# Provider Standards and Procedures

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# Provider Rights, Responsibilities, and Roles

**Provider Rights**

Providers have a right to:

- Be treated by members and other health care workers with dignity and respect
- Receive accurate and complete information and medical histories for members' care
- Have their members act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly
- Expect other network providers to act as partners in members' treatment plans
- Expect members to follow their directions, such as taking the right amount of medication at the right times
- Help members make decisions about their treatment, including the right to recommend new or experimental treatments
- Make a complaint or file an appeal against Piedmont WellStar HealthPlans and/or a member
- Receive copayments, coinsurance, and deductibles as appropriate
- File an appeal with Piedmont WellStar HealthPlans on behalf of a member, with the member's consent
- Have access to information about Piedmont WellStar HealthPlans' Quality Improvement programs, including program goals, processes, and outcomes that relate to member care and services - This includes information on safety issues
- Contact Piedmont WellStar HealthPlans Provider Services with any questions, comments, or problems, including suggestions for changes in the Quality Improvement Program's goals, processes, and outcomes related to member care and services

**Provider Responsibilities**

Providers have a responsibility to:

- Treat members with fairness, dignity, and respect
- Not discriminate against members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency
- Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality

- Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice/office/facility
- Provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA
- Allow members to request restriction on the use and disclosure of their personal health information
- Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records
- Provide clear and complete information to members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process
- Tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment
- Allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that, by refusing or stopping treatment, the condition may worsen or be fatal
- Respect members' advance directives and include these documents in the members' medical record
- Allow members to appoint a parent, guardian, family member, or other representative if they can't fully participate in their treatment decisions
- Allow members to obtain a second opinion, and answer members' questions about how to access health care services appropriately
- Collaborate with other health care professionals who are involved in the care of members
- Obtain and report to the Health Plan information regarding other insurance coverage
- Follow all state and federal laws and regulations related to member care and member rights
- Participate in Health Plan data collection initiatives, such as HEDIS and other contractual or regulatory programs
- Review clinical practice guidelines distributed by the Health Plan
- Comply with Piedmont WellStar HealthPlans Medical Management program as outlined in this manual
- Notify the Health Plan in writing if the provider is leaving or closing a practice
- Contact the Health Plan to verify member eligibility or coverage for services, if appropriate
- Disclose overpayments or improper payments to the Health Plan
- Invite member participation, to the extent possible, in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible
- Provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language

- Provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status

**Provider Role in Compliance**
Piedmont WellStar HealthPlans must comply with various laws, regulations, and accreditation standards in order to operate as a licensed health insurer. In order to meet these requirements, as well as combat cost trends in the health care industry such as fraud, abuse, and wasteful spending, Piedmont WellStar HealthPlans established its distinct Compliance Program.

The Health Plan's Compliance Program serves to assist contracted providers, staff members, management, and our Board of Directors with promoting proper business practices. Proper business practices include identifying and preventing improper or unethical conduct.

**Reporting Compliance Concerns and/or Issues**
Piedmont WellStar HealthPlans has established a helpline for contracted providers, staff members, and other entities to call in order to report compliance concerns and/or issues without fear of retribution or retaliation. The **helpline** number is **855- 222-1046.** Callers may remain anonymous. Compliance concerns include, but may not be limited to, issues related to the Health Insurance Portability and Accountability Act (HIPAA), the Gramm-Leach-Bliley Act, and the Americans with Disabilities Act (ADA).

Responsibilities of provider with regard to compliance:

- All Piedmont WellStar HealthPlans contracted providers are expected to conduct themselves according to the Health Plan's Code of Conduct & Ethics
- All Piedmont WellStar HealthPlans contracted providers have a duty to *immediately* report any compliance concerns and/or issues
- All Piedmont WellStar HealthPlans contracted providers should be alert to possible violations of the law, regulations, and/or accreditation standards, as well as to any other type of unethical behavior - Piedmont WellStar HealthPlans prohibits retaliation against contracted providers who raise, in good faith, a compliance concern and/or issue, or any other question about inappropriate or illegal behavior
- Piedmont WellStar HealthPlans prohibits retaliation against contracted providers who participate in an investigation or provide information relating to an alleged violation

The success of the Piedmont WellStar HealthPlans Compliance Program relies in part upon the actions taken by our contracted providers. It is critical for our contracted providers to be aware of the goals and objectives of the Piedmont WellStar HealthPlans Compliance Program, as well as of their responsibilities as providers.

For any questions regarding the Piedmont WellStar HealthPlans Compliance Program

and/or a contracted provider's responsibilities, please email provider relations at providerrelations@pwplans.org.

**Provider Role in HIPAA Privacy & Gramm-Leach- Bliley Act Regulations**
All Piedmont WellStar HealthPlans policies and procedures include information to make sure the Health Plan complies with the Health Insurance Portability and Accountability Act (HIPAA) regulations and the Gramm-Leach-Bliley Act.

Hospitals and providers subject to HIPAA are trained to understand their responsibilities under these privacy regulations – as is the staff at Piedmont WellStar HealthPlans.

