Quality Care Partners
Creating Partnerships for Life

2016 Provider Administrative Manual

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OVERVIEW I

Quality Care Partners (QCP) is a locally developed, not-for-profit physician-hospital organization (PHO) incorporated in 1995. We are strongly committed to improving and maintaining the health of the people we serve by providing excellence in medical management and the premier provider network in Southeastern Ohio.

Through partnerships with area businesses and carriers, QCP has successfully assisted employers in decreasing their overall healthcare and pharmacy costs.

Our mission is to be the premier comprehensive, cost-effective network coordinating quality healthcare services for all communities served.

To achieve our mission, QCP is committed to:

- Pursuing excellence in delivering and managing cost-effective healthcare based on each patient's needs.
- Focusing on prevention, appropriate care, and improving the health of the communities served.
- Providing a coordinated and comprehensive continuum of care to meet the needs of patients, payers, and the communities served.

Provider Administrative Manual

This **Provider Administrative Manual** is your reference guide and provides a comprehensive overview of the **QCP** procedures you are required to follow to ensure the efficient delivery of health care to your patients and timely payment to you for health care services rendered. This manual only applies to the services you provide to **QCP** members.

This manual is a supplement to the **QCP Participation Agreement**. QCP reserves the right to change the manual from time to time. QCP policies and procedures in force at the time of claim/occurrence supersede the QCP Provider Administrative Manual at all times.

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Networks

The member identification (ID) card identifies which network a member can access. Please see the payer-specific ID card section of this manual to determine whether the member you are seeing is a **QCP** member.

Quality Care Partners provides the network for many commercial plans, self funded employers and government plans such as: Medicare Advantage HMO Product- MediGold, Medicaid HMO Product- Paramount, and multiple commercial networks.

CONTACTS II

Key Contacts and Important Phone Numbers

CONTACT/AREA	WHEN TO USE	NUMBER
Medical Management Department	submission of requested medical documentation/records, prior authorization requests, Case review updates, initiation or verification	Phone: (888)258-7621 Or (740)455-5199 FAX: (740)455-8817
Network Services Department	Network issues, provider credentialing, claims pricing, contracting	Phone: (888)258-7621 Or (740)455-5199

MEMBER ELIGIBILITY and/or **BENEFITS** – Contact the phone number referenced on the back of the member's identification card.

CLAIM QUESTIONS – Contact the phone number referenced on the back of the member's identification card.

REIMBURSEMENT DISPUTES – Contact the phone number referenced on the back of the member's ID card.

AUTHORIZATION VERIFICATION – If **Quality Care Partners** is identified on the ID card as the utilization management vendor, call **QCP** Medical Management at (888)258-7621 or (740)455-5199 after verification of benefits through the TPA to initiate precertification.

PROVIDER RIGHTS III

Providers have specific rights during the credentialing and recredentialing process. The following list describes the provider rights. Practitioner rights are posted on the QCP network website.

- The provider has the right to review information submitted to support their credentialing application. This includes any information used to evaluate the application with the exception of references, recommendations, or other peer-review protected information.

- The provider has the right to correct erroneous information. If practitioner/provider indicates there is a need to provide corrected information, such corrections must be received within two weeks and must be submitted in writing. It can be submitted either to the Credentialing Specialist handling the credentialing application or the Provider Network Manager. Network Services in turn, will supply a written notification that the corrected information has been received and noted on the application.

- The provider has the right to receive status of their credentialing application on request. Network Services will respond with a status update in a timely manner. The response may be via voicemail, e-mail, fax or actual phone conversation.

Network Services will only advise as to receipt of the application and where in the process the application is. Steps in the process are: application receipt, application review, requests for clarification or request for missing documentation, committee review, denial, or approval.

- The provider has the right to receive notice/copy of their rights. QCP notifies practitioners of their rights by including them, as listed above, in this provider manual. Any provider can also request a copy of provider rights by phone, e-mail, fax or written correspondence.

