

Section 3

Provider Responsibility

Medicare, UPIN, National Provider Identification Number

All contracted providers who participate with HC Generations may not be a “Medicare Participating” provider; however providers are required to follow the appropriate requirements that apply to their specialty type identified by CMS.

Providers must submit claims with the appropriate provider identification number, regardless of reimbursement method, on a valid claim form OR via electronic method. Providers must utilize the most current diagnostic and procedure coding guidelines, including International Classification of Diseases (ICD), American Medical Association Current Procedural Terminology (AMA CPT), Health Care Financing Administration Common Procedural Coding System (HCPCS), National Drug Code (NDC), Diagnostic Statistical Manual (DSM), Current Dental Terminology (CDT), CMS 1500, Uniform Billing Data Elements (UB-92) Specification Manual, and State identified CPT/HCPCS codes as directed by Health Choice Arizona Inc.

Notifications - Practice/Company Changes, Updates, Additions, Terminations

Contracted providers are required to notify Network Services in writing of *any changes* at least 30 days prior to the effective date of change. Examples of changes, updates, additions, terminations:

- practice/company name,
- physical services addresses,
- payee address,
- tax identification number
- provider additions/terminations
- phone and/or fax numbers

By not keeping your information current, you may experience claim rejections, non-payments or returned check payments.

Provider may use the Request for Participation / Update Information and Change Sheet or send the information on Letterhead or a notice signed by the Practice/Company staff.

Information may be faxed or mailed to the attention of Network Services.

Web Address: Select Provider then Network Services

<http://www.healthchoiceaz.com/> or <http://www.hcgenerations.com>

Changes in your administrative staffing also should be reported to your Network Services Representative. If we can provide staff training, please contact your Network Service Representative. Keeping your staff trained saves your time and money.

National Provider Identification (NPI) vs. Tax Identification Number (TIN)

Important Information about NPI Numbers: The NPI rule will require health plans to identify providers based first on NPI number, instead of Tax ID. Therefore, all electronic payments and

ERAs (835s) will be based on the NPI. This is especially important for Group Practices. If Group Practices that now bill under one Tax ID do not register for a Group NPI, individual electronic payments will have to be made to each individual NPI holder. To avoid this administrative burden, request a Group NPI for your Group Practice.

In the past a provider's tax identification number determined the address to which payment is sent. HC Generations requires providers to enter their tax identification number on all claims. If the tax identification number is not included in the appropriate box of the claim form or match what is our HC Generations payment system, payments may be denied or claims may be rejected and returned to the provider.

Credentialing and Re-credentialing

All providers must be credentialed with Health Choice Arizona, Inc. before a contract can be offered or a provider being added to an existing contract (associates).

A provider who has **not** been credentialed or contracted should not treat HC Generations members without prior authorization. However, there are exceptions for specific care, such as: Emergency Medical Services, Urgently Needed Care and Renal Dialysis when the Member is outside the Plan's service area, but still in the United States.

Note: Original Medicare Plan will not pay for these services.

The credentialing process can take up to 90 to 180 days to complete. HCA conducts re-credentialing at least once every three (3) years. Contracted providers will be notified by the HCA Credentialing Department. It is important that providers complete the re-credentialing application as quickly as possible. Failure to maintain a credentialed status with HCA can result in contract termination and non-payment of claims.

Licensure/Certification Updates

HCA requires that providers have current copies their state license, DEA certificate and Malpractice insurance on file at all times.

The HCA Credentialing Department sends letters to providers requesting current copies of these documents when the documents on file have expired. Failure to provide HCA with these documents can result in termination from the network.

The Primary Care Physician

HC Generations' Primary Care Physicians (PCPs) and Primary Care Obstetricians (PCOs) perform critical functions for the Health Plan. The Plan relies on you to provide an efficient and effective model of care that assures assigned members receive the medical care and services they require. PCPs are gatekeepers or medical managers and are responsible and accountable for the coordination, supervision, deliverance, and documentation of health care services to assigned members. HCA's Quality Management Committee periodically reviews guidelines for PCP management of HC Generations members. HCA monitors the over and under utilization of covered services in both the inpatient and outpatient settings. This data is used to improve overall performance of the Health Plan using local and national benchmarks. We monitor our PCP's to

see if their members are seeing more or less frequently and for what reason. That helps HCA predict and arrange for the necessary specialists, ancillary and hospital services they may require.

