Provider Manual

Eleventh Edition
2018

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Section I. Welcome!

InteCare is a non-profit 501c3 Behavioral Health Network and Management Corporation with its administrative offices located in Indianapolis, Indiana. Our organization is Provider sponsored and has grown out of the community mental health Provider system in the state of Indiana.

Being both Provider sponsored and non-profit, InteCare is truly committed to values of being quality-focused, consumer -centered-focused and Provider friendly. We hope that the InteCare Network Provider Manual will be of assistance.

While InteCare is an outgrowth of Provider organizations which have historically operated primarily public sector programs, InteCare provides management services for both public and private *(commercial)* sector programming. For example, InteCare is contracted with Managed Care Organizations for behavioral health services.
Provider Manual Overview. InteCare created this Provider Manual with significant input and overall approval of the InteCare Network and Credentialing Subcommittee. This Subcommittee is comprised of a multidisciplinary team of Behavioral Health professionals that includes both InteCare, Inc. employees *and* Network Providers. The contents of the Manual will be reviewed and updated as conditions warrant, as but on no less than a biennial basis.

The Provider Manual is intended to accomplish several goals:

- First, the Manual provides practical information to the Provider regarding practices and procedures as an InteCare Network Participating Provider.
- Second, the Manual provides general information concerning the organization that is useful to a broader audience including Covered Individuals and current or prospective clients. For example, the Manual includes information concerning access to services, InteCare initiatives for improving the quality of services, and what to do if you have a complaint.
- Third, the manual provides additional information about Standards of care in the Network, specifically concerning provider qualifications, access standards, and so on.

As noted above, authority and responsibility for publication and republication of this Manual rests with the InteCare Network and Credentialing Subcommittee. Additionally, input from the Provider Community, Client Organizations, and Covered Individuals will be incorporated into subsequent editions of the Manual.

Policy Creation. The content of this manual is based upon approved InteCare Policies and Procedures. All InteCare Policies with the exception of the Network and Credentialing Plan and its associated policies and procedures must be approved by the

InteCare Management Committee upon recommendation by one of several standing subcommittees and work groups, which include the Quality Improvement Committee, Network and Credentialing Subcommittee, the Customer Satisfaction and Services subcommittee and Clinical Work Group.

Many of the policies that provide the foundation of this manual are sponsored and approved by the Network and Credentialing Subcommittee. The Network and Credentialing Subcommittee has majority representation by participating Network Providers.

Policy Adherence. Every effort is made to insure that this manual is a valid and comprehensive summary of InteCare policies concerning Network Participation. Therefore, this Manual can be used as a source of information when researching references made to "InteCare Policy" in your Network Participating Provider Agreement.

Use of this Manual: Program Specific Requirements. While there is a great deal of consistency across service programs in InteCare Policy and Procedure (e.g. the requirements for credentialing and participation, complaint processes, quality improvement initiatives), certain programs differ in the requirements of participation.

The Provider should *read this section carefully* and reference their Network Participating Provider Agreement and executed exhibits. The InteCare Participating Provider Agreement is designed in such a way that for each InteCare program that the Provider is contracted for participation, there is a separate Exhibit containing program specific information. Such information includes description of Covered Services, standards, service expectations, and reimbursement procedures and rates, among other things. *Providers are only eligible for participation in programs specifically described in the executed exhibits attached to their fully executed Provider Agreement. Each exhibit contains the specific requirements, reimbursement schedule and covered services for that contract.*

In general, the *procedural* requirements for Providers tend to vary amongst programs, and are described in the program-specific Exhibit(s) that are signed in addition to the basic Participating Provider Agreement. Obviously, programs also vary along other lines, including Provider reimbursement rates, Covered Diagnoses, and Covered Services, among other things. Please note that InteCare, Inc. will not refer a Consumer enrolled in a specific program to you who is outside of your executed Exhibit(s). As noted above, however, this information is covered in the program-specific Exhibits in your Participating Provider Agreement, and is not covered in the manual.

The areas where Providers will want to pay close attention in order to follow appropriate procedures include those below.

- How consumer's eligibility for the program is determined and/or verified by the Provider
- Requirements for Provider Precertification/Preauthorization for Payment for Services
- Reimbursement or Claim Payment Mechanisms

Publication Chronology. Since conditions change over time, and as procedures change and new Providers and/or locations are added, the Manual will be periodically updated. Such updates will happen no less than biennially. Additionally, Manual Supplements may be circulated on an as-needed basis. For example, the implementation of a new program which has highly unique procedures might lead to the publication of a "program-specific" manual supplement. To assist Providers in tracking the chronology of Manual updates or supplements, a "Publication Chronology" can be found in Appendix A.

Section II: About InteCare

InteCare is a nonprofit corporation that arranges for the provision of Behavioral Healthcare and Addictions Services in the InteCare Behavioral Health Provider Network as well as provides Managed Behavioral Healthcare Administrative services within the state of Indiana.

The business model for the arrangement of Behavioral Health Services typically finds InteCare contracting with a payor (either commercial or public sector) to arrange for a service delivery network and the payor's unique programmatic needs. InteCare, in turn, purchases or arranges for these services from the contracted Participating Provider Network according to the terms of the Participating Provider Agreement.

Administrative Services such as credentialing, quality improvement activities and initiatives or contracting are housed and operated from the InteCare Administrative offices; it is not unusual for a Network Provider to purchase such services from InteCare. For example, an organization might contract InteCare to oversee and conduct the organization's staff credentialing using InteCare's credentialing process.

The InteCare Participating Provider Network provides high quality, efficient, and cost-effective behavioral healthcare services to eligible participants, or *Covered Individuals*. The Network is able to serve a broad range of Covered Individuals, including seriously mentally ill adults and severely emotionally disturbed children. A wide variety of services are available for the treatment of emotional, behavioral or addiction problems in numerous locations throughout Indiana.

Treatment and Administrative Services. Some of the Behavioral Health and Addictions Treatment services available through InteCare Network Providers are listed below. The array of services provided by any particular Provider for a particular program must be listed in the Program-Specific Exhibit attached to the Provider's Participation Agreement. Behavioral Health and Addiction Services available in the InteCare Network include:

- Crisis intervention services;
- Critical Incident Stress Debriefing services;
- Employee Assistance Programs;
- Mental health and substance use outpatient evaluations and on-going treatment;
- Family and group therapy services;
- Outpatient psychiatric evaluations and follow up medication monitoring;
- Home-based outpatient behavioral healthcare services;
- Detoxification services on an ambulatory and/or inpatient basis;
- Case management services;
- Assertive Community Treatment (PACT model);
- Therapeutic Foster Care;
- Residential and group home services;

- Intensive Psychiatric Services, including inpatient, sub acute and partial hospitalization:
- Intensive outpatient services for mental health and substance use, and;
- Vocational rehabilitation referral and/or Supported Employment services;

Some of the Managed Behavioral Health Administrative Services available through InteCare, Inc. can include:

- Credentialing Services
- Establishing and maintaining the InteCare Provider Network and/or specialty or niche Behavioral Health networks for payors;
- Contracting with Clients to establish customized Behavioral Health Service programs using the InteCare Provider Network;
- Consulting about Management of the financial aspects of Behavioral Health treatment programs such as managing risk and reimbursing Providers for services using a variety of reimbursement models;
- Integrating Services among Providers to improve program quality, viability and cost-effectiveness;
- Overseeing a Continuous Quality Improvement process directed at constantly seeking to improve the quality of services rendered by InteCare Network Providers or addressing specific problems identified by a Provider;
- Marketing and development of new and responsive behavioral health and administrative products;
- Management of the Network to ensure that only qualified, licensed Providers in good standing are rendering services in the Provider Network;
- Consultation and/or education programs for Clinical and/or Disease Management Services; and
- Claims facilitation

InteCare's Noble Purpose: We simplify administrative complexities to strengthen provider and payor relationships that enhance the delivery of care.

Values We Live By

High Quality

InteCare demonstrates high quality services through its personnel, programs, customer, and community interactions.

Cost Effective

We believe as a non-profit organization we can provide the highest quality for the best price.

Integrity

Integrity is a critical asset to us. We set high standards and are committed to practice business fairly and behave ethically. With a high level of integrity and satisfaction, we are able to bring solutions that improve business operations and reduce total operating expenses.

Job Satisfaction

We strive to be the employer of choice through offering competitive salaries, benefits, and an enjoyable atmosphere where employees understand their roles and responsibilities and how it aligns with the goals of the organization.

Respect

Here at InteCare everyone is treated with the respect and dignity they deserve. We value diversity among our employees and customers. We respect all people.

Customer Driven

We recognize that our customers are the reason we are here and strive to provide the best customer experience possible.

Accessing Behavioral Health or Substance use Treatment Services. Each InteCare, Inc. Program-Specific Exhibit attached to the Participating Provider Agreement details how access to Services is obtained. For example, InteCare may provide the behavioral healthcare Network of Providers for Managed Care Organizations operating within the state of Indiana, as well as some administrative services and oversight of dedicated programs. These Managed Care Organizations may provide a centralized access number to the covered individuals who have enrolled in the program to contact and request behavioral healthcare services.

For a handy contact reference sheet, please go to Appendix E.

InteCare Administrative Offices

The InteCare administrative offices are located at 8604 Allisonville Road, Suite 325, Indianapolis, Indiana 46250. Should you have administrative business to conduct with the organization, please contact us at 1-317-237-5770. Some of the key InteCare administrative staff are listed below.

You may visit our website at www.InteCare.org.

Table 1: Key InteCare Contacts and Administrative Office information

Administrative Staff. The following administrative staff is housed at the InteCare Corporate offices in Indianapolis.

Staff Titles	Areas of Responsibility
Chief Executive Officer	Client Contracts; Provider Participation Agreements and Exhibits; Client Contract Marketing and Development Overall Administration of Organization
Medical Director	Administration and Oversight of Credentialing Programs
Director of Operations	Administration and Oversight of Corporate Operations; Administration of Quality Improvement Program; Administration of Compliment, Compliant and Grievance Process; Administration of Regulatory Compliance, Disputes, Responsible for All Performance Measures and Reporting; Administration of Client and Covered individual Satisfaction Programs
MHFRP Manager	Oversight and Management of Medicaid Funds Recovery Program
Credentialing Manager	Administration of Network Credentialing and Development
Chief Financial Officer	Fiscal Policy and Accounting
Credentialing Staff	Network Credentialing
Medicare, Medicaid Enrollment Manager	Responsible for the Provider Information maintained in the Provider Database; Provider Relations
Network, Medicare & Medicaid Enrollment Specialist	Network Credentialing Verification, Enrollments for Medicare and Medicaid
Controller	Administration and Distribution of all Corporate Billing and Claim Activities; Reconciliation of all Corporate Accounts

Section III: Provider Participation & InteCare Credentialing Standards

Applications are available for any Behavioral Health Provider licensed in the state of Indiana and other states as applicable but InteCare, Inc. reserves the right to limit its network geographically on the basis of service demand. In order to become a Network Provider, the candidate must:

- Possess minimum qualifications for application as a Provider (e.g. be licensed for independent practice, maintain sufficient malpractice insurance, etc.);
- Successfully complete the Application and Credentialing Process, and;
- Execute (or have your organization execute) an InteCare Participating Provider Agreement.

