Provider Manual

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Purpose

The Provider Manual serves as a reference guide and educational resource for physicians, ancillary providers and their staff. It is a source for answers to some of the most common questions that providers have about working with GMG. It expands upon and explains some of the GMG policies and procedures referenced in your provider agreement.

Please be advised that nothing in this Provider Manual or the GMG provider agreement is intended to or shall be interpreted to discourage or prohibit a participating provider from discussing with a member treatment options or providing other medical advice or treatment deemed appropriate by a participating provider.

This Provider Manual is made available to all providers via digital format, email or fax.

Gonzaba Medical Group affirms the following:

- Utilization Management (UM) decision making is based only on appropriateness of care and service and existence of coverage.
- The Gonzaba Medical Group (GMG) does not specifically reward practitioners or other individuals for issuing denials of coverage.
- Financial incentives for UM decision makers to not encourage decisions that result in underutilization.

Please Note: If any provision of this Provider Manual comes in conflict with state or federal law or the terms of your provider agreement, the current federal law or state law as applicable takes precedence. The policies and procedures described in this manual are subject to modification, addition and/or deletion. All updates will be incorporated into the online Provider Manual; in some instances, providers may receive additional communication in one of the various formats including, but not limited to; newsletters, mailings, fax blasts, web postings and/or manual revisions that will be incorporated into the online Provider Manual

Provider Relations

Gonzaba Medical Group is committed to make it easy for providers to do business with us. We hope you find we simplify our processes, give you reliable information and are responsive to you and your staff.

- The Credentialing Team can assist with any Credentialing issues and updates to demographic information and directory information.
- Our Network Contract Team will be available to assist with any contracting questions. Responsibilities include educating and servicing physicians, and their office staff.
- Our Referral Staff can assist with Referral and prior authorization submission process, verifying member eligibility, helping you to obtain UM criteria, etc. Business hours 8:00 AM – 5:00 PM Monday through Friday.
- Our Referral Staff can assist with Referral and prior authorization submission process and verifying member eligibility. The Utilization Management (UM) criteria may be obtained through our UM/Referral Department upon request. Business hours 8:00 AM – 5:00 PM Monday through Friday. For individuals that need language assistance, they can contact Case Management who will facilitate connecting with an interpreter.

Department	Phone	Fax	Email
GMG Referrals	(210) 921-3801	(210) 334-2862	Kenneth.sterling@gonzaba.com
GMG Case Management	(210) 890-4441	(210) 334-2864	Gmgmccasemanagement@gonzaba.com
GMG Claims Customer Service	(210) 201-0489	---	https://eznet.innovistaportal.com
GMG Delegation/UM	(210) 921-3801	(210) 334-2862	Claudia.jacobo@gonzaba.com
Provider Relations	(210) 903-8819	(210) 921-5763	Frances.ortiz@gonzaba.com
Credentialing	(210) 890-4272	(210) 334-2851	Credentialing@gonzaba.com
Network Contracting	(210) 903-8819	(210) 921-5763	Frances.ortiz@gonzaba.com
Business Office	(210) 960-3908	(210) 921-5763	Billing@gonzaba.com
Medical Records	(210) 905-4519	(210) 334-2861	Guadalupe.maldonado@gonzaba.com

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Participating Provider Responsibilities

1. Manage the medical and health care needs of health plan members/patients, including monitoring and following up on care provided. Provide coordination necessary for services provided by specialists and ancillary providers (both in and out-of-network) and maintaining medical records meeting GMG Standard (*refer to Section 1n. in the Provider Contract for GMG medical record standards*).
2. Provide coverage 24 hours a day, 7 days a week; regular hours of operation should be clearly defined and communicated to health plan members/patients.
3. Provide all services and treat all patient ethically, legally and in a culturally competent manner, and treat patient disclosures and records confidentially, giving patients the opportunity to approve or refuse their release.
4. Work to meet the unique needs of health plan members/patients with special health care needs.
5. Participate in systems (*refer to Section 1n. in the Provider Contract)* established by GMG to facilitate the sharing of records, subject to applicable confidentiality and HIPAA requirements and with all applicable federal and state laws regarding the confidentiality of patient records.
6. Make provisions to communicate in the language or fashion primarily used by the patient.
7. Provide hearing interpreter services upon request to health plan members/patients who are deaf or hard of hearing.
8. Participate in and cooperate with GMG in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established by GMG.
9. Help foster open communication and cooperation with Quality Improvement (QI) activities. Support and cooperate with GMG Quality Improvement program initiatives.
    - Cooperate with QI activities, including collection of performance measurement data and participation in the GMG's clinical and service measure QI programs.
    - Allow GMG to use provider performance data for quality improvement activities, as outlined contractually.
    - Allow the Plans as specified in Exhibit D of the Participating Provider Agreement to use their performance data.
10. Comply with Medicare laws, regulations, and CMS instructions, agree to audits and inspections by CMS and/or its designees, cooperate, assist, and provide information as requested, and maintain records for a minimum of 10 years.
11. Participate in and cooperate with the GMG appeal and grievance procedures.

