



## PROVIDER RESPONSIBILITIES

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#### Overview

This section of the Provider Manual addresses the respective responsibilities of participating providers.

#### Responsibilities of Primary Care Physicians

Following is a summary of responsibilities specific to Primary Care Physicians (PCPs) who render services to Plan members. Please also refer to the listing of Responsibilities of All Providers. These are intended to supplement the terms of the Provider Agreement.

1. Coordinate, monitor and supervise the delivery of primary care services to each member.
2. Assure the availability of physician services to members in accordance with Appointment Scheduling as outlined in this section.
3. Arrange for on-call and after-hours coverage in accordance with the After-Hours Services as outlined in this section.
4. Assure members are aware of the availability of public transportation where available.
5. Provide access to the Plan or its designee to examine thoroughly the primary care offices, books, records and operations of any related organization or entity. A *related organization or entity* is defined as: having influence, ownership or control and either a financial relationship or a relationship for rendering services to the primary care office.
6. Submit an encounter for each visit where the provider sees the member or the member receives a HEDIS<sup>®</sup> (Health Plan Employer Data and Information Set) service.
7. Submit encounters on a paper CMS 1500 or UB-04 form or its electronic equivalent, as each may be amended from time to time.
8. Ensure members utilize network providers. If unable to locate a participating provider for

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services required, contact Health Services for assistance.

9. See members for an initial office visit and assessment within the first 90 days of enrollment in the Plan. To assist members in receiving such health assessments upon enrollment, the Plan's Quality Improvement department will:

- Send a periodicity letter to members within 45 days of enrollment, encouraging an appointment with their PCP within 90 days;
- Conduct annual medical record reviews on a randomly selected set of high-volume PCPs (targeting both initial and continuous health assessments);
- Develop corrective action and performance improvement plans with the PCP if needed and perform reassessments to ensure compliance of corrective action plans.

10. Comply with and participate in corrective action and performance improvement plan.

### **Primary Care Offices**

Primary Care Physicians (PCPs) provide comprehensive primary care services to Plan members. Primary care offices participating in the Plan provider network have access to the following Plan services:

- Support of the Provider Relations, Customer Service, Provider Service Center, Health Services and Marketing and Sales departments.
- Information on Plan network providers for the purposes of referral management and discharge planning.



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#### **Domestic Violence & Substance Abuse Screening**

PCPs should identify indicators of substance abuse or domestic violence. Sample screening tools for domestic violence and substance abuse are located in the **Member and Provider Education Materials** section of this manual.

#### **Smoking Cessation**

Physicians influence the decisions members make about their health care. The Plan offers a list of national smoking cessation programs that will help members break both their physical and psychological addiction to cigarettes.

PCPs should direct members who smoke and wish to quit smoking to call Customer Service and ask to be directed to the Case Management department. A case manager will educate the member on national and community resources that offer assistance, as well as smoking cessation options available to the member through the Plan.

More information on smoking cessation is located in the **Member and Provider Education Materials** section of this manual.

#### **Adult Health Screening**

An adult health screening should be performed by a physician to assess the health status of all Medicare Advantage members. The adult member should receive an appropriate assessment and intervention as indicated or upon request. Please refer to the Adult Preventive Care Guidelines in the **Member and Provider Education Materials** section of this manual.

#### **Members with Special Health Care Needs**

*Members with special needs* are defined as adults and children who face daily physical, mental or environmental challenges that place their health at risk and whose ability to fully function in society is limited.

They include members with the following conditions:

- Mental retardation or related conditions;

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- Serious chronic illnesses such as HIV, schizophrenia or degenerative neurological disorders;
- Disabilities resulting from years of chronic illness such as arthritis, emphysema or diabetes; or
- Children and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care.

