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Provider Directory Accuracy

Provider Directories are an important tool for members to use when contacting or selecting a care provider. Providing members with an accurate provider directory is a key priority of Health Alliance, and we need your help to achieve this. It is imperative that you inform Health Alliance as soon as possible of the following: new providers joining a practice, demographic changes and provider terminations.

- Complete the Provider Information Addition Form to notify us of any new providers you would like to add to your existing contracted group.
- Complete the Provider Information Change Form to notify us of any changes to your current practice structure.

Send completed forms to:

Mail: Health Alliance Medical Plans
Attn: Provider Network Management
3310 Fields South Drive
Champaign, IL 61822

Email: PSC@healthalliance.org
Fax: 217-902-9702

Primary Care Physician (PCP)

Some Health Alliance plans require members to choose a PCP. The PCP may be a Family Practice, General Practice, Internal (Adult) Medicine, or Pediatric physician. Women can select a Woman’s Principal Health Care Provider (WPHCP) in addition to a PCP.

Primary Care Physician Responsibilities:

- Provide and coordinate the medical care of the member
- Facilitate access to specialists:
  - Standing Referral: If a member has a condition that requires ongoing specialty care, he or she may ask their PCP for a standing referral. The standing referral can be effective for up to one year or a specified number of visits, whichever is less.
  - Before referring to a specialist or making an appointment for a member, verify that the specialist is affiliated by visiting
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HealthAlliance.org or calling the Health Alliance Customer Service Department.

- Women may obtain services from their designated WPHCP (specializing in Obstetrics and Gynecology or Family Practice) without a referral from their PCP.
- Available to members 24 hours a day either directly or by call coverage
- Cooperate fully with Health Alliance’s Medical Management and Quality Divisional programs (including providing access to member medical records)
- Maintain a conventional patient-physician relationship
  - Health Alliance encourages open provider-patient communication regarding appropriate treatment alternatives and does not penalize providers for discussing medically necessary or appropriate care of the patient.
- Forward member coverage or referral issues to Health Alliance for analysis and benefit determination, and advise patients to check with their insurance company regarding specific insurance coverage information
  - Patients frequently mistake their physician’s referral for approval from their insurance company, or they assume their physician knows which providers are plan providers.
- Fulfill contractual requirements
  - Continuity of Care: If a health care provider terminates a provider agreement with Health Alliance, the provider must provide continued care at the member’s request if he or she has a condition that requires ongoing treatment or is in the 2nd or 3rd trimester of pregnancy. The provider will be required to honor the contracted reimbursement rates to qualify for this continued care provision.

The Illinois Managed Care Reform and Patient Rights Act requires healthcare providers to:

- Supply the following information upon request of a member:
  - Educational background, experience, training and board certification
  - The names of facilities where provider has privileges
  - Continuing education and compliance with any licensure, certification or registration requirements
SECTION 3 PHYSICIAN RESPONSIBILITIES

• Give 90 days’ written notification (Provider Information Change Form) for termination of a provider agreement without cause.
  - Health Alliance must give at least 60 days’ notice to members serviced by a terminating provider. Therefore, it is imperative that providers follow the termination guidelines noted here.
• Allow Health Alliance to use practitioner performance data for purposes including, but not limited to, quality improvement activities and public reporting to consumers.

Specialist Physician Responsibilities:

• Available to members 24 hours a day either directly or by call coverage
• Cooperate fully with Health Alliance’s Medical Management and Quality Divisional programs (including providing access to member medical records)
• Maintain a conventional patient-physician relationship
  - Health Alliance encourages open provider-patient communication regarding appropriate treatment alternatives and does not penalize providers for discussing medically necessary or appropriate care of the patient.
• Forward member coverage or referral issues to Health Alliance for analysis and benefit determination, and advise patients to check with their insurance company regarding specific insurance coverage information
  - Patients frequently mistake their physician’s referral for approval from their insurance company, or they assume their physician knows which providers are plan providers.