The Health Plan has incorporated measures in all its departments to make sure potential, current, and former members' personal health information, individually identifiable health information, and personally identifiable financial information are maintained in a confidential manner, whether that information is in oral, written, or electronic format. Health Plan employees may use and disclose this information only for those purposes permitted by federal legislation (for treatment, payment, and health care operations); by the member's written request; or if required to disclose such information by law, regulation, or court order. A form authorizing the release of personal health information is available on the Piedmont WellStar HealthPlans website. This form complies with the core elements and statements required by HIPAA privacy rules. This form must be completed, signed, and returned to the Health Plan before the Health Plan will release information. Members also receive a copy of the privacy information annually. These documents clearly explain the members' rights concerning the privacy of their individual information, including the processes that have been established to provide them with access to their protected health information and procedures to request to amend, restrict use, and receive an accounting of disclosures. The documents further inform members of the Health Plan's precautions to conceal individual health information from employers.

Piedmont WellStar HealthPlans Notice of Privacy Practices is separate and distinct from the Notice of Privacy Practices providers are required to give to their patients under HIPAA. Piedmont WellStar HealthPlans Privacy Statement and Notice of Privacy Practices can be viewed at **www.pwplans.org**, at the bottom of the page under "Privacy Policy."

**Provider Role in ADA Compliance**
Providers' offices are considered places of public accommodation and, therefore, must be accessible to individuals with disabilities. Providers' offices are required to adhere to the Americans with Disabilities Act (ADA) guidelines, Section 504 of the Rehabilitation Act of 1973, and other applicable laws. Providers may contact Provider Services at **855-869-7225** to obtain copies of these documents and other related resources. The Health Plan requires that network providers' offices or facilities comply with this act. The office or facility must be wheelchair-accessible or have provisions to accommodate people in wheelchairs. Patient restrooms should be equipped with grab bars. Handicapped parking must be available near the provider's office and be clearly marked.

A Health Plan representative will determine compliance during the on-site office/facility review.

**Provider Role in Surveys and Assessments**
The Health Plan conducts a series of surveys and assessments of members and providers in a continuous effort to improve performance. All providers are urged to participate when asked.

**Reporting Fraud and Abuse**
The Health Plan has established a hotline to report suspected fraud and abuse committed by any entity providing services to members. The hotline number is 855-222-1046 and it is available 24 hours a day, seven days a week. Voice mail is available at all times. Callers may remain anonymous and may leave a voice mail if they prefer.

Some common examples of fraud and abuse are:

- Billing for services and/or medical equipment that were never provided to the member
- Billing more than once for the same service
- Dispensing generic drugs and billing for brand-name drugs
- Falsifying records
- Performing and/or billing for inappropriate or unnecessary services

Information about submitting suspected fraud and abuse can be found on the website at **www.pwplans.org.**

If reporting fraud and abuse by mail, please mark the outside of the envelope "confidential" or "personal" and send to:

**Piedmont WellStar HealthPlans Compliance Department**
**Overlook III**
**2859 Paces Ferry Road SE, Suite 600**
**Atlanta, GA 30339**

Information reported via the website, by e-mail, or by regular mail may be done anonymously.

The hotline number is **1-800-HHS-TIPS (800-447-8477),** and it is available Monday through Friday from 8:30 a.m. to 3:30 p.m. Callers may remain anonymous and may call after hours and leave a voice mail if they prefer.

# Provider Standards and Requirements

**Office Hours**
Network PCPs must have a minimum of 20 office hours per week.

**Verifying Provider Practice Information**
The network management staff will verify important demographic information about a practice each time a staff member makes a service call. This verification is needed to ensure accuracy in various areas that concern providers, including claims payments and provider directories.

Providers should notify the Health Plan of any provider additions, practice changes, or corrections within 30 days. Notification must be typewritten and submitted on business letterhead and must include the following information:

- Physician name
- Office address
- Billing address (if different than office address)
- Phone number and fax number
- Office hours
- Effective date W-9 tax form

For provider changes fill out the change of contact form available online at www.pwplans.org.

**Voluntarily Leaving the Network**
Providers must give the Health Plan at least 90 days written notice before voluntarily leaving the network. In order for a termination to be considered valid, providers are required to send termination notices by certified mail (return receipt requested) or overnight courier. In addition, providers must supply copies of medical records to the member's new provider and facilitate the member's transfer of care at no charge to the Health Plan or member.

The Health Plan will notify affected members in writing of a provider's termination, as applicable.

Providers must continue to render covered services to members who are existing patients at the time of termination until the later of 60 days, the anniversary date of the member's coverage, or until the Health Plan can arrange for appropriate health care for the member with a participating provider.

Upon request from a member undergoing active treatment related to a chronic or acute medical condition, the Health Plan will reimburse the provider for the provision of covered services for up to 90 days from the termination date. In addition, the Health Plan

will reimburse providers for the provision of covered services to members who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery.