Following is a summary of responsibilities specific to physicians who render services to Plan members who have been identified with special health care needs:

1. Assess members and develop plans of care for those members determined to need courses of treatment or regular care;
2. Coordinate treatment plans with members, family and/or specialists caring for members;
3. Plan of care should adhere to community standards and any applicable sponsoring government agency quality assurance and utilization review standards;
4. Allow members needing courses of treatment or regular care monitoring to have direct access through standing referrals or approved visits, as appropriate for the members' conditions or needs;
5. Coordinate with the Plan, if appropriate, to ensure that each member has an ongoing source of primary care appropriate to his or her needs, and a person or entity formally designated as primarily responsible for coordinating the health care services furnished;
6. Coordinate services with other third party organizations to prevent duplication of services



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and share results on identification and assessment of the member's needs; and

7. Ensure the member's privacy is protected as appropriate during the coordination process.

#### **After-Hours Services**

The PCP shall provide, or arrange for coverage of services, consultation or approval for referrals twenty four hours per day, seven days per week.

To ensure accessibility and availability, PCPs must provide one of the following:

- A 24 hour answering service that connects the member to someone who can render a clinical decision or reach the PCP;
- Answering system with option to page the physician; or
- An advice nurse with access to the PCP or on-call physician.

#### **Closing of Physician Panel**

When requesting closure of their panel to new and/or transferring Plan members, PCPs must:

- Submit the request in writing at least 60 days (or such other period of time provided in their Provider Agreement) prior to the effective date of closing his or her panel;
- Maintain his or her panel to all Plan members who were provided services before the closing of his or her panel; and
- Submit written notice of the re-opening of his or her panel, including a specific effective date.

#### **Responsibilities of All Providers**

The remainder of this section is an overview of responsibilities for which all Plan providers are accountable. Please refer to your Provider Agreement



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or contact your Provider Relations representative for clarification of any of the following.

Physicians must, in accordance with generally accepted professional standards:

1. Comply with all applicable Medicare laws, rules and regulations, reporting requirements, CMS instructions, and applicable requirements of the contract between Plan and CMS (the "Medicare Contract") and with all other applicable state and federal laws and regulations, as may be amended from time to time, including, without limitation: (1) Federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (section 1128B(b) of the Act); and (2) HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164. [42 C.F.R. § 422.504(h)].
2. Comply with all state and federal laws, rules and regulations, Medicare program requirements, and/or requirements in the contract between Plan and CMS regarding privacy, security, confidentiality, accuracy and/or disclosure of records (including, but not limited to, medical records), personally identifiable information and/or protected health information and enrollment information including, without limitation: (1) the Federal Health Insurance Portability and Accountability Act of 1996, as amended and the rules and regulations promulgated there under, (2) 42 C.F.R. § 422.504(a)(13), and (3) 42 C.F.R. § 422.118; (iv) 42 C.F.R. § 422.516 and 42 C.F.R. § 422.310 regarding certain reporting obligations to CMS. Such information may only be released in accordance with applicable State and/or

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Federal law or pursuant to court orders or subpoenas.

3. Permit inspection, evaluation and audit directly by Plan, the Department of Health and Human Services (DHHS), the Comptroller General, the Office of the Inspector General, the General Accounting Office, CMS and/or their designees, and as the Secretary of the DHHS may deem necessary to enforce the Medicare Contract, physical facilities and equipment and any pertinent information including books, contracts (including any agreements between Provider and its employees, contractors and/or subcontractors providing services related to the Agreement), documents, papers, medical records, patient care documentation and other records and information involving or relating to the provision of services under the Agreement, and any additional relevant information that CMS may require (collectively, "Books and Records").

All Books and Records shall be maintained in an accurate and timely manner and shall be made available for such inspection, evaluation or audit for a time period of not less than ten (10) years, or such longer period of time as may be required by law, from the end of the calendar year in which expiration or termination of this Agreement occurs or from completion of any audit or investigation, whichever is greater, unless CMS, an authorized federal agency, or such agency's designee, determines there is a special need to retain records for a longer period of time, which may include but not be limited to: (i) up to an additional six (6) years from the date of final resolution of a dispute, allegation of fraud or similar fault; or (ii) completion of any audit should that date be later than the time frame(s) indicated above; (iii) if CMS determines that there is a reasonable