12. Agree to not balance bill health plan members/patients for monies that are not their responsibility or that should be paid for by another carrier.
13. Continue care in progress during and after termination of a health plan member/patient's contract for up to 60 days, or such longer period of time required by state laws and regulations, until a continuity of service plan is in place to transition the health plan member/patient to another network provider in accordance with applicable state laws and regulations.
14. Develop and have an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood-borne pathogens.
15. Establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act of 1990 (ADA)
16. Inform GMG if a health plan member/patient objects to the provisions of any counseling, treatments, or referral services for religious reasons.
17. Provide health plan members/patients complete information concerning their diagnosis, evaluation, treatment, and prognosis and give them the opportunity to participate in decisions involving their health care, except when contraindicated for medical reasons.
18. Advise health plan members/patients about their health status, medical care or treatment options, regardless of whether benefits for such care are provided under the program and advise them on treatments that may be self-administered.
19. When clinically indicated, contact health plan members/patients as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings.
20. Have a policy and procedure to ensure proper identification, handling, transport, treatment, and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
21. Agree to maintain communication with the appropriate agencies such as local police, social services agencies, and poison control centers to provide high-quality patient care.
22. Provide advanced notification to health plan members/patients of services that are not covered by the plan or Medicare in accordance with Medicare requirements. Please refer to Provider Obligations — Precertification.

Provider Information Change Request

Providers may update their GMG provider data emailing the following information to our Credentialing Department at credentialing@gonzaba.com.

Common provider information changes may include:

- Office Physical Address
- Office Phone or fax number
- Office Billing Address
- Tax ID Number

Verifying Eligibility

The Health Plan record is always considered the primary source for a member's eligibility. A provider should verify their enrollee's eligibility directly with the applicable health plan, either through their secure portal, or through contacting the provider customer service department. It is a provider's responsibility to verify member eligibility at the time of service.

Verifying Eligibility with CMS

Providers may verify eligibility directly with CMS for any Medicare Advantage Plan (MAP). If member eligibility cannot be verified with the applicable health plan, CMS can verify if the member is enrolled in an MAP plan or not.

To verify eligibility through CMS, please contact:

Medicare Eligibility:
Texas IVR: 1-855-252-8782

For other Medicare related questions visit http://www.cms.gov/ or call

Medicare Provider Service:
Texas: 1-800-633-4227

Copays and Coinsurance

It is the provider's responsibility to collect co-payments and co-insurance directly from the patient at the time services are rendered.

Copayment - a fixed amount charged to a MA enrollee on a per service basis.
Co-insurance - percentage of allowed charges for which the enrollee is responsible.

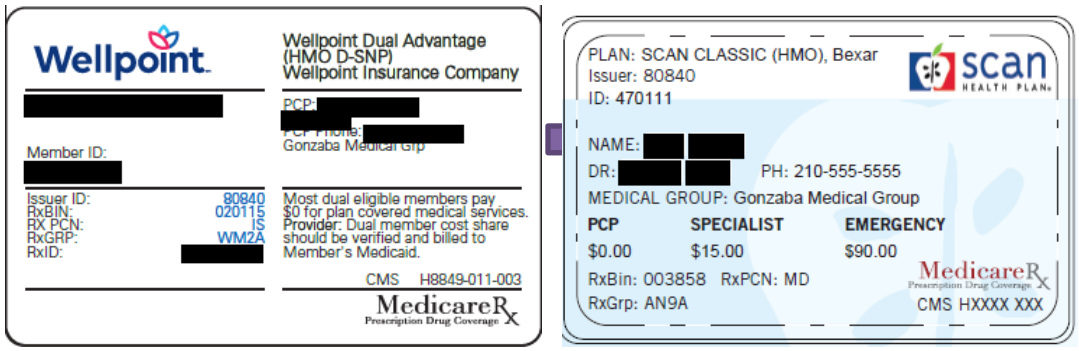
Contracted providers must not bill or collect any amount in excess of the maximum allowable except for the applicable co-payments and co-insurance.

Non-Covered Services

Providers may charge GMG patients for non-covered services. However, such charges must be the usual and customary fee that the provider charges all other enrollees. The patient must agree in writing to accept responsibility for the non-covered service prior to receiving that service. Providers must utilize the Advance Beneficiary Notice of Noncoverage for this purpose.

