INDIANA HEALTH COVERAGE PROGRAMS

PROGRAM REFERENCE MANUAL

Right Choices Program Administrator Manual

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of May 1, 2020 Published: Dec. 17, 2020	New document	FSSA, Optum and Gainwell
2.0	Policies and procedures as of May 1, 2021 Published: Nov. 23, 2021	Scheduled update	FSSA, Optum and Gainwell
3.0	Policies and procedures as of Sept. 1, 2022 Published: Feb. 10, 2023	Scheduled update	FSSA, Optum and Gainwell
4.0	Policies and procedures as of July 1, 2023 Published: July 1, 2023	Scheduled update: • Edited text as needed for clarity • Replaced references to Gainwell with "IHCP FFS PA-UM contractor" where needed • Changed references to IVR system to GABBY • Updated *Figure 1 – The IHCP Portal Care Management Tab* • Clarified what the RCP Administrator does in the *RCP Status – Determination of Placement and Member Notification* section • Clarified information in the *Release of Member Protected Health Information* section and subsections	FSSA, Acentra Health (formerly Kepro), Optum and Gainwell

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Section 1: Introduction

The Right Choices Program (RCP) is the lock-in program developed by the Indiana Health Coverage Programs (IHCP) in accordance with *Code of Federal Regulations 42 CFR Sections 455* and *456* and *Indiana Administrative Code 405 IAC 1-1-2(c)*. The goal of the RCP is to provide quality care through healthcare management, ensuring that the right service is delivered at the right time and in the right place for each member.

RCP Care Coordination Team

All RCP members, providers, RCP Administrators and the IHCP collaborate to create a care coordination team for RCP members. The RCP encourages participation in all coordination efforts available to ensure that RCP processes and guidelines are carried out appropriately while members receive medically necessary care.

RCP Administrators

Multiple vendors administer the RCP according to consistent policies established by the Indiana Family and Social Services Administration (FSSA):

- The IHCP fee-for-service (FFS), prior authorization and utilization management (PA-UM) contractor serves as the RCP Administrator on behalf of the state of Indiana for members who receive benefits under the Traditional Medicaid program.
- Managed care entities (MCEs) contracted with the IHCP serve as the RCP Administrators on behalf of the state for members in managed care programs. The RCP Administrators for Healthy Indiana Plan (HIP), Hoosier Care Connect and Hoosier Healthwise managed care programs are:
  - Anthem
  - CareSource – *HIP and Hoosier Healthwise only*
  - Managed Health Services (MHS)
  - MDwise – *HIP and Hoosier Healthwise only*
  - UnitedHealthcare – *Hoosier Care Connect only*

See the *Care Management* section of the *IHCP Quick Reference Guide* at in.gov/medicaid/providers for RCP Administrator contact information.

RCP Administrators are responsible for identification of members who qualify for placement in the RCP and continued administrative duties required because of the lock in.

RCP Members

IHCP members eligible for placement in the RCP include members in HIP, Hoosier Care Connect, Hoosier Healthwise and Traditional Medicaid (with the exception of dually eligible members and hospice participants). For instructions on determining a member's RCP status, see the *Right Choices Program* provider reference module.

Members are selected for review based on their behavior patterns and utilization practices compared with other members of the same population within each IHCP program. Reviews may also be initiated by referral, based on reports of potential overuse or abuse from various sources such as IHCP providers or other agencies. After the review process, if it is determined that the member is overusing or abusing services, the member is placed in the RCP, which includes provider assignment, member education and

interventions. The member is locked in to a single primary medical provider (PMP), a pharmacy and approved specialty providers, as appropriate.

RCP Providers

IHCP members who have been placed in the RCP are assigned to primary lock-in providers:

- One primary medical provider (PMP)
- One pharmacy

If a member requires services from a specialty provider or from a pharmacy other than the primary lock-in pharmacy, the PMP must make the referral in order for those services to be reimbursed.

The IHCP reimburses only the providers to whom the RCP member is locked in, unless a referral is on file with the member's RCP Administrator and appears on the member's lock-in list. Certain services are exempted from this requirement, as described in the *Services Carved Out of the RCP* section. However, PMPs are encouraged to provide RCP referrals for **all** nonhospital services, including carved-out services. This process ensures better coordination of care among providers and allows members to obtain prescriptions written by providers other than their PMP from their lock-in pharmacy. Because pharmacy claims are adjudicated at the pharmacy point of sale (POS), RCP members are able to receive their medications only if prescribed by their PMP or an authorized referral provider.

Non-IHCP and Out-of-State Providers

All providers, including out-of-state providers, must be enrolled in the IHCP, with a valid IHCP Provider ID, to be eligible for consideration as a covered provider for the RCP. If the PMP submits a referral for a provider that is out of state, the RCP Administrator checks to see whether the provider has an IHCP Provider ID and then makes a determination as follows:

- If the out-of-state provider has an IHCP Provider ID, the provider may be considered a covered provider for an RCP member if the referral or use of service is deemed valid by the RCP Administrator.
- If the out-of-state provider does not have an IHCP Provider ID, the provider is not a covered provider for the RCP and cannot be added to the RCP lock-in list.

Services Carved Out of the RCP

Certain services are carved out of the RCP and can be accessed by RCP members without a PMP referral. However, the PMP is *encouraged* to write referrals to **all** nonhospital services to ensure better coordination of care among providers.

> *Note: For RCP members enrolled in HIP, Hoosier Care Connect or Hoosier Healthwise, unless the service is considered self-referral under the managed care delivery system, it continues to require a PMP referral just as for non-RCP members; however, for these carved-out services, the PMP is not required to add the referral provider to the RCP lock-in list. See the Member Eligibility and Benefit Coverage provider reference module for a list of services that are considered self referral under the managed care delivery system.*

If the provider writes a prescription that will be dispensed at a pharmacy, an RCP referral by the PMP for the service is necessary for the prescription claim to be paid.

Services that do not require an RCP referral, *if no prescriptions will be written*, include the following:

- Behavioral health services*
- Chiropractic services
- Dental services*
- Diabetes self-management training (DSMT) services
- Family planning services
- Home health care
- Hospice
  (Note: When the RCP Administrator receives notification that a member is approved for IHCP hospice benefits, the member is removed from the RCP.)
- Hospital services, including hospital inpatient and outpatient services as well as professional services provided in a hospital setting
- Podiatry services
- Transportation services
- Routine eye care (except surgery)
- Home- and Community-Based Services (HCBS) waiver services

** Note that RCP Administrators may require PMP referrals for **behavioral health** providers and **dental** services, because these services are highly likely to generate prescriptions, especially for controlled substances.*

Section 2: Right Choices Program Provider Responsibilities

This section outlines the responsibilities of healthcare providers for Right Choices Program (RCP) members.

Lock-In PMP Responsibilities

The same provider specialties eligible to serve as primary medical providers (PMPs) for managed care programs are eligible for assignment as the RCP PMP. See the *Provider Enrollment* provider reference module for applicable specialties.

When a PMP is assigned for an RCP member, the RCP Administrator notifies the PMP of lock-in status through letter generated via the IHCP Provider Healthcare Portal (IHCP Portal). See the *Provider Letters* section.

By providing a care coordination team, a lock-in PMP is better able to manage a member's care and coordinate service delivery. One medical practitioner is aware of all the member's treatments and medications, which reduces the potential for adverse health outcomes and contradictory medical treatments. The goal of the PMP's intervention is to improve the member's care and health outcomes. A reduction is also anticipated in inappropriate use of pharmacy and other health services, which could harm the member and create unnecessary and wasteful program expenditures.

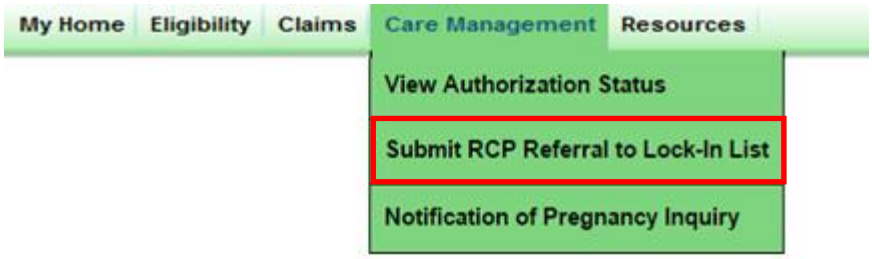
Adding Referral Providers

The PMP must use referrals if the RCP member requires evaluation or treatment by a specialist or another doctor or needs to use a pharmacy other than the primary lock-in pharmacy. The purpose of the referral is to ensure that the PMP has authorized the visit to the referral provider. The referral ensures that claims from referral providers may be processed for payment and should also be sent to the RCP Administrator.

PMPs may submit referrals to the RCP Administrator by mail or fax, or by adding them directly to the member's lock-in provider list in the IHCP Portal, as described in the following steps:

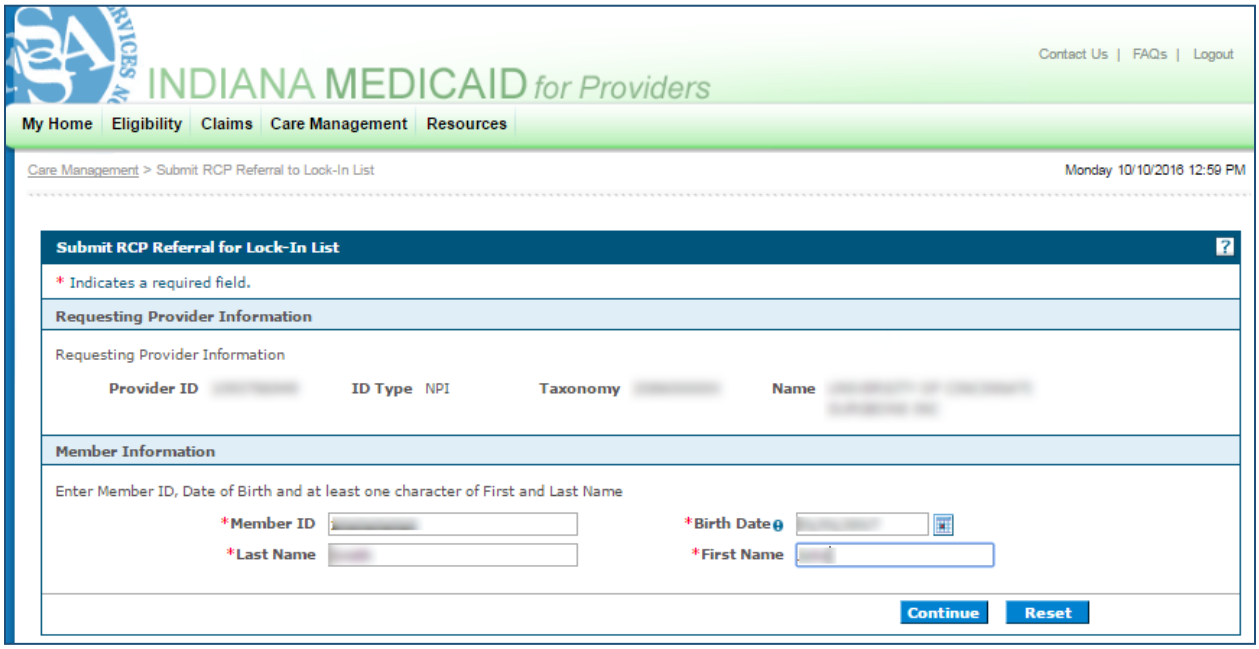
1. Log in to the IHCP Provider Healthcare Portal, accessible from the homepage at in.gov/medicaid/providers.
2. From the Care Management tab of the IHCP Portal menu bar, select **Submit RCP Referral to Lock-In List**.

Figure 1 – The IHCP Portal Care Management Tab



3. Enter the RCP member information in the *Member Information* section of the *Submit RCP Referral for Lock-In List* panel, and click **Continue**.

Figure 2 – Member Information



4. The IHCP Portal displays the member's *Lock-In Providers* list (Figure 3).

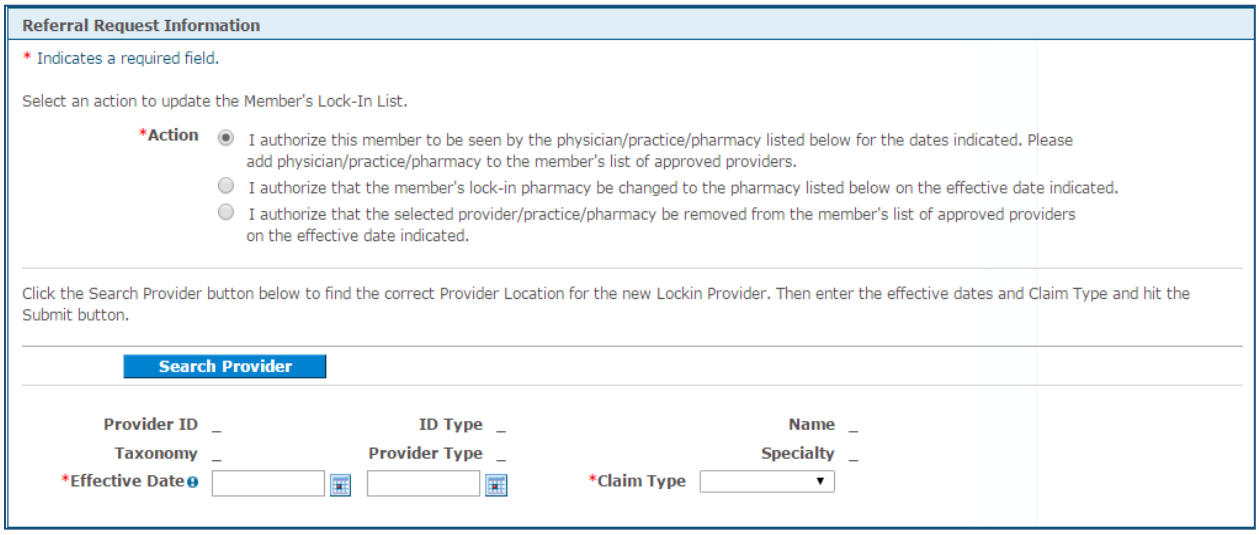
   This list is displayed only if the user is the member's PMP (or an authorized delegate with the appropriate permissions). All other users will see a message that only the member's PMP can submit an RCP referral.

Figure 3 – Lock-In Providers

Provider ID	NPI	Provider Name	Provider Type	Provider Specialty	PMP	Lock-In Type	Claim Type	Effective Date	End Date
			Physician	General Internist	Yes	Primary Medical Provider	Medical	01/11/2015	04/15/2016
			Pharmacy	Pharmacy	No	Pharmacy	Pharmacy	01/11/2015	04/15/2016
			Physician	General Surgeon	No	Referral	Medical	03/10/2015	04/15/2015
			Physician	General Internist	No	Referral	Medical	06/01/2015	02/01/2016

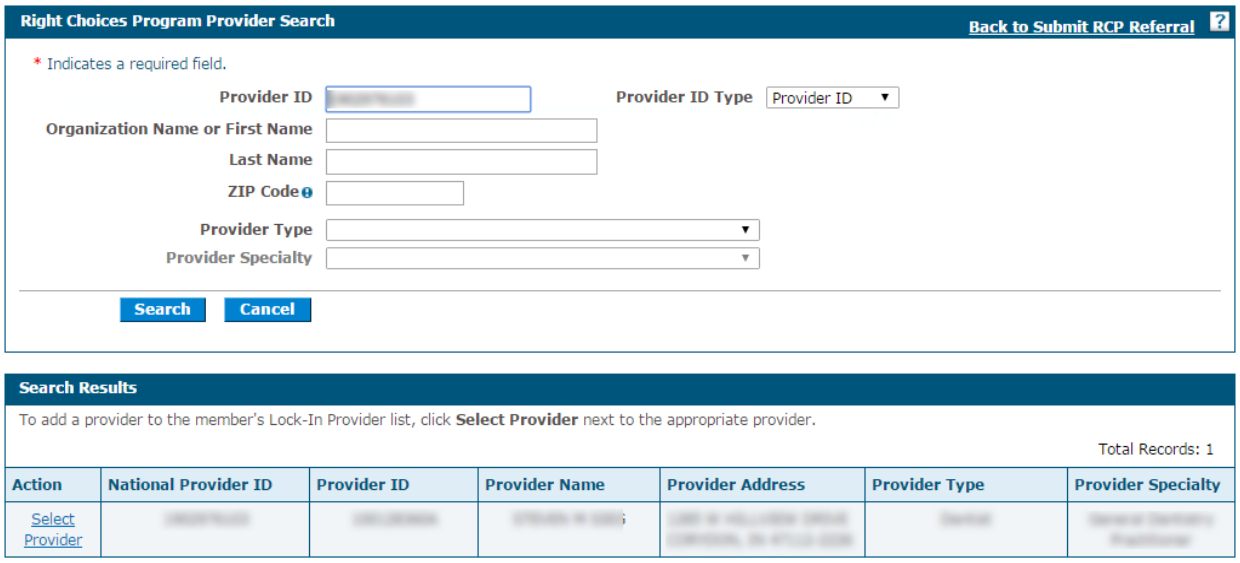
5. Select the appropriate option in the *Referral Request Information* section and click **Search Provider**.

Figure 4 – Referral Request Information



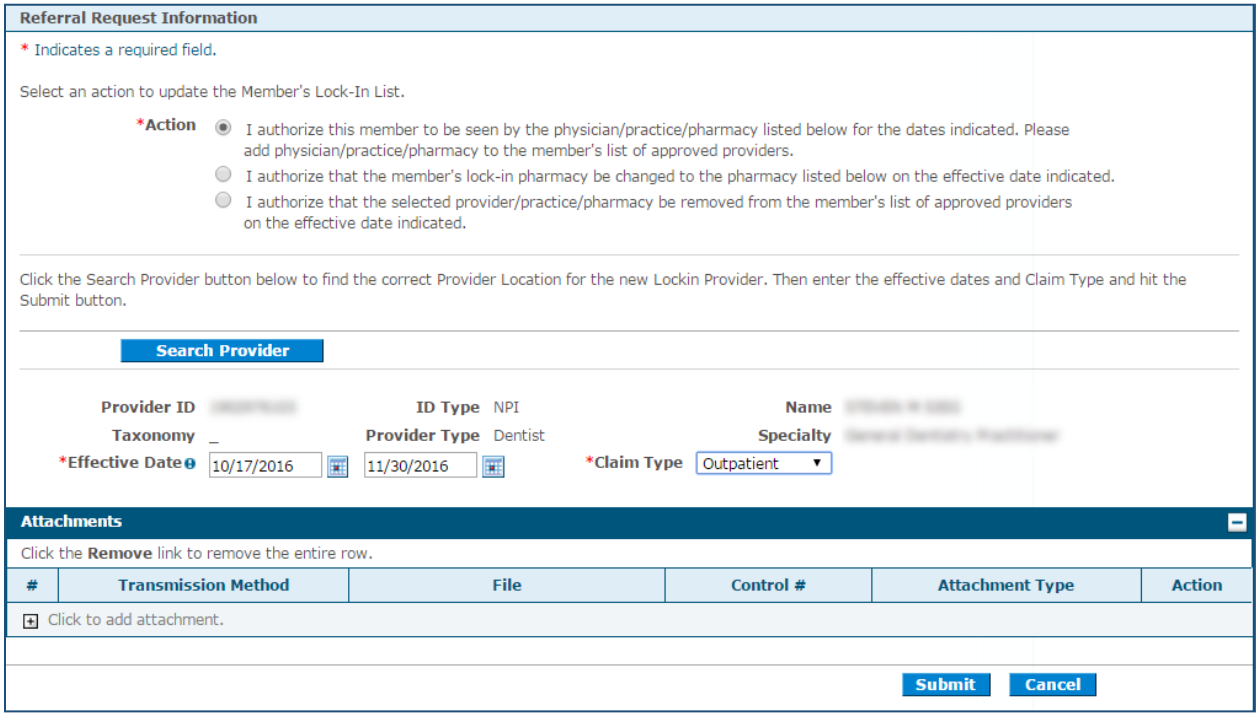
6. In the *Right Choices Program Provider Search* panel, enter information for the provider to be added to the lock-in list and click **Search**. Providers that match the criteria will be listed in the *Search Results* panel.

Figure 5 – Right Choices Program Provider Search and Search Results



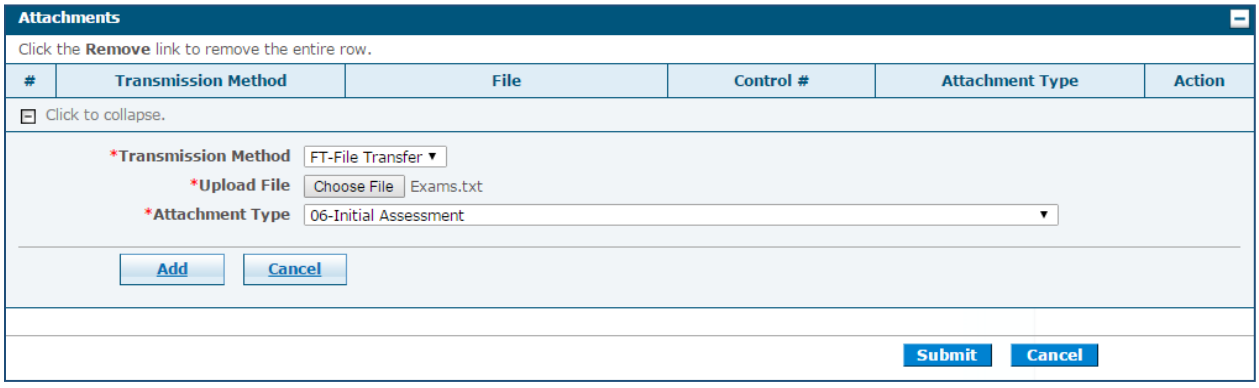
7. Click the **Select Provider** link for the desired provider to add that provider's information to the *Referral Request Information* section.
8. Enter the effective dates and the claim type for the referral.

Figure 6 – Referral Request Information



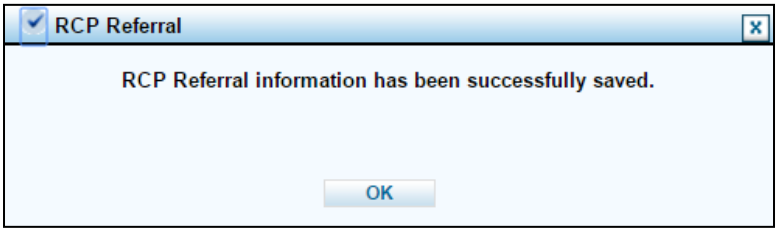
9. If appropriate, click the plus sign (+) in the *Attachments* panel and follow the instructions to add one or more files to support the referral being made. The RCP Administrator uses this information during the review process.

Figure 7 – Attachments for RCP Referral



10. Click **Submit** to finalize the submission of the RCP referral.
11. The IHCP Portal displays a confirmation message for the provider submission. Click **OK**.

Figure 8 – RCP Referral Confirmation Message



When the PMP adds a referral as described in these steps, the referral provider is automatically added to the member's lock-in list and the referral is transmitted to the RCP Administrator to review. PMPs can authorize RCP provider referrals for up to one year; however, referrals submitted through the IHCP Portal will default to a maximum of seven days until reviewed by the RCP Administrator. RCP Administrators are responsible for reviewing all the referrals submitted on the IHCP Portal and will update the applicable end date indicated on the PMP's referral.

Referral providers that treat lock-in members are responsible for verifying IHCP eligibility and must not treat the member without obtaining a referral from the member's PMP.

Submitting Referrals from Referral Providers

If the referral physician would like to refer the member to a third physician, the PMP must also sign the referral and submit it to the RCP Administrator before the third provider can be added to the member's lock-in list. The referral must include the following information:

- IHCP member's name
- IHCP Member ID (state-assigned number)
- First and last name of the referring physician (the second physician)
- First and last name of the referral physician (the third physician)
- New provider's National Provider Identifier (NPI)
- Date of the referral
- Dates of service for which the referral is valid
  - If no time period is specified on the referral, the referral is approved for up to one year depending on the type of provider being added.
  - The start date of the referral is the date indicated on the referral unless an alternate start date is specified by the PMP on the referral.
  - A second pharmacy may be added for the dates of service only.
- PMP's manual or electronic signature (unless the PMP submits the referral via the IHCP Portal)
  - Signatures of office staff for the PMP are unacceptable.

Retroactive Referrals

If the PMP has not submitted a referral to the RCP Administrator for a member, and the PMP is not available to submit a referral, temporary physician coverage may be approved by the RCP Administrator.

When the PMP approved the services provided on the date of service but failed to submit the referral to the RCP Administrator at that time, the PMP may submit retroactive referrals. Retroactive referrals may be accepted if the start date of the retroactive referral is within the claims' filing limit. The retroactive referral may be valid for up to one year from the retroactive start date. The PMP's medical records for the member should indicate that on or near the date of service, the referred service was approved. PMPs are not required to approve any service they did not know about on the date of service.

If the RCP Administrator receives a retroactive referral request from a member's PMP after the member has been removed from the RCP, and the referral dates meet the timely filing guidelines, the RCP Administrator must submit the referral information to INXIXCareProgram@gainwelltechnologies.com. This information will be entered into *Core*MMIS, so that claims for services rendered by that provider on the applicable dates can be processed appropriately. This procedure applies to RCP Administrators for both FFS and managed care members.

The following circumstances may be eligible for a retroactive referral:

- PMP change still pending after a previously auto-assigned member has selected a new PMP
- Death of PMP
- PMP moves out of the region without proper notification to the program
- Newly transitioned members into the program, such as wards and foster children, who are in need of treatment within the first 60 days of enrollment
- Auto-assigned member living in an underserved area and unable to select a PMP from that area
- Other urgent, emergency or ongoing issues, such as dialysis, in which the member is unable to access necessary services and the assigned PMP is unwilling or unable to provide services or the appropriate referral

Referrals for Services Carved Out of the RCP

PMPs are encouraged to provide referrals for **all** nonhospital services. Although RCP referrals are not mandatory for services that are carved out of the RCP, as described in the *Services Carved Out of the RCP* section, following the RCP referral process for these services provides better coordination of care among providers and allows members to obtain prescriptions written by the referral providers at their lock-in pharmacy. Because pharmacy claims are adjudicated at the pharmacy POS, members are able to receive their medications only if their prescribers are authorized referral providers.

Participating in Reviews

PMPs are expected to participate in the Exit Care Conference to help evaluate the RCP member's readiness for removal from the program, as described in the *Removal from the RCP: Case Closure* section.