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possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit Books and Records at any time; or (iv) such greater period of time as provided for by law. Provider shall cooperate and assist with and provide such Books and Records to Plan and/or CMS or its designee for purposes of the above inspections, evaluations, and/or audits, as requested by CMS or its designee and shall also ensure accuracy and timely access for MA Members to their medical, health and enrollment information and records. Provider shall: (i) provide Plan and/or CMS with timely access to records, information and data necessary for: (1) Plan to meet its obligations under its Medicare Contract(s); and/or (2) CMS to administer and evaluate the MA program; and (ii) to submit all reports and clinical information required by the Plan under the Medicare Contract. [42 C.F.R. § 422.504(e)(4), (h), (i)(2), and (i)(4)(v).]

4. In no event, including but not limited to, non-payment by Plan, Plan's determination that services were not Medically Necessary, Plan insolvency, or breach of the Provider agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an MA Member for amounts that are the legal obligation of Plan. MA Members shall be held harmless from and shall not be liable for payment of any such amounts. This requirement shall be construed for the benefit of MA Members, shall survive the termination of the agreement between Provider and Plan regardless of the cause giving rise to termination, and this requirement supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and MA Members, or persons acting on behalf of an MA Member. [42 C.F.R. § 422.504(g)(1)(i) and (i)(3)(i).]

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5. Comply with all policies and procedures of Plan contained in this manual including, without limitation, written standards for the following: (a) timeliness of access to care and member services; (b) policies and procedures that allow for individual medical necessity determinations (e.g., coverage rules, practice guidelines, payment policies); (c) provider consideration of MA Member input into Provider's proposed treatment plan; and (d) Plan's compliance program which encourages effective communication between Provider and Plan's Compliance Officer and participation by Provider in education and training programs regarding the prevention, correction and detection of fraud, waste and abuse and other initiatives identified by CMS. [42 C.F.R. § 422.112; 422.504(i)(4)(v); 42 C.F.R. § 422.202(b); 42 C.F.R. § 422.504(a)(5); 42 C.F.R. § 422.503(b)(4)(vi)(C) & (D) & (G)(3).]
  
6. Except in instances of immediate termination by Plan for reasons related to professional competency or conduct and upon expiration or termination of Provider's participation agreement, Provider will continue to provide Covered Services to Members as indicated below and shall cooperate with Plan to transition Members to other Participating Providers in a manner that ensures medically appropriate continuity of care.

In accordance with the requirements of the Medicare Contract, Plan's accrediting bodies and applicable law and regulation, Provider will continue to provide Covered Services to MA Members after the expiration or termination of the Agreement, whether by virtue of insolvency or cessation of operations of Plan, or otherwise: (i) for those MA Members who are confined in an inpatient facility on the date of termination until discharge; (ii) for all MA Members through the

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date of the applicable Medicare Contract for which payments have been made by CMS to the Plan; and (iii) for those MA Members undergoing active treatment of chronic or acute medical conditions as of the date of expiration or termination through their current course of active treatment not to exceed ninety (90) days unless otherwise required by item (ii) above. [42 C.F.R. 422.504(g)(2) & (3).]

7. Acknowledge that nothing in this manual or the agreement is a financial incentive or inducement to reduce, limit or withhold Medically Necessary services to MA Members and that any incentive plans between Plan and Provider and/or between Provider and its employed or contracted physicians and other health care practitioners and/or providers shall be in compliance with applicable state and federal laws, rules and regulations and in accordance with the Medicare Contract. Upon request, Provider agrees to disclose to Plan the terms and conditions of any “physician incentive plan” as defined by CMS and/or any state or federal law, rule or regulation. [42 C.F.R. § 422.208.]
8. Shall not deny, limit, or condition the furnishing of benefits to an MA Member on the basis of any factor that is related to health status, including, but not limited to the following: (a) medical condition, including mental as well as physical illness; (b) claims experience; (c) receipt of health care; (d) medical history; (e) genetic information; (f) evidence of insurability, including conditions arising out of acts of domestic violence; or (g) disability. [42 C.F.R. § 422.110(a).]
9. Shall make Covered Services available and accessible to MA Members twenty-four hours per day, seven days per week, when Medically Necessary, and with reasonable

