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Section 1: Overview

Overview of the Right Choices Program: Mission, Goals, and Philosophy

Right Choices Program Mission

The mission of the Right Choices Program (RCP) is to safeguard against unnecessary or inappropriate use of Medicaid services and against excessive payments by identifying members who use Indiana Health Coverage Programs (IHCP) services more extensively than their peers. The RCP also helps each member choose the right service at the right time in the right place.

RCP Goals

The goal of the RCP is to provide quality healthcare through healthcare management. Member utilization reviews identify members who use IHCP services more extensively than their peers. Based on results of the review, members identified as candidates for the program are assigned (or locked in) to:

- One primary medical provider (PMP)
- One pharmacy
- One hospital (for nonemergent visits)

If a member requires specialty services, the PMP must make the referral for those services to be reimbursed.

RCP Philosophy

To achieve the goal of delivering quality healthcare for RCP members, RCP stakeholders, including members, providers, RCP Administrators, and the State, collaborate to create a care coordination team for each RCP member. The RCP encourages and participates in coordination efforts to ensure that RCP processes and guidelines are applied appropriately while members receive medically necessary care.
Section 2: Right Choices Program Policies and Procedures

Overview

Per 42 Code of Federal Regulations (CFR) Sections 455 and 456, the Indiana Health Coverage Programs (IHCP) has developed the Right Choices Program (RCP) to assist members in utilizing the appropriate care at the appropriate place and time. The IHCP assigns a member to particular provider(s) when it determines that the member is overusing or abusing services, or has a history of doing so. After a review process, members are placed in a high intensity utilization management program (known as RCP), which includes member education and interventions.

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 referrals of potential overuse or abuse from various sources such as IHCP providers or other agencies.

Member Information

RCP Eligibility Review

IHCP members eligible for enrollment in the RCP include members of Hoosier Healthwise, Care Select, and the Healthy Indiana Program (HIP), with the exception of Enhanced Services Plan (ESP) HIP members. ESP is a special plan for HIP enrollees with certain high-risk medical conditions. The ESP plan member utilization practices are managed specifically within the ESP program.

Identification of members eligible for the RCP may come from a variety of sources including the following:

1. 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.

2. Referrals to the RCP Administrator – Any person or source may contact the RCP Administrator upon suspicion of overuse or misuse of services by a member. Such sources may include the Office of Medicaid Policy and Planning (OMPP), state and local law enforcement agencies, the Division of Family Resources (DFR), pharmacies, physician offices, and emergency rooms. Referrals may be made by telephone, mail, or email. The RCP Administrator’s designated department shall complete the RCP screening process within 60 calendar days. Typical referral reasons include over-utilization 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; paying cash for Medicaid services; prescription forgery; and selling drugs, supplies, or equipment obtained through Medicaid.

3. Data Mining Techniques – Patterns of member utilization can be aggregated from the RCP Administrator’s applicable data source, such as the Medicaid Management Information Systems (MMIS). The RCP Administrator is required to run a report that contains, at minimum:
   - Number of prescribers
   - Number of primary medical provider (PMP) changes
The specifications for the previously mentioned reports are found in the reporting manual for each of the managed care entity’s (MCE’s) programs. Additional areas of high utilization are determined from the review of multiple areas including, but not limited to, the following:

- Number of physicians visited
- Distance to physician from the member’s home
- Number of prescriptions
- Review of diagnoses with a focus on the medical necessity of all services provided to a member
- County-by-county analysis with predetermined review factors, such as ER and volume indicators
- Member ranking report, such as a ranked report of members based on cost or diagnosis
- Number of inpatient stays
- Inpatient length of stay (LOS)
- Number of PMP and specialist visits
- 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

Once a member is identified for initial review, the RCP Administrator completes the *Member Summary Worksheet* electronically via Web interChange. After the member’s information is entered, Web interChange produces a completed Portable Document Format (PDF) file of the *Member Summary Worksheet*, which is stored in Web interChange.

Any member who meets or exceeds the thresholds, as determined by the OMPP, in at least one of the four utilization criteria groups or receives a clinical indicator flag in the medication therapy management analysis is sent for clinical review. The clinical reviewer then determines whether the member should be placed in the RCP. If the member’s utilization is within the established thresholds, he or she is not sent to clinical review unless it is believed the member obtained Medicaid services under fraudulent pretenses. The OMPP notifies the RCP Administrator of any changes in the thresholds at least 60 days prior to implementation.

- Examples of fraudulent pretenses may include, but are not limited to, paying for prescriptions with cash or stealing prescription pads.
- Other reasons for automatic placement in the RCP include, but are not limited to, receiving five or more psychotropic medications in a recent 45-day period, as recommended by the Mental Health Quality Advisory Committee and approved by the Drug Utilization Review Board, or receiving benzodiazepines from three or more prescribers in a recent 90-day period.

Once screening has been completed, the clinical review result, the date of the clinical review, and the name of the staff member completing the clinical review is entered into Web interChange. After screening the member using the previous reporting tools and the *Member Summary Worksheet*, the RCP Administrator determines whether the member shall be placed in the RCP. If the member is not placed in the program, the member either:

- Is referred to care or case management for further interventions and education
- Continues the current course of action if the member’s information documents clinically appropriate behaviors and utilization
• Is reported to the Indiana Family and Social Services Administration (FSSA) Bureau of Investigations for potential fraud investigation

**RCP Initiation and Member Notification**

When a member is selected for the RCP, the information is entered into Web interChange so the member can be properly identified as a member of the RCP. The member is enrolled in the RCP until it can be determined that he or she is utilizing services appropriately and is compliant with his or her treatment plan, for up to five years.

Note: The Web interChange application prevents entry of an anticipated end date greater than five years in the future.

Interim care compliance reviews are also conducted during a member’s enrollment in the program, and may be used to determine a member’s compliance.

Once the member’s eligibility has been verified, an *Initial Notification Letter* is generated through Web interChange and is sent to the member by the RCP Administrator via mail with delivery confirmation or any other carrier with whom 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 notifies the member that he or she 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. A minimum of three attempts on three separate dates must be made by the RCP Administrator to reach the member by telephone.

The member has 10 calendar days from the date the letter was sent to respond by telephone or in writing of his or her selected RCP providers within the RCP Administrator’s designated network. The member selects one PMP, one pharmacy, and one hospital in the RCP Administrator’s network. The hospital must be one where the PMP has privileges to practice and one that the PMP prefers to use for the member’s care. If the member does not respond within 10 calendar days to indicate provider selections, the member’s providers are chosen for him or her. The RCP reviewer or specialist reviews the member’s past claims history to select and assign providers. Once selections have been made, the RCP reviewer or specialist enters the member’s providers into Web interChange, and Web interChange generates a *Provider Assignment Letter* to be sent to the member. When the letter is sent to the member, providers are also notified by mail of these selections and given a summary of their responsibilities as the assigned providers.

If the member is currently under the care of a specialist, or if the member indicates that he or she has an upcoming initial appointment with a specialist, the member is informed that his or her PMP must make the referral to the specialist and send a copy of the referral to the RCP Administrator. The RCP Administrator’s medical director may authorize a one-time referral if the PMP cannot be reached.

If a member is admitted to a long-term care (LTC) facility, the facility doctor and pharmacy are added to the member’s lock-in list and are active only during the member’s length of stay at the facility. The LTC facility provider may make referrals, as applicable, during the member’s length of stay. During this time, the member’s outside pharmacy is suspended; however, the member’s original PMP remains on the lock-in list. When the member is discharged from the LTC facility, the facility providers are suspended, and all providers active before the admission resume responsibility as the member’s providers.

If the member does not have a PMP, wants to change PMP, or if the chosen PMP displays utilization abnormalities, the RCP Administrator assists the member in selecting a new PMP. If the member initiates the PMP change, a new PMP may be selected only in one or more of the following circumstances:
1. Access to Care
   - Member moves more than 30 miles from his or her 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 (not applicable to the Healthy Indiana Plan [HIP]);
   - Excessive delay between requests for appointments and scheduled appointments, as noted in a documented pattern over six months
   - Difficulty contacting the PMP office for care after normal business hours

2. Continuity of Care
   - Current PMP disenrolls from the member’s current MCE, program, or the IHCP

3. Quality of Care or Service
   - Member dissatisfaction with treatment by doctor or staff
     - This 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

4. Selected Assignment
   - Member was auto-assigned and did not select the current PMP, and the selection was made by the RCP Administrator or auto-assigned. This reason may be used only once during the member’s enrollment in the RCP, pending Administrator approval.

If the member is assigned because of failure to respond to his or her Initial Notification, the member is allowed to change primary lock-in providers one time during his or her tenure in the RCP. Members are required to submit a written request to the RCP Administrator detailing the reasons for the requested changes. If there is a change in the member’s lock-in providers, he or she receives a letter with the new providers’ information. The new lock-in providers also receive a copy of the letter.

Once enrolled in the RCP program, the RCP Administrator is responsible for the general operations and oversight of the RCP and all RCP members assigned to the MCE. The RCP Administrator is required to perform the following duties:

1. Intervene in the care provided to RCP members by providing, at minimum, enhanced education, case management, and care coordination with the goal of modifying member behavior.

2. Provide appropriate customer service to providers and members.

3. Evaluate and monitor the member’s compliance with his or her treatment plan to determine if the RCP restrictions should terminate or continue.

If care management is incorporated into the MCE’s contract for RCP members, these members are assigned to a care manager for additional assistance with care coordination.

**Member Utilization Review: Interim Care Compliance Reviews**

Interim care reviews should be completed by the member’s two-year anniversary and at least annually thereafter while the member is in the RCP. RCP Administrators should use the periodic review worksheet in Web interChange for annual reviews. Additional reviews may be conducted as needed.
(for example, the member’s primary lock-in physician may, at any time, for crisis or other indications related to the member’s care, request an “emergent” conference with the member’s assigned care or case manager). Emergent conferences are strongly recommended to PMPs as an alternative to dismissing members from their practices. Maintaining a relationship with the PMP and, therefore, a stable care plan is of utmost importance to the member’s success in the RCP.

If an interim review reveals a member’s misuse of services, the member may be sent a letter from his or her 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, including ongoing documentation of issues of noncompliance with the program, and 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 the interim care reviews, the RCP Administrator may ask the PMP to provide an authorization statement of when he or she was specifically aware that the member was receiving care from the physician in question or another physician in his or her practice. The PMP’s medical records should 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 should 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 no longer in practice, 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 an interim care review, the RCP member may be recommended for removal from the RCP by his or her care or case manager if the care or case manager believes the member will utilize services appropriately without supervision.

**Removal from the RCP: Case Closure**

Thirty to 60 days prior to 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 his or her performance in the program.

The RCP Administrator convenes a multidisciplinary Exit Care Conference to evaluate the RCP member’s readiness for removal from the program and to assess any therapeutic situations or circumstances that may be present and may contribute to the member’s return to inappropriate utilization once 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
- Primary lock-in physician 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*
Section 2: Right Choices Program Policies and Procedures

• Active diagnoses and corresponding medications (such as appropriateness of medications).
• ER claims and reasons for using ER, consistent with desired program quality outcomes
• Input from care or case manager
• Input from primary lock-in physician
• 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 the 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 respective areas of interest on the care conference record may include, but are not limited to, 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 and reason for PMP changes

INSPECT findings are also gathered and reported 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 need to be answered before the group can make a final decision, the conference may be continued at a future date. The conference results in one of three decisions:

1. The member has been compliant and will be removed from the RCP.
2. The member has not been compliant and will continue on RCP (for an additional two to five years).
3. A legal exit strategy will be proposed to refer the member to the proper authorities, and the member will maintain his or her RCP status for two to five years.

