQH, but the office will be contacted if additional information is required. According to NCQA requirements, recredentialing must be completed no later than 3 years from the prior credentialing date. Providers that fail to submit required credentialing documents in a timely manner may be terminated from the network and no longer eligible to see members. At the time of recredentialing, complaints and grievances regarding the provider are reviewed.

A credentials file is maintained on each provider. IU Health Plans maintains credentialing files in a confidential manner and uses all information collected solely for the purpose of credentialing. Committee minutes and discussions are confidential and protected under I.C. 34-30-15.

DISCIPLINARY ACTION

IU Health Plans may take disciplinary action against a provider as a result of any adverse quality of care, utilization, licensure, or credentialing issues. Potential issues may be identified through a number of sources including, but not limited to, medical record reviews, complaint investigation, credentialing issues, quality improvement studies, and review of over and under-utilization practices. As required by applicable law, issues are investigated through the peer review process. If, after investigation, the Peer Review Committee believes a quality issue exists, it may impose the following types of sanctions:

• monitoring of performance
• educate
• counsel
• focused oversight
• termination

If the Committee believes a quality of care issues exists, the provider will be notified in writing. The letter will contain:

• the determination of the Committee
• a general description of the basis for the determination
• specific actions the provider must take to correct the problem
• a description of the process that will be used to evaluate the effectiveness of the intervention
• the provider’s appeal rights
IU Health Plans will report any decision to reduce, suspend or terminate a provider’s participation in the network as required by applicable law and regulation.

Issues that are not related to clinical competency may also be reviewed by the Committee, and action taken, if necessary. Such issues may include:

- failure to participate in Quality Management or peer review activities
- failure to meet other contractual requirement not related to clinical competency
- unethical conduct
- failure to cooperate with IU Health Plans quality improvement program
- failure to cooperate with IU Health Plans utilization management program
- failure to respond to an investigational request
- failure to respond to or comply with a corrective action plan

Any of these failures may result in corrective action by IU Health Plans, including, but not limited to, termination. Termination based on grounds not related to clinical competency shall not constitute grounds for a Peer Review Committee hearing.
SECTION 8

Claims Policy

IU Health Plans/Medicare Advantage provides enrolled beneficiaries with Plan benefit coverage for Medicare Parts A, B, C, & D. We are responsible for the accurate adjudication of medical claims submitted by providers rendering services for our beneficiaries. Our goal is to ensure timely, efficient, and accurate inital determinations, and adjudication of Medicare Advantage Claims as outlined by CMS laws, regulations and Medicare Advantage benefits. The Plan assumes financial responsibility for emergency services in and out of the service area and for out of area urgently needed services. It is the responsibility of the provider and/or beneficiary to follow IU Health Plan’s authorization and in-network expectations as outlined in the Benefit Summary.

- Clean claims must be processed within 30 days.
- Non-Clean claims are to be adjudicated within sixty (60) days of receipt.
- Upon whole or partial adverse determination of a claim, the member is issued an Explanation of Benefits (EOB) and a right to appeal notice.
- Claims adjustments are completed within 60 days of receipt/acknowledgement of required adjustment.

Services Not Covered by Medicare or Not Medically Necessary

Use of the appropriate form is essential when communicating to members that services are not covered, are not medically necessary, etc. It is important that members receiving such services are informed of potential financial responsibility as an outcome.

- Notice of Medicare Non-Coverage: NMNC - See Appendix-H, I
- Detailed Explanation of Non-Coverage: DENC - See Appendix-L, M
- Notice of Denial of Medical Coverage: NDMC - See Appendix-L, M
- Waiver of Non-Coverage (Participating Providers)

Clean claims

Are defined as invoices whereby the services were covered and/or authorized; the member was eligible at the time of service; the invoice was submitted on CMS 1500 or UB 04 and a Medicare Remittance Advice form with the correct codes (CPT-4, ICD-9, DRG, HCPCS or Revenue Code); and the invoice includes member name, date of birth, member number, place of service and date of service.

Non-clean claims

Are defined as claims missing any required documentation and/or information that are required for the accurate adjudication of the claim. Many times documentation is required from an outside source. Such information will be requested either via a letter or EOP to the
submitting/servicing provider. Failure to respond to such correspondence may result in whole or partial adverse determinations.

- Requested information that requires a corrected claim(s) to be submitted:
  - UB04-Bill Type (locator 4) on claim must reflect the appropriate value for corrected claim submission i.e., 00XX7
  - CMS 1500 – To ensure claims do not deny as duplicate please submit CMS 1500 claims via paper with the notation of ‘CORRECTED CLAIM’ on the claim and use only a black pen/marker for quality imaging purposes. Mail claims to the following address:
    Government Products Claims
    Indiana University Health Plans
    PO Box 4287
    Scranton, Pa 18505

Corrected Claims

When submitting corrected claims for reconsideration please see below:
  - UB04-Bill Type (locator 4) on claim must reflect the appropriate value for corrected claim submission i.e., 00XX7
  - CMS 1500 – To ensure claims do not deny as duplicate please submit CMS 1500 claims via paper with the notation of ‘CORRECTED CLAIM’ on the claim and use only a black pen/marker for quality imaging purposes. Mail claims to the following address:
    Government Products Claims
    Indiana University Health Plans
    PO Box 4287
    Scranton, Pa 18505

Billing

Providers and Hospitals shall submit claims data in accordance to appropriate Medicare Billing and National Correct Coding Initiatives (NCCI). All methods of billing for services must include current and applicable CPT-4, DRG, ICD-9, HCPCS, Revenue codes and appropriate modifiers. Claims submitted without such information will be returned to the submitting entity for resubmission. It is required that providers maintain documentation to support the level of service billed and maintain an accurate medical record. Please be aware of the following billing criteria:

- Members cannot be billed for covered services except for uncollected co-pays, co-insurance and deductibles
- Members can be billed for non-covered services but must be made aware of their financial obligation prior to the services being rendered
- Members cannot be held liable for an non-covered CMS service unless notified via provider and a signed document is completed. Applicable modifiers submitted on claim forms noting the member was notified and the provider has a signed document supporting this action will be honored in the payment process.
• Note: When using modifiers to substantiate member knowledge of liability and notification of non-covered services, the provider is required to be able to produce such documentation should the Plan and/or CMS request such information.

Authorization(s) for Medical Services (See Appendix –F or G for appropriate Forms)

If a member has not selected an IU Health Medicare Advantage Plans PCP and services require Plan prior approval, please fax Authorization/Precertification Request form to:

IU Health Ambulatory Care Management
Fax: 317.962.6219 or 317. 962.4005

If a member has selected an IU Health Medicare Advantage Plans PCP and services require Plan prior approval, please fax Authorization/Precertification Request form to:

IU Health Ambulatory Care Management
Fax: 317.962.6219 or 317. 962.4005

Authorization(s) for Part B Drugs

Physician determines that patient needs one of the drugs on the Prior Authorization List (See Appendix –B, Part B Prior Authorization List)
• Prior Authorization (PA) forms can be found under the provider tab at www.iuhealthplanmedicare.org
• Complete PA form and fax to: 317-962-4070 or 866-412-8656
• Pharmacist will review the request and notify you of the results by phone and fax as quickly as required for the medical situation.
  • Standard requests may take up to 14 calendar days
  • Expedited requests may take up to 72 hour
For any questions or urgent needs please call the Pharmacy Medical Mgmt Provider Service line:
• Monday-Friday 8am-4:30pm: 317-962-4019 or 866-412-8644
• Urgent After Hours needs: Page the pharmacist on-call: 317-367-3871

Authorization(s) for Part D Drugs

Determine if the drug prescribed has any prior authorization or step therapy requirements by visiting our website: www.iuhealthplanmedicare.org or See Appendix –B, Part B Prior Authorization List)

Obtain a Coverage Determination/Part D Prior Authorization Form on-line at www.iuhealthplanmedicare.org
• Complete form and fax to:
  • 1-866-429-2260 – Standard - 72 hour response
  • 1-866-497-1386 – Expedited - 24 hour response

• For additional assistance or to request urgent medication(s) by phone call: 1-866-907-7088
Part B and D Drug Authorization Request Tips

- Provide the prescriber information, including contact numbers and address, is complete and accurate.
- Ensure members’ information is completed on the form and the ID number is accurate.
- Attach any supporting documentation that is applicable to expedite the process:
  - Requested laboratory results
  - Diagnostic test results
  - Peer-reviewed medical literature for off-label indications
- Complete the authorization form in its entirety and put applicable information in the comments section:
  - Drugs previously tried or failed
  - Patient medical conditions that favor requested drug over an alternative
  - Special circumstances or medical opinion necessitating requested drug
- This information helps the request get processed faster and avoids unnecessary follow-up and appeals later.

Claim Filing Time Limits

Providers and Hospitals shall submit claims in accordance with applicable contracts with IU Health Plans. CMS claims filing time limit is 365 days from the date of service and or admission date. Claims will be denied when submitted past the filing deadline.

- **In-Network providers**: contracted claims filing limits are specified in your Provider Agreement.
- **Out of Network providers**: claims filing time limits are governed by Medicare law which prescribes specific time limits within which claims for benefits may be submitted.
  - An Out of Network provider that does not have a contract establishing the amount of payment for services furnished to a Medicare beneficiary enrolled in an MA plan must accept the amount that would have been paid under the original Medicare programs as payment in full [42 C.F.R. § 422.214]
  - Non-contracted providers are required to participate in Medicare to receive payment for services unless services are deemed medically necessary for the member or are approved by the Plan.
- **Provider Enrollment, Chain and Ownership (PECOS)**: Provider Enrollment, Chain and Ownership (PECOS): Provider Enrollment, Chain and Ownership (PECOS) supports the Medicare provider and supplier enrollment process by capturing provider/supplier information from the CMS-855 family of forms. The system manages, tracks, and validates enrollment data collected in both paper form and electronically via the Internet. This website allows registered users to securely and electronically manage Medicare enrollment information. Information provided below is from the Center for Medicare and Medicaid Services listed as: https://pecos.cms.hhs.gov/pecos/login.do
  - Registered users may:
    - Submit an enrollment application to Medicare.
    - View or update existing enrollment information.
• View the status of applications submitted to Medicare from this website.
• Voluntarily withdraw enrollment in Medicare.
• IU Health Plans encourages participating Medicare providers to enroll and maintain data in the PECOS. This will ensure CMS has the most current enrollment information for participating providers’ data and confirm the provider is enrolled in Medicare. Remember, non-contracted providers are required to participate in Medicare to receive payment for services unless services are deemed medically necessary for the member or are approved by the Plan.

