PROVIDER MANUAL

FOR ALLIANCE CARE MANAGEMENT IPA
NETWORK PROVIDERS

May, 2013
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OFFICE INFORMATION

Hours of Operation

Monday through Friday 9:00 AM to 5:00 PM, with After Hours service for urgent issues

Contact Information

Contact Numbers:

Main Number 1-212-740-4300
After Hours Number 1-212-740-4300
Fax Number 1-212-740-4500

Email Contact:

Accounts Payable claims@allianceipa.com
Provider Relations Providerrelations@allianceipa.com

Mailing Address:

755 Second Avenue – 2nd Floor
New York, NY 10017

Website

www.AllianceIPA.com
INTRODUCTION

Alliance Care Management Independent Practice Association (ACM IPA) would like to take this opportunity to welcome you to our LHCSA (Licensed Home Care Service Agency) network. As a LHCSA, you play a central role in the delivery of services to our Patient community. We believe that by working together our combined efforts will provide quality and efficient service to our members and plans. This manual is designed as a reference guide to assist you and your staff in the member referral process.

We are happy to have you as a participating Provider and look forward to a long lasting relationship with you.

PROGRAM OVERVIEW

ACM IPA was established to assist Managed Care Organizations (MCOs) and Managed Long Term Care Programs (MLTCPs) in the coordination of home healthcare services for chronically ill adults wishing to remain in their own home and communities as long as possible. ACM IPA contracts with a select network of licensed home care agencies to provide home health aides for non-skilled services on a long term basis.

A Patient’s home healthcare needs are assessed and defined by the Patient’s MCO/MLTCP Case Manager assessment. ACM IPA then works with the plan to assign the Patient to a participating LHCSA in the ACM IPA Provider network. If a Patient already has an agency or an aide in our network that they have a relationship with, every effort is made to maintain services with that aide or agency. Services to be provided to the Patient are indicated on the Plan of Care provided by the MCO/MLTCP to the network Provider, no additional eligibility or preauthorization is needed.

Our current service area includes all of five boroughs of New York City, as well as Westchester and Nassau counties, ACM IPA will inform each LHSCA as new MLTCP plans are added.
ALLIANCE CARE MANAGEMENT IPA RESPONSIBILITIES

General Information

ACM IPA has formed a network of credentialed LHCSAs to provide paraprofessional home healthcare services to MCO and MLTCP Plan members.

ACM IPA manages the Provider network by credentialing, auditing, placing referrals, monitoring care and quality, processing claims and collecting required data. ACM IPA will integrate the payor and Provider data systems, reducing the costs for both entities, while improving the delivery and quality of care.

ACM IPA offers LHCSAs an opportunity to become a Provider in a network that can access referrals from MCOs and MLTCPs previously unavailable to them, and to receive additional referrals from those payors that they are currently contracted with. ACM IPA will reduce the LHSCA’s operational costs by reducing the time and costs associated with acquiring referrals and with multiple credentialing and audit processes.

IPA responsibilities include:
- Initial credentialing and contracting
- Credentialing performed every three years,
- Placing Patient referral with approved Licensed Home Care agencies
- Providing home health aide profiles to payor prior to start of care
- Information conduit regarding care issues
- Provision of electronic visit verification, claims scrubbing, billing services
- Payment of claims to LHCSAs

Network Provider Credentialing

ACM IPA Provider Relations maintains credentialing files for each Provider. Providers must submit information and all credentialing documentation as required to validate the Provider’s qualifications and to provide uninterrupted services to Patients. Required documents include completed and signed:

- Participating Network Provider Agreement
- Credentialing Checklist
- Credentialing Application
- Wage Parity Attestation
- Anti-Lobbying Form
• Licensures and Accreditations where applicable
• W-9 Form
• EDI Agreement
• Evidence of Insurances: (ACM IPA must be included as certificate holder and additional insured)
  ▪ General Liability
  ▪ Professional Liability
  ▪ Worker’s Compensation

Renewed licenses and insurances must be submitted to Provider Relations within 7 business days of receipt. We can accept information by mail, fax or scanned to email.

ACM IPA will inform the Provider of any deficiencies or missing documents. Provider re-credentialing will be conducted every three years, or more often if required by the contracted MCO or MLTCP. ACM IPA and/or MCO/MLTCP may conduct a site survey of the Provider’s premises. ACM IPA will consider the results of the site survey in determining whether to contract or re-contract with a Provider. ACM IPA reserves the right to deny any Provider participation in the network if:

• Licensure or Certification Issues do not meet the minimum standard set by ACM IPA for entry
• Quality of care issues have been recorded against the Provider in the past

Patient Referral Placement

Upon enrollment in the chosen MLTCP, ACM IPA will receive the Patient demographics, plan of care, and schedule of services from the MLTCP. A sample referral form is at the back of this manual in the “Important Forms” section.

This information will be posted through our HHA eXchange portal to a LHCSA for acceptance. Posting will occur in one of two ways:

1. The Patient will be posted back to the LHCSA that initiated the referral. If the LHCSA does not accept the referral on a timely basis, the referral will be sent to an alternate LHCSA
2. If the Patient was not referred by a specific LHCSA, the Patient’s demographic information and special needs will determine a list of at least 3 LHCSAs that may qualify to accept the Patient
Referrals can be received to ACM IPA either by the LHCSA or directly by the MLTCP. See workflows below:

**MLTC Referral Workflow**

**LHCSA Referral Workflow**
Referring to Network Providers

Providers are selected based on the following criteria:

- Patient request for a specific Network Provider
- Patient has a special need (such as language)
- Geographic area
- Provider performance
- Level of complaints & incidents
- Level of past assistance in providing services
- Providers that meet or exceed minimum employment standards described in this manual

Temporary Patient Placement

After a break in coverage for any significant period, often because of an acute incident, ACM IPA will attempt to return that Patient to the LHCSA previously providing services. If, for any reason, that LHCSA cannot at that time accept the Patient, ACM IPA will offer that Patient to another LHCSA for temporary coverage.