The Illinois Managed Care Reform and Patient Rights Act requires healthcare providers to:

• Supply the following information upon request of a member:
  - Educational background, experience, training and board certification
  - The names of facilities where provider has privileges
  - Continuing education and compliance with any licensure, certification or registration requirements
SECTION 3 PHYSICIAN RESPONSIBILITIES

- Give 90 days’ written notification ([Provider Information Change Form](#)) for termination of a provider agreement without cause.
  - Health Alliance must give at least 60 days’ notice to members serviced by a terminating provider. Therefore, it is imperative that providers follow the termination guidelines noted here.
- Allow Health Alliance to use practitioner performance data for purposes including, but not limited to, quality improvement activities and public reporting to consumers.

### Copayments

Physician offices are responsible for collecting copayments. Members are instructed that copayments are due at the time of service.

#### Copayment Exclusions:

- Copayments may or may not be required for office visits with the following health care providers: nurse, nurse practitioner, physician assistant, technician, audiologist and other ancillary personnel (except speech, occupational and physical therapy) or physician extenders. This varies by plan.
- Please verify copayment responsibility at [Your Health Alliance for providers](#) or call the Health Alliance Customer Service Department at 1-800-851-3379.

#### Other Types of Office Visit Copayments:

- Plans with vision coverage allow self-referred optometry visits for routine vision testing with separate and specific copayment amounts.
  - Services from an optometrist for a medical condition (if the optometrist is licensed and contracted to perform such services) shall be subject to the medical office visit copayment and may require a PCP referral.
- Outpatient mental health care and substance abuse treatment have separate copayments. These services require a copayment regardless of whether they are provided by a physician or other mental health professional.
- Physical therapy, occupational therapy, and speech therapy services are also subject to a separate copayment.
- Obstetrical care normally requires only one global copayment to cover all physician visits for routine prenatal care and the post-partum check-up. Specialty visits during pregnancy and services by a perinatologist outside the scope of routine prenatal care have an additional office visit copayment.

**Appointment Scheduling Guidelines**

<table>
<thead>
<tr>
<th>Access Descriptions</th>
<th>Definition</th>
<th>Accessibility Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Preventive Care</td>
<td>Well-child exam, annual physical, wellness visits, or gynecological exams</td>
<td>Within 48 weeks of request</td>
</tr>
<tr>
<td>2. Routine Primary Care</td>
<td>Primary care for non-urgent symptomatic conditions (distinguishes it from wellness visits), such as chronic health problem or ongoing illness in which the member is experiencing no significant change in AUCs, i.e., HTN, seasonal allergies, medication checks</td>
<td>Within 10-14 days of request</td>
</tr>
<tr>
<td>3. Urgent Care</td>
<td>Sudden, severe onset of illness or health problem requiring medical attention, i.e., sore throat with fever, localizing abdominal pain</td>
<td>Within 1 business day</td>
</tr>
<tr>
<td>4. Emergency Care</td>
<td>Sudden, severe injury or symptoms requiring immediate attention, i.e., chest pain with cardiac Hx/unrelieved by NTG, uncontrollable bleeding</td>
<td>Provide and/or refer for emergency care immediately</td>
</tr>
<tr>
<td>5. Afterhours Care</td>
<td>Practitioners are available to members 24 hours a day either directly or by call coverage * • Calls are answered within 45 seconds at least 95 percent of the time</td>
<td>Answering system that arranges access of: • ER calls = 30 min • Urgent = 24 hr • Life-threatening = refer to appropriate health care facility</td>
</tr>
</tbody>
</table>

*If you use an answering machine, please make sure the recording specifically includes the following information. NCQA requires messages include instructions for the terms urgent, emergency and life threatening. “If this is an urgent situation, please contact (appropriate contact). If this is an emergency or life-threatening situation, please call 911 or go to the nearest emergency room.”

