Chapter 3: Provider Responsibility

National Identification Number (NPI)

HIPPA requires that all providers use a NPI number as the only provider identifier in electronic transmissions such as claims billing and claims payment. Providers must obtain an NPI number. For information regarding the NPI enrollment, visit the CMS website at https:nppes.cms.hhs.gov or call 1-800-465-3203.

Tax Identification Number

A provider's tax identification number determines who the payee is and where the payment is sent. It also allows Health Choice Insurance Co. to properly report payment information to the IRS on form 1099-MISC.

Federal Exclusion

Providers are obligated under 42 C.F.R. §1001.1901(b), to screen all employees, contractors, and/or subcontractors to determine whether any of them have been excluded from participation in Federal health care programs. While Health Choice Insurance Co. is a commercial insurance program, we apply this standard to our provider contracts. You can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE, and can be accessed at www.oig.hhs.gov/fraud/exclusions.asp.

Health Choice Insurance Co. Credentialing and Recredentialing

Health Choice Insurance Co. in collaboration with several other health plans in Arizona is an associate of AzAHP Alliance. The purpose of this alliance is to enable providers to complete a credentialing application form one time as the form is interchangeable between plans. Health Choice Insurance Co. works with the Council for Affordable Quality Healthcare (CAQH) where provider information is housed and updated making it accessible for providers.Please contact your Provider Services Representative for a copy of the AzAHP form.

All providers must be credentialed with Health Choice Insurance Co. Insurance Co. before a contract can be offered or prior to being added to an existing contract (associates). A provider who has not been credentialed or is not contracted cannot treat Health Choice I Insurance Company members and will not receive payment for services rendered to Health Choice Insurance Co. members. The credentialing process may take ninety (90) days to complete.

Health Choice Insurance Co. conducts re-credentialing at least once every three (3) years. Contracted providers will be notified by the Health Choice Insurance Co. Credentialing Department or a designated entity. It is important that providers complete the re- credentialing application as quickly as possible. Failure to maintain a credentialed status with Health Choice Insurance Co. may result in contract termination and non-payment of claims.

Contract Renewal/Termination

Health Choice Insurance Co. provider contracts renew automatically as long as the provider remains at the same location.

Providers who move or leave a contracted group may not be automatically offered a contract in their new location. A contract offer or renewal in such cases is contingent upon network need. Health Choice Insurance Co. routinely reviews its provider network and may make changes based upon network management considerations. Should you plan to leave a contracted group and go out on your own please contact your Provider Services Representative.

Delegation of Provider Functions

A contracted provider may not delegate any provider function without advance written consent of Health Choice Insurance Co. Insurance Co. Upon receiving consent of Health Choice Insurance Co. Insurance Co., functions further delegated by provider shall be subject to the terms of the Subcontractor Agreement between Health Choice Insurance Co. and the provider in accordance with the most current applicable URAC Standards.

Changes to Provider Information on File

Providers are required to notify Provider Services of any change in practice name, physical address, payee address, tax identification number or NPI. Changes in your staffing should also be reported to your Health Choice Provider Services Representative. If we can provide staff training please contact your Provider Service Representative.

Keeping your staff trained saves you time and money.

Licensure/Certification Updates

Health Choice Insurance Co. Insurance Co. requires that providers have current copies of their state license, DEA certificate and Malpractice insurance on file at all times. The Health Choice Insurance Co. Credentialing Department sends letters to providers requesting current copies of these documents when the documents on file have expired. Failure to provide Health Choice Insurance Co. Insurance Co. with these documents can result in termination from the network.

Continuity of Care/Loss of Eligibility

Providers terminating their contract without cause are required to continue to treat members until their treatment course is completed. Authorization may be necessary for these services.

Primary Care Physician

Health Choice Insurance Co. Primary Care Physicians (PCPs) and Primary Care Obstetricians (PCOs) perform critical functions for the health plan. Health Choice Insurance Co. relies on you to provide an efficient and effective model of care that

assures 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. Capitated providers are required to submit claims regardless of reimbursement.

Health Choice Insurance Co. Quality Management Committee periodically reviews guidelines for PCP management of Health Choice Insurance Co. members.

Health Choice Insurance Co. monitors the over and under-utilization of covered service, 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 seen more or less frequently and for what reason. That helps Health Choice Insurance Co. predict and arrange for the necessary specialists, ancillary and hospital services they may require.

For guidance as to which specialists/services require Prior Authorization, please refer to the Member Evidence of Coverage (EOC) and Chapter 6: Medical Authorizations & Referrals. Specialists are required to submit the appropriate authorization number on their claims. Health Choice Insurance Co. contracted specialists work in concert with the member's Primary Care Physician to coordinate the overall care for the member. Our goal at Health Choice Insurance Co. is to develop partnerships with the specialists in our network.

General Dentists

Health Choice Insurance Co. relies on its contracted general dentists to provide an efficient and effective model of care that assures members receive the dental care and services they require. The general dentist acts as a gatekeeper and is responsible and accountable for the coordination, supervision, deliverance, and documentation of dental health care services to our members.

Health Choice Insurance Co. monitors the over and under-utilization of covered dental services. This data is used to improve overall performance of the Health Plan using local and national benchmarks.

Dental Specialists

Dental specialists are required to submit the appropriate authorization number on their claims. Health Choice Insurance Co. contracted dental specialists work in concert with the members referring dentist to coordinate the overall oral health care for the member.

Patient Education

Health Choice Insurance Co. 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. Documentation of this counseling must be included in the planning and implementation of the member's 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 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. Refer to Chapter 5: Quality Management for health education and preventive services.