Each Patient is assigned to an ACM Care Coordinator who has ongoing responsibility for coordinating, managing and communicating the authorizations for the delivery of care and services to LHCSAs. It is the responsibility of the Care Coordinator to maintain an open channel of communication amongst the MLTCP care team and the LHCSA, and to ensure that services are provided according to the Plan of Care. Their responsibilities include:

- Transmission and management of authorizations for covered services outlined in the Plan of Care
- Ensuring continuity of care by placing the Patient in the agency from which they have been receiving services whenever possible
- Monitoring of all services for quality and completeness
- Patient enrollment status tracking
- Interfacing with Electronic Visit Verification (EVV) process to monitor quality

Reimbursement

ACM IPA agrees to reimburse Providers according to the duly executed Provider Agreement. ACM IPA processes claims according to the claims processing rules outlined in the Claims Submission section of this manual, the Agreement and the NYS Medicaid processing rules and guidelines.
There are no cost-sharing expenses for Patients, including deductibles or co-payments. For more information or any questions, please call Provider Relations@ 212.740.4300

Policy and Procedure Communication

ACM IPA agrees to advise Providers of any administrative, procedural and/or policy changes effecting Providers in a timely manner either through mailings, the Provider newsletter, telephonically, or via website, www.AllianceIPA.com.

**PROVIDER RESPONSIBILITIES**

Overview

Home Health Care coordination and management is critical to the health and well-being of the MLTCP membership. Participating Providers agree through the Participating Provider Agreement to fully cooperate with care coordination, quality assurance and improvement programs as needed, even if the episode of does not result in any payment by ACM IPA to the participating Provider.

Providers are responsible for:

- Ensuring that all Provider’s employees and agents involved in direct contact with Members carry proper Agency identification.
- Notifying Member in advance of name of assigned HHA/PCA
- Notifying Member in advance of need for replacement and name of replacement aide
- Confirming aide daily attendance and adherence to Plan of Care

Home Healthcare Providers/Licensed Home Healthcare agencies will be selected by the ability and timeliness in placing referrals and providing services in the areas indicated in the credentialing package. If you have expanded your service area, please submit an amended credentialing document. Sample credentialing forms are at the back of this manual in the “Important Forms” section.

ACM IPA requires that home healthcare network Providers implement an electronic visit verification system in addition to other manual random verification. Agency protocols on Aide visit verification must be available to ACM IPA upon request.
Medicaid Regulations

Providers are responsible for familiarizing themselves with all Medicaid regulations and procedures currently in effect and as they are issued.

The Department of Health publishes a monthly newsletter, the “Medicaid Update,” which contains information regarding Medicaid programs, policy and billing. The updates are sent to all active, enrolled Providers. New Providers need to be familiar with the past issues of Medicaid Update to have current policy and procedures. Past issues of Medicaid Update are available at:


Contractual Requirements

Providers must comply with all contractual, administrative, medical management, quality management, and reimbursement policies as outlined in ACM IPA’s Provider contract, Provider Manual and circulated updates. Failure to adhere or comply with all contractual and regulatory requirements may result in the termination of your contract.

Non-Discrimination

Providers must not differentiate or discriminate in accepting and treating Patients on the basis of race, ethnicity, national origin, religion, gender, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, or source of payment.

ACM IPA and its contracted Providers shall ensure compliance with Title VI of the Civil Rights Act, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and other laws applicable to recipients of Federal Funds. Title II of the Americans With Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 (Section 504) provides that no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or denied access to the benefits of services, programs or activities of a public entity, or be subject to discrimination by such an entity. Public entities include state and local government and ADA and Section 504 requirements extend to all programs and services provided by state and local government. Since Medicaid is a government program, health services provided through Medicaid Managed Care must be accessible to all who qualify for the program.
Cultural Competence

Providers, in partnership with ACM IPA, are expected to promote a set of congruent behaviors, attitudes, and policies that will come together and enable a supportive and effective experience in cross-cultural situations. Providers should ensure that Patients of various racial, ethnic, religious and health backgrounds are communicated with in an understandable manner, accounting for language, functional and social needs. It is the Provider’s responsibility to ensure that the Patient clearly understands the diagnosis and treatment options that are presented, and that language, cultural differences, or disabilities are not posing a barrier to communication.

Employment Standards for Network Participating Providers

ACM IPA is committed to providing the highest quality of health care to MCO Patients through our LHCSA network.

To provide the best possible care, it is essential that Network Providers attract and retain the highest quality of staff to perform these services. While mindful that providing services must be accomplished within available funding levels, we believe that we have an obligation to encourage our business partners to treat their employees fairly and according to state and federal employment guidelines. A sample paraprofessional profile form is at the back of this manual in the “Important Forms” section.

The four items below enumerate the terms and conditions of employment that we consider to be minimum standards for all Participating Providers. Providers that meet or exceed these minimum standards will be considered “preferred” in consideration of future business.

