

## **2 PROVIDERS' RIGHTS & RESPONSIBILITIES**

The provider rights and responsibilities outlined in this section of the Provider Manual are applicable to all physician and non-physician providers. More specific responsibilities of Primary Care Practitioners and Specialists are addressed later in this Provider Manual.

### **2.1 PROVIDER'S RIGHTS**

The Plan encourages all participating providers to take a very active role in the management of their patient's medical care. As such, participating providers have the right to advise or advocate for members on the following issues, when acting within the scope of their license to practice medicine in the State of New York, without restriction or incrimination:

- Health status, medical care or treatment options including providing the member with sufficient information to allow the member to make a decision regarding treatment options, and also provide sufficient information to allow the member to consider alternative treatments that may be self-administered.
- Risks, benefits and consequences of each of the various treatment options.
- Notification to the member that the member has the opportunity and the right to refuse treatment and/or state their preferences for future treatment options.

### **2.2 PLAN RESPONSIBILITIES TO NETWORK PROVIDERS**

We recognize it is our responsibility to assure each of our providers of the following:

- Receive the necessary and appropriate orientation, continued education and training.
- If provider is a Primary Care Practitioner that the provider receives an Enrollee Membership Roster on a monthly basis.
- Timely payment for covered services rendered to members.
- Thirty (30) day prior notice regarding any changes in Plan policy or procedures.
- Timely response to questions or concerns.
- Assistance with complex member issues.
- Timely resolution of grievances and appeals
- The Plan will not prohibit, terminate or refuse to renew a contract with a provider solely on the grounds that the provider:
  - advocated on behalf of a member,

- filed a complaint against the Plan,
- appealed a decision of the Plan,
- provided information or filed a report that the Plan was in violation of any Public Health regulations pursuant to PHL 4406-c, or
- requested a hearing or review.

## **2.3 PROVIDER'S RESPONSIBILITIES**

Participating providers responsibilities include but are not limited to:

### **2.3.1 Deliver Quality Medical Care**

Plan participating providers are responsible for providing all necessary medical care services within the scope of the provider's license to practice medicine in the State of New York. This includes, but is not limited to the following:

- Provide care within the scope of your practice as defined by the Plan, the Centers for Medicaid and Medicare Services (CMS), the New York State Department of Health (SDOH) and the New York City Department of Health and Mental Hygiene (NYCDOHMH).
- If you are a Plan participating provider in the five boroughs of New York City, follow the ***Compendium of Public Health Requirements and Recommendations*** published by the New York City Department of Health Mental Hygiene (NYCDOHMH) and includes all of the important public health reporting requirements, practice guidelines and instructions on using on-line reporting forms. It also contains additional information on the Nurse Family Partnership, extensive web-based resources and additions of NYCDOHMH City Health Information Provider Newsletter on public health topics. This compendium can be found out [www.nyc.gov/health](http://www.nyc.gov/health), click on publications and scroll to Health Care Access and Improvement then select Compendium.
- Adhere to the Plan Medical Record requirements as follows:
  - Keep a separate medical record for each enrollee
  - The medical record must serve as verification that the PCP coordinates and manages all of the enrollee's medical care
  - Medical Records must be retained at least six (6) years for adults and six (6) years from the age of majority for children.
  - Medical Records pertaining to Medicare beneficiaries must be retained for a period of ten (10) years after the date of service rendered.
  - For Prenatal Care only: maintain a centralized medical record for the provision of prenatal care and all other services
- Comply with the Plan's access to care, quality of care and participation standards.
- Deliver optimal quality medical care to all members without regard to age, race, sex, religious background, national origin, disability, sexual orientation,

source of payment, veteran status, social status, health status or marital status.

- Ensure that access to your office, your patient waiting area and your examination rooms all comply with the Americans with Disabilities Act (ADA) guidelines as set forth by the New York State Department of Health (e.g. wheelchair accessible).
- Be respectful of the cultural diversity of our members when providing information regarding diagnosis, treatment plan and potential outcomes.
- Have access to interpreter services to eliminate any language barriers between you and our member so that information regarding diagnosis, treatment plan and potential outcomes is conveyed in an accurate and easily understandable manner.