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 Health Choice Insurance Co. formulary. For further details, refer to Chapter17: Pharmacy and Drug Formulary or refer to the Health Choice Insurance Co. web site at www.healthchoiceessential.com.

Referrals

Health Choice Insurance Co. members are required to obtain a referral from their PCP to see a specialist. We encourage PCP's to maintain communication with the specialist when referring members for specialty care. Health Choice Insurance Co. 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.

All Hospital Admission Require Prior Authorization

Health Choice Insurance Co. conducts concurrent review of all inpatient admissions. Health Choice Insurance Co. uses accepted nationally recognized criteria when performing concurrent inpatient review. For a list of services that require authorization, refer to the Member Evidence of Coverage (EOC).

Drug Utilization Concerns

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

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 a Same Day Appointment.

Health Choice Insurance Co. contracts with a number of Urgent Care Centers. Ask your Provider Service Representative for details and a location near you.

Fraud and Abuse

Deficient Reduction Act/False Claims Act

Under the Deficit Reduction Act of 2005 (DRA) (Public Law 109-171 Section 6032), any employer who receives or makes $5 million or more per year in Medicaid payments is required to provide information to its employees about the federal and state False Claims Act.

Even if your practice or entity does not meet the minimum threshold, we recommend this training for all employees.

The goal is to ensure that funds are used effectively, efficiently, and in compliance with applicable state and federal laws and policies. Every dollar lost to the misuse of benefits is one less dollar available to fund programs which provide essential medical services for Arizona residents.

The Office of the Inspector General audits and investigates providers and members who are suspected of defrauding federal programs, recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal prosecution.

Health Choice Insurance Co. 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.
>
> ***Member Abuse****:* Intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault.
>
> ***Provider Fraud****:* Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Examples of Fraud and Abuse include:

- Falsifying Claim/Encounters
  - Altering a claim
  - Incorrect coding
  - Double billing
  - Submitting false data
- Falsifying Services
  - Billing for services/supplies not provided
  - Misrepresentation of services/supplies
  - Substitution of services
- Administrative/Financial
  - Kickbacks
  - Falsifying credentials
  - Fraudulent enrollment practices
  - Fraudulent TPL reporting
  - Fraudulent recoupment practices
- Member Issues (Abuse)
  - Physical abuse
  - Mental abuse
  - Emotional abuse
  - Sexual abuse
  - Discrimination
  - Neglect
  - Financial abuse
  - Providing substandard care
  - Misdiagnosis
- Member Issues (Fraud)
  - Eligibility determination issues
  - Resource misrepresentation (transfer/hiding)
  - Residency
  - Household composition
  - Citizenship status
  - Income
  - Prescription alteration
  - Misrepresentation of medical condition
  - Durable medical equipment theft
  - Failure to report Third Party Liability
- Denial of Services
  - Denying access to services/benefits
  - Limiting access to services or benefits
  - Specialist under-utilization
  - REPORTING FRAUD AND ABUSE (INCLUDING PRESCRIPTION FRAUD)

Health Choice Insurance Co. encourages providers and provider office staff to report potential fraud and abuse to Health Choice Insurance Co. by contacting their Provider Services Representative or sending a letter to Health Choice Insurance Co. Insurance Co., 410 N. 44th Street, Ste 500, Phoenix Arizona 85008, who will refer the case to the Compliance Department for investigation.

Although providers and their staff are encouraged to report potential fraud and abuse cases through Health Choice Insurance Co. as described above, they may also use one of the following external/confidential hotlines:

Call local law enforcement or *DHHS/Office of the Inspector General*

1-(800)-447-8477

Americans with Disabilities Act (ADA) & Titile VI of the Civil Rights Act of 1964

Under Title III of the ADA, requirements for public accommodations such as a physician's office mandate that they must be accessible to those with disabilities. Physicians should ensure that their offices are as accessible as possible to persons with disabilities, and should make efforts to provide appropriate accommodations such as large print, materials or easily accessible doorways for those with disabilities. Health Choice Insurance Co. Insurance Co. also offers over the phone interpreter services at no cost to the provider or member.

Under the provisions of Title VI of the Civil Rights Act of 1964, no person shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

For more information pertaining to available ADA resources offered through Health Choice Insurance Co., please call your Provider Service Representative.

Advanced Directive

Hospitals, nursing facilities, home health agencies, hospice agencies, and organizations responsible for providing personal care must comply with Federal and State law regarding Advance Directives for adult members. These providers are encouraged to provide a copy of the member's executed Advance Directive, or documentation of refusal, to the member's PCP for inclusion in the member's medical record.

Requirements of the Federal and State law include:

- Maintaining written policies that address the rights of adult members to make decisions about medical care, including the right to accept or refuse medical care, and the right to execute an advance directive. If the agency/organization has a conscientious objection to carrying out an advance directive, it must be explained in policies. (A health care provider

is not prohibited from making such objection when made pursuant to A.R.S. § 36-3205.C.1.)

- Provide written information to adult members regarding each individual's rights under State law to make decisions regarding medical care, and the health care provider's written policies concerning advance directives (including any conscientious objections).
- Documentation in the member's medical record whether or not the adult member has been provided the information and whether an advance directive has been executed.
- Not discriminating against a member because of his or her decision to execute or not execute an advance directive, and not making it a condition for the provision of care.
- Providing education to staff on issues concerning advance directives including notification of direct care providers of services, such as home health care and personal care, of any advanced directives executed by members to whom they are assigned to provide services.
- PCPs that have agreements with any of the aforementioned entities must comply with paragraphs listed above.