CHAPTER 3:
Provider Responsibility

Review/Revised: 01/18, 01/19, 01/20, 06/20, 1/21

3.0 MEDICARE PARTICIPATION STANDARDS

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

3.1 PERSONS EXCLUDED FROM MEDICARE PARTICIPATION

Providers must not employ, or contract with, any person who has been excluded from participation in the Medicare Program under Sections 1128 or 1128A of the Social Security Act (42 USC Sections 1320a-7 and 1320a-7a) for the provision of any (1) health care services, (2) utilization review, 3) medical social work or (4) administrative services. Please ensure that you check the Exclusion Lists prior to hiring new employees. You can search the HHS- OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE, and can be accessed at www.oig.hhs.gov/fraud/exclusions.asp, as well, The System for Award Management (SAM) https://sam.gov/SAM/, formerly known as the General Services Administration (GSA) or Excluded Parties List System (EPLS).

3.2 MEDICARE, UPIN, NATIONAL PROVIDER IDENTIFICATION NUMBERS

All contracted providers who participate with Health Choice Pathway may not be a "Medicare Participating" provider (including those who provide urgent or emergent services); however providers are required to follow the appropriate requirements that apply to their specialty type identified by CMS.

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

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

Important Information about NPI Numbers: The NPI rule will require health plans to identify providers based first on NPI number, instead of Tax ID. Therefore, all electronic payments and ERA's (835s) will be based on the NPI. This is especially important for Group Practices.

If Group Practices that now bill under one Tax ID do not register for a Group NPI, individual electronic payments will have to be made to each individual NPI holder. To avoid this administrative burden, request a Group NPI for your Group Practice.

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

3.3 NOTIFICATIONS – PRACTICE/COMPANY CHANGES, UPDATES ADDITIONS

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

- Practice/company name
- Physical services addresses
- Payee address
- Tax identification number
- Provider additions/terminations
- Phone and/or fax numbers

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

Providers may use the Request for Participation / Update Information and Change Sheet or fax the information on Letterhead or a notice signed by the Practice/Company staff to:

ATTN: Contracting (480) 760-4975

Changes in your administrative staffing also should be reported to your Provider Performance Representative.

If we can provide staff training, please contact your Provider Performance Representative.

Keeping your staff trained saves you time and money.

3.4 PROVIDER CONTRACT/TERMINATIONS

Because Health Choice Pathway Members must be notified at least 30 (thirty) days in advance of a terminating provider, providers are required to notify your Provider Performance Representative in writing of your decision to terminate or of all terminated providers in the group practice at least 90 (ninety) days in advance.

This notice must be signed by the physician or practice/company staff with signature authority; it may be mailed or faxed to Health Choice Arizona Inc. Attn: Network Services.

Providers terminating their contracts without cause are required to continue to treat members until their treatment course is completed.

Early notification will assist you and the member in transferring care, should that be required. Authorization may be necessary for these services.

Should a member need to be transferred to another Health Choice Pathway provider as a result of termination, the provider can assist in the process by:

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

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

3.5 CONTRACT RENEWAL

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

3.6 CREDENTIALING AND RE-CREDENTIALING

All providers must be credentialed with Health Choice Pathway *before* a contract can be offered or a provider can be added to an existing contract (associates). All providers who desire to participate in the Health Choice Pathway provider network are required to meet minimum standards at the time of application and as of the date of the initial credentialing or recredentialing.

All provider credentialing verifications are completed and then reviewed by the Credentialing Committee within ninety (90) days of receipt of the completed application.

An application is considered to be complete when at least all of the following elements are present:

- A completed, signed, and dated Council for Affordable Quality Healthcare (CAQH) application.
- Current Attestation (not expired)
- Current Certificate of Insurance (COI)
- Current DEA Certification
- 5-Year Work History (If a gap in work history exceeds three months, the provider must explain the gap in writing).

A provider who has **not** been credentialed or contracted should not treat Health Choice Pathway members without prior authorization except in certain situations such as: Emergency Medical Services, Urgently Needed Care, and Renal Dialysis when the Member is outside the Health Choice Pathway's service area, but still in the United States.

Health Choice Pathway conducts re-credentialing at least once every three (3) years.

Contracted providers will be notified by the Health Choice Pathway Credentialing Department (See Chapter 5: Quality Management). It is important that providers complete the re-credentialing application as quickly as possible.

Failure to maintain a credentialed status with Health Choice Pathway can result in contract termination and non-payment of claims.