**Claims Formats for Submission**
Provider shall submit claims in one of the following formats utilizing all appropriate segments and box/field locators to ensure a clean claim:

- HIPAA Complaint
- EDI Compliant Format
- CMS 1500 (paper claims)
- UB04 (paper claims)

**Claims – Paper**

IU Health Plans must receive paper claims on CMS 1500 or UB04 Standard documents. Claims submitted on any form other than those mentioned will be returned to the submitting entity. All claims with attachments should be stapled when submitted. Paper claims should be sent to:

Government Products Claims
Indiana University Health Plans
PO Box 4287
Scranton, Pa 18505

**Claims - EDI**

IU Health Plans accepts medical claims electronically. Our EDI clearinghouse is Emdeon. If you are interested in submitting claims electronically, please contact IU Health Plans EDI Services at 317.963.9760, 317.963.9775 or visit [www.iuhealthplansmedicare.org](http://www.iuhealthplansmedicare.org).

**Imaging Quality - Claims and/or Requested Documentation**

Paper claims and/or requested documentation are to be free of add-on items or any markings that will deter the claim from meeting the criteria required to obtain a quality image for adjudication. Some examples of these claim add-ons or items are: stickers, highlighting of fields, combination of written and keyed data, non-standard fonts, and light or faded ink/toner color, etc.

**Clinical Editing**
Clinical Editing encompasses a comprehensive set of clinical claims editing criteria that will allow for the evaluation of medical billing information and coding accuracy. IU Health Plans clinical editing criteria follow guidance from CPT Coding instructions, The National Correct Coding Initiative (NCCI) and other Medical Specialty Guidelines. Please note this essential transition allows us to ensure consistency in coding, processing and payment of claims in accordance NCCI practice standards for both CMS 1500 and UB04 outpatient claims. Clinical Editing is designed to detect irregularities in medical billings such as:

1. Incidental Procedures
2. Mutually Exclusive/Redundant Procedures
3. Unbundling/Rebundling
4. Clinical Editing also checks for cosmetic procedures, outdated/invalid codes, assistant surgeon eligible, investigational (experimental) codes, diagnosis codes, same day procedures, surgical follow-up days and appropriateness of age/gender/place of service.

As an IU Health Plans provider, we appreciate your commitment to accurate claims coding and “clean claims” submission. Please use the IU Health Plans, Inc. Clinical Editing Provider Dispute Form for providers who question the consideration of a claim for payment. (See Appendix-O & P) Please see the bottom of the form for submission address and contact information. This document is to be used for Clinical Editing Disputes Only. Failure to use this form appropriately will ensure no review of the request and immediate return of the request to the submitting provider.

**National and Local Coverage Determinations (LCD & NCD)**

National Coverage Determinations (NCD) are a United States' nationwide determination of whether Medicare will pay for an item or service. Medicare coverage is limited to items and services that are considered "reasonable and necessary" for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category).

Local Coverage Determinations (LCD) are contractor-developed coverage policies, pertaining to services or items not addressed in National Coverage Determinations (NCDs) or program manuals. LCDs contain coding and utilization guidelines as well as descriptive passages. LCDs sometimes contain some Centers for Medicare & Medicaid Services (CMS) language as well, which is italicized.

LCDs are developed for various reasons, some of which are:

- To define the appropriate use of new technologies
- To address services with an abuse history or potential
- High volume, high dollar services

In the absence of a NCD, an item or service is covered at the discretion of the Medicare contractors based on a Local Coverage Determination (LCD) that is defined by each States’ MAC (Region and Medicare Contractor). Indiana follows WPS Medicare Part A J5 MAC/J8 MAC and WPS Medicare Part B J8 MAC LCD’s.

**Coordination of Benefits (COB)**
Claims for secondary reimbursement must be submitted to IU Health Plans in such timeframe as required under applicable law and regulation. All explanations of payment or denials from the Member’s primary carrier must be provided with the Claim. You may send this information to:

**Disputing Claims Payment Decisions**

If a Provider or Hospital disagrees with the adjudication of a claim by IU Health Plans, call the Provider Services at 317.963.9920 or 866.218.1524. The Provider and the Plan shall do all that is possible to resolve the concern, to the extent possible, by informal meetings and discussion in good faith between appropriate representatives of the parties. (See Appendix-D or C)

**Explanation of Payment**

Providers will receive a Remittance Advise (paper and/or electronic 835) along with claim(s) payments/checks. The EOP will provide detailed information about submitted claims received and adjudicated by IU Health Plans.

- Corrected paper claims may be sent directly to the address below with a notation of “corrected claim on the document:

  Government Products Claims  
  Indiana University Health Plans  
  PO Box 4287  
  Scranton, Pa 18505

- Corrected EDI claims may be sent via electronic transmission with the appropriate value displayed to ensure claim is identified as a “corrected claim.”

**Preventive Services**

IU Health Plans provides coverage for preventive and/or wellness care for its beneficiaries as outlined by CMS. Such services are provided under Part B and are determined to meet certain requirements, effective for services furnished on or after January 1, 2009. These services are defined as services that identify medical conditions or risk factors and that are determined to be

1. reasonable and necessary for the prevention or early detection of an illness or disability,  
2. recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF), and  
3. appropriate for individuals entitled to benefits under Part A or enrolled under Part B. Such services are noted as the IPPE, screening mammography, colorectal cancer screening services, cardiovascular screening tests, etc. To see a complete list of such benefits refer to the appropriate IU Health Plans Summary of Benefits link provided in Section 5 Benefits and or the Medicare @ www.medicare.gov.

**Preventive and Sick Visit Coding on Professional Claims**
IU Health Plans policy does not allow for reimbursement of additional services billed on the same date of service and that is covered and/or is a part of a Preventive and/or Wellness visit. Some of the components of a medically necessary E/M service (e.g., a portion of history or physical exam portion) may have been part of the Preventive Visit Exam and should not be included when determining the most appropriate level of E/M service to be billed for the medically necessary E/M service.

**National Provider Identifier (NPI)**

The National Provider Identifier is required on all claims for adjudication consideration. Applicable fields on both paper UB04 and CMS 1500 claims must contain NPI for primary and secondary providers. EDI claims must contain NPI in the appropriate segments for primary and secondary providers. Claims submitted without the Provider NPI will be returned to the provider.

**Overpayment Recoveries**

Overpayment recoveries will be deducted from future payments unless otherwise acknowledged with IU Health Plans Provider Contracting. Such recoveries will be noted on the Remittance Advice for appropriate posting. If there are questions regarding an overpayment recovery, contact IU Health Plans Provider Services at 317.963.9920 or 866.218.1524.

**Provider Medicare Number**

When billing for Home Health, Skilled Nursing, ESRD (facility only) the provider Medicare Number should be displayed in box 51 on the UB04 to ensure timely claim adjudication and potential payment.

**Timely Notice of Demographic Changes**

Please notify Provider Relations (applicable contracting area/IU Health or ProHealth) of changes to demographic information that differs from the information reported with your executed participation agreement with IU Health Plans, including, but not limited to, TIN changes, address change, additions or departures of health care providers from your practice and new service locations.

**Revenue Recovery/Subrogation/Worker’s Compensation (TPL)**

Revenue Recovery/Subrogation is based on the right of IU Health Plans’ member who suffered injury/illness caused or contributed to by a third party to recover damages from that entity. IU Health Plans’ recovery process is solely for the value of services rendered or the expenses incurred in treating the member for those injuries/illnesses. IU Health Plans will first adjudicate claims to ensure appropriate medical care for our members in such situations, and then pursue reimbursement from the appropriate third party payor. Subrogation review/process routinely takes a considerable amount of time to resolve. In almost all cases, the claim for a provider’s services will be paid before the subrogation process is initiated.
As with COB, providers are asked to report potential subrogation and Worker’s Compensation cases (using the appropriate spaces on the CMS 1500 Claim Form) to IU Health Plans. In addition, it is routine practice for IU Health Plans to notify the member via an Accident/Injury Inquiry Form requesting any potential third party liability payer information should claim data depict an accident/injury. IU Health Plans retain all rights to any sums payable under such circumstances unless otherwise contractually noted.

**Health Risk Assessment (HRA)**

Effective January 1, 2012, CMS adopted criteria for a health risk assessment (HRA) to be used as part of the Annual Wellness Visits (AWVs). MAOs and their contracted providers are expected to incorporate this change to the AWV for CY 2012. No cost sharing will be applied to the member for such service(s).
SECTION 9  Member Appeals and Grievances

All members concerns are resolved through one of the following:

Grievance Procedures

The IU Health Plans, Inc., internal grievance procedures apply only in cases when the Medicare appeals procedures do not apply. The following is a list of complaint issues in which the Plan grievance procedures should be used:

- time spent on the telephone with the doctor’s office or in the waiting or exam room
- disrespectful or rude behavior by doctors, nurses, receptionists or other staff,
- cleanliness or condition of doctor’s office, clinics, or hospitals
- the quality of the medical care the member received, including the quality of care during a hospital stay
- if members feel they are being encouraged to leave (disenroll from) IU Health Plans, or feel they are being discouraged from seeking the care that members feel they need
- the quality of customer service members receive
- Involuntary disenrollment situations, though disenrollment for cause requires prior CMS approval.

When members have such problems that have not been resolved to their satisfaction, they may submit a grievance either verbally or in writing. Members can either call the IU Health Plans Membership Services Department at (317) 963-9700 or toll free within Indiana (800) 455-9776 or TTY, call Relay Indiana 1-800-743-3333. Business hours are Monday through Friday, 8:00 a.m. to 5 p.m. Written grievances should be addressed to:

    IU Health Plans, Inc.
    Attention: Grievance and Appeals Department
    950 N. Meridian Street, Suite 200
    Indianapolis, IN 46204

Members must be notified of the decision as quickly as the case requires based on the health status, but no later than 30 calendar days. IU Health Plans can extend to time frame by up to 14 calendar days if a member requests the extension, or if the Plan justifies a need for additional information and the delay is in the member’s best interest.

Medicare Appeals Procedures

IU Health Plans members have a right to appeal any decision about the Plans’ payment for or failure to provide what members believe are Medicare covered services provided with IU Health
Plans Medicare Advantage. Members have the right to appeal if they do not agree with the Plan’s decisions about medical bills or health care.

When members want IU Health Plans to reconsider and change a decision that has been made about what services or benefits that are covered (which includes whether or not we will pay for the care or how much we will pay), members can file an appeal. That is to say specifically, members may file an appeal under these conditions:

- IU Health Plans, or its plan providers, will not approve or give the member the care that the Plan should cover or what we will pay
- If members think that IU Health Plans has refused to pay for services that they think are covered
- IU Health Plans has not paid a bill;
- IU Health Plans has not paid a bill in full.

Members can appeal if they think they are being discharged from a hospital or coverage in a skilled nursing facility (SNF) or comprehensive outpatient rehabilitation facility (CORF) is ending too soon. These appeals should be made by members directly and immediately to Health Care Excel at (800) 288-1491. Health Care Excel is the Quality Improvement Organization in the State of Indiana.