PROVIDER RESPONSIBILITIES IV

PHYSICIANS

General Responsibilities

The following list describes your general responsibilities as a participating provider:

- Have a current, unrestricted license to practice medicine in the state which services are regularly performed
- Provide required credentialing documentation to QCP
- Work cooperatively with others and uphold the standard of ethics for the health care profession
- Be cost conscious in the provision of health care, without compromising quality patient care
- Abide by the policies of **QCP**
- Notify **QCP** immediately in writing of any reduction or cancellation of licensure status, tax identification numbers, telephone numbers, addresses, status at participating hospitals, loss of liability insurance, or any other change which would affect participation with **QCP**.
- Accept QCP members as patients and provide/coordinate all needed services to members as your patient load and appointment calendar permit and without regard to race, religion, gender, color, or national origin

Provider must meet the credentialing requirements for continued participation as indicated in the **QCP** Credentialing Program.

Primary Care Physicians

PCPs are responsible for providing and coordinating the medical care of members, and ensuring their continuity of care. PCPs are: General Internal Medicine, General Practice, Geriatric Medicine, Pediatrics and Family Practice.
A PCP is responsible for:

- Arranging for another **QCP** participating PCP to provide necessary coverage.
- Fully cooperating with any utilization review or case management programs developed by QCP to promote high standards of medical care and control costs.
- Arrange for medical care with necessary specialists
- Twenty-four hour healthcare coverage
- Provide general assessment of medical conditions to determine need for specialty care within **QCP** network when possible

Specialty Care Physicians

SCPs are responsible for providing medical care of members through self-referral or PCP referral. SCPs are American Board of Medical Specialty (ABMS) specialists excluding: Internal Medicine, General Practice, Geriatric Medicine, Pediatrics and Family Practice.

To be listed on the panel as a Specialist: Must be board certified or eligible, or have completed adequate training as defined by QCP Board of Directors.

Specialty Care Physicians are responsible for:

- Fully cooperating with any utilization review or case management programs developed by QCP to promote high standards of medical care and control costs.
- Twenty-four hour healthcare coverage
- Coordinate communication with primary care physicians

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Ancillary Providers

Ancillary providers include those providers who render non-physician services related to care (i.e., laboratory, durable medical equipment, home health care, physical or occupational therapy, etc.). Provider must meet the credentialing requirements for participation as defined by the **QCP** Board and coordinate care plans with physicians of QCP network.

Provider Directory: The QCP Provider Directory can be accessed at: www.qualitycarepartners.com

Laboratory Services: If a **QCP** member requires laboratory services, the following options are available within the plan:

1. Office may give the patient a prescription to take to any one of the approved participating hospitals or ancillary locations to have their lab work completed.
2. Offices that provide phlebotomy services may collect samples in the office and arrange pick up from a courier service that is associated with a participating lab. (Please call the participating laboratory that your office plans to utilize to arrange for the courier service).

Payers may elect to contract directly with a laboratory that is not considered a participating **QCP** laboratory. Providers are expected to use best efforts to educate members of lab utilized by their office.

Please see participating laboratories on **QCP's** website at www.qualitycarepartners.com.

Hospitals and Facilities

Facilities include, but are not limited to: any acute, skilled or rehabilitative facility, hospital, ambulatory surgery center, skilled nursing facility or rehabilitation facility. Provider must meet the credentialing requirements for continued participation as indicated in the **QCP** Credentialing Program.

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MEMBER INFORMATION V

ID CARDS

Health benefit plans are tailored to individual employers and payers. Therefore, members may present different ID cards and have varied levels of health benefits. However, ID cards usually essentially contain the following information:

- Name
- Employer
- Identification number
- Group and/or plan number
- Address for claims submission
- Submitter ID for electronic filing of claims
- Telephone number for verification of eligibility
- Telephone number for claims inquiries
- Precertification/Utilization information
- Phone number for Network Participation (Provider) verification

When providing services, it is important that you and /or your office staff remember to:

- Ask members to present their current ID card at each appointment
- Verify a member's eligibility for coverage via payer
- Identify the phone number for medical management, utilization management, and/or precertification requirements
- File claims electronically for faster reimbursement and claim tracking

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ID CARD EXAMPLE

You will see insurance cards with the QCP logos that include claims submission address. Through an affiliation agreement, QCP is part of a statewide network of providers, Ohio PPO Connect. Contracts held with QCP will be administered for groups bearing this logo on the ID card.

Logos, as well as billing addresses and payer IDs for QCP, QCP-Partners and Ohio PPO Connect are included, so you may easily identify the insurance cards.

A copy of the insurance card should be obtained at each visit to verify if a change has occurred. Claims submitted to the incorrect address may be returned for submission to the correct location.