3.7 DELEGATED PROVIDER FUNCTIONS

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

Health Choice Pathway maintains established policies to ensure oversight and monitoring of delegated duties which include, but are not limited to the following:

- Participation in pre-delegated audits to ensure the ability to meet or exceed applicable regulatory standards;
- Participation in Health Choice Pathway initiated audits (at least annually), to ensure compliance with applicable policies and procedures in coordination with respective regulatory requirements; and
- Submit rosters (at least monthly) identifying terminated providers (aka, provider no longer with the delegated entity) and newly added providers.

- Documentation that the following sites have been queried at the time of Credentialing, Recredentialing, and in between Credentialing cycles on a monthly basis for Ongoing Monitoring.

Any provider that is found to be on any of the lists below may be terminated and the identity of the provider must be disclosed to Health Choice Pathway immediately:

- Health and Human Services-Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE) http://oig.hhs.gov/fraud/exclusions.asp, and
- The System for Award Management (SAM) https://sam.gov/portal/SAM/#1, formerly known as the General Services Administration (GSA) or Excluded Parties List System (EPLS).
- CMS Preclusion List – In order for contracted and non-contracted providers to receive payment from a Medicare plan for health care items and services furnished to beneficiaries enrolled in Medicare plan, such providers must not be included on the Preclusion List. Likewise, in order for Part D drugs to be covered by a Part D plan, the prescriber must not be included on the Preclusion List.

3.8 VERIFY ELIGIBILITY

Providers should check member eligibility at each point of contact, as eligibility can change at any time; however, eligibility is not a guarantee of payment.

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

For assistance referring members please contact Member Services.

3.9 PRIMARY CARE PHYSICIAN

Health Choice Pathway' Primary Care Physicians (PCPs) and Primary Care Obstetricians (PCOs) perform critical plan functions. Health Choice Pathway relies on the providers to provide an efficient and effective model of care that assures assigned members receive the medical care and services they require.

PCPs are gatekeepers or medical managers and are responsible and accountable for the coordination, supervision, deliverance, and documentation of health care services to assigned members. Health Choice Pathway' Quality Management Committee periodically reviews guidelines for PCP management of Health Choice Pathway members.

Health Choice Pathway monitors the over and underutilization of covered services in both the inpatient and outpatient settings. This data is used to improve overall member's treatment outcome.

Health Choice Pathway monitors PCP's to see if their members are being seen more or less frequently and for what reason in an effort to assist Health Choice Pathway to predict and arrange for the necessary specialists, ancillary and hospital services members may require.

3.10 SPECIALISTS

For a list of specialists and services that require prior authorization refer to Health Choice Pathway ***Prior Authorization Grid*** effective to the applicable date of service at https://www.healthchoicepathway.com/ -> Provider -> Provider Information under *Prior Authorization Guidelines.*

Specialists are required to submit the appropriate authorization number on their claims. Health Choice Pathway contracted specialists work in concert with the members Primary Care Physicians to coordinate the overall care for the member. Our goal at Health Choice Pathway is to develop partnerships with the Specialists in our network, as Specialty Physicians are critical to providing quality services to the Health Choice Pathway members.

3.11 REFERRALS

The PCP is responsible for initiating and coordinating referrals to specialists within the Health Choice Pathway network. It is critical that a strong communication link be maintained with specialists or behavioral health providers who treat your patients.

A record of the referral and any treatment notes from the specialists/behavioral health provider must be maintained in the Member's record. Health Choice Pathway encourages PCPs to maintain communication with the specialist when referring assigned members for specialty care. Health Choice Pathway has simplified its referral process to make it easier for the PCPs.

Specialists are responsible for requesting prior authorization for follow up services and other referrals as necessary.

For a list of services that require authorization, refer to Health Choice Pathway Prior Authorization Grid.

3.12 APPOINTMENT AVAILABILITY/APPOINTMENT WAIT TIME

Contracted PCPs and Specialists must maintain availability within the appointment standards according to the Health Choice Pathway Subcontractor Agreement.

Providers are expected to establish a procedure for waiting time so that a member does not wait more than 45 minutes, except in emergency cases or unforeseen circumstances.

Health Choice Pathway monitors providers' appointment availability and members' in office waiting time on an on-going basis.

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

Applicable to	Routine	Urgent
PCPs	21 Days	As expeditiously as the member's health condition requires but no later than 2 days of request
Specialists	45 Days	As expeditiously as the member's health condition requires but no later than 2 days of request
Dental Providers	45 Days	As expeditiously as the member's health condition requires but no later than 3 days of request
BH Providers	***Initial assessment***	***Ongoing services***
	7 days	23 days non IV drug users
	48 hours for pregnant women with substance use disorders	14 days for IV drug users

Maternity Services	***First Trimester***	***Second Trimester***	***Third Trimester***	***High Risk Pregnancy***
	Within 14 days of request	Within 7 days of request	Within 3 days of request	Within 3 days of identification of high-risk status or immediately if an emergency exists

