THE PRIMARY CARE PROVIDER (PCP) AS GATEKEEPER

Primary Care Physicians (PCPs) are the "gatekeepers" of health care services and are responsible for rendering quality care effectively and efficiently. Each PCP is responsible and accountable for the coordination, supervision, delivery and documentation of medical services to assigned members. The use of PCPs as gatekeepers results in greater continuity of care for the member.

PCP Assignment and Panel Status

Members are assigned to PCPs based upon member choice. However, if a member does not exercise the right to choose a PCP, a PCP will be assigned based on closest geographical proximity to their home address. Please remember that Members assigned to a panel must be offered an appointment regardless of panel status. Members assigned to a panel at the time of panel closure are considered an established Member whether or not the Member has been seen in the office.

Phoenix Advantage HMO/Phoenix Advantage Plus (HMO SNP), may, at its sole discretion, limit the number of members assigned to a PCP. PHOENIX HEALTH PLANS may reassign or transfer members that are assigned to a PCP if the PCP has a high number of member complaints or is unable to comply with the Medicare mandated access standards.

SPECIALTY CARE PROVIDER ROLE

Specialty Care Providers are qualified and licensed to provide comprehensive medical services in a designated specialty. Specialists will accept referrals from PCPs for the purpose of providing Medically Necessary Covered Services to PHOENIX HEALTH PLANS Members in the Provider's designated specialty.

APPOINTMENT AVAILABILITY

Appointments for office visits must be available within the standards listed below. Appointment availability and wait time standards are mandated by Medicare and PHOENIX HEALTH PLANS and are monitored by PHOENIX HEALTH PLANS on an ongoing basis.

The Appointment Availability access standards are:

- For preventive care services from a contracted PCP, an appointment date within 4 weeks of the Member’s request, or sooner if necessary, for the enrollee to be immunized on schedule
- For routine-care services from a contracted PCP, an appointment date within 14 days of the request or sooner if medically necessary
- For specialty care services, an appointment date within 45 days of request or sooner if medically necessary
- In-area urgent care services from a contracted provider 7 days/week
- Timely non-emergency inpatient care services from a contracted facility
- Timely services from a contracted physician or practitioner in a contracted facility including inpatient emergency care
- Services from a contracted ancillary provider during normal business hours, or sooner if medically necessary
PATIENT CARE RESPONSIBILITIES

After-Hours Coverage

Network providers must have 24 hours per day, 7 days per week coverage. It is not acceptable to use the emergency department as coverage. The emergency department should only be utilized for members that require emergency services.

Acceptable Practice Coverage:
- An answering service used after business hours. The service must be able to contact the physician or covering physician.
- An answering machine which directs the caller to the physician or to the covering physician at another number.
- Call forwarding services that automatically send the caller to another number that will reach the physician or covering physician.

Unacceptable Practice Coverage:
- An answering machine that directs the caller to leave a message.
- An answering machine that directs the caller to go the emergency room and offers no other option for contacting the physician or covering physician.
- No answering machine or service.

Advising and Advocating for Members

Nothing shall interfere with a Provider’s obligation to the following:

- Exercise independent medical judgment in rendering health care services to Members
- Provide communications necessary or appropriate for the delivery of healthcare services or communications to Members regarding treatment alternatives regardless of the provisions or limitations of the Member’s coverage
- Provide communications to Members regarding applicable rights to appeal coverage determinations

Providers shall assist Members in understanding treatment choices, including the risks, benefits and consequences of treatment and non-treatment, allow Members to participate in health care decisions and to express preferences about future treatment decisions.

Nurse Line

PHOENIX HEALTH PLANS subcontracts with Call Center Services to provide a 24 hours a day, 7 days per week nurse line that is staffed by bilingual registered nurses to answer questions and assist members. After hours urgent/emergent Member calls are triaged according to national protocols and directed to the appropriate level of after hour care. A member will always be instructed to contact their PCP for non-emergent issues. PHOENIX HEALTH PLANS encourages its providers to inform PHOENIX HEALTH PLANS Members to call the nurse line after hours prior to seeking medical services from anyone other than their PCP in order to obtain answers to their medical questions.