**Accessibility Standards for Behavioral Health**

<table>
<thead>
<tr>
<th>Access Descriptions (NCQA NET 2)</th>
<th>Maximum Allowable Waiting Time (defined by NCQA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Non Life-Threatening Emergency</td>
<td>6 hours</td>
</tr>
<tr>
<td>2. Urgent Care</td>
<td>48 hours</td>
</tr>
<tr>
<td>3. Initial Visit for Routine Care</td>
<td>10 business days</td>
</tr>
<tr>
<td>4. Followup Visit for Routine Care</td>
<td>8 weeks</td>
</tr>
</tbody>
</table>
Communications

Conversations with Patients

Health Alliance encourages providers to have open and honest communication with patients. It is recommended that you advise your patients on any of the following:

- patient health status
- medical care and treatment options
- opportunity for the patient to accept or refuse treatment, including the risks, benefits, and consequences of each
- future treatment options

Patients have the right to know about all treatment options available, regardless of their health insurance coverage. Please encourage patients with coverage questions to call the Health Alliance Customer Service Department at the number listed on the back of their ID card or visit HealthAlliance.org for more information.

**It is inappropriate for you or your staff to initiate discussions with patients about disenrollment from any Health Alliance plan.**

Communications Department

The Health Alliance Communications Department is happy to assist you in your communication needs as an affiliated provider.

We can help with the following:

- Use of the Health Alliance name and logo
  - Health Alliance works continuously to maintain a positive brand identity. Thus, Health Alliance closely regulates the use of its name, logo and other identifying references. All providers and other entities must obtain written approval from the Health Alliance Communications Department prior to use of the Health Alliance name, logo, and/or identifying references in publicly disseminated materials including, but not limited to, newspaper ads, fliers, direct mail, pamphlets, brochures, signage, and radio or television broadcasts. We ask that you allow 48 hours for review.
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- Media Relations
  - It is in the best interest of our providers and Health Alliance that all media relations be carefully coordinated for consistency. If you are contacted by the media with inquiries related to Health Alliance, before you respond:
    - Tell the reporter that you are happy to help. Take his or her name and number and say that a representative will return the call promptly.
    - Immediately contact your PRS to connect with the Health Alliance Communications Department for guidance.

Non-discrimination and the Americans with Disabilities Act (ADA)

The following statutes require medical care providers to make their services available in an accessible manner.

- The Americans with Disabilities Act of 1990 (ADA) is a federal civil rights law that prohibits discrimination against individuals with disabilities in everyday activities, including medical services.
  - Visit ADA.gov for more information.

- Section 504 of the Rehabilitation Act of 1973 is a civil rights law that prohibits discrimination against individuals with disabilities on the basis of their disability in programs or activities that receive federal financial assistance, including health programs and services.
  - Visit the United States Department of Labor website for more information.

Health Alliance will provide information and training to physician offices, agencies and other providers on the importance of ADA-compliant facilities for members who have disabilities. As a resource, Health Alliance Provider Services can provide the Health and Human Services publication “Access to Medical Care for Individuals with Mobility Disabilities.” This publication can also be accessed at ADA.gov.

Health Alliance will provide periodic monitoring as deemed necessary to ensure compliance with the non-discrimination requirements, including ADA requirements. Providers will be asked about their accessibility during the initial application/credentialing process and upon recredentialing. Our provider team will assess meaningful compliance with the ADA requirements during on-site provider education visits.
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Medical Record Requirements

Each provider office will maintain a secured separate medical record for each patient. All medical information shall be maintained in a confidential manner except as required for medical treatment and care. Medical record keeping must meet Ambulatory Review criteria (see Ambulatory Review process) and focus on the following six critical elements:

1. Significant illnesses and medical conditions are indicated on the problem list.
2. Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
3. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations, and illnesses
   i. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.
4. Working diagnoses are consistent with findings.
5. Treatment plans are consistent with diagnoses.
6. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.