If the member has been compliant with treatment plans and will be removed from the RCP:

1. The care panel shall disenroll the member from the RCP.
2. The RCP indicator is removed in Web interchange, and Web interchange generates a letter to be sent to the member by the RCP Administrator stating that the member is no longer in the RCP.
3. The RCP Administrator continues to monitor the member’s utilization pattern for six months. For members enrolled in Hoosier Healthwise, HIP, or Care Select, care management observes the member during this trial period to ensure that the member remains stabilized and does not revert to...
former behaviors of misuse. In addition, the member continues to have direct access to a case or case manager for any questions or concerns as the member transitions out of the RCP. For this monitoring to occur without the potential influence of the member’s knowledge, the member is not notified of the trial period.

4. If care management observes during the trial period that a member reverts to misuse, the trial may be aborted and the member re-enrolled in the program prior to or at the end of the six-month trial period. If the member is re-enrolled in the program, the same procedures are re-initiated as if the member were newly enrolled in the program. The RCP reviewer may use data gathered during the six-month trial period to re-enroll the member into the RCP. Care management notifies the member and primary lock-in physician of the occurrence in addition to re-educating the member about appropriate behaviors, and that the RCP is re-initiated.

If a member disputes review results, additional information may be submitted for review. If the member maintains that he or she has received treatment and obtained prescriptions from other physicians with authorization of his or her PMP, the member may contact the applicable PMP and request that he or she provide the RCP Administrator with a written statement concerning additional physicians that should have previously been added through his or her referral to the lock-in list.

Cases may be closed before the end of the member’s enrollment period for the following reasons:

- **Member Assignment to Hospice Care** – The Prior Authorization Department notifies the RCP that the member has been approved for hospice care.

- **Member Appeal with a Judgment in Favor of the Appellant** – The member’s enrollment in the RCP ends when notification is received from the Office of Hearings and Appeals.

- **Member Transfer to HIP ESP** – The member’s current RCP Administrator should end the member’s RCP eligibility segment at the time of transfer to ESP.

**Removal from RCP: Member Eligible for Enhanced Services Plan (ESP)**

HIP members who are assigned to the RCP can be moved to the ESP program, if they meet the requirements for ESP. The RCP Administrator is responsible for changing the member’s PMP assignment to an ESP provider and for end-dating the RCP segment for the member before moving the member to ESP. Failure of the RCP Administrator to reassign the member and end-date the RCP segment can result in access-to-care issues for the member. If this occurs, the RCP Administrator must contact HP’s Managed Care Unit for resolution.

**Member Hearings and Appeals**

**Initial Enrollment in the RCP**

The member has 30 calendar days from the receipt of the *Initial Notification Letter* to appeal his or her 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 30 calendar days, the appeal is timely; however, his or her enrollment is initiated and remains in effect until the hearing occurs and the decision to rescind is rendered.

**Continued Enrollment in the Program**

The previous time period also applies to the appeal of a continued enrollment period in the RCP after a compliance 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.
Appeals Process

Hoosier Healthwise and HIP: A Hoosier Healthwise or HIP member should appeal to his or her MCE. Hoosier Healthwise and HIP members must exhaust the MCE’s grievance and appeals process before requesting a hearing from the State.

Care Select (CS) and Fee-for-Service (FFS): CS or FFS members should appeal to the FSSA. If a member would like to request a hearing, he or she must do so in writing to the FSSA Office of Hearings and Appeals. The FSSA schedules the hearing and notifies the member and RCP Administrator once a hearing has been scheduled. In the event of a date conflict, the member shall provide three alternative dates and reason for continuance request in writing to the Office of Hearings and Appeals. Copies are sent to the member, county caseworker (if applicable), and RCP Administrator.

The member may also submit a late appeal. All late appeals should be submitted in writing to the Office of Hearings and Appeals; should include relevant documentation to support the request; and must demonstrate legal cause as to why a timely appeal could not be filed. Upon receipt of the supporting documentation, the FSSA typically schedules a hearing, and the ALJ hears the case on reasons for good cause on the issue of 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 Hearings and Appeals to do so. At a minimum, the RCP Administrator must submit the states’ 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, clinical reviewer, outside specialty consultant, and care or case manager.

The ALJ may rescind the decision to enroll the member in the RCP after the hearing, or continue the member’s RCP enrollment for two to five years as 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 also receives notification of the decision in writing.

Member Appeals Information Packet

Once a hearing has been scheduled, the RCP Administrator should 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 case file, if 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 should be provided to all relevant parties. Additionally, all identifying information of physicians and RCP staff should be removed for confidentiality. If the member has signed a Member Authorization to release protected health information (PHI) to his or her attorney, a copy is sent to the attorney as stated in Release of Member Protected Health Information (PHI).

Provider Information

Primary Lock-in Physician Responsibilities in the RCP

Physicians are notified of lock-in status through the Lock-in Physician Notification letter generated via Web interChange.

By providing a care coordination team, a primary lock-in physician (the PMP) is better able to manage a member’s care and coordinate service delivery. One physician 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. It is also anticipated that there will be a reduction in inappropriate utilization of pharmacy and other health services, which could harm the member, and create unnecessary and wasteful program expenditures.

The PMP must use referrals if the RCP member requires evaluation or treatment by a specialist or another doctor. 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. The member must be notified in advance of receiving any service that is not covered by Medicaid. The member must sign a waiver acknowledging that he or she will be billed for the noncovered service before receiving the service. However, if a member pays cash (and a provider receives cash) for any Medicaid-covered service, it may be considered a fraudulent activity on the parts of both the member and the provider. Referral physicians that treat lock-in members are still responsible for checking Medicaid eligibility and should not treat the member without obtaining a referral from the member’s PMP.

If the referral physician would like to refer the member to a third physician, the PMP must also sign the referral and send it to the RCP Administrator before the third provider is added to the member’s lock-in list. Additionally, each referral must include the following information:

• IHCP member’s name  
• IHCP member identification number (RID)  
• 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 will be 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 hospital or pharmacy may be added for the dates of service only.

• PMP’s manual or electronic signature
  – Signatures of office staff for the physician are unacceptable.

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

PMPs are encouraged to provide referrals for all Medicaid services, including self-referral services. While referrals are not mandatory for all self-referral services, this process provides better coordination of care among providers, and allows members to obtain prescriptions written by self-referral providers at their lock-in pharmacy. Because pharmacy claims are adjudicated at the pharmacy point of sale (POS), members are able to receive their medications only if their prescribers are authorized referral providers.

When the PMP approved the services provided on the date of service but failed to send the referral to the RCP Administrator at that time, the PMP may send referrals on a retroactive basis. 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 on or near the date of service that the referred service was approved. The PMP is not required to approve any service of which he or she had no knowledge on the date of service.

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 move 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, emergent, or ongoing issues, such as dialysis or emergent ER admission, 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

For additional information on coordination of care with pharmacies and hospitals, consult the Primary Lock-In Pharmacy Responsibilities in the RCP and Primary Lock-in Hospital Responsibilities in the RCP.

The provider may opt to terminate a member’s care for specific reasons outlined in the provider’s internal office policies and the administrator’s provider manuals, such as noncompliance with treatment recommendations and abusiveness to office staff. If this situation should transpire for a RCP member, the following should occur:

• The provider should 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 should 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 physician terminating care.

• Referrals made by the terminating provider expire 30 calendar days after RCP Administrator’s receipt of the dismissal. Upon approval from the administrator’s medical director, the expiration date may be extended under the following extenuating 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.

**Primary Lock-in Pharmacy Responsibilities in the RCP**

Pharmacy providers are notified of the member’s lock-in status through the *Provider Notification Letter* generated via Web interChange. If the pharmacy is also part of a corporation, a letter is also addressed to the pharmacy’s corporate headquarters.

The *Provider Notification 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 primary lock-in pharmacy must fill prescriptions from the primary lock-in physician (the PMP) and any referred prescribers authorized by the PMP only. If, after the primary lock-in pharmacy verifies the RCP member’s Medicaid eligibility, the claim denies for an invalid prescriber identification, the pharmacy should contact the RCP Administrator to confirm whether the prescription is written by an authorized lock-in prescriber. The primary lock-in pharmacy should not fill prescriptions written by non-lock-in prescribers unless the PMP’s referral has been obtained. The primary lock-in pharmacy may fill any legal prescription, but Indiana Medicaid does not reimburse claims for prescriptions that are not written by the PMP or a referred prescriber. If the primary lock-in pharmacy has changed the NPI from a non-lock-in provider to the lock-in prescriber without a valid referral, the reimbursement for the claim is subject to recoupment by the State, and the action will be subject to a Medicaid fraud investigation. It may be considered an act of Medicaid fraud for a Medicaid member to pay cash or a pharmacy provider to receive cash for services to which the member is entitled under Medicaid.

**Obtaining/Documenting Primary Lock-in Physician Authorization for Denied Prescriptions**

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

**Primary Lock-In Physician Authorization for Denied Schedule II Prescriptions**

If an emergency exists, as defined by 856 Indiana Administrative Code (IAC) 2-6-7(e), and the PMP orally authorizes a prescription for a Schedule II controlled substance after a written prescription from a non-lock-in prescriber is denied, the primary lock-in pharmacy shall document the oral 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 oral prescription. The member should then see the PMP to obtain an original written prescription for further supplies of the Schedule II prescription. No claim may be paid by Indiana Medicaid for an oral 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.

**Primary Lock-in Physician Internal Referrals**

For pharmacy claims to be appropriately processed for a RCP member, the prescription must be issued by the PMP or a valid referring prescriber and be presented at the primary lock-in pharmacy. A physician within the same practice group as the PMP is not a valid referring physician unless a valid referral from the PMP is on file with the RCP Administrator.

**Primary Lock-in Physician Referrals to Secondary Pharmacies**

If the primary lock-in pharmacy indicates that it 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. Prior to doing so, the RCP Administrator must verify that the primary lock-in pharmacy does not have the medication, and verify that the second pharmacy does. The secondary pharmacy is added for specific dates of service only, and the RCP Administrator notifies the PMP that the secondary pharmacy was added for those dates.

If the member is transferred to an LTC facility during his or her RCP enrollment period, the member’s primary lock-in pharmacy is changed to the one contracted by the LTC facility. When the member leaves LTC, the member’s primary lock-in pharmacy returns to the original lock-in list.

For additional information on coordination of care with physicians and hospitals, consult the **Primary Lock-in Physician Responsibilities in the RCP** and **Primary Lock-in Hospital Responsibilities in the RCP**.

**Primary Lock-in Hospital Responsibilities in the RCP**

**Selection of the Primary Lock-in Hospital**

The primary lock-in hospital is notified of lock-in status through the Hospital Provider Notification Letter generated via Web interChange, which is sent upon receipt of the RCP member’s selection by the Administrator. The primary lock-in hospital should be a full-service hospital and one where the PMP has been issued admitting privileges.

**Role of the Primary Lock-in Hospital**

The primary lock-in hospital is responsible for ensuring that the RCP member is obtaining appropriate inpatient and outpatient services, including those rendered in the ER setting. If a member is found to be using the ER to obtain nonemergent services, the member’s PMP and RCP Administrator should be notified. The hospital is strongly encouraged to educate the member on appropriate utilization of the ER, and encourage him or her to see the assigned PMP for nonemergent services. The RCP Administrator also provides education on the appropriate use of the ER.

**Hospital Services**

If the primary lock-in hospital is not the desired hospital for a specific inpatient or outpatient service, the PMP may refer the member to a second hospital or facility and request that it be added to the member’s lock-in list. The secondary hospital is added only for the dates of service or time span specified by the PMP, on approval by the RCP Administrator.
Services Provided in the Emergency Room

For Care Select and Traditional Medicaid RCP members, a referral is not necessary for services provided in the emergency room. However, only services rendered for medical emergency conditions are reimbursed for Hoosier Healthwise and HIP members in an ER setting. Once the RCP member has been stabilized, approval from the PMP must be obtained for further treatment. The lock-in hospital should notify the PMP whenever a member is treated in the ER.

