



# INDIANA HEALTH COVERAGE PROGRAMS

## PROGRAM REFERENCE MODULE

# Right Choices Program

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## Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of February 13, 2017 Published: May 30, 2017	Scheduled update	FSSA and HPE
2.0	Policies and procedures as of October 1, 2017 Published: March 8, 2018	Scheduled update: <ul style="list-style-type: none"> <li>• Clarified references to services carved out of the RCP throughout the module</li> <li>• Updated instructions for eligibility verification in the <a href="#">Identification of RCP Members</a> section</li> <li>• Updated and clarified information in the <a href="#">Services Carved Out of the RCP</a> section</li> <li>• Clarified the criteria for clinical review in the <a href="#">Clinical Review</a> section</li> <li>• Clarified care coordination information in the <a href="#">Selecting and Entering Lock-In Providers</a> section</li> <li>• Updated the <a href="#">Removal from the RCP: Case Closure</a> section, including:               <ul style="list-style-type: none"> <li>– Updated the Portal process when a member is removed from RCP</li> <li>– Added receiving Medicare benefits as a reason that cases may be closed before the end of the RCP enrollment period</li> </ul> </li> <li>• Updated <a href="#">Section 2: Right Choices Program Reporting</a> to reflect the current process</li> <li>• Updated all the figures of letters, in <a href="#">Section 4</a> and <a href="#">Section 5</a></li> </ul>	FSSA and DXC



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# **Section 1: Introduction to the Right Choices Program**

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The Right Choices Program (RCP) is Indiana's Restricted Card Program. The goal of the RCP is to provide quality care through healthcare management, ensuring that the right service is delivered at the right time and in the right place for each member. All RCP members, providers, RCP Administrators, and the State collaborate to create a care coordination team for RCP members. The RCP encourages participation in all coordination efforts available to ensure that RCP processes and guidelines are carried out appropriately while members receive medically necessary care.

Managed care entities (MCEs) contracted with the Indiana Health Coverage Programs (IHCP) serve as the RCP Administrators on behalf of the State for members in managed care programs. The RCP Administrators for Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise managed care programs are:

- Anthem
- CareSource (HIP and Hoosier Healthwise only)
- Managed Health Services (MHS)
- MDwise (HIP and Hoosier Healthwise only)

The RCP Administrator for members who receive fee-for-service benefits under Traditional Medicaid is Cooperative Managed Care Services (CMCS).

See the *Care Management* section of the [IHCP Quick Reference Guide](#) at indianamedicaid.com for RCP Administrator contact information.

The RCP identifies IHCP members who use services more extensively than their peers. Members identified with high utilization are assigned to primary lock-in providers, such as:

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

Typically, members are locked in to all three provider types. However, members can be locked in to just one provider type (for example, pharmacy). If a member requires specialty services or services at a non-lock-in hospital or pharmacy, the PMP must make the referral for those services to be reimbursed.

## **Member Utilization Review Process**

Multiple vendors administer the RCP according to consistent policies established by the Family and Social Services Administration (FSSA). Therefore, providers must verify member eligibility to determine the appropriate member health plan assignment and RCP status. See the [Member Eligibility and Benefit Coverage](#) module for member eligibility information.

## Identification of RCP Members

The provider is responsible for checking the status of IHCP member eligibility before rendering services. While verifying eligibility, providers can confirm the member's RCP status. The IHCP reimburses only the providers to whom the member is restricted unless a referral is on file with the member's RCP Administrator or the service is for an emergency condition. If the member receives nonemergency services from providers that are not locked in, the IHCP does not reimburse the services.

RCP status is available through eligibility verification from the following options:

- Interactive Voice Response (IVR) system at 1-800-457-4584
- IHCP [Provider Healthcare Portal](http://portal.indianamedicaid.com) (Portal) at portal.indianamedicaid.com
- Electronic 270/271 interactive or batch transactions

If the member is enrolled in the RCP for the dates searched, the eligibility response indicates provider restrictions, including the provider type, name, and phone number for each provider to which the member is locked in. The eligibility response also provides MCE assignment information, if applicable. For managed care RCP members, the RCP Administrator is the member's assigned MCE. If no managed care information is provided in an RCP member's eligibility response, the member's coverage is fee-for-service and the RCP Administrator is CMCS.

On the IVR, RCP provider restrictions and MCE assignment, if applicable, are stated after the benefit coverage response. When providers verify eligibility on the Portal, the *Coverage Details* page includes all applicable panels, including:

- For managed care members – The **Managed Care Assignment Details** panel (which displays MCE information)
- For all RCP members – The **Right Choices Program** panel (which displays RCP provider restrictions)

Figure 1 – Right Choices Program Panel on the *Coverage Details* Page of the Portal Eligibility Verification

Right Choices Program				
RCP Provider	RCP Provider Phone	Service	Effective Date	End Date
		RCP-Physician	11/21/2016	11/21/2016
		RCP-Pharmacy	11/21/2016	11/21/2016
		RCP-Inpatient Hospital	11/21/2016	11/21/2016
		RCP-Outpatient Hospital	11/21/2016	11/21/2016

If no restrictions are listed, the member is not restricted to any specific provider. If the eligibility response indicates provider restrictions, the member is restricted to receiving services only from the specific providers listed, except for services carved out of the RCP (see the [Services Carved Out of the RCP](#) section). PMPs are encouraged to provide RCP referrals for all Medicaid services, including carved-out services. This process provides better coordination of care among providers and allows members to obtain prescriptions written by the referral providers at the member's 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. The [Electronic Data Interchange](#), [Interactive Voice Response System](#), and [Provider Healthcare Portal](#) modules provide expanded information about the eligibility verification options.

*Note: Claims for nonemergency services rendered by a provider not assigned or referred to an RCP member are denied.*



The provider types to which members are most often restricted are physicians, pharmacies, and hospitals. A member can be restricted to other provider types if such action is warranted.

RCP members include eligible HIP, Hoosier Care Connect, Hoosier Healthwise, and Traditional Medicaid members. The managed care entities (MCEs) monitor utilization for HIP, Hoosier Care Connect, and Hoosier Healthwise members and should be contacted directly to report utilization or billing issues.

For questions about RCP members, providers can find RCP telephone numbers and addresses in the [IHCP Quick Reference Guide](#) at indianamedicaid.com.

## Services Carved Out of the RCP

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

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

If the provider writes a prescription that will be dispensed at a pharmacy, an RCP referral is necessary for the prescription claim to be paid. Services that do not require an RCP referral, if no prescriptions will be written, include the following:

- Behavioral health
- Chiropractic services
- Dental services
- Diabetes self-management training services
- Family planning services
- Home health care
- Hospice
- Podiatric services
- Transportation
- Routine eye care (except surgery)
- Home and Community-Based Services (HCBS) waiver

If a member has shown misuse in one of the areas in this list, the member may be restricted to one provider in that specialty.

*Note: MCEs may require selection and lock-in for **behavioral health** providers and **dental** services, because these services are highly likely to generate prescriptions, especially for controlled substances.*

## RCP Member Initiating PMP Change

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

- Access to care
- Continuity of care
- Quality of care or service

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 letters.

## Emergency Services for RCP Members

The IHCP reimburses any provider for emergency services if the RCP member's case is related to a true emergency. Emergency services are services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in one or more of the following situations:

- Placing the patient's health in jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any body organ or part

For more information, see the [Primary Lock-In Hospital Responsibilities in the RCP](#) section.

## Billing for Services Rendered to RCP Members

A major factor in the success of the RCP is timely and appropriate claim adjudication. Claims may suspend or deny if all claim-processing guidelines have not been followed. Specific procedures on proper claim submission for Traditional Medicaid nonpharmacy claims are provided in the [Claim Submission and Processing](#) module. For pharmacy claim-submission procedures, see the [Pharmacy Services](#) module. For procedures on submitting managed care claims, contact the MCE in which the member is enrolled.

The following claim-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 submit a referral with the referral physician's National Provider Identifier (NPI) to the RCP Administrator by mail or fax, or via the Portal as outlined in the [Primary Lock-In Physician Responsibilities in the RCP](#) section of this document. The referral physician is encouraged to request a copy of the written referral from the PMP; however, this procedure is not necessary. The appearance of the referral physician's information on the member's eligibility verification (in the Portal, IVR system, or 270/271 electronic transaction) for the date of service allows for payment. Referral providers may elect to print the Portal eligibility verification and retain it for billing purposes.

If the referral physician writes a prescription, it is recommended that a copy of the written referral or a printout of the member's eligibility verification from the Portal (with the Right Choices Program detail panel expanded to show the RCP referral provider) accompany the prescription to the primary lock-in pharmacy. If the referral was submitted by mail, and the RCP Administrator has not yet added the written referral to the Portal, the pharmacy should contact the RCP Administrator to verify validity and entry of the referral. If the pharmacy is unable to contact the RCP Administrator, such as in an after-hours situation, the pharmacist is encouraged to use his or her judgment as to whether the medication need is emergent. If the pharmacist makes such a determination, the pharmacist should submit the pharmacy claim with an emergency indicator and dispense a 72-hour supply.

After the RCP Administrator adds a provider to a member's lock-in table, as described in the [Selecting and Entering Lock-In Providers](#) section of this document, the provider files the claim in the usual manner. The PMP NPI must be reported in the referring provider field of the professional claim. For paper claim submissions, the member's PMP lock-in provider taxonomy code and ZZ or PXC qualifier must be included in field 17a of the *CMS-1500* claim form, if necessary to make the required one-to-one match between the NPI and Provider ID.

## ***Non-IHCP and Out-of-State Physicians***

Out-of-state provider numbers do not bypass the lock-in list and are not accepted as a valid lock-in provider number for an RCP member; therefore, all out-of-state physicians must have an IHCP Provider ID to be a covered provider for the RCP. If the physician is out-of-state, the RCP Administrator determines whether the physician has an IHCP Provider ID.

- If the physician has an IHCP Provider ID, 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 ID, the physician is not a covered provider for the RCP.

## ***Lock-In Hospitals and Other Acute Care Facilities***

The primary lock-in hospital and other acute care facilities can file claims as they would for any non-RCP member, but only if the facility's IHCP Provider ID is on the member's lock-in list.

A hospital that is the member's primary lock-in hospital can file claims in the same manner followed for non-RCP members because the hospital's Provider ID is on the member's RCP lock-in table. A hospital that is not the member's primary lock-in hospital must file claims with the lock-in physician's NPI as the "other operating provider" on the institutional claim (field 78 of the *UB-04* claim form). A referral from a PMP is required to add another acute care hospital to the lock-in list if services are being rendered at a facility other than the primary lock-in hospital for applicable dates of service only. See the [Primary Lock-In Physician Responsibilities in the RCP](#) section of this document for information about PMP referrals.

For hospitals billing physician services on the *CMS-1500* claim form or electronic equivalent, see the instructions in the [Referral Physicians](#) section of this document.

## ***Pharmacies (For All IHCP Programs)***

The prescription must be written by the PMP lock-in provider or a valid referral doctor and be presented at the lock-in pharmacy. Claims can be submitted through POS. If an RCP member presents a prescription at the lock-in pharmacy from a prescriber that is not the primary lock-in provider or a valid referral provider, the claim will be denied. If an RCP member presents a prescription to a pharmacy that is not on the member's lock-in list, the claim will be denied.

If the claim denies for an invalid prescriber identification, the pharmacy should contact the RCP Administrator to confirm whether the prescription was written by an authorized lock-in prescriber. The pharmacy should not fill prescriptions written by non-lock-in prescribers until the primary lock-in prescriber's referral has been obtained. The primary lock-in pharmacy may fill any legal prescription, but the IHCP does not reimburse claims for prescriptions that are not written by the primary lock-in prescriber or a referred prescriber. For procedures on submitting managed care claims, contact the MCE in which the member is enrolled. For pharmacy claim-submission procedures, see the [Pharmacy Services](#) module.

See the [Primary Lock-In Pharmacy Responsibilities in the RCP](#) section of this document.

## RCP Policies and Procedures

In accordance with *Code of Federal Regulations 42 CFR Sections 455 and 456*, the IHCP developed the Right Choices Program to assist members with using the appropriate care at the appropriate place and time. 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.

After the review process, if it is determined that the member being reviewed is overusing or abusing services, the member is placed in the RCP, which includes provider assignment, member education, and interventions. The member is assigned to a PMP, a pharmacy, a hospital, and approved specialty providers, as appropriate.

## Member Information

### RCP Eligibility Review

IHCP members eligible for enrollment in the RCP include members in HIP, Hoosier Care Connect, Hoosier Healthwise, and Traditional Medicaid.