Specialists

For guidance as to which specialists/services require Prior Authorization Refer to **Section 6: Authorizations and Referrals and Exhibits 6.1A, 6.2A**. Specialists are required to submit the appropriate authorization number on their claims. HC Generations contracted specialists work in concert with the members Primary Care Physicians to coordinate the overall care for the member. Our goal at HC Generations is to develop partnerships with the Specialists in our network, as Specialty Physicians are critical to our success at HC Generations.

Referrals

The PCP is responsible for initiating and coordinating referrals to specialists within the HC Generations network. It is critical that a strong communication link be maintained with specialists or behavioral health providers who treat your patients. A record of the referral and any treatment notes from the specialists/behavioral health provider must be maintained in the member record. HC Generations encourages PCPs to maintain communication with the specialist when referring assigned members for specialty care. HC Generations has simplified its referral process to make it easier for the PCPs.

Specialists are responsible for requesting prior authorization for follow up services and other referrals as necessary. For a list of services that require authorization, refer to **Section 6: Authorizations and Referrals and Exhibits 6.1A, 6.2A**

Appointment Availability/Appointment Waiting Time

Contracted PCPs and Specialists must maintain availability within the appointment standards according to the HCA Subcontractor Agreement. Providers are expected to establish a procedure for waiting time so that a member does not wait more than 45 minutes, except in emergency cases or unforeseen circumstances. HCA monitors providers' appointment availability and members' in office waiting time on an on-going basis.

Please note that the standards below are applicable to both new and established patients.

PCP Appointment Standards

Emergency appointments	Same day
Urgent appointments	Within 2 days
Routine appointments	Within 21 days

Specialist Appointment Standards

Emergency appointments	Within 24 hours of referral
Urgent appointments	Within 3 days of referral
Routine appointments	Within 45 days of referral

OB/Prenatal Care Appointment Standards

First trimester	Within 14 days of request
Second trimester	Within 7 days of request
Third trimester	Within 3 days of request

High risk pregnancy

Within 3 days of identification of high risk status or immediately if an emergency exists

Telephone Availability

Members are encouraged and expected to contact their PCP to schedule appointments or seek medical advice. Because it is critical for members to be able to reach their physicians, telephones should generally be answered within 5 rings and hold times should not exceed 5 minutes. HCA monitors telephone accessibility to ensure that members can reach you to schedule appointments or seek advice.

Appointment Availability Non-Compliance

HCA ensures contracted physicians; ancillary services and facilities are accessible to members to provide routine and emergent care on a timely basis. Providers will be asked to implement a corrective action plan when the appointment availability standards are not met.

HCA monitors the accessibility of contracted providers through:

- Member complaints
- Quality management audits
- Emergency room utilization
- Appointment availability surveys
- Site visits by HCA staff

Failure to comply with the appointment availability standards is viewed as an access to care issue by HCA and may result in a cap on membership or a reduction/closure of the PCP panel or Specialty referrals.

Maintaining the Medical Record

The primary care medical record is designated to receive and contain documentation of all care and services rendered to the member by the PCP, Specialist, Inpatient care and Ancillary services. This also includes documentation of care and services provided for mental health and/or substance abuse, providing the member has authorized the mental health/substance abuse provider to disclose that information.

Documentation may be direct or consist of summary, consultation letters, discharge notes and progress notes submitted by outside providers. The PCP must establish Medical Records when information is received even if the PCP has not yet seen the member. This information may be maintained in an appropriate labeled file, prior to establishing a medical record as long as it is associated with the member's medical record when established.

When a member changes to a new Health Choice Generations PCP, the medical records must be transferred to the new provider in a timely manner.

Inspection and Audit of Records and Facilities

Providers must provide medical records or copies of medical records for any HC Generations Member upon request by HCA other HCA vendors. Medical records should be available within five (5) working days of a request. Failure to provide Health Choice Arizona, Inc (HCA) dba

Health Choice Generations (HC Generations) with medical records that result in a sanction to (HCA) by CMS will result in such sanction being deducted in full from future payments. HCA will issue a written notification seven (7) days prior to the sanction being imposed.

After-hours Coverage/Physician Vacation Coverage

Each provider must have 24 hours per day, 7 days per week coverage. It is not acceptable to refer HC Generations Members to the emergency room as a means to provide after-hours or vacation coverage. It is the responsibility of the PCP to arrange after hours care and vacation coverage by a contracted physician with HC Generations.