This section will describe the application and credentialing process.

Contracting with InteCare. While in reality this is the final step to becoming a Participating Provider, because of its importance, it will be covered first in this section of the manual.

InteCare policy requires that InteCare, Inc. has fully executed written service agreements (entitled "Participating Provider Agreements") with all participating Providers, and that the Participating Provider Agreement shall be based on a template document generated and provided by InteCare, Inc.

Additionally, InteCare Policy requires that all Participating Provider Agreements are reviewed to ensure consistency in terms, conditions and services with relevant InteCare Payor agreements prior to their execution. Only the Chief Executive Officer, or his or her formally appointed designee(s), shall have authority to execute Participating Provider Agreements on behalf of InteCare.

Providers are only eligible for reimbursement for specifically contracted services or programs.

How to Become a Panel Provider – the Credentialing Process. InteCare is distinguished by its emphasis on a very full continuum of behavioral health services, including those provided by community-based organizations, e.g. CMHCs.

Individual Provider applications are accepted from the following:

- MD/DO Psychiatrists with an approved residency and board eligibility/ certification and current unrestricted licensure in a US state.

State of Indiana licensed-independent practice level professionals:

- Psychologists with the Health Service Provider in Psychology certification
- Advanced Practice Nurses (CNS & NP with prescriptive authority)
- Physician Assistants with prescriptive authority
- Licensed Clinical Social Workers
- Licensed Marriage & Family Therapists
- Licensed Mental Health Counselors
- Licensed Clinical Addiction Counselors

Organizational applications are accepted from behavioral health organizations that are licensed and certified by the state and hold a national accreditation, e.g. JCAHO, CARF, COA, HFAP (AOA). Organizational Network Provider status allows the provision of certain services that are not necessarily directly delivered by licensed personnel, e.g. case management, inpatient hospitalization, etc., provided that such services occur under the supervision of appropriately licensed personnel.

As there are numerous variations of how small groups are organized in the State of Indiana, InteCare has determined that all Providers who practice within a small group and wish to apply for participation in the InteCare Network must complete the application packet as independent Provider applicants with the following exceptions:

1. If the owner and/or designated administrator of the small group practice has signed a Participating Provider Agreement and applicable Exhibits **for the group practice**, all Providers MUST complete the InteCare "Incorporation by Reference Agreement" and return with their application packet. The "Incorporation by Reference Agreement" would be signed by each Provider in the practice instead of each having to complete the entire Participating Provider Agreement and applicable Exhibits.
2. If the owner and/or designated administrator of the small group practice wishes to sign a W-9 form **for the group practice**, he or she must sign a W-9 for each Provider application packet from the group practice.
3. If the owner and/or designated administrator submitted a current insurance declaration page **for the group practice**, the declaration page must include the name of each Provider covered under the policy or a notation on the declaration page that all employees are covered under the policy. In addition, applicants may send a letter from the insurance company that states all employees are covered under the policy. The insurance declaration page and/or letter will be copied and inserted into each Provider file from the group practice.

InteCare, Inc. staff will first conduct a preliminary screening process for all interested applicants to determine if they meet minimum selection criteria requirements. Once it is determined that the applicant meets those minimum requirements, and if the

applicant provides services in an area that has been determined to be in need of services by the InteCare Network and Credentialing Subcommittee, an application packet is distributed to the applicant. The application packet includes a cover letter describing the Provider selection criteria and application process, Checklist of items to be submitted with the credentialing application, Provider Credentialing application, Release of Information**,** two (2) copies of the InteCare Participating Provider Agreement and applicable exhibits, and a W-9 form.

The InteCare, Inc. Credentialing Manager or Staff reviews the application materials upon receipt to determine that all requested documents are included and that the information is complete and accurate. Incomplete packets will not be processed.

InteCare Credential Verification Process. Once the completed application has been received and as supportive materials are being gathered, a credential verification process begins (contingent upon receipt of signed release of information forms).

InteCare, Inc. conducts a full primary and secondary source verification of an applicant's education, work history, licensure, liability insurance history, and present certifications, e.g. DEA, CSR, or Board Certification. Applicants whose credentials are verified are presented to the Network & Credentialing Subcommittee for review and determination.

InteCare Network and Credentialing Subcommittee. The InteCare Network and Credentialing Subcommittee, co-chaired by the InteCare Medical Director and Director of Operations is responsible to provide governance, oversight and overall direction regarding the clinical aspects of the Credentialing program including clinical policies and procedures, payment practices and Network Selection Criteria. The Subcommittee also includes significant Network Provider representation. This Subcommittee has authority for approving and overseeing the Participating Providers that comprise the InteCare network. This includes input and documentation from Providers regarding credentialing & re-credentialing decisions. The Subcommittee includes a full array of network practitioners to ensure Participating Provider input on a peer level.

InteCare reserves the right to limit its network to assure efficient and effective provision of quality behavioral health services. An applicant who is not granted network credentialed status may have specific appeal rights as detailed in the InteCare Provider Agreement and the InteCare Network and Credentialing Plan (See also, "Provider Disputes and Appeals" later in this section).

InteCare Credentialing Policy. In order to insure that the InteCare Network Provider credentialing process is maintained at the highest standard of quality and is in complete compliance with NCQA, InteCare' s strong preference is to conduct credentialing (and recredentialing) activities for all Provider Applicants/Members. While organizational

Providers can and do conduct elaborate internal credentialing or *privileging* of their clinical staff, our experience has been that in most instances such processes are either not in compliance with national accrediting standards, or more often, are applied too narrowly to meet such standards (e.g. only physicians are *fully* credentialed).

For those institutions who wish to seek a delegated credentialing relationship with InteCare, the standards surrounding the process remain the same both in terms of the collection and verification of credentials and supporting materials, and in term of timeliness expectations. In addition, in order to be an organization that conducts delegated credentialing, the organization must be appropriately licensed and accredited, must successfully complete an extensive initial audit, and must execute a delegated credentialing agreement. Thereafter, the organization must supply to InteCare detailed credentialing activity reports on a quarterly basis, and must be re-audited annually.

Failure to comply with InteCare credentialing standards on a delegated basis may result not only in the revocation by InteCare of delegated credentialing functions, but also, suspension from participation as a organizational Network Provider until organizational staff can be appropriately credentialed and activated in the network. Presently, InteCare does not have any delegated credentialing arrangements but interested organizations may contact the Credentialing Manager or the Director of Operations.

Minimum Qualifications of Providers and Credentialing Standards.

The minimum requirements for eligibility to become a Network Provider, by profession, are located in Appendix E.

If you are interested in becoming an InteCare Network Provider, please contact our office for further information. The InteCare Network Provider selection criteria can be made available to you.

Approval for participation occurs only upon successful completion of the credential review process and complete execution of an InteCare Participating Provider Agreement. Network Providers are subject to credential review every three years.

Ethical Standards. In order to qualify for consideration as a Network Provider, providers are required to ascribe to a professional code of ethics, which may be articulated by the employing organizational provider or by a nationally recognized authority**.** This code must include specifications that prohibit discrimination on the basis of race, gender, national origin, religion or disability. All professional providers are encouraged to maintain membership in a professional behavioral health organization that espouses a professional code of ethics. Some examples of recognized organizations are the American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, National Association of Social Workers, and the American Psychological Association. The Code may be drawn from a nationally recognized professional organization, e.g. NASW, American Psychological Association, American

Psychiatric Association, American Academy of Child and Adolescent Psychiatry, or American Medical Association, or NAADAC and IC & RC

- The Code may be developed by a Provider organization as a part of their corporate compliance efforts, or;
- If a Provider is not affiliated with a professional organization, InteCare, Inc. recommends that they ascribe to the State of Indiana Administrative Code regarding the standards for competent practice as it pertains to their profession (IC 25-23.6-2-8). The following can be located at http://www.in.gov/pla/bandc/index.html.

  Standards for the competent practice of social work and clinical social work: 839 IAC 1-3-4
  a. Standards for the competent practice of marriage and family therapy: 839 IAC 1-4-4
  b. Standards for the competent practice of mental health counseling: 839 IAC 1-5-5
  c. Indiana State Psychology Board Uniform Standards of Practice: IC 25-1-9
  d. Medical Licensing Board of Indiana Uniform Standards of Practice: IC 25-1-9
  e. Indiana State Board of Nursing Uniform Standards of Practice: IC 25-1-9
  f. Standards for the competent practice of licensed clinical addictions counselors: 839 IAC 1-55-1
  g. Standards for the competent practice of Physician Assistants: IC 25-27.5

Information regarding the Indiana Professional Licensing Agency requirements can be accessed on the Indiana Professional Licensing Agency website at http://www.in.gov/pla/.

Providers found to have been sanctioned by licensing, certification and/or professional organizations on the basis for ethical violations may have their network status reviewed by the InteCare Network and Credentialing Subcommittee and may be subject to denial, revocation and/or suspension of network participation.

Provider Education and Communication. InteCare values our Network Providers and has set as one of its foremost goals being “Provider Friendly” in all interactions with Network Providers. One component to this commitment is maintaining an easily accessible flow of communication. This is accomplished in several ways.

The InteCare Network Provider Application Packet. The packet includes all the materials a Provider needs to determine their interest in joining the network and completing the application process. The Provider Application packet, while several pages in length, may be easily completed. This is due to a conscious effort to collect only the information needed to complete the credentialing process, to meet national

accrediting standards, and to provide sufficient information to our database so the Provider can function in the network.

InteCare requires the universal credentialing application by the Council of Affordable Quality Healthcare (CAQH).

The InteCare Network Provider Orientation Packet. Once a Provider has successfully completed credentialing and decided to join the Network, an Orientation Packet is sent to the Provider. The packet contains:

- An approval letter from the Co-Chairs of the Network and Credentialing subcommittee, along with instructions on how to access the InteCare Provider Manual:
- A fully executed copy of the InteCare Participating Provider Agreement;
- Separate Exhibits (attachments) to the Provider Agreement for each InteCare Program (Payor Agreements) that the Provider may provide services under;
- Instructions on how to access the most recently published InteCare Provider Newsletter.