Identification of members eligible for the RCP can 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. The 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 on suspicion of overuse or misuse of services by a member. Referral sources may include the FSSA, state and local law enforcement agencies, the FSSA's Division of Family Resources (DFR), pharmacies, physician offices, hospitals, and emergency rooms. Referrals may be made by telephone, mail, or email. The RCP Administrator's designated department must complete the RCP screening process within 60 calendar days of receiving a referral. Typical referral reasons include overutilization of Medicaid services, such as multiple visits to the emergency room (ER), doctor shopping, frequent dismissals by doctors, or polypharmacy. In addition, referrals are made when Medicaid members are suspected of activities such as drug abuse or dependence or prescription forgery and selling drugs, supplies, or equipment obtained through Medicaid. Referrals are made when members pay cash for Medicaid covered services that would exceed predetermined standards as outlined in *42 CFR 456.709*.
3. Data-mining techniques – Patterns of member utilization can be aggregated from the RCP Administrator's applicable data source, such as the IHCP Core Medicaid Management Information System (*CoreMMIS*). The RCP Administrator is required to run a report that contains, at minimum:
  - Number of PMP selections (changes)
  - Number of ER visits
  - Number of prescribers
  - Number of pharmacies used

The specifications for the previously mentioned reports are found in the reporting manual for each program of the MCE. Additional areas of high utilization are determined from the review of multiple areas that include, but are 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

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

## Initial Review

After a member is identified for initial review, the RCP Administrator enters the initial review information into the Portal as follows:

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

Figure 2 – Initial Review Tab: Review Period

History **Initial Review** Clinical Review RCP Status Periodic Review Lock-In Providers Letters Appeals Attachments

To begin, enter the date range covered by this review and click **Continue**.

**Step 1: Review Period**

\* Indicates a required field.

**Dates of Service Reviewed**

→ \* From Date  → \* To Date

**Continue** **Cancel**

6. Enter the dates of service reviewed in the From Date and To Date fields, and then click **Continue** to open the Review Details panel.

Figure 3 – Initial Review Tab: Review Details

**Step 2: Review Details**

\* Indicates a required field.

**Dates of Service Reviewed**

From Date 09/10/2015 To Date 08/10/2016

[Expand All](#) | [Collapse All](#)

**Demographic Information** +

**Utilization Information** +

**Automatic Review** +

**Clinical Review Information** +

[Back](#) [Submit](#) [Cancel](#)

7. Click the plus signs (+) to view and enter information in the four sections of the Review Details panel:
  - Demographic Information (see [Figure 4](#))
  - Utilization Information (see [Figure 5](#))
  - Automatic Review (see [Figure 6](#))
  - Clinical Review Information (see [Figure 7](#))
8. After reviewing each section and adding information as needed, click **Submit** to save the member's initial review.

*Note: PDF files of completed reviews, called Right Choices Program Member Summary Worksheets, may be accessed and printed from the **History** tab of the Right Choices Program Member Summary page.*

Figure 4 – Initial Review Tab: Demographic Information

**Demographic Information** -

\*Referred By ☐ Medical Provider  
☐ Care/Case Management  
☐ Citizen  
☐ Pharmacy  
☐ Data Report  
☐ Other Other, please explain

**Diagnosis Codes**

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

#	Diagnosis Type	Diagnosis Code	Action
<input type="checkbox"/> Click to collapse.			
	*Diagnosis Type	ICD-10-CM <input type="text"/>	
	*Diagnosis Code	<input type="text"/>	

[Add](#) [Cancel](#)

Figure 5 – Initial Review Tab: Utilization Information

Utilization Information			
Total Paid Claims during Review Period \$11,343.07			
Utilization Analysis			
Triggers for Clinical Review	Member Total	Threshold for Review	Member Total Meets or Exceeds Threshold?
# of PMP Selections	1	3	No
# of ER Visits	5	3	Yes
# of Prescribers	0	3	No
# of Pharmacies	0	3	No
# of Controlled Substance Prescriptions	0	For Reference Only	
# of Prescriptions	0	For Reference Only	
*Data Source: CoreMMIS			
Medication Therapy Management Analysis			
Flags	Drug Class or Polypharmacy		
	# of Prescribers 0 # of Pharmacies 0 # of Prescriptions 0 Total Cost \$0.00		
*Data Source: RCP Potential Report			

Figure 6 – Initial Review Tab: Automatic Review

Automatic Review	
Automatic Placement into Right Choices Program	
*Member is suspected or alleged to have obtained Medicaid services under fraudulent pretenses?	<input type="radio"/> Yes <input type="radio"/> No
Description of Fraudulent Activity	<input type="checkbox"/> Allowing another individual to use Medicaid ID card <input type="checkbox"/> Inappropriately paying cash for Medicaid covered goods and/or services <input type="checkbox"/> Selling drugs obtained through Medicaid <input type="checkbox"/> Selling other goods obtained through Medicaid
*Member has received 5 or more psychotropic medications in a recent 45 day period?	<input type="radio"/> Yes <input type="radio"/> No
*Member has received benzodiazepines from 3 or more prescribers in a recent 90 day period?	<input type="radio"/> Yes <input type="radio"/> No
Notes	<div style="border: 1px solid black; height: 40px; width: 100%;"></div>



Figure 7 – Initial Review Tab: Clinical Review Information

## Clinical Review

Members are sent for clinical review if they fit either of the following criteria:

- Meet or exceed the thresholds, as determined by the FSSA, in at least one of the four utilization criteria groups ([Figure 5](#)).
- Receive a Yes answer to any of the questions in the Automatic Review section of the initial review ([Figure 6](#)).

The clinical reviewer determines whether the member is 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 FSSA will notify RCP Administrators of any changes in the thresholds at least 60 days before implementation.

RCP inclusion may be the result of member behaviors such as:

- Fraudulent pretenses that may include, but are not limited to, stealing prescription pads or paying cash for prescriptions that exceed predetermined standards, as outlined in *42 CFR 456.709*
- 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.

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

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



Figure 8 – Clinical Review Tab

History Initial Review **Clinical Review** RCP Status Periodic Review Lock-In Providers Letters Appeals Attachments

Enter the information related to this review and click **Submit**.  
To cancel the entry of this review, click **Cancel**.

\* Indicates a required field.

\* Review Completed By: Test Clinical Review

\* Date Review Completed: 10/08/2016

\* Review Result: Member placed on RCP

\* Member reported to FSSA Bureau of Investigation? ☒ Yes ☐ No

Notes

**Diagnosis Codes**

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

#	Diagnosis Type	Diagnosis Code	Action
1	ICD-10-CM	J020-STREPTOCOCCAL PHARYNGITIS	<a href="#">Remove</a>
2	ICD-10-CM	J029-ACUTE PHARYNGITIS, UNSPECIFIED	<a href="#">Remove</a>

Click to add a new diagnosis code.

**Submit** **Cancel**

## Determination of RCP Placement

Using the previous reporting tools and the *Right Choices Program Member Summary Worksheets* (accessed from the History tab), the RCP Administrator determines whether the member is placed in the RCP. If the member is not placed in the program, one of the following occurs:

- The managed care member is referred to care management or complex case management for further interventions and education.
- The member continues the current course of action if the member's information documents clinically appropriate behaviors and utilization.
- The member is reported to the Indiana FSSA's Bureau of Investigations for potential fraud investigation.

## RCP Initiation and Member Notification

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

Figure 9 – RCP Status Tab

History Initial Review Clinical Review **RCP Status** Periodic Review Lock-In Providers Letters Appeals Attachments

To place a member into the Right Choices Program, enter the start and end date when the member will be in the program, as well as the date of their Periodic Review and click **Submit**.  
To cancel this entry, click **Cancel**.

\* Indicates a required field.

\*Date RCP Starts

\*Date RCP Ends

\*Periodic Review Date

**Submit** **Cancel**

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. The RCP enrollment period may last up to two years and may be renewed for an additional two-year period on review.

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

After the member's eligibility has been verified, the Portal generates an *Initial Notification Letter*. (See the [Right Choices Program Member Letters](#) section.) The RCP Administrator sends the letter to the member via U.S. mail with delivery confirmation or any other carrier with which the RCP Administrator may have negotiated rates, as long as the letter can be tracked. The letter is addressed to the member from the State, and 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. The RCP Administrator must make a minimum of three attempts on three separate dates to reach the member by telephone.

## Selecting and Entering Lock-In Providers

The member has 10 calendar days from the date the *Initial Notification 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. The member may be assigned to more than one pharmacy, if indicated. 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.

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

Figure 10 – Lock-In Providers Tab

History Initial Review Clinical Review RCP Status Periodic Review **Lock-In Providers** Letters Appeals Attachments

To end a member's participation in the Right Choices Program, enter the date their participation will end and a reason for ending their participation, then click **Submit**.

\* Indicates a required field.

[Expand All](#) | [Collapse All](#)

Active RCP Dates			
Indicator	Effective Date	Review Date	End Date
IN	10/28/2016	12/31/2016	12/31/2016

**End Current RCP**

\*End Date

\*Reason

**Lock-In Providers**

☒ Indicates a PMP Provider.

Click "+" to view or update the details in a row. Click "-" to collapse the row.

+/-	Provider ID	NPI	Provider Name	Provider Type	Provider Specialty	PMP	Lock-In Type	Claim Type	Effective Date	End Date
<input type="checkbox"/>	Click to collapse.									

Select a Lockin Type and Click the Search Provider Button to select a lock-in provider.

\*Lock-In Type

\*Effective Date

\*End Date

Provider ID	200200200	NPI	10000100011
Last Name	XXXXXXXX	First Name	XXXXXXXX
Middle	-		
Provider Type	Physician	Provider Specialty	Family Practitioner
PMP	<input checked="" type="checkbox"/>		

After lock-in providers have been entered into the Portal, an *RCP Provider Assignment Letter* can be generated and sent to the member. Letters are also generated and mailed to providers notifying them of these selections and giving a summary of their responsibilities as the assigned providers. See the [Right Choices Program Member Letters](#) and [Right Choices Program Provider Letters](#) sections for details.

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 by mail or fax, or submit the referral via the Portal as described in the [Primary Lock-In Physician Responsibilities in the RCP](#) section of this document. The RCP Administrator's medical director may authorize a one-time referral if the PMP cannot be reached.

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

Figure 11 – Search RCP Referral Requests

**Search RCP Referral Requests**

This page will open displaying only unprocessed requests. To perform another search, use one or more of the fields below.

\* Indicates a required field.

Status:  Request Date From:  To:

Member ID:  Last Name:  First Name:

Requesting Provider ID:  Provider ID Type:

---

**Search Results**

Total Records: 1

+/-	Date of Request	Member	Requesting Provider	Action	Lockin Provider	Effective Date	Temp End Date	Status / Action
<input type="checkbox"/>	10/28/2016	XX XXXXXXXX #####	XXXXXXX ES #####	Remove Provider	XYZ COUNTY MEMORIAL HOSPITAL – ACH ##### Acute Care	10/28/2016 11/05/2016	11/03/2016	Unprocessed <input type="button" value="Approve"/> <input type="button" value="Deny"/>

Referrals submitted by mail or fax can be manually entered into the Portal from the Lock-In Providers tab (see [Figure 10](#)). For these providers, select **Referral** from the Lock-In Type drop-down menu, select the appropriate claim type, and then search for and add the desired provider.

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 or wants to change PMP, or if the chosen PMP displays utilization abnormalities, the RCP Administrator helps the member select 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 (for HIP, this condition applies only to *HIP State Plan – Plus* and *HIP Basic* members, as well as HIP pregnant members)
  - 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's dissatisfaction with treatment by doctor or staff

This provision does not include a member's dissatisfaction with a plan of treatment, prescription utilization contract, written prescriptions (type and quantities), or lack thereof. This provision exists specifically to address any potential quality-of-care or abuse issues that may be present in the treatment of the member by the doctor or staff.

- Specialty services required due to language, cultural, or other communication barriers with current PMP
  - Ongoing unresolved provider or member conflict
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 RCP 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 once 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. The RCP Administrator then reviews the change request. If a member's lock-in providers are changed, he or she receives a letter with the new providers' information. The new lock-in providers also receive a copy of the letter.

After enrolled in the RCP program, the RCP Administrators are responsible for the general operations and oversight of the RCP and all RCP members assigned to them. The RCP Administrators are required to perform the following duties:

1. Intervene in the care provided to RCP members by providing, at minimum:
  - Enhanced education
  - Case management
  - Care coordination with the goal of modifying member behavior
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 will terminate or continue.

The MCEs provide care, case, and/or disease management for managed care RCP members if these members are assigned to a care or case manager for additional assistance with service coordination. CMCS provides care coordination for members in RCP who receive fee-for-service benefits.

## Periodic Reviews

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

Figure 12 – Periodic Review Tab: Dates of Service Reviewed

History Initial Review Clinical Review RCP Status **Periodic Review** Lock-In Providers Letters Appeals Attachments

To begin, enter the date range covered by this review and click **Continue**.

**Step 1: Review Period**

\* Indicates a required field.

**Dates of Service Reviewed**

→ From Date  → To Date

**Continue** **Cancel**

Figure 13 – Periodic Review Tab: Demographic Information, Utilization Information, and Periodic Review Information

**Step 2: Review Details**

\* Indicates a required field.