Nonemergent services rendered in the ER are not covered for Hoosier Healthwise and HIP members. In this case, the hospital should refer the member to his or her PMP, educate the member on appropriate ER use, and notify the member’s PMP of the visit.

Prescriptions upon Discharge from Hospital

If discharge prescriptions are being written for the RCP member to be filled at the primary lock-in pharmacy, the hospital should contact the member’s PMP before discharge to obtain a referral for the discharge physician to be added to the member’s lock-in list for a specified time frame. If an emergency supply of discharge medications is provided by the hospital pharmacy to the RCP member upon discharge, claims for the prescriptions will not be reimbursed by IndianaAIM unless there is an emergency indicator on the pharmacy claim and the PMP has made a valid referral for the discharge physician to be added to the member’s lock-in list for the specified time frame.

For additional information on coordination of care with physicians and pharmacies, consult the Primary Lock-in Physician Responsibilities in the RCP and Primary Lock-in Pharmacy Responsibilities in the RCP.

Claims Review and Adjudication

A major factor in the success of the RCP is timely and appropriate claims adjudication. Procedures on proper claims submission can be found at indianamedicaid.com or within the applicable RCP Administrator’s claims processing manual. Claims for RCP members may suspend if all claims processing guidelines have not been followed. The following claims processing guidelines are specific to RCP members.

Referral Physicians

• The referral physician must receive from the member’s PMP a referral authorizing the member’s care for the initial service. The referral physician must confirm that the member was not referred through other means, such as the member’s self-referral.

• The PMP must directly supply his or her IHCP provider number to the referral physician. This number should not be given to the RCP member.

• If the referral physician writes a prescription, it is recommended that the written referral accompany the prescription to the primary lock-in pharmacy. If the referral does not accompany the prescription, the pharmacy should contact the RCP Administrator to verify validity of the referral.

Non-IHCP and Out-of-State Providers

Out-of-state provider numbers do not bypass the lock-in list or be accepted as a valid lock-in provider number for a RCP member; therefore, all physicians must have an IHCP provider number to be a covered provider for the RCP. If the physician is out of state, the primary lock-in pharmacy should determine whether the physician has an IHCP provider number.

• If the physician has an IHCP provider number, he or she 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 physician does not have an IHCP provider number, the physician is not a covered provider for the RCP, and the RCP Administrator should be contacted to process an override, if appropriate.

Lock-in Hospitals and Other Acute Care Facilities

The primary lock-in hospital, and other acute care facilities, should file claims as they would for any non-RCP member, only if the hospital’s IHCP number is on the member’s lock-in-list.

Administrative Information

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). Documentation of completed activities is maintained. Staff may also complete optional quality assurance and quality control activities on any aspect 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 OMPP on request or as required by the reporting manual.

Release of Member Protected Health Information (PHI)

The RCP Administrator’s Privacy Policy should 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 OMPP. The RCP Administrator’s staff members shall follow their Privacy Policy before any information is released to any person other than the member over the telephone. The member must provide appropriate information for personal identification. Persons other than the member may act on the member’s behalf with appropriate authorization. Those persons must be able to state the member identification number at the time of the telephone call. The following procedures shall be followed:

1. Member must give the following information at the beginning of each call.
   - First and last name and IHCP RID, along with three of the four following pieces of identification:
     • Address that is listed in Web interChange, the MMIS, or the RCP Administrator information system
     • Telephone number that is listed in Web interChange, the MMIS, or the RCP Administrator information system
     • Date of birth
     • Social Security number (or the last four digits of the number)

2. Member must complete the Member Authorization form and return the form to the RCP Administrator. 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 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 paper file. A copy of the form shall be 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.

3. Members who appeal their enrollment in the RCP, as described in Member Hearings and Appeals, may use the Member Authorization 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.

**Program 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 who use IHCP services more extensively than their peers. To that end, the following program objectives and performance measures have been identified. The RCP Administrator and the OMPP monitor and evaluate the program quality and effectiveness based on these measures through on-site visits, annual external quality reviews (EQRs), and performance reporting.

**Program Objectives**

- Reduce inappropriate outpatient hospital use, especially use of the emergency room
- Reduce inappropriate use of pharmacy services, especially controlled substances and other items with potential for misuse or abuse
- 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, and improve provider satisfaction with, the RCP

**Performance Measures and Reporting Requirements**

Performance measures have been developed to assist the OMPP in monitoring the overall effectiveness of the RCP, and to assess progress toward the previously stated program objectives. The following measures are used. Reports for these performance measures and other program statistics are monitored by the OMPP quarterly for each program and plan. Data sources include the RCP Administrator’s information systems, Web interChange, the MMIS, and the RCP database. The 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 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 pre-enrollment baseline
- Prescriptions
  - Average number and range of prescriptions filled for controlled substances
  - Average number and range of prescriptions for noncontrolled substances by therapeutic class; for example, psychotropics (per year by length of time in RCP compared to pre-enrollment baseline)
  - Number of members attempting to receive early refills
Section 2: Right Choices Program Policies and Procedures

− 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, physician)

• Number of members with an addiction or substance abuse diagnosis receiving addiction treatment services

• Providers:
  − Total number of providers participating, and provider-to-members ratios by provider type (for example, physician, pharmacy, hospital)
  − Number of complaints and overall provider satisfaction with the RCP

Annual Evaluation

The OMPP conducts an annual evaluation of the RCP based on the previous performance measures to determine progress made toward the program objectives and targets. As part of the annual evaluation process, the OMPP and RCP Administrator’s staff review and assess 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 and Abuse

The OMPP, RCP Administrator, medical providers, pharmacy providers, and members are empowered to raise issues of suspected fraud and abuse.

Member Fraud and Abuse

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

• Paying cash for services covered by Medicaid

• Selling drugs, equipment, or supplies obtained through Medicaid

• Allowing another individual to use a member’s Medicaid identification card

When a Medicaid member is suspected of such behavior, the activity should 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 (1-800-446-1993), with simultaneous notification to the OMPP via ProgramIntegrity@fssa.in.gov.

Providers and pharmacies are encouraged to directly report issues of suspected Medicaid member fraud to the FSSA Fraud Hotline. The State of Indiana 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 Compliance Division of the FSSA Office of the General Counsel, operates the FSSA Fraud Hotline.

Medical and Pharmacy Provider Fraud and Abuse

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

• Billing inappropriately, such as double billing or billing for services not provided

• Acting in violation of 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 should 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 should report the issue to the MFCU with a simultaneous notification to the OMPP via ProgramIntegrity@fssa.in.gov.

**Surveillance Utilization Review Services (SURS)**

The IHCP Program Integrity Department exists to ensure that correct payments are made to legitimate providers for appropriate and reasonable services to eligible Medicaid members. Through the receipt of provider or public complaints that are initiated through the IHCP Provider and Member Concern Line or the Surveillance and Utilization Review Services (SURS) process, the IHCP Program Integrity Department’s role is to investigate medical and pharmacy providers identified as potentially abusing services that are reimbursed by the IHCP.

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 *Detecting and Reporting Fraud and Abuse*. These issues are referred to the IHCP Program Integrity Department for documentation, preliminary investigation, and tracking. Research of claim history is conducted through the MMIS or other MCE databases to determine type and volume of alleged abuse. If the allegations of the referral are substantiated through the IHCP Program Integrity Department’s review, they are referred to the appropriate entity for further investigation and appropriate action. The IHCP Program Integrity Department refers issues and coordinates efforts with the MFCU, the State, county and local law enforcement agencies, and initiates referrals to the SUR management staff for potential case assignment.

The MFCU discerns whether the referrals initiated by the IHCP Program Integrity Department require further investigation for potential criminal or civil prosecution. The MFCU shall advise the IHCP Program Integrity Department of the necessity to place a provider on hold within 10 business days. A hold is defined as the request that neither the IHCP Program Integrity Department nor the OMPP-contracted staff initiate audit-related contacts with the identified provider without receiving prior approval from the MFCU. The FSSA contracted vendor performs concurrent desk and on-site pharmacy audits of Indiana Medicaid 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 3: Right Choices Program Reporting

The Right Choices Program (RCP) report series is designed to provide data and information to RCP Administrators that assists in the management of their RCP client base. Summary reports may be used by the Office of Medicaid Policy and Planning (OMPP) for the purpose of monitoring overall plan administration and activity.

Managed Care Unit business process/verification process

1. Summary and Potential reports are systematically generated on or before the first Monday following the first Sunday of each month. HP separately produces reports in a pipe-delimited format for the Periodic Review Tracking, Appeals, Provider-Member, and Transition information on or before the fifth business day of each month. The information found on the pipe-delimited reports are pulled directly from the same named tabs on the Summary Report.

2. On or before the first Monday following the first Sunday of each month, the MC Unit analyst verifies report production by accessing the designated File Exchange folder for each of the plans and the OMPP.

3. The MC Unit analyst opens a sampling of posted reports to verify that the correct report period is represented and that the data appears reasonable.

The following table lists RCP reports produced by HP. Additional detail, including field definitions for each of the reports, follows the table.

Table 3.1 – RCP reports produced by HP

<table>
<thead>
<tr>
<th>Report Name</th>
<th>Media</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Right Choices Program (RCP) Monthly Summary Report – Review Summary</td>
<td>Excel Workbook posted to File Exchange</td>
</tr>
<tr>
<td>2 Right Choices Program (RCP) Monthly Summary Report – Type of Review</td>
<td>Excel Workbook posted to File Exchange</td>
</tr>
<tr>
<td>3 Right Choices Program (RCP) Monthly Summary Report – Initial Review</td>
<td>Excel Workbook posted to File Exchange</td>
</tr>
<tr>
<td>4 Right Choices Program (RCP) Monthly Summary Report – Clinical Review</td>
<td>Excel Workbook posted to File Exchange</td>
</tr>
<tr>
<td>5 Right Choices Program (RCP) Monthly Summary Report – Periodic Review</td>
<td>Excel Workbook posted to File Exchange</td>
</tr>
<tr>
<td>7 Right Choices Program (RCP) Monthly Summary Report – Diagnosis</td>
<td>Excel Workbook posted to File Exchange</td>
</tr>
<tr>
<td>8 Right Choices Program (RCP) Monthly Summary Report – Appeals</td>
<td>Excel Workbook posted to File Exchange Pipe-delimited file posted to File Exchange</td>
</tr>
<tr>
<td>Report Name</td>
<td>Media</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td>9    Right Choices Program (RCP) Monthly Summary Report – Provider Member</td>
<td>Excel Workbook posted to File Exchange</td>
</tr>
<tr>
<td></td>
<td>Pipe-delimited file posted to File Exchange</td>
</tr>
<tr>
<td>10   Right Choices Program (RCP) Transition [from Managed Care to fee for service]</td>
<td>Pipe-delimited file posted to File Exchange</td>
</tr>
<tr>
<td>11   Right Choices Program (RCP) Monthly Summary Report</td>
<td>Excel Workbook posted to File Exchange</td>
</tr>
<tr>
<td>12   Potential Right Choices Program (RCP) Members</td>
<td>Excel posted to File Exchange</td>
</tr>
</tbody>
</table>

File location and naming convention:

- /Home/anth2007: Right_Choices_Monthly_Summary_Anthem_<date time>.xls
- /Home/advh1937: Right_Choices_Monthly_Summary_Advantage_<date time>.xls
- /Home/mdwi2003: Right_Choices_Monthly_Summary_MDwise_<date time>.xls
- /Home/mhsi2003: Right_Choices_Monthly_Summary_MHS_<date time>.xls
- /Distribution/OMPP Data Exchange/RCP: Right_Choices_Monthly_Summary_[plan]_<date time>.xls
- /Distribution/OMPP Data Exchange/RCP: Right_Choices_Program_(RCP)_Monthly_Summary_Report_<date time>.xls

Plans also receive the following pipe-delimited files, where “x” in the first section of the name indicates the MCE/Program (key follows):