The InteCare Website and Email Contacts. Relevant information can also be obtained or relayed to InteCare by visiting the InteCare website, at www.InteCare.org, or by emailing InteCare at ICnetwork@intecare.org.

The InteCare Participating Provider Agreement and Notification Standards. The InteCare Participating Provider Agreement has been structured so that each program has a dedicated Exhibit, which contains information that is relevant to day-to-day participation as a Provider for that Program. It serves as good reference and Providers are encouraged to carefully examine it.

Please be aware that certain communications between InteCare and the Participating Provider are required by the Agreement. Please refer to your participation Agreement for further information.

The Participating Provider Agreement requires communication within certain time standards with respect to certain key elements surrounding Network Participation. Immediate Notification requirements are within five days.

The Provider is required to notify InteCare within Immediate Notification deadlines in the following circumstances:

- Changes in individual Provider's employment with a specific Provider Group
- Legal or governmental action initiated against the Provider which could materially affect the Participating Provider Agreement;
- Inability/Failure of Provider to comply with InteCare's Quality Improvement

- Alleged or suspected failure to maintain safe and accessible facilities as required.

Both InteCare and the Provider are required to notify the other within Immediate Notification deadlines in the following circumstances:

- Application for, or appointment of, a receiver, trustee, or liquidator of Provider.
- Insolvency or application for, or appointment of, a receiver, trustee, or liquidator of InteCare
- Any action to remove, rescind or limit practice licenses or accreditation of the Provider;
- Changes in ownership or business address;
- Legal or governmental action initiated against the Provider which could materially affect the Participating Provider Agreement;
- Bankruptcy or similar order of a court or administrative agency;
- Any other occurrence known to the Provider that could materially impair the ability of the Provider to carry out its duties and obligations under this Agreement;
- Determination by InteCare that the health and safety of Covered Individuals is jeopardized by a continuation of the agreement with InteCare.
- Termination, Cancellation, lapse or material change in the general comprehensive or professional liability insurance coverage as specified by InteCare
- The Provider is indicted, arrested, or convicted of a felony or of any criminal charge related to the practice of a behavior health profession.
- Allegations, as received by legal notice of issues in regard to the protection of the medical interests of Covered Individuals
- Allegations, as received by legal notice or governmental contact, that the Provider committed fraud or deception in connection with its behavioral health practice with consumers or knowingly permits such fraud or deception by another in connection with InteCare eligible Covered Individuals.
- Alleged or suspected failure to achieve and/or maintain appropriate licensure, certification, recredentialing, and/or accreditation by the Provider.

Authority for Immediate Action Concerning Network Provider Participation.
Generally speaking, network participation (or non-participation) is voluntary and pursued according to the terms of the Participating Provider's Agreement. As noted above, there are also orderly mechanisms for appealing decisions regarding network participation.

However, when there is credible evidence that some aspect of the Provider's practice or the Provider him or herself jeopardizes or poses a threat to the well being of consumers, InteCare reserves the right to immediately suspend that Provider from participation, pending investigation of the particular concern. This is a rare occurrence; while the conditions precipitating the need for such an action are serious, they are not common. Examples include felony conviction of a crime that may adversely affect one's ability to practice, suspicion of a direct threat to the health and safety of consumers, and loss of malpractice insurance coverage for cause. Such suspensions occur upon review of the

Medical Director, Director of Operations or Chief Operating Officer and are subject to action during the next scheduled meeting of the Network and Credentialing Subcommittee.

Provider Trainings. When InteCare starts and/or is involved in the start up of a new program, InteCare will educate Providers through News Blasts/Newsletters or InteCare may conduct or arrange for Provider Orientation meetings prior to program start-up. These orientations will be focused on program specific information.

Provider Disputes and Appeals. InteCare, Inc. has a formal dispute and appeal process available to all current Network Participating Providers and Provider applicants regarding any actions by InteCare that relate to either: 1) the Participating Providers status within the InteCare Network; 2) Any action taken by InteCare as related to a Provider's professional competency or conduct; 3) Any action taken by InteCare related to the Participating Provider Agreement. **Providers should note that this dispute and appeal process is limited to the above network and credentialing issues and does not substitute for the various claim and/or authorization complaint and dispute processes related to specific payer contracts.**

Network Providers and Provider Applicants wishing to appeal a decision of the Network and Credentialing Subcommittee must submit a written request, which includes all pertinent information supporting the request, for an appeal within sixty (60) calendar days of receipt of the InteCare notification letter. This written request should be submitted by completing the Provider Dispute Resolution Form and Record, which can be located on the InteCare web site.

The Provider submitting the dispute has a right to be present at the dispute meeting in order to share their point of view and any additional supporting and/or relevant information.

There are two levels of appeal available to the Provider and Provider applicant.

The First Level Appeal process is conducted by a Committee comprised of qualified individuals, with one committee member being a participating Provider who is not otherwise involved in network management and is a clinical peer of the individual who is requesting the appeal. In addition, this panel will also include two individuals who were not involved in the initial decision that is the subject of the dispute. Upon receipt of all Provider information the Committee will review the appeal and render a decision based upon the information provided within **45** calendar days. The possible determinations are as follows:

> *Accept Initial Determination* – with clarification, the Initial determination that is being disputed may now be acceptable to the person submitting the dispute; with the Provider(s) and/or InteCare staff now agreeing on the Initial Determination, the dispute is considered resolved.

Pending Status – The Committee may request additional information from the Provider and/or InteCare staff in order to make a final determination. The Provider and InteCare will then have thirty (30) calendar days from receipt of notification to submit the additional information. If the information is not submitted in the allotted time parameters, the resolution will stand with the parties notified of such in writing by the chair of the Committee (or designee).

Uphold initial determination – The Committee may determine that the Initial Determination under dispute was appropriate and should therefore be upheld.

Overturn Initial Determination Action– The Committee, upon reviewing all additional information submitted by the Provider, overturns the initial determination.

The Second Level Appeal process is available to applicants upon an adverse finding of the first level appeal and written notification from the Provider of intent to appeal and any relevant information on support of that appeal. The second level appeal is conducted by a Committee that is comprised of no less than four qualified individuals who did not participate in the initial determination in the Network and Credentialing Subcommittee or in the First Level Appeal panel (with one Provider who is a professional peer of the appellant and not otherwise involved in network management). Upon receipt of all second level appeal information, the Committee has 45 calendar days in which to render a determination following receipt of all necessary Provider information. Decisions by this panel are final, except as subject to legal review related to contractual requirements.

Similar to the First Level Appeal process, the possible outcomes from this review process include the aforementioned determinations listed above. If the Second Level Appeal Committee requests additional information from a Provider applicant, the applicant will have thirty (30) calendar days from receipt of notification to submit the additional information. If the information is not submitted in the allotted time parameters, the applicant will not be allowed to complete the credentialing process, and will be notified of such in writing by the chair of the second-level appeal panel.

Finally, should the Committee determine that the Provider applicant continues to not meet the required InteCare credentialing standards, and recommends that the Initial Determination of ineligible status be upheld, the Provider is notified in writing of this final determination by the Chief Executive Officer.

Section IV. Covered Individual Rights and Responsibilities

Covered Individual Rights and Responsibilities Policy. InteCare, Inc. ensures that all Covered Individuals have access to their rights and responsibilities regarding treatment and services. All InteCare Network Providers must function in a manner that is compliant with 440 IAC 4.3, Indiana Code 12-39 and Federal Code 42 CFR Part 2 with respect to Covered individual Rights. **In addition, all Providers are expected to follow and comply with all current HIPAA rules and regulations which may impact the rights of Covered Individuals during the course of their treatment. Providers serving persons seeking alcohol and/or drug assessment or treatment are subject to specific state and federal guidelines, especially with regard to the confidentiality of covered individual information.**

Providers can obtain additional information regarding the Indiana Code through the *Access Indiana* website at www.in.gov.

Providers can also obtain information regarding all HIPAA rules and regulations through the United States Department of Health and Human Services website at www.hhs.gov/ocr/hipaa/.

InteCare requires that all Providers make their clients aware of their rights and responsibilities. A copy of the InteCare Rights and Responsibilities Statement may be found in Appendix C.

Distribution of Covered Individual Rights and Responsibilities Statements. Distribution of a Rights and Responsibilities statement may include one or more of the following mechanisms:

- InteCare Web Site (Available to All Individuals and Providers)
  The InteCare Rights and Responsibilities statement is available online in an accessible format for printing and distribution.

- Network Provider Organization (Specific to Applicable Programs)
  The organization staff distributes an organization-specific Rights and Responsibilities statement to a Covered Individual through their initial intake process.

V. Communicating with InteCare, Inc.

There are three ways that InteCare will keep you up to date regarding information that you will need to serve our Covered Individuals: written communications, verbal communications, and agreement-controlled communications.

Written communication materials include the Provider Application and Orientation Packets, this Provider Manual, our Network Newsletter, Corporate brochure, and our website.

- Our Provider Application Packet includes a cover letter describing the Provider selection criteria and application process, Provider Credentialing Application, Release of Information**,** InteCare Participating provider Agreement and applicable exhibits, and a W-9 form.
- Our Provider Orientation Packet will be provided to all new InteCare Network Providers and will include such things as how to access this Provider Manual, which includes a variety of information concerning access to services, service standards, the company's mission statement, a Covered Individual's rights and responsibilities statement, and a list of our programs under which you may serve a Covered Individual, a fully executed contract, Corporate brochure and web addresses for the Provider Newsletters.
- Our Network Newsletter is electronically distributed to all Network Providers on a semi-annual basis. The newsletter contains general information and announcements on program or policy changes. You may contribute articles to the newsletter if you are interested; such contributions may focus on a variety of topics including clinical or treatment issues, or it may feature innovative services or programs. However, InteCare maintains absolute editorial control over the contents of the newsletter.
- Our website includes useful information for both you and our Covered Individuals, such as an introduction to InteCare, Covered Individual rights and responsibilities, a Network Provider listing, announcements, and the InteCare, Inc. Provider Manual, among other things.

Verbal communications involve InteCare's response to your telephonic inquiries. Our Credentialing Manager or Staff will respond to your phone calls, written inquiries, and electronic mail inquiries within five (5) business days of receipt of your inquiry. Again, our e-mail address is or icnetwork@intecare.org.

Agreement-controlled communications are the terms and conditions of your Provider agreement and addenda with InteCare. You are expected to know and understand your obligations under the Agreement. If there should be a change in your network status as a result of an action taken by InteCare, you will be notified in writing according to the terms of the Provider Agreement.