Claims Submissions

GMG is responsible for paying claims for <u>Wellpoint (previously Amerigroup) and SCAN</u> patients that are sent to you for healthcare services. **<u>Wellpoint (previously Amerigroup) and SCAN</u>** patients under GMG have been issued new ID cards. Note that "**Gonzaba Medical Grp**" and "**Gonzaba Medical Group**" appears on the front of the ID card. This will help Network staff to identify the patients under the GMG contract. The card includes the claims address information on the back, detailed below.



- **Claims should be submitted electronically to PayerID: GMGSA**
  Electronic submission is preferred, but you are also able to submit paper claims via <u>mail</u>.

GMG Claims
PO Box 7997
Westchester IL 60154

- **EZNET portal** is available to allow Network staff to inquire online about authorizations, claims status, payment, or even to enter referral requests. **Contact GMG Provider Relations to obtain EZ NET login/password.**

- **Submit your appeal packet with the GMG Appeal Form by email to:**

<u>appeals@innovista-health.com</u>

GMGSA Claim Appeal Process

A written appeal request is required (e-mail, fax, or mail). Once the request has been received, all the information provided will be taken into consideration in the determination review.

An administrative appeal does not include a medical review of a member's medical conditions or member's need due to medical necessity. Turnaround time for review is within **30 calendar days from the received date**.

All medical review appeal requests are reviewed by a licensed provider and\or clinician. Turnaround time for medical appeal reviews is **45 calendar days from the received date**.
In your request, include detail information to be considered and reviewed, including why you believe we should change our decision.

- GMG Appeal Form (*form attached on next page*)
- Requestor's name, phone number, E-mail Address
- Member Name
- Member Date of Birth
- Member ID number
- Doctor's name
- Date of the service
- Original Claim in PDF form
- Previous Denial letter
- Any other information or documents that are pertinent to Date of Service

The First Level of Appeal

The First Level of Appeal must be received by (e-mail, fax, or mail) within **90 calendar days** from the date of the original denial, unless otherwise specified. If the Provider fails to submit a written request of GMG's decision regarding compensation **within 90 days** will waive Provider's right to appeal such decision. This will automatically be deemed final and unappealable.

The Second Level of Appeal

The Second Level of Appeal must be received by (e-mail, fax, or mail) within **120 calendar days from the last denial**, unless otherwise specified. If the Provider fails to submit a written request of GMG's decision within **120 calendar days**, it shall automatically waive Provider's right to appeal such decision. This will automatically be deemed final and unappealable.

If a refund is due, any additional amounts due GMG/Provider shall be paid by the other Party within **30 calendar days of notice**. If Provider does not submit the refund payment due within **30 calendar days of written notification to Provider**, **GMG Plan shall have the right to recoup the non-payments from future claims**. Notwithstanding the foregoing, consistent with the Fraud Enforcement and Recovery Act which modified the federal False Claims Act, in all instances Provider shall report and return any Overpayment to GMG **within 60 calendar days** after the Overpayment was identified.

Telephone Inquiries

For GMG Claims customer service line dial (210) 201-0489 or via email at appeals@innovista-health.com

Customer Service Representatives:

GMGSA, Customer Service Representatives are available to assist Monday through Friday from 8:00 a.m. to 5:00 p.m. central standard time. With the exclusion of the following holidays:

- New Year's Day
- Martin Luther King, Jr. Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving holiday (Thursday and Friday)
- Christmas Eve
- Christmas Day

Can assist with:

- Clarifying the denial reason associated with a claim
- Providing general information regarding coverage
- Explaining terminology and information
- Assisting with other issues

GMG is responsible for paying claims for Wellpoint (previously Amerigroup) and SCAN members that are referred to other healthcare services.

Providers are able to check claims status at: https://innovistaportal.com/claim-status

All Appeals and Reconsiderations requests should have a GMG appeal form (*form on the next page*) attached and emailed to:

appeals@innovista-health.com

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Provider Dispute Claim/Reconsideration Request Form

Today's Date: _____ **Medical Group:** _____

Member Information

Member Insurance plan	
Member Last Name:	First Name:
Date of Birth:	Member Identification Number:

Physician/Provider

Contact Name:	Phone Number:
Practice/Facility Name:	
Rendering Provider Name:	
Tax Identification Number (TIN):	NPI Number:
Return Address information	
Street Address:	City:
State:	Zip:

Reason for Request

Date of Service:	Claim Number:
Total Charges:	Expected Amount Owed:

- ☐ 1. Previously denied / Exceeds Timely Filing: must provide proof of timely filing
- ☐ 2. Previously denied requesting additional information: must include requested documentation
- ☐ 3. Previously denied / Coordination of Benefits: must include Primary EOB
- ☐ 4. Previously adjudicated but applied incorrect rate resulting in over/underpayment: Indicate details in comments
- ☐ 5. Previously denied for "no authorization": Indicate Authorization number or attach copy of authorization
- ☐ 6. Other (Provide details below)

  Comments – reason for appeal:

Please include a copy of the initial claim, along with other documents supporting the request for an appeal and email to appeals@innovista-health.com.