Exceptions may include:

- Members requiring only routine monitoring
- Providers unwilling to continue to treat the member or accept Health Plan payment

**Coverage for Providers on Vacation or Leave**
While on vacation or leave of less than 30 days, a network provider must arrange for coverage by another Health Plan provider. If a provider goes on an extended leave for 30 calendar days or longer, the provider must notify **Provider Services at 855-869-7225.**

**Locum Tenens Billing Arrangements**
Substitute providers are often necessary to cover professional practices when the regular providers are absent for reasons such as illness, pregnancy, vacation, or continuing education. The regular provider should bill and receive payment for the substitute provider's services as though these services were performed by the regular provider.

The regular provider may submit the claim and receive payment in the following circumstances:

- The substitute provider does not render services to patients over a continuous period of longer than 60 days
- The regular provider identifies the services as substitute provider services by entering a Q6 modifier (services furnished by a locum tenens provider) after the procedure code

**24-Hour On-Call Coverage**
PCPs and Ob-gyns are required to provide 24-hour on-call coverage and be available 7 days a week. If a provider delegates this responsibility, the covering provider must participate in the Health Plan's network and be available 24 hours a day, 7 days a week.

**Provider Scope of Services**
Providers may bill Piedmont WellStar HealthPlans for all services performed for assigned members. The services should be within the scope of standard practices appropriate to the provider's license, education, and board certification.

**Provider Effective Date**

Prospective effective dates allow time to complete necessary credentialing as

well as provider directory and fee schedule loading processes. New providers who are required to complete the credentialing process will need to be credentialed prior to contract execution. If the contract is executed, all necessary provider data is received and provider is credentialed on or before the 15th of the month, the provider group will be effective the first day of the next month. If this all happened after the 15th of the month, the effective date will be the 15th day of the following month. For example, if the contract was signed and all data received on the 18th of May, the effective date will be July 15th.

**For Specialists: In-Office Procedures**
Specialists should perform procedures only within the scope of their license, education, board certification, experience, and training. The Health Plan will periodically evaluate the appropriateness and medical necessity of in-office procedures.

**In-Office X-Ray**
A licensed radiology technician may perform in-office radiology services. The American College of Radiology must certify radiology facilities. A radiologist must review all x-rays.

**In-Office Laboratory**
Offices that perform laboratory services must meet all regulatory guidelines, including, but not limited to, participation in a Proficiency Testing Program and certification by the Clinical Laboratory Improvement Amendments (CLIA).

**Guidelines Regarding Advance Directives**
An advance directive is generally a written statement that an individual composes in advance of serious illness regarding medical decisions affecting him or her. The two most common forms of advance directives are a living will and a health care durable power of attorney.

All adults have the right to create advance directives. In the event that an individual is unable to communicate the kind of treatment he or she wants or does not want, this directive informs the provider, in advance, about that treatment.

- A Living Will
  A living will takes effect while the individual is still living. It is a written document concerning the kind of medical care a person wants or does not want if he or she is unable to make his or her own decisions about care.

- A Health Care Durable Power of Attorney
  A health care durable power of attorney is a signed, witnessed written statement by an individual naming another person as an agent to make medical decisions if he or she is unable to do so. A health care durable power of attorney can include instructions about any treatment the individual desires to undergo or avoid.

  Neither document becomes effective until the individual is unable to make decisions for himself or herself. The individual can change or revoke either document at any time. Otherwise, the documents remain effective throughout the person's life.

**What Is the Legislative Basis for Advance Directives?**
The requirements for advance directives are outlined in the Omnibus Budget Reconciliation Act of 1990, which went into effect on December 1, 1991.

If a member decides to execute a living will or a health care durable power of attorney, the member is encouraged to notify his or her PCP of its existence, provide a copy of the document to be included in personal medical records, and discuss this decision with the PCP.

**Guidelines for Medical Record Documentation**
Piedmont WellStar HealthPlans requires participating network physicians to maintain member medical records in a manner that is accurate and timely, well-organized, readily accessible by authorized personnel, and confidential. Per Piedmont WellStar HealthPlans policy, all medical records must be retained for ten (10) years.

Consistent and complete documentation in the medical record is an essential component of quality patient care. Medical records should be maintained and organized in a manner that assists with communication among providers to facilitate coordination and continuity of patient care.

The Health Plan has adopted certain standards for medical record documentation, which are designed to promote efficient and effective treatment. The Health Plan periodically reviews medical records to ensure that they comply with the guidelines.

**Medical Record Confidentiality and Security**
Store medical records in a secure location that can be locked and protected when not being used, but still permits easy retrieval of information by authorized personnel only. Periodically train medical office staff and consistently communicate the importance of medical record confidentiality.

**Basic Information**

- Place the member's name or ID number on each page of the medical record
- Include marital status and address, the name of employer, and home and

work telephone numbers

- Include the author's identification in all entries in the medical record. The author identification may be a handwritten signature, a unique electronic identifier, or his or her initials
- Date all entries
- Ensure that the record is legible to someone other than the writer

**Medical History**

- Indicate significant illnesses and medical conditions on the problem list. If the patient has no known medical illnesses or conditions, the medical record should include a flow sheet for health maintenance.
- List all medications and prominently note medication allergies and adverse reactions in the record. If the patient has no known allergies or history of adverse reactions, providers should appropriately note this in the record.
- Document in an easily identifiable manner past medical history (for members seen three or more times), which may include serious accidents, operations, and illnesses. For children and adolescents (18 years old and younger), past medical history should relate to prenatal care, birth, operations, and childhood illnesses.
- For members 14 years old and older, note the use of cigarettes, alcohol, and substances. (For members seen three or more times, query substance abuse history.)
- Maintain an updated immunization record for patients aged 17 and under.
- Include a record of preventive screenings and services in accordance with the Piedmont WellStar HealthPlans Preventive Health Guidelines.
- Include, when applicable, summaries of emergency care, hospital admissions, surgical procedures, and reports on any excised tissue.