Corporate System Safety Protocols. Our system safety encompasses all communications to and from InteCare and internal systems that include electronic and paper based information. Safety or Security is maintained and updated as new

technology is released to the highest standards available insuring accuracy, confidentiality and integrity.

Accessing Benefits and Eligibility. InteCare providers can access the benefits and Member/Covered Individual eligibility through the appropriate Managed Care Entity linkages on the State of Indiana Medicaid website at the following link: https://www.in.gov/medicaid/providers/index.html

Accessing Medication/Formulary Information via the Pharmacy Benefit Manager. Physicians and other prescribers should contact the specific Health Plan Pharmacy Benefit Manager (PBM) in order to access the Plan Formulary requirements. For specific information on the State of Indiana Medicaid programs Pharmacy Benefits Management and Services online, please refer to the following state website link: https://www.in.gov/medicaid/members/232.htm
In addition, please refer to Chapter 9 of the Indiana Health Coverage Programs (IHCP) Provider Manual at the following link: https://www.in.gov/medicaid/providers/453.htm

Claims. Please refer to your Exhibit(s) attached to the Provider Agreement for information regarding claim submission and payment.

Credentialing Issues. Communication regarding Credentialing should be directed to our Credentialing Manager or Staff at 317-237-5770 or, via e-mail ICnetwork@intecare.org.

Provider Disputes & Appeals. A Provider may file a dispute by using the *Provider Dispute Resolution Form* which can be obtained by contacting InteCare or accessing the InteCare web site at www.InteCare.org. For more detailed information regarding the dispute and appeals process, please refer to Section III, “Provider Disputes and Appeals. “

Compliments. Covered Individuals, Providers and Clients may file a compliment by contacting the InteCare office through any of the following methods:

- Calling the corporate office (317-237-5770) and informing any InteCare corporate staff that they wish to file a compliment;
- Writing a letter describing the compliment in detail and sending it to the corporate office to the attention of the “Compliment, Complaint and Grievance Coordinator”;
- Going to the InteCare Web Site (InteCare.org) and completing the InteCare “Compliment, Complaint and Grievance form” and mail;

- Requesting an InteCare Compliment, Complaint and Grievance form be sent to them with a self-addressed and stamped envelope to complete and return, or;
- E-mailing the compliment to the corporate office via lwilliams@intecare.org.

Complaints. Covered Individuals, Providers and Clients may file a complaint by contacting the InteCare office through any of the following methods:

- Contacting the InteCare office (317-237-5770) and informing any InteCare corporate staff that they wish to file a complaint;
- Requesting an InteCare Compliment, Complaint and Grievance form be sent to them with a self-addressed and stamped envelope;
- Writing a letter describing the complaint in detail and sending it to the corporate office to the attention of the "Compliment, Complaint and Grievance Coordinator";
- Going to the InteCare Web Site (InteCare.org) and completing the InteCare "Compliment, Complaint and Grievance form" and mailing it to the corporate office, or;
- **E-mailing the complaint to the corporate office via** lwilliams@intecare.org.

For a handy contact reference sheet, please go to Appendix G.

Section VI: Utilization Management

InteCare Network providers are subject to the utilization requirements of the individual Health Plans for which they are contracted. In general, the criteria for each utilization management program as well as the specific processes for obtaining authorization and re-authorization for covered services will be provided by the health plan.

The information regarding utilization management programs (prior authorizations; request for additional outpatient authorizations; how to submit claims for payment; ability and timeframes to appeal denials; etc.) is typically located in the specific Health

Plan Provider manual. In addition, much information is included in the specific Health Plan contract addendum that your organization, group practice and/or you individually executed.

If you have any questions or concerns about the Utilization Management program, please feel free to contact the specific Health Plan Provider Representative or the InteCare Director of Operations.

Section VII: Confidentiality

Corporate Expectation of Network Provider Compliance regarding HIPAA Regulations. It is InteCare's Policy that each Network Provider should provide each Covered Individual receiving services through the InteCare, Inc. Network an explanation of his/her privacy rights. Additionally, each Provider should have the Covered Individual sign a consent regarding the allowable uses of their protected health information. Refusal to sign shall be grounds for denial of service but cannot be ignored except for specifically allowed purposes. The consent should allow for exchange of protected health information (PHI) for purposes of "treatment, healthcare operations and payment" and HIPAA compliant data exchanges necessary to administer the individual's behavioral health coverage. InteCare, Inc. requires that all Providers demonstrate an ability to provide explanation of privacy rights in a form and language understood by the Covered Individual (e.g. Provider should have capacity/process to interpret and/or have materials for clients who speak only Spanish).

If the Network Provider would like, InteCare, Inc. can provide examples of acceptable privacy consents. However, each Provider is responsible for the creation and application of a suitable consent process that meets the intent of HIPAA guidelines.

InteCare, Inc. shall execute appropriate Business Associate agreements when and if any PHI is shared with an organization or agency outside of the InteCare network, except for legitimate purposes of healthcare operations or payment. Any such agreements shall be disclosed to Network Providers upon request.

In situations where disclosure of protected health information is made by a network Provider or by InteCare, Inc., a fully executed authorization should be obtained and only the information minimally necessary for the purpose should be released.

Beginning in 2005, HIPAA also incorporated security standards which regulate the transmission of protected health information via electronic means. InteCare IS systems are fully compliant with federal standards and have the capability of accepting and transmitting PHI in compliance with HIPAA requirements. Providers should be aware that protected health information, including any identifying information about a covered individual, cannot be sent via open e-mail.

Covered Individual Privacy Consent. InteCare expects that all Providers are compliant with HIPAA requirements for the maintenance of individual privacy of protected healthcare information. In most cases this will mean that the Provider has obtained privacy consent to release confidential information in accord with governmental recommendations. Such consent allows all required communication with InteCare for the purposes of healthcare treatment, operations and/or payment. A sample of consent language follows:

"Prior to using or disclosing your protected health information, we are required under federal and state law to obtain your consent. This consent allows us to use the information obtained for purposes of treatment, healthcare operations and payment, as described in the Privacy Notice. No other disclosure of your private information is permitted except as you specifically authorize in writing.

Please review and be sure you understand this consent; You will be asked to sign it only once while actively receiving services from this Provider but it will allow full communication of your information for the purposes outlined herein. There are certain exceptions to your right to privacy. These fall into the following areas:

- *Uses and disclosures required by law, as in certain communicable diseases*
- *Disclosures required for judicial and legal administrative proceedings*
- *Disclosures for law enforcement activities (new regulations do not supercede federal protections for substance use treatment)*
- *Uses to avert a serious threat to health or safety*
- *Disclosures for worker's compensation*
- *Disclosures in medical emergencies*

You have the right to request that we restrict how your protected health information is used and disclosed to carry out treatment, payment or health care operations. If you do request restrictions, we reserve the right to deny services if we feel we cannot effectively provide care within the restrictions. If we agree to requested restrictions, those restrictions will be binding and we will not use or disclose the restricted information.

By signing this consent, you agree that we may use or disclose your protected health information to carry out treatment, payment or health care operations.

You have the right to revoke this consent in writing at any time, except to the extent that we have already provided services or taken action and may pursue appropriate payment."

If Providers have questions or concerns about the confidential management of patient or Covered Individual information, or would like more information regarding the InteCare Policy and Procedure regarding the management of confidential patient/Covered Individual information, please contact the InteCare Credentialing Manager or Staff at (317) 237-5700, 1-866-323-3464 option 1 or email to ICnetwork@intecare.org.

Section VIII: Appointment Availability and Accessibility of Services Standards

Appointment Availability. It is essential that the InteCare Network include a variety of services that are easily accessible to Covered Individuals. Therefore, InteCare has incorporated standards, consistent with both State and National standards, for access to services both in terms of timeliness of response and geographic accessibility.

Timeliness of Response. Providers in the InteCare Network *must* make services available to Covered Individuals in a timeframe that is appropriate and responsive to the urgency of the Covered Individual's treatment needs. Therefore, the InteCare Quality Improvement Committee has implemented the following standards for the temporal availability of services. As a Network Provider, you are required to provide services within the following time limits for each level of urgency defined below:

InteCare recognizes three levels of urgency in gaining access to services. However, it must be noted that the State of Indiana – Office of Medicaid Policy and Planning has adopted NCQA standards that differ from those standards outlined for "Community Mental Health Centers and Managed Care Providers". The InteCare corporation acknowledges these standards as well, but hopes to engage the State in discussions to more standardize the access requirements across the different departments and divisions of the State government that Providers interact and provide services for. These include:

- **Crisis or Emergent contacts:** The network standard is to provide Covered Individuals in a crisis or emergency situation, usually defined as imminent risk of harm to self or others, professional contact within **15 minutes**, with an

offer for face-to-face assessment within one hour. Providers are required to offer means for 24 hour/ 7 day a week access to the crisis level of care. This standard is in accord with the requirements of the State of Indiana Administrative Code, Article 9, entitled “Minimum Standards for the Provision of Services by Community Mental Health Centers and Managed Care Providers” (440 IAC 9-2-2 and 9-2-4).

The NCQA MBHO standards for calendar year 2013 do not use the same language or time frames as the State of Indiana Administrative Code. The NCQA access standard identifies this level of contact as a “non-life-threatening emergency” in which a member must have access to care within 6 hours of contact.

Urgent: The network must offer Covered Individuals who have serious issues that compromise their ability to perform functions of daily life, e.g. go to work or adequately provide parenting, an appointment within **48 hours of initial contact.** The initial contact may be for an assessment or for the actual beginning of treatment. This standard is consistent with NCQA MBHO standards.

- **Routine:** The network must offer all Covered Individual requests for services that do not involve emergent or urgent events an appointment within **ten** (**10) working days.** It is understood that the corporate preference is that the covered individual is seen by the clinician who will be providing the overall services. However, the overall concern and focus are that covered individuals who are requesting services be seen within the established corporate standards. This standard is consistent with NCQA MBHO standards.

InteCare, Inc. shall maintain a system to regularly assess the success of its network providers in meeting these standards and consider appropriate actions when access is not provided within the standards. Such actions may include efforts to improve the ability of network providers to achieve access standards and/or consideration of network expansion.

Geographic Accessibility. InteCare is committed to maintaining a Provider network that offers Covered Individuals a variety of services in locations that are convenient to their home or place of work. The Geographic Accessibility standards provide criteria for determining the need to expand (or contract) the Provider Network in a given area. InteCare may solicit applications from Providers in areas where the access standard is not consistently met. InteCare may also deny applications when a geographic area appears to have an adequate number of existing Network Providers.

If a Network Provider moves or adds a new service location, they should notify our office thirty (30) days *prior* to the move/addition so that our records may be updated.