- Rcpm1000x.Transition.MMMYYYY.dat (only produced for Advantage)
- Rcpm2000x.PeriodicReview.MMMYYYY.dat
- Rcpm3000x.Provider-Member.MMMYYYY.dat
- Rcpm4000x.Appeals.MMMYYYY.dat

MCE/Program Key:

- Anthem Hoosier Healthwise
- Anthem HIP
- MDwise Hoosier Healthwise
- MDwise HIP
- MDwise CS
- MHS Hoosier Healthwise
- MHS HIP
- Advantage CS
- Advantage TM
Table 3.2 – Right Choices Program (RCP) Monthly Summary Report – Review Summary

<table>
<thead>
<tr>
<th>Report Title</th>
<th>Right Choices Program (RCP) Monthly Summary Report – Review Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report Function</strong></td>
<td>Provide each RCP Administrator and the OMPP with a summary of RCP program activity data for the month reported by IHCP Program: Care Select, Hoosier Healthwise, Healthy Indiana Plan, and Traditional Medicaid.</td>
</tr>
<tr>
<td><strong>Distribution</strong></td>
<td>OMPP and RCP Administrators</td>
</tr>
<tr>
<td><strong>Schedule</strong></td>
<td>RCP Summary reports and files are run and posted to File Exchange each month on or before the first Monday following the first Sunday of each month. This run and post schedule accommodates inclusion of month-end data for the prior month, processed and loaded to Business Objects by the end of the previous month, which is the reporting period.</td>
</tr>
</tbody>
</table>
| **Report Layout**                                                           | **Right_Choices_Monthly_Summary_[Administrator]**  
  Process: Business Objects  
  Run Date: mm/dd/yyyy  
  Run Time: hh:mm  
  For the dates of mm/dd/yyyy to mm/dd/yyyy  
  Right Choices Program Summary of Initial Reviews [program]  
  |                                                                 |
| **Review Type**                                                             | Number of Members by Referral Source                                            | Reasons Not Referred to Clinical Review                                                                                       |
| Clinical                                                                    | Citizen Referrals: 99                                                          | Referred to Care/Case Management: 99                                                                                          |
| Initial                                                                     | Care Management Referrals: 99                                                  | Member Utilization per PMP plan of care: 99                                                                                   |
| Periodic                                                                    | Data Referrals: 99                                                             | Transient Member: 99                                                                                                          |
| Total                                                                       | Pharmacy Referrals: 99                                                         | ER Visit Followed by Inpatient Stay: 99                                                                                       |
|                                                                             | Provider Referrals: 99                                                         | Multiple Prescribers in same Group: 99                                                                                       |
|                                                                             | Other Referrals: 99                                                            | Other: 99                                                                                                                    |
|                                                                             | Initial Review Potential Fraud: 99                                              |                                                                                                                              |
|                                                                             | Clinical Review Potential Fraud: 99                                             |                                                                                                                              |
Section 3: Right Choices Program Reporting

Right Choices Program Policy Manual

Report Title | Right Choices Program (RCP) Monthly Summary Report – Review Summary
--- | ---
**Detailed Field Definitions** | Review Type – Type of review performed: Clinical, Initial, and Periodic.
Number of Members – Number of members reviewed during the month, by review type.
Total – Total number of members reviewed. 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 analyst on the Web interChange *Initial Review*, Demographic Info tab. Selections:
- Citizen Referral
- Care Mgmnt Referral
- Data Referral
- Pharmacy Referral
- Provider Referral
- Other Referral
Reasons *Not* Referred To Clinical Review – Number of members by reason not referred on to clinical review, if clinical review is not warranted, as indicated by the RCP analyst on Web interChange *Initial Review – Review and Submit*. Selections:
- 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 analyst on Web interChange *Initial Review – Automatic Review, Member is suspected… field.*
Clinical Review Potential Fraud – Number of members for which “yes” is selected by the RCP analyst on Web interChange *Clinical Review – Member reported to FSSA Bureau of Investigation* field.

Table 3.3 – Right Choices Program (RCP) Monthly Summary Report – Type of Review

<table>
<thead>
<tr>
<th>Report Title</th>
<th>Right Choices Program (RCP) Monthly Summary Report – Type of Review</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report Function</strong></td>
<td>Provide each RCP Administrator and the OMPP with a summary of RCP reviews performed for the month, reported by review type for each IHCP Program: Care Select, Hoosier Healthwise, Healthy Indiana Plan, and Traditional Medicaid.</td>
</tr>
<tr>
<td><strong>Distribution</strong></td>
<td>OMPP and RCP Administrators</td>
</tr>
<tr>
<td><strong>Schedule</strong></td>
<td>RCP Summary reports and files are run and posted to File Exchange each month on or before the first Monday following the first Sunday of each month. This run and post schedule accommodates inclusion of month-end data for the prior month, processed and loaded to Business Objects by the end of the previous month, which is the reporting period.</td>
</tr>
</tbody>
</table>
## Right Choices Program - Initial Reviews

<table>
<thead>
<tr>
<th>Member RID</th>
<th>Last Name</th>
<th>First Name</th>
<th>Date of Review</th>
<th>Review Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>999999999999</td>
<td>Last</td>
<td>First</td>
<td>mm/dd/yy</td>
<td>Initial</td>
</tr>
<tr>
<td>999999999999</td>
<td>Last</td>
<td>First</td>
<td>mm/dd/yy</td>
<td>Clinical</td>
</tr>
<tr>
<td>999999999999</td>
<td>Last</td>
<td>First</td>
<td>mm/dd/yy</td>
<td>Periodic</td>
</tr>
</tbody>
</table>

### Detailed Field Definitions

- **Member RID** – Medicaid recipient identification number of member reviewed.
- **Last Name** – Member last name.
- **First Name** – Member first name.
- **Date of Review** – Date when the review was completed by the RCP analyst, as entered in Web interChange.
- **Review Type** – Type of review performed: Initial, Clinical, or Periodic.

### Table 3.4 – Right Choices Program (RCP) Monthly Summary Report – Initial Review

<table>
<thead>
<tr>
<th>Report Title</th>
<th>Right Choices Program (RCP) Monthly Summary Report – Initial Review</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report Function</strong></td>
<td>Provide each RCP Administrator and the OMPP with detailed information regarding initial reviews performed during the month, reported for each IHCP Program: Care Select, Hoosier Healthwise, Healthy Indiana Plan, and Traditional Medicaid.</td>
</tr>
<tr>
<td><strong>Distribution</strong></td>
<td>OMPP and RCP Administrators</td>
</tr>
<tr>
<td><strong>Schedule</strong></td>
<td>RCP Summary reports and files are run and posted to File Exchange each month on or before the first Monday following the first Sunday of each month. This run and post schedule accommodates inclusion of month-end data for the prior month, processed and loaded to Business Objects by the end of the previous month, which is the reporting period.</td>
</tr>
</tbody>
</table>

### Report Layout

<table>
<thead>
<tr>
<th>Member RID</th>
<th>Last Name</th>
<th>First Name</th>
<th>Date of Review</th>
<th>Provider Referral</th>
<th>Pharmacy Referral</th>
<th>Care Management Referral</th>
<th>Date of First Service Selected</th>
<th>Date of Last Service Selected</th>
<th>Amount Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>999999999999</td>
<td>Last</td>
<td>First</td>
<td>mm/dd/yy</td>
<td>Y or N</td>
<td>Y or N</td>
<td>Y or N</td>
<td>Y or N</td>
<td>Y or N</td>
<td>Y or N</td>
</tr>
<tr>
<td>999999999999</td>
<td>Last</td>
<td>First</td>
<td>mm/dd/yy</td>
<td>Y or N</td>
<td>Y or N</td>
<td>Y or N</td>
<td>Y or N</td>
<td>Y or N</td>
<td>Y or N</td>
</tr>
<tr>
<td>999999999999</td>
<td>Last</td>
<td>First</td>
<td>mm/dd/yy</td>
<td>Y or N</td>
<td>Y or N</td>
<td>Y or N</td>
<td>Y or N</td>
<td>Y or N</td>
<td>Y or N</td>
</tr>
<tr>
<td>999999999999</td>
<td>Last</td>
<td>First</td>
<td>mm/dd/yy</td>
<td>Y or N</td>
<td>Y or N</td>
<td>Y or N</td>
<td>Y or N</td>
<td>Y or N</td>
<td>Y or N</td>
</tr>
</tbody>
</table>

Continued
| Detailed Field Definitions | Member RID – Medicaid recipient identification 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 analyst, as entered in Web interChange.  
| [source] Referral – Y or N indicating the initial review source, as indicated by the RCP analyst on the Web interChange Initial Review, Demographic Info tab. Sources:  
| • Provider  
| • Pharmacy  
| • Care Management  
| • Data  
| • Citizen  
| • Other  
| Date of First Service Selected – Beginning date of service for the period reviewed, as indicated by the RCP analyst on the Web interChange Initial Review, Demographic Info tab – Dates of Service Reviewed From field.  
| Date of Last Service Selected – Ending date of service for the period reviewed, as indicated by the RCP analyst on the Web interChange Initial Review, Demographic Info tab – Dates of Service Reviewed To field.  
| Amount Paid – Total amount paid for the Date of Service Reviewed period, as automatically calculated by the system when the RCP analyst progresses from the Web interChange Initial Review – Demographic Info tab to the Utilization Info tab.  
| Number of [indicators] – Totals for each of six clinical review triggers, as automatically calculated when the RCP analyst progresses from the Web interChange Initial Review – Demographic Info tab to the Utilization Info tab.  
| • # 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 code 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 unique LPI and service location in the billing provider field of pharmacy claims paid with dispense date during the time period reviewed.  
| • # of Filled Controlled Substance Prescriptions: determined by paid drug claims with dispense dates during the time period reviewed, with National Drug Code (NDC) code Drug Enforcement Administration (DEA) classifications II, III, IV.  
| • # of Filled Prescriptions: determined by paid drug claims with dispense dates during the time period reviewed.  
| • Fraud Indicated – Y or N, as selected by the RCP analyst on Web interChange Initial Review – Automatic Review, Member is suspected… field.  
| • Sent to Clinical Review – Y or N, as indicated by the RCP analyst on Web interChange Initial Review – Review and Submit, Clinical Review Warranted? field. |
Date Sent to Clinical Review
Date sent to clinical review, as indicated by the RCP analyst on Web interChange Initial Review – Review and Submit, Date Sent to Clinical Review field.

Reasons Not Referred To Clinical Review
Y or N indicating reason not referred on to clinical review, if clinical review is not warranted, as indicated by the RCP analyst on Web interChange Initial Review – Review and Submit.