Additional reviews may be conducted as needed prior to the Exit Care Conference. For example, the member's lock-in PMP may, at any time, request an "emergent" conference with the member's assigned care or case manager for crisis or other indications related to the member's care. Emergent conferences are strongly recommended to PMPs as an alternative to dismissing members from their practices. Maintaining a relationship with the PMP and a stable care plan is of utmost importance to the member's success in the RCP.

Referral Provider Responsibilities

The referral provider must confirm that the RCP member's PMP made a referral to add the referral provider to the member's lock-in list. Self-referrals and referrals from non-lock-in providers are not allowed for RCP members, except as described in the *Services Carved Out of the RCP* section.

The PMP must submit a referral to the RCP Administrator (through mail, fax or the IHCP Portal) that includes the referral provider's NPI, as outlined in the *Lock-In PMP Responsibilities* section.

The appearance of the referral provider's information on the member's eligibility verification – from the IHCP Portal, virtual assistant (GABBY) on IHCP Customer Service line or 270/271 electronic transaction – for the date of service allows for IHCP payment of services rendered by that provider. Referral providers may elect to print the eligibility verification from the IHCP Portal and retain it for billing purposes. The referral provider is also encouraged, but not required, to request a copy of the written referral from the PMP.

If the referral provider writes a prescription, it is recommended that a copy of the written referral or a printout of the member's eligibility verification from the IHCP Portal (with the *Right Choices Program* detail panel expanded to show the RCP referral provider) accompany the prescription to the primary lock-in pharmacy. If the referral was submitted by mail, and the RCP Administrator has not yet added the written referral to the IHCP Portal, the pharmacy should contact the RCP Administrator to verify validity and entry

of the referral. If the pharmacy is unable to contact the RCP Administrator, such as in an after-hours situation, the pharmacist is encouraged to use individual judgment as to whether the medication need is an emergency. If the pharmacist makes such a determination, the pharmacist should submit the pharmacy claim with an emergency indicator and dispense a 72-hour supply.

After the RCP Administrator adds a provider to a member's lock-in list, the provider files the claim in the usual manner. The PMP NPI must be reported in the referring provider field of the professional claim. For paper claim submissions, the member's PMP lock-in provider taxonomy code and ZZ or PXC qualifier must be included in field 17a of the *CMS-1500* claim form, if necessary, to make the required one-to-one match between the NPI and Provider ID.

Primary Lock-In Pharmacy Responsibilities

Pharmacy providers are notified of the member's lock-in status through a provider notification letter generated via the IHCP Portal (See the *Provider Letters* section.) If the pharmacy is part of a corporation, a letter is also addressed to the pharmacy's corporate headquarters.

The letter delineates the primary lock-in pharmacy's roles and responsibilities in managing prescription medications for RCP members, lists the authorized lock-in prescribers for the RCP member, and provides contact information for the RCP Administrator.

The member's primary lock-in pharmacy must fill prescriptions from the lock-in PMP and any referred prescribers when authorized by the PMP.

Valid RCP Prescribers

To be eligible for IHCP reimbursement, prescriptions must be written by the RCP member's lock-in PMP or a valid referral provider and must be presented at the member's primary lock-in pharmacy or a valid referral pharmacy. A physician within the same practice group as the PMP is not a valid referral provider unless the RCP Administrator has received a valid referral to that physician from the member's PMP, and the physician has been added to the member's lock in provider list.

When a prescription is written by a provider that has been referred by the RCP member's PMP, it is recommended that a copy of the written referral or a printout of the member's eligibility verification from the IHCP Portal (with the *Right Choices Program* detail panel expanded to show the RCP referral provider) accompany the prescription to the primary lock-in pharmacy.

Pharmacy claims can be submitted through point-of-sale (POS). If an RCP member presents a prescription at the lock-in pharmacy from a prescriber that is not the lock-in PMP or a valid referral provider, the claim will be denied.

If, after the lock-in pharmacy verifies the RCP member's IHCP eligibility, the claim denies for an invalid prescriber identification, the pharmacy must contact the RCP Administrator to confirm whether the prescription was written by an authorized lock-in prescriber. The lock-in pharmacy may choose to fill any legal prescription, but the IHCP does not reimburse claims for prescriptions that are not written by the PMP or a prescriber that has been referred by the PMP.

If the referral was submitted by mail, and the RCP Administrator has not yet added the written referral to the IHCP Portal, the pharmacy should contact the RCP Administrator to verify validity and entry of the referral. If the pharmacy is unable to contact the RCP Administrator, such as in an after-hours situation, the pharmacist is encouraged to use individual judgment as to whether the medication need is an emergency. If the pharmacist makes such a determination, the pharmacist should submit the pharmacy claim with an emergency indicator and dispense a 72-hour supply.

> *Note: If a pharmacy changes the NPI on a claim from the NPI of the non-lock-in provider that wrote the prescription to the NPI of a provider on the member's lock-in list, the reimbursement for the claim is subject to recoupment by the state, and the action is subject to a Medicaid fraud investigation. It may be considered an act of Medicaid fraud for a pharmacy provider to receive cash for services that exceed predetermined standards outlined in Code of Federal Regulations 42 CFR 709(b) to which the member is entitled under Medicaid.*

Obtaining and Documenting Lock-In PMP Authorization for Denied Prescriptions

If an RCP member presents a prescription and the claim is denied because it is from a prescriber who is not the PMP or a valid referral provider, the primary lock-in pharmacy may contact the PMP by telephone or fax to determine whether the PMP wishes to authorize the prescription. All prescriptions authorized in this manner must be documented as oral prescriptions from the PMP, and the claims must be resubmitted as prescriptions from the PMP.

Lock-In PMP Authorization for Denied Schedule II Prescriptions

If an emergency exists, as defined by *Indiana Administrative Code 856 IAC 2-6-7(e)*, and the PMP verbally authorizes a prescription for an emergency supply of a Schedule II controlled substance after a written prescription from a non-lock-in prescriber is denied, the primary lock-in pharmacy must document the verbal prescription and may dispense and submit a claim for an emergency supply per *856 IAC 2-6-7*. As required by this rule, the PMP must provide a written prescription for the emergency quantity to the dispensing primary lock-in pharmacy within seven days after authorizing the emergency verbal prescription. The member must then see the PMP to obtain an original written prescription for further supplies of the Schedule II prescription. No claim may be paid by the IHCP for a verbal prescription for a Schedule II prescription unless an emergency exists under *856 IAC 2-6-7*, as the dispensing of such a prescription is prohibited.

Referrals to Secondary Pharmacies

If an RCP member presents a prescription to a pharmacy that is not on the member's lock-in list, the claim will be denied.

If the primary lock-in pharmacy does not have a specific medication for a specific date of service, a second pharmacy may be added to the member's lock-in list for that date of service only. Before doing so, the RCP Administrator must verify that the primary lock-in pharmacy does not have the medication and that the secondary pharmacy does. The secondary pharmacy is added only for specific dates of service, and the RCP Administrator notifies the PMP that the secondary pharmacy was added for those dates.

> *Note: If a member is transferred to an LTC facility during the RCP enrollment period, the RCP Administrator changes the member's primary lock-in pharmacy to the one contracted by the LTC facility. When the member leaves the LTC facility, the RCP Administrator updates the member's primary lock-in pharmacy to the original lock-in list. See the Member Admission to a Long-Term Care Facility section for details.*

Hospital Responsibilities for RCP Member Prescriptions Upon Discharge

If a provider from a hospital writes a discharge prescription for an RCP member, the hospital must contact the member's PMP before discharge to obtain a referral to add the prescribing provider and the pharmacy that will be filling the prescription (if other than the member's primary lock-in pharmacy) to the member's lock-in list for a specified time frame.

Section 3: Right Choices Program Administrator Responsibilities

Right Choices Program (RCP) Administrators are responsible for the general operations and oversight of the RCP and all RCP members assigned to them. After identifying eligible members and enrolling them into the RCP, the RCP Administrator is required to perform the following duties:

- Intervene in the care provided to RCP members by providing, at minimum:
  - Enhanced education
  - Case management
  - Care coordination with the goal of modifying member behavior
- Provide appropriate customer service to providers and members.
- Evaluate and monitor the member's compliance with the individualized treatment plan to determine if the RCP restrictions will terminate or continue.

> *Note: The managed care entities (MCEs) provide care, case and/or disease management for managed care RCP members, if these members are assigned to a care or case manager for additional assistance with service coordination. The IHCP fee-for-service (FFS) prior authorization and utilization management (PA-UM) contractor provides care coordination for Traditional Medicaid members in the RCP.*

Identifying Members for Initial Review

IHCP members eligible for placement in the Right Choices Program (RCP) include members in the Healthy Indiana Plan (HIP), Hoosier Care Connect and Hoosier Healthwise managed care programs as well as fee-for-service (FFS) Traditional Medicaid members (with the exception of dually eligible members and hospice participants).

Identification of members eligible for placement in the RCP can come from a variety of sources, including the following:

- Statistical analysis databases – The RCP Administrator creates reports to review the cost and utilization data of its members. IHCP contractors may also supply information to the RCP Administrator regarding the member's utilization of services.
- Referrals to the RCP Administrator – Any person or source may contact the RCP Administrator on suspicion of overuse or misuse of services by a member. Referral sources may include the Family and Social Services Administration (FSSA), state and local law enforcement agencies, the FSSA Division of Family Resources (DFR), pharmacies, physician offices, hospitals and emergency rooms (ERs). Referrals may be made by telephone, mail or email. The RCP Administrator's designated department must complete the RCP screening process within 60 calendar days of receiving a referral. Typical referral reasons include overutilization of Medicaid services, such as multiple visits to the emergency room (ER), doctor shopping, frequent dismissals by doctors or polypharmacy. In addition, referrals are made when Medicaid members are suspected of activities such as drug abuse or dependence; prescription forgery; and selling drugs, supplies or equipment obtained through Medicaid. Referrals are made when members pay cash for Medicaid-covered services that would exceed predetermined standards as outlined in *Code of Federal Regulations 42 CFR 456.709*.

- Data-mining techniques – Patterns of member utilization can be aggregated from the RCP Administrator's applicable data source sources including but not limited to:
  - Number of prescribers
  - Number of pharmacies used
  - Number of prescriptions for controlled substances

RCP Administrators use the *Potential Right Choices Program Members* report to identify potential members for the RCP. This report is created on a monthly basis by Optum and Enterprise Data Warehouse (EDW). MCEs can access this report from the FSSA EDW Portal at edwreports.fssa.in.gov (user ID and password required). For details on using this report, see the *Potential Right Choices Program (RCP) Report User Guide*. MCEs can access this user guide on the *MCE Manuals* page at in.gov/medicaid/partners (user ID and password required). For the FFS RCP Administrator access, the report and user guide will be loaded onto the FFS PA-UM SharePoint restricted-access RCP site (user ID and password required).

Data provided in the *Potential Right Choices Program Members* report includes but is not limited to the following:

- Change in PMP count
- Number of ER visits or urgent care visits
- Number of prescribers
- Number of pharmacies
- Number of controlled substance prescriptions
- Average daily morphine milligram equivalent (MME)
- Number of office visits

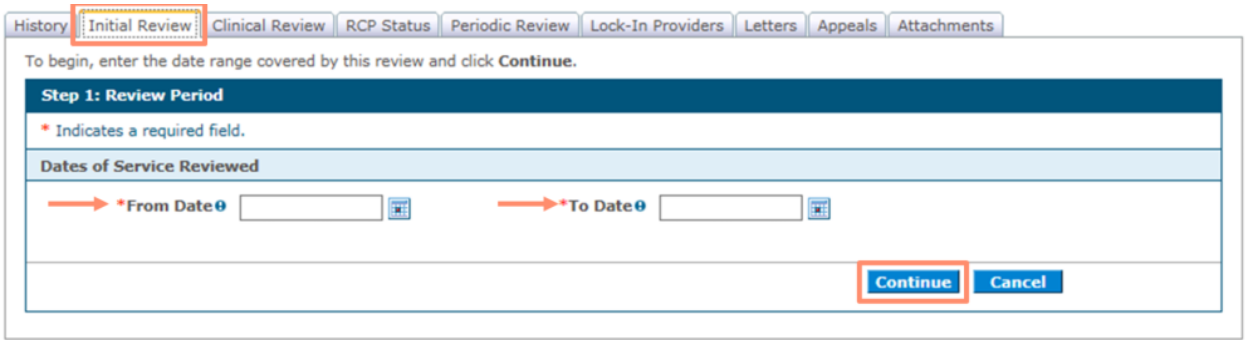
In addition, the RCP Administrator's designated predictive modeling tools, such as statistical analysis, algorithms and aggregate data from the predictive modeling tool, assist with identifying members for further review.

Initial Review

After a member is identified for initial review, the RCP Administrator enters the initial review information into the IHCP Provider Healthcare Portal (IHCP Portal) as follows:

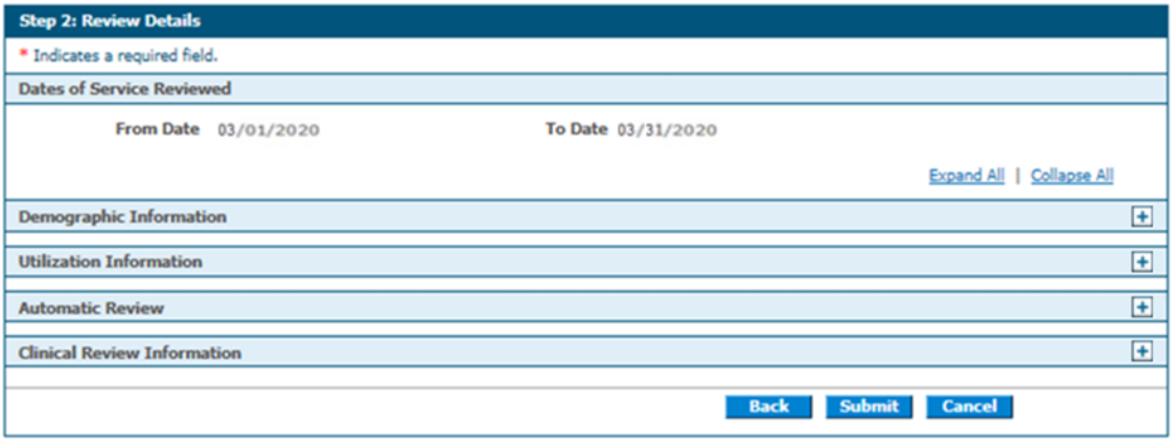
1. Log in to the IHCP Portal.
2. From the Care Management tab in the menu bar, select **Right Choices Program Search**.
3. Locate the member by searching for Member ID, member name (last name, first name and birth date) or member Social Security number (SSN).
4. In the search results, click the Member ID to access the *Right Choices Program Member Summary* page for that member.
5. Select the **Initial Review** tab.

Figure 9 – Initial Review Tab: Review Period



6. In the From Date and To Date fields, enter the first and last date of the month of the *Optum Potential Right Choices Program Report* used to identify member for review and then click **Continue** to open the *Review Details* panel.

Figure 10 – Initial Review Tab: Review Details



7. Click the plus signs (+) to view and enter information in the four sections of *the Review Details* panel:
   - *Demographic Information* (see Figure 11)
   - *Utilization Information* (see Figure 12)
   - *Automatic Review* (see Figure 13)
   - *Clinical Review Information* (see Figure 14)
8. After reviewing each section and adding information as needed, click **Submit** to save the member's initial review.

> *Note: PDF files of completed reviews, called Right Choices Program Member Summary Worksheets, may be accessed and printed from the **History** tab of the Right Choices Program Member Summary page. See Section 5: Right Choices Program Member Summary Worksheets section for details.*

Figure 11 – Initial Review Tab: Demographic Information

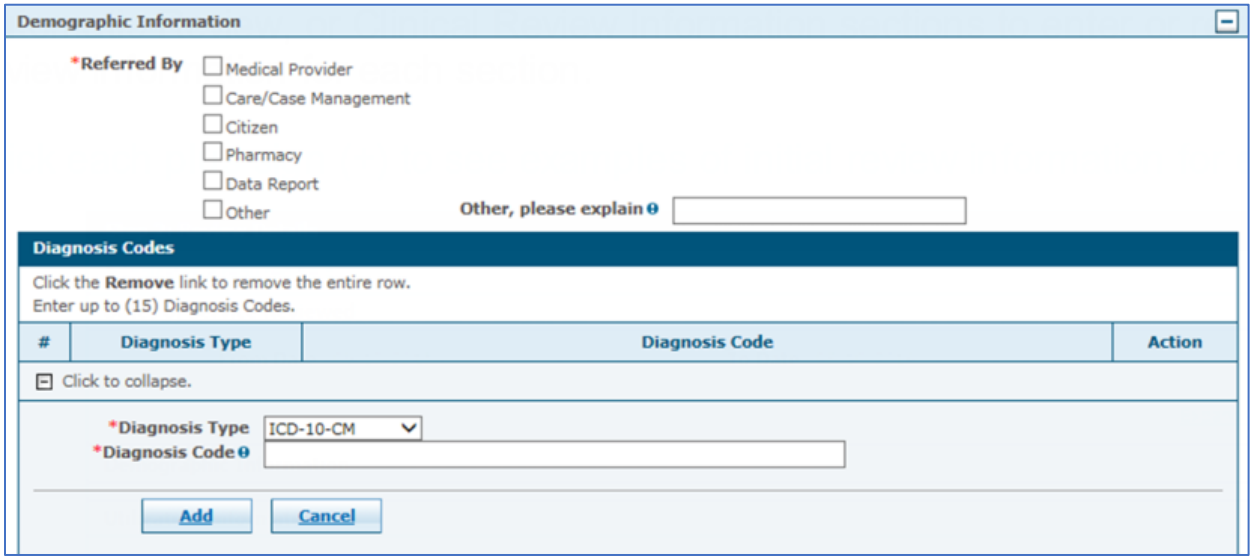


Figure 12 – Initial Review Tab: Utilization Information

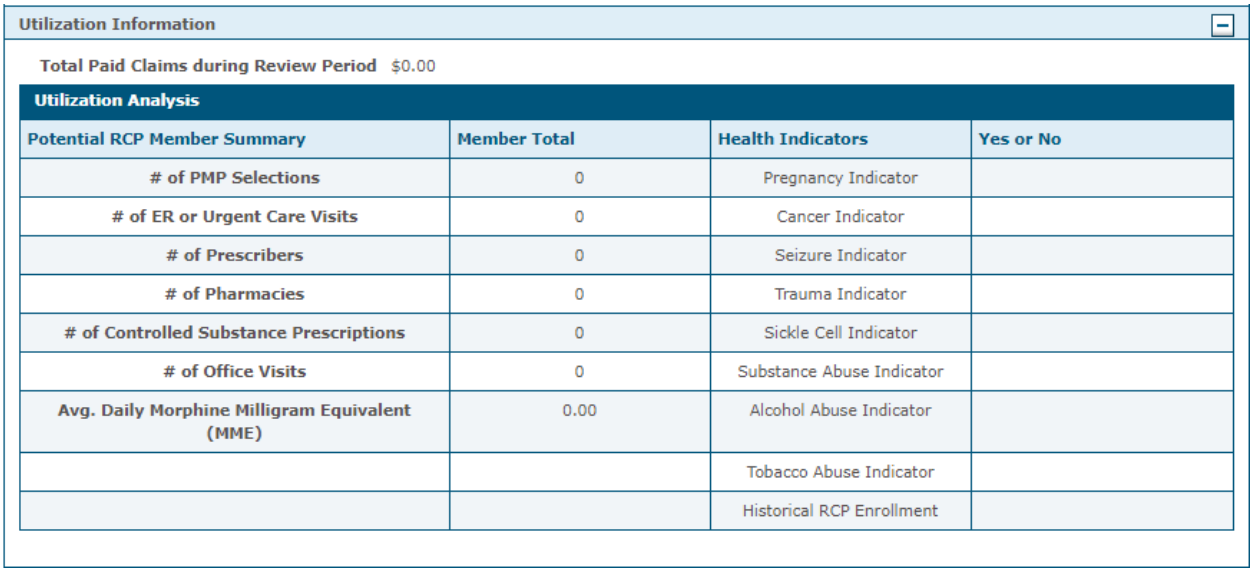


Figure 13 – Initial Review Tab: Automatic Review

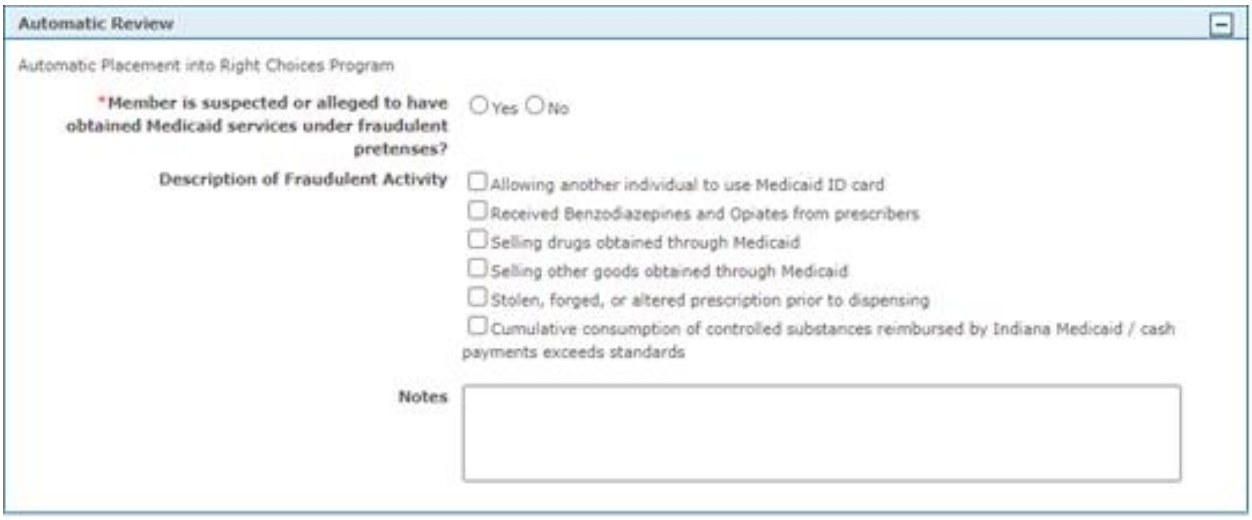
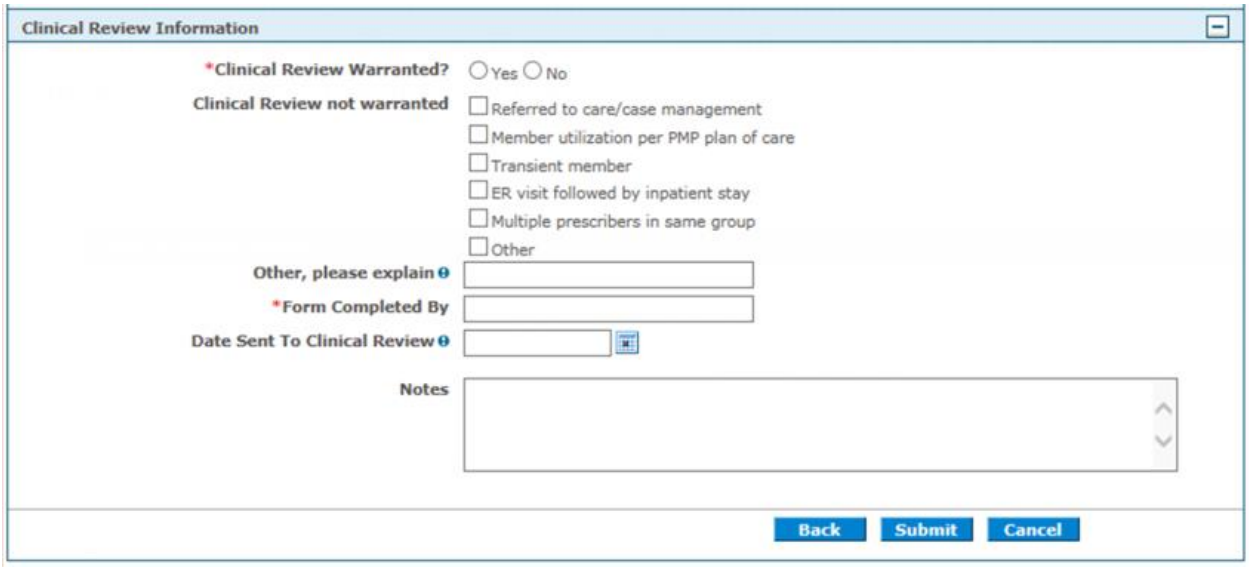


Figure 14 – Initial Review Tab: Clinical Review Information



Clinical Review

Members are sent for clinical review to determine whether the member is placed in the RCP. RCP inclusion may be the result of member behaviors such as fraudulent pretenses that may include, but are not limited to:

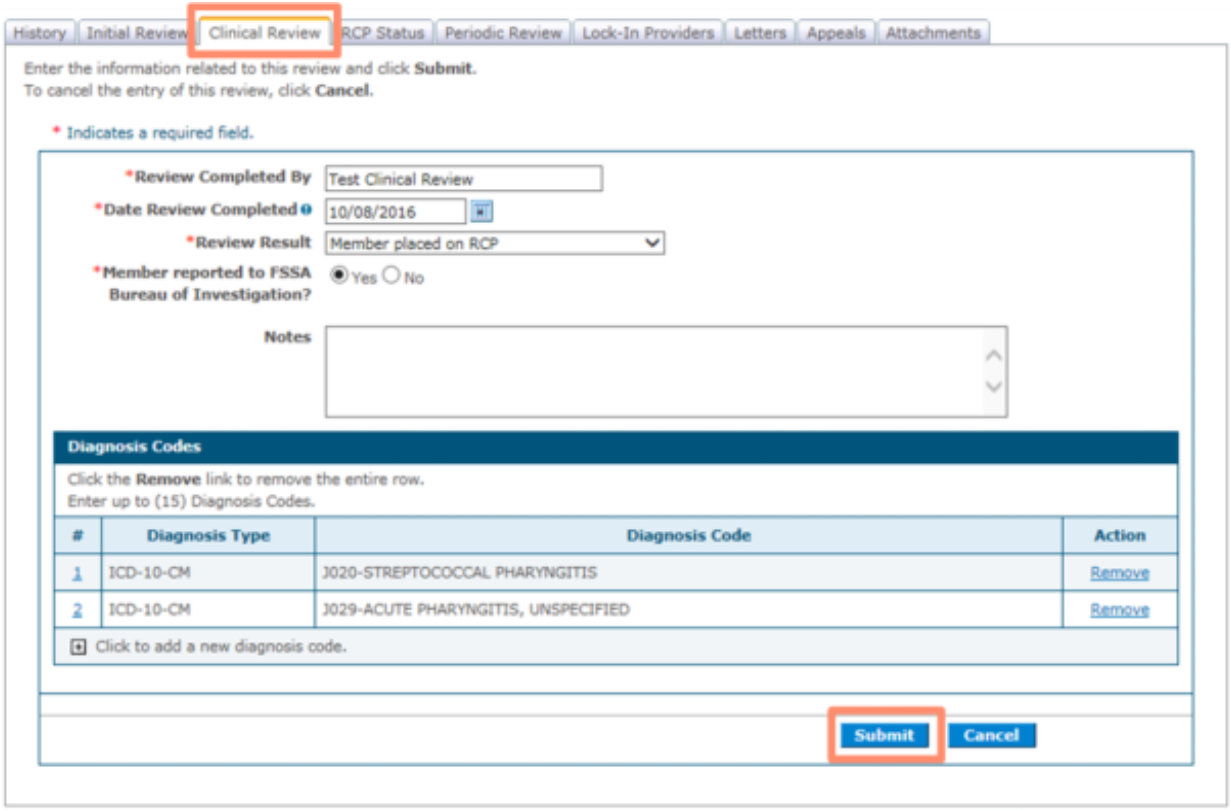
- Stealing prescription pads
- Paying cash for prescriptions that exceed predetermined standards, as outlined in *42 CFR 456.709*
- Allowing another individual to use Medicaid ID card
- Received benzodiazepines and opiates from prescribers
- Selling drugs obtained through Medicaid
- Selling other goods obtained through Medicaid

- Stolen, forged or altered prescription prior to dispensing
- Cumulative consumption of controlled substances reimbursed by Indiana Medicaid/cash payments exceeds standards

After the screening is completed, the RCP Administrator enters the following information into the IHCP Portal using the **Clinical Review** tab on the *Right Choices Program Member Summary* page for the member being reviewed:

- Name of the staff member completing the clinical review
- Date of the clinical review
- Clinical review result

Figure 15 – Clinical Review Tab



RCP Status – Determination of Placement and Member Notification

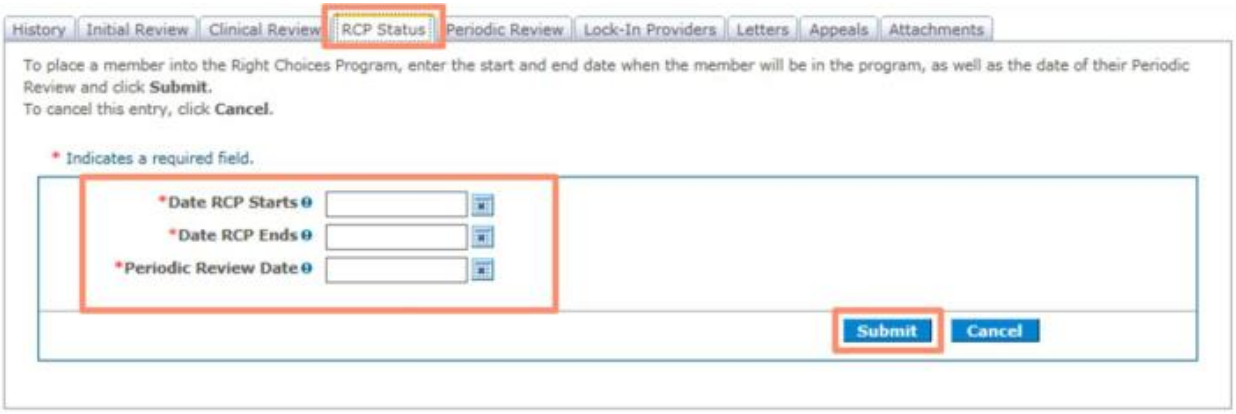
After completing the initial and clinical reviews as described in the previous section, the RCP Administrator uses the previous reporting tools and the *Right Choices Program Member Summary Worksheets* (accessed from the History tab) to determine whether the member is placed in the RCP.

If the member is **not** placed in the program, the RCP Administrator does one of the following:

- Refers the member to care management or complex case management for further interventions and education (applicable for managed care members only).
- Reports the member to the Indiana FSSA Bureau of Investigations at ReportFraud@fssa.in.gov for potential fraud investigation.
- Takes no action. If the member's information documents clinically appropriate behaviors and utilization, the member continues in their current enrollment, with no interventions needed.

When a member **is** selected for the RCP, the dates for the member's RCP enrollment period and for the periodic review are entered into the IHCP Portal in the **RCP Status** tab of the *Right Choices Program Member Summary* page for that member. This step ensures that the member can be properly identified as an RCP member.

Figure 16 – RCP Status Tab



The member is enrolled in the RCP until it can be determined that the member is utilizing services appropriately and is compliant with the individualized treatment plan. The RCP enrollment period may last up to two years and may be renewed for an additional two-year period on review.

Periodic reviews are conducted during a member's enrollment in the program and may be used to determine a member's compliance.

After the member's eligibility has been verified, the IHCP Portal generates an initial notification letter (see the *Member Letters* section). The RCP Administrator sends the letter to the member via U.S. mail with delivery confirmation or any other carrier with which the RCP Administrator may have negotiated rates, as long as the letter can be tracked. The letter is addressed to the member from the state, and provides notification that the member has been chosen for the RCP. The RCP guidelines and the member's appeal rights are explained in the letter. The member is also contacted by telephone. The RCP Administrator must make a minimum of three attempts on three separate dates to reach the member by telephone.

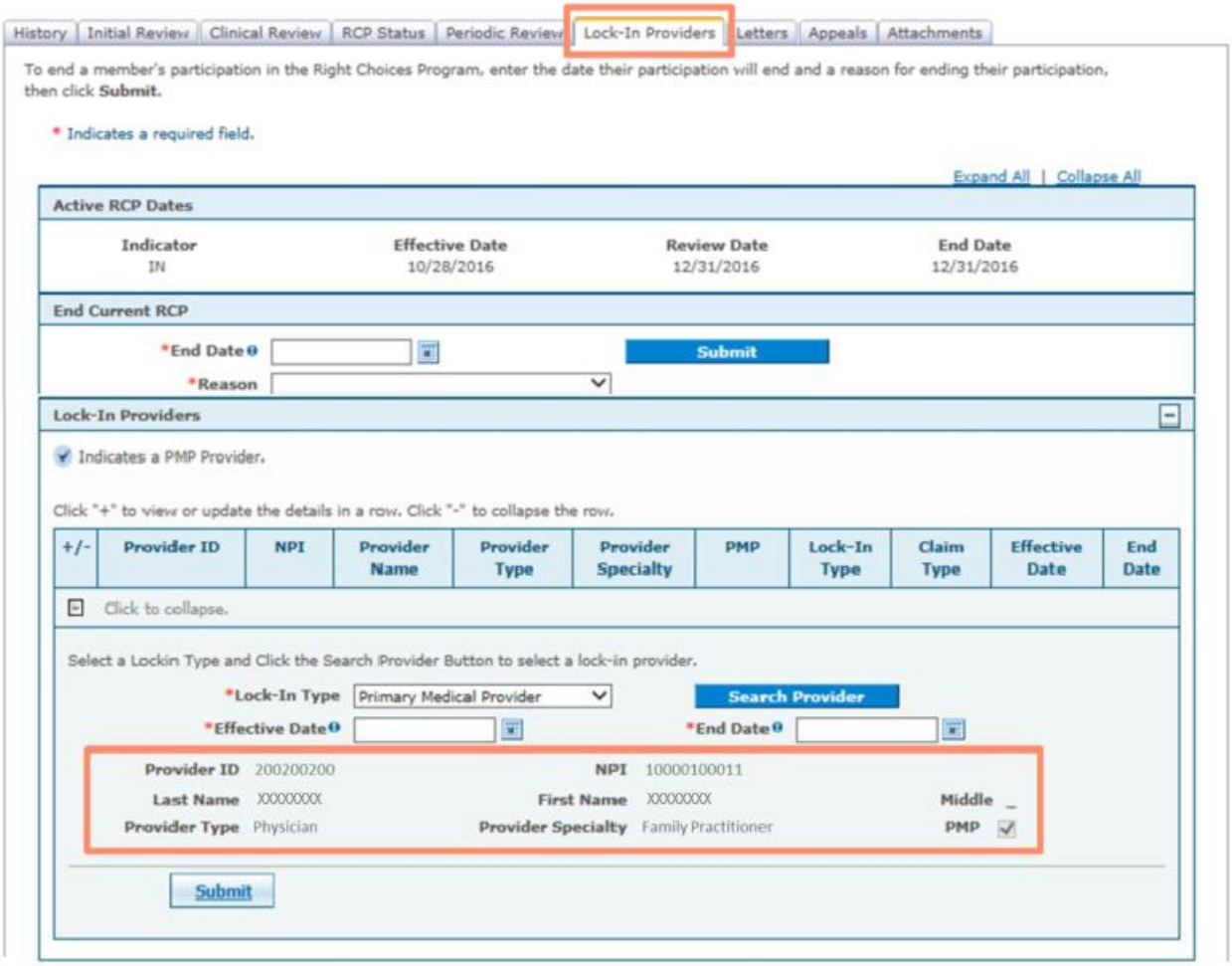
Selecting and Entering Lock-In Providers

Members have 10 calendar days from the date the initial notification letter was sent to respond, by telephone or in writing, and identify their selected lock-in providers. Each member selects one primary medical provider (PMP) and one pharmacy. The selected providers must be enrolled in the IHCP. For managed care members, the providers must also be within the RCP Administrator's MCE network, and the PMP must be the same as the member's managed care PMP.

If the member does not respond within 10 calendar days to indicate provider selections, providers are chosen for the member. The RCP Administrator reviews the member's past claim history to select and assign providers.

After RCP provider selections have been made, the RCP Administrator enters the member's providers into the IHCP Portal, using the **Lock-In Providers** tab of the *Right Choices Program Member Summary* page for that member.

Figure 17 – Lock-In Providers Tab



After lock-in providers have been entered into the IHCP Portal, a provider assignment letter can be generated and sent to the member. Letters are also generated and mailed to providers notifying them of these selections and giving a summary of their responsibilities as the assigned providers. See *Section 6: Right Choices Program Letters* for details.

Members currently under the care of a specialist, or who indicate that they have an upcoming initial appointment with a specialist, are informed by the provider that their PMP must make the referral to the specialist and send a copy of the referral to the RCP Administrator by mail or fax, or submit the referral via the IHCP Portal as described in the *Lock-In PMP Responsibilities* section of this document. The RCP Administrator's medical director may authorize a one-time referral if the PMP cannot be reached.

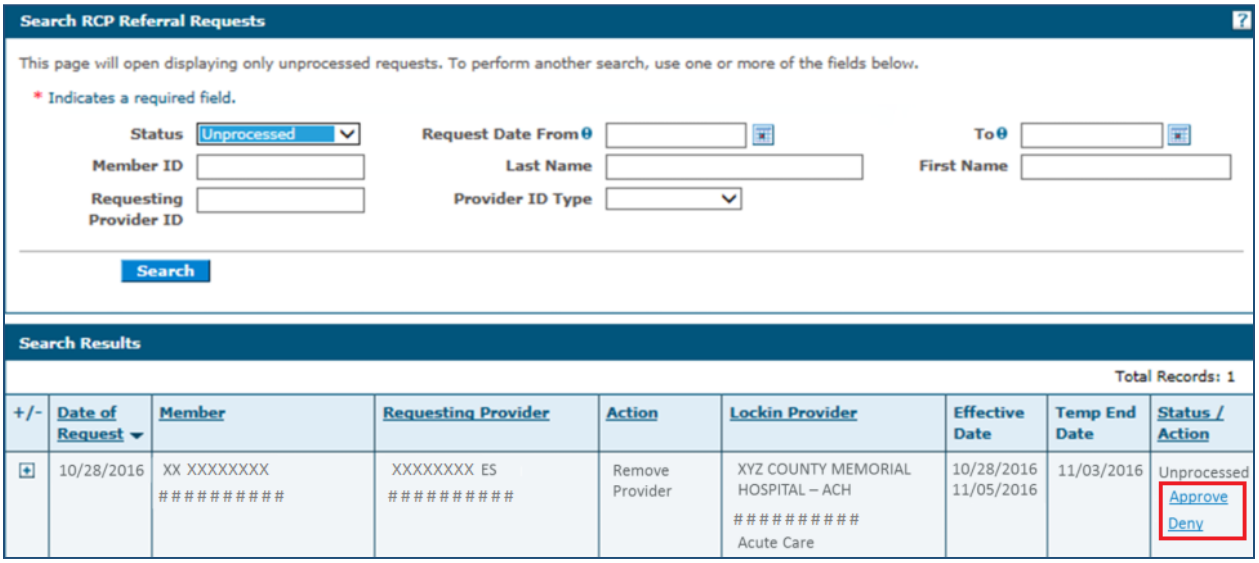
Adding Referral Providers to the Lock-in List

RCP Administrators are responsible for reviewing all PMP-submitted referrals.

Referrals submitted by mail or fax can be manually entered into the IHCP Portal from the Lock-In Providers tab (see Figure 17), as described in the previous section. For these providers, select **Referral** from the Lock-In Type drop-down menu, select the appropriate claim type, and then search for and add the desired provider.

To review and add referrals submitted via the IHCP Portal, RCP Administrators select **Search RCP Referral Requests** from the Care Management tab in the menu bar. The search results automatically display all unprocessed referral requests for all members in the health plan (see Figure 18). The results can be narrowed by selecting additional search criteria. Each referral can be approved by clicking **Approve** in the Status/Action column. Referrals submitted via the IHCP Portal are automatically added to the member's lock-in provider list and remain there for up to seven days without explicit approval from the RCP Administrator.

Figure 18 – Search RCP Referral Requests



Changing Lock-In Providers

The following sections describe situations under which a member's primary lock-in providers may be changed during the member's RCP enrollment.

> *Note: If the member does not have a PMP or wants to change PMP, or if the chosen PMP displays utilization abnormalities, the RCP Administrator helps the member select a new PMP.*

Member Admission to a Long-Term Care Facility

If a member is admitted to a long-term care (LTC) facility, the RCP Administrator adds the facility doctor and pharmacy to the member's lock-in list as follows:

- The LTC facility doctor is added as the member's PMP and may make referrals, as applicable, during the member's length of stay. During this time, the member's original PMP remains on the member's lock-in list, but as a referral provider rather than the PMP.
- The LTC pharmacy is added as the member's lock-in pharmacy, and the member's original primary lock-in pharmacy is suspended (end-dated) for the duration of the member's stay at the facility.

When the member is discharged from the LTC facility, the facility providers are suspended (end-dated), and all providers active before the admission resume responsibility in their previous roles as the member's providers.

Member-Initiated Change in PMP Assignment

If the member initiates a PMP change, a new PMP may be selected only in one or more of the following circumstances:

- Access to care
  - Member moves more than 30 miles from the current PMP.
  - Current PMP moves more than 30 miles from the member.
  - Current PMP's office is not accessible on public transportation.
  - IHCP-reimbursable transportation is not available (for HIP, this condition applies only to *HIP State Plan Plus*, *HIP State Plan Basic* and *HIP Maternity* members).
  - Excessive delay occurs between requests for appointments and scheduled appointments, as noted in a documented pattern over six months
  - Has difficulty contacting the PMP office for care after normal business hours.
- Continuity of care
  - Current PMP disenrolls from the member's current MCE, program or the IHCP.
- Quality of care or service
  - Member's dissatisfaction with treatment by doctor or staff

    This provision does not include a member's dissatisfaction with a plan of treatment, prescription utilization contract, written prescriptions (type and quantities) or lack thereof. This provision exists specifically to address any potential quality-of-care or abuse issues that may be present in the treatment of the member by the doctor or staff.
  - Specialty services required due to language, cultural or other communication barriers with current PMP
  - Ongoing unresolved provider or member conflict
- Selected assignment
  - Member did not select the current PMP.
    - If a member fails to select primary lock-in providers within 10 days of RCP notification, the selection is made by the RCP Administrator or is auto-assigned.
    - This reason may be used only once during the member's enrollment in the RCP, pending approval from the RCP Administrator.

Members are required to submit a written request to the RCP Administrator detailing the reasons for the requested change. The RCP Administrator then reviews the change request. If the member's lock-in providers are changed, the RCP Administrator sends the member a letter with the new providers' information. See the *Member Letters* section for details. The new lock-in providers also receive a copy of the letter.

The former PMP is end dated on the lock-in list and is added as a referral provider for a period of 30 days beginning on the start date of the new PMP.

Provider-Initiated Termination of PMP Status

The provider may opt to terminate a member's care for specific reasons outlined in the provider's internal office policies and in this document, such as noncompliance with treatment recommendations and abusiveness to office staff. If this situation transpires for an RCP member, the following must occur:

- The provider must give a letter to the member, with 30 days' notice, stating that the member's care by the provider is being terminated.
- A copy of this letter must be mailed or faxed to the RCP Administrator with any applicable reassignment request forms. The RCP Administrator's designated staff works with the member to select another provider to replace the provider that is that is terminating care.
- Referrals made by the terminating provider will expire 30 calendar days after the RCP Administrator's receipt of the dismissal. On approval from the administrator's medical director, the expiration date may be extended under the following circumstances:
  - New provider is unable to see member within 30 calendar days.
  - RCP member eligibility terminates during the process of changing the PMP, and the member is auto-assigned to dismissing provider.

Periodic Reviews

Periodic care reviews must be completed by the member's two-year anniversary and at least annually thereafter while the member is in the RCP. RCP Administrators use the **Periodic Review** tab of the *Right Choices Program Member Summary* page to enter this periodic review information into the IHCP Portal.

Figure 19 – Periodic Review Tab: Review Period

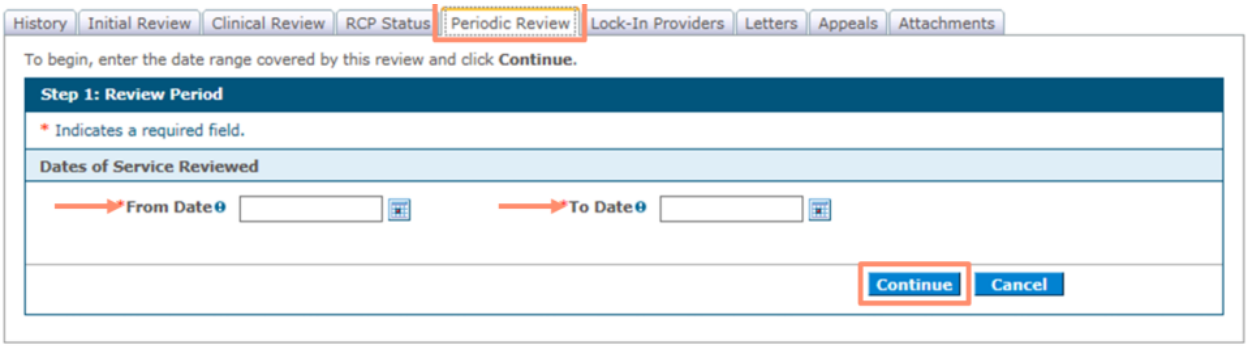
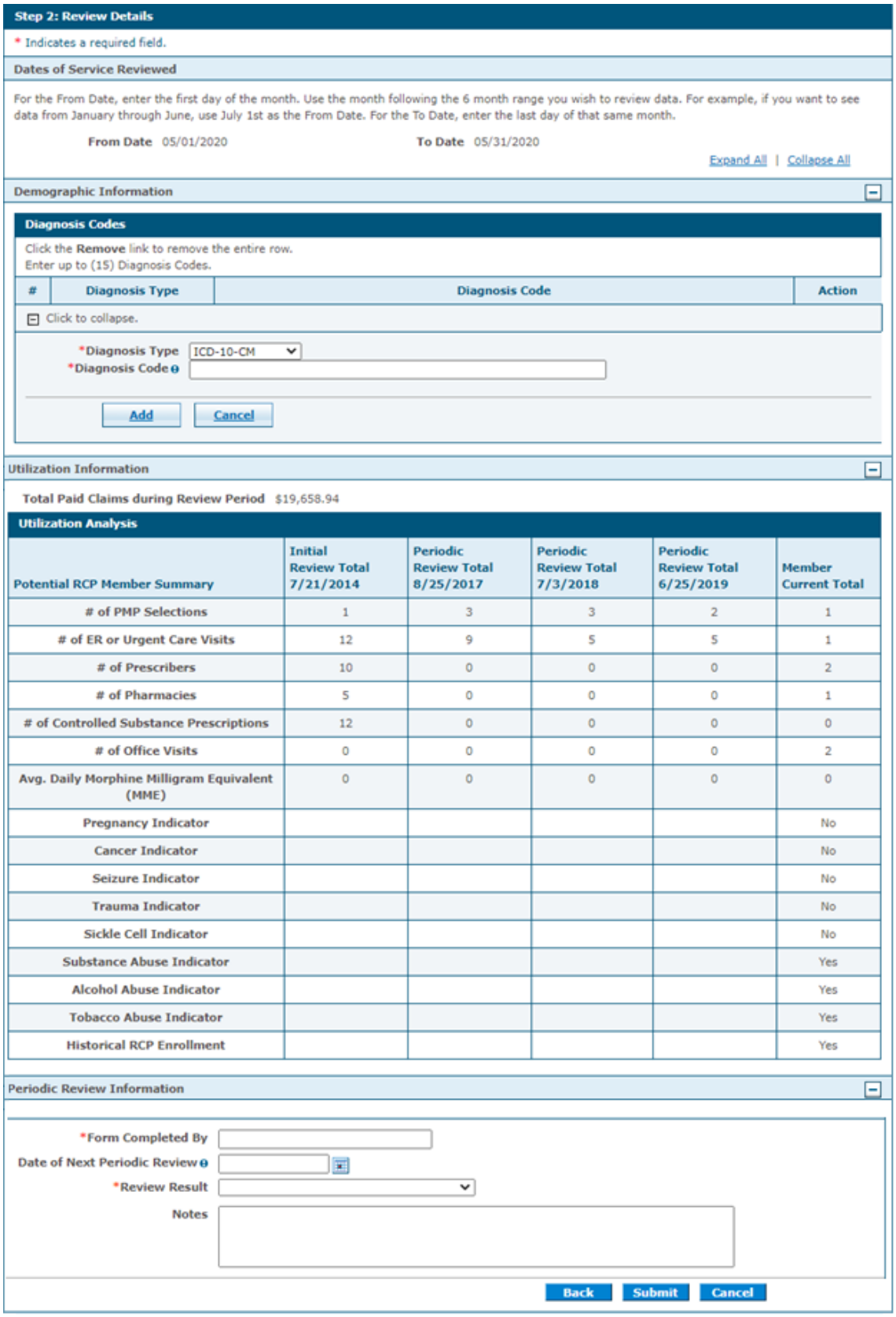


Figure 20 – Periodic Review Tab: Review Details



Step 2: Review Details

* Indicates a required field.

Dates of Service Reviewed

For the From Date, enter the first day of the month. Use the month following the 6 month range you wish to review data. For example, if you want to see data from January through June, use July 1st as the From Date. For the To Date, enter the last day of that same month.

From Date 05/01/2020 **To Date** 05/31/2020

Expand All | Collapse All

Demographic Information

Diagnosis Codes

Click the **Remove** link to remove the entire row.
Enter up to (15) Diagnosis Codes.

#	Diagnosis Type	Diagnosis Code	Action

Click to collapse.

*Diagnosis Type ICD-10-CM

*Diagnosis Code

Add Cancel

Utilization Information

Total Paid Claims during Review Period $19,658.94

Utilization Analysis

Potential RCP Member Summary	Initial Review Total 7/21/2014	Periodic Review Total 8/25/2017	Periodic Review Total 7/3/2018	Periodic Review Total 6/25/2019	Member Current Total
# of PMP Selections	1	3	3	2	1
# of ER or Urgent Care Visits	12	9	5	5	1
# of Prescribers	10	0	0	0	2
# of Pharmacies	5	0	0	0	1
# of Controlled Substance Prescriptions	12	0	0	0	0
# of Office Visits	0	0	0	0	2
Avg. Daily Morphine Milligram Equivalent (MME)	0	0	0	0	0
Pregnancy Indicator					No
Cancer Indicator					No
Seizure Indicator					No
Trauma Indicator					No
Sickle Cell Indicator					No
Substance Abuse Indicator					Yes
Alcohol Abuse Indicator					Yes
Tobacco Abuse Indicator					Yes
Historical RCP Enrollment					Yes

Periodic Review Information

*Form Completed By

Date of Next Periodic Review

*Review Result

Notes

Back Submit Cancel

Additional reviews may be conducted as needed. For example, the member's lock-in PMP may, at any time, request an "emergent" conference with the member's assigned care or case manager for crisis or other indications related to the member's care. Emergent conferences are strongly recommended to PMPs as an alternative to dismissing members from their practices. Maintaining a relationship with the PMP and a stable care plan is of utmost importance to the member's success in the RCP.

If a periodic review reveals a member's continued misuse of services, the member may be sent a letter from the RCP Administrator educating the member about appropriate usage, based on the specific type of misuse. All reviews are documented on the designated forms and in the respective RCP Administrator's database and care or case management notes. RCP Administrators are responsible for maintaining ongoing documentation of issues of noncompliance with the program and of attempts to overuse or misuse services. Noncompliance with the RCP may result in additional RCP enrollment periods. The member also receives additional education and information from the care or case management staff.

If discrepancies are found during a care review, the RCP Administrator may ask the PMP to provide an authorization statement of when the PMP was specifically aware that the member was receiving care from the physician in question or another physician in their practice. The PMP's medical records must reflect that the PMP approved those services near the date of service. The PMP's authorization for prescriptions written by ER physicians must include specific prescriber names and dates of service. In addition, the ER physician's authorization must be accompanied by medical record documentation that indicates the member did contact the PMP immediately before or after the ER visit, and the PMP's approval was obtained near the date of service. If the PMP is not available, authorization from other staff may be supplied only if supporting medical records are included to verify that the PMP had knowledge of the care in question.

In some cases, after the completion of a periodic care review, the RCP member's care or case manager may recommend that the member be removed from the RCP if this individual believes the member will utilize services appropriately without supervision.