**Treatment**

- Document clinical evaluation and findings for each visit. Identify appropriate subjective and objective information in the history and physical exam that is pertinent to the member's complaints.
- Document progress notes, treatment plans, and any changes in a treatment plan, including drugs prescribed.
- Document prescriptions telephoned to a pharmacist.
- Document ancillary services and diagnostic tests that are ordered and diagnostic and therapeutic services for which a member was referred.
- Address unresolved problems from previous office visits in subsequent visits.

**Follow-up**

- Include on encounter forms or notes a notation regarding follow-up care, calls, or visits.
- Providers should note the specific time of recommended return visit in weeks, months, or as needed.

- Keep documentation of follow-up for any missed appointments or no-shows.

  Physicians should initial consultation, lab, imaging, and other reports to signify review.
- Review by and signature of another professional, such as a nurse practitioner or physician assistant, does not meet this requirement.
- Consultation, abnormal lab, and imaging study results must have an explicit notation of follow-up plans in the record.

# Accessibility Standards

The Health Plan follows accessibility requirements set forth by applicable regulatory and accrediting agencies.

**Emergency Services**

In case of a medical emergency, the member should attempt to call his or her PCP, if possible, explain the symptoms, and provide any other information necessary to help determine appropriate action.

The member should go to the nearest emergency facility for the following situations:

- If directed by the PCP
- If the member cannot reach the PCP or the covering provider
- If the member believes he or she has an emergency medical condition

Members with an emergency medical condition should understand they have the right to summon emergency help by calling 911 or any other emergency telephone number, as well as a licensed ambulance service, without getting prior approval.

The Health Plan will cover care for an emergency medical condition with symptoms of such severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

**Urgent Care**

Urgent care is defined as any illness, injury, or severe condition that, under reasonable standards of medical practice, would be diagnosed and treated within a 24-hour period and, if left untreated, could rapidly become an emergency medical condition.

When in the Health Plan primary service area, members should contact their PCPs if they have an urgent medical need. The Health Plan encourages providers to make same-day appointments available for their patients who call with unscheduled urgent health care needs. This improves the quality and continuity of patient care.

If members are unable to contact their PCPs, and they believe they need care immediately, they should seek immediate medical attention. After such treatment, members should contact their PCPs within a reasonable amount of time. A reasonable amount of time is typically considered 24 hours, unless there are extenuating circumstances.

**Out-of-Area Care**

Out-of-area care should not be confused with out-of-network care. Out-of-area care is care rendered to members traveling outside the Health Plan's primary service area. Out-of-network care is care sought by members at a facility or provider not within the

network appropriate to the member's benefit plan. All members are always covered for emergency and urgent care services.

- **Routine Care**
  Members must seek routine and preventive care from providers within their network. Call Medical Management at **855-514-3680** for more information.

- **Injury or Illness**
  A member who needs care while traveling outside the service area should contact his or her PCP, if applicable, within 24 hours, or as soon as reasonably possible, to inform the PCP of the nature of the illness or injury. The member must also call medical management at **855-514-3680** to obtain authorization for services rendered by a non-participating provider.

  If Medical Management authorizes the care, the level of benefits will be determined at that time.

Members who receive a bill or have paid for services provided outside the area should submit those bills to the Health Plan, using an Out-of-Network Care claim form.

An Out-of-Network Care claim form is available at pwplans.org.

The member also may call **Member Services:**

- Piedmont WellStar Our Care Plan (Commercial): 855-869-7137
  Monday through Friday, 7 a.m. to 7 p.m. and Saturday, 8 a.m. to 3 p.m.

# Referrals and Coordination of Care

**Provider Role in Coordinating Care**
The Health Plan relies on each provider to ensure the appropriate use of resources by delivering quality care in the proper setting at the right time. The Health Plan's approach to accountability is based on the belief that providers know what is best for Health Plan members. We rely on our providers to:

- Provide the appropriate level of care
- Maintain high quality
- Use health care resources efficiently

Providers are encouraged to coordinate a member's care with other specialists, therapists, hospitals, laboratories, and facilities in the network appropriate to the member's benefit plan.

Network providers are responsible for determining the type of care the member needs and the appropriate provider or facility to administer that care.

**The Role of the Referring Provider**
It is recommended that providers communicate with specialists, therapists, and other providers regarding members' care. In turn, those providers should reciprocate by informing the referring provider of their findings and proposed treatment. This sharing of information can be accomplished by telephone, fax, letter, or prescription.