Acceptable coverage includes the following:

- An answering service that picks up the physician office's telephone after hours. The operator will then contact the physician or his covering physician
- An answering machine that either directs the caller to the office of the covering physician, or directs the caller to call the physician at another number
- Call forwarding services that automatically send the call to another number that will reach the physician or his covering physician

Unacceptable coverage includes the following:

- An answering machine that directs the caller to leave a message (unless the machine will then automatically page the doctor to retrieve the message)
- An answering machine that directs the caller to go to the emergency room, and gives no other option
- An answering machine that has only a message regarding office hours, etc., without directing the caller appropriately, as outlined above
- An answering machine that directs callers to page a beeper number
- No answering machine or service
- If your answering machine directs callers to a cellular phone, it is not acceptable for charges to be directed to the caller (i.e. members should not receive a telephone bill for contacting the physician in an emergency)

The PCP must notify their Network Services Representative to inform HCA of arrangements made for vacation coverage. Notification for vacation coverage includes: expected departure and return dates; name, address and telephone number of covering physician; and if covering physician office will be available to triage and/or answer questions for assigned members. If the covering physician is unavailable, the PCP should contact their Network Services Representative. Network Services will provide names and telephone numbers of physicians who may be able to render same day treatment. HC Generations will not reimburse physicians who provide coverage for a physician. Reimbursement of the covering physician is the sole responsibility of the PCP who is absent. Arrangements should be made in advance between the physicians.

Verify Eligibility

Providers should check member eligibility at each point of contact, as eligibility can change at anytime. However eligibility is not a guarantee of payment.

Members who lose eligibility with Medicaid (AHCCCS) and continue to have medical needs must be referred to a facility or provider that can provide the needed care at no or low cost. For assistance referring members please contact Member Services.

Provider/Contract Terminations

Because HC Generations Members must be notified at least 30 (thirty) days in advance by the Plan of terminating providers, Providers are required notify Network Services in writing of your decision to terminate or terminated partners at least 90 (ninety) days in advance. This notice must be signed by the physician or practice/company staff with signature authority; it may be mailed or faxed to Health Choice Arizona Inc. Attn: Network Services

Providers terminating their contracts without cause are required to continue to treat members until their treatment course is completed. Early notification will assist you and the member in transferring care, should that be required. Authorization may be necessary for these services.

Should a member require to be transferred to another HC Generations provider as a result termination, please assist the process by:

- Providing a copy of the member's medical record to the member or accepting provider, should it be requested.
- Speaking with the accepting provider regarding transfer of care issues

The transferring provider will communicate all health care treatment to ensure continuity of care for the member. In some areas where there are limited specialty providers, Health Choice Generations may allow a non-participating provider to continue care if a member is under active treatment. Authorization may be necessary for these services. If you identify a member in this circumstance, please contact our Case Management Department for assistance.

Contract Renewal/Termination

Our provider contracts renew automatically. Providers who move or leave a contracted group will not automatically be offered a contract at their new location. A contract offer or renewal in such cases is contingent upon Network need. HC Generations routinely reviews its Network and may make change based upon Network management considerations. Should you plan to leave a contracted group and go out on your own please contact your Network Services Representative at least 30 days prior to the departure date.

Managing Members with Disabilities or Specific Needs

The health care needs for members with disabilities or specific needs often differ from the general population in the type, scope, frequency, coordination and duration of care needed. Should you have a member with special health care needs, please contact HC Generations' Case Management Department by calling (800) 322-8670.

Members with special needs may be characterized as:

1. Persons who have communication barriers, such as speaking a different language; low literacy, visual or hearing impaired; geographically isolated people; and/or people who are homeless

2. People who require health and related services of a type or amount beyond required by people in general as:
 - Common and often-mild chronic health issues with unique presentations, for example, allergies, arthritis, and hypertension
 - Complex and manageable health issues, for example, asthma, diabetes, heart failure
 - Complex and difficult-to-address health issues such as lupus, cerebral palsy, major functional disabilities
 - Chronically mentally ill adults, substance abuse
 - Diagnosis specific groups, such as HIV/AIDS cases
 - Physically disabled adults, children and frail elderly
 - Organ transplant recipient or waiting for transplant

3. Persons whose eligibility status complicates understanding of managed care and enrollment, such as:
 - Dually eligible Medicare/Medicaid members
 - Uninsured families and children less familiar with the health system or managed care, who may be eligible under the states' expansion programs

History and Physical

It is expected that a complete history and physical will be documented in the HC Generations Member's medical chart. This will be reviewed during medical record audits.