Member Education

- PCPs are required to provide education to their Members regarding disease management and the importance of regular health maintenance visits.
• PCPs also should instruct their Members on appropriate use of the emergency room.
• If a contracted physician employs a Physician Assistant(s) (PA) and/or Nurse Practitioner(s) (NP), Members need to be informed when scheduling appointments that they may be seen by a PA or NP.
• Members have the right to see their assigned provider.

Preventive Care

PCPs are responsible for providing appropriate preventive care to all Members; including, but not limited to, immunizations, disease risk assessment, well woman visits and well man visits.

Health risk assessment and screenings for Members should include, but are not limited to, screening for hypertension, elevated cholesterol, colon cancer, sexually-transmitted diseases, tuberculosis, HIV/AIDS, mammography, prostate screenings, physical examinations and diagnostic work-ups.

Prior Authorizations

PCPs are responsible for initiating and coordinating care for their assigned Members to Specialists when medically necessary. The PCP should obtain authorization from PHOENIX HEALTH PLANS for certain specialist visits (refer to the most current Prior Authorization Guidelines). It is critical that PCPs maintain good communication with specialists who are treating their Members.

Please refer to Section F for additional information on the Prior Authorization Process.

EMERGENCY DEPARTMENT UTILIZATION

It is the role of the PCP to assist PHOENIX HEALTH PLANS in reducing unnecessary use of emergency department services. Members receive information about the twenty-four (24) hour nurse line in their Evidence of Coverage and on the back of the Member ID card as alternative resource when seeking after-hours non emergency care.

Daytime Emergency Department Usage

Members are educated to call 911 in a life-threatening emergency. In non-emergent situations they should contact their PCP before going to the emergency department. If a PCP is unable to see a Member who requires urgent care, the Member may be directed to seek assistance from a contracted urgent care facility or Member Services may become involved to facilitate a referral to another PCP.

The test for appropriateness of a life-threatening emergency service is if a prudent layperson, similarly situated, would request such services. Prudent layperson is defined as a person who possesses an average knowledge of health and medicine. The phrase does not apply to a person’s ability to reason but rather the prudence with which he or she acts under a given set of circumstances.

In-Patient Admissions through the Emergency Department

If the Member requires admission, the emergency department must contact the Member's PCP or PHOENIX HEALTH PLANS designated hospitalist. A reference number must be obtained from PHOENIX HEALTH PLANS if the Member is admitted to the hospital by faxing the admission face sheet to the PHOENIX HEALTH PLANS Utilization Management Coordinators.

PHOENIX HEALTH PLANS conducts random retrospective review of all emergency department claims for appropriateness of services rendered.
ADMINISTRATIVE RESPONSIBILITIES

Claims and Encounter Reporting

Care must be reported to PHOENIX HEALTH PLANS. In order to determine the accuracy of encounter data, PHOENIX HEALTH PLANS periodically conducts data validation studies of Members' medical records in order to compare recorded utilization information to submitted encounter data. Physicians must cooperate with PHOENIX HEALTH PLANS when copies of medical records are requested for these studies.

Please refer to Section G for additional information regarding Billing and Claims.

Confidentiality

All protected health information shall be regarded as confidential. Members have the right to be protected from unauthorized disclosure and the use of their health information. However, providers are permitted and expected to release this information to PHOENIX HEALTH PLANS and/or to CMS representatives. Release of Member information to any other third party requires obtaining the Member's consent. The Provider should inform the Member of their rights and responsibilities regarding the confidentiality of their medical record and health information during the initial visit in accordance with the Health and Insurance Portability and Accountability Act (HIPAA).

PHOENIX HEALTH PLANS Members or an authorized representative may view their medical records after written notification to the provider and at a reasonable time and place. Each Member is entitled to one copy of his or her medical records free of charge on an annual basis.