Removal From the RCP: Case Closure

Thirty to 60 days before the projected end of the member's enrollment in the program, the RCP Administrator's staff reviews the member's case to determine the outcome of the member's performance in the program.

Exit Care Conference

To remove a member from the RCP, the RCP Administrator convenes a multidisciplinary Exit Care Conference. The case is evaluated to determine the RCP member's readiness for removal from the program, therapeutic situations or circumstances that may be present, and conditions that may contribute to the member's return to inappropriate utilization when removed from the program. Persons participating in the conference may include, but are not limited to, the following:

- Member's assigned care or case manager
- Lock-in PMP or designee
- Primary lock-in pharmacy staff or designee
- RCP Administrator's staff
- Pharmacy director or medical director

If any of these parties are unable to participate in the conference in person or via telephone, a brief letter of attestation and rationale for continued enrollment in or removal from the program may be submitted for consideration by the panel. Elements considered for review examine appropriateness of care and utilization, and may include the following:

- Indiana Scheduled Prescription Electronic Collection and Tracking (INSPECT) Program report
- Active diagnoses and corresponding medications (such as appropriateness of medications)
- Emergency room (ER) claims and reasons for using ER, consistent with desired quality outcomes of the program
- Input from care or case manager
- Input from lock-in PMP
- Input from primary lock-in pharmacy manager
- Care or case management activities and interventions with corresponding outcomes
- Number of denied claims

The RCP Administrator and care or case manager work together to complete a multidisciplinary exit care conference worksheet. All areas are completed before scheduling the conference with the exception of the action items and decision areas. Comments from the PMP and primary lock-in pharmacy manager may also be included if written statements have been provided from these individuals.

The RCP Administrator must maintain a care conference record that includes, at a minimum, the following:

- Member's PMP
- Date of the care conference
- Lock-in history
- How many times the member has been placed in the program
- Number of PMP changes and reason for the changes

Additional areas of interest include but are not limited to the following:

- INSPECT findings are reported to the appropriate individuals according to *Indiana Code IC 35-48-7*, as to whether the member has circumvented the program and paid cash for controlled substance prescriptions.
- Active diagnoses are listed, as well as an active medication list, to ensure that all diagnoses are being adequately treated and medications taken have an appropriate indication and are being used in an appropriate manner.
- ER claims are listed with the reason the ER was used during active enrollment in the program.
- Denied claims of significance are also included for review, as well as any attempts at early refills.

All documentation is completed by the RCP Administrator to determine if the member is to be removed from the RCP or remain in the program.

If significant questions arise during the discussion that must be answered before the group can make a final decision, the conference may be continued at a future date.

Conference Results

The conference results in one of three decisions:

1. The member has been compliant and is removed from the RCP.
2. The member has not been compliant and will continue in the RCP (for up to an additional two years).
3. If the member is referred to law enforcement because of suspected fraudulent practices, this referral does not terminate the member from the program. The member will continue in the RCP for two years.

If the member has been compliant with treatment plans and is removed from the RCP, the following occurs:

- The RCP Administrator enters an end date and reason for removing the member from the RCP in the *End Current RCP* section of the **Lock-In Providers** tab (see Figure 17). The IHCP Portal generates a letter for the RCP Administrator to send to the member stating that the member is no longer in the RCP; see the *Graduation from Program* section.
- The RCP Administrator continues to monitor the member's utilization pattern for six months to ensure that the member remains stabilized and does not revert to former behaviors of misuse.
- Managed care members continue to have direct access to a care or a case manager for questions or concerns as the member transitions out of the RCP.
- If care management observes during the trial period that a member reverts to misuse, the member may be reenrolled in the program before or at the end of the six-month trial period. If the member is re-enrolled in the program, the same procedures are reinitiated as if the member were newly enrolled in the program. The RCP reviewer may use data gathered during the six-month trial period to reenroll the member into the RCP. Care management notifies the member and lock-in PMP of the occurrence in addition to re-educating the member about appropriate behaviors, and that the RCP is reinitiated.

If the member has not been compliant, and the determination is made to continue the member's RCP enrollment, the RCP Administrator must create a new two-year restriction period in the RCP Status tab (Figure 16) and update applicable lock-in providers. The IHCP Portal generates a letter for the RCP Administrator to send to the member explaining the decision to continue the RCP enrollment; see the *Member Notification of Continued Program Enrollment Following Review* section.

If a member disputes review results, additional information may be submitted for review. If the member maintains that the treatment received and prescriptions obtained from other physicians was done *with PMP authorization*, the member may request that the applicable PMP provide the RCP Administrator with a written statement concerning additional physicians that the PMP added through referral to the member's lock-in list.

Early Removal From the RCP

Cases may be closed by the RCP Administrator before the end of the member's enrollment period for the following reasons:

- The member has been assigned to hospice care. When a member is approved for hospice care, the hospice PA analyst must notify the RCP Administrator so that the member can be removed from the RCP.
- The member appealed and received a judgment in favor of the appellant. The member's enrollment in the RCP ends when the RCP Administrator receives the notification from the FSSA Office of Administrative Law Professionals (for FFS members) or from the MCE (for managed care

members). Details regarding RCP appeal processes are provided to members in their initial RCP notification letter and the accompanying booklet.

- The member receives Medicare benefits in addition to IHCP Medicaid benefits. (Dually eligible members are not subject to placement in the RCP.)
- The member is deceased.
- The member is placed in a 590 Program facility.

Member Hearings and Appeals

Members may appeal their initial enrollment in the RCP, as well as decisions to continue their RCP enrollment, as follows:

- Members have 60 calendar days from the receipt of the initial notification letter to appeal their enrollment in the RCP. The member must respond within 10 calendar days of receiving notice to prevent automatic assignment to the program. If the member appeals after 10 calendar days but before 60 calendar days, the appeal is timely. However, the member's enrollment is initiated and remains in effect until the hearing occurs and the decision to rescind is rendered.
- A 60-day time period also applies to the appeal of a continued enrollment period in the RCP after a periodic review. Members who appeal a continued enrollment period remain in the program until the hearing decision is received from the administrative law judge (ALJ). In this event, the ALJ renders a decision to remove the member from the RCP or for the member to remain in the RCP.

Late appeals may be submitted for consideration, with good cause, as described in the following section.

Requesting a Hearing

> *Note: HIP, Hoosier Care Connect and Hoosier Healthwise members must exhaust the MCE's grievance and appeals process before requesting a hearing from the state as described in this section.*
>
> *Traditional Medicaid members submit appeals directly to the state.*

Members that would like to request a hearing must do so in writing to the FSSA Office of Administrative Law Professionals at the following address:

MS 04
Office of Administrative Law Professionals
Indiana Family and Social Services Administration
402 W. Washington St., Room E034
Indianapolis, IN 46204-2773

The Office of Administrative Law Professionals schedules the hearing and notifies the member and RCP Administrator that a hearing has been scheduled. If the member has a conflict with the date, the member must provide a written request to the Office of Administrative Law Professionals. This request must include three alternative dates and the member's reason for requesting a continuance. Copies are sent to the member, county caseworker (if applicable) and RCP Administrator.

The member may also submit a late appeal. All late appeals must be submitted in writing to the Office of Administrative Law Professionals. Late appeals must include relevant documentation to support the request and must demonstrate legal cause as to why a timely appeal could not be filed. On receipt of the supporting documentation, the FSSA typically schedules a hearing, and the ALJ hears the case when reasons of good cause were submitted about timeliness. The ALJ rules at the time of the hearing as to whether the hearing will proceed or be dismissed for timeliness.

The RCP Administrator is required to participate in the hearing. If the RCP Administrator wants to participate by telephone, the RCP Administrator must make this request in writing and receive approval from the Office of Administrative Law Professionals to do so. At a minimum, the RCP Administrator must submit the state's exhibits into the record, provide testimony and be available to the ALJ and the county caseworker (if applicable) to answer questions about any documentation in the member appeals information packet.

Other parties that may evaluate the decision to place a member in the RCP include, but are not limited to, the following:

- Clinical reviewer
- Outside specialty consultant
- Care or case manager

Member Appeals Information Packet

After the hearing is scheduled, the RCP Administrator must prepare to discuss the case by compiling the member appeals information packet. Member appeals information packets contain, but are not limited to, the following:

- Case file
- Member Summary Worksheet
- Overutilization of ER services, including requested ER medical records from select providers to show inappropriateness of utilization
- Copies of all notification letters
- Illegal drug activity, including copies of probable cause affidavits, arrest reports and sentencing papers in the original case file
- Illegal activity is mapped to utilization and to payment; INSPECT reports are also included to demonstrate cash payments
- Overutilization of physician services by specialty
- Medical record documentation
- Documentation citing inappropriate member behavior
- Letters or records from providers
- Care or case manager notes documenting attempted education and interventions
- Specific claims data supporting outlier utilization

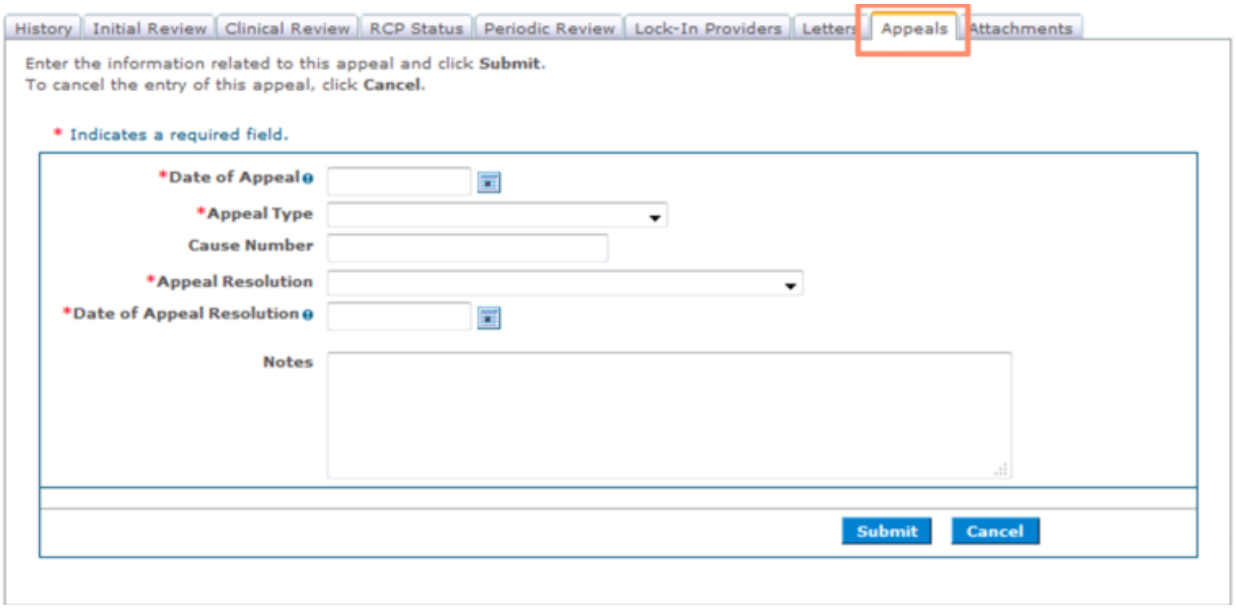
Copies of the member information packet must be provided to all relevant parties. Information that identifies a provider or RCP staff must be removed for confidentiality. If the member has signed a *Member Authorization* to release protected health information (PHI) to the member's attorney, a copy is sent to the attorney as stated in the *Release of Member Protected Health Information* section.

Member Appeal Outcomes

The ALJ may rescind the decision to enroll the member in the RCP after the hearing, or continue the member's RCP enrollment for up to two years if warranted. If the member had appealed within the initial 10 calendar days and, as a result, was not initially enrolled in the RCP, and the ALJ upholds the member enrollment, the member's enrollment is initiated effective the date of decision notification. The member and the RCP Administrator receive notification of the ALJ decision in writing.

The RCP Administrator records member appeal information and the result of the appeal in the IHCP Portal under the **Appeals** tab of the *Right Choices Program Member Summary* page for that member.

Figure 21 – Appeals Tab



Additional Administrative Responsibilities

The following sections outline additional administrative responsibilities of the RCP Administrator.

Quality Assurance and Quality Control

The RCP Administrator completes quality assurance (QA) reviews and quality control (QC) activities as determined by the contract (such as call monitoring and ensuring data-entry integrity) and maintains documentation of completed activities. Staff may also complete optional QA and QC activities for any phase of the RCP processes. Documentation is placed in the departmental files as appropriate. Results of the QA and QC reviews are made available to the FSSA when requested or as required by the MCE reporting manual.

Release of Member Protected Health Information

The RCP Administrator's privacy policy must be consistent with the IHCP privacy policy and the regulations set forth by the *Health Insurance Portability and Accountability Act* (HIPAA), and must be reviewed and approved by the FSSA.

The RCP Administrator's staff members must follow their privacy policy before releasing any information about a member. Persons other than the member may act on the member's behalf with appropriate authorization.

The RCP Administrator's staff members must follow their privacy policy before releasing any information about a member. Persons other than the member may act on the member's behalf with appropriate authorization.

> *Note: Covered entities, including providers, may be provided the minimum necessary information needed, per HIPAA regulations, for the member's related treatment, payment and healthcare operations. Treatment includes, "the provision, coordination, or management of health care and related services for an individual by one or more health care providers, including consultation between providers regarding a patient and referral of a patient by one provider to another." Case management and care coordination are included in healthcare operations.*

Authorized Representatives of the Member

RCP Administrators must provide members with a member authorization form to allow designated individuals to receive information about the member and to take actions on the member's behalf. If the member is unable to sign the form, the person having power of attorney or guardianship may complete the form and have it notarized. The completed form, along with a copy of the legal documentation giving the person the authority to act on the member's behalf, must be returned to the RCP Administrator. The original of any correctly completed forms are filed in the member's file. A copy of the form is sent to the RCP Administrator's privacy officer. The receipt of the member authorization form is noted in the RCP Administrator's database. Incorrect forms are returned to the member for correction. The RCP Administrator uses the official IHCP form and instructions. If no authorization form is received, no protected health information can be given to anyone other than the member or a covered entity (such as a provider), and no other entities can take actions on the member's behalf.

Members who appeal their enrollment in the RCP, as described in *Member Hearings and Appeals* section, may use the member authorization form to have the written appeal packet released to an attorney or other person. Any other release of PHI must be requested by the member through the RCP Administrator's privacy officer.

Telephone Transactions

For telephone transactions, the member or authorized member representative or covered entity (including providers requesting PHI per HIPAA regulations), must provide the following information at the beginning of each call:

- Member's first and last name
- IHCP Member ID
- At least three of the following four pieces of personally identifying information about the member:
  - Address that is listed in the IHCP Portal, *Core*MMIS or the RCP Administrator information system
  - Telephone number that is listed in the IHCP Portal, *Core*MMIS or the RCP Administrator information system
  - Date of birth
  - Social Security number (or the last four digits of the number)

RCP Performance Monitoring and Evaluation

The purpose of utilization management is to ensure that the right service is delivered at the right time in the right place for each member. The primary goal of the RCP is to safeguard against unnecessary or inappropriate use of Medicaid services and excess payments by identifying members whose behavior patterns and utilization practices may indicate abuse or overuse of IHCP service compared to their peers. To that end, the following program objectives and performance measures have been identified. The RCP Administrator and the FSSA monitor and evaluate the program quality and effectiveness based on these measures through on-site visits, annual external quality reviews (EQRs) and performance reporting.

RCP Objectives

The objectives of the RCP include the following:

- Reduce inappropriate use of pharmacy services, especially controlled substances and other items with potential for misuse or abuse
- Reduce inappropriate outpatient hospital use, especially use of the emergency room
- Reduce medical expenditures related to inappropriate use or overuse of services
- Improve the individual's health status by increasing the level of care coordination and utilization control for members enrolled in the RCP
- Increase provider participation in the RCP and improve provider satisfaction with the RCP

Performance Measures and Reporting Requirements

Performance measures have been developed to help the FSSA monitor the overall effectiveness of the RCP, and to assess progress toward the previously stated program objectives. The FSSA uses the following measures and monitors reports for these performance measures. Other program statistics are monitored by the FSSA quarterly for each program and plan. Data sources include the RCP Administrator's information systems, the IHCP Portal, *Core*MMIS and the RCP database.

The RCP Administrator's program statistics may include, but are not limited to, the following:

- Number of new RCP members
- Number of terminated RCP members
- Number of referrals to the FSSA Bureau of Investigation
- RCP administrative costs
- Number of inpatient visits and average length of stay
- Observation stays
- Number of PMP and specialist visits
- Average number and range of ER visits per year, per member by length of time in RCP (up to 12 months, 12 to 24 months, 24 to 36 months and so on) compared to preenrollment baseline
- Prescriptions
  - Average number and range of prescription drugs filled for controlled substances
  - Average number and range of prescription drugs for noncontrolled substances by therapeutic classes; for example, psychotropics, antihyperlipidemics, corticosteroids and anti-infectives (per year by length of time in RCP compared to preenrollment baseline)
  - Number of members attempting to receive early refills
  - Number of members receiving therapeutic duplicative prescriptions from multiple prescribers within 30 days

- Annual overall costs by PMP and by category of service (such as ER, pharmacy or physician)
- Number of members with an addiction or substance abuse diagnosis receiving addiction treatment services
- Providers
  - Total number of providers participating, and provider-to-member ratios by provider type (for example, physician or pharmacy)
  - Number of complaints and overall provider satisfaction with the RCP

Monitoring and Evaluation

The FSSA conducts monthly monitoring reviews of the RCP reports. The FSSA works with the RCP Administrator to assess program performance issues. A program evaluation is conducted every two years to review the appropriateness of the program objectives, performance measures, benchmarks and targets, and recommend any changes or adjustments deemed necessary to ensure the quality and ongoing value of the RCP.

Detecting and Reporting Fraud, Waste and Abuse

The FSSA, RCP Administrator, medical providers, pharmacy providers, as well as IHCP members and other private citizens, are empowered to raise issues of suspected fraud and abuse.

Member Fraud, Waste and Abuse

The following examples of inappropriate behaviors may be considered Medicaid fraud, waste or abuse:

- Paying cash for services covered by Medicaid which would exceed predetermined standards as outlined in *42 CFR 456.709(b)*
- Selling drugs, equipment or supplies obtained through Medicaid
- Allowing another individual to use a member's Medicaid identification card
- Being treated by several physicians for the same or similar medical condition
- Purchasing the same or similar medications from several different pharmacies
- Frequently using the hospital ER for services that are not considered emergencies

When a Medicaid member is suspected of such behavior, the activity must be identified, documented and reported to the RCP Administrator for further evaluation. If, after pertinent review, further action is required, the RCP Administrator should report the suspected activity to the FSSA Fraud Hotline at 800-457-4515 with simultaneous notification to the FSSA via ProgramIntegrity.FSSA@fssa.in.gov.

Providers and pharmacies are encouraged to report issues of suspected Medicaid member fraud to the FSSA Fraud Hotline. The state of Indiana's Medicaid Fraud Control Unit (MFCU) is not designed to pursue complaints of Medicaid member fraud. Therefore, all reports of suspected Medicaid member fraud received by MFCU are forwarded to the FSSA Fraud Hotline. The FSSA Bureau of Investigations, overseen by the chief of investigations in the Quality and Compliance Division of the FSSA Office of the General Counsel, operates the FSSA Fraud Hotline.

Medical and Pharmacy Provider Fraud, Waste and Abuse

The following examples of inappropriate behaviors may be considered Medicaid fraud, waste or abuse:

- Billing inappropriately, such as double billing or billing for services not provided
- Acting in violation of Indiana state statutes or Medicaid rules
- Billing members for services that should be billed to Medicaid
- Balance billing to members as defined in *42 CFR 447.15* (for example, billing individual patients for the difference between the amount paid by the state and the provider's customary charge)

When a Medicaid medical provider is suspected of such behavior, the activity must be identified, documented and reported to the RCP Administrator for further review and evaluation. If, after pertinent review, further action is required, the RCP Administrator must report the issue to the MFCU with a simultaneous notification to the FSSA via ProgramIntegrity.FSSA@fssa.in.gov.

Program Integrity Audit Services

Program Integrity staff within the FSSA Quality and Compliance Division ensures that correct payments are made to legitimate providers for appropriate and reasonable services to eligible Medicaid members. The FSSA Program Integrity staff's role is to investigate medical and pharmacy providers identified as potentially abusing services that are reimbursed by the IHCP. Provider or public complaints are received through the IHCP Provider and Member Concern Line, RCP Administrators or the Program Integrity audit process.

Individuals, such as Medicaid members or employees of a provider, may contact the IHCP Provider and Member Concern Line with issues of suspected fraud and abuse, as stated in the *Detecting and Reporting Fraud, Waste and Abuse* section of the *Right Choices Program* provider reference module. These issues are referred to FSSA Program Integrity for documentation, preliminary investigation and tracking. Research of claim history is conducted through the *Core*MMIS or MCE databases to determine type and volume of alleged abuse. If the allegations of the referral are substantiated through the FSSA Program Integrity review, the information is referred to the appropriate entity for further investigation and appropriate action. FSSA Program Integrity refers issues and coordinates efforts with the MFCU, the state, and county and local law enforcement agencies, and initiates referrals to the audit management staff for potential case assignment.

The MFCU determines if the referrals initiated by FSSA Program Integrity require further investigation for potential criminal or civil prosecution. The MFCU will advise FSSA Program Integrity to place a provider on hold within 10 business days. A hold is a request that neither FSSA Program Integrity nor the FSSA-contracted staff will initiate audit-related contact with the identified provider without prior approval from the MFCU. The FSSA-contracted vendor performs concurrent desk and on-site pharmacy audits of IHCP pharmacy providers. During these reviews, claims are examined for data entry and billing errors, as well as adherence to program policies and procedures. Providers with suspicious billing behaviors are referred to the MFCU for investigation.

Section 4: Right Choices Program Reporting

Right Choices Program (RCP) reports are designed to provide data and information to RCP Administrators that help the administrators manage their RCP client base. The Family and Social Services Administration (FSSA) may use summary reports to monitor overall plan administration and activity.

RCP Report Business Process and Verification Process

The RCP report business process/verification process is as follows:

1. Summary and Potential reports are systematically generated on the 15th of each month.
2. On or before the first Monday following the first Sunday of each month, the RCP report analyst verifies report production by accessing the designated Indiana Office of Technology (IOT) secure file transfer protocol (SFTP) server folder for each of the plans and for the FSSA.
3. The RCP report analyst opens a sampling of posted reports to verify that the correct report period is represented and that the data appears reasonable.

Enterprise Data Warehouse (EDW) produces the following reports, available as Excel workbooks, for RCP Administrators:

- *Right Choices Program Pharmacy Potentials*
- *Right Choices Program Monthly Summary Report*
  - *Right Choices Monthly Summary – Review Summary*
  - *Right Choices Program – Type of Review*
  - *Right Choices Program – Initial Review*
  - *Right Choices Program – Clinical Review*
  - *Right Choices Program – Periodic Review*
  - *Right Choices Program – Periodic Review Tracking Summary*
  - *Right Choices Program – Diagnosis Codes*
  - *Right Choices Program – Appeals*
  - *Right Choices Program – Provider and Member Summary*

The FSSA Division of Health Strategies and Technology manages the *Right Choices Pharmacy Potentials* report. This report is available to provide each RCP Administrator and the FSSA with information that may indicate program abuse. Data reported is based on pharmacy utilization per predefined clinical criteria, as received on a monthly data extract from Optum. Administrators can use the report to assess the risk of abuse or misutilization in consideration of further action, such as RCP enrollment. For more information, see the Optum/EDW *Potential Right Choices Program (RCP) Report User Guide*, accessible to MCE RCP Administrators from the *MCE Manuals* page at in.gov/medicaid/partners (user ID and password required). For FFS RCP Administrators, the manual is available on the FFS PA-UM SharePoint restricted-access RCP site (user ID and password required).

All other EDW reports in the preceding list are managed by Optum. These reports are run monthly to provide RCP information for each of these Indiana Health Coverage Programs (IHCP) programs:

- Healthy Indiana Plan (HIP)
- Hoosier Care Connect
- Hoosier Healthwise
- Traditional Medicaid

The RCP summary reports and files are run and posted to the IOT SFTP server on the 15th of each month. This run-and-post schedule accommodates inclusion of month-end data for the prior month that is processed and loaded to the EDW by the end of the previous month, which is the reporting period.

IOT SFTP server location and file naming conventions are as follows:

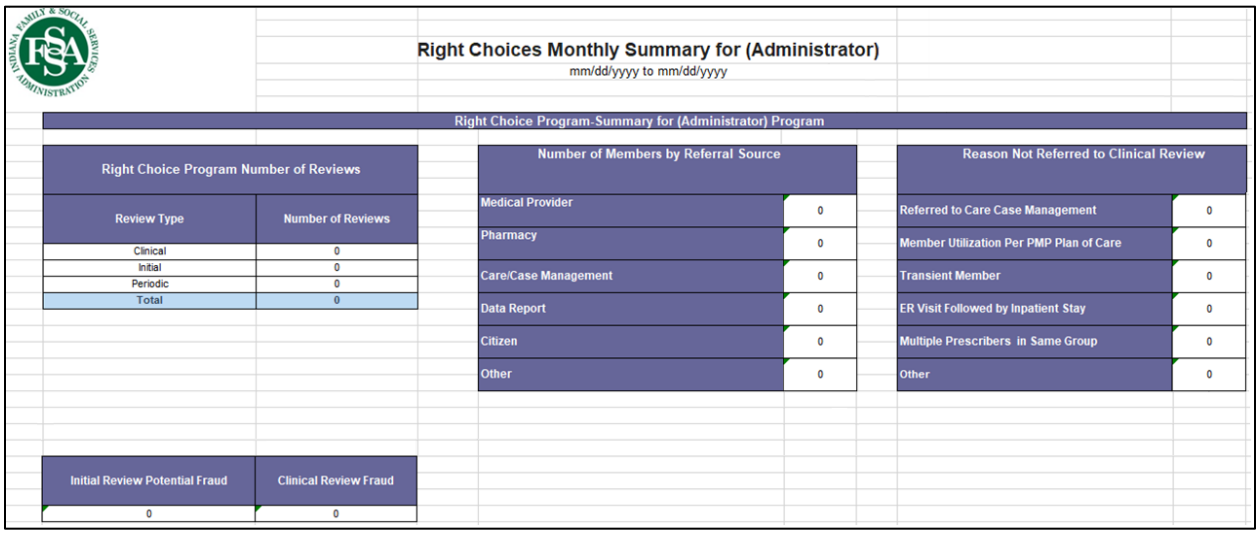
- /EDW/Anthem/OUT/RCP_Reports/
  Right Choices Program - Anthem <yyyy mm>.xlsx
- /EDW/CareSource/OUT/RCP_Reports/
  Right Choices Program - CareSource <yyyy mm>.xlsx
- /EDW/MDWise/OUT/RCP_Reports/
  Right Choices Program - MDwise <yyyy mm>.xlsx
- /EDW/MHS/OUT/RCP_Reports/
  Right Choices Program - MHS <yyyy mm>.xlsx
- /EDW/UHC/OUT/RCP_Reports/
  Right Choices Program – UHC <yyyy mm>.xlsx
- /Distribution/Optum/PA_Reports/
  Right Choices Program - MMIS <yyyy mm>.xlsx
- /EDW/OMPP Data Exchange/RCP_Reports/
  Right Choices Program - <plan (Anthem, CareSource, MDwise, MHS, UHC, MMIS)> <yyyy mm>.xlsx
- /EDW/OMPP Data Exchange/RCP_Reports/
  Right Choices Program (RCP) Monthly Summary Report - OMPP <yyyy mm>.xlsx
- /EDW/OMPP Data Exchange/RCP_Reports/
  Right Choices Program Pharmacy Potentials - <program (HCC, HHW, HIP, UHC, TM)>- OMPP <yyyy mm>.xlsx

These reports will also be uploaded to the FFS PA-UM SharePoint restricted-access RCP site for FFS RCP Administrator access.