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- promptness and in a manner which assures continuity in the provision of Covered Services. [42 C.F.R. § 422.112(a)(7)].
10. Ensure that all marketing activities related to Plan's Medicare Advantage Benefit Programs conform to the requirements of the Medicare Advantage Program, codified at 42 C.F.R. § 422.80, as amended from time to time. Provider agrees not to engage in any such marketing activities, directly or indirectly, without first obtaining Plan and/or CMS approval, as applicable. [42 C.F.R. § 422.80.]
  11. Provide Covered Services in a manner consistent with professionally recognized standards of health care. [42 C.F.R. § 422.504(a)(3)(iii).] Provider agrees further to provide Covered Services in a culturally competent manner to all MA Members by making a particular effort to ensure that those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities receive the health care to which they are entitled. [42 C.F.R. § 422.112(a)(8).]
  12. Provide information to MA Members regarding specific health care needs that require follow-up and appropriate self-care and other measures they may take to promote their own health. [42 C.F.R. § 422.112(b)(5).]
  13. Document in a prominent part of each MA Member's medical record whether or not the MA Member has executed an advance directive; not condition the provision of care or otherwise discriminate against an MA Member based on whether or not the individual has executed an advance directive; comply with Plan's policies and procedures regarding advance directives contained in this manual; and comply with requirements of state and federal law regarding advance directives,

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including without limitation the rules and regulations under the Medicare Advantage Program. [42 C.F.R. § 422.128.]

14. Provide all documents and information necessary for Plan to comply with requirements for submitting information required by the Medicare Contract and pursuant to 42 C.F.R. § 422.503, as determined in the sole discretion of Plan. Provider shall assist Plan in submitting to CMS, all information that is necessary for CMS to administer and evaluate Plan's benefit programs and to assist Plan in facilitating a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services.

This information includes, but is not limited to the information prescribed in 42 C.F.R. § 422.504(f)(2) and downstream agreements and/or contracts entered into between Provider and any individual or entity that may perform duties of Provider under the Agreement. [42 C.F.R. § 422.64(a); 42 C.F.R. § 504(a)(4); 42 C.F.R. § 422.504(f)(2).] Provider further agrees, as a condition to receiving payment under this Agreement, to provide certification to the best of Provider's knowledge, information, and belief, the accuracy, completeness, and truthfulness of the encounter and/or claims data Provider submits to Plan under the Agreement and in accordance with the provisions of 42 C.F.R. § 422.504(l), as may be amended from time to time. [42 C.F.R. § 422.504(a)(8); 42 C.F.R. § 422.504(l)(2) & (3).]

15. Cooperate with, and upon request participate in, any internal or external quality assurance review, utilization review, quality improvement initiatives, peer review and/or grievance procedures established by Plan, CMS, or their respective designees; and shall monitor the



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quality of services delivered to Members by its employed and contracted physicians and other health care practitioners and/or providers and initiate corrective action where necessary for that level of care within the professional practices and standards in the community and/or as established or required by Plan, CMS or its designee. [42 C.F.R. § 422.202(b); 42 C.F.R. § 422.504(a)(5).]

16. Acknowledge that Plan is prohibited from employing or contracting with an individual who is excluded from participation in the Medicare program (or with an entity that employs or contracts with such an individual) for the provision of any of the following: (a) health care; (b) utilization review; (c) medical social work; or (d) administrative services. Provider shall immediately notify Plan in the event Provider or any of Provider's employees or contractors is excluded from participation in the Medicare program or any administrative or regulatory proceeding is initiated that could lead to the exclusion of Provider or any of Provider's employees or contractors from the Medicare program. [42 C.F.R. 422.752(a)(8).]
17. Use physician extenders appropriately. Physician Assistants (PA) and Advanced Registered Nurse Practitioners (ARNP) should provide direct member care within the scope or practice established by the rules and regulations of the state and Plan guidelines.
18. Assume full responsibility to the extent of the law when supervising PAs and ARNPs whose scope of practice should not extend beyond statutory limitations.
19. Clearly identify their titles (examples: MDs, DOs, ARNPs, PAs) to members and to other health care professionals.