Selections:
- 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 [text]

Table 3.5 – Right Choices Program (RCP) Monthly Summary Report – Clinical Review

<table>
<thead>
<tr>
<th>Report Title</th>
<th>Right Choices Program (RCP) Monthly Summary Report – Clinical Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Function</td>
<td>Provide each RCP Administrator and the OMPP with detailed information regarding clinical reviews performed during the month reported for each IHCP Program: Care Select, Hoosier Healthwise, Healthy Indiana Plan, and Traditional Medicaid.</td>
</tr>
<tr>
<td>Distribution</td>
<td>OMPP and RCP Administrators</td>
</tr>
<tr>
<td>Schedule</td>
<td>RCP Summary reports and files are run and posted to File Exchange each month on or before the first Monday following the first Sunday of each month. This run and post schedule accommodates inclusion of month-end data for the prior month, processed and loaded to Business Objects by the end of the previous month, which is the reporting period.</td>
</tr>
</tbody>
</table>
### Table 3.6 – Right Choices Program (RCP) Monthly Summary Report – Clinical Review

<table>
<thead>
<tr>
<th>Member RID</th>
<th>Last Name</th>
<th>First Name</th>
<th>Date of Review</th>
<th>Review Results</th>
<th>Referred to FSSA Fraud Unit</th>
<th>Date Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>999999999999</td>
<td>Last</td>
<td>First</td>
<td>mm/dd/yy</td>
<td>[review result] - placed on RCP - not placed: clinically appropriate - not placed: refer to CM</td>
<td>Y or N</td>
<td>mm/dd/yy</td>
</tr>
<tr>
<td>999999999999</td>
<td>Last</td>
<td>First</td>
<td>mm/dd/yy</td>
<td>[review result] - placed on RCP - not placed: clinically appropriate - not placed: refer to CM</td>
<td>Y or N</td>
<td>mm/dd/yy</td>
</tr>
<tr>
<td>999999999999</td>
<td>Last</td>
<td>First</td>
<td>mm/dd/yy</td>
<td>[review result] - placed on RCP - not placed: clinically appropriate - not placed: refer to CM</td>
<td>Y or N</td>
<td>mm/dd/yy</td>
</tr>
</tbody>
</table>

**Detailed Field Definitions**

- **Member RID** – Medicaid recipient identification number of member reviewed.
- **Last Name** – Member’s last name.
- **First Name** – Member’s first name.
- **Date of Review** – Date when **Submit Clinical Review** was selected by the RCP analyst on the **Clinical Review** tab in Web interChange, upon completion of clinical review data entry.
- **Review Result** – Result of the clinical review, as selected by the RCP analyst on Web interChange **Clinical Review – Clinical Review Results** field. Selections:
  - Placed on RCP
  - Not on RCP: Clinically Appropriate Behaviors
  - Not on RCP: See Case Management
- **Referred to FSSA Fraud Unit** – Y or N indicating whether or not the case was referred to the fraud unit, as entered by the RCP analyst on Web interChange **Clinical Review – Member reported to FSSA Bureau of Investigation?** field.
- **Date Complete** – Date entered by the RCP analyst on Web interChange **Clinical Review Completed** field.

### Table 3.6 – Right Choices Program (RCP) Monthly Summary Report – Periodic Review

<table>
<thead>
<tr>
<th>Report Function</th>
<th>Right Choices Program (RCP) Monthly Summary Report – Periodic Review</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report Function</strong></td>
<td>Provide each RCP Administrator and the OMPP with detailed information regarding periodic reviews performed during the month reported for each IHCP Program: Care Select, Hoosier Healthwise, Healthy Indiana Plan, and Traditional Medicaid.</td>
</tr>
<tr>
<td><strong>Distribution</strong></td>
<td>OMPP and RCP Administrators</td>
</tr>
</tbody>
</table>
### Schedule

RCP Summary reports and files are run and posted to File Exchange each month on or before the first Monday following the first Sunday of each month. This run and post schedule accommodates inclusion of month-end data for the prior month, processed and loaded to Business Objects by the end of the previous month, which is the reporting period.

### Report Layout

<table>
<thead>
<tr>
<th>Report Title</th>
<th>Right Choices Program (RCP) Monthly Summary Report – Periodic Review</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Schedule</strong></td>
<td>RCP Summary reports and files are run and posted to File Exchange each month on or before the first Monday following the first Sunday of each month. This run and post schedule accommodates inclusion of month-end data for the prior month, processed and loaded to Business Objects by the end of the previous month, which is the reporting period.</td>
</tr>
<tr>
<td><strong>Report Layout</strong></td>
<td><strong>Right Choices Program - Periodic Reviews</strong>&lt;br&gt;<strong>[Administrator / Program]</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Summary of Periodic Reviews</strong></td>
</tr>
<tr>
<td>Number of Periodic Reviews</td>
<td>999</td>
</tr>
<tr>
<td>Number of Periodic Review Results: Graduates</td>
<td>999</td>
</tr>
<tr>
<td>Number of Periodic Review Results: Returnees</td>
<td>999</td>
</tr>
<tr>
<td><strong>Member RID</strong></td>
<td><strong>Last Name</strong></td>
</tr>
<tr>
<td>999999999999</td>
<td>Last</td>
</tr>
<tr>
<td>999999999999</td>
<td>Last</td>
</tr>
<tr>
<td>999999999999</td>
<td>Last</td>
</tr>
<tr>
<td><strong>Continued</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number of Prescribers</strong></td>
<td><strong>Number of Pharmacies</strong></td>
</tr>
<tr>
<td>99</td>
<td>99</td>
</tr>
<tr>
<td>99</td>
<td>99</td>
</tr>
<tr>
<td>99</td>
<td>99</td>
</tr>
<tr>
<td>Detailed Field Definitions</td>
<td>Right Choices Program (RCP) Monthly Summary Report – Periodic Review</td>
</tr>
<tr>
<td>----------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Member RID – Medicaid recipient identification number of member reviewed.</td>
<td>Member RID – Medicaid recipient identification number of member reviewed.</td>
</tr>
<tr>
<td>Last Name – Member’s last name.</td>
<td>Last Name – Member’s last name.</td>
</tr>
<tr>
<td>First Name – Member’s first name.</td>
<td>First Name – Member’s first name.</td>
</tr>
<tr>
<td>Date of Review – Date when Submit Periodic Review was selected by the RCP analyst on the Periodic Review – Review and Submit tab in Web InterChange, upon completion of periodic review data entry.</td>
<td>Date of Review – Date when Submit Periodic Review was selected by the RCP analyst on the Periodic Review – Review and Submit tab in Web InterChange, upon completion of periodic review data entry.</td>
</tr>
<tr>
<td>Date of First Service – Beginning date of service for the period reviewed, as indicated by the RCP analyst on the Web InterChange Periodic Review, Demographic Info tab – Dates of Service Reviewed From field.</td>
<td>Date of First Service – Beginning date of service for the period reviewed, as indicated by the RCP analyst on the Web InterChange Periodic Review, Demographic Info tab – Dates of Service Reviewed From field.</td>
</tr>
<tr>
<td>Date of Last Service – Ending date of service for the period reviewed, as indicated by the RCP analyst on the Web InterChange Periodic Review, Demographic Info tab – Dates of Service Reviewed To field.</td>
<td>Date of Last Service – Ending date of service for the period reviewed, as indicated by the RCP analyst on the Web InterChange Periodic Review, Demographic Info tab – Dates of Service Reviewed To field.</td>
</tr>
<tr>
<td>Amount Paid – Total amount paid for the Date of Service Reviewed period, as automatically calculated by the system when the RCP analyst progresses from the Web InterChange Periodic Review – Demographic Info tab to the Utilization Info tab.</td>
<td>Amount Paid – Total amount paid for the Date of Service Reviewed period, as automatically calculated by the system when the RCP analyst progresses from the Web InterChange Periodic Review – Demographic Info tab to the Utilization Info tab.</td>
</tr>
<tr>
<td>Number of [indicators] – Totals for each of six periodic review triggers, as automatically calculated by the system when the RCP analyst progresses from the Web InterChange Periodic Review – Demographic Info tab to the Utilization Info tab.</td>
<td>Number of [indicators] – Totals for each of six periodic review triggers, as automatically calculated by the system when the RCP analyst progresses from the Web InterChange Periodic Review – Demographic Info tab to the Utilization Info tab.</td>
</tr>
<tr>
<td>• # of PMP Selections: determined from the number of PMP assignments on file for the member during the time period reviewed.</td>
<td>• # of PMP Selections: determined from the number of PMP assignments on file for the member during the time period reviewed.</td>
</tr>
<tr>
<td>• # of ER Visits: determined from revenue code 450 and 451 on claims paid with dates of service during the time period reviewed.</td>
<td>• # of ER Visits: determined from revenue code 450 and 451 on claims paid with dates of service during the time period reviewed.</td>
</tr>
<tr>
<td>• # of Prescribers: determined from unique NPIs in the prescribing provider field of pharmacy claims paid with dates of service during the time period reviewed.</td>
<td>• # of Prescribers: determined from unique NPIs in the prescribing provider field of pharmacy claims paid with dates of service during the time period reviewed.</td>
</tr>
<tr>
<td>• # of Pharmacies: determined from unique LPI and service location in the billing provider field of pharmacy claims paid with dispense dates during the time period reviewed.</td>
<td>• # of Pharmacies: determined from unique LPI and service location in the billing provider field of pharmacy claims paid with dispense dates during the time period reviewed.</td>
</tr>
<tr>
<td>• # of Filled Prescriptions: determined by paid drug claims with dispense dates during the time period reviewed.</td>
<td>• # of Filled Prescriptions: determined by paid drug claims with dispense dates during the time period reviewed.</td>
</tr>
<tr>
<td>• # of Controlled Substances: determined by paid drug claims with dispense dates during the time period reviewed, with NDC code DEA classifications II, III, IV.</td>
<td>• # of Controlled Substances: determined by paid drug claims with dispense dates during the time period reviewed, with NDC code DEA classifications II, III, IV.</td>
</tr>
<tr>
<td>Periodic Review Results – Result of the periodic review, as selected by the RCP analyst on Web InterChange Periodic Review – Periodic Review Results field. Selections:</td>
<td>Periodic Review Results – Result of the periodic review, as selected by the RCP analyst on Web InterChange Periodic Review – Periodic Review Results field. Selections:</td>
</tr>
<tr>
<td>• Remain on RCP</td>
<td>• Remain on RCP</td>
</tr>
<tr>
<td>• Graduate from RCP</td>
<td>• Graduate from RCP</td>
</tr>
<tr>
<td>RCP End Date – If RCP analyst determines that RCP should end, this date is entered by the analyst on Web InterChange Lock-in Providers – End this member’s RCP on field.</td>
<td>RCP End Date – If RCP analyst determines that RCP should end, this date is entered by the analyst on Web InterChange Lock-in Providers – End this member’s RCP on field.</td>
</tr>
<tr>
<td>Reason RCP Ended – If RCP analyst determines that RCP should end, this reason is selected by the analyst on Web InterChange Lock-in Providers – Reason RCP is being ended: field. Selections:</td>
<td>Reason RCP Ended – If RCP analyst determines that RCP should end, this reason is selected by the analyst on Web InterChange Lock-in Providers – Reason RCP is being ended: field. Selections:</td>
</tr>
<tr>
<td>• Graduate from RCP</td>
<td>• Graduate from RCP</td>
</tr>
<tr>
<td>• Successful Member Appeal</td>
<td>• Successful Member Appeal</td>
</tr>
<tr>
<td>• Other [text]</td>
<td>• Other [text]</td>
</tr>
</tbody>
</table>
Table 3.7 – Right Choices Program (RCP) Monthly Summary Report – Periodic Review Tracking Summary

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide each RCP Administrator and the OMPP with detailed information that allows tracking of RCP members eligible or overdue for a periodic review by predesignated time intervals, for each IHCP Program: Care Select, Hoosier Healthwise, Healthy Indiana Plan, and Traditional Medicaid.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Distribution</th>
<th>OMPP and RCP Administrators</th>
</tr>
</thead>
</table>

| Schedule | RCP Summary reports and files are run and posted to File Exchange each month on or before the first Monday following the first Sunday of each month. This run and post schedule accommodates inclusion of month-end data for the prior month, processed and loaded to Business Objects by the end of the previous month, which is the reporting period. |

<table>
<thead>
<tr>
<th>Report Layout</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Aging</th>
<th>RCP Program</th>
<th>Recipient Medicaid ID</th>
<th>RCP Start Date</th>
<th>Periodic Review Due Date</th>
<th>Periodic Review Start Date</th>
<th>Days Between Periodic Review Due and Start Dates</th>
<th>Days Between Current and Periodic Review Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-30 Days</td>
<td>[Administrator / Program] 999999999999 mm/dd/yy 2/14/2011</td>
<td>999999999999 mm/dd/yy 2/14/2011</td>
<td>999 999</td>
<td>999 999</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1-30 Days Totals:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60-90 Days</td>
<td>[Administrator / Program] 999999999999 mm/dd/yy 2/14/2011</td>
<td>999999999999 mm/dd/yy 2/14/2011</td>
<td>999 999</td>
<td>999 999</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60-90 Days Totals:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over 90 Days</td>
<td>[Administrator / Program] 999999999999 mm/dd/yy 2/14/2011</td>
<td>999999999999 mm/dd/yy 2/14/2011</td>
<td>999 999</td>
<td>999 999</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Over 90 Days Totals:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future</td>
<td>[Administrator / Program] 999999999999 mm/dd/yy 2/14/2011</td>
<td>999999999999 mm/dd/yy 2/14/2011</td>
<td>999 -999</td>
<td>999 -999</td>
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<td></td>
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<tr>
<td>Future Totals:</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of periodic review members</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>999</td>
</tr>
</tbody>
</table>
### Detailed 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* or *Days Between Current and Periodic Review Dates* fields, as defined by the following:

- 1-30 days overdue
- 60-90 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.

