Independent Living Systems is committed to enhancing quality of life through innovative health and support solutions that help improve health outcomes, reduce costs, and foster independence.

**Redefining Healthcare Values**

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

**About this Guide**

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

**About Our Management Partner**

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

**Contact**

iCircle Care can be contacted as follows for all referrals, provider services and all general inquiries:

1-844-iCircle
TTY/TDD Dial 711
Website: http://www.icirclecarecny.org
iCircle Care Provider Relations: 631-297-0633

**About Our Plan**

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

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

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

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

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

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

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

Each geographic area has a regional approach to serving our members. We offer enrollment, care management and Medicaid specialists who provide direct clinical care and assistance locally, in your neighborhood. Our tagline is – Hometown Care, Centered on You – this regional approach to care is just one way we live up to this.
Verifying Eligibility
The iCircle Care Managers will order and authorize the majority of services. Network providers will need to verify member eligibility prior to providing services. Providers are not allowed to directly bill members.

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

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

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

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

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

**Managed Long Term Care Covered/Non-Covered Services**

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</table>

### Services Provided as Medically Necessary

- PT/OT/SP or other therapies provided in a setting other than a home. Limited to 20 visits of each therapy type per calendar year, except for children under 21 and the developmentally disabled. MLTC plan may authorize additional visits.

### Non-Covered Services; Excluded From The MLTC Benefit; Can Be Billed Fee-For Service

- IPrescription and Non-Prescription Drugs, Compounded Prescriptions
- Respiratory Therapy
- All other services listed in the Title XIX State Plan
- Nutrition
- Private Duty Nursing
- Consumer Directed Personal Assistance Services

### Services provided Through Care Management

- Home Delivered or Congregate Meals
- Social Day Care
- Social and Environmental Supports

1 Includes applicable Medicare coinsurance and deductibles for benefit package services

2 Any of the services listed in this column, when provided in a diagnostic and treatment center, would be included in and covered by the plan

3 Includes nurse practitioners and physician assistants acting as “physician extenders”
MEMBERS RIGHTS AND RESPONSIBILITIES

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

Member Rights
Members have the following rights and responsibilities:

- The right to receive medically necessary care
- The right to timely access to care and services
- The right to be provided with reasonable accommodation for members with disabilities.
- The right to privacy about their medical record and when treatment is received
- The right to get information on available treatment options and alternatives presented in a manner and language the member/family/guardian understands
- The right to get information, including all enrollment notices, informational materials, and instructional materials, in a language, manner, and format the member and his family/caregiver understands. Member can get oral translation services free of charge.
- The right to be free from any form of discrimination on the basis of race/ethnicity, color, national origin, gender, disability, political beliefs, religion, sexual orientation, age, medical condition (including physical and mental illness), claims experience, receipt of health care, medical history, genetic information, or evidence of insurability or disability
- The right to be free from abuse and neglect
- The right to be treated with respect and dignity
- The right to get information necessary to give informed consent before the start of treatment
- The right to get a copy of their health records and ask that the records be amended or corrected
- The right to take part in decisions about their health care, including the right to refuse treatment
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- The right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status, or religion
- The right to be told where, when, and how to get needed services including how to get covered benefits from out-of-network providers if they are not available in the network.
- The right to complain to New York State Department of Health or your Local Department of Social Services and the right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.
- The right to appoint someone to speak for them about member care and treatment
- The freedom to exercise all member rights without any adverse effect on the member’s treatment by the plan or our participating providers.
- In the event we are made aware of a member being denied any of the rights identified above, we will initiate an investigation into the matter and report the findings to the Compliance Department.

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

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

- Contact iCircle Care when they need help or have questions.
- Receive all covered services through the iCircle Care Plan utilizing network providers.
- Follow their plan of care and request changes as needed.
- Obtain prior authorization for covered services, except for pre-approved services.
- Be seen by their physicians if a change in your health status occurs.
- Share complete and accurate health information with their Care Manager and health care providers.
- Notify their Care Managers when they go away or are out of town.
- Inform their Care Manager of any changes in their health and advise if they do not understand or are unable to follow instructions.
- Cooperate with and be respectful of the iCircle Care Plan staff members.
- Notify the iCircle Care Plan within two (2) business days of receiving non-covered services or after receiving emergency care or being admitted to a hospital, so that plan Care Manager can adjust covered services accordingly.
- Take responsibility if they refuse treatments or do not follow iCircle Care Plan instructions.
- Make every effort to pay their Medicaid spend down (Surplus) amount owed to the iCircle Care Plan, if any.