**Dates of Service Reviewed**

From Date 01/01/2015 To Date 06/30/2015

[Expand All](#) | [Collapse All](#)

**Demographic Information**

**Diagnosis Codes**

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

#	Diagnosis Type	Diagnosis Code	Action
<input type="checkbox"/> Click to collapse.			
*Diagnosis Type ICD-10-CM *Diagnosis Code <input type="text"/>			
<input type="button" value="Add"/> <input type="button" value="Cancel"/>			

**Utilization Information**

Total Paid Claims during Review Period \$0.00

**Utilization Analysis**

Triggers for Clinical Review	Initial Review Total 1/26/2012	Periodic Review Total 1/28/2014	Periodic Review Total 10/27/2015	Member Current Total
# of PMP Selections	1	0	3	1
# of ER Visits	17	19	9	3
# of Prescribers	6	1	1	0
# of Pharmacies	5	1	1	0
# of Controlled Substance Prescriptions	9	4	0	0
# of Prescriptions	17	15	1	0

\*Data Source: CoreMMIS

**Medication Therapy Management Analysis**

Medication Therapy Management Analysis	Drug Class or Polypharmacy
	# of Prescribers 0 # of Pharmacies 0 # of Prescriptions 0 Total Cost \$0.00

\*Data Source: RCP Potential Report

**Periodic Review Information**

\*Form Completed By

Date of Next Periodic Review

\*Review Result

Notes



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

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

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

In some cases, after the completion of a periodic care review, the RCP member may be recommended for removal from the RCP by his or her care or case manager if this individual believes the member will utilize services appropriately without supervision.

## **Removal from the RCP: Case Closure**

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

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

- Member's assigned care or case manager
- 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
- Active diagnoses and corresponding medications (such as appropriateness of medications)
- ER claims and reasons for using ER, consistent with desired quality outcomes of the program
- 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 PMP changes and reason for the 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 must 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 is removed from the RCP.
2. The member has *not* been compliant and will continue in the RCP (for up to an additional two years).
3. If the member is referred to law enforcement due to suspected fraudulent practices, this referral does not terminate the member from the program. The member will continue in the RCP for two years.



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

- The care panel disenrolls the member from the RCP.
- The RCP Administrator enters an end date and reason in the End Current RCP section of the Lock-In Providers tab (see [Figure 10](#)). The Portal generates a letter to the member from the RCP Administrator stating that the member is no longer in the RCP.
- The RCP Administrator continues to monitor the member's utilization pattern for six months to ensure that the member remains stabilized and does not revert to former behaviors of misuse.
- Managed care members continue to have direct access to a care or a case manager for questions or concerns as the member transitions out of the RCP.
- If care management observes during the trial period that a member reverts to misuse, the member may be re-enrolled in the program before or at the end of the six-month trial period. If the member is re-enrolled in the program, the same procedures are 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 were added through his or her referral to the lock-in list.

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

- The member has been assigned to hospice care. The Prior Authorization Department notifies the RCP Administrator that the member has been approved for hospice care.
- The member appealed and received a judgment in favor of the appellant. The member's enrollment in the RCP ends when notification is received from the Family and Social Services Administration Office of Hearings and Appeals.
- The member receives Medicare benefits in addition to IHCP Medicaid benefits.
- The member is no longer an IHCP-covered member.
- The member is deceased.
- The member is placed in a 590 Program facility.

## Member Hearings and Appeals

### *Initial Enrollment in the RCP*

The member has 33 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 33 calendar days, the appeal is timely. However, the member's enrollment is initiated and remains in effect until the hearing occurs and the decision to rescind is rendered.

### *Continued Enrollment in the Program*

A 33-day 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*

HIP, Hoosier Care Connect, or Hoosier Healthwise members must exhaust the MCE's grievance and appeals process before requesting a fair hearing from the State.

Traditional Medicaid members must 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 at the following address:

**MS-04  
Hearings and Appeals Section  
Indiana Family and Social Services Administration  
402 W Washington St., Room E034  
Indianapolis, IN 46204-2773**

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

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

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

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

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

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

## Member Appeals Information Packet

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

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

Copies of the member information packet must be provided to all relevant parties. Additionally, information that identifies a physician or RCP staff must 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 the [Release of Member Protected Health Information](#) section.

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

Figure 14 – Appeals Tab

History Initial Review Clinical Review RCP Status Periodic Review Lock-In Providers Letters **Appeals** Attachments

Enter the information related to this appeal and click **Submit**.  
To cancel the entry of this appeal, click **Cancel**.

\* Indicates a required field.

\*Date of Appeal

\*Appeal Type

Cause Number

\*Appeal Resolution

\*Date of Appeal Resolution

Notes

**Submit** **Cancel**

## 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 the Portal.

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. A reduction is also anticipated in inappropriate use of pharmacy and other health services, which could harm the member and create unnecessary and wasteful program expenditures.

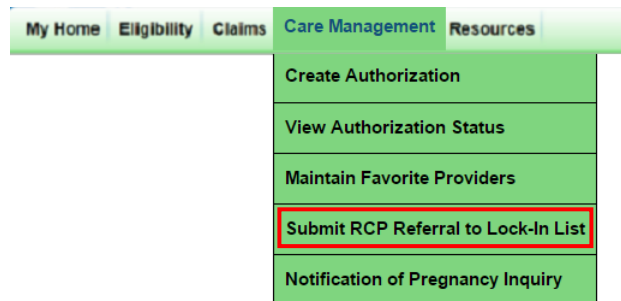
The member must be notified in advance of receiving any service that is not covered by Medicaid. The member must sign a waiver acknowledging that he or she will be billed for the noncovered service before receiving the service. However, if a member pays cash (and a provider receives cash) for any Medicaid-covered service that exceeds predetermined standards outlined in *42 CFR 456.709(b)*, it may be considered a fraudulent activity on the part of both the member and the provider.

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.

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

1. Log into the [Provider Healthcare Portal](http://indianamedicaid.com) at indianamedicaid.com.
2. From the Care Management tab of the Portal menu bar, select **Submit RCP Referral to Lock-In List**.

Figure 15 – The Portal Care Management Tab



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

Figure 16 – Member Information Section

**INDIANA MEDICAID for Providers**

My Home | Eligibility | Claims | Care Management | Resources

Care Management > Submit RCP Referral to Lock-In List

Monday 10/10/2016 12:59 PM

**Submit RCP Referral for Lock-In List**

\* Indicates a required field.

**Requesting Provider Information**

Requesting Provider Information

Provider ID  ID Type  NPI  Taxonomy  Name

**Member Information**

Enter Member ID, Date of Birth and at least one character of First and Last Name

\*Member ID  \*Birth Date

\*Last Name  \*First Name

**Continue** **Reset**

4. If the provider is the member's PMP, the Portal displays the member's Lock-In Providers list.

Figure 17 – Lock-In Providers

Member ID 01		Birth Date							
Member		Gender							
Active RCP Dates									
Indicator IN		Effective Date 1/11/2015	End Date 9/15/2016						
Lock-In Providers									
<input checked="" type="checkbox"/> Indicates a PMP Provider.									
Provider ID	NPI	Provider Name	Provider Type	Provider Specialty	PMP	Lock-In Type	Claim Type	Effective Date	End Date
			Physician	General Internist	Yes	Primary Medical Provider	Medical	01/11/2015	04/15/2016
			Pharmacy	Pharmacy	No	Pharmacy	Pharmacy	01/11/2015	04/15/2016
			Physician	General Surgeon	No	Referral	Medical	03/10/2015	04/15/2015
			Physician	General Internist	No	Referral	Medical	06/01/2015	02/01/2016

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

Figure 18 – Referral Request Information

**Referral Request Information**

\* Indicates a required field.

Select an action to update the Member's Lock-In List.

\*Action

☒ I authorize this member to be seen by the physician/practice/pharmacy listed below for the dates indicated. Please add physician/practice/pharmacy to the member's list of approved providers.

☐ I authorize that the member's lock-in pharmacy be changed to the pharmacy listed below on the effective date indicated.

☐ I authorize that the selected provider/practice/pharmacy be removed from the member's list of approved providers on the effective date indicated.

Click the Search Provider button below to find the correct Provider Location for the new Lockin Provider. Then enter the effective dates and Claim Type and hit the Submit button.

**Search Provider**

Provider ID  ID Type  Name

Taxonomy  Provider Type  Specialty

\*Effective Date  \*Claim Type

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

Figure 19 – Right Choices Program Provider Search and Search Results

**Right Choices Program Provider Search** [Back to Submit RCP Referral](#)

\* Indicates a required field.

Provider ID  Provider ID Type

Organization Name or First Name

Last Name

ZIP Code

Provider Type

Provider Specialty

**Search** **Cancel**

---

**Search Results**

To add a provider to the member's Lock-In Provider list, click **Select Provider** next to the appropriate provider.

Total Records: 1

Action	National Provider ID	Provider ID	Provider Name	Provider Address	Provider Type	Provider Specialty
<a href="#">Select Provider</a>						

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

Figure 20 – Referral Request Information

**Referral Request Information**

\* Indicates a required field.

Select an action to update the Member's Lock-In List.

\*Action

- ☒ I authorize this member to be seen by the physician/practice/pharmacy listed below for the dates indicated. Please add physician/practice/pharmacy to the member's list of approved providers.
- ☐ I authorize that the member's lock-in pharmacy be changed to the pharmacy listed below on the effective date indicated.
- ☐ I authorize that the selected provider/practice/pharmacy be removed from the member's list of approved providers on the effective date indicated.

Click the Search Provider button below to find the correct Provider Location for the new Lockin Provider. Then enter the effective dates and Claim Type and hit the Submit button.

**Search Provider**

Provider ID  ID Type  Name

Taxonomy  Provider Type  Specialty

\*Effective Date   \*Claim Type

**Attachments**

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to add attachment.					

**Submit** **Cancel**

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

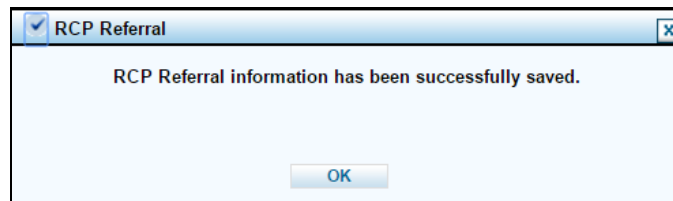
Figure 21 – Attachments for RCP Referral

#	Transmission Method	File	Control #	Attachment Type	Action
Click to collapse.					
*Transmission Method: FT-File Transfer *Upload File: Choose File   Exams.txt *Attachment Type: 06-Initial Assessment					
<input type="button" value="Add"/> <input type="button" value="Cancel"/>					
<input type="button" value="Submit"/> <input type="button" value="Cancel"/>					

10. Click **Submit** to finalize the submission of the RCP referral.

11. The Portal displays a confirmation message for the provider submission. Click **OK**.

Figure 22 – RCP Referral Confirmation Message



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

Referral physicians who treat lock-in members are responsible for checking Medicaid eligibility and must 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 submit it to the RCP Administrator before the third provider is added to the member's lock-in list. The referral must include the following information:

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

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

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

When the PMP approved the services provided on the date of service but failed to submit the referral to the RCP Administrator at that time, the PMP may submit retroactive referrals. Retroactive referrals may be accepted if the start date of the retroactive referral is within the claims' filing limit. The retroactive referral may be valid for up to one year from the retroactive start date. The PMP's medical records for the member should indicate that on or near the date of service, the referred service was approved. The PMP is not required to approve any service he or she did not know about 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 moves out of the region without proper notification to the program
- Newly transitioned members into the program, such as wards and foster children, who are in need of treatment within the first 60 days of enrollment
- Auto-assigned member living in an underserved area and unable to select a PMP from that area
- Other urgent, 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

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

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

## 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 the Portal. 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 when authorized by the PMP. If, after the primary lock-in pharmacy verifies the RCP member's Medicaid eligibility, the claim denies for an invalid prescriber identification, the pharmacy must contact the RCP Administrator to confirm whether the prescription is written by an authorized lock-in prescriber. The primary lock-in pharmacy must 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 the IHCP 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 is 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 which exceed predetermined standards outlined in 42 CFR 709(b) to which the member is entitled under Medicaid.

### *Obtaining and Documenting Primary Lock-In Physician Authorization for Denied Prescriptions*

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

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

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

### *Primary Lock-In Physician Internal Referrals*

For pharmacy claims to appropriately process for an 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. Before doing so, the RCP Administrator must verify that the primary lock-in pharmacy does not have the medication and verify that the secondary pharmacy does. The secondary pharmacy is added only for specific dates of service, and the RCP Administrator notifies the PMP that the secondary pharmacy was added for those dates.

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 the LTC facility, the member's primary lock-in pharmacy returns to the original lock-in list.

## **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 the Portal. This letter is sent on receipt of the RCP member's selection by the RCP Administrator. The primary lock-in hospital must be a full-service hospital and one where the PMP has 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 must be notified. The hospital is strongly encouraged to educate the member about appropriate utilization of the ER and encourage him or her to see the assigned PMP for nonemergent services. The RCP Administrator also provides education about 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, when approved by the RCP Administrator.

### *Services Provided in the Emergency Room*

For 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 HIP, Hoosier Care Connect, and Hoosier Healthwise members in an ER setting. After the RCP member is stabilized, approval from the PMP must be obtained for further treatment. The lock-in hospital must notify the PMP whenever a member is treated in the ER.