Co-Payments

A co-payment is a payment that a Member is required to make to a Participating Provider under a Service Agreement, which is calculated as a fixed dollar payment. Certain Members may have a co-payment. However, services may not be denied to a Phoenix Advantage Health Plan Member who is unable or unwilling to pay a co-payment. Providers may bill Phoenix Advantage HMO members for unpaid co-payments, coinsurances, and deductibles. Phoenix Advantage Plus (HMO SNP) members are covered under Medicare/Medicaid and are not subject to the same rule; you may not bill a Phoenix Advantage (HMO SNP) member for any unpaid amount.

Documentation

Providers are required to maintain records and information including, but not limited to, information relating to the provision of Covered Services to PHOENIX HEALTH PLANS Members, billed charges, and payments received from PHOENIX HEALTH PLANS. PCPs are required to keep a complete medical record for each assigned Member, documenting all office visits, referrals and contact with the Member. All information should be accurate, timely, and complete. Providers are responsible for ensuring that a medical record is established when information is received about a Member. If the PCP has not yet seen the Member, such information may be kept temporarily in an appropriately labeled file in lieu of actually establishing a medical record, but must be associated with the Member’s medical record as soon as the medical record is established.

Advance Directives and patient education should be noted in the Member’s medical record. A record of the Member's immunization status should also be included. Providers should ensure that they have documented information required by PHOENIX HEALTH PLANS disease management guidelines.
PHOENIX HEALTH PLANS conducts periodic audits of medical records to ensure compliance.

Eligibility Verification

Providers are responsible for verifying member eligibility prior to providing medical services. Eligibility can be obtained by accessing secured provider portal through our website or contacting Member Services. Providers will not be reimbursed by PHOENIX HEALTH PLANS for services rendered to Members not eligible with PHOENIX HEALTH PLANS at the time of service.

IMPORTANT FACTS ABOUT DUALLY-ENROLLED MEMBERS

Many members with Phoenix Advantage Plus (SNP HMO) (a Medicare Advantage Prescription Drug plan) also have insurance through Phoenix Health Plan (PHP) or a similar Medicaid plan. This has important implications for providers who care for them.

- Providers must identify these dually-enrolled members because they have greater benefit coverage than would be available otherwise. For example, PHP (a Medicaid plan) may cover services that have been exhausted under the Phoenix Advantage Plus (HMO SNP). Also, the Medicaid health plan may cover co-payments, deductibles, coinsurances, and some other costs, that the Phoenix Advantage Plus (HMO SNP) does not cover. For this reason, it is important for providers to verify member eligibility in both plans. All members are instructed to carry both their Phoenix Advantage Plus (HMO SNP) and AHCCCS identification cards.
  - Please be advised that Phoenix Advantage Plus (HMO SNP) plan membership ends thirty (30) days after AHCCCS eligibility is lost.

- Please use the prior-authorization and formulary processes described for the Phoenix Advantage Plus (HMO SNP) when caring for dually-enrolled members.

- When members join the Phoenix Advantage Plus (HMO SNP) from another Medicare plan, we will coordinate care and pharmacy coverage. For assistance with pharmacy coverage transitions, please call (602) 824-3900.

- The Phoenix Advantage Plus (HMO SNP) has a case management program for members with special medical and social needs. Disease management services, such as those required for patients with diabetes or asthma, are also provided to our dually-enrolled members. The Phoenix Advantage Plus (HMO SNP) also provides extensive patient education to members who need it. To enroll your patient in one of these care coordination programs, please call (602)824-3900.

- Please be advised that dually-enrolled members have appeals and grievance rights in both their Medicare and Medicaid health plans.

CREDENTIALING AND REcredentialing process

The Credentialing Program is designed to reflect PHOENIX HEALTH PLANS standards, as well as federal and state regulatory requirements and national standards.

In order to establish consistent standards for participation, and to meet regulatory requirements, PHOENIX HEALTH PLANS has developed participation criteria. PHOENIX HEALTH PLANS will verify the credentials of physicians and other health care practitioners and incorporate ongoing assessments of the quality of care services provided by those physicians and health care practitioners as they participate in the network.
Credentialing Application

The Credentialing application is used to identify and gather specific information for all Providers that wish to participate with PHOENIX HEALTH PLANS. The PHOENIX HEALTH PLANS credentialing program determines whether physicians or other health care practitioners are qualified to perform their services and meet the minimum standards as defined by national standards. Primary source verification of all required credentials is an essential component of the program.