**If there is no office staff, relative or friend who speaks the member's language, the AT&T Language Bank can assist with translation.**

- Always provide sufficient information regarding diagnosis, treatment options and potential outcomes to enable members to give informed consent prior to the initiation of any treatment or procedure.
- Inform members of the appropriate follow-up and self care measures relevant to their condition.
- Advise members of non-covered treatment options and their cost prior to rendering the treatment or procedure. If member elects to proceed with a non-covered treatment or procedure, you are responsible to obtain the member's consent to accept responsibility for the cost of such treatment or procedure in writing and signed by the member.
- Respond to the Plan's questions or inquiries regarding treatment, services or quality of care matters within three (3) business days unless an immediate response is required to facilitate patient care or meet regulatory requirements.

### **2.3.2 Adhere to Proper Billing Guidelines**

When adjudicating claims the Plan applies all applicable federal and state statutes, regulations and agency guidelines, including but not limited to those payment rules set forth in Title 10 of the New York Code of Rules and Regulations. In addition, the Plan follows CMS Correct Coding guidelines in the adjudication of your claims as well as the Fraud and Abuse guidelines disseminated from the Office of the Medicaid Inspector General. As a Plan participating provider, failure to follow these guidelines in billing us for services provided to our members may result in unnecessary delays in claims payment or inaccurate payments. More details are supplied in Section 11 of this Provider Manual.

The Plan expects that every participating provider will adhere to the following with regard to billing us for the services rendered to our valued members:

- All claims for reimbursement of covered services will be submitted in an acceptable format; i.e. a UB04 or CMS1500 format whichever is appropriate to your practice. Specific standards for the accurate submission of claims are in Section 11.

**Members must never be billed for the covered medical services that you have provided to them.** Providers are prohibited from seeking monetary reimbursement from members, their responsible relatives or legal guardians, except for any applicable co-payments.

**If you render a non-covered service to a member, as stated previously, you must inform the member that the service is not a covered service under the Plan prior to rendering the medical service and that they will be billed as a private pay patient if they decide to receive the service. If the member decides to have the service and agrees to being billed as a private pay patient, you should obtain this consent in writing and maintain that documentation in the member's medical record.**

- The Plan should not be billed for non-covered services.
- Advise members that they may contact the Plan Member Services Department if they have any concerns regarding a non-covered service or wish to file an appeal.

### **2.3.3 Maintain Member Confidentiality**

Participating providers are bound by the patient confidentiality provisions set forth in the Plan's Policies and Procedures and all applicable Federal, State and local laws, rules and regulations. This includes, but is not limited to, HIPAA, the Social Services Law of the State of New York, New York State Public Health Law, New York State Insurance Law and the Federal Social Security Act regarding confidentiality and disclosure of medical records or other health or enrollment information pertaining to Enrollees. It is the provider's responsibility to:

- safeguard the privacy of all confidential and protected health information (as defined in HIPAA) of Enrollees, including medical records, and ensure that copies of or information from such records are released only to authorized individuals;

- release such information or records only in accordance with HIPAA and other applicable Federal, State or local laws, or pursuant to court orders or subpoenas;
- maintain all such information and records in an accurate and timely manner; and in a secure environment,
- assure timely access by Enrollees to their medical records and information.

As part of the Health Insurance Portability and Accountability Act (HIPAA), Protected Health Information (PHI) of members must be kept strictly confidential. While members authorize the Plan to obtain necessary PHI to adjudicate claims at the time of their enrollment in our Plan, we expect our participating providers to take the following actions:

- Maintain all members' PHI as strictly confidential in compliance with HIPAA standards and regulations.
- Keep all members' medical records in locked, secure filing cabinets.
- Provide the Plan with necessary member PHI, in compliance with HIPAA standards, when required for payment, treatment, quality assurance, regulatory audits, data collection and reporting activities.
- Communicate member PHI in a secure format such as confidential fax, in writing via United States Postal Service or password protected e-mail (password must be sent in a separate e-mail).