InteCare tracks geographic Accessibility by service line or type. Our service availability standard states that, as a Provider, you must contract with InteCare only for those services that you currently offer, so that we may have an accurate picture of our network's capabilities. If you should begin offering a new service, please contact us so that your contract and service profile can be updated. Services provided at a new or unlisted Provider location may not be reimbursed until the contract is amended.

Section IX: Customer Satisfaction

Compliment, Complaint & Appeal Process. Please note that the InteCare Compliment, Complaint & Appeal process is only available for contractual relationships with Client organizations such as Health Plans, Managed Care Organizations, and/or the State of Indiana Division of Mental Health and Addiction. The InteCare Complaint Process may operate in parallel with a complaint and grievance procedure by a specific health plan and/or managed care organization. A credentialed provider has access to the InteCare process but may be directed to utilize the health plan for concerns related to claims, reimbursement and/or service authorizations.

It is InteCare's policy that we have a formal mechanism for Covered Individuals, Providers, Clients and any other concerned party to express dissatisfaction as well as compliments. The InteCare Compliment, Complaint and Grievance Procedure potentially involves a basic three-level process.

Complaints.
The initial review of the complainants concern is referred to as the *"initial review and determination"*. If the complainant is not satisfied with the initial determination, two levels of appeals are available.

> ***Initial Review and Determination.*** *Covered Individuals, Providers and Clients may file a complaint by contacting the InteCare office through any of the following methods:*
>
> - Contacting the InteCare office (317-237-5770) and informing any InteCare corporate staff that they wish to file a complaint
> - Requesting an InteCare Compliment, Complaint and Grievance form be sent to them with a self-addressed and stamped envelope
> - Writing a letter describing the complaint in detail and send to the corporate office to the attention of the "Compliment, Complaint and Grievance Coordinator"

- Going to the InteCare Web Site (InteCare.org) and completing the InteCare "Compliment, Complaint and Grievance form" and mail to the corporate office
- E-mailing the complaint to the corporate office to lwilliams@intecare.org

Once a complaint is received, the complainant should expect the following process:

- An acknowledgement letter is sent out to the complainant within two (2) business days indicating receipt of the complaint. The letter may request additional information as needed, or that the complainant arrange for the submission of such information (e.g. sign a consent for access to certain records, etc.)
- Upon receipt of all needed information, the complaint will be assigned to the appropriate representative for research and resolution
- The individual designated to research, process the complaint, and respond to the complainant must do so (or make a reasonable attempt to do so) within 10 working days from receipt of complaint.

Level One Appeal. If the complainant is not satisfied with the offered resolution, a first level appeal may be requested and initiated verbally or in writing. The Appellants complaint:

- Will be researched again, and will be presented to the appropriate InteCare Committee for discussion and resolution
- Will be responded to within thirty (30) working days from filing the Appeal and receipt of any documentation or other information necessary to investigate the Appeal.

Grievances (Level Two Appeal). *If the appellant is not satisfied with the resolution offered from the first level appeal, a "grievance", or level two appeal may be pursued and submitted either verbally or in writing. The grievance is:*

- Researched and presented to the InteCare Management Committee for final resolution
- The grievant will be contacted within thirty (30) working days of receipt of all necessary documentation.

The InteCare Participating Provider Agreement requires Providers to comply with InteCare's policies and procedures regarding complaints and appeals. Providers are expected to notify Covered Individuals of InteCare complaint procedures when a Covered Individual airs a concern. Providers are also expected to notify InteCare in writing if any Covered Individual makes a complaint to any regulatory board or professional ethics committee about the Provider or the Providers' organization.

Compliments. Covered Individuals, Providers and Clients may submit a compliment by contacting the InteCare office through any of the following methods:

- Calling the corporate office (317-237-5770) and informing any InteCare corporate staff that they wish to submit a compliment
- Writing a letter describing the compliment in detail and mailing it to the corporate office to the attention of the "Compliment, Complaint and Grievance Coordinator"
- Going to the InteCare Web Site (InteCare.org), completing the InteCare "Compliment, Complaint and Grievance form", and mailing it to InteCare
- Requesting an InteCare Compliment, Complaint and Grievance form be sent to them with a self-addressed and stamped envelope to complete and return
- E-mailing the compliment to the corporate office via lwilliams@intecare.org.

Provider Disputes and Appeals Procedures. A Provider may file a dispute by using the *Provider Dispute Resolution Form* which can be obtained by contacting InteCare or accessing the InteCare web site at www.InteCare.org. For more detailed information regarding the dispute and appeals process, please refer to Section III, "Provider Disputes and Appeals. "

It should be pointed out that the Dispute Resolution process is not a legal proceeding, nor does it carry the force of law. InteCare will not entertain an appeal for a dispute that arises between an organizational Provider and its employee or contracted individual Providers. These disputes are considered "internal" to the organizational Provider and it is the responsibility of that organizational Provider to resolve these disputes.

Reporting Quality of Care Issues. The InteCare complaint process ensures identification, review, determination and if applicable, corrective action for possible issues surrounding network quality of care and services. The intent of this policy is to identify and take action with respect to any issue that potentially compromises the health or safety of InteCare Covered Individuals.

A quality of care issue may include, but is not limited to, the following:

- An Adverse incident or event regarding:
  - Suicide and or suicide attempt alleged to be related to a failure of treatment
  - Drug overdose by a Covered Individual receiving addiction services
  - Treatment error leading to hospitalization
  - Death alleged to be related to a relevant behavioral health service
  - Homicide by a Covered Individual and/or Provider alleged to be related to a behavioral health concern
- Treatment recommendations seen as harmful and/or dangerous
- Alleged unprofessional and/or unethical Provider conduct
- Alleged inappropriate and/or unethical staff conduct

Once a potential quality of care issue has been identified, the investigation process is immediately initiated via the Network and Credentialing subcommittee with appropriate corrective actions to ensure the health and safety of InteCare Covered Individuals. All

confirmed quality of care issues are also reviewed by the Network and Credentialing Subcommittee upon Provider recredentialing if the Provider is currently active in the InteCare network**.**

Covered Individual, Client and Provider Satisfaction Survey Process.
InteCare, Inc. seeks to continually monitor and improve the quality and responsiveness of its services. To provide accurate covered individual and client information necessary to achieve improvement, InteCare surveys Clients, Covered individuals and Providers annually, with all information and results reported through appropriate subcommittees and committees for analysis consistent with the corporate quality improvement program. The purpose of this process is to establish mechanisms to obtain feedback and suggestions regarding how the network can improve services based on feedback from:

- Clients - in order to determine their perception, experiences, effectiveness and overall satisfaction with InteCare, Inc.

- Covered individuals – in order to determine their satisfaction with their experience with InteCare and participating Providers

- Providers – in order to determine their satisfaction with network services, ensure that their perspective and input is reviewed and represented in the network management processes, and receive suggestions and guidance regarding how the InteCare Network can best serve covered individuals.

InteCare incorporates complaints, appeals, grievances, compliments and Covered Individual satisfaction survey scores in its network Provider recredentialing process.

For a handy contact reference sheet, please go to Appendix G.

Section X: Quality Improvement

A Continuous Quality Improvement Philosophy. InteCare, Inc. is firmly and steadfastly committed to the implementation of a comprehensive Quality Improvement Plan and the growth of a Continuous Quality Improvement culture throughout the Provider Network.

InteCare firmly embraces a “CQI” (Continuous Quality Improvement) philosophy and is deeply invested in the processes that translate this philosophy into action within the Network. All Providers are expected to participate in these processes, which are directed at continuously examining and searching for improvement in the services provided to our Covered Individuals.

The InteCare Participating Provider Agreement requires Providers to comply with all of InteCare’s policies and procedures that involve quality improvement. This includes, but is not limited to, access to Covered Individual records as needed where disclosure is not prohibited by state or federal law.

Provider feedback is a key element in determining ways in which InteCare can improve services to Providers and Covered Individuals. That is why Network Providers participate as members on InteCare committees, subcommittees, work groups and task forces. If a Provider, Covered Individual or Client has a concern that they would like addressed, they should contact InteCare’s QI and Special Projects Coordinator at 317-237-5771.

Another way we capture Provider feedback is through a Provider Satisfaction Survey. These surveys are sent out to all Providers on an annual basis (based upon applicable InteCare, Inc. Client contracts). The survey is a key method for InteCare to collect information and to identify areas of concern to Providers and therefore, to identify areas to be targeted for improvement. Results of the annual Provider Satisfaction Survey are *carefully* evaluated by InteCare’s Network and Credentialing Subcommittee and Quality Improvement Committee. Any collective response on the survey determined not to meet InteCare’s standards will be prioritized as an improvement project.

Minimum Performance Standards. InteCare, Inc. has researched and developed specific standards, based upon national benchmarks whenever possible, which are applicable for its Network and any Administrative Services provided via contractual arrangements. These standards are developed, reviewed and approved through the InteCare Committee Structure, and therefore include input from InteCare Administrative Staff, credentialed Network Practitioners and Organizations. Final approval of a given standard rests with the InteCare Quality Improvement Committee and Management Committee.

The table below is a listing of performance standards the Quality Improvement Committee will be monitoring. It would be useful for Network Providers to familiarize themselves with this listing in order to be aware of the overall standards that InteCare is striving to achieve.

Area of Performance/Service:	*Applies Primarily To:*	*Standard:*
Client and Business Partner Overall Satisfaction with Quality of Service	InteCare Administration	≥90% Overall Satisfaction with InteCare quality of service
Provider Overall Level of Satisfaction with InteCare, Inc.	InteCare Administration	≥85% Overall Level of Satisfaction with InteCare, Inc.

XI: Appendices (A)

Appendix A – InteCare Provider Manual Publication Chronology.

The “Publication Chronology” is provided to assist Providers in tracking the chronology of Manual updates or supplements. Each time an updated Manual or Supplement is circulated; the Chronology will likewise be updated and circulated.

Document	Date	Notes
Provider Manual	January, 2001	First Edition
Provider Manual	September, 2002	Second Edition
Provider Manual	April, 2004	Third Edition
Provider Manual	June, 2006	Fourth Edition
Provider Manual	December, 2008	Fifth Edition
Provider Manual	December, 2010	Sixth Edition
Provider Manual	May, 2013	Seventh Edition
Provider Manual	December, 2014	Eighth Edition
Provider Manual	September, 2015	Ninth Edition
Provider Manual	December, 2016	Tenth Edition
Provider Manual	December, 2018	Eleventh Edition

XI: Appendices (B)

Appendix B– InteCare Corporate Glossary

Appeal – The formal process through which InteCare systematically reviews, considers and renders a decision about disputes. Nothing in this definition implies a legal proceeding or has the force of law.