Response for Referrals or Requests for Appointments for Psychotropic Medications

For eligible members who may need to be seen by a Behavioral Health Medical Practitioner (BHMP), it is required that the person's need for medication be assessed immediately and, if clinically indicated, that the person be scheduled for an appointment within a timeframe that ensures:

- The person does not run out of any needed psychotropic medications; or
- The person is evaluated for the need to start medications to ensure that the person does not experience a decline in his/her behavioral health condition, but no later than 30 days from the identification of need as per **ACOM 417-3 Appointment Availability, Monitoring and Reporting**.
- WHEN: Have a BHMP assess the urgency of the need immediately. Provide an appointment with a BHMP within a timeframe indicated by clinical need, but no later than 30 days from the identified need.
- WHAT: Screening, consultation, assessment, medication management, medications, and/or lab testing services as appropriate.
- WHO: All Title XIX/XXI eligible persons, all Non-Title XIX/XXI persons enrolled with a T/RBHA, all persons determined to have a Serious Mental Illness and any person in an emergency or crisis.

*Additional information regarding appointment standards and timeliness requirements for behavioral health services can also be found in Chapter 18 of the Health Choice Arizona Provider Manual, Behavioral Health Services.

3.13 TELEPHONE AVAILABILITY

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

Health Choice Pathway monitors telephone accessibility to ensure that members can reach your office to schedule appointments or seek advice.

3.14 APPOINTMENT AVAILABILITY NON-COMPLIANCE

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

Health Choice Pathway monitors the accessibility of contracted providers through:

- Member complaints
- Quality management audits
- Emergency room utilization
- Appointment availability surveys
- Site visits by Health Choice Pathway staff
- Member Surveys

Failure to comply with the appointment availability standards is viewed as an access to care issue by Health Choice Pathway and may result in a closure of your membership panel.

3.15 AFTER-HOURS COVERAGE/PHYSICIAN VACATION COVERAGE

Each provider must have 24 hours per day, 7 days per week coverage.

It is not acceptable to refer Health Choice Pathway members to the emergency room as a means to provide after-hours or vacation coverage.

It is the responsibility of the PCP to arrange for after-hours care and vacation coverage by a contracted Health Choice Pathway physician.

Acceptable coverage includes the following:

- An answering service that picks up the physician office's telephone after hours. The operator will then contact the physician or his covering physician
- An answering machine that either directs the caller to the office of the covering

physician, or directs the caller to call the physician at another number
- Call forwarding services that automatically send the call to another number that will reach the physician or his covering physician

Unacceptable coverage includes the following:

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

The PCP must notify their Provider Performance Representative of the arrangements made for vacation coverage. Notification of vacation coverage includes: expected departure and return dates; name, address and telephone number of covering physician; and if the covering physician office will be available to triage and/or answer questions for assigned members. If the covering physician is not available, the PCP should contact their Provider Performance Representative.

Network Services will provide names and telephone numbers of physicians who may be able to render same day treatment. Health Choice Pathway will not reimburse physicians who provide coverage for a physician. Reimbursement of the covering physician is the sole responsibility of the PCP who is absent. Arrangements should be made in advance between the physicians.

3.16 MAINTAINING THE MEDICAL RECORD

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

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

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

3.17 INSPECTION AND AUDIT OF RECORDS AND FACILITIES

Providers must provide medical records or copies of medical records for any Health Choice Pathway member upon request by Health Choice Pathway. Medical records must be available within five (5) working days of a request.

Failure to provide Health Choice Pathway with medical records that result in a sanction to Health Choice Pathway by CMS will result in such sanction being deducted in full from future payments to the offending provider.

Health Choice Pathway will issue a written notification seven (7) days prior to the sanction being imposed.

3.18 MANAGING MEMBERS WITH DISABILITIES OR SPECIFIC NEEDS

The health care needs of members with disabilities or specific needs often differ from the general population in the type, scope, frequency, coordination and duration of care needed.

Should you have a member with special health care needs, please contact Health Choice Pathway Member Services by calling (800) 656-8991.

Members with special needs may be characterized as:

1. Persons who have communication barriers, such as speaking a different language; low literacy, visual or hearing impaired; geographically isolated people; and/or people who are homeless
2. People who require health and related services of a type or amount beyond required by people in general as:
    - Common and often-mild chronic health issues with unique presentations, for example, allergies, arthritis, and hypertension
    - Complex and manageable health issues, for example, asthma, diabetes, heart failure
    - Complex and difficult-to-address health issues such as lupus, cerebral palsy, major functional disabilities
    - Chronically mentally ill adults, substance abuse
    - Diagnosis specific groups, such as HIV/AIDS cases
    - Physically disabled adults, children and frail elderly
    - Organ transplant recipient or waiting for transplant
3. Persons whose eligibility status complicates understanding of managed care and enrollment, such as:
    - Dually eligible Medicare/Medicaid members
    - Uninsured families and children less familiar with the health system or managed care, who may be eligible under the states' expansion programs.