- Provide a high level of care and customer service
- Provide wages according to NYSDOH wage parity regulations (form attached in back of manual
- Ensure safe and healthy working conditions
- Treat employees with dignity and respect

Communication

Providers are responsible for effectively communicating with ACM IPA in order to promote optimal scheduling of services, prevent duplication of services, remove barriers to care, increase continuity of care, and progress toward goal achievement.

Cooperate with ACM IPA and/or MCO/MLTCP on any grievance, appeal, or incident investigations as required. Incident reports must be submitted immediately to ACM IPA.
Communicate to ACM IPA any complaint made by or on behalf of the Patient.

Providers must notify ACM IPA immediately if; an authorized or requested service is refused, inability to access Patient’s home, or inability to provide service for any reason.

**NYS DOH MLTC Information**


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**QUALITY MANAGEMENT**

ACM IPA monitors Provider performance on an ongoing basis as follows:

- ACM IPA will review and archive all Patient satisfaction surveys
- ACM IPA will review and address all Patient complaints.
- Repeated complaints regarding a particular Provider are followed up by Provider Relations.
- Provider Relations will contact the Provider to discuss complaints and institute a plan of correction.

If repeated issues cannot be remedied, Provider Relations will initiate contract termination procedures.

**Provider Performance Standards**

Providers must maintain a mechanism for 24 hour/7 day Patient telephone access and office coverage to respond to urgent issues for their Patients. Pre-recorded referral to a hospital Emergency Department does not constitute appropriate 24 hours/7 day coverage. ACM IPA maintains a 24/7 answering service for after-hours urgent calls.

Providers who fail to meet office performance standards will need to prepare a corrective action plan for submission to the QA Committee. Providers deemed not in compliance with office performance standards may have their contract terminated.

ACM IPA should be notified in advance, if the situation permits, of any appointment cancellations or postponements.

**Provider Audits**

ACM IPA will review a sampling of Provider records documenting evidence of service delivery to determine accuracy and any patterns of error when deemed necessary.
Documents collected and reviewed will include but not limited to:

- Medical Record Notes
- Home Health aide certification
- Attendance Sheets
- Activity Records
- Time Slips
- Trip Verification
- Monitoring Reports from Network Providers

Audits will be based upon a sampling of paid claims for a specific time frame. Provider selection will be rotated based on highest utilization.

Audit Methodology:

- Upon thirty (30) day notice to Provider, ACM IPA will give the Provider a list of invoice numbers, Patient Names and service dates.
- Provider will make available service rendered documents for review against the paid claims.
- ACM IPA will compile data into a report indicating number of Providers audited, number of claims, and number of errors, if any, found.
- Providers showing a pattern of errors (excess of 5%) will be notified, and corrective action requested. Re-audits of these Providers will be conducted quarterly.
- If no corrective action is taken, Provider Relations will be notified and contract termination procedures will be initiated.
- All MLTCPs contracted by ACM IPA also reserve the right to audit LHCSA Patient records.

Medical Records:

ACM IPA may perform a medical record documentation audit as a component of the ACM IPA’s quality improvement program. Results are analyzed by Quality Assessment Committee and communicated to the Provider. This assessment may include, but not be limited to visit verification data, timesheet record keeping, care plan adherence, curriculum and attendance records for aide training courses. Providers who fail to meet this standard will be notified in writing of the area(s) that are subject to an individual performance improvement plan and monitoring.
Providers are required to allow ACM IPA, the New York State Department of Health, and the Centers for Medicare and Medicaid Services access to ACM IPA Patient information.

Quality of Care Concerns

If a quality of care concern is uncovered during a medical record review or in response to a Patient quality grievance, ACM IPA will share its findings with the Provider. The Provider will have the opportunity to respond to ACM IPA’s findings within thirty (30) days of receipt of the notice. If a response is not received within thirty (30) days of the notice, ACM IPA may request a plan of correction from the Provider.

Non-Compliance with Medical Records Requests

Providers who are not compliant with ACM IPA’s requests for medical records will be notified by phone and/or mail of their non-compliance. The Provider Relations Department will be made aware of non-compliance issues. Non-compliance events will be documented in the Provider’s file for further review and action.

PROVIDER TERMINATION

ACM IPA may terminate its contract with a Provider pursuant to the provisions of the Provider Agreement.

ACM IPA shall not terminate a contract with an individual health care Provider except in compliance with the requirements of Section 4406(d) of the New York Public Health Law.

Under this policy, the term “health care professional” shall be defined in accordance with Section 4406(d) of Public Health Law, as a health care professional licensed, registered or certified pursuant to Title Eight of the New York Education Law.

In accordance with the requirements of Section 4406(d), termination by Alliance Care Management IPA of a contract with a health care professional shall comply with the following:

ACM IPA shall not terminate a contract with a health care professional unless it provides to the health care professional a written explanation of the reasons for the proposed contract termination and an opportunity for a review or hearing as hereinafter provided. This provision shall not apply in cases involving imminent harm.
to Patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional’s ability to practice.

The notice of the proposed contract termination provided by ACM IPA to the healthcare professional shall include:

- The reasons for the proposed action;
- Notice that the health care professional has the right to request a hearing or review, at the professional’s discretion, before a panel appointed by Alliance Care Management IPA
- A time limit of not less than thirty (30) days within which a health care professional may request a hearing; and
- A time limit for a hearing date which must be held within thirty (30) days after the receipt of a request for a hearing.

**PATIENT RIGHTS**

Providers will uphold the Patient’s rights and responsibilities as outlined below.