Members can ask for a “fast decision” by calling IU Health Plans at (317) 963-9700, toll free within Indiana, (800) 455-9776 (Business hours are Monday through Friday, 8:00 a.m. to 5 p.m.) or members deliver a written request to IU Health Plans, 1776 N. Meridian, Suite 300, Indianapolis, IN 46202 or fax it to (317) 963-9800. Members must be sure to ask for a “fast” or “72 hour” review.

**Medicare Appeals Process**

There are two (2) appeals processes for Medicare appeals. There is a 30-day process and an expedited, or 72-hour, appeal process. The following will provide information on how members can file and appeal under each of these processes.

**30-days Appeal Process**

The 30-day appeals process can be used for all Medicare appeals. If members want to file an appeal which will be processed within 30 days, they can do the following:

A. Notify IU Health Plans by mail or deliver in person the written appeal request to the Plan at the following address:

   IU Health Plans  
   Attention: Grievance and Appeals Department  
   950 N. Meridian Street, Suite 200  
   Indianapolis, IN 46204

B. Members must file the appeal request within 60 calendar days of the date they are notified of the initial decision from IU Health Plans.
C. The Plan is responsible for processing the appeal request within 30 days from the date the request is received at IU Health Plans. If the Plan does not rule in the member’s favor, IU Health Plans will forward the appeal request for a decision to an independent review organization contracted by the Centers for Medicare and Medicaid Services.

**Fast or 72-hour Appeals Process**

IU Health Plans normally has 30 days to process a member’s appeals requests. In some cases, members may have the right to a faster 72-hour process. Members can get a fast appeal if 30 days for a standard 30-day appeal could seriously harm their health. If members ask for a fast appeal, IU Health Plans will decide, based upon established criteria, whether a 72-hour/fast appeal should be granted. If it is decided the appeal does not meet the expedited criteria, the appeal will be processed in 30 days. If any doctor asks the Plan to give the member a fast appeal, IU Health Plans must grant the appeal.

**Please note:** The fast 72-hour appeal option does **not** apply to the denial of a claim payment.

A. Filing a 72-hour Appeal – If members want to file an appeal that will be processed in 72 hours, they should do the following:

1. File an **oral or written** request for a 72-hour appeal. The member should specifically state, “I want a fast appeal or 72-hour appeal,” or “I believe my health could be seriously harmed by waiting 30 days for a standard appeal.”
   a. The member can file a request for a 72-hour appeal by calling IU Health Plans at (317) 963-9700; toll free at (800) 455-9776 or TTY, call Relay Indiana 1-800-743-3333. Business hours are Monday through Friday, 8:00 a.m. to 5 p.m. IU Health Plans will document the oral request in writing.
   b. The member can hand deliver or mail the request for an appeal to:

   IU Health Plans, Inc  
   Attention: Grievance and Appeals Department  
   950 N. Meridian Street, Suite 200  
   Indianapolis, IN 46204

The 72-hour time frame will not begin until the request for an appeal is received. **Members must file their request within 60 days of the date of notice that a health care service is not being approved or that a health care service is being stopped.**

B. 14-Day Extension

An extension of up to 14 days is permitted for a 72-hour appeal, if the extension of time benefits the member. For example, an extension is permitted if the member needs time to provide IU Health Plans with additional information or if the Plan needs to have additional diagnostic tests completed.

C. 72-Hour or Fast Appeal Decision Notification
IU Health Plans will make a decision on the appeal and notify the member within 72-hours of receipt of the request. If the IU Health Plans does not rule in the member’s favor, the Plan will forward the appeal request for a decision to an independent review organization contracted by the Centers for Medicare and Medicaid Services.

- For an appeal about payment for care, the independent review organization has up to 60 calendar days to make a decision.

- For a standard appeal about medical care, the independent review organization has up to 30 calendar days to make a decision. This time period can be extend by up to 10 calendar day if more information is needed and the extension will benefit the member.

- For a fast appeal about medical care, the independent review organization has up to 72 hours to make a decision. This time period can be extended by up to 10 calendar days if more information is needed and the extension benefits the member.

The following information applies to both 30-day appeals and 72-hour appeals:

Support for the Member’s Appeal

The member is not required to submit additional information to support the request for services or payment for services already received. IU Health Plans is responsible for gathering all necessary medical information; however, it may be helpful for the member to include in the appeal request for information such as medical records or physician opinions in support of the appeal. To obtain medical records, the member can send a written request to the primary care physician.

If the member’s medical records from the specialist physicians are not included in the medical records from the primary care physician, the member may need to make separate written request(s) to each specialist physician(s) who provided medical services. The Plan will provide an opportunity for the member to submit additional information in person or in writing.

Who May File an Appeal?

A. The member may file an appeal.

B. Member may have someone else file an appeal on their behalf. The person named will be the authorized representative. In order for members to have someone else file an appeal on their behalf, they must give IU Health Plans a written statement that includes:

1. The member’s name;

2. The member’s Medicare number;

3. A statement which appoints an individual as the member’s representative. An example of that statement would be:

   “I [member’s name], appoint [name of representative] to act as my representative requesting an appeal from IU Health Plans and/or the Centers for Medicare and Medicaid Services regarding the Plan’s denial of payment for services.”

4. The member’s signature and written date of the statement;
5. The signature of the representative and the date, unless the representative is an attorney.
6. Included this written statement with the appeal.

C. Non-IU Health Plans providers (non-plan providers) may file a standard appeal for a denied claim if they complete a “waiver of payment” statement indicating they will not ask members to pay for medical services under review regardless of the outcome of the appeal.

D. A court appointed guardian or an agent under a health care proxy to the extent provided under state law.

Help with the Appeal
If members decide to appeal and want help with the appeal, they may have a doctor, a friend, a lawyer or someone else help. There are several groups that can assist the member. The member may want to contact the Central Indiana Council on Aging at (800) 432-2422 or (317) 254-5465; the state’s Senior Health Insurance Information Program (SHIIP) at (800) 452-4800; or the Medicare Rights Center toll free at (888) 466-9050.

Appealing an Independent Review Organization Decision
The independent review organization will inform members in writing about its decision and the reason for it. Members may continue the appeal by asking for a review by an Administrative Law Judge, provided the dollar value of the medical care of the payment in the appeal meets the annual dollar requirement. (Members can contact IU Health Plans Member Services if they need the current year’s dollar requirement.)

Members must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date the member was notified of the decision by the independent review organization. Members can extend this deadline for good cause. Members must send the written request to the entity specified by the independent review organization.

- The appeal may be sent directly to the independent review organization that reviewed the appeal. They will send the request along with the appeal information to the Administrative Law Judge who will hear the appeal or to;
- IU Health Plans, Inc., or to the local Social Security Administration office. In these cases it will take longer because the request must first be forwarded to the independent review organization. The independent review organization will then send the request along with the appeal information to the Administrative Law Judge who will hear the appeal.

Administrative Law Judge Decision
Member may request a hearing before an administrative law judge by writing to IU Health Plans, CMS, or any Social Security office within 60 days of the date of the notice of an adverse reconsideration decision. (This 60-day period may be extended for good cause.)

A hearing can be held only if the dollar value of the medical care meets the annual dollar requirement. (Members can contact IU Health Plans Member Services if they need the current year’s dollar requirement.) During the review by the Administrative Law Judge, members may present evidence, review the record, and be represented by counsel.
If the Administrative Law Judge rules for the member, IU Health Plans must pay for, authorize or provide the service the member has asked for within 60 calendar days from the date we receive notice of the decision. The Plan has the right to appeal this decision by asking for a review by the Medicare Appeals Council.

**Appealing an Administrative Law Judge’s Decision**

An Administrative Law Judge’s adverse decision can be reviewed by the Medicare Appeal Council, either by its own action or as the result of a request from the member or the Plan. The Council is part of the federal department that runs the Medicare program.

If the dollar value of the member’s contested medical care meets the annual dollar requirement, either the member or IU Health Plans may request that a decision be made by the Medicare Appeals Council or Administrative Law Judge be reviewed by a federal district court. (Members can contact IU Health Plans Member Services if they need the current year’s dollar requirement.)

An initial, revised, or reconsidered determination made by IU Health Plans, the independent review organization, the administrative law judge, or the Medicare Appeals Council can be reopened:

- within 12 months;
- within four years for just cause, or
- Any time for clerical correction or in cases of fraud.

**Medicare Appeals Council**

The Medicare Appeals Council does not review every case it receives. When the Council receives the case, it will first decide whether to review it. If the Council decides not to review the case, then either the member or the Plan may request a review by a Federal Court Judge. The Federal Court Judge will only review cases when the amount involved is equal to or greater than a specific dollar amount. If the dollar value is less than the specified amount, members may not appeal further.

If the Medicare Appeals Council reviews the case, they will make their decision as soon as possible. IU Health Plans must pay for, authorize or provide the medical services within 60 calendar days from the date we receive notice of the decision. However, the Plan has the right to appeal this decision by asking for a Federal Court Judge to review the case provided the amount involved meets the dollar value criteria. If the dollar value criterion is not met, the Council’s decision is final and no further appeal can be made.

**Quality Compliant Processes**

Following are two quality complaint processes which are separate from the claims appeal process described above.

A. **Quality Improvement Organization (QIO)**

   If the members are concerned about the quality of care they have received, they may also file a complaint with the local Quality Improvement Organization (QIO). The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of IU Health Plans or the
hospital. There is one QIO in each state. The QIOs have different name, depending on which state they are in. In Indiana, the QIO is called Health Care Excel and can be reached, at (800) 288-1499. The doctors and other health experts at Health Excel (the QIO) review certain types of complaints made Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think coverage for their hospital stay is ending too soon. (This review process is designed to help stop any improper practices.)

B. IU Health Plans Quality Complaint Process

If members have complaints IU Health Plans encourages them to first call Member Services at (317) 963-9700 or toll free within Indiana at (800) 455-9776 or TTY, call Relay Indiana 1-800-743-3333. Business hours are Monday through Friday, 8:00 a.m. to 5 p.m. IU Health Plans tries to resolve any complaints over the phone. If the Plan cannot resolve the complaint over the phone, we have a formal procedure to review complaints. IU Health Plans calls this the grievance procedures.

The IU Health Plans internal grievance procedures apply only in cases when the Medicare appeals procedures do not apply.

When members have such a problem that has not been resolved to their satisfaction, then they may submit a grievance either verbally in writing to:

IU Health Plans, Inc.
Attention: Grievances and Appeals Department
950 N. Meridian Street, Suite 200
Indianapolis, IN 46204

IU Health Plans will send a letter verifying receipt of the grievance request within three (3) business days. The Plan must notify members of the decision about the grievance as quickly as the case requires based on the member’s health status, but no later than 30 calendar days after receiving the complaint. IU Health Plans may extend the time frame by up to 14 calendar days if members request the extension or if IU Health Plans justifies a need for additional information and the delay is in the member’s best interests.

Members can ask for a “fast decision” by calling Member Services or delivering a written request to the Plan.