Right Choices Monthly Summary – Review Summary

The *Right Choices Monthly Summary* report provides each RCP Administrator and the FSSA with a summary of RCP activity data for the month, reported for each IHCP program. Figure 22 provides an example of the report layout.

Figure 22 – Right Choices Monthly Summary – Review Summary



Right Choices Monthly Summary for (Administrator)
mm/dd/yyyy to mm/dd/yyyy

Right Choice Program-Summary for (Administrator) Program

Right Choice Program Number of Reviews

Review Type	Number of Reviews
Clinical	0
Initial	0
Periodic	0
Total	0

Initial Review Potential Fraud	Clinical Review Fraud
0	0

Number of Members by Referral Source

Medical Provider	0
Pharmacy	0
Care/Case Management	0
Data Report	0
Citizen	0
Other	0

Reason Not Referred to Clinical Review

Referred to Care Case Management	0
Member Utilization Per PMP Plan of Care	0
Transient Member	0
ER Visit Followed by Inpatient Stay	0
Multiple Prescribers in Same Group	0
Other	0

Field Definitions

Right Choices Program Number of Reviews – Number of reviews conducted during the month, by review type (Clinical, Initial and Periodic), and total number of reviews conducted. For the Total field, members are counted per review category. Example: If a member had an initial and clinical review during the report month, the member is counted twice in the total.

Number of Members by Referral Source – Number of members by source of referral for initial review, as indicated by the RCP Administrator in the **Demographic Information** section under the **Initial Review** tab on the IHCP Provider Healthcare Portal (IHCP Portal) *Right Choices Program Member Summary* page (see Figure 11). Selections are as follows:

- Medical Provider Referrals
- Pharmacy Referrals
- Care/Case Management Referrals
- Data Report Referrals
- Citizen Referrals
- Other Referrals

Reasons Not Referred to Clinical Review – Number of members by reason not referred on to clinical review, when clinical review is not warranted, as indicated by the RCP Administrator in the **Clinical Review Information** section under the **Initial Review** tab on the IHCP Portal *Right Choices Program Member Summary* page (see Figure 14). Selections are as follows:

- Referred to Care Case Management
- Member Utilization Per PMP Plan of Care

- Transient Member
- ER Visit Followed by Inpatient Stay
- Multiple Prescribers in Same Group
- Other

Initial Review Potential Fraud – Number of members for which "yes" is selected by the RCP Administrator in the **Member is suspected…** field in the **Automatic Review** section under the **Initial Review** tab on the IHCP Portal *Right Choices Program Member Summary* page (see Figure 13).

Clinical Review Potential Fraud – Number of members for which "yes" is selected by the RCP Administrator in the **Member reported to FSSA Bureau of Investigation?** field, under the **Clinical Review** tab on the IHCP Portal *Right Choices Program Member Summary* page (see Figure 13).

Right Choices Program – Types of Reviews

This report provides each RCP Administrator and the FSSA with a summary of RCP reviews performed for the month, reported by review type for each IHCP program. Figure 23 provides an example of the report layout.

Figure 23 – Right Choices Program – Types of Reviews

Right Choices Program - Types of Reviews
(Administrator) Program

Member ID	Member Last Name	Member First Name	Date of Review	Review Type
xxxxxxxxxxx	Last Name	First Name	mm/dd/yyyyy	Periodic
xxxxxxxxxxx	Last Name	First Name	mm/dd/yyyyy	Initial

Total Distinct Members: 2

Field Definitions

Member ID – IHCP Member ID number of member reviewed.

Member Last Name – Member's last name.

Member First Name – Member's first name.

Date of Review – Date when the review was completed by the RCP Administrator, as entered in the IHCP Portal.

Review Type – Type of review performed:

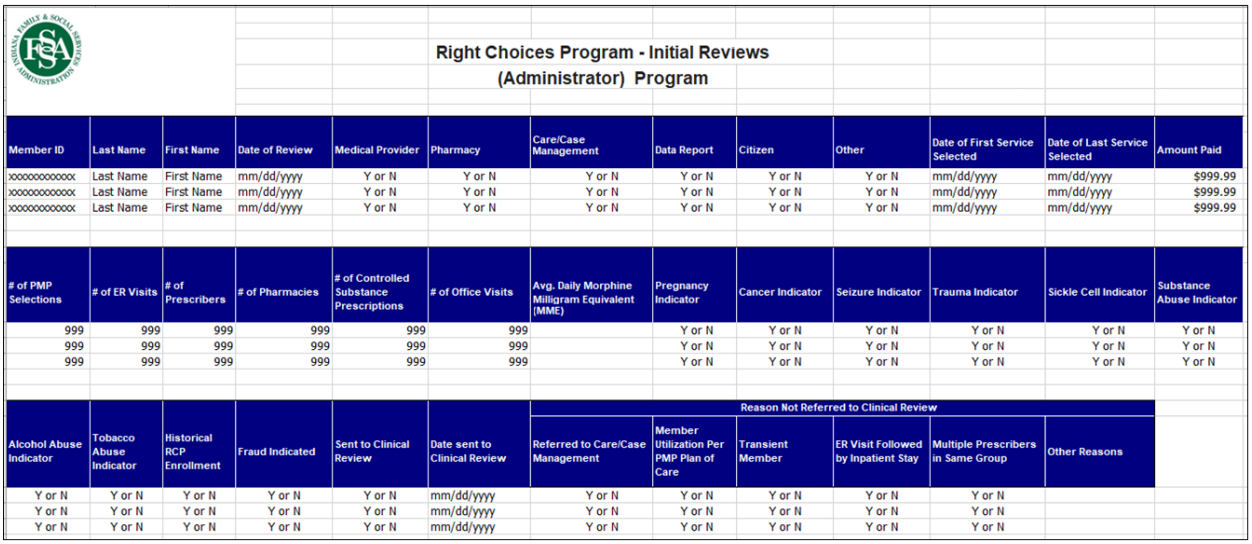
- Initial
- Clinical
- Periodic

Total Distinct Members – Total number of members for whom reviews were performed.

Right Choices Program – Initial Reviews

The *Right Choices Program – Initial Reviews* report provides each RCP Administrator and the FSSA with detailed information regarding initial reviews performed during the month, reported for each IHCP program. Figure 24 provides an example of the report layout.

Figure 24 – Right Choices Program – Initial Reviews



Right Choices Program - Initial Reviews
(Administrator) Program

Member ID	Last Name	First Name	Date of Review	Medical Provider	Pharmacy	Care/Case Management	Data Report	Citizen	Other	Date of First Service Selected	Date of Last Service Selected	Amount Paid
xxxxxxxxxxx	Last Name	First Name	mm/dd/yyyy	Y or N	Y or N	Y or N	Y or N	Y or N	Y or N	mm/dd/yyyy	mm/dd/yyyy	$999.99
xxxxxxxxxxx	Last Name	First Name	mm/dd/yyyy	Y or N	Y or N	Y or N	Y or N	Y or N	Y or N	mm/dd/yyyy	mm/dd/yyyy	$999.99
xxxxxxxxxxx	Last Name	First Name	mm/dd/yyyy	Y or N	Y or N	Y or N	Y or N	Y or N	Y or N	mm/dd/yyyy	mm/dd/yyyy	$999.99

# of PMP Selections	# of ER Visits	# of Prescribers	# of Pharmacies	# of Controlled Substance Prescriptions	# of Office Visits	Avg. Daily Morphine Milligram Equivalent (MME)	Pregnancy Indicator	Cancer Indicator	Seizure Indicator	Trauma Indicator	Sickle Cell Indicator	Substance Abuse Indicator
999	999	999	999	999	999		Y or N	Y or N	Y or N	Y or N	Y or N	Y or N
999	999	999	999	999	999		Y or N	Y or N	Y or N	Y or N	Y or N	Y or N
999	999	999	999	999	999		Y or N	Y or N	Y or N	Y or N	Y or N	Y or N

Alcohol Abuse Indicator	Tobacco Abuse Indicator	Historical RCP Enrollment	Fraud Indicated	Sent to Clinical Review	Date sent to Clinical Review	Reason Not Referred to Clinical Review					
						Referred to Care/Case Management	Member Utilization Per PMP Plan of Care	Transient Member	ER Visit Followed by Inpatient Stay	Multiple Prescribers in Same Group	Other Reasons
Y or N	Y or N	Y or N	Y or N	Y or N	mm/dd/yyyy	Y or N	Y or N	Y or N	Y or N	Y or N	
Y or N	Y or N	Y or N	Y or N	Y or N	mm/dd/yyyy	Y or N	Y or N	Y or N	Y or N	Y or N	
Y or N	Y or N	Y or N	Y or N	Y or N	mm/dd/yyyy	Y or N	Y or N	Y or N	Y or N	Y or N	

Field Definitions

Member ID – IHCP Member ID number of member reviewed.

Last Name – Member's last name.

First Name – Member's first name.

Date of Review – Date when the review was completed by the RCP Administrator, as entered in the IHCP Portal.

<Source> Referral – Y or N indicating the initial review source, as indicated by the RCP Administrator in the **Demographic Information** section under the **Initial Review** tab on the IHCP Portal *Right Choices Program Member Summary* page (see Figure 11):

- Medical Provider
- Pharmacy
- Care/Case Management
- Data Report
- Citizen
- Other

Date of First Service Selected – Beginning date of service for the period reviewed, as indicated by the RCP Administrator in the **From Date** field in the **Dates of Service Reviewed** section under the **Initial Review** tab on the IHCP Portal *Right Choices Program Member Summary* page (see Figure 9).

Date of Last Service Selected – Ending date of service for the period reviewed, as indicated by the RCP Administrator in the **To Date** field in the **Dates of Service Reviewed** section under the **Initial Review** tab on the IHCP Portal *Right Choices Program Member Summary* page (see Figure 9).

Amount Paid – Total amount paid during the review period, as automatically calculated by the system when the RCP Administrator progresses from the **Demographic Information** section to the **Utilization Information** section under the **Initial Review** tab on the IHCP Portal *Right Choices Program Member Summary* page (see Figure 12).

<*Utilization Indicators*> – Total numbers for each of six clinical review triggers, as automatically calculated when the RCP Administrator progresses from the **Demographic Information** section to the **Utilization Information** section under the **Initial Review** tab on the IHCP Portal *Right Choices Program Member Summary* page (see Figure 12):

- *# of PMP Selections* – Determined from the number of PMP assignments on file for the member during the time period reviewed.
- *# of ER Visits* – Determined from revenue codes 450 and 451 on claims paid with dates of service during the time period reviewed.
- *# of Prescribers* – Determined from unique National Provider Identifiers (NPIs) in the prescribing provider field of pharmacy claims paid with dates of service during the time period reviewed.
- *# of Pharmacies* – Determined from unique IHCP Provider ID in the billing provider field of pharmacy claims paid with dispense date during the time period reviewed.
- *# of Controlled Substance Prescriptions* – Determined by paid drug claims with dispense dates during the time period reviewed, with National Drug Code (NDC) Drug Enforcement Administration (DEA) classifications II, III and IV.
- *# of Office Visits* – Determined from the number of office visits for the Medicaid member during the reporting period (six months).
- *Avg. Daily Morphine Milligram Equivalent (MME)* – Determined by the morphine milligram equivalency for an individual within the given 90-day period across all pharmacy claims.

<*Health Indicators*> – Yes (Y) or No (N) answers for each of nine health indicators, as marked in the **Utilization Information** section under the **Initial Review** tab on the IHCP Portal *Right Choices Program Member Summary* page (see Figure 12):

- *Pregnancy Indicator*
- *Cancer Indicator*
- *Seizure Indicator*
- *Trauma Indicator*
- *Sickle Cell Indicator*
- *Substance Abuse Indicator*
- *Alcohol Abuse Indicator*
- *Tobacco Abuse Indicator*
- *Historical RCP Enrollment Indicator*

Fraud Indicated – Y or N, as selected by the RCP Administrator in the **Member is suspected…** field in the **Automatic Review** section under the **Initial Review** tab on the IHCP Portal *Right Choices Program Member Summary* page (see Figure 13).

Sent to Clinical Review – Y or N, as selected by the RCP Administrator in the **Clinical Review Warranted?** field in the **Clinical Review Information** section under the **Initial Review** tab on the IHCP Portal *Right Choices Program Member Summary* page (see Figure 14).

Date Sent to Clinical Review – Date sent to clinical review, as indicated by the RCP Administrator in the **Date Sent to Clinical Review** field in the **Clinical Review Information** section under the **Initial Review** tab on the IHCP Portal *RCP Member Summary* page (see Figure 14).

Reasons Not Referred to Clinical Review – Y or N indicating reason not referred to clinical review, if clinical review is not warranted, as indicated by the RCP Administrator in the **Clinical Review Information** section under the **Initial Review** tab on the IHCP Portal *RCP Member Summary* page (see Figure 14). Selections are as follows:

- *Referred to Care/Case Management*
- *Member Utilization Per PMP Plan of Care*
- *Transient Member*
- *ER Visit Followed by Inpatient Stay*
- *Multiple Prescribers in Same Group*
- *Other Reasons*

Right Choices Program – Clinical Reviews

The *Right Choices Program – Clinical Reviews* report provides each RCP Administrator and the FSSA with detailed information regarding clinical reviews performed during the month reported for each IHCP program. Figure 25 provides an example of the report layout.

Figure 25 – Right Choices Program – Clinical Reviews

Right Choices Program - Clinical Reviews
(Administrator) Program

Member ID	Last Name	First Name	Date of Review	Review Result	Reported to FSSA Bureau of Investigation	Date Completed
xxxxxxxxxxx	Last Name	First Name	mm/dd/yyyy	Placed on RCP	Y or N	mm/dd/yyyy
xxxxxxxxxxx	Last Name	First Name	mm/dd/yyyy	Placed on RCP	Y or N	mm/dd/yyyy
xxxxxxxxxxx	Last Name	First Name	mm/dd/yyyy	Placed on RCP	Y or N	mm/dd/yyyy

Field Definitions

Member ID – IHCP Member ID number of member reviewed.

Last Name – Member's last name.

First Name – Member's first name.

Date of Review – Date when the RCP Administrator selected **Submit** under the **Clinical Review** tab in the IHCP Portal, on completion of clinical review data entry (see Figure 15).

Review Result – Result of the clinical review, as selected by the RCP Administrator in the **Review Results** field under the **Clinical Review** tab in the IHCP Portal (see Figure 15). Selections are as follows*:*

- Placed on RCP
- Not on RCP: Clinically Appropriate Behaviors
- Not on RCP: See Case Management

Reported to FSSA Bureau of Investigation – Y or N indicating whether the case was referred to the Medicaid Fraud Control Unit, as entered by the RCP Administrator in the **Member reported to FSSA Bureau of Investigation?** field under the **Clinical Review** tab in the IHCP Portal (see Figure 15).

Date Completed – Date entered by the RCP Administrator in the **Date Review Completed** field under the **Clinical Review** tab in the IHCP Portal (see Figure 15).

Right Choices Program – Periodic Reviews

The *Right Choices Program – Periodic Reviews* report provides each RCP Administrator and the FSSA with detailed information regarding periodic reviews performed during the month reported for each IHCP program. Figure 26 provides an example of the report layout.

Figure 26 – Right Choices Program – Periodic Reviews

Right Choices Program - Periodic Reviews
(Administrator) Program

Summary of Periodic Review	
Number of Periodic Reviews	999
Number of Periodic Reviews Results: Graduated	999
Number of Periodic Reviews Results: Returnees	999

Member ID	Last Name	First Name	Date of Review	Date of First Service	Date of Last Service	Amount Paid	# of PMP Selections	# of ER Visits
xxxxxxxxxxx	Last Name	First Name	mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy	$9,999.99	999	999

# of Prescribers	# of Pharmacies	# of Controlled Substance Prescriptions	# of Office Visits	Avg. Daily Morphine Milligram Equivalent (MME)	Periodic Review Results	RCP End Date	Reason RCP Ended
999	999	999	999		X	mm/dd/yyyy	

Total Distinct Members: 999

Field Definitions

Number of Periodic Reviews – Total number of periodic reviews conducted.

Number of Periodic Reviews Results: Graduated – Number of periodic reviews resulting in the member graduating from RCP.

Number of Periodic Review Results: Returnees – Number of periodic reviews resulting in the member being returned to RCP.

Member ID – IHCP Member ID number of the member reviewed.

Last Name – Member's last name.

First Name – Member's first name.

Date of Review – Date when the RCP Administrator selected **Submit** under the **Periodic Review** tab on the IHCP Portal *Right Choices Program Member Summary* page, upon completion of periodic review data entry (see Figure 20).

Date of First Service – Beginning date of service for the period reviewed, as indicated by the RCP Administrator in the **From Date** field in the **Dates of Service Reviewed From** section under the **Periodic Review** tab on the IHCP Portal *Right Choices Program Member Summary* page (see Figure 19).

Date of Last Service – Ending date of service for the period reviewed, as indicated by the RCP Administrator in the **To Date** field in the **Dates of Service Reviewed To** section under the **Periodic Review** tab on the IHCP Portal *Right Choices Program Member Summary* page (see Figure 19).

Amount Paid – Total amount paid for claims during the review period, as automatically calculated by the system when the RCP Administrator progresses from the **Demographic Information** section to the **Utilization Information** section under the **Periodic Review** tab on the IHCP Portal *Right Choices Program Member Summary* page (see Figure 20).

<*Utilization Indicators*> – Totals for each of six periodic review triggers, as automatically calculated by the system when the RCP Administrator progresses from the **Demographic Information** section to the **Utilization Information** section under the **Periodic Review** tab on the IHCP Portal *Right Choices Program Member Summary* page (see Figure 20):

- *# of PMP Selections* – Determined from the number of PMP assignments on file for the member during the time period reviewed.
- *# of ER Visits* – Determined from revenue codes 450 and 451 on claims paid with dates of service during the time period reviewed.
- *# of Prescribers* – Determined from unique NPIs in the prescribing provider field of pharmacy claims paid with dates of service during the time period reviewed.
- *# of Pharmacies* – Determined from the unique IHCP Provider ID in the billing provider field of pharmacy claims paid with dispense dates during the time period reviewed.
- *# of Controlled Substance Prescriptions* – Determined by paid drug claims with dispense dates during the time period reviewed, with NDC code DEA classifications II, III, and IV.
- *# of Office Visits* – Determined from the number of office visits for the Medicaid member during the reporting period (six months).
- *Avg. Daily Morphine Milligram Equivalent (MME)* – Determined by the morphine milligram equivalency for an individual within the given 90-day period across all pharmacy claims.

Periodic Review Results – Result of the periodic review, as selected by the RCP Administrator in the **Review Results** field in the **Periodic Review Information** section under the **Periodic Review** tab on the IHCP Portal *Right Choices Program Member Summary* page (see Figure 20). Selections are as follows:

- Remain on RCP
- Graduate from RCP

RCP End Date – If the RCP Administrator determines that RCP should end, the Administrator enters the end date in the **End Date** field in the **End Current RCP** section under the **Lock-In Providers** tab on the IHCP Portal *Right Choices Program Member Summary* page (see Figure 17).

Reason RCP Ended – If the RCP Administrator determines that RCP should end, the Administrator selects the reason in the **Reason** field in the **End Current RCP** section under the **Lock-In Providers** tab on the IHCP Portal *RCP Member Summary* page (see Figure 17). Selections are as follows:

- Graduate from RCP
- Successful Member Appeal
- Other <*text*>

Total Distinct Members – Total count of distinct members.

Right Choices Program – Periodic Review Tracking Summary

The *Right Choices Program – Periodic Review Tracking Summary* report provides each RCP Administrator and the FSSA with detailed information that allows tracking of RCP members eligible or overdue for a periodic review by predesignated time intervals, for each IHCP program. Figure 27 provides an example of the report layout.

Figure 27 – Right Choices Program – Periodic Review Tracking Summary

Right Choices Program - Periodic Review Tracking Summary
(Administrator) Program

Aging	RCP Program	Member ID	RCP Start Date	Periodic Review Due Date	Periodic Review Start Date	Days Between Periodic Review Due and Start Dates	Days Between Current and Periodic Review Dates
1 - 30 Days	(Administrator/Program)	xxxxxxxxxxxx	mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy	999	999
1 - 30 Days Totals:		**999**					
31 - 60 Days	(Administrator/Program)	xxxxxxxxxxxx	mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy	999	999
31 - 60 Days Totals:		**999**					
61 - 90 Days	(Administrator/Program)	xxxxxxxxxxxx	mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy	999	999
61 - 90 Days Totals:		**999**					
Over 90 Days	(Administrator/Program)	xxxxxxxxxxxx	mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy	999	999
Over 90 Days Totals:		**999**					
Future	(Administrator/Program)	xxxxxxxxxxxx	mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy	999	999
Future Totals:		**999**					
Total number of periodic review members							999

Field Definitions

Aging – Predefined time intervals, indicating when the periodic review is due. Time intervals follow and are determined by the *Days Between Periodic Review Due and Start Dates* field or the *Days Between Current and Periodic Review Dates* field in this report, as defined by the following*:*

- 1–30 days overdue
- 31–60 days overdue
- 61–90 days overdue
- Over 90 days overdue
- Future due date

> *Note: Days report as negative if the periodic review was completed before the scheduled due date, or if the due date is in the future.*

RCP Program – The RCP Administrator plan name and program.

Member ID – IHCP Member ID number of RCP member listed.

RCP Start Date – The beginning date of the currently active RCP enrollment period, as entered by the RCP Administrator in the **Date RCP Starts** field under the **RCP Status** tab on the IHCP Portal *Right Choices Program Member Summary* page (see Figure 16).

Periodic Review Due Date – The date the RCP Administrator enters, when activating RCP for a member, in the **Periodic Review Date** field under the **RCP Status** tab on the IHCP Portal *Right Choices Program Member Summary* page (see Figure 16). If the restriction is continued after the initial placement, a new lock-in period is created and the new end date is entered in the **Periodic Review Date** field.

Periodic Review Start Date – Date when the RCP Administrator selected **Submit** under the **Periodic Review** tab on the IHCP Portal *Right Choices Program Member Summary* page, after entering periodic review data (see Figure 20).

Days Between Periodic Review Due and Start Dates – If the **Periodic Review Start Date** field on the report is not blank, this field shows the result of the **Periodic Review Start Date** field minus the **Periodic Review Due Date** field.

Days Between Current and Periodic Review Dates – If the **Periodic Review Start Date** field on the report is blank, this field shows the result of the date the report was run minus the **Periodic Review Due Date** field; otherwise, this field is blank.

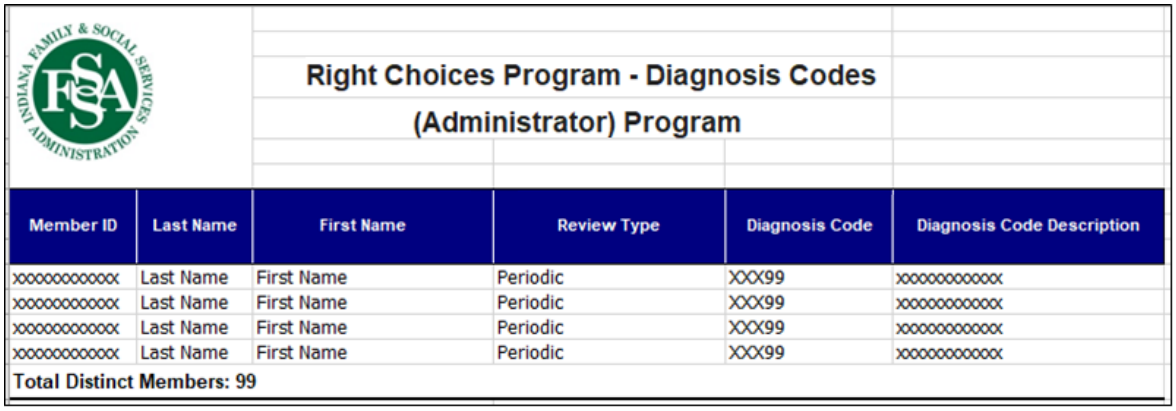
Future Totals – Total number of periodic reviews scheduled.

Total number of periodic review members – Total number of distinct members with a periodic review scheduled.

Right Choices Program – Diagnosis Codes

The *Right Choices Program – Diagnosis Codes* report provides each RCP Administrator and the FSSA with detailed information indicating the diagnosis codes reviewed for each review type performed during the report period for each IHCP program. Figure 28 provides an example of the report layout.

Figure 28 – Right Choices Program – Diagnosis Codes



Right Choices Program - Diagnosis Codes

(Administrator) Program

Member ID	Last Name	First Name	Review Type	Diagnosis Code	Diagnosis Code Description
xxxxxxxxxxx	Last Name	First Name	Periodic	XXX99	xxxxxxxxxxx
xxxxxxxxxxx	Last Name	First Name	Periodic	XXX99	xxxxxxxxxxx
xxxxxxxxxxx	Last Name	First Name	Periodic	XXX99	xxxxxxxxxxx
xxxxxxxxxxx	Last Name	First Name	Periodic	XXX99	xxxxxxxxxxx

Total Distinct Members: 99

Field Definitions

Member ID – IHCP Member ID number of the member reviewed.