Claims Submission address: QCP PO Box 595 Arnold, MD 21012 Emdeon Payer ID is 89461	**Claims Submission address:** Ohio PPO Connect PO Box 828 Arnold, MD 21012 Emdeon Payer ID is 74431 www.ohioppoconnect.com

If you have questions, please feel free to contact Quality Care Partners, 455-5199 or 888-258-7621.

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Member Eligibility

You and/or your office staff can verify member eligibility by calling the appropriate payor indicated on the member's identification card.

Please note, possession of an ID card does not guarantee coverage of benefits.

PLEASE REMEMBER, QCP CANNOT VERIFY ELIGIBILITY.

Covered Services

At the time of enrollment, members are given an Evidence of Coverage document. This document is designed to answer most questions that could arise regarding coverage and membership services. If a member has any questions that you are unsure of, please direct the member to contact the payer's telephone number on the back of their member ID card.

How to Identify a QCP Member

QCP Network members will have a logo imprinted on their identification card. The card will provide the name of the Third Party Administrator who manages the benefit plan, payment of claims, and the name of the employer who is providing the health insurance coverage.

QCP providers agree to accept the allowable fee schedule of the Network and are not permitted to Balance Bill the patient.

Benefit Verification

To verify benefits for your patient, please call the benefits verification phone number on the patient's Identification card.

PLEASE REMEMBER QCP CANNONT VERIFY BENEFITS.

Copayments and deductibles

Patients required to pay an office visit copayment may have the amount due indicated on their identification card. Members without and office visit copay may be responsible for a portion of the bill due to co-insurance (i.e. 20% co-insurance after deductible has been met).

Please contact appropriate payer for copay or coinsurance amounts if they are not indicated on the member's identification card.

THIRD PARTY ADMINISTRATORS VI

Third Party Administrators (TPAs)

QCP contracts with several payers. You may request a copy of QCP's Claim Submission Information Sheet at any time. Please refer to www.claimsbridge.net to request login information for claims reviews.

MEDICAL MANAGEMENT PROGRAM VII

Programs

Medical Management services are performed for selected QCP clients. The following section details the QCP Medical Management programs. Employers/Payers have the opportunity to take advantage of all services below.

QCP Medical Management services include:

QCP Medical Management department will promote the health of our population. Care Management will empower clients to be appropriate users of healthcare by providing the tools and resources that will engage consumers in the process of lifestyle, health and healthcare self-management. Care managers will support early identification of health issues and encourage members to take an active and informed role in their healthcare decisions.

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Utilization Management Program

To obtain access to on-line precert initiation tools, contact QCP at (888) 258-7621.

Case Management Program

To refer a patient to QCP Case Managers call (888) 258-7621 or contact us at www.qualitycarepartners.com .

Case Management is a proactive approach designed to provide support to members with complex or chronic diagnoses with an acute episode or issue requiring coordination or monitoring of services such as therapies, home care, DME, specialty clinic, specialist, etc. Patients with compliance issues, knowledge deficits, or need for emotional support can benefit from this program. This involves collaboration with the individual and/or physician. Interventions are aimed at keeping membership healthy, improving their health, and/or helping them accept and live more productive lives with chronic disease. Quality, holistic care plans are developed in partnership with participating providers. These focused care plans are time specific and action oriented with total health management in mind.

Disease Management Program

Disease Management is a population-based strategy. Members with targeted chronic disease have risk factors that can be reduced with lifestyle changes and compliance with treatment/guidance. National evidence based medicine guidelines are evaluated and supported in optimizing self-management techniques. The goals of Disease Management are to manage the disease process in order to minimize the occurrence of complications and the need for costly medical intervention in the future.