Major Areas of Impacts to IU Health Plans Providers regarding the 72-hour or Fast Appeal:

- Supporting member’s appeals
  Members may ask the physician to support an appeal. If supporting documentation is required, IU Health Plans will need an immediate response from the provider to meet the 72-hour deadline.

- Representing the member in appeals
  A physician may represent or support the member in requesting a 72-hour appeal or expedited appeal if the physician gives a written or oral statement to the effect that the
standard or 30 day appeal process could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function.

If any physician asks IU Health Plans or the Medical Group to grant them a fast appeal, it will be granted.

- Copying medical records

IU Health Plans is responsible for gathering all necessary medical information, it is imperative physicians and their staff are quick to respond to requests for information when a member has requested the 72-hour appeal. The 72-hour period begins when the appeal is received by IU Health Plans and is not limited to business days.

**Inpatient Member Appeals Rights**

When members are admitted as hospital patients, they have the right to get all the hospital care covered by IU Health Plans that is necessary to diagnosis and treat their illness or injury. According to federal law, the date a patient leaves the hospital (the discharge date) must be determined solely by medical needs, not by any method of payment. This section tells members what to do if they feel they are being asked to leave the hospital too soon.

When members are admitted to the hospital, they should be given a notice called **Important Message from Medicare.** (See Appendix-Q, Important Message from Medicare.) This notice explains:

- the member’s right to get all medically necessary hospital services covered
- the member’s right to know about any decisions the hospital, the doctor, or anyone else makes about the patient’s hospital stay and who will pay for it
- that the doctor or the hospital may arrange for services members will need after they leave the hospital
- The member has the right to appeal a discharge decision.

If members do not receive this notice they should be sure to ask for it right away. When a doctor decides patients are ready to leave the hospital (to be “discharge”), members will again be shown the notice, **Important Message from Medicare.** At this time, the second part of this document will include information about the hospital discharge. It will tell the patient:

- why the patient was discharged
- the date IU Health Plans will stop paying for hospital costs, and
- what members can do if they think they are being asked to leave the hospital too soon and
- Who to contact for help.

Members of IU Health Plans should receive this information about their discharge before they leave the hospital. They (or someone they authorize) will be asked to sign and date this document, to show that the member received the notice. If members do not receive the notice when they are being told about the discharge form the hospital, they should be sure to ask for it immediately.
If Members think they are being asked to leave the Hospital Too Soon

Patients and their doctor know more about their condition and health needs than anyone else. Decisions about medical treatment should be between the patient and the doctor. If members have questions about their medical treatment, their need for continued hospital care, their discharge, or their need for possible post-hospital care, members should not hesitate to ask their doctor. IU Health Plans, the hospital’s representative or social worker will also help with questions and concerns about hospital services. If patients feel they are being asked to leave the hospital too soon, they must ask IU Health Plans to give them notice of non-coverage called the Notice of Discharge & Medicare Appeal Rights, then they must act quickly and the patient has the right by law to get an outside agency called the QIO (Quality Improvement Organization), to review the discharge. QIOs are groups of doctors who are paid by the federal government to review medical necessity, appropriateness, and quality of hospital treatment furnished to Medicare patients, including those enrolled in a managed care plan (or an HMO like IU Health Plans). The telephone number and address of the QIO for this area are:

Health Care Excel  
2901 Ohio Boulevard  
P.O. Box 3713  
Terre Haute, IN 47803  
(800) 288-1499

- Members must ask the QIO for a “fast review” (also call a “fast appeal”) of whether they are ready to leave the hospital.

- Members must be sure they have made the request to the QIO no later than noon on the date given in Notice of Discharge & Medicare Appeal Rights. The QIO will make its decision within one working day after it has received from the hospital and IU Health Plans all of the medical information it needs to make a decision. The QIO will let the member know as soon as it decides.

- If the QIO decides members should be discharged, members will not be responsible for paying the hospital charges until noon the day after the QIO gives its decision.

- If the QIO agrees with the patient, then IU Health Plans will continue to cover the hospital stay.

What if the patient does not ask the QIO for a review by the deadline?

If patients do not ask the QIO by noon on the date that is written in Notice of Discharge & Medicare Appeal Rights, and if they stay in the hospital after the discharge date, members may be financially responsible for the cost of many of the services received. However, members can appeal any bills for hospital care received.

The other option members have is to ask IU Health Plans for a “fast appeal” of the discharge. Please see “Fast or Expedited Appeals” section in this manual. If the Plan decides, based on the fast appeal, that members need to stay in the hospital, IU Health Plans will continue to cover the hospital care. However, if IU Health Plans decides that members should not have stayed in the hospital beyond the discharge date, the IU Health Plans will not cover any hospital care received if members stayed in the hospital after the original date.
Post-Hospital Care

When the doctor determines that the patient no longer needs all of the specialized services provided in a hospital, but members still require medical care, the doctor may discharge the member to a skilled nursing facility or home care. IU Health Plans, or the discharge planner at the hospital, will help arrange for the services the member may need after the discharge.

Medicare managed care plans, like IU Health Plans, have limited coverage for skilled nursing facility care and home health care. Therefore, the member should find out which services will or will not be covered and whether there are any other expenses, such as copayments. Members should consult with their doctors, IU Health Plans or hospital discharge planner, patient representative, and the family in making preparations for care after the patient leaves the hospital. Members should not hesitate to ask questions.
SECTION 10

Participating Providers

Primary & Specialty Medical Physicians

IU Health Plans, Inc. has contracted with physicians to provide a network of physicians for our Medicare Advantage members. These physicians are affiliated with IU Health Hospitals and out-patient facilities throughout Indiana. This includes Primary Care Physicians as well as specialists. Participating IU Health Plans physicians have been credentialed and are involved in the Plan Quality Management Program. (See Appendices- Exhibit N, Indiana Approved Service Area Counties/Facilities and www.iuhealthplansmedicare.org for Physician/Provider Directory.)

Dental Care – See Section 5 Member Benefits for specific dental care coverage.

The Dental benefits are available only to those members of IU Health Plans who select the **Choice, Select Plus or Select Plans**. IU Health Plans dental benefits are provided through the Guardian Dental Plan. For a current list of IU Health Plans dental providers, please reference the Plan Physician/Provider Directory www.iuhealthplansmedicare.org for Physician/Provider Directory or call Provider Services at 317.963.9920.

IU Health Plans members eligible for Dental Care benefits may call and schedule a routine examination with any of the dental providers listed in the most current IU Health Plans Physician/Provider Directory. When scheduling an appointment members are instructed to confirm provider is still participating with the IU Health Plans program.

If there are any questions about the dental services offered through IU Health Plans please contact Provider Services at (317) 963-9920.

Prescriptions

Medicare covers and thus IU Health Plans covers a limited number of Part B outpatient prescription drugs

**Prescriptions Part D** – IU Health Plans covers Part B drugs and Part D Prescription Drugs. See Section 5 for those Plans offering this benefit.

Neighborhood Pharmacies

IU Health Plans wants the health plan to be easy to use, so members are offered a selection of convenient pharmacies for filling prescriptions. Eligible members, enrolled in applicable Plan may have prescriptions filled at any of the IU Health Plans participating pharmacies.

1. If members have questions, they can contact IU Health Plans Customer Solutions Center at (317) 963-9700, toll-free (within Indiana) 1-800-455-9776 (TTY only, call Indiana Relay at 1-800-743-3333) and calls to these numbers are free. From November 15, 2011 through March 1, 2012, a representative will be available to speak to you 8:00 a.m. to 8:00 p.m. seven days a week. Beginning March 2, 2012, a representative will be available from 8:00 a.m. to 8:00 p.m. Monday through Friday. You may receive assistance through alternate technology after hours, on weekends, and holidays. You can also visit our website, www.iuhealthplansmedicare.org.

Providers may call IU Health Plans Provider Services at (317) 963-9920.
Using Mail Order

- Prescriptions filled by IU Health Plans mail order service must be written for a 90 day supply.
- A nominal dispensing fee is also charged per prescription.
- To get information about filling prescriptions by mail providers should direct members to our Customer Solutions Department at (317) 963-9700, toll-free (within Indiana) 1-800-455-9776.

Medicare Part D

Everyone, regardless of income, health status, or prescription drug usage, will have access to prescription drug coverage beginning on January 1, 2006. Medicare prescription drug coverage is insurance that covers both brand-name and generic prescription drugs at participating pharmacies. Medicare prescription drug coverage provides protection for people who have very high drug costs. If Medicare beneficiaries join a Medicare prescription plan, they will pay a monthly premium, which varies by plan. Beneficiaries will pay a part of the cost of the prescriptions, including copayment of coinsurance.

1. Enrollment in the Select Plan does not include this prescription coverage. IU Health Plans members who are interested in enrolling in the Medicare prescription drug coverage should enroll in Choice or Select Plus Plans. Members may get more information by contacting the IU Health Plans Customer Solutions Center at (317) 963-9700, toll-free (within Indiana) 1-800-455-9776 (TTY only, call Indiana Relay at 1-800-743-3333) and calls to these numbers are free. From November 15, 2011 through March 1, 2012, a representative will be available to speak to you 8:00 a.m. to 8:00 p.m. seven days a week. Beginning March 2, 2012, a representative will be available from 8:00 a.m. to 8:00 p.m. Monday through Friday. You may receive assistance through alternate technology after hours, on weekends, and holidays. You can also visit our website, www.iuhealthplansmedicare.org.

Providers who want more information may call IU Health Plans Provider Services at (317) 963-9920.

Vision Care -

IU Health Plans offers some routine vision benefits that are not covered by Medicare for Choice, Select Plus, & Select members. IU Health Plans contracts with EyeMed Vision Care to provide this routine benefit.

Choice, Select Plus and Select Plan members are subject to an applicable copay for routine eye exams when performed by an EyeMed Vision Care provider once a year. See Section 5 for member benefits.

All IU Health Plans members have $0 copay for 1 pair of eyeglasses or contact lenses after cataract surgery.

Per IU Health Plans contract arrangements with EyeMed Vision Care, a routine eye exam and the basic eyeglass frames and lens benefit are the only services EyeMed Vision Care providers
are authorized to furnish to Plan members. Should an EyeMed Vision Care provider detect a medical problem such as cataracts or glaucoma, IU Health Plans members **must** contact their IU Health Plans primary care physician. The EyeMed Vision Care provider should neither refer the Plan member to a specialist, nor provide any medical care required. The only referral the EyeMed Vision Care provider can make is to the member’s IU Health Plans primary care physician. The primary care physician is responsible for referring the member to the appropriate in-plan specialist for medical eye treatment.

IU Health Plans encourages EyeMed Vision Care providers to inquire if the patient has any coverage in addition to Medicare when an appointment is scheduled. Even if the patient has IU Health Plans coverage, the patient has only routine (non-medical) coverage through IU Health Plans and EyeMed Vision Care. Only if the EyeMed Vision Care provider is also participating in IU Health Plans through IU Health Physicians/Indiana Clinic, can the specialist treat the member’s medical conditions.