Last Name – Member's last name.

First Name – Member's first name.

Review Type – Type of review performed:

- Initial
- Clinical
- Periodic

Diagnosis Code – International Classification of Diseases (ICD) diagnosis code, as selected by the RCP Administrator in the IHCP Portal when completing the initial, clinical or periodic review. The user selects up to 15 diagnoses on the following screens, according to review type performed:

- Initial – **Initial Review** tab, **Demographic Information** section, **Diagnosis Codes** panel (see Figure 11)
- Clinical – **Clinical Review** tab, **Diagnosis Codes** panel (see Figure 15)
- Periodic – **Periodic Review** tab, **Demographic Information** section, **Diagnosis Codes** panel (see Figure 20)

Diagnosis Code Description – Diagnosis code description, auto population as associated with the diagnosis codes selected by the RCP Administrator.

Total Distinct Members – Total number of members for whom reviews were performed.

Right Choices Program – Appeals

The *Right Choices Program – Appeals* report provides each RCP Administrator and the FSSA with detailed information related to open appeals and appeals resolved during the reporting month for each IHCP program. Figure 29 provides an example of the report layout.

Figure 29 – Right Choices Program – Appeals

Right Choices Program - Appeals
(Administrator) Program

Member ID	Member Name	Date of Appeal	Appeal Type	Appeal Resolution	Date of Appeal Resolution	Date Clinical Review completed	Clinical Review Results
xxxxxxxxxxx	Recipient Name	mm/dd/yyyy	F - FSSA	O - Overturned	mm/dd/yyyy	mm/dd/yyyy	P - Placed on RCP
xxxxxxxxxxx	Recipient Name	mm/dd/yyyy	M - MCE	U - Upheld	mm/dd/yyyy	mm/dd/yyyy	B - Appropriate Behavior
xxxxxxxxxxx	Recipient Name	mm/dd/yyyy	F - FSSA	D- Dismissed	mm/dd/yyyy	mm/dd/yyyy	C- Refer to CM

Field Definitions

Member ID – IHCP Member ID number of the member reviewed.

Member Name – Member's first and last name.

Date of Appeal – The date of the appeal, as entered by the RCP Administrator in the **Date of Appeal** field under the **Appeals** tab on the IHCP Portal *Right Choices Program Member Summary* page (see Figure 14).

Appeal Type – One-character alpha code indicating the appeal type, as selected by the RCP Administrator in the **Appeal Type** field under the **Appeals** tab on the IHCP Portal *Right Choices Program Member Summary* page (see Figure 21). Selections are as follows:

- M – MCE
- F – FSSA

Appeal Resolution – One-character alpha code indicating the appeal resolution, as selected by the RCP Administrator in the **Appeal Resolution** field under the **Appeals** tab on the IHCP Portal *Right Choices Program Member Summary* page (see Figure 21). Selections are as follows*:*

- U – Upheld – Decision upheld; member on RCP
- O – Overturned – Decision overturned; member removed or released from RCP
- D – Dismissed – Appeal dismissed; member on RCP

Date of Appeal Resolution – Date that the appeal was resolved, as entered by the RCP Administrator in the **Date of Appeal Resolution** field under the **Appeals** tab on the IHCP Portal *Right Choices Program Member Summary* page (see Figure 21).

Date Clinical Review Completed – The date the clinical review being appealed was completed, as entered by the RCP Administrator in the **Date Review Completed** field under the **Clinical Review** tab in the IHCP Portal (see Figure 15).

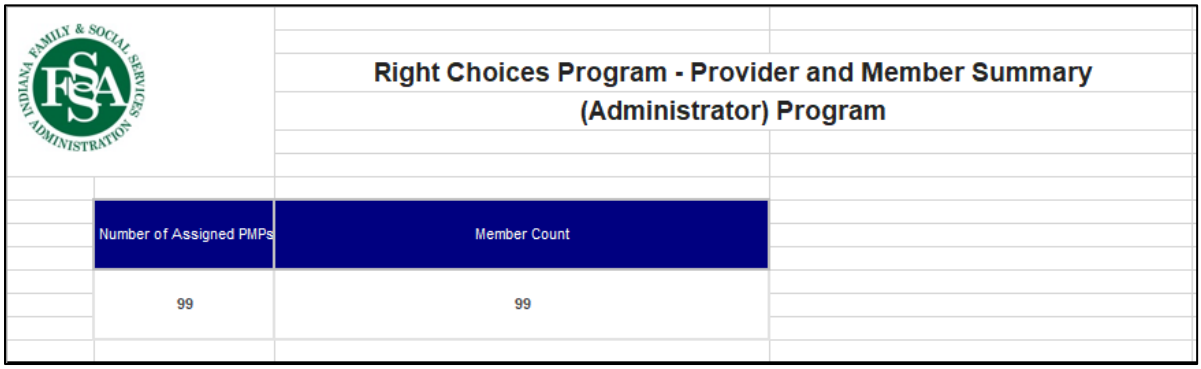
Clinical Review Result – One-character alpha code indicating the finding from the clinical review being appealed, as selected by the RCP Administrator in the **Review Results** field under the **Clinical Review** tab in the IHCP Portal (see Figure 15). Selections are as follows:

- P – Placed on RCP
- B – Appropriate Behavior – Not on RCP
- C – Refer to CM – Not on RCP; refer to case management

Right Choices Program – Provider and Member Summary

The *Right Choices Program – Provider and Member Summary* report provides each RCP Administrator and the FSSA with detailed information related to lock-in providers associated with RCP members during the reporting month for each IHCP program. Figure 30 provides an example of the report layout.

Figure 30 – Right Choices Program – Provider and Member Summary



Field Definitions (Summary Fields)

> *Note: Providers for which the **PMP** checkbox has been selected and whose effective dates are within the reporting month are the only ones that are reported in these summary fields.*

Number of Assigned PMPs – Summary count of assigned PMPs for RCP as reported for the individual RCP Administrator program.

Member Count – Summary count of members enrolled in RCP as reported for the individual RCP Administrator program.

Right Choices Program Monthly Summary Report

The *Right Choices Program Monthly Summary Report* provides the FSSA with high-level statistics regarding reviews performed during the reporting month; report per RCP Administrator and program. Figure 31 provides an example of the report layout.

Figure 31 – Right Choices Program Monthly Summary Report

Right Choices Program Monthly Summary Report

mm/dd/yyyy to mm/dd/yyyy

As of Date: mm/dd/yyyy

RCP Administrator and Program	Number of Initial Reviews	Potential Fraud	Citizen Referrals	Data Referrals	Pharmacy Referrals	Provider Referrals	Care Management Referrals	Other Referrals
Anthem - HCC	999	999	999	999	999	999	999	999
Anthem - HHW	999	999	999	999	999	999	999	999
Anthem - HIP	999	999	999	999	999	999	999	999
CareSource - HHW	999	999	999	999	999	999	999	999
CareSource - HIP	999	999	999	999	999	999	999	999
MMIS	999	999	999	999	999	999	999	999
MDWise - HCC	999	999	999	999	999	999	999	999
MDwise - HHW	999	999	999	999	999	999	999	999
MDwise - HIP	999	999	999	999	999	999	999	999
MHS - HCC	999	999	999	999	999	999	999	999
MHS - HHW	999	999	999	999	999	999	999	999
MHS - HIP	999	999	999	999	999	999	999	999
Total	**999**	**999**	**999**	**999**	**999**	**999**	**999**	**999**

RCP Administrator and Program	Referred to Care/Case Management	Member Utilization per PMP plan of care	Transient Member	ER Visit Followed by Inpatient Stay	Multiple Prescribers in same Group	Other
Anthem - HCC	999	999	999	999	999	999
Anthem - HHW	999	999	999	999	999	999
Anthem - HIP	999	999	999	999	999	999
CareSource - HHW	999	999	999	999	999	999
CareSource - HIP	999	999	999	999	999	999
MMIS	999	999	999	999	999	999
MDWise - HCC	999	999	999	999	999	999
MDwise - HHW	999	999	999	999	999	999
MDwise - HIP	999	999	999	999	999	999
MHS - HCC	999	999	999	999	999	999
MHS - HHW	999	999	999	999	999	999
MHS - HIP	999	999	999	999	999	999
Total	**999**	**999**	**999**	**999**	**999**	**999**

Field Definitions

Number of Initial Reviews – Number of initial reviews performed during the reporting month, as reported on each corresponding individual RCP Administrator/program *RCP Monthly Summary Report – Initial Review* tab.

Potential Fraud – Number of initial reviews performed where potential fraud is indicated, as reported on each corresponding individual RCP Administrator/program *RCP Monthly Summary Report – Initial Review* tab.

Citizen Referrals – Number of initial reviews performed that reported as **Referred By – Citizen** on each corresponding individual RCP Administrator/program *RCP Monthly Summary Report – Initial Review* tab.

Data Referrals – Number of initial reviews performed that reported as **Referred By – Data Report** on each corresponding individual RCP Administrator/program *RCP Monthly Summary Report – Initial Review* tab.

Pharmacy Referrals – Number of initial reviews performed that reported as **Referred By – Pharmacy** on each corresponding individual RCP Administrator/program *RCP Monthly Summary Report – Initial Review* tab.

Provider Referrals – Number of initial reviews performed that reported as **Referred By – Medical Provider** on each corresponding individual RCP Administrator/program *RCP Monthly Summary Report – Initial Review* tab.

Care Management Referrals – Number of initial reviews performed that reported as **Referred By – Care/Case Management** on each corresponding individual RCP Administrator/program *RCP Monthly Summary Report – Initial Review* tab.

Other Referrals – Number of initial reviews performed that reported as **Referred By – Other** on each corresponding individual RCP Administrator/program *RCP Monthly Summary Report – Initial Review* tab.

Referred to Care/Case Management – Number of initial reviews performed that reported as **Clinical Review not warranted – Referred to care/case management** on each corresponding individual RCP Administrator/program *RCP Monthly Summary Report – Initial Review* tab.

Member Utilization per PMP plan of care – Number of initial reviews performed that reported as **Clinical Review not warranted – Member utilization per PMP plan of care** on each corresponding individual RCP Administrator/plan *RCP Monthly Summary Report – Initial Review* tab.

Transient Member – Number of initial reviews performed that reported as **Clinical Review not warranted – Transient member** on each corresponding individual RCP Administrator/program *RCP Monthly Summary Report – Initial Review* tab.

ER Visit Followed by Inpatient Stay – Number of initial reviews performed that reported as **Clinical Review not warranted – ER visit followed by inpatient stay** on each corresponding individual RCP Administrator/program *RCP Monthly Summary Report – Initial Review* tab.

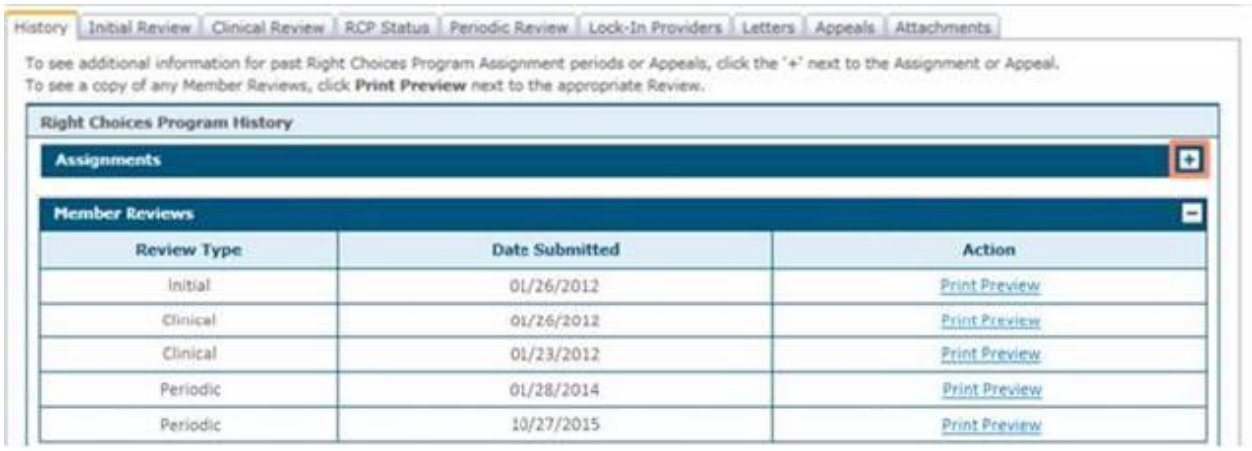
Multiple Prescribers in same Group – Number of initial reviews performed that reported as **Clinical Review not warranted – Multiple prescribers in same group** on each corresponding individual RCP Administrator/program *RCP Monthly Summary Report – Initial Review* tab.

Other – Number of initial reviews performed that reported as **Clinical Review not warranted – Other** on each corresponding individual RCP Administrator/program *RCP Monthly Summary Report – Initial Review* tab.

Section 5: Right Choices Program Member Summary Worksheets

The Right Choices Program (RCP) Administrator uses the Provider Healthcare Portal (IHCP Portal) to complete member reviews as described in *Section 3: Right Choices Program Administrator Responsibilities*. Completed reviews may be printed or downloaded from the history tab of the member's *Right Choices Program Member Summary* page.

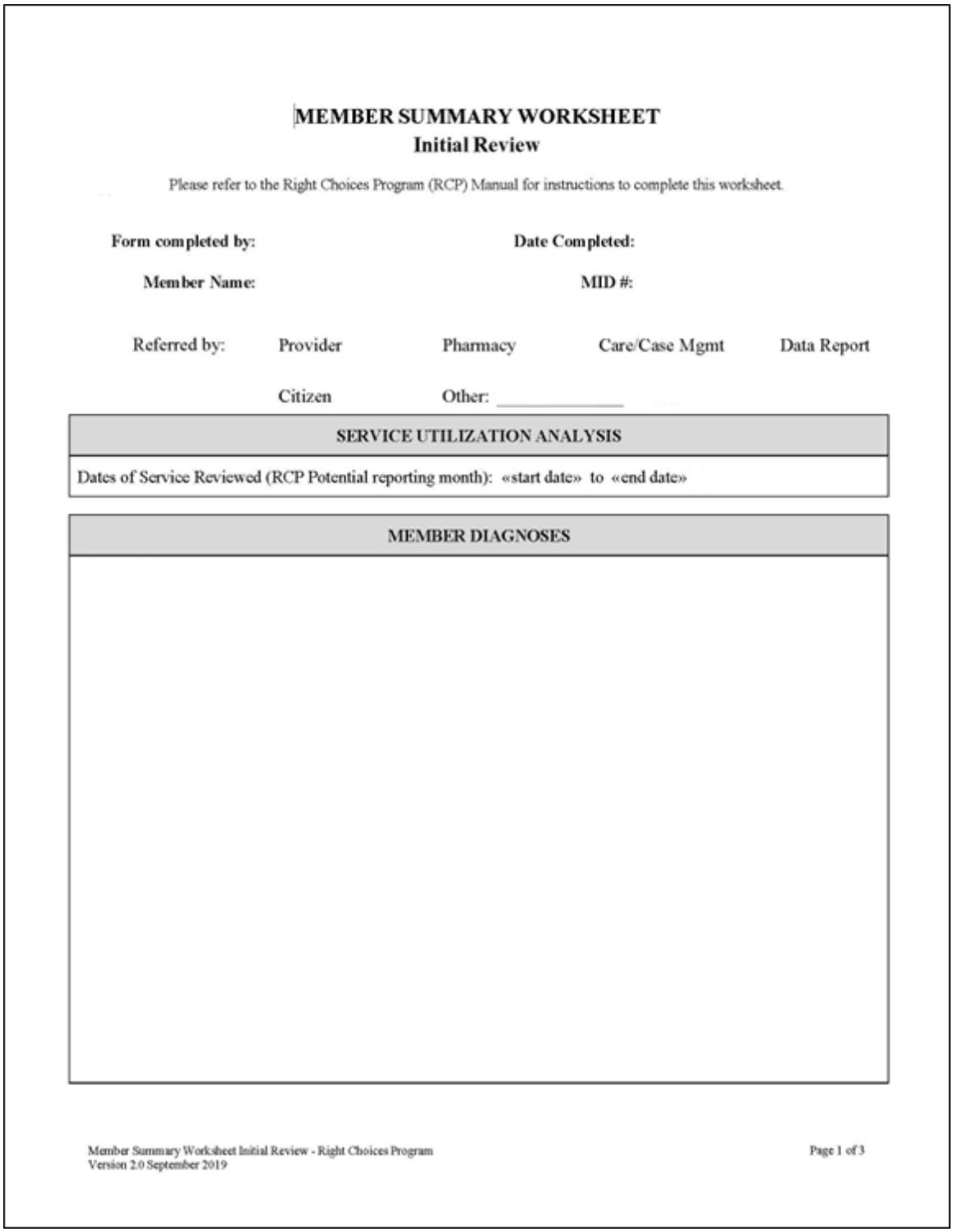
Figure 32 – History Tab



The following figures show the worksheets that correspond to each completed review on the IHCP Portal.

Member Summary Worksheet Initial Review

Figure 33 – Member Summary Worksheet Initial Review (Page 1 of 3)



MEMBER SUMMARY WORKSHEET
Initial Review

Please refer to the Right Choices Program (RCP) Manual for instructions to complete this worksheet.

Form completed by: **Date Completed:**

Member Name: **MID #:**

Referred by: Provider Pharmacy Care/Case Mgmt Data Report

Citizen Other: _____

SERVICE UTILIZATION ANALYSIS
Dates of Service Reviewed (RCP Potential reporting month): «start date» to «end date»

MEMBER DIAGNOSES

Member Summary Worksheet Initial Review - Right Choices Program
Version 2.0 September 2019

Page 1 of 3

Figure 33 – Member Summary Worksheet Initial Review (Page 2 of 3)

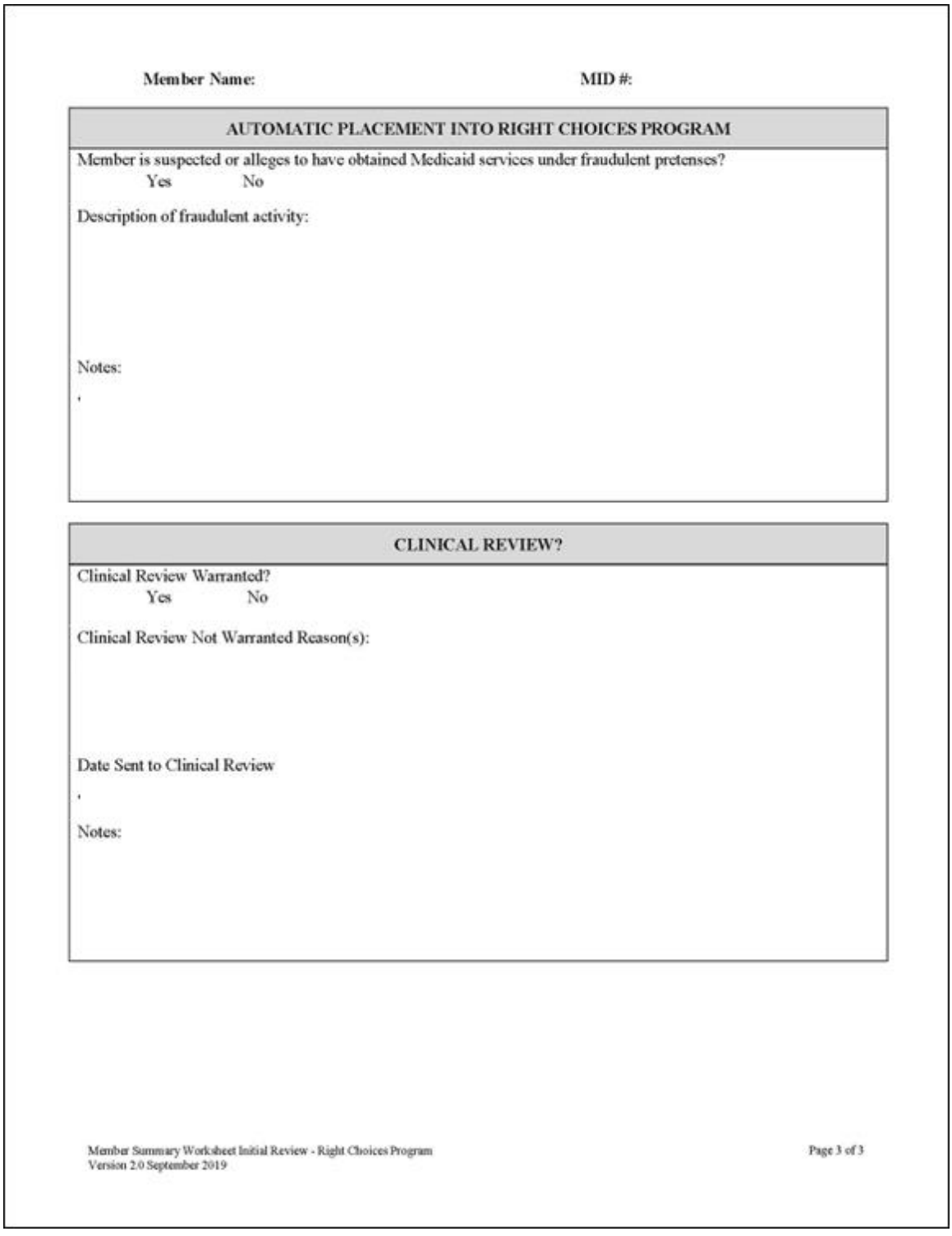
Member Name: **MID #:**

UTILIZATION ANALYSIS			
Total Dollar Amount of Paid Claims during the Review Period:			
Potential RCP Member Summary	**Member's Total**	**Health Indicators**	**Yes / No**
Number of PMP		Pregnancy Indicator	
Number of ER or Urgent Care Visits		Cancer Indicator	
Number of Prescribers		Seizure Indicator	
Number of Pharmacies		Trauma Indicator	
Number of Controlled Substance Prescriptions		Sickle Cell Indicator	
Number of Office Visits		Substance Abuse Indicator	
Average Daily Morphine Milligram Equivalent (MME)		Alcohol Abuse Indicator	
		Tobacco Abuse Indicator	
		Historical RCP Enrollment	

Member Summary Worksheet Initial Review - Right Choices Program
Version 2.0 September 2019

Page 2 of 3

Figure 33 – Member Summary Worksheet Initial Review (Page 3 of 3)



Member Name: **MID #:**

AUTOMATIC PLACEMENT INTO RIGHT CHOICES PROGRAM
Member is suspected or alleges to have obtained Medicaid services under fraudulent pretenses? Yes No Description of fraudulent activity: Notes: ,

CLINICAL REVIEW?
Clinical Review Warranted? Yes No Clinical Review Not Warranted Reason(s): Date Sent to Clinical Review , Notes:

Member Summary Worksheet Initial Review - Right Choices Program
Version 2.0 September 2019

Page 3 of 3

Member Summary Worksheet Clinical Review

Figure 34 – Member Summary Worksheet Clinical Review (Page 1 of 2)

MEMBER SUMMARY WORKSHEET
Clinical Review

Please refer to the Right Choices Program (RCP) Manual for instructions to complete this worksheet.

Member Name: **MID #:**

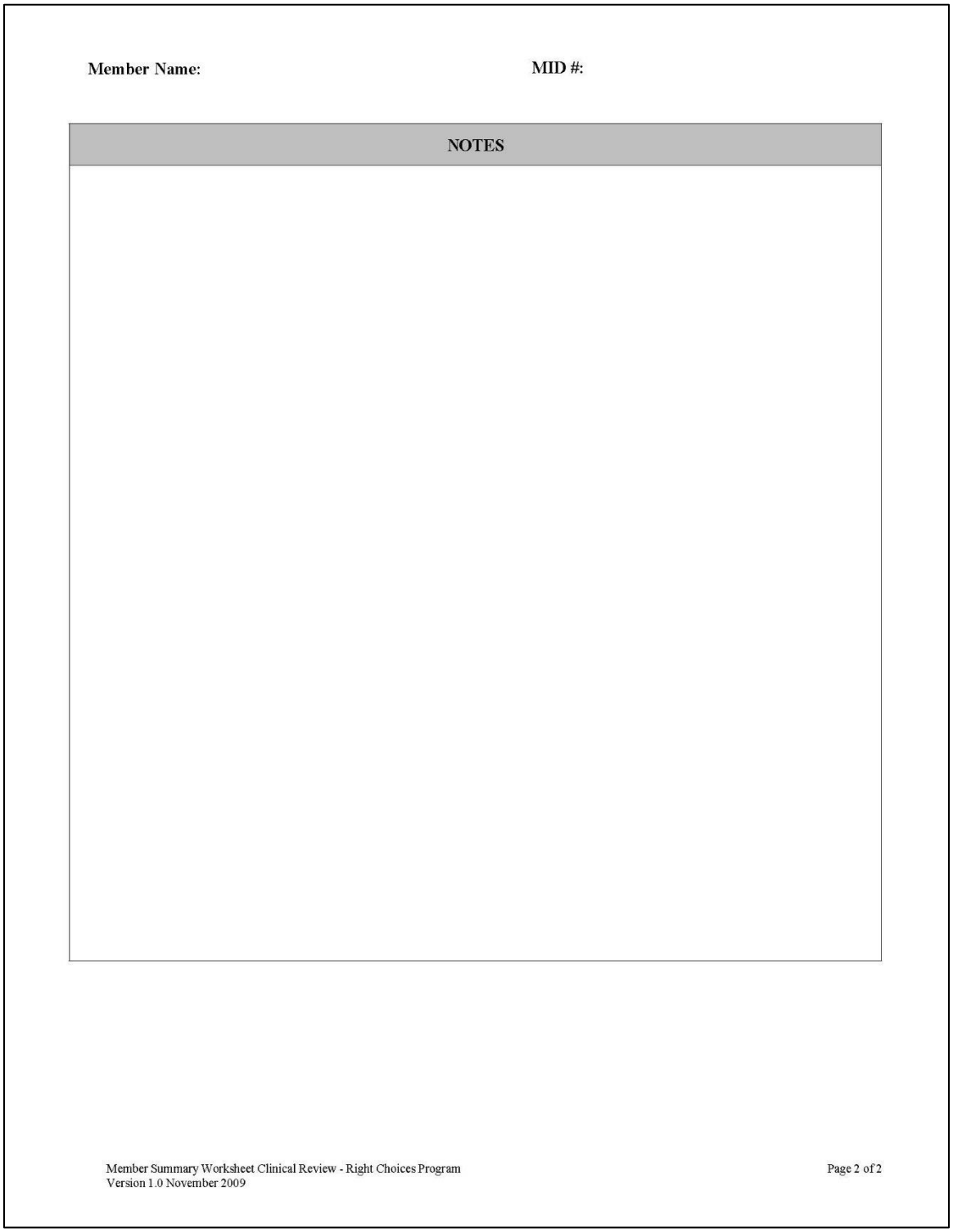
CLINICAL REVIEW RESULTS
Clinical Review Completed by: Date Clinical Review Completed by: Clinical Review Result: Member Reported to FSSA Bureau of Investigation? Yes No

MEMBER DIAGNOSES CLINICAL REVIEW

Member Summary Worksheet Clinical Review - Right Choices Program
Version 1.0 November 2009

Page 1 of 2

Figure 34 – Member Summary Worksheet Clinical Review (Page 2 of 2)



Member Name: **MID #:**

NOTES

Member Summary Worksheet Clinical Review - Right Choices Program
Version 1.0 November 2009

Page 2 of 2

Member Summary Worksheet Periodic Review

Figure 35 – Member Summary Worksheet Periodic Review (Page 1 of 3)

MEMBER SUMMARY WORKSHEET
Periodic Review

Please refer to the Right Choices Program (RCP) Manual for instructions to complete this worksheet.