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20. Honor at all times any member request to be seen by a physician rather than a physician extender.
21. Administer treatment for any member in need of health care services they provide.
22. Refer Plan members with problems outside of his or her normal scope of practice for consultation and/or care to appropriate specialists contracted with the Plan.
23. Refer members to participating physicians or providers, except when they are not available or in the case of an emergency.
24. Admit members only to participating hospitals, skilled nursing facilities (SNFs) and other inpatient care facilities, except in an emergency or when unusual circumstances require specialized care rendered in non-participating facilities.
25. Respond promptly to Plan requests for medical records in order to comply with regulatory requirements.
26. Inform Plan in writing within 24 hours of any revocation or suspension of his/her DEA number and/or suspension, limitation or revocation of his or her license, certification or other legal credential authorizing him or her to practice in any state.
27. Consistent with the Plan's credentialing and re-credentialing policies, immediately inform the Plan, in writing, of changes to license status, tax identification numbers, telephone numbers, addresses, status at participating hospitals, loss of liability insurance and any other change which would affect his/her status with the Plan.



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28. Inform members proactively of non-covered services and obtain members' written acknowledgement that they have been informed.
29. Maintain accurate medical records and adhere to all Plan policies governing the content of medical records as outlined in the quality improvement guidelines as set forth in the **Medical Records** section of this manual.
30. Maintain valid Clinical Laboratory Improvement Amendment(s) (CLIA) certificate(s), if applicable.
31. Ensure that: (a) all employed physicians and other health care practitioners and providers comply with the terms and conditions of the agreement between Provider and Plan; (b) to the extent physician maintains written agreements with employed physicians and other health care practitioners and providers, such agreements contain similar provisions to the Agreement; and (c) physician maintains written agreements with all contracted physicians or other health care practitioners and providers, which agreements contain similar provisions to the Agreement.
32. Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene.
33. Communicate timely clinical information between Plan providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to the Plan, the member or the requesting party at no charge, unless otherwise agreed.
34. Preserve member dignity and observe the rights of members to know and understand

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the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimen.

35. Not discriminate in any manner between Plan members and non-Plan members.
36. Encourage members to utilize the nurse help line (Plan's telephone-based triage program available in certain markets) for free-telephonic, medical advice 24 hours a day, 7 days a week. Please refer to your state-specific **Quick Reference Guide** for the telephone number for the Plan's nurse help line.
37. Identify members that are in need of services related to children's health, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation or substance abuse. If indicated, providers must refer members to Plan-sponsored or community-based programs.
38. Must document the referral to Plan-sponsored or community-based programs in the member's medical record and provide the appropriate follow-up to ensure the member accessed the services.

### Specialist Responsibilities

Specialists are responsible for treating Plan members referred to them by the PCP and communicating with the Plan's Health Services department for authorizations. Specialists may not refer to another Plan specialist. Referrals for Medicare Advantage members must be coordinated through members' PCPs.

A PCP referral is not required for access to network behavioral health specialists. Behavioral health specialists are responsible for communicating treatment, admissions, discharges and prescribing practices to the PCP.



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#### **Appointment Scheduling**

Providers must adhere to the standards of timeliness for appointments and in-office waiting times for various types of services that take into consideration the immediacy of the member's needs. A copy of the timeliness for appointments and in-office waiting times standards is available in the **Member and Provider Education Materials** section of this manual.

'Ohana shall monitor providers against these standards to ensure members can obtain needed health services within the acceptable appointments and in-office waiting times and after-hours. Providers not in compliance with these standards will be required to implement corrective actions set forth by the Plan.

#### **Covered Out-of-Network Services in Non-Emergency Situations**

In non-emergency cases, POS and PPO benefit plan options cover certain services by non-participating providers at a lower benefit level. This means the member's cost share is higher than if they receive covered services from a participating provider. Members' ID cards will list the type of benefit plan to which they belong.