As a Patient of MCO/MLTCP, the Patient has the right to:

- Receive medically necessary care;
- Privacy about the Patient’s medical record and treatment;
- Timely access to care and services;
- Receive information on available treatment options and alternatives presented in a manner and language understood by Patient;
- Receive information necessary to give informed consent before the start of treatment;
- Be treated with respect and dignity;
- Receive a copy of their medical records and ask that the records be amended or corrected;
- Take part in decisions about their health care, including the right to refuse treatment;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- Receive care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion;
- Appoint someone to speak for them about their care and treatment; and
- Make advance directives and plans about their care.

**Refusal of Care**

A Patient may refuse care that has been specified in the Patient’s Plan of Care.

MCO/MLTCP will not place, or will terminate services that the Patient refuses after the Patient, their family, or representative has been fully informed of the health risks and consequences involved in such refusal, and the Patient, upon being fully informed, continues to refuse care.

**Patient Health Status**

All Providers are required to notify ACM IPA immediately whenever there is identification of a clinical issue of serious concern, change in Patient status, need for clinical intervention or the need for services outside the agency’s scope of services or area of expertise. An incident report must be completed and sent to ACM IPA immediately after incident occurs. A sample form entitled *Quality Assurance Investigation Form* is attached at the end of this manual in the ‘Important Forms’ section. LHCSA staff that identify any emergency should call 911.

**Patient Confidentiality**

Providers shall ensure the confidentiality of all Patient related information by maintaining all Patient specific information and Patient records in accordance with New York State Public Health Law and the New York State Social Services Law and HIPAA (Health Insurance Portability Accountability Act). Patient information shall be used or disclosed by a Provider only with the Patient’s consent unless otherwise required by law and only for purposes directly connected with Provider’s performance and obligations under Provider Agreement.

Provider will inform and train its employees and personnel to comply with the confidentiality and disclosure requirements of New York State statutes and HIPAA (Health Insurance Portability Accountability Act). Documentation regarding this training will be provided to ACM IPA as requested.
Patient Grievances

A grievance is any communication by a Patient about dissatisfaction with the care and treatment received from staff or Providers of covered services, which does not amount to a change in scope, amount, and duration of service or other actionable reason.

Patients are instructed during enrollment of their right to appeal a grievance determination if the Patient is dissatisfied with the determination of a grievance.

Patients are advised how to file a grievance appeal and if needed, told how to obtain assistance from staff. MCO/MLTCP staff will review the grievance appeal with no disruption in the Patient’s care and Patients will be free from coercion, discrimination or reprisal by the program.

ACM IPA will coordinate with the MCO/MLTP for any follow up or instructions for the Provider during and after the grievance process, when applicable.

CLAIMS SUBMISSION

Participating Providers must submit electronic claims for authorized services. In most instances, the claims will be submitted to Alliance Care Management IPA. In these instances:

- Provider must obtain access to an FTP product or Provider must supply IP address of machine(s) that will send and receive files
- Provider must supply Public Key and obtain ACM IPA’s Public Key
- Provider will have to sign a copy of the ACM IPA Electronic Data interchange Agreement

An MLTCP may also elect to process claims directly. ACM IPA will notify you of the instructions for direct submission to an MLTCP is applicable.

For accurate and timely payment of claims, Providers must inform ACM IPA Provider Relations of any changes in Tax ID, Corporate Name and/or addresses as soon as they are known.

Covered Codes

The Following Codes are covered under the ACM IPA Program. New Codes may be issued in the future either as a result of changes to the coding system or as a result of
new services being covered. An addendum will be issued to the Provider manual will a full outline of covered codes when any changes are made.

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Claim Submission Parameters

Claims for services provided shall be submitted accordingly:

- 90% within thirty (30) days of the date of service.
- 100% within forty-five (45) days of the date of service.

All claims must include:

- Patient name and Medicaid ID #
- Provider Name, Tax ID Number and NPI number
- Date of Service

ACM IPA may pay claims denied for untimely filing where the Provider can demonstrate that a claim submitted after forty-five (45) days of the date of service resulted from an unusual occurrence and the Provider has a pattern of timely claims submissions.

Prompt Payment

Electronic Claims will be submitted in standardized HCFA 1500 format. Services authorized and according to the Plan of Care will be paid within thirty (30) days of receipt.

Claim Issues

Discrepancies between the submitted claim and the Plan of Care will be processed as follows:

- If the Claim Processing Provider denies a claim due to a discrepancy between MCO/MLTCPs approval record (plan of care) and the claim, or any other
problem with the claim or authorization, the Provider may submit a corrected claim within forty-five (45) days of the denial

- If the designated claim inquiry staff decides against the Provider, the Provider can appeal to the Director of Provider Relations.
- The Provider will be notified in writing of the decision.
- If the Provider wishes to pursue the discrepancy further, the discrepancy becomes a dispute, and is adjudicated through the dispute resolution process.

If a dispute arises out of, or relates to the Provider’s contract with ACM IPA and the dispute cannot be resolved by the parties within a reasonable time of either party’s notice to the other party of the dispute, the dispute shall be resolved by arbitration, unless otherwise stipulated. Arbitration shall be conducted pursuant to the contract between ACM IPA and the Provider. Arbitration decisions shall be final and binding.

Claim Inquiry

All Claim inquiries/appeals must be submitted within forty-five (45) days of receipt of claim determination, contact:

1-212-740-4300
claims@allianceipa.com

Partial or Non-Payment

Compare the claim to the authorized plan of care. Only authorized services are paid.