Health Alliance Ambulatory Review Process

What is an ambulatory review?

An ambulatory review is a medical record review conducted by Health Alliance to ensure quality care is provided to our members. It is a process for evaluating a primary care physician’s documentation of member visits.

Why do we conduct ambulatory reviews?

The Illinois Department of Public Health (IDPH), per the Health Maintenance Organization Act, requires Health Alliance to have a program for the review and evaluation of medical record documentation of primary care physicians once every two years. In an effort to ensure quality care is provided to our members, Health Alliance scores each ambulatory review and includes that score as part of the recredentialing process conducted every three years.

Who conducts an ambulatory reviews?

Ambulatory reviews are conducted by our medical record review staff from the Quality Management Department. The medical record reviewer will
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contact the primary care physician’s office to coordinate a review date, which will include confirmation of the appointment and a list of charts identified for review.

If there are any questions or concerns at any time during the review process, feel free to contact your medical record reviewer at 1-800-851-3379.

When is an ambulatory review conducted?

New primary care physicians are reviewed within their second year of affiliation with Health Alliance, as long as they have 50 or more members on their panel. Subsequent reviews are completed according to the following schedule:

<table>
<thead>
<tr>
<th>Compliance Rating</th>
<th>Next Review</th>
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</thead>
<tbody>
<tr>
<td>90 – 100%</td>
<td>Two years</td>
</tr>
<tr>
<td>≤ 89%*</td>
<td>6 months</td>
</tr>
</tbody>
</table>

*If a compliance rating is ≤ 89%, a corrective action plan must be submitted to Health Alliance by the primary care physician within 10 working days of receiving their compliance rating.

How are the criteria applied?

Our medical record reviewers utilize specific criteria based on record keeping, confidentiality, and quality of care to evaluate 10–12 member visits for each primary care physician. Some of the criteria may not be applicable for a review based upon the member’s age, gender, and/or medical history. If the criteria are not applicable, it will not be factored into the compliance rating.

Health Alliance evaluates criteria for ambulatory reviews each year to ensure the best quality of care is provided to our members. Any changes to the ambulatory review, including new, deleted, or modified criteria, will be communicated in writing to providers at least 30 days in advance.

Credentialing Process

Health Alliance adheres to standards set by the National Committee for Quality Assurance (NQCA), Centers for Medicare and Medicaid Services (CMS) and the State of Illinois to ensure the quality of our provider network.
Legal and accreditation requirements mandate a thorough credentialing process for all managed care plans.

The credentialing process applies to all participating providers licensed in the states in which Health Alliance is qualified to do business. The credentialing process includes review of licensure, standing, medical malpractice history, board certification status, responses from references, affiliations, and review by the Credentialing Committee. The credentialing process must be completed before a provider can be added to the provider network. Only providers who have fulfilled the requirements for credentialing or re-credentialing are permitted to see Health Alliance members and bill for services.

Please contact your PRS for more information regarding the credentialing process. You can also visit Your Health Alliance for providers for more information.

**Midlevel Providers**

To ensure accurate and prompt claim reimbursements, Health Alliance requires all practitioner offices to submit information about certain midlevel providers in their practice. Some midlevel providers will need to complete the credentialing process. Your PRS can tell you which midlevel providers need to be credential. You will be advised to complete and return either a credentialing application or a Provider Information Addition Form for each new midlevel practitioner employed by your practice. Please be sure to include copies of the following with your submission:

- Midlevel practitioner’s state license
- State controlled substance license
- DEA registration certificate

This information will be used by Health Alliance to verify the midlevel practitioner’s license. Please use the Provider Information Change Form to notify Health Alliance when a midlevel practitioner terminates employment. Proper notification of midlevel practitioners will ensure timely payment of claims.