For more information regarding IU Health Plans Member EyeMed Vision Care Benefits refer to Section 5 for specific benefit information.

**Other Discounts for IU Health Plans Members**

- Fitness Club Reimbursement up to $150.00 reimbursement per calendar year.
  - Provide copy of Fitness Club contract and/or have Fitness Club Reimbursement form signed by authorized employee.
  - Be a current eligible member at time of reimbursement request.
  - Premiums must be paid up to date.
  - Allow 4-6 weeks for reimbursement
This section describes how medical information about members may be used and disclosed and how they can get access to this information. IU Health Plans requests our members review this carefully.

If members have any questions about this notice, they should contact IU Health Plans Customer Solutions Center at (317) 963-9700, or toll free within Indiana at (800) 455-9776. Business hours are Monday through Friday, 8:00 a.m. to 5 p.m.

**Our Pledge Regarding Medicare Information**

IU Health Plans is required by law to maintain the privacy of our members’ health information and to provide them with notice of our legal duties and privacy practices. The healthcare provider may have different policies or notices regarding the use and disclosure of the medical information created in the provider’s office or clinic.

**How IU Health Plans May Use and Disclose Medical Information about Members**

The following categories describe different ways IU Health Plans uses and discloses medical information. For each category of uses or disclosures IU Health Plans will explain what is meant and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways IU Health Plans is permitted to use and disclose information will fall within one of the categories.

**For Treatment**

- IU Health Plans may review patient medical information to provide authorization for certain medical treatment.
- IU Health Plans may disclose patient medical information to healthcare providers who are involved in their care.
- For example, IU Health Plans may obtain medical information for services providers requested that may be considered experimental/investigational. The Plan may also review medical information when the members request treatment by an out of network provider.

**For Payment**

- IU Health Plans may use and disclose patient medical information to providers so that they can bill and receive payment for the treatment and services they provided.
- For example, IU Health Plans may need to give patient insurance information to providers so they can bill the Plan for the treatment that the patient received.

**For Health Care Operations**

- IU Health Plans may use and disclose medical information about the patient for our business operations. These uses and disclosures are necessary to run IU Health Plans, Inc., and make sure that all of our members receive quality care.
- For example, IU Health Plans may use the medical information to review the provider’s treatment and services and to evaluate their performance.
• IU Health Plans may remove information that identifies the patient from this set of medical information when used to evaluate specific disease conditions.

Health-Related Benefits and Services
IU Health Plans may use and disclose medical information to tell the patient about health related benefits or services. For example, the Plan may remind the patient that it is time for the patient’s yearly mammogram or diabetic retinal exam.

Individuals Involved in the Care or Payment for Patient Care
IU Health Plans may release medical information about the patient to a friend or family member who is involved in his or her care medical care that the patient has designated and the appropriate authorization is on file.

Workers’ Compensation
IU Health Plans may release medical information about the patient for workers’ compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Health Oversight Activities
IU Health Plans may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If members are involved in a lawsuit or a dispute, IU Health Plans may disclose medical information about the member in response to a court or administrative order. IU Health Plans may also disclose medical information about members in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute.

Member Rights Regarding Medical Information
Right to Inspect and Copy
Members have the right to inspect and copy medical information that may be used to make decisions about their care. This includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information that may be used to make decisions the member must submit a request in writing to the IU Health Plans, ATTN: Grievance & Appeal Coordinator, 1776 N. Meridian St., Suite 300, Indianapolis, IN 46202. If requesting a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with the request.

The Plan may deny the request to inspect and copy in certain circumstances. If members are denied access to medical information, members may request that the denial be reviewed as a grievance. Grievances can be submitted either verbally or in writing. Members can refer to the IU Health Plans “Evidence of Coverage” for more information on requesting and processing of grievances.
Right to Amend

If members feel that the medical information IU Health Plans has is incorrect, they may ask to amend the information. Members have the right to request an amendment for as long as the information is kept by the Plan. To request an amendment, a request must be made in writing by the member and submitted to IU Health Plans, Inc. ATTN: Grievance & Appeal Coordinator, 950 N. Meridian Street, Suite 200 Indianapolis, IN 46204.

In addition, the member must provide a reason that supports request.

IU Health Plans may deny the request for an amendment if it is not in writing or does not include a reason to support the request. In addition, IU Health Plans may deny the request if the member asks the Plan to amend information that:

- Was not created by IU Health Plans, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by the IU Health Plans, Inc.;
- Is not part of the information which the member would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures

Members have the right to request an “accounting of disclosures.” This is a list of the disclosures IU Health Plans made of member medical information.

To request this list or accounting of disclosures, members must submit the request in writing to IU Health Plans Customer Solutions Center. The request must state a time period which may not be longer than six years and may not include dates before January 1, 2009. The first list requested within a 12 month period will be free. For additional lists, the Plan may charge members for the cost of providing the list. IU Health Plans will notify members of the cost involved. Members may choose to withdraw or modify the request at that time before any costs are incurred.

Right to Request Restrictions

Members have the right to request a restriction or limitation on the medical information IU Health Plans uses or discloses about them. Members also have the right to request a limit on the medical information IU Health Plans discloses about them to someone who is involved in their care or the payment for their care, like a family member or friend. For example, members could ask that IU Health Plans not use or disclose information about a surgery they had.

IU Health Plans is not required to agree with the request. If IU Health Plans does agree, we will comply with the request unless the information is needed to provide emergency treatment. To request restrictions, members must make a written request to IU Health Plans Customer Solutions Center. In the request, members must tell the Plan (1) what information they want to limit; (2) whether they want to limit IU Health Plans’ use, disclosure or both; and (3) to whom they want the limits to apply, for example, disclosures to the spouse.

Right to Request Confidential Communications
Members have the right to request that IU Health Plans communicate with them about medical matters in a certain way or at a certain location. For example, members can ask that the Plan only contact them at work or by mail.

To request confidential communications, members must make a written request to IU Health Plans Customer Solutions Center. IU Health Plans will not ask members the reason for the request. The Plan will accommodate all reasonable requests. The request must specify how or where the member wishes to be contacted.

**Change to this Notice**

IU Health Plans reserves the right to change this notice. IU Health Plans reserves the right to make the revised or changed notice effective for medical information we already have about members as well as any information we receive in the future. The Plan will make the notice available at all times. The notice will contain the effective date.

**Complaints**

If members believe their privacy rights have been violated, they may file a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201 or by calling them at (877) 696-6775. A member can also file a complaint by calling 1-800 – MEDICARE (1-800-633-4227). Members may also contact IU Health Plans Customer Solutions Center at 950 N. Meridian Street, Suite 200 Indianapolis, IN 46204 or by calling (317) 963-9700, or toll free within Indiana at (800) 455-9776. Business hours are Monday through Friday, 8:00 a.m. to 5 p.m.

Members will not be penalized for filing a complaint.

**Other Uses of Medical Information**

Other uses and disclosures of medical information not covered by this notice or law will be made only with the member’s written permission. If members provide IU Health Plans permission to use or disclose medical information, they may revoke that permission, in writing, at any time. If members revoke permission, IU Health Plans will no longer use or disclose medical information about them for the reasons covered by the written authorization. Members understand that IU Health Plans is unable to take back any disclosures we have already made pursuant to member permission, and that IU Health Plans is required to retain our records of the care that we have provided.

**Nondiscrimination**

Providers agree to render Medicare covered services to Medicare members in accordance with prevailing community medical standards applying the same standards to Medicare members they apply to other patient and must provide Medicare covered services to all Medicare members without regard to race, color, religion, national origin, handicap, sex or age, health status or income.

**Noninterference with Medical Care**

Providers shall at all times provide treatment to Medicare Members in a manner consistent with sound medical judgment and practice. IU Health Plans shall not require Provider to take any action
inconsistent with his/her professional judgment concerning the medical care and treatment to be provided to Medicare Members. However, the Plan reserves the right to make coverage decisions when a dispute exists between the Medicare Member and the Network Physician/Provider regarding the Medical Necessity of a Covered Service. Physicians will maintain the relationship of physician and patient with Medicare Members, without intervention in any manner by IU Health Plans or employees, and Physician will be solely responsible for all medical advice to and treatment of his/her patients and for the performance of all medical services in accordance with accepted professional standards and practices. Providers shall be free to communicate with their patients regarding the treatment options available to them including medication treatment options, regardless of benefit coverage limitations and shall also be free to discuss their compensation arrangements with their patients.
Appendix:

B. Provider Claim Dispute Form
C. Provider Standard Claim Inquiry Form
D. Member Health Risk Assessment Form
E. IU Health Ambulatory Care Management Referral Requirements and Form
F. Notice of Medicare Non-Coverage
G. Notice of Medicare Non-Coverage Instructions
H. Detailed Explanation of Non-Coverage
I. Detailed Explanation of Non-Coverage Instructions
J. Notice of Denial of Medical Coverage
K. Notice of Denial of Medical Coverage Instructions
L. List of Approved Indiana Counties/Facilities-Service Areas 2013
M. Clinical Editing Provider Information
N. Clinical Editing Dispute/Appeal Form
O. An Important Message from Medicare
IU Health Plans Medicare Advantage Identification Card:
All members will have an ID card. Look for IU Health Plans logo and Plan name Medicare Choice, Medicare Select or Medicare Select Plus.