- If you are denied for a claim and subsequently find that there is an error in submittal call Provider Relations
- If you provided a service different from the service requested (changed hours or days, completed visit after expiration date, etc.) contact the Patient’s case manager or staff person who issued the authorization to discuss the situation. (Note: Case Management is not required to change an authorization if a different service was provided).
- If your claim is incorrect, resubmit the claim with the corrections clearly noting “CORRECTED CLAIM”
Common Reasons for Denial

“NO AUTH” or “SERVICE NOT AUTHORIZED”: This means that there is no authorization found for date of service or that there is an authorization but not for the service (code) billed: Check your authorization dates and codes.

Denied for Duplicate or Paid Authorized Units - This means that a payment for that code and that day of service was previously paid in full.

Units Not Authorized - means that the number of units charged is in excess to the amount authorized or the date of service falls within the authorization effective date range but no units are authorized for that particular day. (I.e. authorized MWF; billed Tues)

Appeal of Denied Claims

All claim inquiries and appeals must be submitted within forty-five (45) days of receipt of claim determination and include the following information:

- Claim Number
- Authorization Number ( if applicable)
- Patient Name
- ID Number
- Exact Date(s) of Service
- Service Code Billed
- Units Billed
- Amount Billed
- Reason for Inquiry or Appeal

Adverse Reimbursement Change

Notice of adverse reimbursement change will be provided at least thirty (30) days prior to an adverse reimbursement change to the Network Providers contract.

If the health care professional objects to the change that is the subject of the notice by the MCO, the health care professional may, within thirty (30) days of the date of the notice, give written notice to ACM IPA to terminate the contract effective upon the implementation of the adverse reimbursement change. An adverse reimbursement change is one that “could reasonably be expected to have an adverse impact on the aggregate level of payment to a health care professional.”
Fraud and Abuse/False Claims Act

Do not submit claims based on authorizations without proper documentation. Billing for services not rendered or different than the service actually provided is considered to be Fraud and Abuse.

False Claims Act

**Scope of the False Claims Act:**
The False Claims Act (the “FCA”) is a federal law (31 U.S.C. § 3279) that is intended to prevent fraud in federally funded programs such as Medicare and Medicaid. The FCA makes it illegal to knowingly present, or cause to be presented, a false or fraudulent claim for payment to the federal government. Under the FCA, the term “knowingly” means acting not only with actual knowledge but also with deliberate ignorance or reckless disregard of the truth.

**FCA Penalties**
The federal government may impose harsh penalties under the FCA. These penalties include “treble damages” (damages equal to three times the amount of the false claims) and civil penalties of up to $11,000 per claim. Individuals or organizations violating the FCA may also be excluded from participating in federal programs.

**Potential FCA Violations**
Knowingly submitting claims for services not actually provided; Examples of the type of conduct that may violate the FCA include the following:

- Submitting a claim for services when it was refused by the Patient;
- Submitting a claim for a service not provided.

**The FCA’s Qui Tam Provisions**
The FCA contains a qui tam, or whistleblower, provision that permits individuals with knowledge of false claims activity to file a lawsuit on behalf of the federal government.
The FCA’s Prohibition on Retaliation

The FCA prohibits retaliation against employees for filing a qui tam lawsuit or otherwise assisting in the prosecution of an FCA claim. Under the FCA, employees who are the subject of such retaliation may be awarded reinstatement, back pay and other compensation. AGENCY’s False Claims Act Policy strictly prohibits any form of retaliation against employees for filing or assisting in the prosecution of an FCA case.

State Law Regarding False Claims and Statements

There are a number of New York State laws punishing the submission of false claims and the making of false statements:

*Article 175* of the Penal Law makes it a misdemeanor to make or cause to make a false entry in a business record, improperly alter a business record, omit making a true entry in a business record when obligated to do so, prevent another person from making a true entry in a business record or cause another person to omit making a true entry in a business record. If the activity involves the commission of another crime it is punishable as a felony. Article 175 of the Penal Law also makes it a misdemeanor to knowingly file a false instrument with a government agency. If the instrument is filed with the intent to defraud the government, the activity is punishable as a felony.

Article 176 of the Penal Law makes it a misdemeanor to commit a “fraudulent insurance act,” which is defined, among other things, as knowingly and with the intent to defraud, presenting or causing to be presented a false or misleading claim for payment to a public or private health plan. If the amount improperly received exceeds $1,000, the crime is punishable as a felony.

Article 177 of the Penal Law makes it a misdemeanor to engage in “health care fraud,” which is defined as knowingly and willfully providing false information to a public or private health plan for the purpose of requesting payment to which the person is not entitled. If the amount improperly received from a single health plan in any one year period exceeds $3,000, the crime is punishable as a felony.
The last section of this manual contains samples of forms as follows:

- MLTCP Referral Form
- Paraprofessional Profile
- Alliance Care Management IPA Credentialing Checklist
- Licensed Home Health Service Agency Credentialing Application
- Licensed Home Health Service Agency Certification of Compliance with Home Care Worker Wage Parity
- Quality Assurance Investigation Form

Updated forms will soon be available on our website, or you can call our office.
Patient MLTCP Enrollment Preference (if applicable):

___________________

Refferrer Information:
Last Name: ___________________ First Name: ___________________
Address of Referrer: ____________________________
Phone #: ___________________ Fax #: ___________________

LHCSA Information:
Agency Name: ___________________ Contact Name: ___________________
Address of LHCSA: ____________________________
Phone #: ___________________ Fax #: ___________________

Home Health Aid Information:
Last Name: ___________________ First Name: ___________________