Hospital Admissions

HC Generations uses a fully participatory Hospitalists program at most of its network hospitals within Maricopa, Pima and Pinal Counties. The PCP may contact the appropriate contracted Hospitalist group to arrange hospitalization or call HC Generations for assistance. The PCP will continue to manage the patient's care after discharge. The Hospitalist program does not cover pediatric or obstetrical cases. In these situations, as well as those cases where a hospital is not covered under the Hospitalist program, the PCP or obstetrician should expect to follow the member in the hospital. The PCP or PCO should communicate directly with the Prior Authorization Department when a hospital admission is necessary. **All hospital admissions require prior authorization.** HC Generations conducts concurrent review of all inpatient admissions. HC Generations uses accepted nationally recognized criteria when performing concurrent inpatient review.

Adult Immunization/Preventive Services

Health Choice Generations Members may directly access a contracted provider for mammography, influenza and women's health specialists for routine and all preventative health care.

Physicians are strongly encouraged to provide immunizations for influenza and pneumonia vaccinations when medically indicated and in conjunction with current CDC recommendations. Collection of co-payments is prohibited for routine injections, routine immunizations, flu immunizations, and the administration of pneumococcal/pneumonia vaccine.

Patient Education

HC Generations contracted providers are expected to provide appropriate prevention and disease management education. Providers may discuss medically necessary or appropriate treatment options with members even if the options are not covered services. Health maintenance education is not only expected and encouraged, it is required. Members should receive counseling about disease prevention and the importance of regular health maintenance visits, and they must be included in the planning and implementation of their care. It is expected that providers will educate patients about their unique health care needs; share the findings of physical examinations; discuss potential treatment options, side effects and management of symptoms; and, in general recognize that the patient has the right to choose the final course of action among clinically acceptable options.

It is particularly expected that members will be advised about the difference between urgent conditions, such as earaches, or flu, and emergent conditions and be instructed to contact their PCP first before visiting an emergency room or calling an ambulance unless they have a real emergency.

Prescriptions

Prescriptions should be written to allow generic substitution when available and signature on prescriptions must be legible in order for the prescription to be dispensed. It is the responsibility of the physician to obtain prior authorization prior to prescribing drugs not on the HC Generations formulary. For further detail, refer to *Section 10: Drug Formulary*

HC Generations Formulary is only available on the website.

Web Address: Select Medicare Part D Plans

www.hcgenerations.com.

(Note: if you do not have internet access, contact your Network Services Representative to arrange for a CD or assistance.)

Drug Utilization Concerns

HC Generations' goal is to provide safe, quality care for assigned members. Providers with concerns about a member's drug utilization should refer the member to HC Generations Case Management Department. HC Generations may identify members as having a potential substance abuse issue through provider information, utilization review, pharmacy reports, or emergency room visits. HC Generations will contact the PCP when there is a suspected substance abuse problem and assist with coordination of care.

Member Death

HC Generations providers are required to notify the Member Services Department of a member's death. Please provide the member's name, member's ID number, date of birth, date and place of death.

Emergency Room

An "emergency" is medical condition (including emergency labor a delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could result in: a) placing the patient's health in serious jeopardy; b)

serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part. **Providers may not refer members to the Emergency Room due solely to non-availability of same day appointment.** HC Generations contracts with a number of Urgent Care Centers. Ask your Network Representative for details and a location near you. All assigned members are considered **active** patients.

Fraud and Abuse

HC Generations is committed to detecting, reporting and preventing potential fraud and abuse. Fraud and abuse is defined as:

Fraud: Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under federal or state law.

(Source: 42 CFR 455.2)

Member Abuse: Intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault.

(Source: 42 CFR 455.2)

Provider Fraud: Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the Medicare or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare.

Providers must train staff on the following aspects of the Federal False Claims Act provisions;

- The administrative remedies for false claims and statements;
- Any state laws relating to civil or criminal penalties for false claims and statements;
- The whistleblower protections under such laws.

How are Fraud, Waste and Abuse Reported

If a provider is aware of potential Fraud, Waste or Abuse of the Medicare system, a referral should be made to Health Choice Generations. The process for reporting is the same as you report now with the AHCCCS program for Health Choice Arizona.

Health Choice Generations
Attn: Compliance
410 N. 44th St. Ste 900
Phoenix, AZ 85008

The MEDIC contractor for Arizona is assigned to take in all FWA referrals. Health Choice Generations will work with the MEDIC on all referrals.

Medicare Participation Standards

All Providers must meet the standards for participation and all applicable requirements for providers of health care services under the Medicare Program and follow facility standards established by CMS.

Persons Excluded from Medicare Participation

Providers must not employ, or contract with, any person who has been excluded from participation in the Medicare Program under Sections 1128 or 1128A of the Social Security Act (42 USC Sections 1330a-7 and 1330a-7a) for the provision of any (1) health care services, (2) utilization review, 3) medical social work or (4) administrative services.