**Recipient Medicaid ID** – Medicaid recipient identification number of RCP member listed.

**RCP Start Date** – The beginning date of the currently active RCP enrollment period, as entered by the RCP analyst on Web interChange *RCP Status – Date RCP Starts* field.

**Periodic Review Due Date** – When activating RCP for a member, the date entered by the RCP analyst on Web interChange RCP Status – Periodic Review Date field. After the initial placement, the RCP analyst indicates subsequent Periodic review due dates, as Periodic reviews are completed, by entry on the *Periodic Review – Review and Submit – Date of Next Periodic Review* field.

**Periodic Review Start Date** – Date when **Submit Periodic Review** was selected by the RCP analyst on the *Periodic Review – Review and Submit* tab in Web interChange, after entering periodic review data.

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

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

[total] – Total number of Periodic Reviews scheduled.

---

### Table 3.8 – Right Choices Program (RCP) Monthly Summary Report – Diagnosis Codes

<table>
<thead>
<tr>
<th>Report Title</th>
<th>Right Choices Program (RCP) Monthly Summary Report – Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report Function</strong></td>
<td>Provide each RCP Administrator and the OMPP with detailed information indicating the diagnosis codes reviewed for each review type performed during the report period for each IHCP Program: Care Select, Hoosier Healthwise, Healthy Indiana Plan, and Traditional Medicaid.</td>
</tr>
<tr>
<td><strong>Distribution</strong></td>
<td>OMPP and RCP Administrators</td>
</tr>
<tr>
<td><strong>Schedule</strong></td>
<td>RCP Summary reports and files are run and posted to File Exchange each month on or before the first Monday following the first Sunday of each month. This run and post schedule accommodates inclusion of month-end data for the prior month, processed and loaded to Business Objects by the end of the previous month, which is the reporting period.</td>
</tr>
</tbody>
</table>
## Right Choices Program - Diagnosis Codes

<table>
<thead>
<tr>
<th>Medicaid ID</th>
<th>Last Name</th>
<th>First Name</th>
<th>Review Type</th>
<th>Diagnosis Code</th>
<th>Diagnosis Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>999999999999</td>
<td>Last</td>
<td>First</td>
<td>Initial</td>
<td>x9999</td>
<td>xxxxxxxxxxxxxxxxxxxxxxxxxxxx</td>
</tr>
<tr>
<td>999999999999</td>
<td>Last</td>
<td>First</td>
<td>Clinical</td>
<td>x9999</td>
<td>xxxxxxxxxxxxxxxxxxxxxxxxxxxx</td>
</tr>
<tr>
<td>999999999999</td>
<td>Last</td>
<td>First</td>
<td>Periodic</td>
<td>x9999</td>
<td>xxxxxxxxxxxxxxxxxxxxxxxxxxxx</td>
</tr>
</tbody>
</table>

### Detailed Field Definitions
- **Medicaid ID** – Medicaid recipient identification number of member reviewed.
- **Last Name** – Member’s last name.
- **First Name** – Member’s first name.
- **Review Type** – Type of review performed: Initial, Clinical, or Periodic.
- **Diagnosis Code** – ICD diagnosis code, as selected by the RCP analyst in Web interChange when completing the Initial, Clinical or Periodic review. Diagnoses are selected by the user on the following Web interChange screens, according to review type performed:
  - Initial – Initial Review – Demographic Info – Choose Diagnosis (15 max) field.
  - Clinical – Clinical Review – Choose Diagnosis (15 max) field.
  - Periodic – Periodic Review – Demographic Info – Diagnosis (choose up to 15) field.
- **Diagnosis Code Description** – Diagnosis code description, auto-population as associated with the diagnosis codes selected by the RCP analyst.
- **[total]** – Total number of reviews performed.

## Right Choices Program - Appeals

<table>
<thead>
<tr>
<th>Medicaid ID</th>
<th>Last Name</th>
<th>Date of Appeal</th>
<th>Appeal Type</th>
<th>Appeal Resolution</th>
<th>Date of Appeal Resolution</th>
<th>Date Clinical Review Completed</th>
<th>Clinical Review Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>999999999999</td>
<td>First</td>
<td>mm/dd/yy</td>
<td>M (MC)</td>
<td>U (Upheld)</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td>P (placed on RCP)</td>
</tr>
<tr>
<td>999999999999</td>
<td>First</td>
<td>mm/dd/yy</td>
<td>F (FSSA)</td>
<td>D (Dismissed)</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td>B (appropriate behavior)</td>
</tr>
<tr>
<td>999999999999</td>
<td>First</td>
<td>mm/dd/yy</td>
<td>O (Overturned)</td>
<td>C (refer to CM)</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td></td>
</tr>
</tbody>
</table>

### Report Function
Provide each RCP Administrator and the OMPP with detailed information related to open appeals and appeals resolved during the reporting month for each IHCP Program: Care Select, Hoosier Healthwise, Healthy Indiana Plan, and Traditional Medicaid.

### Distribution
OMPP and RCP Administrators

### Schedule
RCP Summary reports and files are run and posted to File Exchange each month on or before the first Monday following the first Sunday of each month. This run and post schedule accommodates inclusion of month-end data for the prior month, processed and loaded to Business Objects by the end of the previous month, which is the reporting period.
### Detailed Field Definitions

- **Medicaid ID** – Medicaid recipient identification number of member reviewed.
- **Recipient Name** – Member’s first and last name.
- **Date of Appeal** – The date of the appeal, as entered by the RCP analyst on the Web interChange Appeals – Date of Appeal: field.
- **Appeal Type** – One-character alpha code indicating the appeal type, as selected by the RCP analyst on the Web interChange Appeals – Appeal Type: field. Selections:
  - “M” – Appeal to MCE within 10 days
  - “F” – Appeal to FSSA
- **Appeal Resolution** – One-character alpha code indicating the appeal resolution, as selected by the RCP analyst on the Web interChange Appeals – Appeal Resolution: field. Selections:
  - “U” – Decision upheld – member on RCP
  - “O” – Decision overturned – member removed/released from RCP
  - “D” – Appeal Dismissed – member on RCP
- **Date of Appeal Resolution** – Date that the appeal was resolved, as entered by the RCP analyst on the Web interChange Appeals – Date of Appeal Resolution: field.
- **Date Clinical Review Completed** – The date the clinical review being appealed was completed, as entered by the RCP analyst on Web interChange Clinical Review – Date Clinical Review Completed: field.
- **Clinical Review Result** – One-character alpha code indicating the finding from the clinical review being appealed, as selected by the RCP analyst on Web interChange Clinical Review – Clinical Review Results field. Selections:
  - “P” – Placed on RCP
  - “B” – Not on RCP: Clinically Appropriate Behaviors
  - “C” – Not on RCP: See Case Management

### Table 3.10 – Right Choices Program (RCP) Monthly Summary Report – Provider and Member Summary

<table>
<thead>
<tr>
<th>Report Title</th>
<th>Right Choices Program (RCP) Monthly Summary Report – Provider and Member Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report Function</strong></td>
<td>Provide each RCP Administrator and the OMPP with detailed information related to lock-in providers associated with RCP members during the reporting month for each IHCP Program: Care Select, Hoosier Healthwise, Healthy Indiana Plan, and Traditional Medicaid.</td>
</tr>
<tr>
<td><strong>Distribution</strong></td>
<td>OMPP and RCP Administrators</td>
</tr>
<tr>
<td><strong>Schedule</strong></td>
<td>RCP Summary reports and files are run and posted to File Exchange each month on or before the first Monday following the first Sunday of each month. This run and post schedule accommodates inclusion of month-end data for the prior month, processed and loaded to Business Objects by the end of the previous month, which is the reporting period.</td>
</tr>
</tbody>
</table>
### Report Layout

#### Right Choices - Provider and Member Summary

<table>
<thead>
<tr>
<th>Provider Specialty</th>
<th>315</th>
<th>316</th>
<th>318</th>
<th>320</th>
<th>322</th>
<th>344</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Providers</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
</tr>
</tbody>
</table>

#### Provider Type

<table>
<thead>
<tr>
<th>Number of Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>999</td>
</tr>
</tbody>
</table>

#### Provider ID

<table>
<thead>
<tr>
<th>Provider ID</th>
<th>Number of Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>999999999</td>
<td>999</td>
</tr>
<tr>
<td>999999999</td>
<td>999</td>
</tr>
<tr>
<td>999999999</td>
<td>999</td>
</tr>
</tbody>
</table>

#### Provider and Member Detail for [Administrator / Program]

<table>
<thead>
<tr>
<th>Provider ID</th>
<th>Lockin Provider Name</th>
<th>Provider NPI</th>
<th>Provider Type Code</th>
<th>Provider Specialty Code</th>
<th>Recipient Medicaid ID</th>
<th>Lock In Effective Date</th>
<th>Lock In End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>999999999</td>
<td>First Last</td>
<td>99999999999</td>
<td>x</td>
<td>999</td>
<td>9999999999999999999</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
</tr>
<tr>
<td>999999999</td>
<td>First Last</td>
<td>99999999999</td>
<td>x</td>
<td>999</td>
<td>9999999999999999999</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
</tr>
<tr>
<td>999999999</td>
<td>First Last</td>
<td>99999999999</td>
<td>x</td>
<td>999</td>
<td>9999999999999999999</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
</tr>
</tbody>
</table>
### Detailed Field Definitions

**Report Title**

**Right Choices Program (RCP) Monthly Summary Report – Provider and Member Summary**

<table>
<thead>
<tr>
<th>Summary fields:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Specialty Number of Providers – Summary count of primary care physicians, by specialty; specialty as selected by the RCP analyst on Web interChange <em>Lock-in Providers</em> tab, when <strong>Assign a PCP</strong> is selected.</td>
</tr>
<tr>
<td>• Only providers designated as “yes” in the PCP? field of the <em>Lock-in Providers</em> tab, whose effective dates are within the reporting month, report.</td>
</tr>
<tr>
<td>Provider Type Number of Providers – Summary count of primary care physicians, by billing claim type, as systematically populated, based on the provider’s type and specialty selected by the RCP analyst on Web interChange <em>Lock-in Providers</em> tab, when <strong>Assign a PCP</strong> is selected.</td>
</tr>
<tr>
<td>• Only providers designated as “yes” in the PCP? field of the <em>Lock-in Providers</em> tab, whose effective dates are within the reporting month, report.</td>
</tr>
<tr>
<td>Provider ID Number of Members – Summary count of members assigned to each unique primary care physician, as selected by the RCP analyst on Web interChange <em>Lock-in Providers</em> tab, when <strong>Assign a PCP</strong> is selected.</td>
</tr>
<tr>
<td>• Only providers designated as “yes” in the PCP? field of the <em>Lock-in Providers</em> tab, whose effective dates are within the reporting month, report.</td>
</tr>
</tbody>
</table>