#### **HMO**

There is no out-of-network option offered with this plan except in the event of an emergency. Members must be referred to participating physicians or providers, except when they are not available. Contact the Health Services department for assistance.

#### **HMO with POS**

Before referring members to a non-participating provider for services, contact Health Services for assistance determining whether the services will be covered at the in-network or out-of-network benefit level. Out-of-network services may be covered at the in-network benefit level if, for example, a participating provider for the required services cannot be located. The referring physician should advise members whether to expect to pay their in-network (co-pay) or



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out-of-network (coinsurance) cost share for the covered services.

#### **PPO Plans**

PPO plans do not require referrals or authorizations for covered out-of-network services. Out-of-network services may be covered at the in-network benefit level if, for example, a participating provider for the required services is not available.

#### **Out-of-Area Member Transfers**

Participating physicians and providers should assist the Plan in arranging and accepting the transfer of members receiving care out of the service area if the transfer is considered medically acceptable by the Plan physician and/or provider and the out-of-network attending physician.

#### **Request for Transfer of a Member**

A Plan physician or provider may not seek or request to terminate his or her relationship with a member, or transfer a member to another provider of care, based upon the member's medical condition, amount or variety of care required or the cost of covered services required by the Plan's member.

Reasonable efforts should always be made to establish a satisfactory provider and member relationship in accordance with practice standards. The physician or provider should provide adequate documentation in the member's medical record to support his/her efforts to develop and maintain a satisfactory provider and member relationship. If a satisfactory relationship cannot be established or maintained, the provider or physician shall continue to provide medical care for the Plan member until such time that written notification is received from the Plan stating that the member has been transferred from the provider's or physician's practice, and such transfer has occurred.

In the event that a participating physician or provider desires to terminate his/her relationship with a Plan member, the physician or provider should submit



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adequate documentation to support that although they have attempted to maintain a satisfactory provider and member relationship, the member's non-compliance with treatment or uncooperative behavior is impairing the ability to care for and treat the member effectively.

The physician or provider should complete a Request for Transfer of Member form, attach supporting documentation and fax the form to Customer Service. A copy of the form is available in the **Forms** section of this manual.

### **Confidentiality of Member Information & Release of Records**

Medical records should be maintained in a manner designed to protect the confidentiality of such information and in accordance with applicable state and federal laws, rules and regulations. All consultations or discussions involving the member or his/her case should be conducted discreetly and professionally in accordance with all applicable state and federal laws, including the HIPAA privacy and security rules and regulations of the Health Insurance Portability and Accountability Act of 1996, as may be amended (HIPAA). All physician practice personnel should be trained on HIPAA Privacy and Security regulations. The practice should ensure there is a procedure or process in place for maintaining confidentiality of members' medical records and other protected health information (PHI as defined under HIPAA); and the practice is following those procedures and/or obtaining appropriate authorization from members to release information or records where required by applicable state and federal law.

Procedures should include protection against unauthorized/inadvertent disclosure of all confidential medical information, including PHI.

Every practice is required to provide members with information regarding their privacy practices and to the extent required by law, with their Notice of Privacy Practices (NPP). Employees who have access to member records and other confidential information are required to sign a Confidentiality Statement.



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Some examples of confidential information include:

- Medical records;
- Communication between a member and a physician regarding the member's medical care and treatment;
- All personal and/or protected health information as defined under the federal HIPAA privacy regulations, and/or other state or federal laws;
- Any communication with other clinical persons involved in the member's health, medical and mental care (i.e., diagnosis, treatment and any identifying information such as name, address, Social Security Number (SSN), etc);
- Member transfer to a facility for treatment of drug abuse, alcoholism, mental or psychiatric problem;
- Any communicable disease, such as Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) testing that is protected under federal or state law.

The Notice of Privacy Practice (NPP) informs the patient or member of their member rights under HIPAA and how the provider and/or the Plan may use or disclose the members' PHI. HIPAA regulations require each covered entity to provide a NPP to each new patient or member.