3.19 HISTORY AND PHYSICAL

It is expected that a complete history and physical is documented in the Health Choice Pathway member's medical chart. The member's medical record will be reviewed during medical record audits.

3.20 HOSPITAL ADMISSIONS

Health Choice Pathway uses a fully participatory hospitalists program at most of its network hospitals within Maricopa, Pinal and Yavapai Counties. The PCP may contact the appropriate contracted hospitalist group to arrange hospitalization or call Health Choice Pathway for assistance. The PCP will continue to manage the patient's care after discharge.

The hospitalist program does not cover pediatric or obstetrical cases. In these situations, as well as those cases where a hospital is not covered under the hospitalist program, the PCP or obstetrician is expected to follow the member in the hospital. The PCP or PCO should communicate directly with the Prior Authorization Department when a hospital admission is necessary.

All hospital admissions require prior authorization.

Health Choice Pathway conducts concurrent review of all inpatient admissions. Health Choice Pathway uses accepted nationally recognized criteria when performing concurrent inpatient reviews.

3.21 ADULT IMMUNIZATION/PREVENTIVE SERVICES

Health Choice Pathway members may directly access a contracted provider for mammography and influenza and pneumonia vaccines; and women's health specialists for routine and all preventative health care.

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

3.22 PATIENT EDUCATION

Health Choice Pathway contracted providers are expected to provide appropriate prevention and disease management education. Providers may discuss medically necessary or appropriate treatment options with members even if the options are not covered services. Health maintenance education is required.

Members should receive counseling about disease prevention and the importance of regular health maintenance visits and they must be included in the planning and implementation of their care.

It is expected that providers will educate patients about their unique health care needs; share the findings of physical examinations; discuss potential treatment options, side effects and management of symptoms; and in general recognize that the patient has the right to choose the final course of action among clinically acceptable options.

It is expected that members will also be advised of the difference between urgent conditions, such as earaches or flu and emergent conditions. The member is to be instructed to contact their PCP first before visiting an emergency room or calling an ambulance, unless it is a true emergency.

3.23 PRESCRIPTIONS

Prescriptions should be written to allow generic substitution when available and signature on prescriptions must be legible in order for the prescription to be dispensed. It is the responsibility of the physician to obtain prior authorization prior to prescribing drugs not on the Health Choice Pathway formulary.

For further detail, refer to Health Choice Pathway Provider Manual Chapter 10: Prescription Benefits and Drug Formulary.

Health Choice Pathway Formulary is available on the Health Choice Pathway web site at https://www.healthchoicepathway.com/.

(Note: if you do not have internet access, contact your Provider Performance Representative to arrange for a paper copy).

3.24 DRUG UTILIZATION CONCERNS

Providers with concerns about a member's drug utilization should refer the member or contact Health Choice Pathway Case Management Department.

Health Choice Pathway may identify members as having a potential substance abuse issue through provider information, utilization review, pharmacy reports, or emergency room visits. Health Choice Pathway will contact the PCP when there is a suspected substance abuse problem and assist with coordination of care.

3.25 MEMBER DEATH

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

3.26 EMERGENCY ROOM

An "emergency" is a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention could result in:

a) Serious jeopardy to the health of the individual;
b) Serious impairment to bodily functions; or
c) Serious dysfunction of any bodily organ or part.

Providers may not refer members to the Emergency Room due solely to non-availability of same day appointment.

Health Choice Pathway contracts with a number of Urgent Care Centers.

Ask your Provider Performance Representative for details and a location near you.

3.27 FRAUD AND ABUSE

Health Choice Pathway is committed to detecting, reporting and preventing potential fraud and abuse. Fraud and abuse is defined as:

Fraud: Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under federal or state law.
(Source: 42 CFR 455.2)

Member Abuse: Intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault.
(Source: 42 CFR 455.2)

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

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

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

3.28 REPORTING FRAUD, WASTE AND ABUSE

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

Health Choice Pathway HMO SNP
Attn: Compliance
410 N. 44th St., Suite 900
Phoenix, AZ 85008

The Medicare Drug Integrity Contractor (MEDIC) for Arizona is assigned to take in all Fraud Waste and Abuse referrals.

Health Choice Pathway will work with the MEDIC on all referrals.

You may also call the AlertLine to report Fraud, Waste and Abuse at 1-800-237-0916.
The line is available 24 hours a day, 7 days a week.