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

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

In the event we are made aware of a member being denied any of the rights identified above, the Plan will make a good faith effort to address the issue with the member and his or her authorized representative, educate the member and his or her authorized representative about their responsibilities, and document the interaction.
ENROLLMENT IN A MANAGED LONG TERM PLAN

Enrollment Policies

Enrollment Process

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

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

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

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

Denial of Enrollment

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

- Applicant is not at least 18 years of age
- Applicant is not Medicaid eligible.
- Applicant is not eligible for MLTC as per the eligibility assessment tool (UAS), where applicable.
- Applicant is not capable of returning to or remaining in the home without jeopardy to his/her health and safety.
- Applicant does not require community-based long term care services for more than 120 days.

If the eligibility criteria for age, county of residence, and Medicaid are not met, the applicant will not be assessed for enrollment and will be so informed by letter. If the applicant chooses to pursue enrollment despite a lack of eligibility, iCircle will send this information to NY Medicaid Choice or LDSS for review and eligibility determination. If iCircle determines that the enrollment should be denied based on failure to meet the enrollment criteria, iCircle Care will recommend to NY Medicaid Choice or LDSS that the enrollment application be denied. NY Medicaid Choice or LDSS makes the final determination in the denial of enrollment and NY Medicaid Choice or LDSS will notify the applicant of his/her rights.

If the applicant disagrees with iCircle Care regarding eligibility due to age, county of residence or Medicaid eligibility, information that has been provided to the plan will be sent in writing to NY Medicaid Choice or LDSS with a copy to the applicant. NY Medicaid Choice or LDSS will decide if the plan was correct in informing the applicant that he/she is ineligible to enroll. If NY Medicaid Choice or LDSS agrees that the applicant is ineligible to enroll, then the applicant will be denied enrollment.

If the applicant is determined to be clinically ineligible for enrollment, the applicant will be advised and may withdraw the application. Clinical Ineligibility means that based on the in-home assessment the applicant is not eligible for MLTC using the eligibility assessment tool (UAS), where applicable and/or that the applicant does not meet health and safety criteria, and/or the applicant does not require managed community-based long term care services for at least 120 days. If the applicant does not wish to withdraw the application for clinical denial, the enrollment application will be processed as a proposed denial, pending NY Medicaid Choice or LDSS agreement.

Applicant will be assured that his or her enrollment in plan will not be subject to discrimination based upon health status or change in health status and the need for or cost of covered services.

Withdrawal of Enrollment

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

Transitional Care

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

In addition, iCircle Care members may continue an ongoing course of treatment for a transitional period of up to ninety (90) calendar days should the member’s participating provider leave the Provider Network, provided that such provider: (a) accepts payment at an agreed upon rate with the plan; (b) adheres to the plan requirements for quality assurance and other policies and procedures; and (c) provides necessary medical information about the care being rendered. Individuals transitioning from fee-for-service Medicaid to MLTC in mandatory counties must continue to receive services under the enrollee’s pre-existing service plan for at least 90 days after enrollment or until a care assessment has been completed by the Plan, whichever is later. In addition, the patient/worker(s) relationship must be preserved for the same 90 day period. The worker in this case is defined as both professional and paraprofessional staff of the provider agency.
Disenrollment Policies

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

Voluntary Disenrollment

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

If after enrolling in iCircle Care, a member then enrolls in or receives services from another Medicaid Managed Long Term Care plan, Community Based waiver program, or OPWDD Day Treatment Program, this will be considered voluntary disenrollment. A member may dis-enroll to regular Medicaid or join another health plan as long as they qualify.

Involuntary Disenrollment

If iCircle Care feels that it is necessary to disenroll a member involuntarily, the plan must obtain authorization from the LDSS or New York Medicaid Choice. iCircle Care Program will not involuntarily dis-enroll members on the basis of adverse change in health status or the need for and/or cost of covered services. The reasons for involuntary disenrollment are listed below. Involuntary disenrolled members have to be approved by the LDSS or NY Medicaid Choice.

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

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

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

for non-dual eligible Enrollees, no longer meets the nursing home level of care as determined using the assessment tool prescribed by the Department. The plan will provide the LDSS or enrollment broker the results of its assessment and recommendations regarding disenrollment within five (5) business days of the assessment making such a determination.