Providers are also encouraged to supply the Health Plan with critical information needed to authorize certain types of care and process claims.

Providers should follow these steps when referring a member to a specialist:

- **Direct specialty care to providers, therapists, laboratories, and/or Hospitals appropriate to the member's benefit plan.**
  The only time a provider should send a member to specialists, therapists, labs, and hospitals outside the member's benefit plan is when extenuating circumstances require the use of an out- of-network specialist or facility or because the only available specialist or facility is not part of the member's benefit plan. The provider must have prior authorization from Medical Management at **(855) 514-3680** to refer a member to an out-of-network specialist or facility.

- **Correspond with the specialist/behavioral health provider.**
  The provider may call or send a letter, fax, or prescription to the specialist. The referring provider should communicate clinical information directly to the specialist without involving the member.

- **Give the facility, specialist, or behavioral health provider the following referral information:**
  - Member's name
  - Reason for the referral
  - All relevant medical information (e.g., medical records, test results),
  - Referring provider's name and Unique Provider Identification Number (UPIN) or National Provider Identifier (NPI) (This information is required in boxes 17 and 17A on the CMS-1500 claim form.)

Please refer to the Health Plan provider directory, which is available online at **www.pwplans.org.** For additional copies, call Provider Services at **855-869-7225.**

**The Role of the Specialist for All Piedmont WellStar HealthPlans Members**

**Verify whether the care was coordinated.**
When a member sees a specialist, the specialist's office needs to determine whether a provider coordinated the care or the member directly accessed the specialist for care. (If care was coordinated, the PCP's name and UPIN are required in boxes 17 and 17A on the CMS-1500 claim form.)

*If a provider coordinated the care,* collect any paperwork or check office records for communication from the referring doctor.

*If the member self-directed care to a specialist,* contact the PCP, if applicable, to obtain medical records and check to see if any diagnostic testing already has been completed to avoid duplicate testing.

*If the member does not have a PCP,* obtain a medical history and try to determine whether any prior diagnostic testing has been performed.

- **Determine the copayment.**
  *If the visit is self-directed by a member whose benefit plan does not require the selection of a PCP,* care is covered at a higher benefit level if the member uses a network provider and at a lower benefit level if the member uses an out-of-network provider.

- **Communicate findings.**
  The specialist must communicate findings and treatment plans to the referring provider within 30 days from the date of the visit. The referring provider and specialist should jointly determine how care is to proceed.

  Specialists who need to send their members to out-of-network specialists and facilities must get prior authorization from Medical Management at **(855) 514-3680.** The requesting provider must give the reason for the out-of-network

referral. If written information is required, it may be sent to:

**Piedmont WellStar**
**HealthPlans Medical**
**Management Department**
**PO Box 710**
**Pittsburgh, PA 15230-0710**

# Hospital Guidelines

**Observation Status**
Observation status applies to members for whom inpatient hospital admission is being considered but is not certain. Observation status should be used when:

- The member's condition is expected to be evaluated and/or treated within 24 hours with follow-up care provided on an outpatient basis.
- The member's condition or diagnosis is not sufficiently clear to allow the member to leave the hospital.

**Inpatient Admissions**
Network providers may admit a member to any network hospital appropriate to the member's benefit plan. If the admitting provider is a specialist, the specialist must communicate the admission to the member's PCP, if applicable, to ensure continuity and quality of care.

**Emergency Admission**
Upon admitting a member from the emergency department, the hospital should collect the following information:

- The practice name of the member's PCP, if applicable
- The name of the member's referring provider if referred for emergency care
- The name of the admitting provider if different from the referring provider or PCP

The hospital or facility must notify Medical Management at **855-514-3680** within 48 hours or on the next business day following the emergency admission. Notifications can also be faxed to Medical Management at **855-431-8762**.

**Out-of-Network Hospitals: Emergencies**
When a member is admitted to an out-of-network hospital for an emergency medical condition, the member's provider should contact Medical Management at **855-514-3680** and ask to speak to a medical review nurse. The nurse may coordinate a transfer to a hospital appropriate to the member's benefit plan when the member is medically stable.

**Out-of-Network Hospitals: Non-Emergencies**
Members should not be admitted to out-of-network hospitals unless prior authorization is obtained for medically necessary services not available in the network. Call Medical Management at **855-514-3680** for prior authorization.

**Inpatient Consultation and Referral Process**
If the admitting provider determines that a member requires consultation with a specialist, the admitting provider can refer the member to a network specialist appropriate to the member's benefit plan. The referral should follow the hospital's locally approved procedures (e.g., consultation form, physician order form).

The admitting provider and specialist jointly should determine how care should proceed. Coordination of care occurs through active communication among the PCP, the admitting provider, and the specialist.

**Pre-Admission Diagnostic Testing**
All pre-admission diagnostic testing conducted before a member's medically necessary surgery or admission to the hospital is covered when performed at a hospital appropriate to the member's benefit plan. Some procedures may require prior authorization.

Pre-admission diagnostic testing includes:

- Laboratory diagnostic tests
- Radiological diagnostic tests
- Other diagnostic tests, including electrocardiogram, pulmonary function, and neurological

**Transfers**

- *Transfers between Network Facilities*
  If a member is admitted to a network hospital and needs to be transferred to another hospital, please contact Medical Management at **855-514-3680**.