Authorization - The process through which a clinical service for a covered individual is eligible for payment, assuming all documentation and claim requirements are met. Authorization is a financial and administrative process separate from care management.
Authorized Representative **–** A designated InteCare executive who has been given authority to approve corporate initial and subsequent investments. They include the Chief Executive Officer, Chief Financial Officer and President of the Board.

Business Associate – A Covered Entity, defined as a Provider, Health Plan or Health Care Clearinghouse, who performs or assists in the performance of:

- A function or activity involving the use of disclosure of individually identifiable Health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or any other function or activity regulated by the regulations; or
- Provision of, other than in the capacity of a member of the workforce of the aforementioned covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such Covered Entity, or to or for an Organized Health Care Arrangement in which the Covered Entity participates, where the provision of the service involves the Disclosure of Individually identifiable Health Information from such Covered Entity or arrangement, or from another Business Associate of such Covered Entity or arrangement, to the person.

Care Management - The application of approved clinical care guidelines and/or criteria to the assessment of which services may be authorized for payment on the basis of medical necessity. InteCare does not determine the treatment or services delivered by a provider to a patient.

Certification - The term applied when a service request has been reviewed clinically through Care Management and/or Peer Review and found to be in compliance with InteCare, Inc. UM criteria. Such a service request is both authorized and certified.

Clinical Criteria or Criteria – Sets of symptoms, diagnoses and/or clinical states that are empirically tied to defined intensities or appropriate care. Used by the health plan as the basis for guidance and decision-making in utilization management.

Complaint - Expression of dissatisfaction of services communicated verbally by a consumer (or person acting in the consumers behalf), provider or client to an InteCare staff organizational, when an InteCare service, provider, or administrative process does not meet their standards or expectations. The complainant may also elect to write their complaint on the InteCare complaint/grievance form, or in a letter format, and submit to the corporate office.

Complaint, Compliment and Grievance (CCG) Coordinator – InteCare staff person designated to monitor, collect and coordinate response to consumer, provider and client feedback about the quality and appropriateness of services in the InteCare network.

Compliment - A verbal or written expression of satisfaction and/or appreciation for services received through InteCare, and InteCare provider, or InteCare administrative services.

Confidential Information - Any and all information that is specific to a consumer's individual health status, including information related to his/her history, prior use of behavioral health services or current need for services.

Conflict of Interest - An activity by an employee, Board member, committee, subcommittee, and/or work group member which may include, but is not limited to, the following:

- Receiving, or being in position to receive, compensation for services rendered to other competing Behavioral Health Managed Care firms or organizations;
- Serving as an officer, director, or Board member to a competing firm or other organization with a business relationship with InteCare;
- Serving as a member or chairperson of a committee or work group of a competing firm or organization with a business relationship with InteCare;
- Receiving, or being in a position to receive, gifts, gratuities, or discounts from suppliers or other organizations with a business relationship with InteCare; or
- Being in a position that would require the sharing of proprietary information with a competing firm or other organization.

Consent for Treatment – A signed and witnessed statement of willingness to receive and cooperate with behavioral health services, which includes notification of the consumer's right to rescind and/or change this consent at any time.

Continuing Education Opportunities - Programs designed to assist an individual with continued professional growth in relation to their current position within the InteCare, Inc. organization. Programs include but are not limited to professionally sponsored seminars, college courses, and professionally sponsored workshops.

Covered Entity - An organization and/or provider of health care services as defined by HIPAA to be subject to the privacy and security requirements for Protected Health Information.

Covered Individual or Consumer - an individual who is entitled by virtue of meeting criteria set forth by the Payor to receive behavioral health services through the network.

Covered Services - those behavioral health/addictions services included in the coverage agreement between InteCare and the Payor or are described in other mutually acceptable documents between InteCare and Payor.

Credentialing – The initial process of collecting and verifying required Provider information and subsequently approving Provider's participation in the network.

Customer Satisfaction and Services Subcommittee – subcommittee which has authority over the implementation and ongoing monitoring of covered individual services provided within InteCare programs. The subcommittee is responsible for ongoing monitoring and review of all applicable corporate quality improvement performance indicators, and identification of potential performance improvement projects through indicator analysis.

Delegation Agreement – A written contractual agreement which defines the expectations, scope, functions and responsibilities which have been delegated to the Provider on behalf of InteCare, Inc.

Disclosure – The release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

Duty to Disclose - Once a potential conflict of interest is discovered by an InteCare employee, board member, committee/subcommittee, work group and/or task force member he/she must inform the InteCare Chief Executive Officer immediately regarding the nature of potential conflict of interest. If the potential conflict of interest involves the Chief Executive Officer, the President of the InteCare Board of Directors should be informed.

Electronic Information - Any information related specifically to an individual consumer and/or his/her health status that is contained in an electronic format and/or communicated in an electronic medium, e.g. via facsimile machine, e-mail or electronic data transfer.

Emergency or Emergent – The sudden and unexpected onset of a symptom or condition which requires immediate diagnosis or treatment of a Covered Individual in order to relieve a condition which is or has a high probability of imminent risk of harm to self or others.

Employee Orientation Checklist - The form that is provided for each new Hire that delineates the basic training and educational experiences that must be successfully completed before the employee completes the New Hire period.

Firewall - A system designed to prevent unauthorized access to or from a private network. Firewalls can be implemented in both hardware and software, or a combination of both. Firewalls are frequently used to prevent unauthorized Internet users from accessing private networks connected to the Internet, especially intranets. All messages entering or leaving the intranet pass through the firewall, which examines each message and blocks those that do not meet the specified security criteria.

Grievance - A formal, written expression of dissatisfaction following the failure, or perception of failure by the complainant, to resolve their level one appeal to their satisfaction. A "Grievance" is the level two appeal in the complaint process.

Health Literacy - The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate decisions regarding their health

Health Professionals **–** Includes any and all InteCare staff that has job responsibilities which require clinical decisions or judgments. Examples of such positions include the InteCare Medical Director and Director of Clinical Operations.

High Volume Behavioral Health Provider - The top 10% of all types of providers by numbers of enrollees seen.

HIPAA - The Health Insurance Portability and Accountability Act, which mandates procedures for the security and consent for release of health, related information.

Holiday – Term used to describe days of the year that InteCare is officially closed for business.

Incidental Use or Disclosure - A secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure under the Privacy Rule.

Individually Identifiable Health Information – Any information, including demographic information collected from an individual, that:

A) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual, and
    i) identifies the individual; or

ii) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

Information System - The infrastructure and procedures used to collect and share data and information, including electronic and paper based means of storage.

Informed Consent - The process through which a consumer indicates understanding of and consent to the release of information from one source to an outside recipient. Informed consent must be specific as to the information to be released, the source releasing the information and the desired recipient.

Institutional Review Board (IRB) – a duly constituted body of a university, research organization or other qualified organization which receives, reviews and, when appropriate, approves research protocols, including those for research with human subjects in accord with the requirements and recommendations of the Department of Health and Human Services.

InteCare Management Committee – committee chaired by the Chief Executive Officer which has authority over all daily management operations. It is responsible for the development of the corporate infrastructure, including all policies and procedures. The Committee serves as the "communication center" for all departments and corporate activities. It incorporates weekly reports from all designated departments and/or corporate staff regarding Human Resources, Management Information Systems, Quality Improvement, Finance, regulatory compliance, new business/marketing, and Client Contract activities and issues. The committee is also responsible for oversight of the Quality Improvement committee.

InteCare Quality Improvement Committee – Provides direct oversight of both Quality Improvement and utilization management programs through identified subcommittees, work groups, and task forces. These include the: Network and Credentialing subcommittee; Customer Satisfaction and Services subcommittee and Clinical work group.

The QI Committee is responsible for oversight of all aforementioned subcommittee, work group and task force activities, approval and ongoing monitoring of QI program documents, establishing and maintaining mechanisms for the identification and review of quality of care and service issues, and providing a method for Providers, covered individuals, and other relevant stake holders to have input into the QI program.

Interoperability – The ability of two or more systems or components to exchange information and to use the information that has been exchanged.

LAN – Local Area Network, is a computer network that spans a relatively small area. Most LANs are confined to a single building or group of buildings. However, one LAN

can be connected to other LANs over any distance via telephone lines and radio waves. A system of LANs connected in this way is called a wide-area network (WAN).

Level One Appeal - A formal, written expression of dissatisfaction following the failure, or perception of failure by the complainant, to resolve their initial complaint to their satisfaction.

Medically Necessary or Medical Necessity – Covered Services rendered to a Covered Individual which meet the requirement of being:

- Appropriate for the symptoms, diagnosis and treatment of particular conditions described under DSM- 4 or DSM-5 or its successor
- Which are provided in accord with nationally accepted standards of behavioral healthcare practice, as determined by an applicable licensed provider.
- With conformity with the professional and technical standards adopted by InteCare and/or an applicable Payor, and
- Without consideration of cost of care or limitations on staff resources above clinical effectiveness. Medically necessary services are not rendered primarily for the convenience of the covered individual, the provider or any outside legal authority.

When applied to the provision of inpatient services, the term implies that the services cannot safely be provided outside the hospital.

Member - an organization, which is a Member organization of InteCare, Inc. as, defined in InteCare's Articles of Incorporation and Bylaws.

More Stringent **-** means in the context of a comparison of a provision of state law and a standard, requirement, or implementation specification adopted under the HIPAA Privacy Regulations, a state law that meets one or more of the following criteria:

(1) With respect to a use or disclosure, the law prohibits or restricts a use or disclosure in circumstances under which such use or disclosure otherwise would be permitted under the Regulations, except if the disclosure is:

(i) Required by the Secretary of Health and Human Services in connection with determining whether a covered entity is in compliance with the Privacy Regulations; or

(ii) To the individual who is the subject of the individually identifiable health information.

(2) With respect to the rights of an individual, who is the subject of the individually identifiable health information, regarding access to or amendment of individually identifiable health information, permits greater rights of access or amendment, as applicable.

(3) With respect to information to be provided to an individual who is the subject of the individually identifiable health information about a use, a disclosure, rights, and remedies, provides the greater amount of information.

(4) With respect to the form, substance, or the need for express legal permission from an individual, who is the subject of the individually identifiable health information, for use or disclosure of individually identifiable health information, provides requirements that narrow the scope or duration, increase the privacy protections afforded (such as by expanding the criteria for), or reduce the coercive effect of the circumstances surrounding the express legal permission, as applicable.

Network - the network (which may vary depending upon the Payor contract) of Providers that has been contracted by InteCare, Inc., as a behavioral health care delivery network designed to provide healthcare services for Covered Individuals.