Patient Information:
Last Name: ___________________ First Name: ___________________
Address of Patient: ____________________________
Phone #: ___________________ Language Spoken: ___________________
Sex: M ____ F ____ Understands English? Y ____ N ____
Social Security #: ___________________ Date of Birth: ___________________
Medicaid #: ___________________ Medicare #: ___________________
Diagnosis: ____________________________
Needs Assistance with: ____________________________

Emergency Contact:
Name: ___________________ Relationship: ___________________
Address: ____________________________
Phone #: ___________________
Other Comments: ____________________________

Please fax this form to: 212-740-4500 or email: agillette@allianceipa.com
**HOME CARE**

**PARAPROFESSIONAL PROFILE**

**VENDOR NAME:** ____________  **VENDOR CODE:** V618  **EMP ID:** ____________

Your Vendor Name

**SSN:** _______ _______ _______  **LASTNAME:** ____________  **FIRST:** ____________

Aide’s last name  Aide’s first name

**EMPLOYMENT DATE:** _______  **TERMINATION DATE:** _______  **SEX:** _____  **I-9 STATUS:** _______

In/Complete

**VEREMPL:** _______  **ID:** _______  **REF1:** _______  **TYPE:** _______  **REF2:** _______  **TYPE:** _______

Date  Date  Date  P/B (personal/bus.)  Date

**REVIEW=>CONFIDENT:** _______  **UNIV. PRECAUT:** _______  **EMERG DISAST:** _______

In-service Date  In-service Date  In-service Date

**EXPOSURE CONTROL/OSHA:** _______  **TB PROTOCOL:** _______

In-service Date  In-service Date

**DISCIPLNE:** _______  **CERTIF DATE:** _______  **DATE VERIF:** _______  **DATE REVIEW JOB DESC:** _______

HHA/PCA

**TRAINING ==>INSTIT NAME:** ____________  **DATE COMPLETED:** _______  =FOR TRN

**AIDS TRAINING COMPLETED DATE:** _______  **HOSPICE TRAINING COMPLETED DATE:** _______

**PHYSICAL DATE:** _______  **HEALTH ASSESS/PHY DATE:** _______

**ADMIN EVAL DATE:** _______  **PROF EVAL DATE:** _______

**RUBELLA DATE:** _______  **RES:** _______  **VACC DATE:** _______  **PREG:** _______

P/N  Leave Blank  Leave Blank

**CERT OF MEASLES ON FILE:** _______  **OR DOB < JAN/57:** _______  **DATE VERIFIED:** _______

**MANTOUX DATE:** _______  **MANTOUX RESULTS:** _______

**X-RAY DATE:** _______  **X-RAY RESULTS:** _______

**DATE DRUG TEST:** _______  **CRIMINAL BACKGROUND CHECK DATE:** _______

**BOROUGH LOCATION:** _______  **LOA FLAG:** _______  **LANGS SPOKEN:** 1): _______ 2): _______ 3): _______

Please make sure and fill in the Boro

**INSERVICE DATE**  1: _______  2: _______  3: _______  4: _______

**EDUCATION DATE**  5: _______  6: _______  7: _______  8: _______

9: _______ 10: _______  11: _______  12: _______

Name of Patient being serviced:

______________________________________________________________________
ATTACHED COPIES

☐ STATE LICENSURE
☐ JCAHO or CHAPS accreditation
☐ PROOF OF INSURANCE
☐ TAX ID # ____________________
☐ LIVING WAGE ATTESTATION (to be submitted quarterly)

REQUIREMENTS
IPA Providers agree, to comply with, participate in, and be bound by the applicable rules, policies, procedures and programs of the ACM and the MCO/MLTCP including, without limitation and attest that:

THE FOLLOWING ARE IN PLACE AND AVAILABLE FOR REVIEW:

☐ Utilization Management and Review
☐ External review programs
☐ Care Management
☐ Encounter data reporting-electronic visit verification
☐ Quality Assurance and Improvement Programs
Performance improvement and Member satisfaction surveys
Outcome measurements
HHA training and In-services
HIPAA Compliance
Notice of Non Coverage and PRO Reviews
Member Grievances and Appeals
Fraud, Waste and Abuse detection and prevention;
24 hour access
Electronic Data transfer & Billing submittal

CREDENTIALING PROCESS COMPLETE

ABILITY TO COMPLY WITH ALL REQUIREMENTS
BY: ___________________________ date_____

TRAINING
BY: ___________________________ date_____

DATA INTEGRATION
BY ___________________________ date
NOTES: ____________________________________________

Licensed Home Health Service Agency
Credentialing Application

**IDENTIFYING INFORMATION**

Name of Company______________________________________

Address_____________________________________________________

Phone Number_________________ Fax__________________________

Email__________________________

Contact Name_________________ Phone Number/Ext_____________

Email__________________________ Cell__________________________

Tax Status (check one) [ ] For-Profit [ ] Non-Profit

Date of Incorporation: ______________________

Tax ID # ________________________________

Medicaid # _____________________________

NPI# _________________________________

State Department of Health License No. ________________________

Date Issued: _______________________

**ATTACHED COPIES**

☐ STATE LICENSURE

☐ JCAHO or CHAPS accreditation

☐ PROOF OF INSURANCE

☐ TAX ID # ___________________________

☐ LIVING WAGE ATTESTATION (to be submitted quarterly)
1) **OWNERSHIP INFORMATION**
List the names and provide all other requested information for all individual partnerships and corporations with a financial interest in the company in the grid below

<table>
<thead>
<tr>
<th>Name</th>
<th>% Ownership</th>
<th>Position in Company</th>
</tr>
</thead>
<tbody>
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</table>