Eligibility and Benefits Verification, Claims Inquiry:
IU Health Plans Provider Services
Phone: 317.963.9920 or 866.218.1524

Claims Submission:
Submission Date 12/8/2012 or after
Government Products Claims
PO Box 4287
Scranton, PA 18505
EDI Payer ID: 95444

EDI Contact:
Chris Hainlen, Sr. Systems Analyst
Email: CHainlen@iuhealth.org
Phone: 317.963.0293

Claim Disputes and Appeals:
IU Health Plans Provider Services
Phone: 317.963.9920 or 866.218.1524
Fax Claim Inquiry or Dispute Form to:
Fax: 317.963.9801

Clinical Editing Appeals:
Mail to: IU Health Plans Medicare Advantage
1776 N Meridian St., Ste 300
Indianapolis, IN 46202
Attention: Claims Clinical Editing
Fax: 317.963.9801

Provider Directory:
IU Health Plans
www.iuhealthplansmedicare.org
Go to Resources
Find a Doctor or Hospital

Member Services:
Refer member questions to:
IU Health Plans
Phone: 317.963.9700 or 800.455.9776

Medical Prior Authorization:
Services requiring authorization are listed on the reverse side. Call or fax Authorization Request form to:
IU Health Medical Management
Phone: 317.962.2378 or 866.492.5878
Fax: 317.962.6219 or 317.962.4005

Authorization Request Form can be obtained by calling the number above or at
www.iuhealthplansmedicare.org

Part B Medication Authorization:
Part B authorization list available at:
www.iuhealthplansmedicare.org

IU Health Pharmacy Benefit Management
Phone: .317.963.6830 or .866.412.8644
Fax: 317.962.4070 or 866.412.8656

Part D Medication Authorization:
Formulary available at:
www.iuhealthplansmedicare.org

Perform RX Phone: 866.907.7088
Perform RX Fax: 866.429.2260 (72 hr response)
866.497.1386 (24 hr response)

Updated December 2012
## Services Requiring Prior Authorization

**ALL SERVICES PROVIDED BY OUT OF NETWORK PROVIDERS REQUIRE PRIOR APPROVAL**

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Prior Approval Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Services Performed by Non-Contracted Providers, Physicians or Vendors</td>
<td>Yes</td>
</tr>
<tr>
<td>Ambulance (non-emergent transport)</td>
<td>Yes</td>
</tr>
<tr>
<td>Behavioral Health/Substance Abuse Services</td>
<td>Inpatient and Partial Hospitalization Only</td>
</tr>
<tr>
<td>Durable Medical Equipment:</td>
<td></td>
</tr>
<tr>
<td>Non-Specific HCPCS codes: A9279, A9280, A9900, A9999, E0446, E0625, E0769, E0770, E1229, E1239, E1399, E1699, E2599, K0108, K0898, K0899, Q0505</td>
<td></td>
</tr>
<tr>
<td>Power Mobility Devices K0800-K0899</td>
<td></td>
</tr>
<tr>
<td>CPAP</td>
<td></td>
</tr>
<tr>
<td>BIPAP</td>
<td></td>
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<tr>
<td>Oxygen</td>
<td></td>
</tr>
<tr>
<td>Enteral Formulas</td>
<td></td>
</tr>
<tr>
<td>Any Item that is Capped Rental by CMS Policy</td>
<td>Yes</td>
</tr>
<tr>
<td>Home Health Services</td>
<td></td>
</tr>
<tr>
<td>Part B Drugs</td>
<td></td>
</tr>
<tr>
<td>Scheduled Inpatient Admissions (medical, surgical and behavioral health)</td>
<td>Call Pharmacy Department for Prior Auth Form 317.963.6830 or 866.412.8644 then fax completed form to 317.962.4070 or 866.412.8656</td>
</tr>
<tr>
<td>Scheduled Observation Stays (medical and surgical)</td>
<td>Yes</td>
</tr>
<tr>
<td>Skilled Nursing Facility Services (both skilled stays and therapies for custodial residents)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*COVERAGE IS BASED ON 2012 CMS APPROVED SERVICES/ITEMS, CMS DEFINED MEDICAL NECESSITY AND LIMITS

*DME PROVIDERS MUST FOLLOW ALL CMS GUIDELINES

Please contact IU Health Medical Management via phone for authorization request or fax Authorization Request form to:
- IU Health Medical Management
- Phone: 317.962.2378 or 866.492.5878
- Urgent Requests for Weekends and Holidays: 317.910.0499
- Fax: 317.962.6219 or .317.962.4005
- Hours: 8:30 to 4:30 Monday-Friday

The Authorization Request Form is available at [www.iuhealthplansmedicare.org](http://www.iuhealthplansmedicare.org)

Updated December 2012
## IU Health Plans Medicare Advantage

**Provider Claim Dispute Form**

<table>
<thead>
<tr>
<th>Date of Inquiry:</th>
<th>/ / /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Group Name:</td>
<td>________________________________</td>
</tr>
<tr>
<td>Provider Phone Number:</td>
<td>________________________________</td>
</tr>
<tr>
<td>Contact Name:</td>
<td>________________________________</td>
</tr>
<tr>
<td>Return Fax Number:</td>
<td>________________________________</td>
</tr>
</tbody>
</table>

*******Please do not use this form for Clinical Edit Appeals**********

### 1.

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>DOB</th>
<th>CHP ID#</th>
<th>DOS</th>
<th>Amount Billed</th>
<th>Patient Acct#</th>
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**Provider Notes:**

**CHP Response:**

### 2.

<table>
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<tr>
<th>Patient Name</th>
<th>DOB</th>
<th>CHP ID#</th>
<th>DOS</th>
<th>Amount Billed</th>
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</tbody>
</table>

**Provider Notes:**

**CHP Response:**

---

Dispute response time is within 10 days. Routine inquiry response time (if faxed on this form) is between 2-4 weeks.

Appendix B -05/2013
# IU Health Plans Medicare Advantage
## Provider Claim Standard Inquiry Form

**Date of Inquiry:**

**Provider Group Name:**

**Provider Phone Number:**

**Contact Name:**

**Return Fax Number:**

---

**Please do not use this form for Clinical Edit Appeals**

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### 1.

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>DOB</th>
<th>IU Health ID#</th>
<th>DOS</th>
<th>Amount Billed</th>
<th>Patient Acct#</th>
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</table>

**Provider Notes:**

**IU Health Plans Response:**

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### 2.

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>DOB</th>
<th>IU Health ID#</th>
<th>DOS</th>
<th>Amount Billed</th>
<th>Patient Acct#</th>
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</table>

**Provider Notes:**

**IU Health Plans Response:**

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- Routine inquiry response time (if faxed on this form) is between 3 to 6 weeks

**APPENDIX C-05/2013**
Indiana University Health Plans Medicare Health Risk Assessment

Member Name _________________________________ Member No. __________________

1. In general would you say your health is
   □ Excellent
   □ Very good
   □ Good
   □ Fair
   □ Poor

2. In the previous 12 months, have you stayed overnight as a patient in a hospital?
   □ 0
   □ 1
   □ 2-3
   □ More than 3

3. In the previous 12 months, how many times did you visit a physician or clinic?
   □ 0
   □ 1
   □ 2-3
   □ 4-6
   □ More than 6

4. In the previous 12 months, did you have diabetes?
   □ Yes
   □ No

5. Have you ever had coronary heart disease, angina pectoris, myocardial infarction, or any other heart attack?
   □ Yes
   □ No
   □ Don’t know

6. Is there a friend, relative or neighbor who would take care of you for a few days, if necessary?
   □ Yes
   □ No

7. Have you ever had cancer (except skin cancer)?
   □ Yes
   □ No
8. How frequently do you take medication for chronic pain?
   □ Never, no chronic pain
   □ Monthly
   □ Weekly
   □ Daily

9. Have you lost ten (10) pounds or more in the past six (6) months?
   □ Yes
   □ No

10. Have you received home health services from an agency in the past year?
    □ Yes
    □ No

11. During the past month have you often been bothered by feeling down, depressed or hopeless?
    □ Not at all
    □ Several days
    □ More than half the days
    □ Nearly every day

12. During the past month have you often been bothered by little interest or pleasure in doing things?
    □ Not at all
    □ Several days
    □ More than half the days
    □ Nearly every day

13. Is there anything else you wish us to know about your health or present needs?
    □ Yes
    □ No
    If yes, please explain:
    __________________________________________________________
    __________________________________________________________
    __________________________________________________________
    __________________________________________________________

14. Are you?
    □ Male
    □ Female

15. What is your date of birth?  (Month/Day/Year) ______________________
16. Who completed this form?
   □ Self
   □ Spouse, spouse age ________
   □ Other Family Member (Please write the name and relationship of the person who helped you below)

   Name ____________________________________________________________

   Relationship to you _________________________________________________

PERMISSION TO SHARE RESPONSES WITH PRIMARY CARE PHYSICIAN

   □ I give IU Health Plans permission to send my responses to my Primary Care Physician (PCP).

   My PCP’s name is ____________________________________________________

   □ I do NOT give IU Health Plans permission to send my responses to my Primary Care Physician.

   Signature ____________________________________________________________

   Date ____________________________

Please send this completed form to:

   Indiana University Health Plans
   Attention: Enrollment Department
   Suite 300
   1776 N. Meridian St.
   Indianapolis, IN 46202-1404
Business Hours – Monday through Friday – 8:30am to 4:30pm
Phone – (317) 962-2378 or 866-492-5878
Fax – (317) 962-6219 or (317) 963-9949

✓ ALL Services Performed by Non-Contracted Providers, Physicians or Vendors
✓ Scheduled Inpatient Admissions (medical, surgical and behavioral health)
✓ Scheduled Observation Stays (medical and surgical)
✓ Skilled Nursing Facility Services (both skilled stays and therapies for custodial residents)
✓ Home Health Services
✓ Behavioral Health/Substance Abuse Services--- (inpatient and partial hospitalization only)
✓ Ambulance (non-emergent transport)

✓ Durable Medical Equipment Non-Specific HCPCS codes: A9279, A9280, A9900, A9999, E0446, E0625, E0676, E0769, E0770, E1229, E1239, E1399, E1699, E2599, K0108, K0812, K0898, K0899, Q0505
Power Mobility Devises K0800-K0899
CPAP
BIPAP
Oxygen
Enteral Formulas
Any Item that is a Capped Rental by CMS Policy

✓ Part B Drugs (Call Pharmacy Department for Prior Auth Form (317) 963-6830 or (866) 412-8644 then fax completed form to (317) 962-4070

COVERAGE IS BASED ON 2012 CMS APPROVED SERVICES/ITEMS, CMS DEFINED MEDICAL NECESSITY & LIMITS
DME PROVIDERS MUST FOLLOW ALL CMS GUIDELINES
**Please complete all fields for review**

### REQUESTING PHYSICIAN INFORMATION

| Ordering MD: | ------------------------- |
| TAX ID: | ------------------------- |
| Address: | ______________________ |
| Phone: | ____________ Fax: ____________ |
| Contact: | ______________________ |

### REQUESTING VENDOR INFORMATION

| Vendor: | ------------------------- |
| TAX ID: | ------------------------- |
| Address: | ______________________ |
| Phone: | ____________ Fax: ____________ |
| Contact: | ______________________ |

### MEMBER INFORMATION

| Name: | ______________________ |
| ID#: | ______________________ |
| DOB: | ______/_____/______ |
| SS#: | ______/_____/______ |
| Phone: | ______________________ |

### CLINICAL SUMMARY

(Form will be rejected if CLINICAL SUMMARY is NOT completed). (Send attachments, if needed).

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>CPT or HCPC Code</th>
<th>Requested Service</th>
<th>Place of Service</th>
<th>INP OP OBS</th>
<th>Units</th>
<th>Diagnosis / ICD9 Code</th>
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### IUHMM USE ONLY

| AUTHORIZATION NUMBER | | |
|----------------------|--|
| □ Services APPROVED As Requested | |
| □ Request MODIFIED (see below for detail) | |
| □ Request DENIED, Letter To Follow | |

| Modifications Made: | ______________________ |
| IUHMM Staff: | ______________________ |
| Date: | ______________________ |

**SIGNATURE OF REQUESTING MD:** ______________________ **DATE:** ______________________

Appendix E-05/2013
Notice of Medicare Non-Coverage

Patient name:      Patient number:

The Effective Date Coverage of Your Current Skilled Services at Will End:

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current skilled services at after the effective date indicated above.
- You may have to pay for any services you receive at after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  o Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
• Call your QIO at: Healthcare Excel @ 1-800-288-1499 to appeal, or if you have questions.