• An Enrollee is incarcerated. The effective date of disenrollment shall be the first day of the month following incarceration.

iCircle Care Can Ask Members to Leave the plan if:

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

Re-Enrollment Provisions

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

a) “Providers or Referral Sources” shall mean any person, group of persons, or entity, including, but not limited to, health care providers that contracts with one or more Medicaid managed long term care plans.

b) “Marketing” shall mean all forms of communication, written or oral, used to encourage or induce Medicaid recipients to enroll in a Medicaid managed long term care plan.

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

d) Providers may give permission to iCircle Care marketing representatives to conduct marketing activities at their facility. Plans at these activities must prominently display a list of all other Plans with a fair market value of no more than $5.00, with such gifts being offered regardless of beneficiary’s intent to enroll.

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

Reporting Attendance and Significant Health Events:

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

a) Adverse Events related to the following:

- **Decline in management of medications**
- **Significant worsening of ADLs**
- **Two or more Behavioral Problems**
- **Disaster that leaves Provider facility diminished**
- **Falls or Accidents (with or without injury)**

All Adverse Event reporting and Reviews are part of the Quality Initiatives for both Contractor and Provider. This Quality Initiative and Risk Management process anticipates the information will not be included in the discoverable elements of the enrollee file.
Incident Reporting
Provider agrees to implement a systemic process for incident reporting and notifying the appropriate iCircle Care plan staff within 48 hours of occurrence of an incident that may jeopardize the health, safety and welfare of an enrollee or impair continued service delivery.

Reportable conditions include but are not limited to:
- Closure of Provider services or facilities due to license violations
- Provider financial concerns/difficulties
- Loss or destruction of enrollee records
- Compromise of data integrity;
- Fire or natural disasters; and
- Critical issues or adverse incidents that affect the health, safety, and welfare of enrollees.

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

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

Policies

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

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

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

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

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

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

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

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

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

Home Care Workers Parity
Home care providers are expected to comply with the New York State Medicaid and CMS.  In addition, they are expected to maintain appropriate documentation of each member trip.
Hygiene Law.

Services Law, and Section 33.13 of the Mental

27-F of Public Health Law, Section 369 of the Social

and regulation including but not limited to Section

laws including applicable sections of the State law

partners comply with any state and local privacy

In addition, iCircle Care and it’s management

• Leave minimum data on voice mail

• Fax numbers should be confirmed before

• Fax machines should be positioned for privacy

• Email should not be used to transfer files with

or health care operations”.

CHIPAA and Confidentiality Standards

The task of handling enrollee records and related

administration functions is accomplished with

consideration to Health Insurance Portability and

Accountability Act (HIPAA). Enrollee Member files

will be kept confidential at all times and includes

some or all of the following precautions:

• Only request and work with Protected Health

Information (PHI) related to “treatment, payment,

or health care operations”.

• Email should not be used to transfer files with

member info unless it is encrypted.

• Fax machines should be positioned for privacy

• Fax numbers should be confirmed before

sending info to ILS or MLTC PLAN

• Leave minimum data on voice mail

In addition, iCircle Care and it’s management partners comply with any state and local privacy laws including applicable sections of the State law and regulation including but not limited to Section 27-F of Public Health Law, Section 369 of the Social Services Law, and Section 33.13 of the Mental Hygiene Law.

Change of Provider Data

Any change in a Provider’s name, address, telephone number, or change of ownership, must be reported in writing without delay to Provider Relations.

Policies on Billing

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

Abuse, Neglect, and Exploitation Training

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

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

• Each victim’s name, age, sex, race, and physical description

• Location of each victim alleged to have been

abused, neglected, or exploited

• Name, address and telephone number of the

victims’ family members

• Name, address and telephone number of each

alleged perpetrator

• Name, address, and telephone number of the
care giver, if this differs from the perpetrator

• Name, address, and telephone number of

the person reporting the abuse, neglect, or
exploitation

• Description of the physical or psychological

injuries sustained

• Actions you’ve taken, such as call the police,
ofamily of the victim

• Any information you may have regarding the
cause of the abuse, neglect or exploitation

Medicaid Managed Care Organizations (MLTC Plans) are required to ensure that all direct care providers have knowledge of and attest they will maintain compliance with staff training relative to Abuse, Neglect & Exploitation. It is your responsibility as the Provider to ensure that Abuse, Neglect and Exploitation training occurs and to maintain necessary documentation of this training for the employees who have contact with iCircle enrollees. You may be requested to make such documentation available.