Network and Credentialing Subcommittee - subcommittee which has authority for approving and overseeing the InteCare network and credentialing plan. This includes input and documentation from Providers regarding credentialing & re-credentialing decisions. Committee membership includes network Practitioners which insures participating Provider input on a peer level, especially when discussing standards of care for Provider type and specialty areas. The subcommittee is responsible for ongoing monitoring and review of all applicable corporate quality improvement performance indicators, and identification of potential performance improvement projects through indicator analysis.

Network Provider or Provider or Participating Provider - an organization or individual under contract with InteCare or a subcontract with an InteCare Provider that meets the appropriate licensure, certification, and/or accreditation requirements of InteCare or any Payor for which services will be arranged or provided. This includes both individual practitioners and facilities.

New Hire - An employee within their first ninety (90) days of employment with InteCare, Inc., or an employee that remains on extended New Hire Orientation.

New Hire Orientation Program - The program of learning and training activities that must be completed by all New Hires during the first ninety (90) days of employment.

Non-Covered Services - Those services, provided by a Participating Provider, for which a claim is denied for a Member by Payor due to and including the following reasons:

(a) The service is not covered under the Member's Benefit Contract
(b) Benefits have been exhausted under the Member's Benefit Contract Manager

Non-member Provider - a Provider which is not a Member organization of InteCare, Inc.

Organized Health Care Arrangement - 1) A clinically integrated care setting in which individuals typically receive health care from more than one health care provider; 2) an organized system of health care in which more than one Covered Entity participates and in which the participating Covered Entities:

- Hold themselves out to the public as participating in a joint arrangement; and
- Participate in joint activities that include at least one of the following:
  - Utilization Review, in which health care decisions by participating Covered Entities are reviewed by other participating Covered Entities or by a third party on their behalf;
  - Quality assessment and improvement activities, in which treatment provided by participating Covered Entities is assessed by other participating Covered Entities or by a third party on their behalf; or
  - Payment activities, if the financial risk for delivering health care is shared, in part of in whole, by participating Covered Entities through the joint arrangement and if protected health information created or received by a Covered Entity is reviewed by other participating Covered Entities or by a third party on their behalf for the purpose of administering the sharing of financial risk.

3) A group health plan and a health insurance issuer or HMO with respect to such group health plan, but only with respect to PHI created or received by such health insurance issuer or HMO that relates to individuals who are or who have been participants or beneficiaries in such group health plan; or 4) A group health plan and one or more other group health plans each of which are maintained by the same plan sponsor; or 5) The group health plans described in section (4) of this definition and health insurance issuers or HMOs with respect to such group health plans, but only with respect to PHI created or received by such health insurance issuers or HMOs that related to individuals who are or have been participants or beneficiaries in any of such group health plans.

The Orientation Update Program - An annual program provided to all employees prior to the beginning of the benefit renewal date; it provides an update to all employees concerning changes in company policy and procedure.

Payor or Client - any third party Payor, including but not limited to the Indiana Division of Mental Health (DMH), health insurance company, self-funded employer, or other groups or entities with whom InteCare, Inc. contracts or seeks to contract to arrange for the provision of Covered Services. Payor may also include third parties not directly contracting with InteCare, but to whom InteCare may have indirect responsibility as the entity responsible for the arrangement of services or oversight of services provided by InteCare Providers or other providers or networks.

Performance Improvement Project - A Performance Improvement Project (PIP) is designed to identify barriers, implement interventions and activities, and complete

period measurements to determine effectiveness of the interventions in order to improve the identified problem/barrier.

Performance Indicators – Specific performance measures approved by the QI committee to measure service and care elements. These measures are specifically defined, and are usually reported on a monthly basis.

Plain Language - Communication that uses short words and sentences, common terms instead of medical jargon, and focuses on the essential information recipients need to understand

Potential High Volume Provider- A practitioner who has been approved for Network participation and provides services in a specific geographic area who has been determined to potentially offer greater than or equal to 20% utilization of the behavioral and/or addictions services to a given contract population in a calendar year. All "potential high volume providers" will be required to participate with site visits of all current practice locations.

Primary Source Verification – Is validation of education, training or licensure based on information obtained directly from the issuing source of the credential.

Protected Health Information (PHI) – PHI is individually identifiable health information that is transmitted by, or maintained in, electronic media or any other form or medium. This information must relate to 1) the past, present, or future physical or mental health, or condition of an individual; 2) provision of health care to an individual; or 3) payment for the provision of health care to an individual. If the information identifies or provides a reasonable basis to believe it can be used to identify an individual, it is considered individually identifiable health information.

Provider Employee – is an employee of a Network Provider who provides services under the terms of the Network Providers agreement with InteCare, and who meets the appropriate licensure and or certification requirements of InteCare and any Payor for which services will be arranged or provided.

Provider Relations Liaison – shall mean InteCare employee whose role includes serving as the contact person for Participating Providers and coordinating and overseeing Provider Communication activities.

Psychotherapy Notes – Notes that are recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. This excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests,

and any summary of the following items; diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Public Health Authority **-** an agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.

Qualified Protective Order - An order of a court or of an administrative tribunal or a stipulation by the parties to the litigation or administrative proceeding that prohibits the parties from using or disclosing the protected health information for any purpose other than the litigation or proceeding for which such information was requested. It further requires the return to InteCare, Inc. or destruction of the protected health information at the end of the litigation proceeding.

Quality Improvement Program - *The scope of the InteCare quality improvement program includes specific monitoring, trending and detailed analysis of quality behavioral health care and support services provided to the consumers of InteCare client organizations.*

Quality of Care – InteCare has adopted the definition of quality of care promulgated by the Institute of Medicine: "Quality of Care is the degree to which (behavioral) health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

Quality of Service - This is defined as a provider's ability to meet, but not be limited to, the following InteCare standards for: access & availability; office location and overall presentation; confidentiality of consumer information and storage facilities; evidence of compliance with appropriate safety protocols; and office staff courtesy and responsiveness.

Raid 5 - Redundant Array of Independent Disks, a category of disk drives that employ two or more drives in combination for fault tolerance and performance. Level 5: Provides data striping at the byte level and also stripe error correction information. This results in excellent performance and good fault tolerance.

Recredentialing – The biennial process of re-verifying Provider information and approving continued participation in the network on the basis of observed data, as well as verified documentation.

Reasonable Charges - Charges incurred for covered services as a result of services provided by a Network Provider which do not, as determined by InteCare, exceed the amount provided for in the InteCare usual and customary fee schedule, or if applicable, a negotiated rate schedule.

Relates To The Privacy Of Individually Identifiable Health Information – With respect to a State Law, that the State Law has the specific purpose of protecting the privacy of health information or affects the privacy of health information in a direct, clear, and substantial way.

Router - A device that forwards data packets along networks. A router is connected to at least two networks, commonly two LANs or WANs or a LAN and its ISP's network. Routers are located at gateways, the places where two or more networks connect.

Secondary Source Verification – Is validation of education, training, experience or other credential based on objective information obtained from a source other than the original issuing source of the credential.

SQL - Structured Query Language developed by IBM has become the standard for querying databases.

SSL - Secure Sockets Layer, a protocol developed by Netscape for transmitting private documents via the Internet. SSL works by using a public key to encrypt data that's transferred over the SSL connection. Both Netscape Navigator and Internet Explorer support SSL, and many Web sites use the protocol to obtain confidential user information, such as credit card numbers. By convention, URLs that require an SSL connection start with *https:* instead of *http*:.

State Law - means a constitution, statute, regulation, rule, common law, or other state action having the force and effect of law.

Telepsychiatry, or telemedicine - a form of video conferencing that can provide psychiatric services to patients living in remote locations or underserved areas. It allows the ability to connect patients, psychiatrists, physicians, and other healthcare professionals through the use advanced telecommunications technology. Information is exchanged in real-time communication from the Spoke Site, where the client is located, to a Hub Site, where the physician is located, allowing them to interact as if they are having a face-to-face session.

Treatment, Payment & Operation (T.P.&O.) - "Health Care Operations" means any of the following activities of InteCare, Inc. to the extent that the activities are related to covered functions:

(1) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include Treatment;
(2) Reviewing the competence or qualifications of health care professionals,

evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;

(3) Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);

(4) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

(5) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of Payment or coverage policies; and

(6) Business management and general administrative activities of the entity, including, but not limited to:

(i) Management activities relating to implementation of and compliance with privacy policies and procedures;

(ii) Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that Protected Health Information is not disclosed to such policy holder, plan sponsor, or customer.

(iii) Resolution of internal grievances;

(iv) The sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and

(v) Creating de-identified health information or a limited data set, and fundraising for the benefit of InteCare, Inc..

"Payment" means:

(1) The activities undertaken by:

- A health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or
- A health care provider or health plan to obtain or provide reimbursement for the provision of health care; and

(2) The activities in paragraph (1) of this definition relate to the individual to whom health care is provided and include, but are not limited to:

- Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing;
- Review of health care services with respect to medical necessity, coverage under

a health plan, appropriateness of care, or justification of charges;
- Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
- Disclosure to consumer reporting agencies of any of the following Protected Health Information relating to collection of premiums or reimbursement:
  (A) Name and address;
  (B) Date of birth;
  (C) Social security number;
  (D) Payment history;
  (E) Account number; and
  (F) Name and address of the health care provider and/or health plan.

"Treatment" means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

Violation of the Conflict of Interest Policy - Failure to disclose actual or possible conflicts of interest by InteCare employees, Board Members, committee/subcommittee and/or work group members which may result in disciplinary action resulting in termination of employment and/or severing of their membership on an InteCare committee, subcommittee, and/or work group.

If a residing InteCare Board Member is found to be in violation of the Conflict of Interest Policy, the Board shall follow all guidelines outlined in the InteCare, Inc. By-Laws, Article VII, sections 7.1 through 7.12. These guidelines include initiation of appropriate disciplinary and corrective actions.

Warm Transfer - Maintaining a connection with an individual on the phone while dialing another phone number, and then transferring the individual to the second number once the call has been answered. This usually includes introducing the individual that is being connected to the second party.

XI Appendices (C)

Appendix C – Covered Individual Rights and Responsibilities Statement

Covered Individual Rights and Responsibilities Policy Statement

InteCare Covered Individual Rights About Treatment:

- You will be given access to treatment without regard to sex, race, religion, age, or disability.
- You have the right to get services as soon as possible and in an easy way.
- You have the right to all that is being talked about. It must be shared in a language that you can understand.
- You have the right to a clear list and description of the services available. You have a right to choose which services you want.
- You will receive a clear and complete description of services recommended for you. This list will be based on an assessment you will complete with staff. Help to understand your condition and options

for your care will be offered. You have the right to participate in the development of your treatment plan.