See page 2 of this notice for more information.

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

• If you have Original Medicare: Call the QIO listed on page 1.
• If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information
Indiana University Health Plans
Dedicated to Medicare
950 N. Meridian Street, Suite 200
Indianapolis, IN 46204
317-963-9700 (local) or 1-800-455-9776 (toll-free)

Additional Information (Optional)

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

Signature of Patient or Representative ___________________________ Date ___________________________
When to Deliver the NOMNC

A Medicare health provider must give an advance, completed copy of the Notice of Medicare Non-Coverage (NOMNC) to enrollees receiving skilled nursing, home health (including psychiatric home health), or comprehensive outpatient rehabilitation facility services, no later than two days before the termination of services. This notice fulfills the requirement at 42 CFR 422.624(b)(1) and (2). In situations where the termination decision is not delegated to a provider, the plan must provide the service termination date to the provider not later than two days before the termination of services for timely delivery to occur.

Valid Notice Delivery

The notice must be validly delivered. Valid delivery means that the enrollee must be able to understand the purpose and contents of the notice in order to sign for receipt of it. The enrollee must be able to understand that he or she may appeal the termination decision. If the enrollee is not able to comprehend the contents of the notice, it must be delivered to and signed by a representative.

Valid delivery does not preclude the use of assistive devices, witnesses, or interpreters for notice delivery. Thus, if an enrollee is not able to physically sign the notice to indicate receipt, then delivery may be proven valid by other means.

Valid delivery also requires delivery of an Office of Management and Budget (OMB) - approved notice consistent with either the standardized OMB-approved original notice format, or a Centers for Medicare and Medicaid Services (CMS) regional office approved variation of the OMB-approved format. Details regarding what constitutes an approved variation of an OMB-approved format are included in these form instructions and manual guidance. (CMS Medicare Managed Care Manual, Chapter 13, Rev. 88, 09-21-07.)

In general, notices are valid when all patient specific information required by the notice is included, and any non-conformance is minor; that is, the non-conformance does not change the meaning of the notice or the ability to request an appeal. For example, misspelling the word “health” is a minor non-conformance of the notice that would not invalidate the notice. However, a transposed phone number on the notice would not be considered a minor non-conformance since the enrollee would not be able to contact the QIO and or health plan to file an appeal. Errors brought to the attention of the plan or provider should also be reported to the regional office plan manager. The plan manager may assist the plan in correcting the error, determine what corrective action may be required, and re-approve any subsequent variations of the NOMNC.
**Notice Delivery to Incompetent Enrollees in an Institutionalized Setting**

CMS requires that notification of changes in coverage for an institutionalized enrollee who is not competent be made to a representative acting on behalf of the enrollee. Notification to the representative may be problematic because that person may not be available in person to acknowledge receipt of the required notification. Providers are required to develop procedures to use when the enrollee is incapable or incompetent, and the provider cannot obtain the signature of the enrollee’s representative through direct personal contact. If the provider is personally unable to deliver a NOMNC to a person acting on behalf of an enrollee, then the provider should telephone the representative to advise him or her when the enrollee’s services are no longer covered.

The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date. When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested. The date that someone at the representative’s address signs (or refuses to sign) the receipt is the date of receipt. Place a dated copy of the notice in the enrollee’s medical file. When notices are returned by the post office with no indication of a refusal date, then the enrollee’s liability starts on the second working day after the provider’s mailing date.

**Special Circumstances**

Do not use the NOMNC if coverage is being terminated for any of the following reasons:

- Because the Medicare benefit is exhausted;
- For denial of Medicare admission;
- For denial of non-Medicare covered services; or
- Due to a reduction or termination of a Medicare service that does not end the skilled Medicare stay.

In these cases, the plan must issue the CMS form 10003 - Notice of Denial of Medical Coverage (NDMC).

**Modifications to the NOMNC**

The NOMNC is a standardized notice. Therefore, plans and providers may not re-write, re-interpret, or insert non-OMB-approved language into the body of the notice except where indicated. Without CMS regional office approval, however, you may modify the notice for mass printing to indicate the kind of service being terminated if only one type of service is provided by the facility; that is, skilled nursing, home health, or comprehensive outpatient rehabilitation facility. You may also modify the form to reference the kind of plan issuing the notice. Notices may not be highlighted or shaded. Additionally, text must be no less than 12-point type, and the background must be high contrast. Please note that the CMS form number and the OMB control number must be displayed on the notice.
Substantive modifications, such as wrapping a letter format around the notice, may not be adopted without regional office approval. Regional office approval must be obtained for each modification not described in these instructions or other CMS guidance. Plans should contact their CMS regional office for additional questions regarding modifications to the notice.

**Heading**

**Contact information:** The name, address and telephone number of the provider that delivers the notice must appear above the title of the form. The provider's registered logo may be used.

**Member number:** Providers may fill in the enrollee’s unique medical record or other identification number. Note that the enrollee’s HIC number must not be used.

**THE EFFECTIVE DATE YOUR {INSERT TYPE} SERVICES WILL END:** {Insert Effective Date}: Fill in the type of services ending, {home health, skilled nursing, or comprehensive outpatient rehabilitation services} and the actual date the service will end. Note that the date should be in no less than 12-point type. If handwritten, notice entries must be at least as large as 12-point type and legible.

**YOUR RIGHT TO APPEAL THIS DECISION**

- **Bullet # 1** not applicable
- **Bullet # 2** not applicable
- **Bullet # 3** not applicable
- **Bullet # 4** not applicable
- **Bullet # 5** not applicable

**HOW TO ASK FOR AN IMMEDIATE APPEAL**

- **Bullet # 1** not applicable
- **Bullet # 2** not applicable
- **Bullet # 3** not applicable
- **Bullet # 4** Insert the name and telephone numbers (including TTY) of the applicable QIO in no less than 12-point type.
Signature page:

Plan contact information: The plan’s name and contact information must be displayed here for the enrollee’s use in case an expedited appeal is requested or in the event the enrollee or QIO seeks the plan’s identification.

Optional: Additional information. This section provides space for additional pertinent information that may be useful to the enrollee. It may not be used as a Detailed Explanation of Non-Coverage, even if facts pertinent to the termination decision are provided.

Signature line: The enrollee or the representative must sign this line.

Date: The enrollee or the representative must fill in the date that he or she signs the document. If the document is delivered, but the enrollee or the representative refuses to sign on the delivery date, then annotate the case file to indicate the date that the form was delivered.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0910. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attention: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Detailed Explanation of Non-coverage

Date:

Patient name: Patient number:

This notice gives a detailed explanation of why your Medicare provider and/or health plan has determined Medicare coverage for your current services should end. **This notice is not the decision on your appeal.** The decision on your appeal will come from your Quality Improvement Organization (QIO).

We have reviewed your case and decided that Medicare coverage of your current {insert type} services should end.

• The facts used to make this decision:

• Detailed explanation of why your current services are no longer covered, and the specific Medicare coverage rules and policy used to make this decision:

• Plan policy, provision, or rationale used in making the decision (health plans only):
If you would like a copy of the policy or coverage guidelines used to make this decision, or a copy of the documents sent to the QIO, please call us at:

Indiana University Health Plans
Dedicated to Medicare

950 N. Meridian Street, Suite 200 Indianapolis, IN 46204

317-963-9700 (local) or 1-800-455-9776 (toll-free)
Form Instructions for the Detailed Explanation of Non-Coverage (DENC)  
CMS-10095

A Medicare health plan ("plan") must provide a completed copy of this notice to enrollees receiving skilled nursing, home health or comprehensive outpatient rehabilitation facility services upon notice from the Quality Improvement Organization (QIO) that the enrollee has appealed the termination of services in these settings. This notice fulfills the requirement at 42 CFR 422.626(e)(1), and must be provided no later than close of business of the day of the QIO’s notification.

Do not use the DENC if coverage is being terminated for any of the following reasons:
  • Because the Medicare benefit is exhausted;
  • For denial of Medicare admission to a skilled nursing facility or comprehensive outpatient rehabilitation facility or denial of Medicare home health services;
  • For denial of non-Medicare covered services; or
  • Due to a reduction or termination of a Medicare-covered service that does not conclude the skilled Medicare stay.

In these cases, the plan must issue the CMS form 10003 – Notice of Denial of Medical Coverage (NDMC).

The DENC is a standardized notice. Plans may not deviate from the wording or content of the form except where authorized to do so. Please note that the OMB control number must be displayed in the upper right of the notice. Notice entries may be typed or handwritten. Handwritten entries must be at least as large as 12-point type and legible.

**Heading**

**Insert contact information here:** The name, address and telephone number of the plan or provider that actually delivers the notice must appear above the title of the form. The entity’s registered logo is not required, but may be used.

**Date:** Fill in the date the notice is generated by the plan.

**Patient Name:** Fill in the enrollee’s first and last name.

**Member number:** Fill in the enrollee’s medical record or identification number. Note that the enrollee’s HIC number must not be used.

**{Insert type}** – Insert the kind of service being terminated, i.e., skilled nursing, home health, or comprehensive outpatient rehabilitation services.
**Bullet # 1** The facts used to make this decision: Fill in the patient specific information that describes the current functioning and progress of the enrollee with respect to the services being provided. Use full sentences, in plain English.

**Bullet # 2** The detailed explanation of why your services are no longer covered under your plan: Fill in the detailed and specific reasons why services are either no longer reasonable or necessary for the enrollee or are no longer covered according to the Medicare guidelines. Describe how the enrollee does not meet these guidelines.

**Bullet # 3** The plan policy, provision, or rationale used in the decision: Fill in the reasons services are either no longer reasonable or necessary for the enrollee or are no longer covered according to the plan’s policy guidelines. Describe how the enrollee does not meet these guidelines. If the plan relied exclusively on Medicare coverage guidelines, please indicate so here.

**If you would like a copy of the policy:** If the plan has not provided the Medicare guidelines or policy used to decide the termination date, inform the enrollee how and where to obtain the policy. The plan should provide a telephone number for enrollees to get a copy of the relevant documents sent to the QIO. If a provider has been delegated to supply this information, the provider’s contact number should be included.

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938–0910. The time required to complete this information collection is estimated to average 1.25 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attention: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Notice of Denial of Medical Coverage

Date: Member number:

Beneficiary's name:

We have denied coverage of the following medical services or items that you or your physician requested:

We denied this request because:

What If I Don’t Agree With This Decision?

You have the right to appeal. File your appeal in writing within 60 calendar days after the date of this notice. We can give you more time if you have a good reason for missing the deadline.

Who May File An Appeal?