**Midlevel supervision:** By contracting with a physician, Health Alliance assumes the physician is the primary provider of medical care for members and therefore, should be present to see patients in the office at least 50% of the time the office is open. The Credentialing Committee must review exceptions to this requirement.
Please contact your PRS for more information regarding midlevel credentialing.

**Proper Credentials Ensure Quality Health Care**

Midlevel providers play an important role in providing care for our members, and we want Health Alliance members to receive appropriate, high-quality health care from certified or licensed midlevels. We only reimburse claims submitted by contracted midlevel providers with valid and current state licensure. If you are a member of a contracted group practice, and a claim reimbursement is disallowed because these requirements are not met, by contract you cannot bill an HMO member.

**Midlevel Service Billing Clarification**

When billing for services provided by a midlevel, please use his or her provider number. Health Alliance does not need the supervising physician’s provider number as long as the midlevel’s provider number is given. When a new midlevel joins your office, please be sure to submit a [Provider Information Change Form](#).

Billing for services provided by an individual delivering care outside their scope of practice is considered fraudulent billing and is subject to recovery, termination of contract, and prosecution to the full extent of the law.

**Administrative Complaints and Grievances**

Health Alliance is committed to promoting satisfaction among its participating providers in the delivery of covered services to members pursuant to the terms of the Participating Provider Agreement. In the event that a provider has a complaint or grievance related to claims resolution disputes, contract disputes, or other administrative issues, Health Alliance has a Provider Administrative Compliant and Grievance Policy.

*Please note: A separate Policy and Procedure exists for provider grievances related to medical necessity determinations made by the Health Alliance Quality Management Division (see Member Complaints and Appeals Procedure in the Membership section of this Provider Manual).*

**Inquiry:** A provider may contact the Provider Network Management (PNM) Department or the Customer Service Department to discuss any questions or concerns. Staff from these departments will investigate and respond to the inquiry within 5 working days of the date of inquiry.
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**Complaint:** If a provider is not satisfied with the response to an inquiry, they may submit a written complaint to their PRS within 30 calendar days after the date of the response to the inquiry. The PRS will respond in writing to the provider within 30 working days from the date of receipt of the written complaint. The provider may bypass the inquiry and submit a written complaint directly.

**Grievance:** If a provider is not satisfied with the response to a complaint, they may request that it be considered a grievance and acted upon by the Provider Administrative Review Committee (PARC). This committee is made up of senior leadership within Health Alliance. A written request for PARC consideration should be submitted to the Director of Provider Network Management within 15 working days after the response to the complaint is received. The request should include all necessary documentation for the PARC to render a decision. The PARC will meet and render a decision within 30 days of the receipt of the grievance. The Director of Provider Network Management will communicate the Committee's decision in writing to the provider within 10 days of the committee’s decision.

**Arbitration:** If a provider is dissatisfied with the decision of the PARC, the Arbitration Process outlined in the Provider Agreement will be implemented.

**Resolution of Disputes**

Disputes between Health Alliance and a provider about actual terms of contracts that are not resolved within 90 days (the period of good faith dispute resolution) can be settled through binding arbitration.

Both parties have 120 days after the written notice of arbitration to gather all information needed to resolve the issue. This information includes business records, patient care and billing records or depositions relevant to the dispute. The arbitration proceedings will be completed no more than 180 days after written notice of arbitration. The arbitration will be held in Champaign, Illinois, or other location as long as all other parties agree. Once the arbitrator reaches a decision, no punitive damages will be awarded and the losing party will be responsible for all costs and fees of the arbitration proceeding.

**Risk Adjustment Coding and Documentation**

Health Alliance participates in the Illinois Insurance Marketplace which is overseen by the U.S. Health and Human Services Department (HHS). Payment
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from the State of Illinois to Health Alliance for members covered under private and public exchange plans is based on risk adjustment methodology which reimburses health plans based on the health status of the individual enrollee. The risk of the individual enrollee is determined by the diagnosis code(s) included on the claims submitted to Health Alliance from risk adjustment-approved providers and facilities throughout the calendar year and then passed to the State.