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

### *Prescriptions upon Discharge from Hospital*

If discharge prescriptions are written for the RCP member to fill at the primary lock-in pharmacy, the hospital must contact the member's PMP before discharge to obtain a referral to add the discharge physician to the member's lock-in list for a specified time frame. If an emergency supply of discharge medications is provided to the RCP member by the hospital pharmacy on discharge, claims for the prescriptions are not reimbursed by the IHCP unless there is an emergency indicator on the pharmacy claim and the PMP has made a valid referral to add the discharge physician to the member's lock-in list for the specified time frame.

For additional information about 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](#) sections of this document.

## Claim Review and Adjudication

A major factor in the success of the RCP is timely and appropriate claims adjudication. Procedures for proper claim submission are available in the [Claim Submission and Processing](#) module or from the applicable managed care entity. Claims for RCP members may suspend if all claim-processing guidelines are not followed. See the [Billing for Services Rendered to RCP Members](#) section for claim-processing guidelines specific to RCP members.

## 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) and maintains documentation of completed activities. Staff may also complete optional QA and QC activities for any phase of the RCP processes. Documentation is placed in the departmental files as appropriate. Results of the QA and QC reviews are made available to the FSSA when requested or as required by the reporting manual for each MCE program.

### Release of Member Protected Health Information

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

The RCP Administrator's staff members must follow their Privacy Policy before 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 provide the Member ID at the time of the telephone call. The following procedures must be followed:

1. Member must give the following information at the beginning of each call: First and last name and IHCP Member ID, along with three of the four following pieces of identification:
  - Address that is listed in the Portal, CoreMMIS, or the RCP Administrator information system
  - Telephone number that is listed in the Portal, CoreMMIS, or the RCP Administrator information system
  - Date of birth
  - Social Security number (or the last four digits of the number)
2. RCP Administrators must provide members with a *Member Authorization* form to complete and return. 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 is sent to the RCP Administrator's privacy officer. The receipt of the *Member Authorization* form is noted in the RCP Administrator's database. Incorrect forms are returned to the member for correction. The RCP Administrator uses the official IHCP form and instructions.
3. Members who appeal their enrollment in the RCP, as described in [Member Hearings and Appeals](#) section, 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 FSSA monitor and evaluate the program quality and effectiveness based on these measures through on-site visits, annual external quality reviews (EQRs), and performance reporting.

### 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 the RCP and improve provider satisfaction with the RCP

### Performance Measures and Reporting Requirements

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

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

- Number of new RCP members
- Number of terminated RCP members
- Number of referrals to the FSSA Bureau of Investigation
- RCP administrative costs
- Number of inpatient visits and average length of stay
- Observation stays
- Number of PMP and specialist visits
- Average number and range of ER visits per year, per member by length of time in RCP (up to 12 months, 12 to 24 months, 24 to 36 months, and so on) compared to 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
  - 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-member ratios by provider type (for example, physician, pharmacy, hospital)
  - Number of complaints and overall provider satisfaction with the RCP

### *Monitoring and Evaluation*

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

## **Detecting and Reporting Fraud and Abuse**

The FSSA, 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 which would exceed predetermined standards as outlined in 42 CFR 456.709(b)
- Selling drugs, equipment, or supplies obtained through Medicaid
- Allowing another individual to use a member's Medicaid identification card

When a Medicaid member is suspected of such behavior, the activity must be identified, documented, and reported to the RCP Administrator for further evaluation. If, after pertinent review, further action is required, the RCP Administrator should report the suspected activity to the FSSA Fraud Hotline at 1-800-457-4515 with simultaneous notification to the FSSA via [Program.Integrity@fssa.in.gov](mailto:Program.Integrity@fssa.in.gov).

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

- Medical and Pharmacy Provider Fraud and Abuse
- The following examples of inappropriate 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 must be identified, documented, and reported to the RCP Administrator for further review and evaluation. If, after pertinent review, further action is required, the RCP Administrator must report the issue to the MFCU with a simultaneous notification to the FSSA via [Program.Integrity@fssa.in.gov](mailto:Program.Integrity@fssa.in.gov).

## Surveillance Utilization Review Services

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

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

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

## Section 2: Right Choices Program Reporting

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

### RCP Report Business Process and Verification Process

The following is the RCP report business process/verification process:

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

The following table lists RCP reports that Electronic Data Warehouse (EDW) produces for RCP Administrators.

Table 1 – RCP Reports Posted to the IOT SFTP Server

Report Name	Media
<i>Right Choices Monthly Summary – Review Summary</i>	Excel Workbook
<i>Right Choices Program – Type of Review</i>	Excel Workbook
<i>Right Choices Program – Initial Review</i>	Excel Workbook
<i>Right Choices Program – Clinical Review</i>	Excel Workbook
<i>Right Choices Program – Periodic Review</i>	Excel Workbook
<i>Right Choices Program – Periodic Review Tracking Summary</i>	Excel Workbook
<i>Right Choices Program – Diagnosis Codes</i>	Excel Workbook
<i>Right Choices Program – Appeals</i>	Excel Workbook
<i>Right Choices Program – Provider and Member Summary</i>	Excel Workbook
<i>Right Choices Program Monthly Summary Report</i>	Excel Workbook
<i>Potential Right Choices Program Members*</i>	Excel Workbook
<i>* The <b>Potential Right Choices Program Members</b> reports are produced by the FSSA Division of Health Strategies and Technology. All other reports in this table are produced by Optum.</i>	

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

- /EDW/anthem/OUT/Reports2007: Right\_Choices\_Monthly\_Summary\_Anthem\_<yyyymm>.xls
- /EDW/Advantage/To\_Advantage: Right\_Choices\_Monthly\_Summary\_CMCS\_<yyyymm>.xls
- /EDW/MDwise/OUT/Reports: Right\_Choices\_Monthly\_Summary\_MDwise\_<yyyymm>.xls
- /EDW/MHS/ OUT/Reports: Right\_Choices\_Monthly\_Summary\_MHS\_<yyyymm>.xls
- /EDW/CareSource/OUT/Reports: Right\_Choices\_Monthly\_Summary\_CAR\_<yyyymm>.xls
- /EDW/OMPP Data Exchange/RCP: Right\_Choices\_Monthly\_Summary\_<plan>\_<yyyymm>.xls
- /EDW/OMPP Data Exchange/RCP:  
Right\_Choices\_Program\_(RCP)\_Monthly\_Summary\_Report\_<yyyymm>.xls

## Right Choices Monthly Summary – Review Summary

The *Right Choices Monthly Summary* report provides each RCP Administrator and the FSSA with a summary of RCP program activity data for the month reported by Indiana Health Coverage Programs (IHCP) program:

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

The RCP summary reports and files are run and posted to the IOT SFTP server on the 15th of each month. This run-and-post schedule accommodates inclusion of month-end data for the prior month that is processed and loaded to the EDW by the end of the previous month, which is the reporting period. Figure 23 provides an example of the report layout.

Figure 23 – Right Choices Monthly Summary – Review Summary

## Right Choices Monthly Summary for [Administrator]

mm/dd/yyyy to mm/dd/yyyy

### Right Choice Program-Summary for [Administrator] [Program]

#### Right Choice Program

##### Number of Reviews

Review Type	Number of Members
Clinical	99
Initial	99
Periodic	99
Total	99

#### Number of Members by Referral Source

Provider Referrals	99
Pharmacy Referrals	99
Care Management Referrals	99
Data Referrals	99
Citizen Referrals	99
Other Referrals	99

#### Reason Not Referred to Clinical Review

Referred to Care Case Management	99
Member Utilization Per PMP Plan of Care	99
Transfer Member	99
ER Visit Followed by Inpatient Stay	99
Multiple Prescribers in Same Group	99
Other	99

Initial Review  
Potential Fraud

99

Clinical Review  
Potential Fraud

99



## Field Definitions

*Review Type* – Type of review performed:

- Clinical
- Initial
- 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 in the **Demographic Information** section under the **Initial Review** tab on the IHCP Provider Healthcare Portal (Portal) *Right Choices Program Member Summary* page (see [Figure 4](#)). Selections are as follows:

- Provider Referrals
- Pharmacy Referrals
- Care Management Referrals
- Data Referrals
- Citizen Referrals
- Other Referrals

*Reasons Not Referred to Clinical Review* – Number of members by reason not referred on to clinical review, when clinical review is not warranted, as indicated by the RCP analyst in the **Clinical Review Information** section under the **Initial Review** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 7](#)). Selections are as follows:

- Referred to Care Case Management
- Member Utilization Per PMP [primary medical provider] 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 in the **Member is suspected...** field in the **Automatic Review** section under the **Initial Review** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 6](#)).

*Clinical Review Potential Fraud* – Number of members for which “yes” is selected by the RCP analyst in the **Member reported to FSSA Bureau of Investigation?** field, under the **Clinical Review** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 8](#)).


## Right Choices Program – Types of Reviews

This report provides each RCP Administrator and the FSSA with a summary of RCP reviews performed for the month, reported by review type for each IHCP program:

- HIP
- Hoosier Care Connect
- Hoosier Healthwise
- Traditional Medicaid

The RCP summary reports and files are run and posted to the IOT SFTP server on the 15th of each month. This run-and-post schedule accommodates inclusion of month-end data for the prior month that is processed and loaded to the EDW by the end of the previous month, which is the reporting period. Figure 24 provides an example of the report layout.

Figure 24 – Right Choices Program – Types of Reviews

				
		<b>Right Choices Program - Types of Reviews</b>		
		<b>[Administrator/Program]</b>		
Member ID	Member Last Name	Member First Name	Date of Review	Review Type
XXXXXXXXXX	Last Name	First Name	mm/dd/yyyy	Periodic
XXXXXXXXXX	Last Name	First Name	mm/dd/yyyy	Initial
<b>Total Distinct Members: 2</b>				

### Field Definitions

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

*Member Last Name* – Member's last name.

*Member First Name* – Member's first name.

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

*Review Type* – Type of review performed:

- Initial
- Clinical
- Periodic

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


## Right Choices Program – Initial Reviews

The *Right Choices Program – Initial Reviews* report provides each RCP Administrator and the FSSA with detailed information regarding initial reviews performed during the month, reported for each IHCP program:

- HIP
- Hoosier Care Connect
- Hoosier Healthwise
- Traditional Medicaid

The RCP summary reports and files are run and posted to the IOT SFTP server on the 15th of each month. This run-and-post schedule accommodates inclusion of month-end data for the prior month that is processed and loaded to the EDW by the end of the previous month, which is the reporting period. Figure 25 provides an example of the report layout.

Figure 25 – Right Choices Program – Initial Reviews

 <b>Right Choices Program - Initial Reviews</b> <b>[Administrator/Program]</b>														
Member ID	Last Name	First Name	Date of Review	Provider Referral	Pharmacy Referral	Care Management Referral	Data Referral	Citizen Referral	Other Referral	Date of First Service Selected	Date of Last Service Selected	Amount Paid		
XXXXXXXX	Last Name	First Name	mm/dd/ccyy	Y or N	Y or N	Y or N	Y or N	Y or N	Y or N	mm/dd/ccyy	mm/dd/ccyy	\$999.99		
XXXXXXXX	Last Name	First Name	mm/dd/ccyy	Y or N	Y or N	Y or N	Y or N	Y or N	Y or N	mm/dd/ccyy	mm/dd/ccyy	\$999.99		
XXXXXXXX	Last Name	First Name	mm/dd/ccyy	Y or N	Y or N	Y or N	Y or N	Y or N	Y or N	mm/dd/ccyy	mm/dd/ccyy	\$999.99		
Reason Not Referred to Clinical Review														
Number of PMP's	Number of ER Visits	Number of Prescribers	Number of Pharmacies	Number of Filled Prescriptions	Number of Controlled Substances	Fraud Indicated	Sent to Clinical Review	Date sent to Clinical Review	Referred to Care/Case Management	Member Utilization Per PMP Plan of Care	Transient Member	ER Visit Followed by Inpatient Stay	Multiple Prescribers in Same Group	Other Reasons
999	999	999	999	999	999	Y or N	Y or N	mm/dd/ccyy	Y or N	Y or N	Y or N	Y or N	Y or N	
999	999	999	999	999	999	Y or N	Y or N	mm/dd/ccyy	Y or N	Y or N	Y or N	Y or N	Y or N	
999	999	999	999	999	999	Y or N	Y or N	mm/dd/ccyy	Y or N	Y or N	Y or N	Y or N	Y or N	

### Field Definitions

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

*Last Name* – Member's last name.

*First Name* – Member's first name.

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

<Source> *Referral* – Y or N indicating the initial review source, as indicated by the RCP analyst in the **Demographic Information** section under the **Initial Review** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 4](#)):

- *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 in the **From Date** field in the **Dates of Service Reviewed** section under the **Initial Review** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 2](#)).

*Date of Last Service Selected* – Ending date of service for the period reviewed, as indicated by the RCP analyst in the **To Date** field in the **Dates of Service Reviewed** section under the **Initial Review** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 2](#)).

*Amount Paid* – Total amount paid during the review period, as automatically calculated by the system when the RCP analyst progresses from the **Demographic Information** section to the **Utilization Information** section under the **Initial Review** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 5](#)).