- *Transfers to Out-of-Network Facilities*
  The Health Plan requires prior authorization for transfer to an out-of-network facility. The transferring provider must contact Medical Management at **855-514-3680** and speak to a medical review nurse. Without prior approval, coverage will be denied.

**Discharges**
Medical Management works with the hospital's Utilization Management Department to coordinate discharge planning.

A discharge planner is available to assist in coordinating follow-up care, ancillary services, and other appropriate services. Contact Medical Management at **855-514-3680** to speak to a discharge planner.

**Hospital Delivery Notification**
The hospital in which a Health Plan newborn is delivered should call Medical Management to inform them of the delivery.

# Provider Disputes

If a provider disagrees with a decision by the Health Plan to deny coverage of care or services the provider may be able to dispute the decision or bring an appeal on behalf of the affected member. Punitive action will not be taken against a provider who requests an expedited resolution, or supports a Member's appeal.

Requests for appeals must include the reason for the appeal and a copy of the medical record or other supporting documentation. The request for appeal should clearly state why and on what basis the provider wishes to appeal. To answer any additional questions about the right to appeal or how to file an appeal, providers may call Provider Services at **855-869-7225**.

**Resubmitting a corrected claim due to minor error or omission is not an appeal.** Corrections or resubmissions of claims due to minor errors or omissions should be sent to the customary claims address. Please note, providers must indicate on the CMS-1500 form that this submission is a correction claim. Failure to do so will result in the claim being denied as a duplicate.

**Medical Necessity Appeal**
For Piedmont WellStar HealthPlans a request for a medical necessity appeal must be submitted in writing within 60 days of the denial notification. The request must include the reason for the appeal and a copy of the medical record or other supporting documentation. The request for appeal should clearly state why and on what basis the provider wishes to appeal.

Prior to filing an appeal, although not required, in cases involving a pre-service or concurrent review determination of a health care service, the provider has the opportunity to request a peer to peer discussion with an identified health care provider representing Piedmont WellStar HealthPlans (which may be an outside private review agent). This reconsideration will occur within three business days of the provider's request. Based on the member's condition, the provider can request an expedited reconsideration. If the provider is not satisfied with the outcome of the peer to peer/reconsideration, they have the right to request an appeal within 60 days.

- **Provider sends a written appeal to Piedmont WellStar HealthPlans.** Within 60 days of the denial notification, the provider sends a written appeal to the Health Plan by mail at the following address:

  **Piedmont WellStar HealthPlans**
  **Provider Appeals**
  **MSC: PW03**
  **PO Box 105278**
  **Atlanta, GA 30348-5278**

- **Panel reviews the appeal.**

A panel of a minimum of three individuals will review the appeal. The panel is comprised of at least one provider who was not involved in the initial determination and who is competent in the specialty of the issue. None of the members of the panel are subordinate to the provider who made the initial determination.

- **Panel members render a decision.**
  Within 30 business days, the panel determines whether any additional information has been presented that supports a reversal of the denial.

- **Provider receives notification of the decision.**
  The provider is notified of the decision in writing within 30 days of the date of decision.

To answer any additional questions about the right to appeal or how to file an appeal, providers may call Provider Services at **855-869-7225**.

**Expedited Appeal**
If it is the provider's opinion that that the member's life, health or ability to regain maximum function would be in jeopardy if the requested care or service is delayed by the usual review process, an expedited review is available. In the case of an Expedited Appeal, a decision will be rendered as timely as the condition requires, but no later than 48 hours after the review is requested. To request an Expedited Appeal, please call Provider Services at **855-869-7225**. Under Medicare guidelines a decision is rendered as quickly as it warranted by the member's condition but no later than 72 hours after the review is received. An expedited review can be requested by calling Medical Management at **855-514-3680**. Clinical documentation is required.

To answer any additional questions about the right to appeal or how to file an appeal, providers may call Provider Services at **855-869-7225**.

**Administrative Appeal**
An Administrative Appeal is an appeal that involves claims that have been denied for reasons other than those based on medical necessity or other clinical decisions (i.e. care not coordinated with a PCP, or prior authorization not obtained, out of network, not a covered benefit).

- **Provider sends a written appeal to Piedmont WellStar HealthPlans.**
  Within 60 days of the denial notification, the provider sends a written appeal to the Health Plan by mail at the following address:

  **Piedmont WellStar HealthPlans**
  **Provider Appeals**
  **MSC: PW03**
  **PO Box 105278**
  **Atlanta, GA 30348-5278**

- **Panel reviews the appeal.**
  If the appeal does not involve medical judgment, it will be reviewed by a committee that

consists of 1 to 3 individuals not involved in the initial adverse benefit determination.

- **Panel members render a decision.**
  Within 60 business days, the panel determines whether any additional information has been presented that supports a reversal of the denial.

- **Provider receives notification of the decision.**
  The provider is notified of the decision in writing within 30 calendar days.

To answer any additional questions about the right to appeal or how to file an appeal, providers may call Provider Services at **855-869-7225**.