Applications will be considered complete under the following circumstances:

- The application is filled out in its entirety;
- The attestation page is signed and dated;
- The following documentation is enclosed with the application:

For Physicians and Health Care Practitioners:
1. Explanations to any questions regarding additional information
2. Copy of AZ State license
3. Copy of current DEA, if applicable
4. Copy of Board Certification or proof of board eligibility and exam date, if applicable
5. Copy of current malpractice liability

For Facility/Ancillary Providers
1. Copy of Clinical Laboratory Information Act (CLIA), if applicable
2. Copy of current DEA, if applicable
3. Copy of liability insurance
4. Copy of state license, if applicable
5. Copy of all accreditation certificates, as applicable
6. Copy of most recent State and/or Medicare Survey/Audit (NON-ACCREDITED FACILITIES)

Credentialing Policies

PHOENIX HEALTH PLANS has policies and procedures in place for both the initial and recredentialing process. These policies are subject to change and should be used as a guideline only. Final determination of credentialing status is the decision of the PHOENIX HEALTH PLANS Credentialing and Peer Review Committee (CPRC).

Providers that are not credentialed should not provide covered services to PHOENIX HEALTH PLANS members in an office or outpatient setting until the credentialing and contracting process has been completed without obtaining prior authorization.

Certain provider types will have a site visit and chart content audit prior to completion of the credentialing process.

Practitioner Credentialing Process

The following information is required and/or will be primary source verified:

- Absence of Medicare/Medicaid sanctions
- Board certification or proof of board eligibility and exam date
- Clinical privileges in good standing, if applicable
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www.phoenixhealthplans.com

- Current malpractice insurance
- Current, valid DEA or Controlled Dangerous Substances (CDS) certification
- Current, valid, unrestricted license
- Disciplinary status with regulatory board, or agency
- History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner
- National Practitioner Data Bank (NPDB) report
- Work history for five years with documented gaps (over 30 days)

All primary source information is to be no more than 180 days old, including the attestation when presented to the CPRC.

Recredentialing Process

All Practitioners will be recredentialed at a minimum of every three years. Recredentialing must be completed prior to the recredentialing date or the process can not proceed. If recredentialing is not completed by the due date, the provider’s contract may be terminated and, if applicable, members will be reassigned. The recredentialing process will be the same as the initial credentialing process with the inclusion of the following:

- All primary source verification must be current within 180 days when presented to the CPRC
- If Board Certification expires, renewal will be verified

In addition, the following information, if applicable, will be presented to the CPRC for consideration during the decision-making process:

- Medicare/ Medicaid sanctions
- State sanctions or limitations on licensure
- Member concerns including grievances (complaints), appeals and quality of care concerns

FALSE CLAIMS ACT

PHOENIX HEALTH PLANS encourages you to understand and provide training for your staff on the following aspects of the Federal False Claims Act:

- 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.

Refer to our website for educational tools and resources available to assist in staff education and training.

COMPLIANCE PROGRAM

PHOENIX HEALTH PLANS is committed to conducting health plan management administrative services in a manner that is consistent with recognized compliance standards.

PHOENIX HEALTH PLANS has documented these standards as part of its compliance program resources, which includes policies, procedures and training materials that provide guidance on federal and state laws, such as the Deficit Reduction Act (DRA) and False Claims Act (FCA) policy.
Please refer to Manual’s Attachment and Forms Section for more information about the DRA/FCA, which requires health plans and providers to train their personnel on the above listed provisions. Please note that PHOENIX HEALTH PLANS makes information about its compliance resources, including DRA/FCA training materials, available online at www.phoenixhealthplans.com and upon request.

