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Provider Manual Checklist

The page number for each the components below must be identified when the Provider Manual is submitted for review.

Narrative Elements:

Article 4

- A statement defining delineation of procedures that may be considered either medical or dental. **Page 30**
- A process for providing emergency dental services for all enrollees. **Page 43**
- An explanation of the prior authorization process which will include the following: **Page 70**
  - Prior authorization process for authorizing the dispensing of non-formulary medications (medically necessary).
- A brand name medication exception process for prescribers to use when medically necessary. **Page 70**

Prior Authorization Process for Authorizing MLTSS Services

- An explanation of the contractor's internal review and resolution of complaints/grievances (such as timely access and coverage issues, drug utilization review, and claim management based on standards of drug utilization review. **Page 82**
- Requirement for providers to notify enrollees of lab and radiology results within 24 hours of receipt of results in urgent or emergent cases and notification within 10 business days of receipt of results for non-urgent or non-emergent lab and radiology results. **Page 18**
- The contractor shall monitor its providers to provide follow up on missed appointments and referrals for problems identified through the EPSDT exams. **Page 24**
- An explanation of the referral process to be used by providers which shall include providing a copy of the medical consultation and diagnostic results to the mental health/substance abuse provider. **Page 44**
- The provider shall notify an enrollee's mental health/substance abuse provider of the findings of his/her physical examination and laboratory/radiological tests within 24 hours of receipt for urgent cases and within 5 business days in non- urgent cases. **Page 18**
- A section for Enrollees with Special Needs (Article 4.5.1) to include the following: **Pages 20 and 57**
  - Methods to identify those at risk who should be referred for a Complex Needs Assessment;
  - Methods to identify those at risk for nursing home level of care;
  - Methods and guidelines of determining specific needs of referred individuals; Assure required services are furnished;
  - Allow for continuation of existing relationships with non-par providers; Referrals to special care facilities for highly specialized care;
  - Standing referrals for long term specialty care;
  - Responding to crisis situations after hours for enrollees with special needs; Provision for dental services for enrollees with developmental disabilities; and Process to respond to crisis situations after hours.

- A section for Children with Special Health Care Needs (Article 4.5.2) to include the following: **Page 57** Methods for well-child care, health promotion, disease prevention, specialty care; and continuation of existing relationships with out-of-network providers when considered to be in the best medical interest of the enrollee.
- Providers must assure the use of the most current diagnosis and treatment protocols and standards established by the DHSS and medical community (Article 4.5.4) **Page 58**
- A detailed explanation of the UM appeal process (including expedited appeals). **Page 86**
- A statement regarding PCP notification of specialty and referral services. **Page 14**
- Justification of a specialist as a PCP which will include the following:
  - Scope and services to be provided; and
  - Coverage arrangements/availability 24 hrs/day, 7 days/week. **Page 20**
- Provision for standing referral to a specialist when an enrollee needs ongoing care. **Page 24**
- Provision for referral to a specialist or specialty care center in lieu of a traditional PCP for enrollees with specialty needs. **Page 24**
- Vaccines for Children (VFC) Program (Article 4.2.7.D) – the provider must enroll with the Department of Health and Senior Services VFC program. **Page 52**

Article 5

- Process for a PCP to request reassignment of an enrollee. **Page 16**
- Appointment standards to indicate that an enrollee's waiting time at a PCP or specialist office is no more than 45 minutes. **Page 14**
- The contractor shall educate its provider network about appointment time requirements. Education during Orientation and **Pages 14-16**
- The contractor shall incorporate the following values when addressing health care needs of an enrollee: **Page 26**
  - Honoring enrollee's beliefs;
  - Sensitivity to cultural diversity; and
  - Fostering respect for enrollee' cultural backgrounds.
- A statement indicating that a provider shall not discriminate against an enrollee or attempt to disenroll an enrollee for filing a complaint or grievance/appeal against the HMO **Page 26**

Article 6

- A mechanism by which providers can access the contractor by telephone (provide telephone number), including the hours of operation and days of the week/numbers of personnel available. **Page 10**
- Procedure to resolve billing, payment, and other administrative disputes between providers and the contractor for any reason including, but not limited to: (The procedure shall include an appeal process and require direct communication between the provider and the contractor and shall not require any action by the enrollee.) **Page 73**
  - Lost or incomplete claim forms or electronic submissions;
  - Requests for additional explanation as to services or treatment rendered by a health care provider;
  - Inappropriate or unapproved referrals initiated by the providers; or
  - Any other reason for billing disputes. **Page 73**
- Description of provider complaint, grievance/appeal procedures. **Pages 87-89**