**Detail fields:**

- **Lock-in Provider ID** – Each unique primary care physician is listed, as selected by the RCP analyst on Web interChange *Lock-in Providers* tab, when **Assign a PCP** is selected.
- **Provider Name** – Name associated with each unique primary care physician listed, as cross-referenced systematically using IndianaAIM Provider tables.
- **Provider NPI** – NPI associated with each unique primary care physician listed, as cross-referenced systematically using IndianaAIM Provider tables.
- **Provider Type Code** – Two-digit provider type code associated with each unique primary care physician listed, as cross-referenced systematically using IndianaAIM Provider tables.
- **Provider Specialty Code** – Three-digit provider specialty code associated with each unique primary care physician listed, as cross-referenced systematically using IndianaAIM Provider tables.
- **Recipient Medicaid ID** – Recipient identification number for each RCP member where “yes” is designated in the PCP? of the *Lock-in Providers* tab for the reported provider ID during the month reported.
- **Lock-In Effective Date** – Effective date of the lock-in provider segment, as entered by the RCP analyst on Web interChange *Lock-in Providers* tab, for the reported provider ID during the month reported.
- **Lock-In End Date** – End date of the lock-in provider segment, as entered by the RCP analyst on Web interChange *Lock-in Providers* tab, for the reported provider ID during the month reported.
Table 3.11 – Right Choices Program (RCP) Transition [from Managed Care to fee-for-service]

<table>
<thead>
<tr>
<th>Report Title</th>
<th>Right Choices Program (RCP) Transition [from Managed Care to fee for service]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Function</td>
<td>Provide the fee-for-service RCP Administrator with detailed information related to RCP members who transitioned from managed care to fee-for-service during the reporting month.</td>
</tr>
<tr>
<td>Distribution</td>
<td>ADVANTAGE</td>
</tr>
<tr>
<td>Schedule</td>
<td>RCP Summary reports and files are run and posted to File Exchange each month on or before the first Monday following the first Sunday of each month. This run and post schedule accommodates inclusion of month-end data for the prior month, processed and loaded to Business Objects by the end of the previous month, which is the reporting period.</td>
</tr>
<tr>
<td>Report Layout</td>
<td>Medicaid RID</td>
</tr>
<tr>
<td></td>
<td>999999999999XXXXXX</td>
</tr>
<tr>
<td>Detailed Field Definitions</td>
<td>Medicaid RID – Medicaid recipient identification number of member who transferred.</td>
</tr>
<tr>
<td></td>
<td>Last Name – Member’s last name.</td>
</tr>
<tr>
<td></td>
<td>First Name – Member’s first name.</td>
</tr>
<tr>
<td></td>
<td>Effective Date – The beginning date of the currently active RCP enrollment period, as entered by the RCP analyst on Web interChange RCP Status – Date RCP Starts: field.</td>
</tr>
<tr>
<td></td>
<td>Submitted Periodic Review – Date when Submit Periodic Review was selected by the RCP analyst on the Periodic Review – Review and Submit tab in Web interChange, upon completion of periodic review data entry.</td>
</tr>
<tr>
<td></td>
<td>Periodic Review Date – The date when the next periodic review is due, as entered by the RCP analyst on Web interChange RCP Status – Periodic Review Date: field.</td>
</tr>
<tr>
<td></td>
<td>From MCO – The MCE number from which the member transferred, as referenced on the IndianaAIM PMP Assignment file.</td>
</tr>
</tbody>
</table>

Table 3.12 – Right Choices Program (RCP) Monthly Summary Report

<table>
<thead>
<tr>
<th>Report Title</th>
<th>Right Choices Program (RCP) Monthly Summary Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Function</td>
<td>Provide the OMPP with high-level statistics regarding reviews performed during the reporting month; report per RCP Administrator and program.</td>
</tr>
<tr>
<td>Distribution</td>
<td>OMPP</td>
</tr>
<tr>
<td>Schedule</td>
<td>RCP Summary reports and files are run and posted to File Exchange each month on or before the first Monday following the first Sunday of each month. This run and post schedule accommodates inclusion of month-end data for the prior month, processed and loaded to Business Objects by the end of the previous month, which is the reporting period.</td>
</tr>
</tbody>
</table>
### Right Choices Program (RCP) Monthly Summary Report

**Process:** Business Objects  
**Run Date:** mm/dd/yy  
**Run time:** HH:MM:SS

**For the dates of mm/dd/yy to mm/dd/yy**

<table>
<thead>
<tr>
<th>RCP Administrator and Program</th>
<th>Number of Initial Reviews</th>
<th>Potential Fraud</th>
<th>Citizen Referrals</th>
<th>Data Referrals</th>
<th>Pharmacy Referrals</th>
<th>Provider Referrals</th>
<th>Care Management Referrals</th>
<th>Other Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advantage - CS</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
</tr>
<tr>
<td>Advantage - TM</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
</tr>
<tr>
<td>Anthem - HHW</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
</tr>
<tr>
<td>Anthem - HIP</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
</tr>
<tr>
<td>MDwise - CS</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
</tr>
<tr>
<td>MDwise - HHW</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
</tr>
<tr>
<td>MDwise - HIP</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
</tr>
<tr>
<td>MHS - HHW</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
</tr>
<tr>
<td>MHS - HIP</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>999</strong></td>
<td><strong>999</strong></td>
<td><strong>999</strong></td>
<td><strong>999</strong></td>
<td><strong>999</strong></td>
<td><strong>999</strong></td>
<td><strong>999</strong></td>
<td><strong>999</strong></td>
</tr>
</tbody>
</table>

### Number of Reviews not Referred to Clinical Review by Reason

<table>
<thead>
<tr>
<th>RCP Administrator and Program</th>
<th>Referred to Care/Case Management</th>
<th>Member Utilization per PMP plan of care</th>
<th>Transient Member</th>
<th>ER Visit Followed by Inpatient Stay</th>
<th>Multiple Prescribers in same Group</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advantage - CS</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
</tr>
<tr>
<td>Advantage - TM</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
</tr>
<tr>
<td>Anthem - HHW</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
</tr>
<tr>
<td>Anthem - HIP</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
</tr>
<tr>
<td>MDwise - CS</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
</tr>
<tr>
<td>MDwise - HHW</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
</tr>
<tr>
<td>MDwise - HIP</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
</tr>
<tr>
<td>MHS - HHW</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
</tr>
<tr>
<td>MHS - HIP</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>999</strong></td>
<td><strong>999</strong></td>
<td><strong>999</strong></td>
<td><strong>999</strong></td>
<td><strong>999</strong></td>
<td><strong>999</strong></td>
</tr>
</tbody>
</table>
### Detailed Field Definitions

For each RCP Administrator and program:

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

- **Citizen Referrals** – Number of initial reviews performed that reported as Citizen Referrals on each corresponding individual RCP Administrator/program Right Choices Program (RCP) Monthly Summary Report – Initial Review tab.

- **Data Referrals** – Number of initial reviews performed that reported as Data Referrals on each corresponding individual RCP Administrator/program Right Choices Program (RCP) Monthly Summary Report – Initial Review tab.

- **Pharmacy Referrals** – Number of initial reviews performed that reported as Pharmacy Referrals on each corresponding individual RCP Administrator/program Right Choices Program (RCP) Monthly Summary Report – Initial Review tab.

- **Provider Referrals** – Number of initial reviews performed that reported as Provider Referrals on each corresponding individual RCP Administrator/program Right Choices Program (RCP) Monthly Summary Report – Initial Review tab.

- **Care Management Referrals** – Number of initial reviews performed that reported as Case Management Referrals on each corresponding individual RCP Administrator/program Right Choices Program (RCP) Monthly Summary Report – Initial Review tab.

- **Other Referrals** – Number of initial reviews performed that reported as Other Referrals on each corresponding individual RCP Administrator/program Right Choices Program (RCP) Monthly Summary Report – Initial Review tab.

Number of reviews not referred to clinical review, by reason, for each RCP Administrator and program:

- **Referred to Care/Case Management** – Number of initial reviews performed that reported as Not Referred to Clinical Review – Referred to Care/Case Management on each corresponding individual RCP Administrator/program Right Choices Program (RCP) Monthly Summary Report – Initial Review tab.

- **Member Utilization per PMP plan of care** – Number of initial reviews performed that reported as Not Referred to Clinical Review – Member Utilization per PMP plan of care on each corresponding individual RCP Administrator/plan Right Choices Program (RCP) Monthly Summary Report – Initial Review tab.

- **Transient Member** – Number of initial reviews performed that reported as Not Referred to Clinical Review – Transient Member on each corresponding individual RCP Administrator/program Right Choices Program (RCP) Monthly Summary Report – Initial Review tab.

- **ER Visit Followed by Inpatient Stay** – Number of initial reviews performed that reported as Not Referred to Clinical Review – ER Visit Followed by Inpatient Stay on each corresponding individual RCP Administrator/program Right Choices Program (RCP) Monthly Summary Report – Initial Review tab.

- **Multiple Prescribers in same Group** – Number of initial reviews performed that reported as Not Referred to Clinical Review – Multiple Prescribers in same Group on each corresponding
Table 3.13 – Potential Right Choices Program (RCP) Recipients

<table>
<thead>
<tr>
<th>Report Title</th>
<th>Potential Right Choices Program (RCP) Recipients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Function</td>
<td>Provide each RCP Administrator 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 Affiliated Computer Services (ACS). Administrators can use the report to assess the risk of abuse or misutilization in consideration of further action, such as RCP enrollment. Data reported is as of last day of month prior to run date. Look-back period is unique to each clinical criteria.</td>
</tr>
<tr>
<td>Distribution</td>
<td>RCP Administrators</td>
</tr>
<tr>
<td>Schedule</td>
<td>RCP Summary reports and files are run and posted to File Exchange each month on or before the first Monday following the first Sunday of each month. This run and post schedule accommodates inclusion of month-end data for the prior month, processed and loaded to Business Objects by the end of the previous month, which is the reporting period.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid ID</th>
<th>Last Name</th>
<th>First Name</th>
<th>Number of Prescribers</th>
<th>Number of Pharmacies</th>
<th>Number of Claims</th>
<th>Amount Paid</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>9999999999999</td>
<td>Last</td>
<td>First</td>
<td>999.99</td>
<td>999.99</td>
<td>999.99</td>
<td>999.99</td>
<td>INCAID: Psychotropic Polypharmacy</td>
</tr>
<tr>
<td>9999999999999</td>
<td>Last</td>
<td>First</td>
<td>999.99</td>
<td>999.99</td>
<td>999.99</td>
<td>999.99</td>
<td>PolyRx 10 or greater drugs (with CA/HIV/CRF)</td>
</tr>
<tr>
<td>9999999999999</td>
<td>Last</td>
<td>First</td>
<td>999.99</td>
<td>999.99</td>
<td>999.99</td>
<td>999.99</td>
<td>PolyRx 10, 1 MD</td>
</tr>
</tbody>
</table>

(Data reported is as of last day of month prior to run date. Look-back period is unique to each Rx clinical criteria.)

(Data Source: ACS Potential Report)
<table>
<thead>
<tr>
<th>Report Title</th>
<th>Potential Right Choices Program (RCP) Recipients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detailed Field</td>
<td>Medicaid RID – Medicaid recipient identification number of targeted member.</td>
</tr>
<tr>
<td>Definitions</td>
<td>Last Name – Member’s last name.</td>
</tr>
<tr>
<td></td>
<td>First Name – Member’s first name.</td>
</tr>
<tr>
<td></td>
<td>Number of Prescribers – Number of different prescribers, as submitted on claims for the member.</td>
</tr>
<tr>
<td></td>
<td>Number of Pharmacies – Number of different pharmacies, as submitted on claims for the member.</td>
</tr>
<tr>
<td></td>
<td>Number of Claims – Number of claims submitted for the member.</td>
</tr>
<tr>
<td></td>
<td>Amount Paid – Amount paid for claims submitted on behalf of the member.</td>
</tr>
<tr>
<td></td>
<td>Indicators – Clinical indicator flag description. See <a href="#">RCP Eligibility Review</a> for a complete list of</td>
</tr>
<tr>
<td></td>
<td>associated rules, flags, and clinical criteria.</td>
</tr>
</tbody>
</table>
Appendix A: Right Choices Program Member Summary Worksheets

The following screenshots represent pages found on Web interChange.