For additional information please refer to the New York State Office of Children and Family Services website:

https://www.ofcs.state.ny.us/main/psa/

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

Emergency Service Responsibilities

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

Weather-related and Emergency-related Closings

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

Additional New York State information can be found at www.nyalert.gov and specifically for health care providers at:

http://www.health.ny.gov/environmental/emergency/health_care_providers/
Advance Directives

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

Credentiaing and Termination

Application Process

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

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

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

Provisional Credentialing

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

Ongoing Credentialing

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

Provider Termination and Disciplinary Action

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

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

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

(I) the reasons for the proposed action;

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

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

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

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

CARE MANAGEMENT

Role of Care Manager

Upon joining the iCircle Care, all new members will be assigned a Care Manager (RN) who will provide care management services including person centered service planning. These services include:

- Development of a person-centered service plan (PCSP)
- Care management of covered services and coordination of non-covered services and other services provided by community resources and informal supports
- Development of a “back-up” plan to ensure continuation of services in the event that regular services in the PCSP are temporarily unavailable.
- Regular periodic assessment and reevaluation of service needs
- Communication with member, family, informal supports to develop health care goals, supports needed, and types and duration of authorized services required.

- Provide referrals and authorize covered services
- Provide discharge planning support and participate in the coordination of members transitioning between settings such as hospital to nursing home or nursing home to home
- Be available to the member, or provide coverage by another Care Manager, 24 hours a day, seven days a week to assist member with urgent care or other issues.

Transportation Guidelines

Non-Emergent Transportation by ambulance, ambulance, taxi or livery service as well as public transportation (where available) is a covered benefit to assist a member in obtaining necessary medical care and services. In order to access this cover service the member will need to make prior arrangements with the Care Manager 24 to 48 hours in advance of the appointment date. Members should speak with their iCircle Care Manager about recurring transportation requests.

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

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

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

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

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

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

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

Timeframes for prior and service authorization requests
- Standard review: within 3 business days of receipt of necessary information, but no more than 14 days of receipt of request for services.
- Expedited review: within 3 business days from request for service.

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

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

If the plan needs more information to make either a standard or expedited decision about the member’s service request, the timeframes above can be extended up to fourteen (14) calendar days. The plan will:
- Write and inform the member what information is needed. If the request is an expedited review, the plan will call the member immediately and send a written notice later.
- Tell the member why the delay is in his or her best interest.
- Make a decision as quickly as it can when the plan receives the necessary information, but no later than fourteen (14) calendar days from the end of the original timeframe.

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

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

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

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

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

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

Respiratory Therapy Services

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

Durable Medical Equipment

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

Medical Social Services

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

Nursing Home Care

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

CLAIMS MANAGEMENT

Provider Billing for Services

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

Instructions and all information required for a clean or complete claim

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

Examples of Acceptable Paper Claims Forms

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

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

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

a. The first step is to register with Emdeon or another Clearing House.
b. Once registered Provider will be able to submit electronic claims following instructions from clearinghouse.
c. Provider will need to use the payer ID of TO BE DETERMINED when billing through the clearinghouse.

Providers can submit hard copy claims directly to iCircle Care via US mail at:
iCircle Care
P.O. Box 1320
Webster, NY 14580

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

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

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

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

ATTN: Claims Dept. - Reconsideration Claim
iCircle Care
P.O. Box 1320
Webster, NY 14580

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

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

Completing the UB-04
The UB-04 form is used when billing for facilities services, including nursing home room and board and ICF services.
PROVIDER APPEALS AND GRIEVANCE

Policies and Procedures that cover the Provider Complaint System
You may contact iCircle to file a provider complaint, including complaints about claims issues. Please call 1-877-775-3778 TTY:711 for details of Address, Office Hours, and who has the authority to review your complaint.

Additional information regarding provider complaints can be found at the NY State Department of Financial Services: http://www.dfs.ny.gov/

MEMBER GRIEVANCES AND APPEALS

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

When the Plan:

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

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

Grievances

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

There will be no change in the member’s services or the way he or she is treated by the staff or a health care provider because he or she has filed a grievance or an appeal. iCircle Services will maintain the member’s privacy. The plan will give the member any help he or she may need to file a grievance or appeal. This includes providing the member with interpreter services or assistance if he or she has vision and/or hearing problems.

The member may choose someone (such as a relative, friend, or provider) to act on his or her behalf.

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

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

External Appeals

Determination

A determination is a decision made by the plan or provider about a member’s health care or services.

Appeal

An appeal is a request by a member or provider for an independent review of a determination.

Grievance

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

What is a Grievance?

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

Grievance Procedures

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

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

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

How do I Appeal a Grievance Decision?