# Provider Credentialing

The provider credentialing process involves several steps: application, primary source verification, on-site evaluation, notification, and a Credentials Committee review.

**Application**
Piedmont WellStar Healthplans uses CAQH as its application. To download the application directly, providers can go to the Georgia Uniform Credentialing Application website at http://georgiacredentialing.org/. If you have questions, please contact Provider Relations at ProviderRelations@pwplans.org. Physicians must be re-credentialed every 2 to 3 years.

**Primary Source Verification**
The Credentialing Department contacts each primary source to verify the following credentials:

- Board certification or its equivalency
- Malpractice insurance coverage and history of liability claims
- Medicare and Medicaid sanctions
- Residency or medical school only if not board-certified (highest level of education or training must be verified)
- Sanctions, restrictions, or suspensions of a state license
- Status of staff privileges at a network Health Plan hospital(s)
- Valid DEA or CDS certification
- Valid, unrestricted license to practice in state(s) in which the practice resides
- Work history—this does not require primary source verification, although gaps of 6 months must be reviewed with the practitioner and gaps of 1 year need to be clarified in writing by the practitioner for inclusion in the credentialing file

**On-Site Evaluation**
If deemed necessary, a Health Plan representative will contact PCPs, ob-gyns, and high-volume specialists to arrange an on- site evaluation of practice site(s) and medical record documentation.

The following Health Plan standards will be assessed:

- Adequacy of waiting room and exam room space
- Availability of appointments
- Emergency care and CPR certification
- Hazardous waste elimination
- Medical equipment management
- Medical record documentation
- Medication administration
- Physical accessibility, availability, and appearance of practice site(s)

- Radiology, cardiology, and laboratory services (if applicable)

**Notification**
Once all information is complete, including primary source verification and office site review (if applicable), the Credentialing Department reviews and compares all information on the application to the primary source data. If any discrepancies are noted, the provider is notified in writing and has 2 weeks to forward the correct information in writing to the Credentialing Department supervisor.

In addition, a provider has the right to review the information submitted in support of his or her application. If the provider discovers erroneous information on the application, the provider has the opportunity to correct this information before the Credentials Committee reviews it. The provider must initial and date the corrected information.

Upon request, a provider also has the right to request information regarding the status of his/her credentialing/re-credentialing application.

**Credentials Committee Review**
Completed credentialing files are then presented to the Credentials Committee for review and deliberation. Usually, a welcome letter and packet are sent to providers once they are approved as providers in the Piedmont WellStar HealthPlans provider network.

Providers will be notified in writing if they are denied credentialing status for some reason. In the event that a practitioner wishes to appeal a credentialing denial decision, the request must be submitted via a letter addressed to the chairperson of the Credentials Committee.

**Re-credentialing Process**
All practitioners must be re-credentialed within 2 to 3 years of the date of their last credentialing cycle. The re-credentialing process is the same basic process as that for credentialing, except that providers also are evaluated on their professional performance, judgment, and clinical competence. Criteria used for this evaluation may include, but not be limited to, the following:

- Compliance with the Health Plan's policies and procedures
- Health Plan sanctioning related to utilization management, administrative issues, or quality of care
- Member complaints
- Member satisfaction survey
- Participation in quality improvement activities
- Quality-of-care concerns

Applications for reappointment are forwarded to the provider about 6 months before their re-credentialing date to enable the credentialing process to be completed within the required period.

**Dual Credentialing and Re-credentialing as a PCP and Specialist**

The Health Plan will consider, as an exception, requests from providers to participate as both a PCP and specialist when the provider:

- Meets Health Plan credentialing standards for each specialty requested
- Provides documentation demonstrating adequate professional training, expertise, capacity, and capabilities to undertake such responsibilities for providing both primary care and specialty services
- Agrees to be listed as a PCP in all member literature and accept membership
- Provides evidence of continuing medical education credits (CMEs) per 3-year period in the additional area in which he or she wants to be credentialed
- Agrees not to bill consultation charges for members enrolled in the PCP practice regardless of the nature of the visit

**Credentialing and Re-credentialing Issues**

**Board Certification**

The Health Plan requires that PCPs and specialists be board-certified in their respective specialties by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA). If a provider is not board-certified, this will be identified during the credentialing and/or recredentialing period and remedied then. Depending on the availability of qualified, board-certified providers, the following exceptions may apply:

- Providers who meet all other qualifications but began practicing a specific scope of medical practice before the availability of board certification in their particular specialty. Such providers must have active admitting privileges at a Health Plan-affiliated hospital and maintain 40 hours of Category I CMEs per year in their practice focus.
- Providers who are within 5 years of completion of an approved residency or fellowship in the specialty in which they practice.
- Providers who are members of a group practice in which 50 percent of the group providers are board-certified in the requesting provider's specialty.
- Providers who are practicing in federally designated underserved areas and meet all other credentialing standards, including:
    - Practicing in a requested specialty for more than 5 years
    - Active admitting privileges at a Health Plan network facility in the appropriate department
    - 40 CMEs per year in their particular practice focus

**Malpractice Insurance**

The Health Plan requires that providers carry professional liability at no less than the current GA Insurance Department minimum requirements or in accordance with the state requirements in which their practice resides.