*Number of <indicators>* – Total numbers for each of six clinical review triggers, as automatically calculated when the RCP analyst progresses from the **Demographic Information** section to the **Utilization Information** section under the **Initial Review** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 5](#)):

- *PMPs* – Determined from the number of PMP assignments on file for the member during the time period reviewed.
- *ER Visits* – Determined from revenue codes 450 and 451 on claims paid with dates of service during the time period reviewed.
- *Prescribers* – Determined from unique National Provider Identifiers (NPIs) in the prescribing provider field of pharmacy claims paid with dates of service during the time period reviewed.
- *Pharmacies* – Determined from unique IHCP Provider ID in the billing provider field of pharmacy claims paid with dispense date during the time period reviewed.
- *Filled Prescriptions* – Determined by paid drug claims with dispense dates during the time period reviewed.
- *Controlled Substances* – Determined by paid drug claims with dispense dates during the time period reviewed, with National Drug Code (NDC) Drug Enforcement Administration (DEA) classifications II, III, and IV.

*Fraud Indicated* – Y or N, as selected by the RCP analyst in the **Member is suspected...** field in the **Automatic Review** section under the **Initial Review** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 6](#)).

*Sent to Clinical Review* – Y or N, as selected by the RCP analyst in the **Clinical Review Warranted?** field in the **Clinical Review Information** section under the **Initial Review** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 7](#)).

*Date Sent to Clinical Review* – Date sent to clinical review, as indicated by the RCP analyst in the **Date Sent to Clinical Review** field in the **Clinical Review Information** section under the **Initial Review** tab on the Portal *RCP Member Summary* page (see [Figure 7](#)).

*Reasons Not Referred to Clinical Review* – Y or N indicating reason not referred to clinical review, if clinical review is not warranted, as indicated by the RCP analyst in the **Clinical Review Information** section under the **Initial Review** tab on the Portal *RCP Member Summary* page (see [Figure 7](#)). Selections are as follows:

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

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


## Right Choices Program – Clinical Reviews

The *Right Choices Program – Clinical Reviews* report provides each RCP Administrator and the FSSA with detailed information regarding clinical reviews performed during the month reported for each IHCP program:

- HIP
- Hoosier Care Connect
- Hoosier Healthwise
- Traditional Medicaid

The RCP summary reports and files are run and posted to The IOT SFTP server on the 15th each month. This run-and-post schedule accommodates inclusion of month-end data for the prior month, processed and loaded to the EDW by the end of the previous month, which is the reporting period. Figure 26 provides an example of the report layout.

Figure 26 – Right Choices Program – Clinical Reviews

			<b>Right Choices Program - Clinical Reviews</b>			
			<b>[Administrator/Program]</b>			
Member RID	Last Name	First Name	Date of Review	Review Result	Referred to FSSA Fraud Unit	Date Completed
XXXXXXXX	Last Name	First Name	mm/dd/ccyy	Placed On RCP	Y or N	mm/dd/ccyy

### Field Definitions

*Member RID* – IHCP Member ID number of member reviewed.

*Last Name* – Member's last name.

*First Name* – Member's first name.

*Date of Review* – Date when the RCP analyst selected **Submit** under the **Clinical Review** tab in the Portal, on completion of clinical review data entry (see [Figure 8](#)).

*Review Result* – Result of the clinical review, as selected by the RCP analyst in the **Review Results** field under the **Clinical Review** tab in the Portal (see [Figure 8](#)). Selections are as follows:

- 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 the case was referred to the fraud unit, as entered by the RCP analyst in the **Member reported to FSSA Bureau of Investigation?** field under the **Clinical Review** tab in the Portal (see [Figure 8](#)).

**Date Completed** – Date entered by the RCP analyst in the **Date Review Completed** field under the **Clinical Review** tab in the Portal (see [Figure 8](#)).


## Right Choices Program – Periodic Reviews

The *Right Choices Program – Periodic Reviews* report provides each RCP Administrator and the FSSA with detailed information regarding periodic reviews performed during the month reported for each IHCP program:

- HIP
- Hoosier Care Connect
- Hoosier Healthwise
- Traditional Medicaid

The RCP summary reports and files are run and posted to IOT SFTP Server on the 15<sup>th</sup> of each month. This run-and-post schedule accommodates inclusion of month-end data for the prior month that is processed and loaded to the EDW by the end of the previous month, which is the reporting period. Figure 27 provides an example of the report layout.

Figure 27 – Right Choices Program – Periodic Reviews



Right Choices Program - Periodic Reviews

[Administrator/Program]

Summary of Periodic Review							
Number of Periodic Reviews		999					
Number of Periodic Reviews Results: Graduated		999					
Number of Periodic Reviews Results: Returnees		999					
Member RID	Last Name	First Name	Date Review	Date of First Service	Date of Last Service	Amount Paid	Number of PMP's
XXXXXXXXXX	Last Name	First Name	mm/dd/ccyy	mm/dd/ccyy	mm/dd/ccyy	\$9,999.99	999
Number of ER Visits	Number of Prescribers	Number of Pharmacies	Number of Filled Prescriptions	Number of Controlled Substances	Periodic Review Results	RCP End Date	Reason RCP Ended
999	999	999	999	999	X	mm/dd/ccyy	
Total Distinct Members: 999							

### Field Definitions

**Member RID** – IHCP Member ID number of member reviewed.

**Last Name** – Member's last name.

**First Name** – Member's first name.

*Date Review* – Date when the RCP analyst selected **Submit** under the **Periodic Review** tab on the Portal *Right Choices Program Member Summary* page, upon completion of periodic review data entry (see [Figure 13](#)).

*Date of First Service* – Beginning date of service for the period reviewed, as indicated by the RCP analyst in the **From Date** field in the **Dates of Service Reviewed From** section under the **Periodic Review** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 12](#)).

*Date of Last Service* – Ending date of service for the period reviewed, as indicated by the RCP analyst in the **To Date** field in the **Dates of Service Reviewed To** section under the **Periodic Review** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 12](#)).

*Amount Paid* – Total amount paid during the review period, as automatically calculated by the system when the RCP analyst progresses from the **Demographic Information** section to the **Utilization Information** section under the **Periodic Review** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 13](#)).

*Number of <indicators>* – Totals for each of six periodic review triggers, as automatically calculated by the system when the RCP analyst progresses from the **Demographic Information** section to the **Utilization Information** section under the **Periodic Review** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 13](#)):

- *PMPs* – Determined from the number of PMP assignments on file for the member during the time period reviewed.
- *ER Visits* – Determined from revenue codes 450 and 451 on claims paid with dates of service during the time period reviewed.
- *Prescribers* – Determined from unique NPIs in the prescribing provider field of pharmacy claims paid with dates of service during the time period reviewed.
- *Pharmacies* – Determined from the unique IHCP Provider ID in the billing provider field of pharmacy claims paid with dispense dates during the time period reviewed.
- *Filled Prescriptions* – Determined by paid drug claims with dispense dates during the time period reviewed.
- *Controlled Substances* – Determined by paid drug claims with dispense dates during the time period reviewed, with NDC code DEA classifications II, III, and IV.

*Periodic Review Results* – Result of the periodic review, as selected by the RCP analyst in the **Review Results** field in the **Periodic Review Information** section under the **Periodic Review** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 13](#)). Selections are as follows:

- Remain on RCP
- Graduate from RCP

*RCP End Date* – If the RCP analyst determines that RCP should end, the analyst enters the end date in the **End Date** field in the **End Current RCP** section under the **Lock-In Providers** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 10](#)).



**Reason RCP Ended** – If the RCP analyst determines that RCP should end, the analyst selects the reason in the **Reason** field in the **End Current RCP** section under the **Lock-In Providers** tab on the Portal *RCP Member Summary* page (see [Figure 10](#)). Selections are as follows:

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


## Right Choices Program – Periodic Review Tracking Summary

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

- HIP
- Hoosier Care Connect
- Hoosier Healthwise
- Traditional Medicaid

The RCP summary reports and files are run and posted to the IOT SFTP server on the 15th of each month. This run-and-post schedule accommodates inclusion of month-end data for the prior month, processed and loaded to the EDW by the end of the previous month, which is the reporting period. Figure 28 provides an example of the report layout.

Figure 28 – Right Choices Program – Periodic Review Tracking Summary

		Right Choices Program - Periodic Review Tracking Summary					
		[Administrator/Program]					
Aging	RCP Program	Recipient Medicaid ID	RCP Start Date	Periodic Review Due Date	Periodic Review Start Date	Days Between Periodic Review Due and Start Dates	Days Between Current and Periodic Review Dates
1-30 Days	[Administrator/Program]	XXXXXXXXXX	mm/dd/ccyy	mm/dd/ccyy	mm/dd/ccyy	999	999
1-30 Days Totals:		999					
30-60 Days	[Administrator/Program]	XXXXXXXXXX	mm/dd/ccyy	mm/dd/ccyy	mm/dd/ccyy	999	999
30-60 Days Totals:		999					
60 - 90 Days	[Administrator/Program]	XXXXXXXXXX	mm/dd/ccyy	mm/dd/ccyy	mm/dd/ccyy	999	999
60 - 90 Days Totals:		999					
Over 90 Days	[Administrator/Program]	XXXXXXXXXX	mm/dd/ccyy	mm/dd/ccyy	mm/dd/ccyy	999	999
Over 90 Days Totals:		999					
Future	[Administrator/Program]	XXXXXXXXXX	mm/dd/ccyy	mm/dd/ccyy	mm/dd/ccyy	999	999
Future Totals:		999					
Total number of periodic review members							999



## Field Definitions

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

- 1–30 days overdue
- 30–60 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** – IHCP Member ID number of RCP member listed.

**RCP Start Date** – The beginning date of the currently active RCP enrollment period, as entered by the RCP analyst in the **Date RCP Starts** field under the **RCP Status** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 9](#)).

**Periodic Review Due Date** – The date the RCP analyst enters, when activating RCP for a member, in the **Periodic Review Date** field under the **RCP Status** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 9](#)). After the initial placement, the RCP analyst indicates subsequent Periodic review due dates, as periodic reviews are completed, in the **Date of Next Periodic Review** field.

**Periodic Review Start Date** – Date when the RCP analyst selected **Submit** under the **Periodic Review** tab on the Portal *Right Choices Program Member Summary* page, after entering periodic review data (see [Figure 11](#)).

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

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

**Future Totals** – Total number of periodic reviews scheduled.


## Right Choices Program – Diagnosis Codes

The *Right Choices Program – Diagnosis Codes* report provides each RCP Administrator and the FSSA with detailed information indicating the diagnosis codes reviewed for each review type performed during the report period for each IHCP program:

- HIP
- Hoosier Care Connect
- Hoosier Healthwise
- Traditional Medicaid

The RCP summary reports and files are run and posted to The IOT SFTP server on the 15th of each month. This run-and-post schedule accommodates inclusion of month-end data for the prior month that is processed and loaded to the EDW by the end of the previous month, which is the reporting period. Figure 29 provides an example of the report layout.

Figure 29 – Right Choices Program – Diagnosis Codes

					
<b>Right Choices Program - Diagnosis Codes</b>					
<b>[Administrator/Program]</b>					
Medicaid ID	Last Name	First Name	Review Type	Diagnosis Code	Diagnosis Code Description
XXXXXXXXXX	Last Name	First Name	Periodic	XX99	AAAAAAAA
XXXXXXXXXX	Last Name	First Name	Initial	XX99	AAAAAAAA
XXXXXXXXXX	Last Name	First Name	Clinical	XX99	AAAAAAAA
XXXXXXXXXX	Last Name	First Name	Periodic	XX99	AAAAAAAA
XXXXXXXXXX	Last Name	First Name	Clinical	XX99	AAAAAAAA
XXXXXXXXXX	Last Name	First Name	Periodic	XX99	AAAAAAAA
XXXXXXXXXX	Last Name	First Name	Periodic	XX99	AAAAAAAA
XXXXXXXXXX	Last Name	First Name	Initial	XX99	AAAAAAAA
XXXXXXXXXX	Last Name	First Name	Periodic	XX99	AAAAAAAA
XXXXXXXXXX	Last Name	First Name	Periodic	XX99	AAAAAAAA
XXXXXXXXXX	Last Name	First Name	Periodic	XX99	AAAAAAAA
<b>Total Distinct Members: 999</b>					

## Field Definitions

**Medicaid ID** – IHCP Member ID number of member reviewed.

**Last Name** – Member's last name.

**First Name** – Member's first name.

**Review Type** – Type of review performed:

- Initial
- Clinical
- Periodic

**Diagnosis Code** – ICD diagnosis code, as selected by the RCP analyst in the Portal when completing the initial, clinical, or periodic review. The user selects up to 15 diagnoses on the following Portal screens, according to review type performed:

- Initial – **Initial Review** tab, **Demographic Information** section, **Diagnosis Codes** panel (see [Figure 4](#))
- Clinical – **Clinical Review** tab, **Diagnosis Codes** panel (see [Figure 8](#))
- Periodic – **Periodic Review** tab, **Demographic Information** section, **Diagnosis Codes** panel (see [Figure 10](#))

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

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


## Right Choices Program – Appeals

The *Right Choices Program – Appeals* report provides each RCP Administrator and the FSSA with detailed information related to open appeals and appeals resolved during the reporting month for each IHCP program:

- HIP
- Hoosier Care Connect
- Hoosier Healthwise
- Traditional Medicaid

The RCP summary reports and files are run and posted to the IOT SFTP server on the 15th of each month. This run-and-post schedule accommodates inclusion of month-end data for the prior month, processed and loaded to the EDW by the end of the previous month, which is the reporting period. Figure 30 provides an example of the report layout.