Form completed by: **Date Completed:**

Member Name: **MID #:**

SERVICE UTILIZATION ANALYSIS
Dates of Service Reviewed (RCP Potential reporting month): «start date» to «end date»

MEMBER DIAGNOSES

Member Summary Worksheet Periodic Review - Right Choices Program
Version 2.0 September 2019

Page 1 of 3

Figure 35 – Member Summary Worksheet Periodic Review (Page 2 of 3)

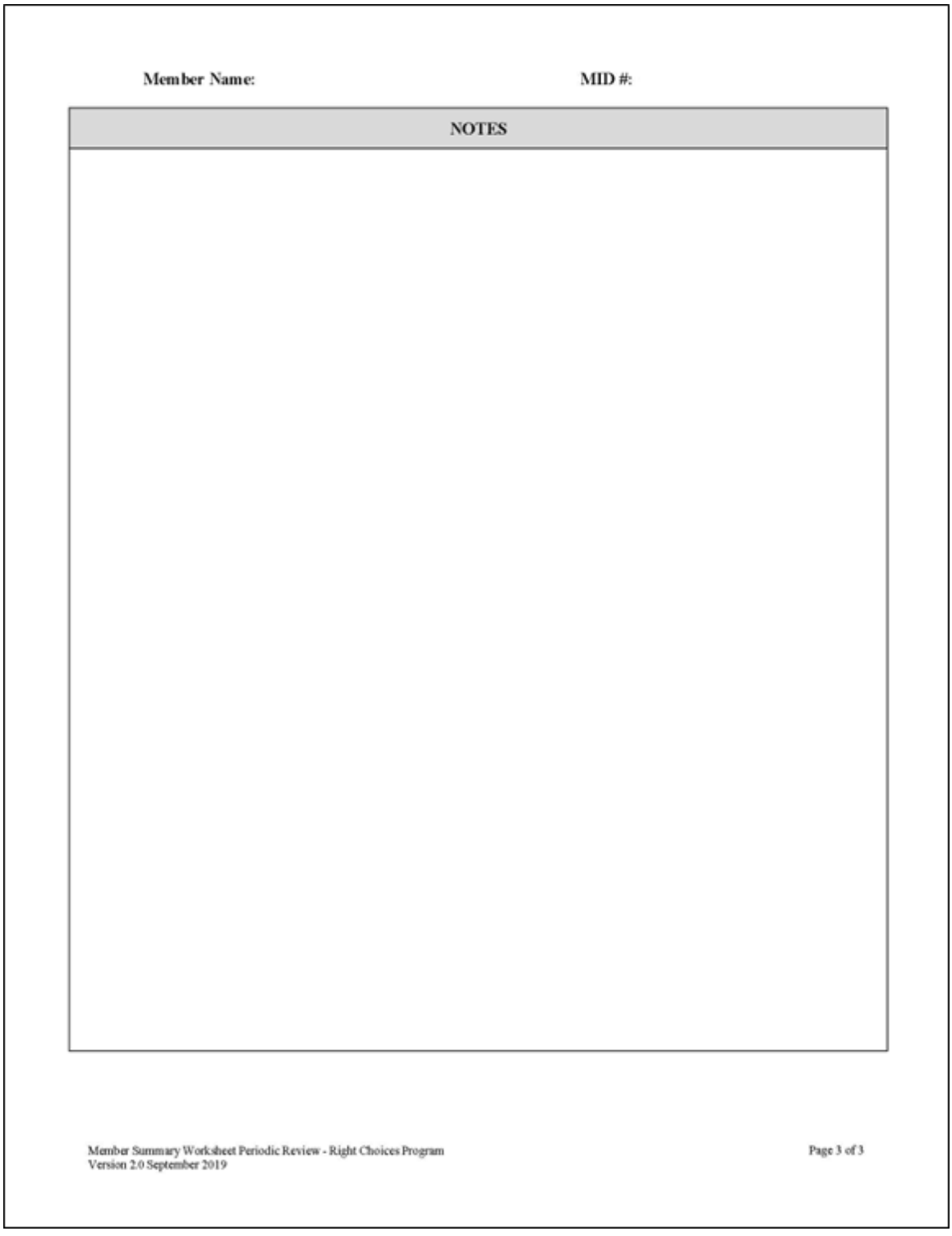
Member Name: **MID #:**

UTILIZATION ANALYSIS					
Total Dollar Amount of Paid Claims during the Review Period:					
Potential RCP Member Summary	**Initial Review Total**	**Periodic Review Total**	**Periodic Review Total**	**Periodic Review Total**	**Member's Current Total**
Number of PMP Selections					
Number of ER or Urgent Care Visits					
Number of Prescribers					
Number of Pharmacies					
Number of Filled Controlled Substance Prescriptions					
Number of Office Visits					
Average Daily Morphine Milligram Equivalent (MME)					
Pregnancy Indicator					
Cancer Indicator					
Seizure Indicator					
Trauma Indicator					
Sickle Cell Indicator					
Substance Abuse Indicator					
Alcohol Abuse Indicator					
Tobacco Abuse Indicator					
Historical RCP Enrollment					

Member Summary Worksheet Periodic Review - Right Choices Program
Version 2.0 September 2019

Page 2 of 3

Figure 35 – Member Summary Worksheet Periodic Review (Page 3 of 3)



Member Name: MID #:

NOTES

Member Summary Worksheet Periodic Review - Right Choices Program
Version 2.0 September 2019

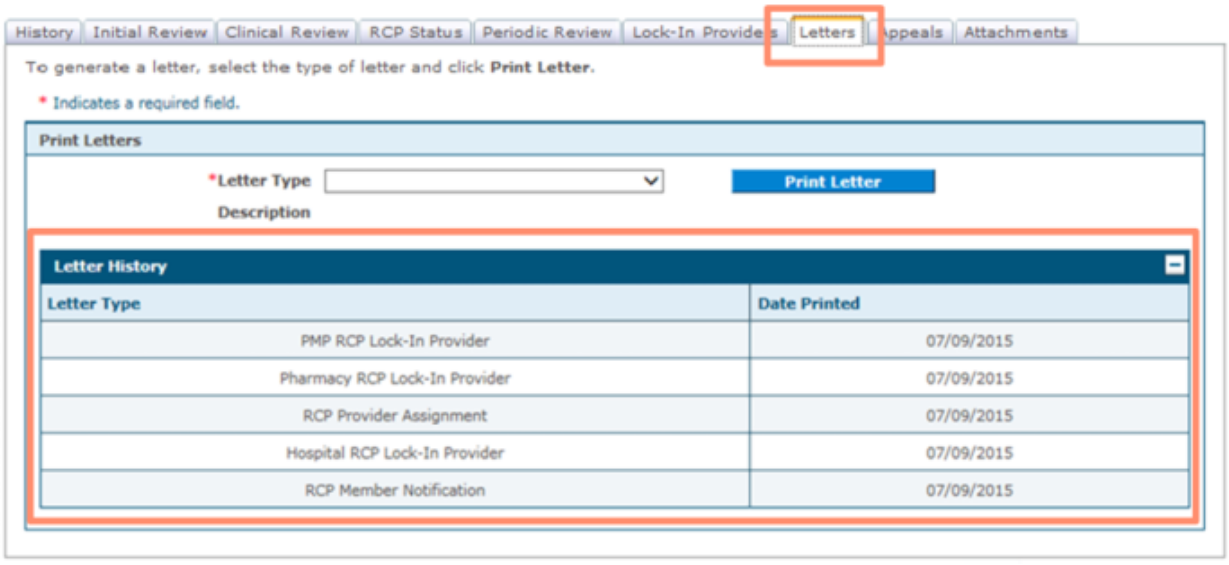
Page 3 of 3

Section 6: Right Choices Program Letters

The Right Choices Program (RCP) Administrator uses the Provider Healthcare Portal (IHCP Portal) to generate appropriate letters for RCP members and providers. To create a new letter, the RCP Administrator follows these steps:

1. Log in to the IHCP Portal.
2. From the Care Management tab in the menu bar, select **Right Choices Program Search**.
3. Locate the member by searching for Member ID, member name (last name, first name and birth date) or member Social Security number (SSN).
4. In the search results, click the Member ID to access the *Right Choices Program Member Summary* page for that member.
5. Select the Letters tab.
6. Select the desired letter from the Letter Type drop-down menu.
7. The letter is displayed, with all member and provider information automatically populated into the selected letter.
8. Click **Print Letter**.
9. Select options for downloading or printing the letter.

Figure 36 – Letters Tab



Note: The Hospital RCP lock-In Provider letter may appear in the Letter History if it has been previously printed. However, this letter is no longer generated by the IHCP Portal because, effective April 30, 2020, the hospital lock-in requirement has been removed from the RCP.

All RCP letters are produced on Indiana Family Social Services Administration (FSSA) Indiana Health Coverage Programs (IHCP) letterhead.

Member Letters

The following member letters are available for RCP Administrators to print from the IHCP Portal.

Member Notification – Managed Care Member

The following is an example of the initial notification letter, sent via mail with delivery confirmation, to notify managed care members that they have been chosen for the RCP.

Figure 37 – *RCP Member Notification* Letter – Managed Care

«Letter Date»

«Member Name»
«Street Address»
«City, State ZIP Code»

Member ID: «000000000»

Dear «Member Name»:

You have been selected for the Indiana Medicaid **Right Choices Program**. In the Right Choices Program, a team of experts will help you get the right healthcare at the right time at the right place. Your team will consist of one primary medical provider (PMP), one pharmacy, and a care manager.

You will choose one PMP to manage all of your medical needs and one pharmacy to fill your prescriptions. If you need to see another physician or use another pharmacy, your PMP **must** provide a referral for you. If you are not sure if you have a medical emergency, you can call your PMP for advice. Your care manager will help you access your Medicaid-covered healthcare benefits.

To choose your Right Choices Program providers, call your Right Choices Program Administrator:

«RCP Administrator Name»
«RCP Administrator Phone»

If you do not call within 10 calendar days of the date you received this letter, the program will select the providers for you based on the providers you already use most often or that best meet your medical needs. Both you and your chosen providers will receive a letter from Indiana Health Coverage Programs (Medicaid) confirming the providers that have been chosen for your team.

If you have questions about the Right Choices Program, refer to the enclosed Right Choices Program Member Booklet or call your Right Choices Program Administrator at the telephone number provided in this letter. If you disagree with our decision to select you for the Right Choices Program, you have 60 calendar days from the date of this letter to appeal. Appeals must be sent in writing to the address listed in the Right Choices Program Member Booklet. Be sure to include a copy of this letter with your appeal.

We are here to help you get the healthcare you need.

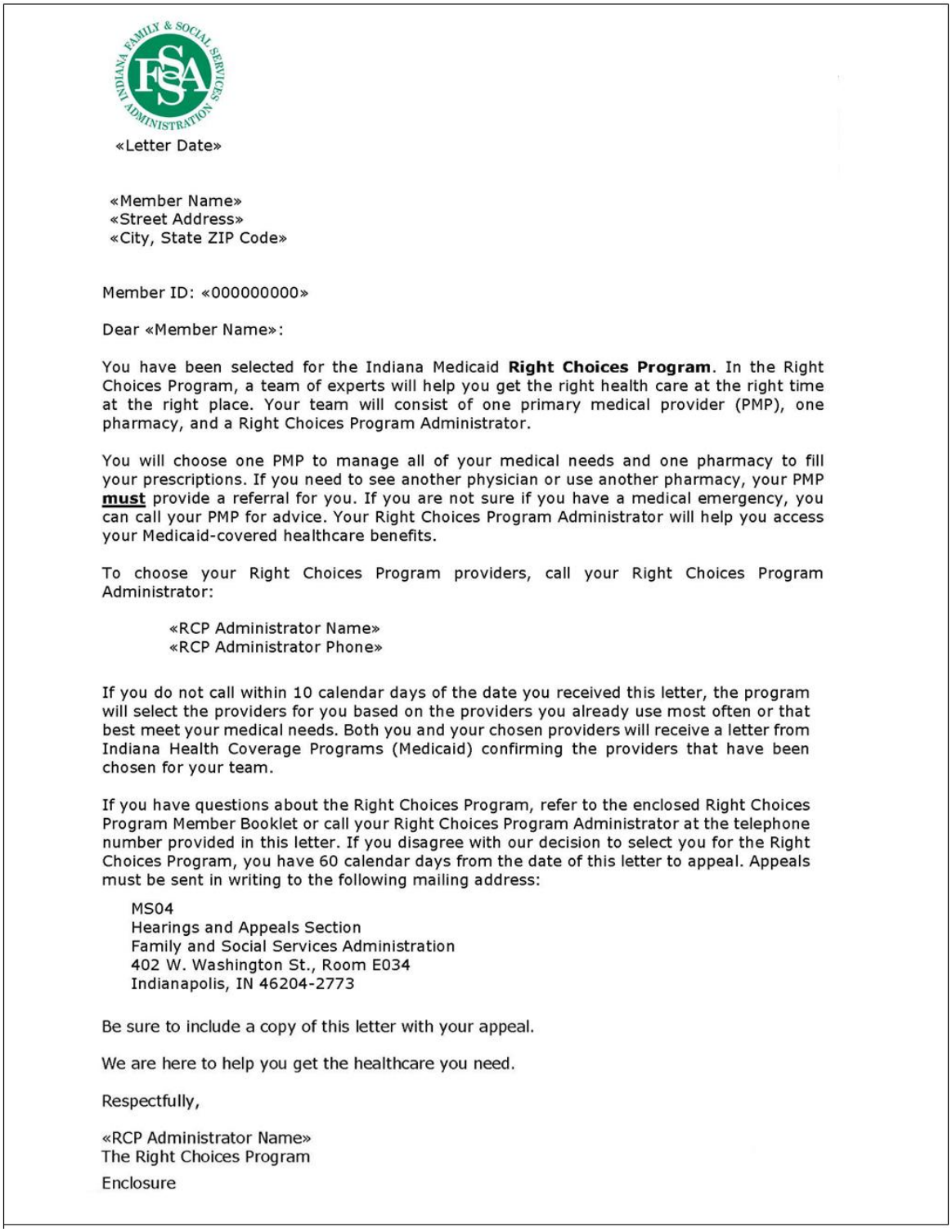
Respectfully,
«RCP Administrator Name»
The Right Choices Program
Enclosure

Page 1 of 1

Member Notification – Traditional Medicaid Member

The following is an example of the initial notification letter, sent via mail with delivery confirmation, to notify Traditional Medicaid members that they have been chosen for the RCP.

Figure 38 – *RCP Member Notification Letter* – Fee-for Service (FFS)



«Letter Date»

«Member Name»
«Street Address»
«City, State ZIP Code»

Member ID: «000000000»

Dear «Member Name»:

You have been selected for the Indiana Medicaid **Right Choices Program**. In the Right Choices Program, a team of experts will help you get the right health care at the right time at the right place. Your team will consist of one primary medical provider (PMP), one pharmacy, and a Right Choices Program Administrator.

You will choose one PMP to manage all of your medical needs and one pharmacy to fill your prescriptions. If you need to see another physician or use another pharmacy, your PMP **must** provide a referral for you. If you are not sure if you have a medical emergency, you can call your PMP for advice. Your Right Choices Program Administrator will help you access your Medicaid-covered healthcare benefits.

To choose your Right Choices Program providers, call your Right Choices Program Administrator:

«RCP Administrator Name»
«RCP Administrator Phone»

If you do not call within 10 calendar days of the date you received this letter, the program will select the providers for you based on the providers you already use most often or that best meet your medical needs. Both you and your chosen providers will receive a letter from Indiana Health Coverage Programs (Medicaid) confirming the providers that have been chosen for your team.

If you have questions about the Right Choices Program, refer to the enclosed Right Choices Program Member Booklet or call your Right Choices Program Administrator at the telephone number provided in this letter. If you disagree with our decision to select you for the Right Choices Program, you have 60 calendar days from the date of this letter to appeal. Appeals must be sent in writing to the following mailing address:

MS04
Hearings and Appeals Section
Family and Social Services Administration
402 W. Washington St., Room E034
Indianapolis, IN 46204-2773

Be sure to include a copy of this letter with your appeal.

We are here to help you get the healthcare you need.

Respectfully,

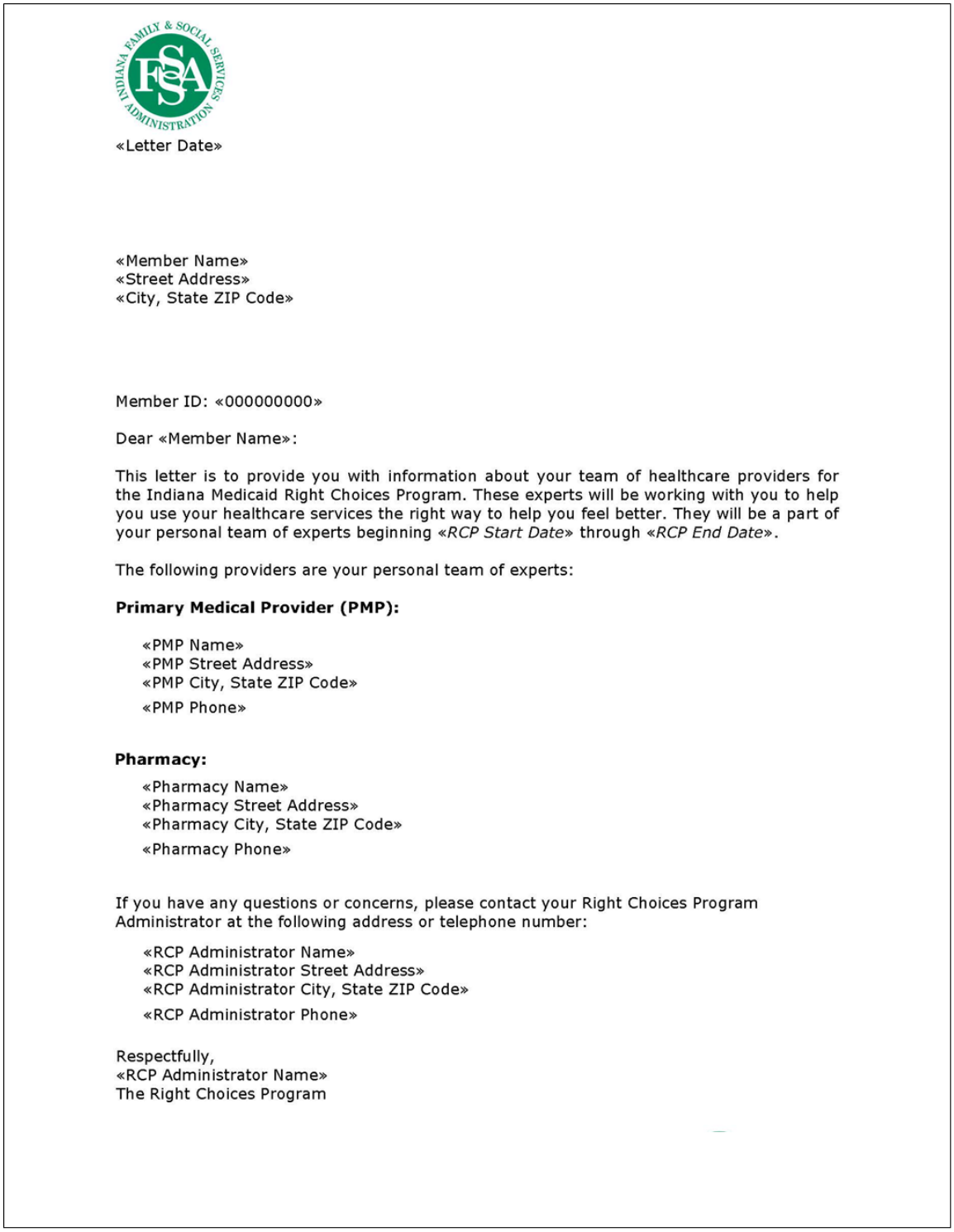
«RCP Administrator Name»
The Right Choices Program

Enclosure

Provider Assignment

The following is an example of the letter sent to the member to acknowledge the selection of the member's lock-in providers. A copy of the letter is also sent to the assigned providers.

Figure 39 – *RCP Provider Assignment* Letter



«Letter Date»

«Member Name»
«Street Address»
«City, State ZIP Code»

Member ID: «000000000»

Dear «Member Name»:

This letter is to provide you with information about your team of healthcare providers for the Indiana Medicaid Right Choices Program. These experts will be working with you to help you use your healthcare services the right way to help you feel better. They will be a part of your personal team of experts beginning «*RCP Start Date*» through «*RCP End Date*».

The following providers are your personal team of experts:

Primary Medical Provider (PMP):

«PMP Name»
«PMP Street Address»
«PMP City, State ZIP Code»
«PMP Phone»

Pharmacy:

«Pharmacy Name»
«Pharmacy Street Address»
«Pharmacy City, State ZIP Code»
«Pharmacy Phone»

If you have any questions or concerns, please contact your Right Choices Program Administrator at the following address or telephone number:

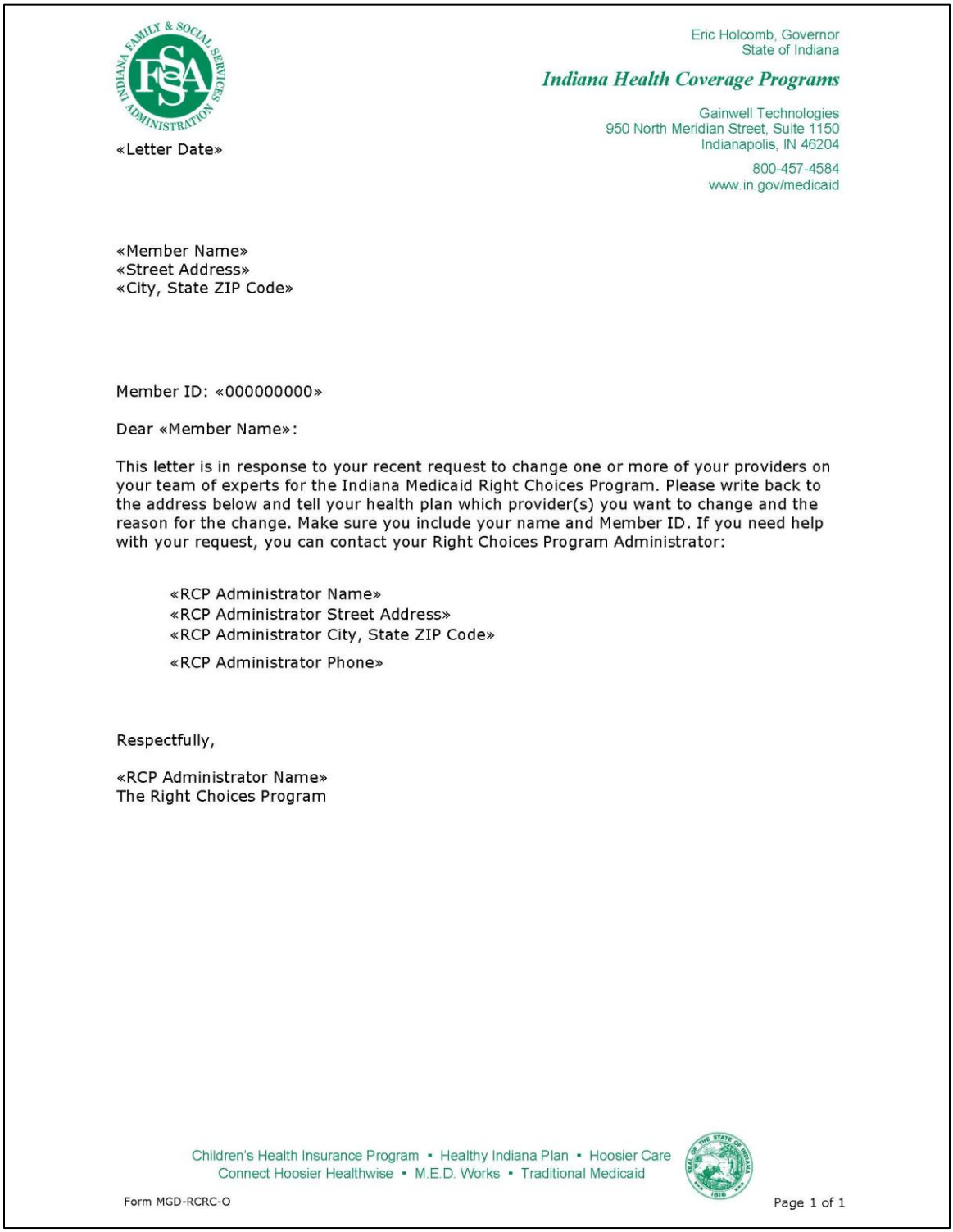
«RCP Administrator Name»
«RCP Administrator Street Address»
«RCP Administrator City, State ZIP Code»
«RCP Administrator Phone»

Respectfully,
«RCP Administrator Name»
The Right Choices Program

Member-Requested Change of RCP Provider

The following is an example of the letter sent to the member after the member has contacted the RCP Administrator to request a change of provider.