2) **COMPANY STRUCTURE**
Is the company a parent or subsidiary of, or under common ownership with, another company? If so, give name and principals of other company in the grid below

<table>
<thead>
<tr>
<th>Name</th>
<th>% Ownership</th>
<th>Position in Company</th>
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</thead>
<tbody>
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3) **BOARD OF DIRECTORS**
List the names and provide all requested information for each member in the grid below

<table>
<thead>
<tr>
<th>Name</th>
<th>Position on Board</th>
<th>Occupation</th>
<th>Place of Employment</th>
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</tbody>
</table>
4) **KEY MANAGERIAL STAFF**
List the names and provide all requested information for the key managerial staff in the grid below:

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Professional Qualifications</th>
<th>Years with Company</th>
<th>Prior Home Care Experience</th>
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</table>

5) **INSURANCE INFORMATION**
Attach a current copy of certificates of insurance (general liability, worker’s compensation, etc.)
Are you currently the defendant in any lawsuits that might have a material impact on your financial viability and/or your ability to provide services relating to your provider contract?  
[ ] Yes  [ ] No  
If yes, describe the nature of the lawsuit(s)
__________________________________________________________
__________________________________________________________
__________________________________________________________

7) **PARAPROFESSIONAL TRAINING**
Do you have a licenses training program?  
[ ] Yes  [ ] No
If YES, Who provides the training?
__________________________________________________________

Hours of training provided:
Didactic ___________ Supervised Clinical Evaluations ___________

How frequently is your training program offered? _____________

Does your agency offer a training program in special areas?  
[ ] Yes  [ ] No
If yes, which area:
___________Live-InS  ___________Difficult to Serve Client
___________Language  ___________Other

How many hours of in-service education does your agency require annually for:
___________HHAs
What level of personnel, in your agency, performs paraprofessional evaluation?

__________________________________________________________

How are the results of the professional evaluation shared with the paraprofessional?

__________________________________________________________

8) POLICIES AND PROCEDURES
Screening and Hiring of Paraprofessionals
What level(s) of personnel in your agency screens applications?

__________________________________________________________

Do you perform criminal background checks? [ ] Yes [ ] No

What is your policy on drug screening? ________________________________

Does your agency offer an “Open House” for recruitment of paraprofessionals? [ ] Yes [ ] No

Does your agency provide applicants with a designated?
Interview Date [ ] Yes [ ] No
Interview Time [ ] Yes [ ] No

How many interviews does an applicant receive prior to hiring?

__________________________________________________________

Does your agency administer a verbal exam to each applicant? [ ] Yes [ ] No
If yes, the required passing grade is ________________

Does your agency administer a written exam to each applicant? [ ] Yes [ ] No
If yes, the required passing grade is ________________

How many references does your agency obtain for each applicant? ______

Does your agency request references for all prior positions on each applicant? [ ] Yes [ ] No
If no, how far back do you check? __________________________

What are your agency’s criteria for the hiring of applicants (e.g., experience, education, etc.)? ________________________________

__________________________________________________________

Lateness and Absence of Paraprofessionals
What is the length of time paraprofessionals are on probationary status?

_________________________________________ Certified
_________________________________________ Trainee
How many incidence of lateness and/or absence does your agency permit for paraprofessionals?

On probation __________
Not on probation __________

What level(s) of personnel, in your agency, monitors the paraprofessionals lateness and/or absence? ____________________________________________
____________________________________

How far in advance does your agency require paraprofessionals to call the office if they will be late and/or absent? ______________

What is your agency's process for handling lateness and absence of paraprofessionals?________________________________________
___________________________________________________
___________________________________________________
___________________________________________________

9) INCIDENTS
What is your agency's internal process when a report of an incident or alleged theft is received?
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________

What actions does your agency take to prevent incidents of theft?
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________

Are employees bonded? [ ] Yes [ ] No
If yes, what are the terms of the coverage? __________________________
___________________________________________________
___________________________________________________
If no, what is your policy regarding reimbursement to patients?
___________________________________________________
___________________________________________________
___________________________________________________
10) SERVICE DELIVERY
What are the indicators your agency utilizes to measure the quality of service delivered?

What level(s) of personnel, in your agency, monitors the quality of service delivered?

What level(s) of personnel, in your agency, is responsible for the management of a CHHA's contract?

What steps does your agency employ to assure all cases are covered each day?

What steps does your agency employ to assure all cases are provided timely service?

What procedures does your agency utilize to assure:
   (a) Cases are accepted and serviced appropriately
   (b) Cases are serviced on appropriate days/time

What steps does your agency employ to assure communication is disseminated to all levels of staff?

What do you think are the key components to assuring patient satisfaction?
What do you think are the key components to assuring payor satisfaction?
___________________________________________________
___________________________________________________
___________________________________________________

Does your agency offer any special or uncommon services?
___________________________________________________
___________________________________________________

11) CASE ACCEPTANCE
Which boroughs does your agency service?

- _______Manhattan  - _______Bronx  - _______Other
- _______Queens    - _______Brooklyn - _______
- _______Westchester - _______Nassau

How many cases are your currently servicing in each of the following ranges of hours/week?

- 0 -19 Hours  __________
- 20 - 40 Hours  __________
- 41-168 Hours  __________
- Total  __________

How many of your current cases are:

- live-ins  __________
- special language needs  __________
- AIDS (HIV) cases with 20 hours __________ of service/week or less

12) STAFFING
What is your agency’s coordinator to case ratio?