As a participating provider, you and your employees must ensure that all individually identifiable information relating to members is kept confidential as mandated by State and Federal regulations including those regulations specific to members with HIV/AIDS. Providers must develop policies and procedures to assure confidentiality of HIV related information. Such policies must include:

- Initial and annual in-service education of staff
- Identification of staff allowed access to medical records and limits of that access
- Procedure to limit access to trained staff (including contractors)
- Protocol for secure storage (including electronic storage)
- Procedures for handling requests for HIV-related information
- Protocols to protect persons with or suspected of having HIV infection from discrimination.
- The Legal Action Center has revised New York States Department of Health's Model HIV Confidentiality Policies & Procedures for HIV/AIDS Service Providers in New York State, which is available at:  
[http://www.lac.org/doc\\_library/lac/publications/Model\\_HIV\\_Confidentiality\\_Policies\\_Procedures\\_FINAL\\_6-14-11.pdf](http://www.lac.org/doc_library/lac/publications/Model_HIV_Confidentiality_Policies_Procedures_FINAL_6-14-11.pdf).
- NYSDOH recently disseminated two new HIV release forms: Authorization for Release of Health Information and Confidential HIV-Related Information, which is a slightly streamlined revision of the 2005 form, and Authorization for

Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information, which is a new form to facilitate sharing of substance use, mental health and HIV/AIDS Information. As well as Technical Assistance Bulletins that explain how to complete the forms, when to use them, etc. Both the forms and the bulletins can be downloaded from the Department of Health website: <http://health.ny.gov/diseases/aids/forms/>.

### **2.3.4 Notify the Plan when Your Practice Information Changes**

Be sure to send a letter, fax, e-mail or electronically through our website ([www.getnhp.com](http://www.getnhp.com) or [www.suffolkhealthplan.com](http://www.suffolkhealthplan.com) ) to the Provider Relations Department when any information related to your practice changes or requires update. This information includes, but is not limited to:

- Changes in the tax and/or billing information (a new W-9 must be filed with NHP)
- Changes in office location(s) (address changes)
- Changes in the office telephone numbers that members would call to make appointments.
- Request to close your panel at one or more locations. Please be specific in stating if the panel should be closed to all new **and** existing patients **OR** to new patients only.

### **2.3.5 Avoid Fraud and Abuse**

Health care fraud and abuse affects all of us directly or indirectly by leading to increased health care costs.

Specifically, health care fraud is the intentional misrepresentation, deception or the intentional act of deceit to receive a higher level of reimbursement for services rendered to members.

Health care abuse by Providers occurs in many ways. This includes, but is not limited to:

- Billing for services that were not provided.
- Duplicate submission of a claim for the same service
- Misrepresenting the service provided.
- "Up-coding" - charging for a more complex or expensive service than was actually provided.
- Billing for a covered service when the service actually provided was not covered.
- Having members return to the office for unnecessary follow-up visits.
- Taking of unnecessary x-rays, blood work, etc.

- Accepting payment from a provider for referring a member.
- Submitting false information to gain greater reimbursement.
- Denying services based on a member's inability to pay an applicable co-payment.
- Practicing beyond the scope of your license.

The Plan maintains contracts and business associate agreements with two independent firms who audit professional and institutional claims on both a prospective and retrospective basis to assure that our providers are using correct billing practices as required under New York Regulation Title 10 part 98 and CMS Correct Coding Guidelines.

Our Plan encourages our providers to also be aware of possible fraudulent activities by our members.

It is important for our providers to check the date of birth of the member as well as other identifying information when providing health care services.

Examples of fraudulent activities are:

- Loaning Medicaid Identification card or Plan ID card to another person;
- Forging or altering a prescription;
- Using multiple Medicaid/ Plan ID cards;
- Intentionally receiving duplicative, excessive, contraindicated, or conflicting health care services or supplies; and
- Re-selling items provided by the Medicaid/Plan program.

If you suspect that a member has engaged in any of the activities listed above or any other questionable activity, please report the incident to the Compliance Hotline 1-877-655-9900 (TTY 1-800-877-8973).

Any participating provider who suspects fraud and abuse by another provider or a member should contact the NHP Compliance Hotline at 1-877-655-9900. Providers may also call the Medicaid Fraud Hotline at 1-877-87FRAUD.

The Plan is required to report to the State Department of Health (SDOH) and the Office of the Medicaid Inspector General (OMIG) any adverse actions taken for program integrity reasons against a Provider.

The Plan must notify SDOH of any Provider denied credentialing or termination of the Provider's contract for program integrity related reasons such as being on the excluded Provider list and/or having existing fraud, licensing or Office of Professional Medical Conduct (OPMC) issues.