You or your treating physician may file an appeal. Or you may name a relative, friend, advocate, attorney, doctor (other than your treating physician), or someone else to act as your representative. Others also already may be authorized under State law to act for you.

You can call us at: (317) 963-9700 (local) or 1- (800) 455-9776 (toll-free) to learn how to name your representative.

If you have a hearing or speech impairment, please call us at TTY 1- (800) 743-3333.

If you want someone to act for you, you and your representative must sign, date, and send us a statement naming that person to act for you.

Important Information About Your Appeal Rights
There are two kinds of appeals you can file:

Standard (30 days) - You can ask for a standard appeal. We must give you a decision no later than 30 days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

Fast (72 hour review) - You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting up to 30 days for a decision. We must decide on a fast appeal no later than 72 hours after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

- If any doctor asks for a fast appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 30 days could seriously harm your health, we will automatically give you a fast appeal.
- If you ask for a fast appeal without support from a doctor, we will decide if your health requires a fast appeal. We will notify you if we do not give you a fast appeal, and we will decide your appeal within 30 days.

What do I include with my appeal?
Your written request should include: your name, address, member number, reasons for appealing, and any evidence you wish to attach. You may send in supporting medical records, doctors' letters, or other information that explains why we should provide the service. Call your doctor if you need this information to help you with your appeal. You may send in this information or present this information in person.

How Do I File An Appeal?

For a Standard Appeal: Mail or deliver your written appeal to the address below:

Indiana University Health Plans
Attention: Medicare Advantage
950 N. Meridian Street, Suite 200
Indianapolis, IN 46204

For a Fast Appeal: Contact us by telephone or fax: (317) 963-9777 or fax: (317)963-9801.

What Happens Next?
If you appeal, we will review our decision. After we review our decision, if any of the services you requested are still denied, Medicare will provide you with a new and impartial review of your case by a reviewer outside of your Medicare health plan. If you disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens.

Contact Information:
If you need information or help, call us at:
Toll Free: 1-800-455-9776
TTY: 1-800-743-3333

Other Resources to Help You:
Medicare Rights Center:
Toll Free: 1-888-HMO-9050
Elder Care Locator
Toll Free: 1-800-677-1116
1-800-MEDICARE (1-800-633-4227)
TTY: 1-877-486-2048
Form Instructions for the Notice of Denial of Medical Coverage
CMS-10003-NDMC

A Medicare health plan ("plan") is to complete and issue this notice when it denies a request for medical service, in whole or in part. This is not model language. This is a standard form. Plans may not deviate from the content of the form provided. Please note that the OMB control number must be displayed on the notice.

**Heading**

- **Date:** Enter the month, day, and year the notice is being issued.
- **Beneficiary’s name:** Enter the full name of the enrollee.
- **Member number:** Enter the enrollee’s medical or other identification number. (HIC number must not be used.)
- We have denied coverage of the following medical services or items requested: List the denied medical services or items.
- We denied this request because: The plan must provide a specific and detailed explanation of why the medical services or items are being denied, with the description of any applicable Medicare coverage rule or any other applicable plan policy upon which the denial decision was based.

**Section Titled: What If I Don't Agree With This Decision?**
No information is required to be completed.

**Section Titled: Who May File An Appeal?**
In the spaces provided, the plan is required to enter the plan's telephone and TTY numbers where the enrollee can learn how to name a representative.

**Section Titled: There Are Two Kinds of Appeals You Can File**
No information is required to be completed.

**Section Titled: What Do I Include With My Appeal?**
No information is required to be completed.

**Section Titled: How Do I File An Appeal?**
Under the subsection "For a Standard Appeal", the plan must provide the address where the enrollee, physician or representative can mail or hand deliver a standard appeal.

Under the subsection "For a Fast Appeal", the plan is required to enter the telephone, TTY, or fax numbers where the enrollee, physician or representative can request an expedited (fast) appeal.

**Section Titled: What Happens Next?**
No information is required to be completed.
Section Titled: Contact Information
In the spaces provided, the plan is required to enter the plan’s telephone and TTY
numbers for the enrollee, physician or representative to call if they need information or
help.

Section Titled: Other Resources to Help You
No information is required to be completed.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0829. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attention: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
List of Approved Indiana Counties, Facilities, Service Area

1. Greene County General Hospital
2. Hancock Regional Hospital
3. Henry County Hospital
4. IU Health Arnett Hospital
5. IU Health Ball Memorial Hospital
6. IU Health Bedford Hospital
7. IU Health Blackford Hospital
8. IU Health Bloomington Hospital
9. IU Health Goshen Hospital
10. IU Health Morgan Hospital
11. IU Health North Hospital and Riley Hospital for Children at IU Health North
12. IU Health Paoli Hospital
13. IU Health Saxony Hospital
14. IU Health Starke Hospital
15. IU Health Tipton Hospital
16. IU Health West Hospital
17. IU Health White Memorial Hospital
18. Jay County Hospital
19. Johnson Memorial Hospital
20. Major Hospital
21. Putnam County Hospital
22. Union Hospital
23. Union Hospital Clinton
24. Witham Memorial Hospital

Marion County Hospitals
- IU Health Methodist Hospital
- IU Health University Hospital
- Rehabilitation Hospital of Indiana
- Riley Hospital for Children at IU Health

Visit iuhealthplansmedicare.org to get the most up-to-date information about IU Health Plans network of providers in your area.
Health Plans

Clinical Editing
Dispute Process

Provider Appeals

How do I appeal a Clinical Editing decision and what is the “dispute” process?

Process/Procedure

- Provider completes the IU Health Plans, Clinical Editing Provider Dispute Form and attaches all appropriate documents to support their dispute within (30) business days from date of the EOP.
- Clinical Editing Disputes are researched utilizing applicable CMS LCD/NCD’s, CPT/HCPC, National Correct Coding Initiative (CCI) guidelines and/or other appropriate Plan resource tools.
- If the Clinical Editing is supported by the CPT/HCPC or National Correct Coding Initiative (CCI) guidelines then the denial of payment will remain and a Clinical Editing Letter explaining the reason for the upheld edit will be sent to the provider within (14) working days of receipt of dispute.
- The Provider may then submit a written request to the Coding Coordinator for review by a IU Health Plans Medical Director if they deem a clinical issue is misinterpreted. The IU Health Plans Medical Director will review and determine the final outcome based upon appropriate documentation and submitted data by the provider on the Dispute Form.
- If the decision is to uphold the edit, then a Clinical Editing Letter explaining the reason for the upheld edit will be sent back to the provider within (14) fourteen business days from receipt of dispute.
- If the decision is to pay – claim will be sent for adjustment and the disputed provider is notified within (14) fourteen business days from receipt of dispute via Explanation of Payment (EOP).
Clinical Editing
Provider Dispute Form...

This form is to be used **ONLY** for Clinical Editing disputes
Clinical Editing-PROVIDER DISPUTE FORM

*Do not use this form for Routine Claims Inquiries, Corrected Claims or Fee Schedule Disputes*

Provider Name___________________________

Date of Submission of Dispute: ____________

Provider Telephone Number #1(____)_______________

Provider Telephone Number #2(____)_______________

Preferred Contact Name___________________________

Provider Address: _______________________________________________________________________________________

Patient Name: ________________________Claim Number: ______________________

Patient MA or SSC ID#: ______________________Date of Service: _________________

Reason for Dispute:
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

Documentation - Attach copies for review (operative notes, office notes, etc.).

Signature : ______________________________

Date________________

Return to:
Cassie Lane, CPC, Coding Coordinator
IU Health Plans, Inc
950 N. Meridian Street, Suite 200
Indianapolis, IN 46204

Phone: (317) 963-9743
Fax Number: (317) 963-9800
An Important Message From Medicare About Your Rights

As A Hospital Inpatient, You Have The Right To:

• Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.

• Be involved in any decisions about your hospital stay, and know who will pay for it.

• Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here:

Name of QIO

Telephone Number of QIO

Your Medicare Discharge Rights

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

• You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.

• You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.

  □ If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.

  □ If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).

• If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.

• Step by step instructions for calling the QIO and filing an appeal are on page 2.

To speak with someone at the hospital about this notice, call __________________________.

Please sign and date here to show you received this notice and understand your rights.

Signature of Patient or Representative | Date/Time
Steps To Appeal Your Discharge

• **Step 1**: You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).

  □ Here is the contact information for the QIO:
  
<table>
<thead>
<tr>
<th>Name of QIO (in bold)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone Number of QIO</td>
</tr>
</tbody>
</table>

  □ You can file a request for an appeal any day of the week. **Once you speak to someone or leave a message, your appeal has begun.**

  □ Ask the hospital if you need help contacting the QIO.

  □ The name of this hospital is:
  
<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Provider ID Number</th>
</tr>
</thead>
</table>

• **Step 2**: You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.

• **Step 3**: The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.

• **Step 4**: The QIO will review your medical records and other important information about your case.

• **Step 5**: The QIO will notify you of its decision within 1 day after it receives all necessary information.

  □ If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.

  □ If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day **after** the QIO notifies you of its decision.

If You Miss The Deadline To Appeal, You Have Other Appeal Rights:

• You can still ask the QIO or your plan (if you belong to one) for a review of your case:

  □ If you have Original Medicare: Call the QIO listed above.

  □ If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.

• If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

Additional Information:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0692. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Appendix

Notice Instructions: The Important Message From Medicare

Completing The Notice

Page 1 of the Important Message from Medicare

A. Header

Hospitals must display “Department of Health & Human Services, Centers for Medicare & Medicaid Services” and the OMB number.

The following blanks must be completed by the hospital. Information inserted by hospitals in the blank spaces on the IM may be typed or legibly hand-written in 12-point font or the equivalent. Hospitals may also use a patient label that includes the following information:

Patient Name: Fill in the patient’s full name.
Patient ID number: Fill in an ID number that identifies this patient. This number should not be, nor should it contain, the social security number.
Physician: Fill in the name of the patient’s physician.

B. Body of the Notice

Bullet number 3 – Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here ____________________________.

Hospitals may preprint or otherwise insert the name and telephone number (including TTY) of the QIO.

To speak with someone at the hospital about this notice call: Fill in a telephone number at the hospital for the patient or representative to call with questions about the notice. Preferably, a contact name should also be included.

Patient or Representative Signature: Have the patient or representative sign the notice to indicate that he or she has received it and understands its contents.

Date/Time: Have the patient or representative place the date and time that he or she signed the notice.

Page 2 of the Important Message from Medicare

First sub-bullet – Insert name and telephone number of QIO in bold: Insert name and telephone number (including TTY), in bold, of the Quality Improvement Organization that performs reviews for the hospital.

Second sub-bullet – The name of this hospital is: Insert/preprint the name of the hospital, including the Medicare provider ID number (not the telephone number).

Additional Information: Hospitals may use this section for additional documentation, including, for example, obtaining beneficiary initials, date, and time to document delivery of the follow-up copy of the IM, or documentation of refusals.