### **Fraud and Abuse**

The Plan is committed to the prevention, detection and reporting of health care fraud and abuse according to applicable federal and state statutory, regulatory and contractual requirements. The Plan has developed an aggressive, proactive fraud and abuse program designed to collect, analyze and evaluate data in order to identify suspected fraud and abuse. Effective detection tools have been developed to identify patterns of health care service use, including over



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utilization, unbundling, up-coding, misuse of modifiers and other common schemes.

Federal and state regulatory agencies, law enforcement, and the Plan vigorously investigate incidents of suspected fraud and abuse. Service providers are cautioned that unbundling, fragmenting, up-coding, and other activities designed to manipulate codes contained in the International Classification of Diseases (ICD), Physicians' Current Procedural Terminology (CPT), the Healthcare Common Procedure Coding System (HCPCS), and/or Universal Billing Revenue Coding Manual as a means of increasing reimbursement, may be considered an improper billing practice and may be a misrepresentation of the services actually rendered.

In addition, providers are reminded that medical records and other documentation must be legible and support the level of care and service indicated on claims. Providers engaged in fraud and abuse may be subject to disciplinary and corrective actions, including but not limited to, warnings, monitoring, administrative sanctions, suspension or termination as an authorized provider, loss of licensure, and/or civil and/or criminal prosecution, fines and other penalties.

To report suspected fraud and abuse, please refer to the state-specific **Quick Reference Guide** of this manual and call our confidential Trust Program hotline.

### **Fraud and Abuse Definitions**

*Medicare Advantage Managed Care Fraud* – Any type of intentional deception or misrepresentation made by an entity or person in a Medicare Advantage Managed Care health plan with the knowledge that the deception could result in some unauthorized benefit to the entity, himself, or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Some examples of health care fraud include, but are not limited to the following:

- Falsifying any medical record, note, diagnostic

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test result, report, claim, or any financial, administrative or clinical documents used to validate services.

- Billing for services, supplies, or equipment not actually furnished to any health plan member.
- Providing false and intentionally misleading information regarding health plan coverage, limitations, and exclusions to any health plan member.
- Misrepresentation of any date of service, frequency, duration, or description of any service, or the identity of the recipient of such services, or the identity of the service provider.
- Billing for non-covered or non-chargeable services, supplies, or equipment disguised as any covered or chargeable service.
- Duplicate billings (e.g., billing more than once for the same service, multiple providers billing for the same service for the same member on the same day, billing the health plan and the member for the same services, or submitting claims to both the health plan and other third parties without making full disclosure of relevant facts to all parties).
- Providing payment or other inducement to any health plan member in exchange for the use of their identification card or other member information with or without the permission of the health plan member for the purpose of obtaining wrongful payment.
- Receipt or offering of any unlawful kickback, gratuity, or other inducement made with the intent to increase referrals.
- Reciprocal billing (e.g., billing or claiming services furnished by another provider or

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furnished by the billing provider in a capacity other than claimed).

- Practicing medicine or other health care without a valid license, or with an expired or revoked license, or without proper credentials, or while excluded from participation in any Federal or State health care program.
- Any agreement or other arrangement between a provider and a health plan member that results in claims for unnecessary costs or charges to the health plan (e.g., providing health care services, supplies, or equipment to an ineligible person that is in possession of a health plan member's identification card, or any fraudulent scheme involving the use of member information to submit false claims).
- Any other intentional misrepresentation of a material fact regarding the provision of health care services for the purpose of obtaining wrongful payment.

*Medicare Advantage Managed Care Abuse* – Practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicare program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations for health care.

A *Medicare Advantage* Managed Care health plan, contractor, subcontractor, provider or *Medicare Advantage* Managed Care member, among others, can commit the abuse. It also includes beneficiary practices in the *Medicare Advantage* Managed Care health plan that results in unnecessary cost to the *Medicare Advantage* program or *Medicare Advantage* Managed Care health plan, contractor, subcontractor, or provider. It should be noted that *Medicare Advantage* funds paid to a *Medicare Advantage* Managed Care health plan, then passing to

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subcontractors, are still *Medicare Advantage* funds from a fraud and abuse perspective.