### **2.3.6 CMS Integrity Audit Requirement**

The Plan is required to check providers against the Medicaid excluded Provider List. In addition the Plan will require the Providers to maintain on-going monitoring of all staff and employees against any exclusion lists and to report any findings to the Plan on a monthly basis.

## **2.4 24 HOUR ACCESS AND APPOINTMENT AVAILABILITY STANDARDS**

Plan participating providers are responsible for complying with the Plan's access and appointment availability standards. Providers are informed of this responsibility during the on-site environmental review process, in the Provider Manual and the orientation session. Providers are monitored for compliance through unscheduled on-site visits and the semi-annual Access and Appointment Availability survey.

### **2.4.1 24 Hour Access Standards**

All participating Primary Care Practitioners and OB/GYNs are required to provide access to covered medical services 24 hours a day, 7 days a week. This means that:

- Member calls should be answered by a live answering service that is able to connect the member with his or her provider, or a covering provider, within 30 minutes.
- Providers who utilize an answering machine to answer their telephone after hours must have a the message that directs the member to a phone number **that is answered by a live person** capable of offering the member information and referrals as necessary.

**IT IS NOT ACCEPTABLE TO HAVE A MESSAGE THAT DIRECTS MEMBERS DIRECTLY TO THE EMERGENCY ROOM FOR NON-LIFE THREATENING CONDITIONS.**

**ALL CALLS MUST BE RETURNED WITHIN 30 MINUTES BY THE PROVIDER ON-CALL.**

## 2.4.2 Appointment Availability Standards

As a Plan participating provider you are required to adhere to the following appointment scheduling guidelines upon receiving a request from a member:

<b>For:</b>	<b>Members must be seen:</b>
Emergency Care	Immediately upon presentation
Urgent Care	Within 24 hours of request
Non-urgent "sick" visit	Within 48 to 72 hours of request as clinically indicated
Routine Non-Urgent Preventive Appointment (Well Visit)	Within 4 weeks of request
Specialist Visit	Within 4 to 6 weeks of the request
Initial Family Planning Visit	Within 2 weeks of the request
Initial Prenatal Visit	Within 3 weeks during the 1 <sup>st</sup> trimester Within 2 weeks during the 2 <sup>nd</sup> trimester Within 1 week during the 3 <sup>rd</sup> trimester
Initial PCP Visit for Newborns	Within 2 weeks of hospital discharge
Well Child Care	Within 4 weeks of request
Adult Baseline and Routine Physicals (adults age 21 and older)	Within 90 days of enrollment
Mental Health Assessment for Work Preparedness (as requested by HRA)	Within 10 days of member request
Mental Health or Substance Abuse Visit following ER Visit or Hospital Discharge	Within 5 days of request or as clinically indicated
Non-Urgent Mental Health or Substance Abuse Visit	Within 2 weeks of request

### **2.4.3 Appointment Wait Time**

Members must be seen within one (1) hour of their scheduled appointment time. If an urgent or emergent situation arises that will cause a delay in the provider seeing the member within that timeframe, the provider's office staff must advise the member of the delay and offer the member the choice to wait or re-schedule their appointment.

## **2.5 OTHER RESPONSIBILITIES**

### **2.5.1 Conduct of Practice**

Participating providers are solely and exclusively responsible for the establishment and maintenance of their office and for all personnel matters in connection with the operation of their medical practice.

### **2.5.2 Advance Directive Policy**

Participating providers are required to adhere to the Plan's advance directive policy. This policy states that it is the right of each adult member to make decisions regarding his/her health care when accepting or refusing medical or surgical treatment. This includes the right to request or agree to a treatment, to refuse a treatment before it is started and to have treatment stopped once it has started. Our Plan respects the rights of its members, including the right to execute Advance Directives. This policy is referenced in the product specific Member Handbook, mailed to all members. Members seeking more information on Advance Directives should be instructed to call Member Services. Providers should clearly indicate that a member has an Advance Directive in a prominent place in the member's medical record.

### **2.5.3 Encounter Data**

Providers are required to submit claims to us for services rendered to members regardless of providers' payment arrangements. Claims (or encounter forms) are required for both capitated and fee-for-service encounters so that we can monitor service utilization and fulfill regulatory reporting requirements.