Figure 30 – Right Choices Program – Appeals

				Right Choices Program - Appeals			
				[Administrator/Program]			
Recipient Medicaid ID	Recipient Name	Date of Appeal	Appeal Type	Appeal Resolution	Date of Appeal Resolution	Date Clinical Review completed	Clinical Review Results
XXXXXXXXXXXX	Recipient Name	mm/dd/ccyy	F-FSSA	O - Overturned	mm/dd/ccyy	mm/dd/ccyy	P - Placed on RCP
XXXXXXXXXXXX	Recipient Name	mm/dd/ccyy	M-MCE	U - Upheld	mm/dd/ccyy	mm/dd/ccyy	B - Appropriate Behavior
XXXXXXXXXXXX	Recipient Name	mm/dd/ccyy	F	D - Dismissed	mm/dd/ccyy	mm/dd/ccyy	C - Refer to CM

### Field Definitions

*Medicaid ID* – IHCP Member ID 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 in the **Date of Appeal** field under the **Appeals** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 14](#)).

*Appeal Type* – One-character alpha code indicating the appeal type, as selected by the RCP analyst in the **Appeal Type** field under the **Appeals** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 14](#)). Selections are as follows:

- M – MCE – Appeal to MCE within 10 days
- F – FSSA – Appeal to the FSSA

*Appeal Resolution* – One-character alpha code indicating the appeal resolution, as selected by the RCP analyst in the **Appeal Resolution** field under the **Appeals** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 14](#)). Selections are as follows:

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

*Date of Appeal Resolution* – Date that the appeal was resolved, as entered by the RCP analyst in the **Date of Appeal Resolution** field under the **Appeals** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 14](#)).

*Date Clinical Review Completed* – The date the clinical review being appealed was completed, as entered by the RCP analyst in the **Date Review Completed** field under the **Clinical Review** tab in the Portal (see [Figure 8](#)).

*Clinical Review Result* – One-character alpha code indicating the finding from the clinical review being appealed, as selected by the RCP analyst in the **Review Results** field under the **Clinical Review** tab in the Portal (see [Figure 8](#)). Selections are as follows:

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


## Right Choices Program – Provider and Member Summary

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

- HIP
- Hoosier Care Connect
- Hoosier Healthwise
- Traditional Medicaid

The RCP summary reports and files are run and posted to the IOT SFTP server on the 15th of each month. This run-and-post schedule accommodates inclusion of month-end data for the prior month, processed and loaded to the EDW by the end of the previous month, which is the reporting period. Figure 31 provides an example of the report layout.

Figure 31 – Right Choices Program – Provider and Member Summary

		<b>Right Choices Program - Provider and Member Summary</b> <b>[Administrator/Program]</b>				
Provider Specialty	328	331	339	316	311	
Number of Providers	999	999	999	999	999	
Provider Type Code	31					
Number of Providers	999					
Provider ID	Number of Members					
XXXXXXXXXX	999					
XXXXXXXXXX	999					
XXXXXXXXXX	999					
XXXXXXXXXX	999					
XXXXXXXXXX	999					
<b>Number of Members:</b>	<b>999</b>					
<b>Provider and Member Detail for [Administrator] [Program]</b>						
Lock In Provider ID	Provider Type Code	Provider Specialty Code	Recipient Medicaid ID	Lock In Effective Date	Lock In Date	
XXXXXXXXXX	99	999	XXXXXXXXXX	mm/dd/ccyy	mm/dd/ccyy	
XXXXXXXXXX	99	999	XXXXXXXXXX	mm/dd/ccyy	mm/dd/ccyy	
XXXXXXXXXX	99	999	XXXXXXXXXX	mm/dd/ccyy	mm/dd/ccyy	
XXXXXXXXXX	99	999	XXXXXXXXXX	mm/dd/ccyy	mm/dd/ccyy	
XXXXXXXXXX	99	999	XXXXXXXXXX	mm/dd/ccyy	mm/dd/ccyy	
XXXXXXXXXX	99	999	XXXXXXXXXX	mm/dd/ccyy	mm/dd/ccyy	
XXXXXXXXXX	99	999	XXXXXXXXXX	mm/dd/ccyy	mm/dd/ccyy	
XXXXXXXXXX	99	999	XXXXXXXXXX	mm/dd/ccyy	mm/dd/ccyy	
XXXXXXXXXX	99	999	XXXXXXXXXX	mm/dd/ccyy	mm/dd/ccyy	
XXXXXXXXXX	99	999	XXXXXXXXXX	mm/dd/ccyy	mm/dd/ccyy	
XXXXXXXXXX	99	999	XXXXXXXXXX	mm/dd/ccyy	mm/dd/ccyy	
XXXXXXXXXX	99	999	XXXXXXXXXX	mm/dd/ccyy	mm/dd/ccyy	
XXXXXXXXXX	99	999	XXXXXXXXXX	mm/dd/ccyy	mm/dd/ccyy	
<b>Count:</b>			<b>999</b>			

## Field Definitions (Summary Fields)

*Provider Specialty/Number of Providers* – Summary count of primary care physicians, by IHCP provider specialty code, as selected by the RCP analyst under the **Lock-in Providers** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 10](#)).

- Providers for which the **PMP** checkbox has been selected and whose effective dates are within the reporting month are the only ones that report in this field.

*Provider Type Code/Number of Providers* – Summary count of primary care physicians, by IHCP provider type code, as selected by the RCP analyst under the **Lock-in Providers** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 10](#)).

- Providers for which the **PMP** checkbox has been selected and whose effective dates are within the reporting month are the only ones that report in this field.

*Provider ID/Number of Members* – Summary count of members assigned to each unique primary care physician, as selected by the RCP analyst under the **Lock-in Providers** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 10](#)).

- Providers for which the **PMP** checkbox has been selected and whose effective dates are within the reporting month are the only ones that report in this field.

## Field Definitions (Detail Fields)

*Lock In Provider ID* – Each unique primary care physician is listed, as selected by the RCP analyst under the **Lock-in Providers** tab on the Portal *Right Choices Program Member Summary* page (see [Figure 10](#)).

*Provider Type Code* – Two-digit provider type code associated with each unique primary care physician listed, as cross-referenced systematically using *CoreMMIS* Provider tables.

*Provider Specialty Code* – Three-digit provider specialty code associated with each unique primary care physician listed, as cross-referenced systematically using *CoreMMIS* provider tables.

*Recipient Medicaid ID* – IHCP Member ID number for each RCP member where the PMP checkbox, under the **Lock-in Providers** tab on the Portal *Right Choices Program Member Summary* page, is selected 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, under the **Lock-in Providers** tab on the Portal *Right Choices Program Member Summary* page, for the reported Provider ID during the month reported.


*Lock In Date* – End date of the lock-in provider segment, as entered by the RCP analyst under the **Lock-in Providers** tab on the Portal *Right Choices Program Member Summary* page, for the reported Provider ID during the month reported.

## Right Choices Program Monthly Summary Report

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

The RCP summary reports and files are run and posted to the IOT SFTP server on the 15th of each month. This run-and-post schedule accommodates inclusion of month-end data for the prior month that is processed and loaded to the EDW by the end of the previous month, which is the reporting period. Figure 32 provides an example of the report layout.

Figure 32 – Right Choices Program Monthly Summary Report

		<b>Right Choices Program Monthly Summary Report</b>						As of Date: mm/dd/yyyy			
		mm/dd/yyyy to mm/dd/yyyy									
RCP Administrator and Program	Number of Initial Reviews	Potential Fraud	Citizen Referrals	Data Referrals	Pharmacy Referrals	Provider Referrals	Care Management Referrals	Other Referrals			
Anthem - HCC	999	999	999	999	999	999	999	999			
Anthem - HHW	999	999	999	999	999	999	999	999			
Anthem - HIP	999	999	999	999	999	999	999	999			
CareSource - HHW	999	999	999	999	999	999	999	999			
CareSource - HIP	999	999	999	999	999	999	999	999			
CMCS	999	999	999	999	999	999	999	999			
MDWise - HCC	999	999	999	999	999	999	999	999			
MDWise - HHW	999	999	999	999	999	999	999	999			
MDWise - HIP	999	999	999	999	999	999	999	999			
MHS - HCC	999	999	999	999	999	999	999	999			
MHS - HHW	999	999	999	999	999	999	999	999			
MHS - HIP	999	999	999	999	999	999	999	999			
<b>Total</b>	<b>999</b>	<b>999</b>	<b>999</b>	<b>999</b>	<b>999</b>	<b>999</b>	<b>999</b>	<b>999</b>			
RCP Administrator and Program	Referred to Care/Case Management	Member Utilization per PMP plan of care	Transient Member	ER Visit Followed by Inpatient Stay	Multiple Prescribers in same Group	Other					
Anthem - HCC	999	999	999	999	999	999					
Anthem - HHW	999	999	999	999	999	999					
Anthem - HIP	999	999	999	999	999	999					
CareSource - HHW	999	999	999	999	999	999					
CareSource - HIP	999	999	999	999	999	999					
CMCS	999	999	999	999	999	999					
MDWise - HCC	999	999	999	999	999	999					
MDWise - HHW	999	999	999	999	999	999					
MDWise - HIP	999	999	999	999	999	999					
MHS - HCC	999	999	999	999	999	999					
MHS - HHW	999	999	999	999	999	999					
MHS - HIP	999	999	999	999	999	999					
<b>Total</b>	<b>999</b>	<b>999</b>	<b>999</b>	<b>999</b>	<b>999</b>	<b>999</b>					

## Field Definitions

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

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

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

*Note:* 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 *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 *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 *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 *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 individual RCP Administrator/program *RCP Monthly Summary Report – Initial Review* tab.

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

## Potential Right Choices Program Recipients


The *Potential Right Choices Program Recipients* report provides each RCP Administrator and the FSSA with information that may indicate program abuse. Data reported is based on pharmacy utilization per predefined clinical criteria, as received on a monthly data extract from Optum. Administrators can use the report to assess the risk of abuse or misutilization in consideration of further action, such as RCP enrollment.

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

The RCP summary reports and files are run and posted to the IOT SFTP server on the 15th of each month. This run-and-post schedule accommodates inclusion of month-end data for the prior month that is processed and loaded to the EDW by the end of the previous month, which is the reporting period. Figure 33 provides an example of the report layout.



Figure 33 – Potential Right Choices Program Recipients

		<b>Potential Right Choices Program Recipients</b> <b>[Administrator/Program]</b> mm/dd/yyyy to mm/dd/yyyy						As of Date: mm/dd/yyyy
Medicaid RID	Last Name	First Name	Number of Prescribers	Number of Pharmacies	Number of Claims	Amount Paid	Indicators	
XXXXXXXXXXXX	Last Name	First Name	999	999	999	\$9,999.99	>=5 Rxs AND >=3 Pharmacies or >=4 Providers	
XXXXXXXXXXXX	Last Name	First Name	999	999	999	\$9,999.99	>=5 Rxs AND >=3 Pharmacies or >=4 Providers	
XXXXXXXXXXXX	Last Name	First Name	999	999	999	\$9,999.99	>=5 Rxs AND >=3 Pharmacies or >=4 Providers	

## Field Definitions

*Medicaid RID* – IHCP Member ID number of targeted member.

*Last Name* – Member's last name.

*First Name* – Member's first name.

*Number of Prescribers* – Number of different prescribers, as submitted on claims for the member.

*Number of Pharmacies* – Number of different pharmacies, as submitted on claims for the member.

*Number of Claims* – Number of claims submitted for the member.

*Amount Paid* – Amount paid for claims submitted on behalf of the member.

*Indicators* – Clinical indicator flag description. See the [RCP Eligibility Review](#) section for a complete list of associated rules, flags, and clinical criteria.



## Section 3: Right Choices Program Member Summary Worksheets

The Right Choices Program (RCP) Administrator uses the Provider Healthcare Portal (Portal) to complete member reviews as described in the [RCP Enrollment Policies and Procedures](#) section. Completed reviews may be printed or downloaded from the history tab of the member's *Right Choices Program Member Summary* page.