Compliance program violations and suspected fraud, waste and/or abuse

As part of PHOENIX HEALTH PLANS compliance program, PHOENIX HEALTH PLANS also encourages health professionals and members to detect, report and prevent any suspected violations of federal and/or state laws as well potential fraud, waste and abuse. Fraud and abuse are defined as follows:

- **FRAUD** - an intentional deception or misrepresentation made by a person with the knowledge that the deception may result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. [42 CFR § 455.2]
- **ABUSE** - Provider practices that are inconsistent with sound fiscal, business, or medical practice, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. [42 CFR § 455.2]
- **ABUSE OF MEMBER** - Any intentional, knowing or reckless infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, emotional or sexual abuse, or sexual assault. [ARS § 46-451:13-3623]

Examples of Fraud, Waste and/or Abuse

The following list provides examples of fraud, waste and abuse. The list is intended for informational purposes and does not purport to represent the universe of actions which may be construed as fraud, waste and/or abuse.

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Failure to Refer to a Needed Specialist
Under and/or Over Utilization

Reporting Fraud and Abuse

If you have information about potential fraud, waste and/or abuse that is committed by a member, someone claiming to be a member, or a health professional or his/her staff, please contact the PHOENIX HEALTH PLANS compliance officer at (602) 824-3900 or, if out of area, dial 1-888-864-1114. You may also forward information about suspected fraud and abuse to:

Phoenix Advantage Health Plan
Attn: Compliance Officer
7878 North 16th Street, Suite 105
Phoenix, Arizona 85020

You may also report any incidents of suspected fraud to the national Office of the Inspector General Fraud Hotline at Dial 1-800-HHS-TIPS (1-800-447-8477).

All information provided to PHOENIX HEALTH PLANS regarding a potential fraud and abuse occurrence is maintained in the strictest confidence and in accordance with the terms and conditions of PHOENIX HEALTH PLANS compliance program policies and procedures and applicable law. Any information developed, obtained or shared among participants in an investigation of a potential fraud and abuse occurrence is maintained specifically for this purpose and no other.
The PHOENIX HEALTH PLANS compliance program works to insure compliance with all applicable laws, including, but not limited to:

Title XVIII of the Social Security Act
www.ssa.gov/OP_Home/ssact/title18/1800.htm

Title XIX of the Social Security Act
www.ssa.gov/OP_Home/ssact/title19/1900.htm

Title XXI of the Social Security Act
www.ssa.gov/OP_Home/ssact/title21/2100.htm

Medicare Parts C and D, 42 CFR §§ 422 and 423, respectively
(Go to Title 42 Public Health, click on 422 for Part C or 423 for Part D)
www.ecfr.gov

Patient Protection and Affordable Care Act (Pub.L. No. 111-148, 124 Stat. 119)

Health Insurance Portability and Accountability Act (HIPAA) (Pub.L.104-191)
http://aspe.hhs.gov/admnsimp/pl104191.htm

Federal False Claims Act (31 USC §§ 3729-3733)
www.falseclaisact.com/ffca_fcastatute.php

Federal Criminal False Claims Statutes (18 USC §§287, 1001)
www.ussc.gov/Guidelines

Anti-kickback Statute (42 USC § 1320a-7(b))
www.ssa.gov/OP_Home/ssact/title11/1128B.htm#f

The Beneficiary Inducement Statute (42 USC § 1320a-7a(a)(5))
http://codes.lp.findlaw.com/usc/code/42/7/XI/A/1320a-7a

Civil Monetary penalties of the Social Security Act (42 USC § 1395w-27(g))
http://codes.lp.findlaw.com/usc/code/42/7/XVII/C/1395w-27

Physician Self-Referral (“Stark”) Statute (42 USC §1395nn)

Fraud Enforcement and Recovery Act of 2009

Employee Retirement Income Security Act of 1974 (29 § USC §§ 1002)
www.dol.gov/dol/topic/health-plans/erisa.htm

Michigan False Claims Act (MCL 400.601-400.613)
www.legislature.mi.gov

Arizona False Claims Act (ARS § 36-2918)
www.azleg.gov