Diseases Generally Targeted for Disease Management Include:

- Diabetes
- Chronic Obstructive Pulmonary Disease
- Asthma
- Maternity

The Process of Disease Management Includes:

- Evaluation of baseline understanding of disease
- Evaluation of Medical Screening Schedule
- Evaluation of Behavioral and Lifestyle Risk Factors
- Evaluation and Engagement of Family and Support Systems
- Providing Education on the Disease Process
- Providing Education on Self-Management Tools

Wellness Promotion

QCP will follow URAC guidelines for Wellness and will support Payers and Members in tailoring the product to include multiple interventions to support:

- Risk Identification
- Risk Assessment
- Prevention
- Motivational Ready for Change
- Healthy Lifestyles

The information secured from a mutually agreed upon web-based/self-report health risk assessment will be used to drive multiple Medical Management Programs that will be administered by QCP. This tool provides for risk stratification and identification for four (4) nursing initiatives:

- Wellness coaching
- Care Coordination
- Disease Education & Management
- Case Management

Provider Medical Necessity Reconsiderations/Appeals

Medical necessity determination may be submitted directly to **QCP via fax (740) 455-8817 or through web portal at www.qualitycarepartners.com.** Reconsiderations must be made in writing, directly from a provider, and should include all information relevant to making the medical necessity determination. The reconsideration must be submitted within thirty days of the denial. Please call the **QCP** Med Management Team at (888) 258-7621 or (740) 455-5199 for questions regarding additional information that is helpful in making specific determinations. **QCP** provides one level of reconsideration for providers. The reconsideration request and submitted information will be reviewed and the provider will be notified within 30 days of the decision.

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CLAIMS VIII

Claims Submission

Claims are to be sent to the appropriate address identified on the member's identification card.

QCP requires that the physician file the patient's claim to the appropriate claims submission address.

Claims must be filed within 180 days from date of service or reimbursement may be denied. The claim should be submitted electronically in 5010 format. If a paper claim submission is needed, please submit all physician charges on a standard CMS-1500 form. Submit all inpatient and outpatient facility charges on a standard UB-04 form. The claim must include the group number and employer group name. This information will be on the patient's identification card. Missing information will delay adjudication and may cause the claim to reject.

Claims are processed by the employee's Health Plan. Please call them with any questions about a specific claim. **QCP** does not adjudicate any claims.

Guidelines

All claim fields must be completed when submitting claims. QCP requires that providers make best efforts to submit claims electronically in 5010 format. When a paper claim is required the most current version of the 1500 or UB should be used. Please follow the industry-standard instructions published by the authors of the forms to determine appropriate completion. In addition:

- Verify that a member's name and ID number is entered exactly as it appears on the member's ID card
- Verify that the group number listed on the member's ID card is listed on the claim
- List dates of service in chronological order, with separate charges itemized on separate lines
- Attach an operative, radiology or pathology report to claims with unusual or extended procedures
- Provide concise descriptions of unlisted or not otherwise classified (NOC) procedure codes

- Identify the applicable modifiers, which comprise the use of a 9 modifier
- Submit a different claim form for each provider and member by utilizing the correct NPI number
- Submit claims with an Explanation of Benefits (EOB) from the primary carrier when the member has other insurance coverage and that carrier is the primary carrier
- Identify the individual provider of the service
- Electronic claims should be submitted to the location indicated on the member's card.
- Paper claims should be directed to the address indicated on the member's ID card and only when electronic submission is not possible
- Assure NPI numbers are correct

Claims Inquiries

Providers with claim inquiries should contact the appropriate company and contact indicated on the member's ID card. When making an inquiry, please have the following information available.

- Provider name and tax ID number
- Member name and ID number
- Date of Service
- Claim number
- Employer group name/number

Reimbursement

All providers are reimbursed in accordance with your **QCP** Participation Agreement.

Any questions concerning claim status, denials, request for information or potential payment error should be directed to the TPA that adjudicated the claim.

QCP performs repricing of network claims. Web based access is available through QCPS vendor: www.claimsbridge.net.

Coordination of Benefits

1. The Explanation of Benefits (EOB) and claim should be submitted to the appropriate TPA for claim adjudication.
2. Providers must abide by the TPA rules regarding Coordination of Benefits.
3. The payment will be made based on the Coordination of Benefits language identified in each Summary Plan Description determined by the payer.

Claims Appeal Process

Each Provider is entitled to a full and fair review of any denial of a claim or claim payment issue. Please contact the appropriate payer for the claim appeal process for all claim and payment related issues. Claim appeals must be submitted in writing within one year of the explanation of benefits.

DISPUTE RESOLUTION IX

Quality Care Partners is committed to meeting and exceeding the expectations of its providers. QCP investigates all disputes in a timely manner and attempts to resolve them at the provider relations level. If a problem cannot be resolved, a formal Grievance Procedure is available to members and providers.