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

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

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

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

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

Contents of the Notice of Action
Any notice sent to a member about an action will:

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

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

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

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

Request to Continue Services
If the member is appealing a reduction, suspension or termination of services he or she is currently authorized to receive, he or she may request to continue to receive these services while the plan is deciding the appeal. The plan must continue the member’s service if he or she makes the request no later than ten (10) calendar days from the mailing of the notice about the plan’s intent to reduce, suspend or terminate services, or by the intended effective date of its action. The member’s services will continue until he or she withdraws the appeal, or until ten (10) days after the plan mails the member’s notice about the plan’s appeal decision if the decision is not in the member’s favor, unless he or she has requested a New York State Medicaid Fair Hearing with continuation of services. Although a member may request a continuation of services while his or her appeal is under review, if the appeal is not decided in the members favor, the plan may require the member to pay for these services if they were provided only because the member requested to continue to receive them while the appeal was being reviewed.

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

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

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

If the plan does not agree with the request to expedite the appeal, the plan will make best efforts to contact the member in person to let him or her that we have denied the request for an expedited appeal and will handle it as a standard appeal. Also, the plan will send a written notice of its decision to deny the request for an expedited appeal within two (2) business days of receiving the request.

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

If the plan did not decide the appeal totally in the member’s favor, he or she may request a Medicaid Fair Hearing from New York State within sixty (60) calendar days of the date the plan sent the notice about its decision on the Fair Hearing.

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

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

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

Members can use one of the following ways to request a Fair Hearing:
• By phone. Call toll free 1-800-342-3334
• By fax at 518-473-6735
• By Internet at www.otda.state.ny.us/oah/forms.asp
• By mail:
  Fair Hearing Section
  NYS Office of Temporary and Disability Assistance
  Managed Care Unit
  P.O. Box 22023
  Albany, New York 12201-2023

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

State External Appeals

If the plan denies an appeal because it may determine the service is not medically necessary or is experimental or investigational, the member may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for the plan or New York State. These reviewers are qualified people approved by New York State. The member does not have to pay for an external appeal.

Before the appeal to the State:
• The member must file an action appeal with the Plan and get the plan’s final adverse determination, or
• If the member has not gotten the service and he or she ask for a fast track action appeal with the MLTC plan, he or she may ask for an expedited external appeal at the same time. The member’s doctor will have to say an expedited external appeal is necessary, or
• The member can prove Circle Services did not follow the rules correctly when reviewing your action appeal.

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

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

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

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

Here are some ways for a member to get an application:
• Call the New York State Department of Financial Services,
  Monday – Friday 9:00- 5:00pm 1-800-400-8882
• Send an email to externalappealquestions@dfs.ny.gov
• Go to the New York State Insurance Department’s website at www.dfs.ny.gov/

The external appeal will be decided within (30) days. More time (up to five (5) business days) may be needed if the external appeal reviewer asks for more information. The reviewer will tell the member and the plan of the final decision within two (2) business days after the decision is made.

Members can get a faster decision if his or her physician(s) believes that a delay will cause serious harm to the member’s health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in 72 hours or less. The reviewer will tell the member and the plan the decision right away by phone or fax. Later, a letter will be sent that informs member of the decision.

A member may ask for both a Fair Hearing and an external appeal. If the member asks for a Fair Hearing and an external appeal, the decision of the Fair Hearing Officer will be the one that counts.

UTILIZATION MANAGEMENT AND QUALITY IMPROVEMENT
Providers are expected to review and adhere to the requirements of the outlined in the Provider Contract. This includes activities including but not limited to:
1. Concurrent review of service, referral processes or protocols
2. Pre-Admission Testing Guidelines
3. Claims Payment Review
4. Member Grievances
5. Submission of Claims and other Data
6. Provider Credentialing
PROVIDER QUICK REFERENCE GUIDE

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

Claims Submission
For Paper Submission:

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

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

All paper claim submissions are to be mailed to the following address:
iCircle Care
P.O. Box 1320
Webster, New York, 14580

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

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

Referrals
Providers can make referrals to iCircle Care in three ways listed below:
Call: 1-844-iCircle (424-7253)
Visit: www.icirclecarecny.org
Email: enrollment@icirclecarecny.org
Mail: 860 Hard Road, Webster, NY 14580 (Referral Form Attached)
Please call us 24/7 with any questions regarding your coverage. You'll always be greeted by a live person.

General Inquiry/Enrollment: 1-844-ICIRCLE (424-7253)
Member Assistance Line: 1-844-MY-ICARE (694-2273)
Grievance/Appeals: 1-855-775-3778
Email: info@icirclecarecny.org

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