The risk adjustment model closely matches that of the Medicare model, with the addition of diagnosis classifications for enrollees of non-Medicare age. The conditions in the HHS Hierarchical Condition Categories (HHS-HCC) represent conditions that are classifiable as higher-cost conditions in the disease burden among the population in the exchanges. HHS sees the member with International Classification of Disease, Tenth Revision, Clinical Modification (ICD-10-CM) codes in the HHS-HCC model as sicker than the “average” member, resulting in higher reimbursement from CMS. In this program, Health Alliance is reimbursed by diagnosis code, not Current Procedural Terminology (CPT) codes.

The provider role in this process is to submit medical record documentation that is clear, concise, consistent, complete and legible. All diagnoses, supported in the medical record documentation for each encounter, must be submitted on the claim. To that end, Health Alliance places an increased emphasis on provider education and recommendations related to HHS-HCCs, diagnosis coding and documentation regulations. HHS-HCCs are given a severity ranking and the higher the medical risk to the patient, the higher the ranking. It is important to follow normal coding practices, but specificity is of utmost importance, and all diagnosis codes that apply to a particular visit must be documented. The medical record documentation must support the diagnosis that was assigned within the correct data collection period by an appropriate provider type (provider visit, hospital inpatient or hospital outpatient) and an acceptable physician data source as defined in the HHS instructions. In addition, the diagnosis must be coded according to ICD-10-CM Guidelines for Coding and Reporting.

Risk Adjustment Data Validation

Risk adjustment data validation (RADV) is a process of verifying that diagnosis codes submitted for payment by the health plan are supported by participating provider medical record documentation for an enrollee. The primary goals of HHS through RADV are to identify discrepancies, measure accuracy and the impact of potential discrepancies, improve and inform plans
of the quality of their risk adjustment process. HHS instated a six-stage annual
data validation process for the Commercial Marketplaces on behalf of the
states.

**Step 1:** A sample selection of Members will be reviewed by an
Independent Data Validation Auditor (IVA) engaged by the Health
Plan.

**Step 2:** The initial validation audit is performed.

**Step 3:** A second validation audit is performed by data validation
contractors engaged by CMS.

**Step 4:** An error estimation is done.

**Step 5:** Health plans have the opportunity to appeal.

**Step 6:** Payments and adjustments.

Health Alliance is required to retrieve and provide medical records to the IVA
in a short window of time. As a participating provider it is mandatory that
your staff members provide medical records as requested by the deadline
indicated in our correspondence to accomplish step 1 in the process above.

### Risk Adjustment Revenue Management Department

Health Alliance is committed to maintaining affordable premiums and quality
care. Correct diagnosis coding is critical to ensure we have an accurate
assessment of the health status of and expected level of care for our
membership. Our Risk Adjustment Revenue efforts include financial accounting,
reconciliation and analysis, certified coding consulting and analytics, advanced
practitioner visits and complex care coordination to monitor ongoing issues
related to member needs.

As such, Health Alliance sends mid-level practitioners into members’ homes for
comprehensive Health Risk Assessment (HRA) and complex care coordination.
These assessments are provided to the member’s PCP and Health Alliance’s
Medical Management Division to assist in care coordination.

Health Alliance regularly performs provider medical record reviews to ensure
correct diagnosis coding compared to codes submitted on claims. As such, our
coding team requests electronic or paper copies of medical records for our
members. Coding analysts may also need to visit provider offices to review
member medical records. The information provided should include, but should
not be limited to:

- Face sheet
- History and physical exams
- Physician orders
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- Progress notes
- Operative and pathology reports
- Consultation reports
- Diagnostic reports
- Discharge summaries

Reviews are conducted in accordance with CMS ICD-10-CM Official Guidelines for Coding and Reporting.

Please note: Claims data found to not be supported by medical records could be subject to a delay in reimbursement, as applicable.