________________________________________
What is your agency’s coordinator to supervisor ratio?

________________________________________
How many paraprofessionals does your agency utilize per 100 cases?

________________________________________
How many "on-call" paraprofessionals does your agency utilize per 100 cases?

________________________________________
What strategies does your agency utilize to retain paraprofessionals?

________________________________________
________________________________________
________________________________________
13.) ADDITIONAL INFORMATION
Specialties: Languages, Disease/Event Management etc.
Please provide any additional information that you believe will help us in evaluating your application:
___________________________________________________
___________________________________________________
___________________________________________________

14.) MULTIPLE SITES? IF SO LIST BELOW
___________________________________________________
___________________________________________________
___________________________________________________

15.) ELECTRONIC DATA TRANSFER
Prior to a “go live date” we will integrate your system with ours, please indicate your system for visit verification

_____ SANDATA SANTRAX

_____ HHA XCHANGE

_____ OTHER _______________________________

_____ NONE
LICENSED HOME CARE SERVICES AGENCY

Certification of Compliance with Home Care Worker Wage Parity

I hereby certify that services provided by my organization for the period of March 1, 2013 through May 31st, 30th, 2013 are in full compliance with the terms of subdivision c of section 3614 of the Public Health Law, Home Care Worker Wage Parity and any regulations promulgated pursuant to this provision of Law.

In addition, I will provide the CHHA/LTHHCP/MCO, on a quarterly basis, all information to verify my compliance with the terms of this section (including this certification), that I will maintain all such information for a period of no less than ten years from the end of the applicable calendar year and that such information shall be made available to the Department upon request.

Name of Organization _____________________________________________

License No. (If applicable) _________________________________________

Signature _______________________________________________________

Date_______________________________

Name (Please Print) _________________________________________________

Title (Please Print) ________________________________________________

Does your organization currently have a collective bargaining agreement (CBA) that covers home care aides? Yes/No

Please note that in accordance with Parts 86-1.2 of Title 10 of the Commissioner’s Administrative Rules and Regulation, only the following individuals may sign the certification form:

Proprietary Sponsorship – Operator/ Owner

Voluntary Sponsorship – Officer (President, Vice President Secretary or Treasurer), Chief Executive Officer, Chief Financial Officer or any Member of the Board of Directors

Public Sponsorship – Public Official Responsible for the Operation of the Facility.
Quality Assurance Investigation Form

Vendor: ___________________________ Patient Name: ______________________________

Date of Incident: ___________________ MRN: ________________________________

Additional details of incident:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Report / Investigation

Review of HHA’s File (complete separate form for each HHA)

Name of HHA: ___________________ SS# ______________________________

1. Date of employment

________________________________________________________________________

2. Have there been any prior incidents / complaints? [ ] Yes [ ] No

   If yes, explain:

________________________________________________________________________

3. What was the date and rating of HHA’s most recent performance evaluation?

   Date: ______________________________ Rating: ______________________________

   [ ] not applicable due to length of employment of less than one year

Interview with HHAs involved (in person interview must be conducted as part of the preliminary investigation if injuries requiring medical intervention / emergency room treatment, unsafe and HHA abuse requiring HHA services to be placed on hold pending further investigation, physical abuse of patient, and unplanned absence of HHA that puts patients at risk)

[ ] In person [ ] By phone

Date completed: ____________________________
1. Summary and interpretation of HHA’s interview(s) and ‘signed’ statements with HHA:

________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

Vendor: ___________________________  Patient Name: ___________________________
Date of Incident: ______________________  MRN: ___________________________
If applicable

2. Detail / discrepancies with HHA’s statement:

________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

Interview with patient / family   [ ] In person  [ ] By phone  [ ] Date completed: _____
[ ] Not Applicable

Summary of patient / family interviews:
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

Interview with VN:  [ ] In person  [ ] By phone  [ ] Date completed: _____________________
[ ] Not Applicable

Summary of interviews with VN:
________________________________________________________________________________________________________
__________________________________________________________________________________
_______________________________________________________________________________________
___________________________________________________________________________________________
____________________________________________________________________________________________
________________________________________________________________________________________________________

Other Interviews conducted: (if applicable) [ ] In person [ ] By phone [ ] Date completed: ________
[ ] Not Applicable

Summary of Other interviews:
____________________________________________________________________________________________
____________________________________________________________________________________________

Vendor: Patient Name: ______________________________________________
Date of Incident: __________________________ MRN: _______________________________________________________________________

Findings from other reviews / action(s) taken (i.e., vendor, patient file, a log book, etc.):
____________________________________________________________________________________________

Vendor’s Conclusion

1. Steps taken to reach conclusion (check all that apply)

__ Interview HHA __ Consulted with VNS Investigators (Date)
__ Signed Statement(s) obtained __ Consulted with NYPD (Date)
__ Reviewed personnel record (Date) __ Conducted criminal background check (Date)
__ Interviewed VN __ Interviewed patient / family / others
__ Reviewed vendor / Administrative record
2.  [ ] Substantiated  [ ] Inconclusive  [ ] Unsubstantiated

Rationale:

____________________________________________________________________________________________

Resolution / Recommendation

1.  [ ] Indication

   A. Action taken with HHA(s) involved:

   __________________________________________________________________________________________

   B. Actions taken by vendor to prevent occurrence of a similar incident:

   __________________________________________________________________________________________

2.  [ ] Not indicated:

   Explain:

   __________________________________________________________________________________________

NAME AND TITLE OF PERSON COMPLETING REPORT

__________________________________________________________________________________________

SIGNATURE: ____________________________ DATE: _____________