Figure 34 – History Tab

Right Choices Program History		
Assignments		
Member Reviews		
Review Type	Date Submitted	Action
Initial	01/26/2012	<a href="#">Print Preview</a>
Clinical	01/26/2012	<a href="#">Print Preview</a>
Clinical	01/23/2012	<a href="#">Print Preview</a>
Periodic	01/28/2014	<a href="#">Print Preview</a>
Periodic	10/27/2015	<a href="#">Print Preview</a>

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

## Member Summary Worksheet Initial Review

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

<b>MEMBER SUMMARY WORKSHEET</b>			
<b>Initial Review</b>			
Please refer to the Right Choices Program (RCP) Manual for instructions to complete this worksheet.			
<b>Form completed by:</b>		<b>Date Completed:</b>	
<b>Member Name:</b>		<b>MID #:</b>	
<b>Referred by:</b>	<b>Provider</b>	<b>Pharmacy</b>	<b>Care/Case Mgmt</b>
	<b>Citizen</b>	<b>Other:</b>	<b>Data Report</b>
SERVICE UTILIZATION ANALYSIS			
Dates of Service Reviewed (6 months within a 12 month rolling period): «review/start_date» to «review/end_date»			
MEMBER DIAGNOSES			
<div style="display: flex; justify-content: space-between;"> <span>Member Summary Worksheet Initial Review - Right Choices Program Version 1.0 November 2009</span> <span>Page 1 of 3</span> </div>			

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

<b>Member Name:</b>		<b>MID #:</b>	
<b>UTILIZATION ANALYSIS</b>			
Total Dollar Amount of Paid Claims during the Review Period: «util/total_amt»			
<b>Triggers for Clinical Review</b>	<b>Member's Total</b>	<b>Threshold for Review</b>	<b>Member's Total Meets or Exceeds Threshold?</b>
Number of PMP Selections			
Number of ER Visits			
Number of Prescribers			
Number of Pharmacies			
Number of Filled Controlled Substance Prescriptions		For Reference Only	
Number of Filled Prescriptions		For Reference Only	
Data Source: CareMMS			
<b>MEDICATION THERAPY MANAGEMENT ANALYSIS</b>			
<b>Flags</b>	<b>Drug Class or Polypharmacy</b>		
	Number of Prescribers		
	Number of Pharmacies		
	Number of Filled Prescriptions		
	Total Cost		
Data Source: RCP Potential Report			
Member Summary Worksheet Initial Review - Right Choices Program Version 1.0 November 2009			
Page 2 of 3			

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

<b>Member Name:</b>	<b>MID #:</b>
<b>AUTOMATIC PLACEMENT INTO RIGHT CHOICES PROGRAM</b>	
Member is suspected or alleges to have obtained Medicaid services under fraudulent pretenses? <div style="display: flex; justify-content: space-around;"> <span>Yes</span> <span>No</span> </div>	
Description of fraudulent activity: <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>	
Member has received 5 or more psychotropic medications in a recent 45 day period? <div style="display: flex; justify-content: space-around;"> <span>Yes</span> <span>No</span> </div>	
Member has received benzodiazepines from 3 or more prescribers in a recent 90 day period? <div style="display: flex; justify-content: space-around;"> <span>Yes</span> <span>No</span> </div>	
Notes: <div style="border: 1px solid black; height: 80px; margin-top: 5px;"></div>	
<b>CLINICAL REVIEW?</b>	
Clinical Review Warranted? <div style="display: flex; justify-content: space-around;"> <span>Yes</span> <span>No</span> </div>	
Clinical Review Not Warranted Reason(s): <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>	
Date Sent to Clinical Review: <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>	
Notes: <div style="border: 1px solid black; height: 80px; margin-top: 5px;"></div>	
<div style="display: flex; justify-content: space-between; font-size: small;"> <span>Member Summary Worksheet Initial Review - Right Choices Program Version 1.0 November 2009</span> <span>Page 3 of 3</span> </div>	

## Member Summary Worksheet Clinical Review

Figure 36 – Member Summary Worksheet Clinical Review (Page 1 of 2)

MEMBER SUMMARY WORKSHEET	
Clinical Review	
Please refer to the Right Choices Program (RCP) Manual for instructions to complete this worksheet.	
Member Name:	MID #:
<b>CLINICAL REVIEW RESULTS</b>	
Clinical Review Completed by:	
Date Clinical Review Completed by:	
Clinical Review Result:	
Member Reported to FSSA Bureau of Investigation? Yes No	
<b>MEMBER DIAGNOSES CLINICAL REVIEW</b>	
Member Summary Worksheet Clinical Review - Right Choices Program Version 1.0 November 2009	
Page 1 of 2	

<b>Member Name:</b> <span style="border-bottom: 1px solid black; display: inline-block; width: 80%;"></span>	<b>MID #:</b> <span style="border-bottom: 1px solid black; display: inline-block; width: 80%;"></span>
<b>NOTES</b>	



## Member Summary Worksheet Periodic Review

Figure 37 – Member Summary Worksheet Periodic Review (Page 1 of 3)

<b>MEMBER SUMMARY WORKSHEET</b> <b>Periodic Review</b>	
Please refer to the Right Choices Program (RCP) Manual for instructions to complete this worksheet.	
<b>Form completed by:</b>	<b>Date Completed:</b>
<b>Member Name:</b>	<b>MID #:</b>
<b>SERVICE UTILIZATION ANALYSIS</b>	
Dates of Service Reviewed (6 months within a 12 month rolling period): <review/start_date> to <review/end_date>	
<b>MEMBER DIAGNOSES</b>	

Figure 37 – Member Summary Worksheet Periodic Review (Page 2 of 3)

Member Name: <input style="width: 150px;" type="text"/>		MID #: <input style="width: 100px;" type="text"/>			
UTILIZATION ANALYSIS					
Total Dollar Amount of Paid Claims during the Review Period: <input style="width: 150px;" type="text"/>					
Triggers for Clinical Review	Initial Review Total	Periodic Review Total	Periodic Review Total	Periodic Review Total	Member's Current Total
Number of PMP Selections	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>
Number of ER Visits	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>
Number of Prescribers	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>
Number of Pharmacies	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>
Number of Filled Controlled Substance Prescriptions	<input style="width: 30px;" type="text"/>	For Reference Only			<input style="width: 30px;" type="text"/>
Number of Filled Prescriptions	<input style="width: 30px;" type="text"/>	For Reference Only			<input style="width: 30px;" type="text"/>
<small>Data Source: CareMII</small>					
MEDICATION THERAPY MANAGEMENT ANALYSIS					
Flags	Drug Class or Polypharmacy				
<div style="border: 1px solid black; height: 150px; width: 100%;"></div>	Number of Prescribers	<input style="width: 60px;" type="text"/>			
	Number of Pharmacies	<input style="width: 60px;" type="text"/>			
	Number of Filled Prescriptions	<input style="width: 60px;" type="text"/>			
	Total Cost	<input style="width: 60px;" type="text"/>			
<small>Data Source: RCP Potential Report</small>					
<small>Member Summary Worksheet Periodic Review - Right Choices Program Version 1.0 November 2009</small>					
<small>Page 2 of 3</small>					

<b>Member Name:</b>	<b>MID #:</b>
<b>NOTES</b>	
<div style="border: 1px solid black; height: 590px; margin-bottom: 5px;"></div>	



## Section 4: Right Choices Program Member Letters

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

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

Figure 38 – Letters Tab

To generate a letter, select the type of letter and click **Print Letter**.

\* Indicates a required field.

**Print Letters**

\*Letter Type  **Print Letter**

Description


Letter History	
Letter Type	Date Printed
PMP RCP Lock-In Provider	07/09/2015
Pharmacy RCP Lock-In Provider	07/09/2015
RCP Provider Assignment	07/09/2015
Hospital RCP Lock-In Provider	07/09/2015
RCP Member Notification	07/09/2015

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

## Member Notification – Managed Care Member

The following is an example of the initial notification letter, sent via mail with delivery confirmation, to notify the managed care member that he or she has been chosen for the RCP.

Figure 39 – RCP Member Notification Letter (page 1 of 2)



Eric Holcomb, Governor  
State of Indiana

**Indiana Health Coverage Programs**

DXC TECHNOLOGY  
950 NORTH MERIDIAN STREET, SUITE 1150  
INDIANAPOLIS, IN 46204  
800-457-4584  
[www.indianamedicaid.com](http://www.indianamedicaid.com)

Member Number:

Dear

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

You will choose one PMP to manage all of your medical needs, one pharmacy to fill your prescriptions, and one hospital. If you need to see another physician, your PMP must provide a referral for you. If you receive services from other providers without a referral, the program will **not** pay for those services. If you have a medical emergency in which your life or health is at serious risk, go to your Right Choices hospital emergency room. If you are not sure if you have a medical emergency, you can call your PMP for advice. Your care manager will help you access your Medicaid covered health care benefits.

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

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

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




Figure 39 – RCP Member Notification Letter (page 2 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 33 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 – Traditional Medicaid Member

The following is an example of the initial notification letter, sent via mail with delivery confirmation, to notify the Traditional Medicaid member that he or she has been chosen for the RCP.

Figure 40 – RCP Member Notification – Fee-for Service (FFS) Letter (page 1 of 2)



Eric Holcomb, Governor  
State of Indiana

*Indiana Health Coverage Programs*

DXC TECHNOLOGY  
950 NORTH MERIDIAN STREET, SUITE 1150  
INDIANAPOLIS, IN 46204  
800-457-4584  
[www.indianamedicaid.com](http://www.indianamedicaid.com)

Member Number:

Dear

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

You will choose one PMP to manage all of your medical needs, one pharmacy to fill your prescriptions, and one hospital. If you need to see another physician, your PMP must provide a referral for you. If you receive services from other providers without a referral, the program will **not** pay for those services. If you have a medical emergency in which your life or health is at serious risk, go to your Right Choices hospital emergency room. If you are not sure if you have a medical emergency, you can call your PMP for advice. Your Right Choices specialist will help you access your Medicaid covered health care benefits.

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

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

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






Figure 40 – *RCP Member Notification – FFS Letter* (page 2 of 2)

If you have questions about the Right Choices Program, refer to the enclosed Right Choices Program Member Booklet or call your Right Choices specialist at the phone number above. If you disagree with our decision to select you for the Right Choices Program, you have 33 calendar days from the date of this letter to appeal. Appeals must be sent in writing to the following address:

Family and Social Services Administration, Appeals and Hearings Section  
402 W Washington Street, Room E034  
Indianapolis, IN 46204

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

## Provider Assignment

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

Figure 41 – RCP Provider Assignment Letter (page 1 of 2)

The logo for the Indiana Family & Social Services Administration (FSAS) is a circular emblem. It features a green outer ring with the text "INDIANA FAMILY & SOCIAL SERVICES" at the top and "ADMINISTRATION" at the bottom. In the center is a white circle containing the letters "FSAS" in a stylized, green, serif font.

Eric Holcomb, Governor  
State of Indiana

*Indiana Health Coverage Programs*

DXC TECHNOLOGY  
950 NORTH MERIDIAN STREET, SUITE 1150  
INDIANAPOLIS, IN 46204

800-457-4584  
[www.indianamedicaid.com](http://www.indianamedicaid.com)

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 <<Month, Day, Year>> through <<Month, Day, Year>>.

The following Medicaid providers are your personal team of experts:

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

The Seal of the State of Indiana is a circular emblem. It features a green outer ring with the text "SEAL OF THE STATE OF INDIANA" at the top and "1816" at the bottom. In the center is a white circle containing a green landscape scene with a rising sun, a river, and a plow.

Figure 41 – RCP Provider Assignment Letter (page 2 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

## Member-Requested Change of RCP Provider

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

Figure 42 – *Member Request Provider Change Letter*

Eric Holcomb, Governor  
State of Indiana

*Indiana Health Coverage Programs*

DXC TECHNOLOGY  
950 NORTH MERIDIAN STREET, SUITE 1150  
INDIANAPOLIS, IN 46204

800-457-4584  
[www.indianamedicaid.com](http://www.indianamedicaid.com)

Member Number:

Dear

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

Respectfully,

The Right Choices Program

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

## Member Notification of Continued Program Enrollment Following Review

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

Figure 43 – Continued RCP Enrollment After Review Letter (page 1 of 2)



	<p>Eric Holcomb, Governor State of Indiana</p> <p><b>Indiana Health Coverage Programs</b></p> <p>DXC TECHNOLOGY 950 NORTH MERIDIAN STREET, SUITE 1150 INDIANAPOLIS, IN 46204 800-457-4584 <a href="http://www.indianamedicaid.com">www.indianamedicaid.com</a></p>
<p>Member Number:</p> <p>Dear</p> <p>This letter is to inform you that the Indiana Right Choices Program has reviewed how you have used your health care services. After our review, we believe the program is an important benefit that should continue to help you better manage your overall health care needs. Therefore, you will continue to be part of the Indiana Right Choices Program for an additional two years. The following is a list of the providers previously selected to manage your medical care.</p>	
<p>Children's Health Insurance Program • Healthy Indiana Plan • Hoosier Care Connect Hoosier Healthwise • M.E.D. Works • Traditional Medicaid</p> 	

Figure 43 – *Continued RCP Enrollment After Review Letter* (page 2 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 33 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

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

Figure 44 – RCP Enrollment after Member Appeal Letter (page 1 of 2)