Member Summary Worksheet Initial Review

Figure A.1 – Member Summary Worksheet Initial Review (Page 1 of 3)
### UTILIZATION ANALYSIS

<table>
<thead>
<tr>
<th>Triggers for Clinical Review</th>
<th>Member's Total</th>
<th>Threshold for Review</th>
<th>Member's Total Meets or Exceeds Threshold?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of PMP Selections</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of ER Visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Prescribers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Pharmacies</td>
<td></td>
<td></td>
<td></td>
</tr>
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### MEDICATION THERAPY MANAGEMENT ANALYSIS

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<td>Number of Filled Prescriptions</td>
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<td>Total Cost</td>
</tr>
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</table>

---

Figure A.1 – Member Summary Worksheet Initial Review (Page 2 of 3)
### AUTOMATIC PLACEMENT INTO RIGHT CHOICES PROGRAM

Member is suspected or alleged to have obtained Medicaid services under fraudulent pretenses?
- Yes [ ]
- No [ ]

**Description of fraudulent activity:**

---

Member has received 5 or more psychotropic medications in a recent 45 day period?
- Yes [ ]
- No [ ]

Member has received benzodiazepines from 3 or more prescribers in a recent 90 day period?
- Yes [ ]
- No [ ]

**Notes:**

---

### CLINICAL REVIEW?

Clinical Review Warranted?
- Yes [ ]
- No [ ]

**Clinical Review Not Warranted Reason(s):**

---

**Date Sent to Clinical Review:**

---

**Notes:**

---

---

Figure A.1 – Member Summary Worksheet Initial Review (Page 3 of 3)
Figure A.2 – Member Summary Worksheet Clinical Review (Page 1 of 2)
Figure A.2 – Member Summary Worksheet Clinical Review (Page 2 of 2)
Member Summary Worksheet Periodic Review

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:  
RID #:  

SERVICE UTILIZATION ANALYSIS

Dates of Service Reviewed (6 months within a 12 month rolling period):  to  

MEMBER DIAGNOSES


Figure A.3 – Member Summary Worksheet Periodic Review (Page 1 of 3)
# Member Summary Worksheet Periodic Review

## UTILIZATION ANALYSIS

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<td>Number of Prescribers</td>
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*Data Source: RCM Information Management*

## MEDICATION THERAPY MANAGEMENT ANALYSIS

<table>
<thead>
<tr>
<th>Flags</th>
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<td>Number of Filled Prescriptions</td>
</tr>
<tr>
<td></td>
<td>Total Cost</td>
</tr>
</tbody>
</table>

*Data Source: RCP Personal Report*

Figure A.3 – Member Summary Worksheet Periodic Review (Page 2 of 3)
Figure A.3 – Member Summary Worksheet Periodic Review (Page 3 of 3)
Appendix B: Right Choices Program Member Letters

The Right Choices Program (RCP) Administrator generates the appropriate letter for the eligible RCP member. All member letters are on Indiana Family Social Services Administration (FFSA) letterhead.

Member Notification

This is the initial notification letter, sent via mail with delivery confirmation to notify the member they have been chosen for the RCP.

---

Figure B.1 – Member Notification Letter (page 1 of 2)
If you have questions about the Right Choices Program, refer to the enclosed Right Choices Program Member Booklet or call your Member Services line at the phone number above. If you disagree with our decision to select you for the Right Choices Program, you have 30 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 health care you need.

Respectfully,

The Right Choices Program
Enclosure.
Member Notification – Fee for Service

Figure B.2 – Member Notification Letter for Members in Traditional (Fee-for-Service) Medicaid (page 1 of 2)
If you have questions about the Right Choices Program, refer to the enclosed Right Choices Program Member Booklet or call your Member Services line at the phone number above. If you disagree with our decision to select you for the Right Choices Program, you have 30 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 health care you need.

Respectfully,

The Right Choices Program
Enclosure

Figure B.2 – Member Notification Letter for Members in Traditional (Fee-for-Service) Medicaid (page 2 of 2)
Provider Assignment

This letter is sent to the member to acknowledge the selection of his or her lock-in providers. A copy of the letter is also sent to assigned providers.

Member Number:

Dear

This letter is to provide you with a list of your team of providers for the Right Choices Program. This team of experts will be working with you to help you use your health care services the right way to help you feel better. They will be a part of your personal team of experts beginning through

The following Medicaid providers are your personal team of experts:

Figure B.3 – Provider Assignment Letter (page 1 of 2)
If you have any questions or concerns, please contact your Right Choices Program Administrator at the following address and phone:

Respectfully,

The Right Choices Program
Requesting a Change of RCP Provider

This letter is sent if the member has called the RCP Administrator to request a change of provider.

Figure B.4 – Requesting a Change of RCP Provider Letter
Member Notification of Continued Program Enrollment Following Review

This is the notification sent after completion of the periodic review.

Figure B.5 – Member Notification of Continued Program Enrollment Following Review Letter (page 1 of 2)
If you have any questions about your selected providers, please call your Right Choices Program Administrator.

NOTE: The Indiana Health Coverage Program will not pay charges for services obtained without a written referral from your primary medical provider.

If you disagree with our decision to place you in the Right Choices Program, you have 30 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 health care you need.

Respectfully,

The Right Choices Program
Enclosure
Member Program Enrollment Notification after Appeal in Favor of State

This is the notification sent after the appeal of the RCP decision.

Figure B.6 – Member Program Enrollment Notification after Appeal in Favor of State Letter (page 1 of 2)
If you have any questions, please call or write your Right Choices Program Administrator.

Respectfully,

The Right Choices Program
Graduation from Program

The letter is sent after a review to members who are being removed from the program.

Figure B.7 – Graduation from Program Letter
Confirmation Letter to Member of Change of Provider

This letter is sent if the member has called the RCP Administrator to request a change of provider.

Figure B.8 – Confirmation Letter to Member of Change of Provider (page 1 of 2)
If you have any questions, please call or write to your Right Choices Program Administrator:

Respectfully,

The Right Choices Program
Appendix C: Right Choices Program Provider Letters

Primary Care Physician Assignment

This is the initial letter sent to notify a provider of its selection as lock-in provider.

Figure C.1 – Primary Care Physician Letter (page 1 of 3)
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 also been assigned to the following providers:

The RCP Administrator for this member is:

HOW TO MAKE REFERRALS TO OTHER MEDICAL PROVIDERS

It is essential that a copy of your written referral be sent (preferably by fax) to the address below, when referring this member to any other provider outside of your care (e.g., referral to a cardiologist) 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.

(ATTN: RIGHT CHOICES PROGRAM)

FAX:

If another physician will be acting on your behalf, be aware that referrals are also required for all associates in your office, all associates in the referred office, and all on-call providers. Additionally, professional services, typically obtained by member self-referral (such as vision, podiatry, dental, and psychiatry), will require a referral from you in order for the provider to be added to this member’s lock-in list of approved providers.

Each referral must include the following information:
1. The HCFP member’s name
2. The HCFP member’s ID
3. The name and NPI number of the medical provider receiving the referral
4. The date of the referral
5. The primary lock-in medical provider’s signature (your signature).

Figure C.1 – Primary Care Physician Letter (page 2 of 3)
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 one 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 number to the RCP member. In order to safeguard your provider number, we ask that you communicate directly with the referred physician or referred physician’s office staff. The referred provider will be able to submit his or her claim electronically by supplying the primary lock-in medical provider’s number (i.e., your NPI number) in field 17A on the CMS-1500 claim form to note the referring provider.

OMPP greatly appreciates your assistance in coordinating the health care 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:

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

Sincerely,

The Right Choices Program

www.in.gov/fssa
Equal Opportunity/Affirmative Action Employer

Figure C.1 – Primary Care Physician Letter (page 3 of 3)
Hospital Provider Assignment

This is the initial letter sent to notify a hospital of its selection as lock-in hospital provider.

C/O BILLING DEPARTMENT
C/O EMERGENCY DEPARTMENT

Re:

Dear Hospital Provider:

The above referenced member is being placed in the IHCP Right Choices Program (RCP). You have been selected to serve as this member’s lock-in hospital provider.

WHAT IS THE RIGHT CHOICES PROGRAM?

The Right Choices Program (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 RCP is to provide quality health care through education and intervention that includes restriction to specific medical (physician), pharmacy, and hospital providers (lock-in providers). The RCP manages member utilization through intensive member education and case management. Please refer to the IHCP Provider Manual for more information about the Right Choices Program.

YOUR ROLE AS THE LOCK-IN HOSPITAL

The primary lock-in hospital is responsible for assuring that the RCP member is obtaining appropriate inpatient and outpatient services, including those rendered in an Emergency Room setting. If a member is found to be using the ER to obtain non-emergent services, the member’s PMP and RCP Administrator should be notified. The hospital is strongly encouraged to educate the member on appropriate utilization of the ER, and encourage him or her to see the assigned PMP for non-emergent services. The RCP Administrator will also provide education on the appropriate use of the ER.
This member has also been assigned to the following providers:

The RCP Administrator for this member is:

The PMP must make referrals for any other provider, including your hospital ER physicians, to receive payment for services rendered to this member.

Your role in the management of this member’s care will be essential to the efforts of the Right Choices Program. The OMEP and the RCP Administrator greatly appreciate the time and effort required to support this process. It is our hope that your support of this member, combined with the assigned physician and pharmacy, will promote appropriate utilization of IECP services and lead to positive health outcomes for this member.

If you need additional information regarding the Right Choices Program, please do not hesitate to contact:

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

Sincerely,

The Right Choices Program
Pharmacy Provider Assignment

This is the initial letter sent to notify a pharmacy of its selection as lock-in pharmacy provider.

ATTN: PHARMACY MANAGER

Re:

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 (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 RCP is to provide quality health care through education and intervention that includes restriction to specific medical (physician), pharmacy, and hospital providers (lock-in providers). The RCP manages member utilization through intensive member education and case management. Please refer to the IHCP Provider Manual for more information about the Right Choices Program.

This member has also been assigned to the following providers:

Figure C.3 – Pharmacy Provider Letter (page 1 of 3)
The RCP Administrator for this member is shown below:

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 OMFP and the RCP Administrator greatly appreciate the time and effort required to support this process. It is our hope that your support of this member, together with the assigned physician and hospital, will promote appropriate utilization of HCUP services and lead 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 lock-in medical provider (PMP), or other lock-in provider, can be filled through normal claims submission procedures (via paper, electronically, or POS). Each physician must be an HCUP enrolled provider to be an authorized provider for the RCP.

If a member presents a prescription from a provider not on the member’s lock-in eligibility screen, 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. When the pharmacist enters the level of service (e.g., 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/her primary lock-in medical provider, 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 Identification (NPI) number from a non-lock-in PMP to the lock-in PMP without a valid referral. If the NPI number 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. It is considered an act of Medicaid fraud for a Medicaid member to pay cash or a pharmacy provider to receive cash for services to which he or she is entitled under Medicaid.

If you have questions regarding these procedures, you may contact:

HP Pharmacy Claims Processor
(317) 655-3240 or (800) 577-1278
inxxpharmacy@hp.com

HP Pharmacy Claims Administrative Review
P.O. Box 7263
Indianapolis, IN 46207-7268

www.in.gov/fssa
Equal Opportunity/Affirmative Action Employer
If you verify the member’s eligibility and do not see the prescribing provider listed with the lock-in, 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 their lock-in provider; this situation will not affect your ability to file a claim for payment of service.

The OMFP greatly appreciates your assistance in coordinating the health care of this member. It is our hope that your support of this member, combined with the assigned physician and hospital, will promote appropriate utilization of HCP services and lead to positive health outcomes for this member.

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

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

Sincerely,

The Right Choices Program
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### Right Choices Program Policy Manual

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