Some examples of health care abuse include, but are not limited to the following:

- Unauthorized waiver or reduction of applicable member co-payment or deductible.
- Billing for services, supplies or equipment in any amount in excess of the applicable Federal and/or State fee schedules, negotiated or contract rate.
- Direct or balance billing of health plan members where prohibited.
- Billing for services that are not medically necessary, or if medically necessary, not to the extent actually provided.
- Providing health care services of an inferior quality (i.e., services that do not meet generally accepted standards of care), or in an inappropriate setting, or at a level of care that is in excess to medical necessity.
- Failure to fully document services according to generally accepted standards (i.e., records must be legible, clearly document the services provided, etc.) and maintain adequate clinical, financial, and other records substantiating claims.

### Member Rights & Responsibilities

Plan members have specific Rights and Responsibilities which physicians should post in their offices for all members to see. Contact a Provider Relations representative for copies of the Patient Rights and Responsibilities as needed.

Refer to the **Member Services** section for more information on member rights and responsibilities.



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#### **Living Will & Advance Directive**

Members have the right to control decisions relating to their medical care, including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their life.

Each Plan member (age 18 years or older and of sound mind), should receive information regarding living will and advance directives. This allows them to designate another person to make a decision should they become mentally or physically unable to do so.

Information regarding living will and advance directives should be made available in provider offices and discussed with the members. Completed forms should be documented and filed in members' medical records.

A provider shall not, as a condition of treatment, require a member to execute or waive an advance directive.

#### **Covering Physicians**

In the event that participating providers are temporarily unavailable to provide care or referral services to Plan members, providers should make arrangements with another Plan-contracted and credentialed physician to provide services on their behalf, unless there is an emergency.

Covering physicians should be credentialed by the Plan, must sign an agreement accepting the negotiated rate and agreeing not to balance bill Plan members. For additional information, please contact Provider Relations.

In non-emergency cases, should you have a covering physician who is not contracted and credentialed with the Plan, contact the Plan for approval.

#### **Provider Billing & Address Changes**

Prior notice to your Provider Relations representative is required for any of the following changes:

- 1099 mailing address
- Tax Identification Number (TIN) or Entity

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Affiliation (W-9 required)

- Group name or affiliation
- Physical or billing address
- Telephone and fax number

### Provider Termination

In addition to the provider termination information included in your Provider Agreement with the Plan, the provider must adhere to the following terms:

- Any contracted provider must give at least 60 days prior written notice to the Plan for Medicare before terminating their relationship with Plan “without cause.” This ensures adequate notice may be given to Plan members regarding the provider’s participation status with the Plan. Please refer to your contract for the details regarding the specific required days for providing termination notice, as you may be required by contract to give more notice than listed above.
- Unless otherwise provided in the termination notice, the effective date of a termination will be on the last day of the month.
- Please refer to the **Credentialing** section of this manual for specific guidelines regarding rights to appeal plan termination (if any).

**Note:** The Plan will notify in writing all appropriate agencies and/or members prior to the termination effective date of a participating PCP, hospital, specialist or significant ancillary provider within the service area as required by Medicare Advantage program requirements and/or regulations and statutes.



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#### **Marketing & Sales**

Providers should contact the Plan's Marketing & Sales department to discuss and coordinate permissible provider involvement in Plan marketing activities.

All marketing materials (including any type of advertising such as billboards, flyers, ads, TV, radio, etc.) describing or mentioning the Plan, affiliation or utilizing the Plan's name or logo must be approved by the Plan prior to any use or distribution. All materials must adhere to the Medicare guidelines and approval from the Plan and CMS, as appropriate.

#### **Disclosure of Information**

Periodically, members may inquire as to the operational and financial nature of their health plan. The Plan will provide that information to the member upon request. Members can request the above information verbally or in writing.

For more information about how to request this information, members should contact Customer Service. The toll-free telephone number can be found on the member's ID card.

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<sup>1</sup>Ohana Health Plan  
*A plan offered by WellCare Health Insurance of Arizona, Inc.*