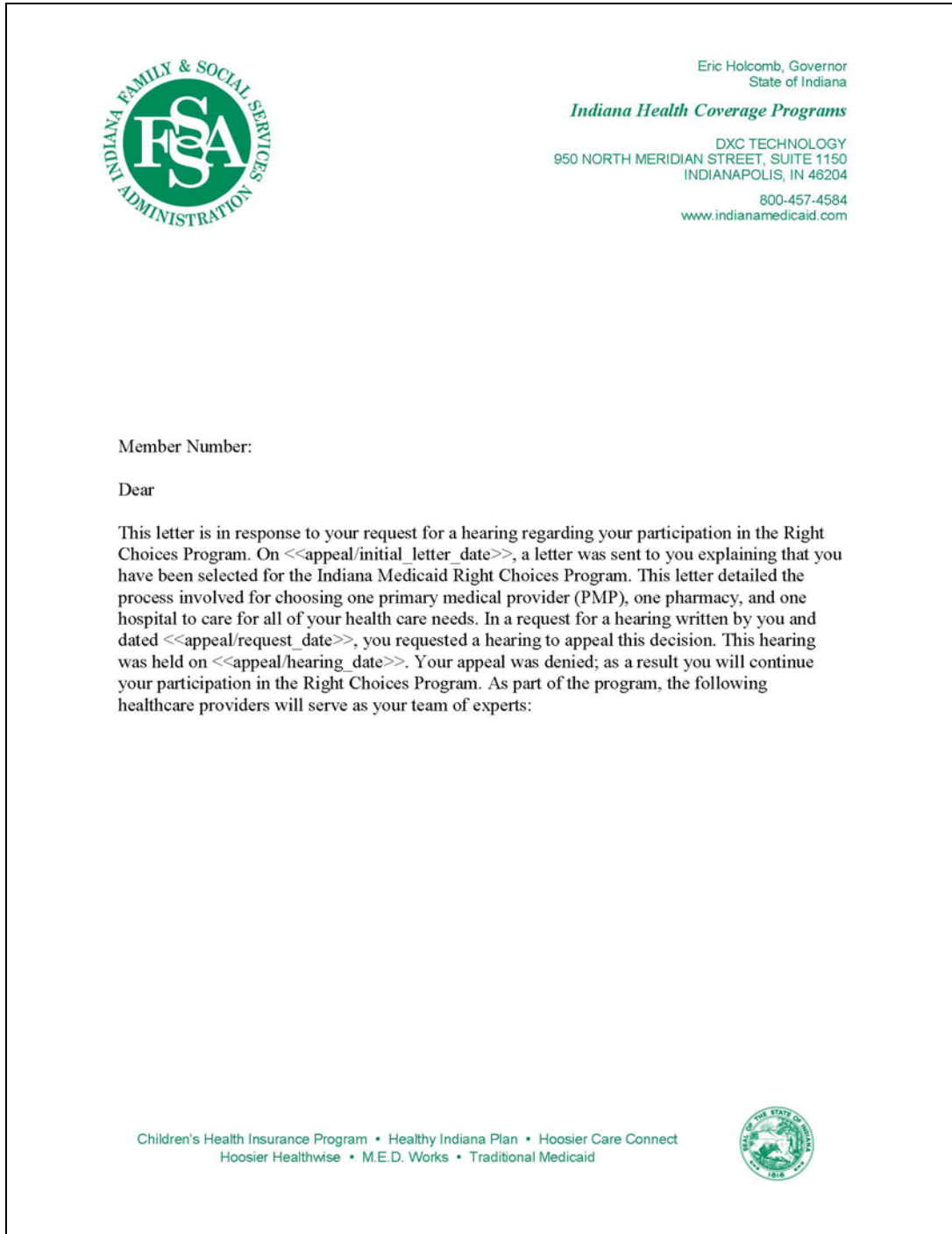


Figure 44 – *RCP Enrollment after Member Appeal Letter* (page 2 of 2)

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

Respectfully,

The Right Choices Program



## Graduation from Program

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

Figure 45 – RCP Program Graduation Letter

	<p>Eric Holcomb, Governor State of Indiana</p> <p><i>Indiana Health Coverage Programs</i></p> <p>DXC TECHNOLOGY 950 NORTH MERIDIAN STREET, SUITE 1150 INDIANAPOLIS, IN 46204</p> <p>800-457-4584 <a href="http://www.indianamedicaid.com">www.indianamedicaid.com</a></p>
<p>Member Number:</p>	
<p>Dear</p>	
<p>Congratulations! You have successfully completed and will be graduating from the Right Choices Program. The final date of your enrollment in the program is &lt;&lt;member/end_date&gt;&gt;.</p>	
<p>Graduating from this program does not affect your eligibility for Indiana Health Coverage Programs. If you are currently enrolled with an IHCP managed care program such as Hoosier Healthwise (HHW), the Healthy Indiana Plan (HIP), or Hoosier Care Connect, you will continue to receive health coverage through that program and be required to follow their guidelines.</p>	
<p>We hope this program helped you better understand your Medicaid benefit. We recommend that you continue to receive quality health care from your primary medical provider (PMP). By continuing to see your PMP, he or she will be able to assist you in managing all of your medical needs.</p>	
<p>Congratulations again on your successful completion of the Right Choices Program. If you have any questions, please call:</p>	
<p>Respectfully,</p>	
<p>The Right Choices Program</p>	
<p>Children's Health Insurance Program • Healthy Indiana Plan • Hoosier Care Connect Hoosier Healthwise • M.E.D. Works • Traditional Medicaid</p>	

## Confirmation Letter to Member of Change of Provider

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

Figure 46 – Member Confirmation of Provider Change Letter (page 1 of 2)



	<p>Eric Holcomb, Governor State of Indiana</p> <p><i>Indiana Health Coverage Programs</i></p> <p>DXC TECHNOLOGY 950 NORTH MERIDIAN STREET, SUITE 1150 INDIANAPOLIS, IN 46204 800-457-4584 <a href="http://www.indianamedicaid.com">www.indianamedicaid.com</a></p>
<p>Member Number:</p> <p>Dear</p> <p>This letter is to let you know that your request to change your Right Choices Program provider(s) has been reviewed. Your providers are:</p>	
<p>Children's Health Insurance Program • Healthy Indiana Plan • Hoosier Care Connect Hoosier Healthwise • M.E.D. Works • Traditional Medicaid</p> 	

Figure 46 – *Member Confirmation of Provider Change Letter* (page 2 of 2)

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

Respectfully,

The Right Choices Program



## Section 5: Right Choices Program Provider Letters

The Right Choices Program (RCP) Administrator uses the Provider Healthcare Portal (Portal) to generate the appropriate letter for the lock-in provider assigned to the RCP member. To create a new RCP letter, the RCP Administrator follows these steps:

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

Figure 47 – Letters Tab

To generate a letter, select the type of letter and click **Print Letter**.

\* Indicates a required field.

**Print Letters**

\*Letter Type  **Print Letter**

Description


Letter History	
Letter Type	Date Printed
PMP RCP Lock-In Provider	07/09/2015
Pharmacy RCP Lock-In Provider	07/09/2015
RCP Provider Assignment	07/09/2015
Hospital RCP Lock-In Provider	07/09/2015
RCP Member Notification	07/09/2015

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

## Primary Care Physician Assignment

The following is an example of the initial letter sent to notify a provider that he or she has been selected as a lock-in primary medical provider (PMP).

Figure 48 – PMP RCP Lock-In Provider Letter (page 1 of 3)



Eric Holcomb, Governor  
State of Indiana

**Indiana Health Coverage Programs**

DXC TECHNOLOGY  
950 NORTH MERIDIAN STREET, SUITE 1150  
INDIANAPOLIS, IN 46204  
800-457-4584  
[www.indianamedicaid.com](http://www.indianamedicaid.com)

Re: (Member Name)  
(Member ID Number)

Dear Medical Provider:

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

**WHAT IS THE RIGHT CHOICES PROGRAM?**

The Right Choices Program (formerly known as Indiana Medicaid's Restricted Card Program) monitors utilization of IHCP members who have been identified as over-utilizing or inappropriately using IHCP services. The goal of the RCP is to provide quality health care through education and intervention that includes restriction to specific 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 *Right Choices Program* program reference module for more information about the Right Choices Program.

**YOUR ROLE AS THE PRIMARY LOCK-IN MEDICAL PROVIDER**

Your role in the management of this member's care will be essential to the efforts of the RCP. The OMPP and the RCP Administrator greatly appreciate the time and effort required to support this process. All RCP members are assigned medical, pharmacy, and hospital providers; it is our hope that your support of this member, together with the member's other assigned providers, will promote appropriate utilization of IHCP services and lead to positive health outcomes.

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

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




Figure 48 – PMP RCP Lock-In Provider Letter (page 2 of 3)

The RCP Administrator for this member is shown below:

#### 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 IHCP member's name
2. The IHCP member's RID
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).

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.

Figure 48 – *PMP RCP Lock-In Provider Letter* (page 3 of 3)

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



## Hospital Provider Assignment

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

Figure 49 – Hospital RCP Lock-In Provider Letter (page 1 of 2)



	<p>Eric Holcomb, Governor State of Indiana</p> <p><b>Indiana Health Coverage Programs</b></p> <p>DXC TECHNOLOGY 950 NORTH MERIDIAN STREET, SUITE 1150 INDIANAPOLIS, IN 46204 800-457-4584 <a href="http://www.indianamedicaid.com">www.indianamedicaid.com</a></p>
<p>C/O BILLING DEPARTMENT C/O EMERGENCY DEPARTMENT</p>	
<p>Re: (Member Name) (Member ID Number)</p>	
<p>Dear Hospital Provider:</p>	
<p>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.</p>	
<p><b>WHAT IS THE RIGHT CHOICES PROGRAM?</b></p>	
<p>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 <i>Right Choices Program</i> program reference module for more information about the Right Choices Program.</p>	
<p><b>YOUR ROLE AS THE LOCK-IN HOSPITAL</b></p>	
<p>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.</p>	
<p>Children's Health Insurance Program • Healthy Indiana Plan • Hoosier Care Connect Hoosier Healthwise • M.E.D. Works • Traditional Medicaid</p>	

Figure 49 – *Hospital RCP Lock-In Provider Letter* (page 2 of 2)

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 OMPP 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 IHCP 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

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

Figure 50 – Pharmacy RCP Lock-In Provider Letter (page 1 of 3)



Eric Holcomb, Governor  
State of Indiana

**Indiana Health Coverage Programs**

DXC TECHNOLOGY  
950 NORTH MERIDIAN STREET, SUITE 1150  
INDIANAPOLIS, IN 46204  
800-457-4584  
[www.indianamedicaid.com](http://www.indianamedicaid.com)

(Pharmacy Name)  
ATTN: PHARMACY MANAGER

Re: (Member Name)  
(Member ID Number)

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 see the IHCP *Right Choices Program* program reference module for more information about the Right Choices Program.

This member has also been assigned to the following providers:

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




Figure 50 – Pharmacy RCP Lock-In Provider Letter (page 2 of 2)

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 Family and Social Services Administration (FSSA) and the RCP Administrator greatly appreciate the time and effort required to support this process. Appropriate utilization of IHCP services leads to positive health outcomes for this member.

### HOW TO FILE CLAIMS FOR THE RIGHT CHOICES PROGRAM MEMBER

Any prescriptions written by the member's lock-in primary medical provider (PMP), or other lock-in provider can be filed through normal claim submission procedures (via paper or POS). Each physician must be an IHCP 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 (=03), up to a 4-day supply of medication can be dispensed. For packaging that inherently cannot be broken down to a 4-day or less supply (example: metered-dose inhalers), the pharmacy is advised to dispense the smallest quantity possible adequate for the emergency situation. The provider should internally document that the quantity dispensed was, due to manufacturer packaging constraints, the least that could be dispensed while meeting the patient's needs during the emergency situation. This option should be utilized with careful discretion. If the provider writing the prescription is not on the member's lock-in list, and the RCP Administrator has not received a referral, the member must contact his/her pharmacy 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 Identifier (NPI) from a non-lock-in PMP to the lock-in PMP without a valid referral. If the NPI has been altered, the reimbursement for the claim will be subject to recoupment by the State and the action will be subject to a Medicaid fraud investigation.

**If you have questions regarding these procedures, please contact the pharmacy vendor associated with the member's RCP Administrator, as referenced below. The member's RCP Administrator is identified for you, in this letter, immediately above the *Your Role As The Primary Lock-In Pharmacy* section. For further information regarding the pharmacy vendor, please see *IHCP Bulletin BT201532* at [indianamedicaid.com](http://indianamedicaid.com).**

Member's RCP Administrator	PROGRAM/PHARMACY VENDOR FOR CLAIM FILING			
	Healthy Indiana Plan	Hoosier Care Connect	Hoosier Healthwise	Traditional Medicaid
<b>Anthem</b>	<Vendor name> <Telephone number>	<Vendor name> <Telephone number>	<Vendor name> <Telephone number>	
<b>Managed Health Services</b>	<Vendor name> <Telephone number>	<Vendor name> <Telephone number>	<Vendor name> <Telephone number>	
<b>MDwise</b>	<Vendor name> <Telephone number>	<Vendor name> <Telephone number>	<Vendor name> <Telephone number>	
<b>CareSource</b>	<Vendor name> <Telephone number>			
<b>Cooperative Managed Care Services</b>				<Vendor name> <Telephone number>

Figure 50 – Pharmacy RCP Lock-In Provider Letter (page 3 of 3)

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 FSSA greatly appreciates your assistance in coordinating the healthcare 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 IHCP 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:

(PLAN)  
(Plan Phone Number)

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

Sincerely,

(PLAN)

The Right Choices Program