Providers must submit a copy of their current malpractice insurance face sheet with the amount of coverage and policy effective dates at the time of credentialing or re-credentialing.

**Credentialing Denials and Appeals**
The Health Plan will send a letter to a provider who has been denied credentialing. A provider may appeal a credentialing decision in the following manner:

- **Provider sends written request to Credentials Committee chairperson**
  Providers should send requests for appeals to the following address:

  **Piedmont WellStar HealthPlans Credentialing Committee**
  **Overlook III**
  **2859 Paces Ferry Road SE, Suite 600**
  **Atlanta, GA 30339**

- **The Credentials Committee chairperson sends the provider written notice of the hearing**
  The hearing date, time, and place, as well as the composition of the appeals committee, will be sent to the provider at least 30 calendar days before the scheduled hearing date. The notice will include a request for the provider's consent to disclose the specifics of his or her application and all credentialing documentation to be discussed at the hearing.

  The provider has the right to be present and is allowed to offer evidence or information to explain or refute the cause for denial. Legal counsel also can represent the provider, as long as the Health Plan is informed of such representation at least 7 days before the hearing.

- **The Appeals Committee conducts the hearing and sends recommendation to the Quality Improvement Committee (QIC)**
  The Appeals Committee, consisting of three voting providers selected by the Credentials Committee chairperson, will deliberate without the provider present. Its decision will be by majority vote and will be forwarded to the Health Plan's Quality Improvement Committee (QIC) as a recommendation.

- **The QIC makes a decision and notifies provider**
  The QIC's decision is final. Written notice of the QIC's decision will be sent to the provider in an expeditious and appropriate manner and will include a written statement giving the basis of the decision.

# Provider Sanctioning

Piedmont WellStar HealthPlans follows a three-phase process for addressing the actions of providers who fail to follow the policies and procedures of the health plan.

**Actions That Could Lead to Sanctioning**
Actions that could lead to sanctioning fall into three main categories: administrative non-compliance, unacceptable resource utilization, and quality of care concerns.

- **Administrative Noncompliance**
  Administrative noncompliance is consistent or significant behavior that is detrimental to the success or functioning of the Health Plan. Examples include:
    - Conduct that is unprofessional or erodes the confidence of Health Plan members
    - Direct or balance-billing for services

- **Unacceptable Resource Utilization**
  Unacceptable resource utilization is a utilization pattern that deviates from acceptable medical standards and may adversely affect a member's quality of care.

**Quality of Care**
A quality of care issue may arise from an episode that adversely affects the functional status of a member or a pattern of medical practice that deviates from acceptable medical standards. For quality of care concerns, the QIC has selected a severity scale. This scale ranks cases that may involve a practice pattern deviating significantly from the norm. The sanctioning process and focused monitoring of the provider remain in effect for no less than one year from the date the provider is notified by a Piedmont WellStar HealthPlans representative. The provider is notified when the process and follow-up activities are satisfied and the sanctioning is no longer in effect. In instances of recurring similar noncompliance activities, the Health Plan reserves the right to expedite the sanctioning process.

# Provider Termination

The QIC, as part of the sanctioning process, may recommend the termination of a provider contract. The provider will be notified in writing and offered the opportunity to appear at a hearing, if appropriate. The termination process involves the following steps:

- **Medical director notifies provider about termination.**
  The provider will be given notice stating that a professional review action was recommended and the reasons for the proposed action. The provider has the right to request a hearing within 30 calendar days.

- **Provider may request a hearing**
  If a hearing is requested, the provider will be given notice stating the place, time, and date of the hearing—to occur no later than 60 calendar days after the date of the notice—and the names of witnesses, if any, expected to testify on behalf of Piedmont WellStar HealthPlans.

- **QIC appoints an Appeals Committee**
  The QIC will appoint an Appeals Committee on an ad hoc basis. The QIC will not select as members of the Appeals Committee anyone in direct economic competition with the provider who is the subject of the hearing or anyone who has previously voted on the action.

- **Appeals Committee conducts hearing and makes recommendations**
  After the QIC recommends termination of participation status or other sanction, the Appeals Committee will hear the appeal from a provider if the QIC—in its sole discretion—offered the provider the opportunity to appeal. The Appeals Committee will conduct the hearing and recommend to the QIC that it accept, reject, or modify its original recommendation. The right to the hearing may be forfeited if the provider fails, without good cause, to appear.

  At the hearing, the provider has the right to:
  - Receive representation by an attorney or other person of the provider's choice
  - Have a record made of the proceedings, copies of which may be obtained by the provider upon payment of any reasonable charges associated with the preparation of the records
  - Call, examine, and cross-examine witnesses
  - Present evidence determined to be relevant by the hearing officer regardless of its admissibility in a court of law
  - Submit a written statement at the close of the hearing
  - Upon completion of the hearing, the provider has the right to receive the written recommendation of the Appeals Committee from the Health Plan in an expeditious and appropriate manner, including a written statement giving the basis of the decision