Figure 40 – *Member Request Provider Change* Letter



Eric Holcomb, Governor
State of Indiana

Indiana Health Coverage Programs

Gainwell Technologies
950 North Meridian Street, Suite 1150
Indianapolis, IN 46204

800-457-4584
www.in.gov/medicaid

«Letter Date»

«Member Name»
«Street Address»
«City, State ZIP Code»

Member ID: «000000000»

Dear «Member Name»:

This letter is in response to your recent request to change one or more of your providers on your team of experts for the Indiana Medicaid Right Choices Program. Please write back to the address below and tell your health plan which provider(s) you want to change and the reason for the change. Make sure you include your name and Member ID. If you need help with your request, you can contact your Right Choices Program Administrator:

«RCP Administrator Name»
«RCP Administrator Street Address»
«RCP Administrator City, State ZIP Code»
«RCP Administrator Phone»

Respectfully,

«RCP Administrator Name»
The Right Choices Program

Children's Health Insurance Program ▪ Healthy Indiana Plan ▪ Hoosier Care Connect Hoosier Healthwise ▪ M.E.D. Works ▪ Traditional Medicaid

Form MGD-RCRC-O

Page 1 of 1

Member Notification of Continued Program Enrollment Following Review

The following is an example of the notification sent to the member after completing the periodic review.

Figure 41 – *Continued RCP Enrollment after Review* Letter

«Letter Date»

«Member Name»
«Street Address»
«City, State ZIP Code»

Member ID: «000000000»

Dear «Member Name»:

This letter is to inform you that the Indiana Medicaid Right Choices Program has reviewed how you have used your healthcare services. After our review, we believe the program is an important benefit that should continue to help you better manage your overall healthcare needs. Therefore, you will continue to be part of the Right Choices Program for an additional 2 years. The following providers were previously selected to manage your medical care:

Primary Medical Provider (PMP):

«PMP Name»
«PMP Street Address»
«PMP City, State ZIP Code»
«PMP Phone»

Pharmacy Provider:

«Pharmacy Name»
«Pharmacy Street Address»
«Pharmacy City, State ZIP Code»
«Pharmacy Phone»

*NOTE: If you need to see another physician or use another pharmacy, your PMP **must** provide a referral for you.*

If you have any questions about your selected providers, please call your Right Choices Program Administrator:

«RCP Administrator Name»
«RCP Administrator Phone»

If you disagree with our decision to place you in the Right Choices Program, you have 60 calendar days from the date of this letter to appeal. Please refer to the enclosed member booklet for your appeal rights.

We are here to help you get the healthcare you need.

Respectfully,

«RCP Administrator Name»
The Right Choices Program Enclosure

Member Program Enrollment Notification After Appeal in Favor of the State

The following is an example of the notification letter sent to the member after the appeal of the RCP decision when the decision favors the state.

Figure 42 – *RCP Enrollment after Member* Appeal Letter

«Letter Date»

«Member Name»
«Street Address»
«City, State ZIP Code»

Member ID: «000000000»

Dear «Member Name»:

This letter is in response to your request for a hearing regarding your participation in the Indiana Medicaid Right Choices Program. On «*Initial Letter Date*», a letter was sent to you explaining that you have been selected for the Right Choices Program. This letter detailed the process involved for choosing one primary medical provider (PMP) and one pharmacy to care for all of your healthcare needs.

In a letter dated «*Request Date*», you requested a hearing to appeal this decision. This hearing was held on «*Hearing Date*». Your appeal was denied. As a result, you will continue your participation in the Right Choices Program. As part of the program, the following healthcare providers will serve as your team of experts:

«PMP Name»
«PMP Street Address»
«PMP City, State ZIP Code»
«PMP Phone»

«Pharmacy Name»
«Pharmacy Street Address»
«Pharmacy City, State ZIP Code»
«Pharmacy Phone»

If you have any questions, please call or write your Right Choices Program Administrator:

«RCP Administrator Name»
«RCP Administrator Street Address»
«RCP Administrator City, State ZIP Code»
«RCP Administrator Phone»

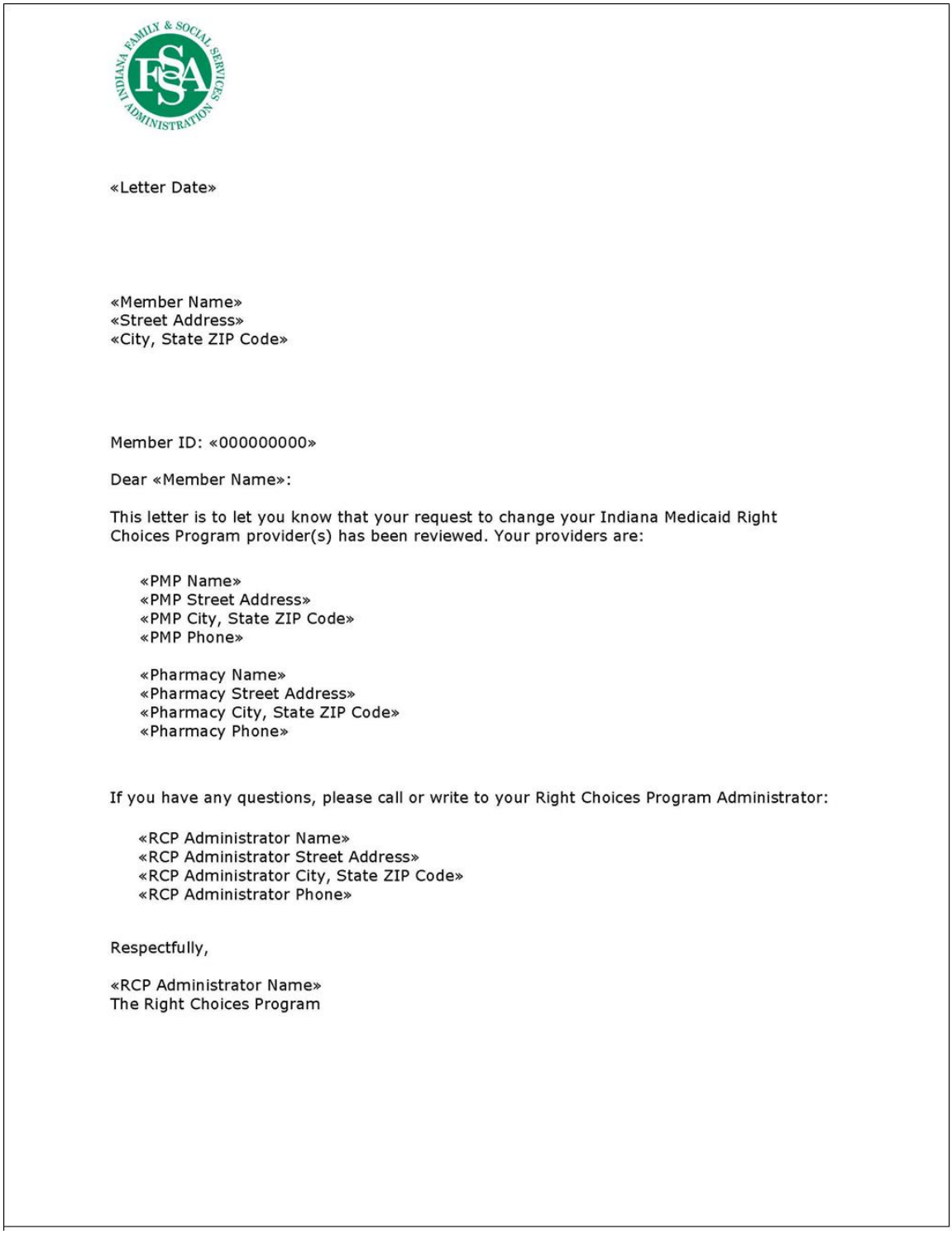
Respectfully,

«RCP Administrator Name»
The Right Choices Program

Confirmation Letter to Member of Change of Provider

The following is an example of the letter sent to the member after the member has contacted the RCP Administrator to request a change of provider, and the change has been approved.

Figure 43 – *Member Confirmation of Provider Change* Letter



«Letter Date»

«Member Name»
«Street Address»
«City, State ZIP Code»

Member ID: «000000000»

Dear «Member Name»:

This letter is to let you know that your request to change your Indiana Medicaid Right Choices Program provider(s) has been reviewed. Your providers are:

«PMP Name»
«PMP Street Address»
«PMP City, State ZIP Code»
«PMP Phone»

«Pharmacy Name»
«Pharmacy Street Address»
«Pharmacy City, State ZIP Code»
«Pharmacy Phone»

If you have any questions, please call or write to your Right Choices Program Administrator:

«RCP Administrator Name»
«RCP Administrator Street Address»
«RCP Administrator City, State ZIP Code»
«RCP Administrator Phone»

Respectfully,

«RCP Administrator Name»
The Right Choices Program

Graduation From Program

The following is an example of the letter sent to the member after a review removes the member from the RCP program.

Figure 44 – *RCP Program Graduation* Letter

«Letter Date»

«Member Name»
«Street Address»
«City, State ZIP Code»

Member ID: «000000000»

Dear «Member Name»:

Congratulations! You have successfully completed program requirements and will be graduating from the Indiana Medicaid Right Choices Program. The final date of your enrollment in the program is «*RCP End Date*».

Graduating from this program does not affect your eligibility for Indiana Health Coverage Programs (IHCP). If you are currently enrolled with an IHCP program such as Hoosier Healthwise, Healthy Indiana Plan (HIP), Hoosier Care Connect, or Traditional Medicaid, you will continue to receive health coverage through that program and be required to follow its guidelines.

We hope this program helped you better understand your Medicaid benefit. We recommend that you continue to receive quality healthcare from your primary medical provider (PMP), who can continue to assist you in managing all your medical needs.

Congratulations again on your successful completion of the Right Choices Program. If you have any questions, please call:

«RCP Administrator Name»
«RCP Administrator Phone»

Respectfully,

«RCP Administrator Name»
The Right Choices Program

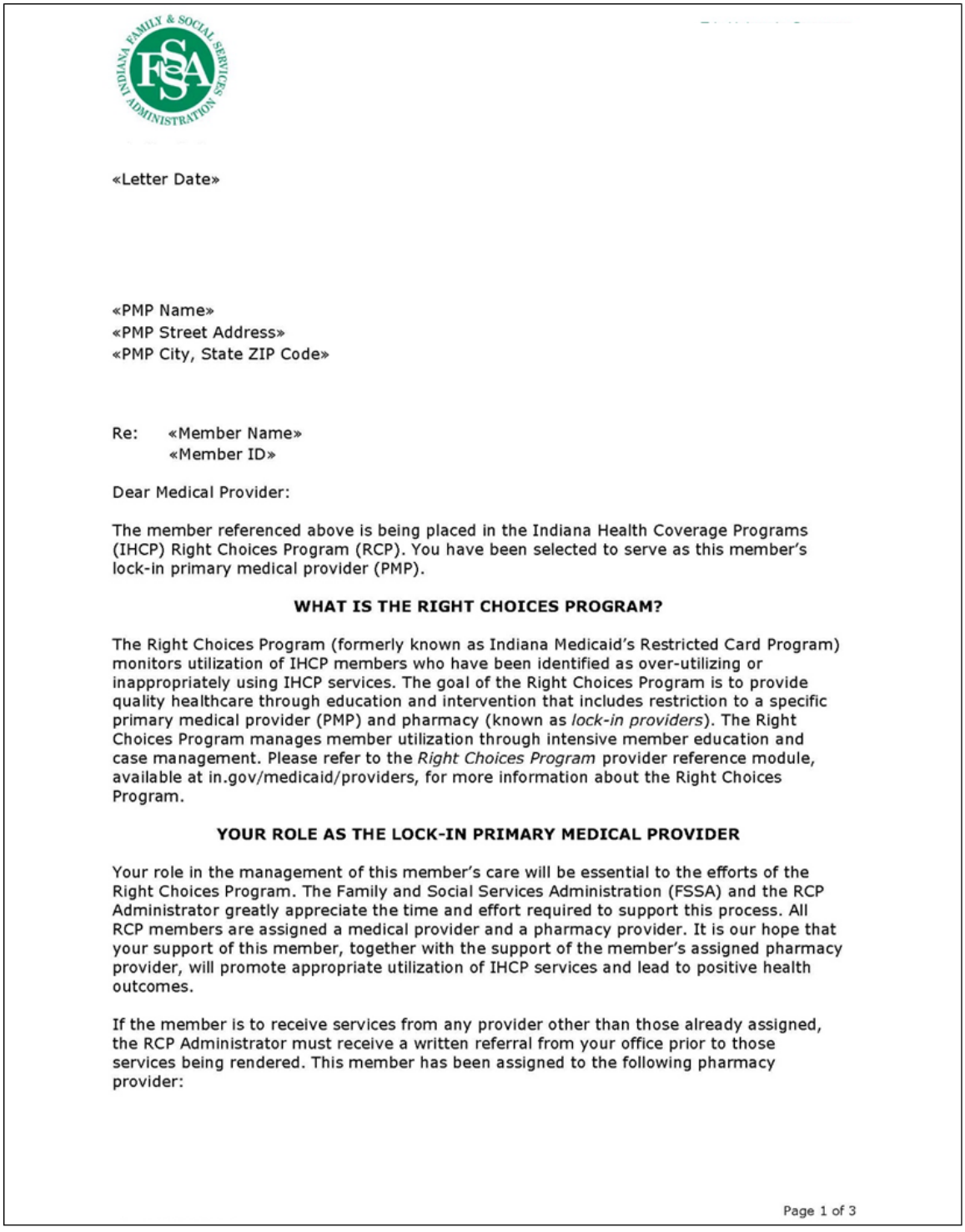
Provider Letters

The following lock-in provider letters are available for RCP Administrators to print from the IHCP Portal.

Primary Medical Provider Assignment

The following is an example of the initial letter sent to notify providers that they have been selected as a lock-in primary medical provider (PMP).

Figure 45 – *PMP RCP Lock-In Provider* Letter (page 1 of 3)



«Letter Date»

«PMP Name»
«PMP Street Address»
«PMP City, State ZIP Code»

Re: «Member Name»
«Member ID»

Dear Medical Provider:

The member referenced above is being placed in the Indiana Health Coverage Programs (IHCP) Right Choices Program (RCP). You have been selected to serve as this member's lock-in primary medical provider (PMP).

WHAT IS THE RIGHT CHOICES PROGRAM?

The Right Choices Program (formerly known as Indiana Medicaid's Restricted Card Program) monitors utilization of IHCP members who have been identified as over-utilizing or inappropriately using IHCP services. The goal of the Right Choices Program is to provide quality healthcare through education and intervention that includes restriction to a specific primary medical provider (PMP) and pharmacy (known as *lock-in providers*). The Right Choices Program manages member utilization through intensive member education and case management. Please refer to the *Right Choices Program* provider reference module, available at in.gov/medicaid/providers, for more information about the Right Choices Program.

YOUR ROLE AS THE LOCK-IN PRIMARY MEDICAL PROVIDER

Your role in the management of this member's care will be essential to the efforts of the Right Choices Program. The Family and Social Services Administration (FSSA) and the RCP Administrator greatly appreciate the time and effort required to support this process. All RCP members are assigned a medical provider and a pharmacy provider. It is our hope that your support of this member, together with the support of the member's assigned pharmacy provider, will promote appropriate utilization of IHCP services and lead to positive health outcomes.

If the member is to receive services from any provider other than those already assigned, the RCP Administrator must receive a written referral from your office prior to those services being rendered. This member has been assigned to the following pharmacy provider:

Page 1 of 3

Figure 45 – *PMP RCP Lock-In Provider* Letter (page 2 of 3)

«Pharmacy Name»
«Pharmacy NPI»
«Pharmacy Street Address»
«Pharmacy City, State ZIP Code»
«Pharmacy Phone»

The RCP Administrator for this member is shown below:

«RCP Administrator Name»
«RCP Administrator Phone»

HOW TO MAKE REFERRALS TO OTHER MEDICAL PROVIDERS

When referring this member to any provider outside of your care (for example, a referral to a cardiologist), it is ***essential*** that your referral be sent either online through the IHCP Provider Healthcare Portal or by mail or fax to the address below), so the provider may be added to this member's list of authorized providers. Referrals may be handwritten on your letterhead or prescription pad paper.

Right Choices Program
«RCP Administrator Name»
«RCP Administrator Street Address»
«RCP Administrator City, State ZIP Code»

Fax: «RCP Administrator Fax»

Be aware that referrals are also required for all providers that will be acting on your behalf, including associates in your office and on-call providers. The same applies to associates and on-call providers acting on behalf of a referred provider. Additionally, although certain professional services (such as vision, podiatry, dental, and behavioral health) are carved out of the Right Choices Program, a referral from you will still be required for coverage of any prescriptions made by such providers.

Each referral must include the following information:
1. The member's name
2. The member's IHCP Member ID
3. The name and National Provider Identifier (NPI) of the medical provider receiving the referral
4. The date of the referral
5. The signature of the lock-in PMP (your signature)

As the PMP, you may list the period for which the referral is valid. If no time period is specified on the referral, the referral will be effective for 1 year from the date of the referral. The IHCP will not reimburse for services or prescriptions until a valid referral has been received by the RCP Administrator.

We advise that you do **not** give your NPI to the RCP member. To safeguard your provider number, we ask that you communicate directly with the referred provider or that provider's office staff. The referred provider will be able to submit his or her claim electronically by

Page 2 of 3

Figure 45 – *PMP RCP Lock-In Provider* Letter (page 3 of 3)

supplying the lock-in PMP's number (your NPI) in the referring provider field of the claim (for example, field 17A on the *CMS-1500* paper claim form).

The FSSA and RCP Administrator greatly appreciate your assistance in coordinating the healthcare of this member. Your support in this process is vital to the well-being of the member and helps to control costs in an effort to save taxpayer dollars in the state of Indiana.

If you need additional information regarding the Right Choices Program, please do not hesitate to contact the member's RCP Administrator:

«RCP Administrator Name»
«RCP Administrator Phone»

When calling, be sure to choose the Right Choices Program option.

Sincerely,

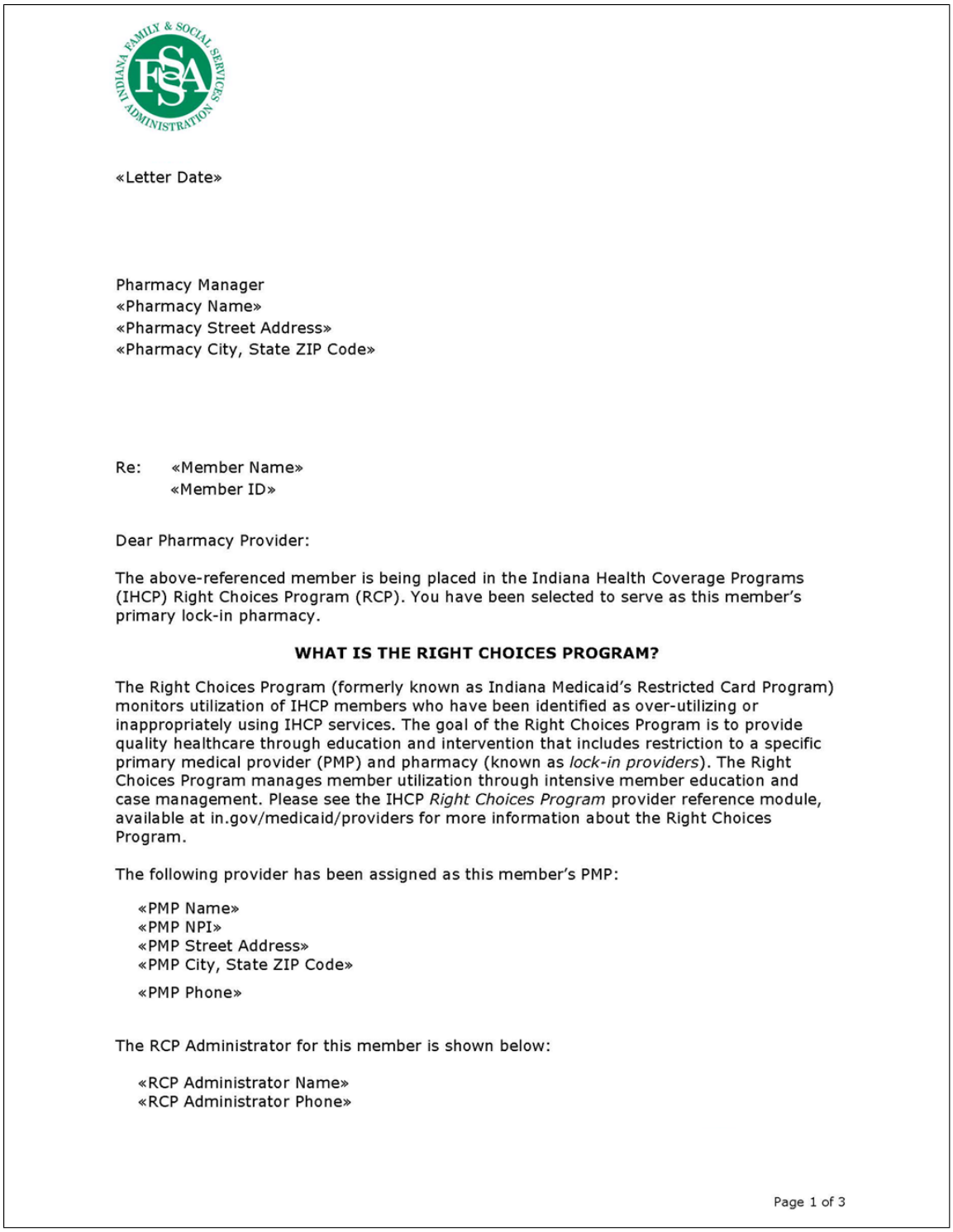
«RCP Administrator Name»
The Right Choices Program

Page 3 of 3

Pharmacy Provider Assignment

The following is an example of the initial letter sent to notify pharmacies of their selection as a lock-in pharmacy provider.

Figure 46 – *Pharmacy RCP Lock-In Provider* Letter (page 1 of 3)



«Letter Date»

Pharmacy Manager
«Pharmacy Name»
«Pharmacy Street Address»
«Pharmacy City, State ZIP Code»

Re: «Member Name»
«Member ID»

Dear Pharmacy Provider:

The above-referenced member is being placed in the Indiana Health Coverage Programs (IHCP) Right Choices Program (RCP). You have been selected to serve as this member's primary lock-in pharmacy.

WHAT IS THE RIGHT CHOICES PROGRAM?

The Right Choices Program (formerly known as Indiana Medicaid's Restricted Card Program) monitors utilization of IHCP members who have been identified as over-utilizing or inappropriately using IHCP services. The goal of the Right Choices Program is to provide quality healthcare through education and intervention that includes restriction to a specific primary medical provider (PMP) and pharmacy (known as *lock-in providers*). The Right Choices Program manages member utilization through intensive member education and case management. Please see the IHCP *Right Choices Program* provider reference module, available at in.gov/medicaid/providers for more information about the Right Choices Program.

The following provider has been assigned as this member's PMP:

«PMP Name»
«PMP NPI»
«PMP Street Address»
«PMP City, State ZIP Code»
«PMP Phone»

The RCP Administrator for this member is shown below:

«RCP Administrator Name»
«RCP Administrator Phone»

Page 1 of 3

Figure 46 – *Pharmacy RCP Lock-In Provider* Letter (page 2 of 3)

YOUR ROLE AS THE PRIMARY LOCK-IN PHARMACY

Your role in the management of this member's care will be essential to the efforts of the Right Choices Program. The Family and Social Services Administration (FSSA) and the RCP Administrator greatly appreciate the time and effort required to support this process. Appropriate utilization of IHCP services leads to positive health outcomes for this member.

HOW TO FILE CLAIMS FOR THE RIGHT CHOICES PROGRAM MEMBER

Any prescriptions written by the member's primary medical provider (PMP) or other lock-in provider can be filed through normal claim-submission procedures (via paper or point of sale [POS]). Each prescriber must be an IHCP-enrolled provider to be authorized for the Right Choices Program. If a member presents a prescription from a provider not on the member's lock-in eligibility list, contact the member's RCP Administrator. The administrator will verify if a referral for the provider in question is on file. If the member presents to you both a prescription and a referral, contact the RCP Administrator for verification.

The pharmacy also has the option of an *emergency fill*, which will bypass the member's lock-in list. When the pharmacist enters the level of service (=03), up to a 4-day supply of medication can be dispensed. For packaging that inherently cannot be broken down to a 4-day or less supply (example: metered-dose inhalers), the pharmacy is advised to dispense the smallest quantity possible adequate for the emergency situation. The provider should internally document that the quantity dispensed was, due to manufacturer packaging constraints, the least that could be dispensed while meeting the patient's needs during the emergency situation. This option should be utilized with careful discretion. If the provider writing the prescription is not on the member's lock-in list, and the RCP Administrator has not received a referral, the member must contact his or her PMP, listed on page 1 of this letter, for a referral. Claims will deny if these procedures are not followed.

The lock-in pharmacy must not change the National Provider Identifier (NPI) from a non-lock-in provider to the lock-in PMP. If the NPI has been altered, the reimbursement for the claim will be subject to recoupment by the State, and the action will be subject to a Medicaid fraud investigation.

If you have questions regarding these procedures, please contact the pharmacy vendor associated with the member's RCP Administrator. For the most up-to-date pharmacy vendor information, please see the *IHCP Quick Reference Guide*, available under the Contact Information tab at in.gov/medicaid/providers.

If you verify the member's eligibility and do not see the prescribing provider in the member's Right Choices Program lock-in list, or you are concerned with the validity of the referral, please contact the RCP Administrator at the number listed below to confirm whether the prescription is related to a valid referral. The member may or may not have a copy of the referral from his or her PMP; this situation will not affect your ability to file a claim for payment of service.

The FSSA and the RCP Administrator greatly appreciate your assistance in coordinating the healthcare of this member. It is our hope that your support of this member, combined with the support of the assigned PMP, will promote appropriate utilization of IHCP services and lead to positive health outcomes for this member.

'age 2 of 3

Figure 46 – *Pharmacy RCP Lock-In Provider* Letter (page 3 of 3)

If you have any questions, please do not hesitate to contact the member's **RCP Administrator**:

«RCP Administrator Name»
«RCP Administrator Phone»

When calling, be sure to choose the Right Choices Program option.

Sincerely,

«RCP Administrator Name»
The Right Choices Program

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