- You will receive complete descriptions of the steps you may take if you have concerns or complaints about your treatment.
- You have the right to know about services in your community. Types of services are; advocacy, prevention services and support groups.
- You have the right to know about all your staff's work experience, specialty, his or her training and education.
- You have the right to request how to participate in services offered. You also have the right to request how to provide suggestions on InteCare policies and services offered.
- You have the right to be treated with dignity and respect.

InteCare Covered Individual Responsibilities During Treatment:

- You need to share with staff the information they need. You should ask questions about your care so that staff can most effectively work with you to give you the best care and services possible.
- You need to follow through with your treatment plan that you and staff create for your care. If you find the plan and services in the treatment plan are not helping you meet your treatment goals you need to tell staff. They will discuss this with you and make the needed changes.
- You need to keep all scheduled appointments. If you need to cancel or reschedule an appointment, you need to notify staff as soon as possible. Staff would request at least 24-48 hours notice in advance.
- You need to report any concerns you have that affect your quality of care.
- You need to follow your medication plan. You need to report any medication changes to staff. This includes other medications you receive from other doctors.
- You need to treat staff with dignity and respect.

Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

XI: Appendices (D)

Minimum Qualifications of Providers and Credentialing Standards

InteCare, Inc.
Minimum Qualifications of Providers and Credentialing Standards

InteCare has minimum professional qualifications to qualify for consideration and acceptance into the InteCare Provider Network. **The minimum requirements for eligibility to become a Network Provider, by profession, are as follows:**

Psychiatrists and other Physicians (MD/DO)

1. have minimum malpractice and liability insurance coverage of at least $1,000,000 per occurrence and $3,000,000 aggregate or proof of participation in the Indiana Patient's Compensation Fund;

2. hold a current and unrestricted Federal Drug Enforcement Administration registration, unless specifically exempted under a written agreement approved by the Network and Credentialing Subcommittee;

3. if a psychiatrist, demonstrate eligibility for Board Certification by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry. If physicians are not board certified they must have completed a psychiatric residency program that is accredited by the Accreditation Council for Graduate Medical Education for Psychiatry or the American Osteopathic Association, and;

4. hold a current and unrestricted state license with Controlled Substances Registration (CDS) (unless specifically exempted under a written agreement approved by the Network and Credentialing Subcommittee).

All specialists in addictions are encouraged to hold qualifications in Addictions Psychiatry or the American Society of Addiction Medicine (ASAM).

Licensed Clinical Psychologists

1. have minimum malpractice and liability insurance coverage of at least $1,000,000 per occurrence and $3,000,000 aggregate with evidence of participation in the Indiana Patient's Compensation Fund coverage.

2. hold a current Indiana state license as a Psychologist with the Health Service Provider in Psychology (HSPP) certification;

3. hold a doctoral degree from an American Psychological Association (APA) accredited program (or) a regionally accredited university or professional school (or be licensed as a HSPP on the basis of "grandfathering")

Physician's Assistants & Advanced Practice Nurses (CNS & NP)

1. hold a current unrestricted license as a Physician's Assistant or Registered Nurse from the Indiana Professional Licensing Agency;

2. have minimum malpractice and liability insurance coverage of at least $1,000,000 per occurrence and $3,000,000 aggregate or proof of participation in the Indiana Patient's Compensation Fund, and;

3. An approved supervisory agreement or collaboration agreement under the direction of a qualified physician.

4. Physician's Assistants, Clinical Nurse Specialists and/or Nurse Practitioners must provide evidence of their completion of advanced training and board certification.

5. Physician's Assistants or Nurses applying as Advanced Practice Level Nurses must provide evidence of current licensing for prescription privileges from the Indiana Board of Nursing, as well as a copy of the supervisory agreement or collaboration agreement(s) under which they practice.

7. Hold a current and unrestricted Federal Drug Enforcement Administration Registration and CSR/CDS in the state in which they practice, unless specifically exempted under a written agreement approved by the Network and Credentialing Subcommittee.

Clinical Social Workers (LCSW)

1. hold a master's or doctoral degree in Social Work from a school accredited by the Council on Social Work Education (or be licensed as a LCSW on the basis of "grandfathering");

2. have current licensure as a Licensed Clinical Social Worker in the State of Indiana, meeting requirements for post degree supervised experience, and;

3. have minimum malpractice and liability insurance coverage of at least $1,000, 000 per occurrence and $3,000, 000 aggregate.

All Other Master's Prepared Therapists (LMFT/LMHC/LCAC)

1. have minimum malpractice and liability insurance coverage of at least 1,000,000 per occurrence and $ 3,000,000 aggregate, and;

2. have a current State of Indiana licensure as a Licensed Marriage & Family Therapist which includes meeting all requirements to hold this license as outlined in the State of Indiana Code (or be licensed as a LMFT on the basis of "grandfathering"); or

3. have a current State of Indiana licensure as a Licensed Mental Health Counselor which includes meeting all requirements to hold this license as

outlined in the State of Indiana Code (or be licensed as a LMHC on the basis of “grandfathering”)

Organizational Facilities

- Be fully accredited by one or more of the following national accrediting organizations or agencies: JCAHO, HFAP, CARF, or COA.
- Maintain State, Medicaid, and Medicare licenses as a Provider of services, if applicable.
- Maintain a defined access process with 24-hour availability for crisis response.
- Have access to and/or operate an inpatient level of care
- Have minimum malpractice and liability insurance coverage of at least $1,000,000 per occurrence and $3,000.000 aggregate or proof of participation in the Indiana Patient’s Compensation Fund. The declaration page should state that either the individual provider is covered by the policy if the individual provider is an employee of the organization or state that all employees are covered by the policy. The individual provider’s name shall be included on the organization’s designated employee staff listing if the provider’s name is not included on the policy. A letter from the insurance carrier stating the employee is covered under the policy will also meet this requirement.
- If an FQHC will show proof of deeming through HRSA

XI: Appendices (E)

Quick Reference Guide for InteCare, Inc.
Key Contact Information

Quick Reference Guide for InteCare, Inc.
Key Contact Information

"I need to know how to…"	"Who to contact at InteCare…"	"How?"
Make a Suggestion or Comment to the InteCare Organization	**InteCare, Inc. Corporate Office:** Director of Operations **InteCare, Inc. Web Site**	Phone: (317) 237-5770 E-mail: lwilliams@intecare.org www.Intecare.org

Give a Compliment to the InteCare Organization Submit a Complaint to the InteCare Organization		
Find out more about the InteCare organization, its Corporate staff, Provider Network, etc. Access InteCare Specific forms, such as: Rights and Responsibilities; Complaint Form	**InteCare, Inc. Web Site**	www.Intecare.org
Find out more information about the organization's communication methods, security procedures and compliance with HIPAA regulations Ask questions about the Utilization Management process for programs and/or receive clinical consultation	**InteCare Director of Operations**	Phone: (317) 237-5770 E-mail: lwilliams@intecare.org
Access information regarding the credentialing process, status of my application to become a panel Provider with InteCare, Inc., Appeal Process Inquire about the InteCare Provider Agreement and/or Exhibits Become a panel Provider with InteCare, Inc.	**InteCare Network & Credentialing Department: Credentialing Staff or Manager**	Phone: (317) 237-5770 E-mail: Credentialing Manager at jmaxwellcoker@intecare.org

XI: Appendices (F)

Quick Reference Guide for Service Codes
For
InteCare Individual Providers

InteCare, Inc.

Quick Reference Description Individual Provider Service Codes

These are most frequently used codes and are not exhaustive..
Appearance on the list does not indicate payment coverage. Refer to the specific contract attachment and/or the State of Indiana IHCP website and Provider Manual.

Description of Code	Code/Event
Outpatient Services	
Psychiatric Diagnostic Evaluation	**90791,** psychiatric diagnostic evaluation (with no medical services) **90792,** psychiatric diagnostic evaluation with medical services (this includes prescribing of medications) Evaluation/Management (E/M) new patient codes may be used in lieu of 90792)
Interactive Diagnostic Psychiatric Evaluation	**90791** or **90792**, with **+90785** (interactive complexity add-on code)
Outpatient Psychotherapy (Time is face-to-face with patient)	**90832**, psychotherapy, 30 min (actual time can be 16-37 mins) **Appropriate outpatient E/M code** (not selected on basis of time), and **+90833**, 30-minute psychotherapy add-on code **90834,** psychotherapy, 45 min (actual time can be 38-52 mins **Appropriate outpatient E/M code-99xxx** (not selected on basis of time), and **+90836**, 45-minute psychotherapy add-on code **90837,** psychotherapy, 60 min (actual time can be 53-67 min) **Appropriate outpatient E/M code-99xxx** (not selected on basis of time), and **+90838**, 60-minute psychotherapy add-on code
Outpatient Interactive Psychotherapy (Time is face-to-face with patient)	**90832** psychotherapy, 30 min., and **+90785**, interactive complexity add-on code **Appropriate outpatient E/M code-99xxx** (not selected on basis of time), and **+90833,** 30-minute psychotherapy add-on code, and **+90785**, interactive complexity add-on code **90834,** psychotherapy, 45 min. and **+90785,** interactive complexity add-on code **Appropriate outpatient E/M code-99xxx** (not selected on basis of time), and **+90836,** 45-minute psychotherapy add-on code, and **+90785,** interactive complexity add-on code **90837**, psychotherapy, 60 min., and **+90785,** interactive complexity add-on code **Appropriate outpatient E/M code-99xxx** (not selected on basis of time), and **+90838,** 60-minute psychotherapy add-on code, and **+90785,** interactive complexity add-on code

Other Psychiatric Services or Procedures	**Appropriate E/M code-99xxx** (Note: A new Add On code, +90863, pharmacologic management, including prescription and review of medication, can be added to a primary psychotherapy code-90833, 90836, 90837-but NOT with an E/M code. This Add On code should NEVER be used by a physician, only by a Prescribing Psychologist.)

For additional resources and information you may refer to the following website links:

http://www.psych.org/cptcodingchanges

https://www.psychiatry.org/home/search-results?k=billing%20psychotherapy%20codes

XII: Appendices (G)

Contact Information for Current Contracts

Program	Payer	Contact	Phone
Hoosier Healthwise/HIP	Cenpatico	www.managedhealthservices.com	877 647-4848

IU Health Plans Medicare Advantage Program	IU	http://Iuhealthplansmedicare.com	866-218-1524
IU Health Plans Commercial	IU	www.iuhealthplans.org	855-413-2434