Medicaid

Medicaid is the program that provides access to health care for low-income families and individuals. Medicaid also assists aged and disabled people with the costs of nursing facility care and other medical expenses. Eligibility for Medicaid is usually based on the families or individual's income and assets. Many dual eligible patients (those that have Medicare and Medicaid) enrolled in a Medicare Advantage Plan will have no co-payments or co-insurance.

If you are uncertain as to an enrollee's Medicaid eligibility, you may contact Texas Medicaid & Healthcare Partnership (TMHP) for additional information:
Texas: 1-800-925-9126 www.tmhp.com

Referrals to Contracted Providers

Primary Care Physicians are required to refer enrollees within the GMG contracted network. Occasionally, it may be necessary to refer to an out-of-network provider when a service is required that is not available within the network. All out-of-network services require Prior Authorization. Requests for referrals should be faxed to 210-334-2862 along with clinical patient documentation supporting medical necessity of the request.

Pharmacy Services

Part D Medications
Physicians are expected to use the current health plan formulary as the first step in the patient's pharmaceutical treatment. For drug requests not on the health plan's formulary, will require completion and submission of the health plan non-formulary exception request form by the prescribing physician. At times, there may be a need to prescribe outside of the formulary.

You can find out if a drug has any additional requirements or limits by looking at the pharmacy formulary information on the applicable health plan's website.

Enrollee Direct Access Services

Enrollees have direct access to the following services without going through their PCP:

- Annual Well Woman Exam
- Annual Mammogram
- Disease Management programs
- Hearing exam (coverage varies by benefit plan)
- Vaccines
- Optometry – Annual eye exam and glasses (coverage varies by benefit plan)
- Out-of-area dialysis

Cultural Competency and Language Assistance

GMG strives to provide services in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds by providing a culturally diverse provider network. We gather information from providers concerning languages other than English that are spoken in each office.

Providers are encouraged to deliver care in a manner that is sensitive to the cultural background and language of the enrollee. It is required by law and the responsibility of the provider to obtain and pay for interpreters for language interpretation other than English, as well as for visually impaired, hearing/vision impaired, hard of hearing and speech disabled enrollees. At a minimum this involves arranging for a language interpreter for enrollees who do not speak English.

Non-Discrimination

GMG employed and contracted providers maintain a policy of non-discrimination to all enrollees on the basis of race, color, national origin, disability, sex, sexual orientation or sexual identity, marital status age, mental or physical disability or medical condition, such as ESRD, religion, claims experience, medical history, or genetic information. In accordance with Title VI of the Civil Rights Act of 1964, et seq., Section 2000d Rules and Regulations or as otherwise provided by law or regulation.

Provider Administrative Dispute Resolution

GMG defines the provider dispute resolution process to ensure that all provider complaints, grievances, and concerns are handled appropriately and in compliance with the contract, CMS, State Regulatory and health plan requirements. This resolution process is available to all participating providers.

GMG encourages its providers to express any concern or dispute in the form of a written complaint. The written account should include:

- Provider/Organization name, address, Tax ID
- Description of the Dispute
- Expected Outcome
- Contact Name, Title, Phone, Fax, Email
- Any additional information or documents

Once completed, the written account should be submitted for review and processing to the Compliance Department at the following address:

Gonzaba Medical Group
Attn: Compliance Officer
720 Pleasanton Rd
San Antonio, TX 78214

Administrative disputes will be reviewed within 30 days of original request receipt. A final written communication will be sent to the provider addressing the concerns and explaining the outcome/resolution.

UTILIZATION MANAGEMENT (UM)

GMG Utilization Management (UM) Program includes the evaluation of requests for coverage by determining the medical necessity, appropriateness and efficiency of the health care services under the applicable health benefit plan. UM services will be provided where licensed or permissible under state and federal law, or other regulatory authority.

The Chief Medical Officer (CMO) has senior level executive responsibility for UM and reports directly to the President and Chief Executive Officer (CEO).

GMG adheres to the following guidelines when administering its UM Program:

- It is the responsibility of the PCP/attending provider to make clinical decisions regarding medical treatment. These decisions must be made consistently with generally accepted principles of professional medical practice and in consultation with the patient.
- It is the responsibility of GMG to determine benefit coverage based on the patient's health plan benefits. GMG uses Medicare medical necessity guidelines, plan specific utilization criteria, if applicable, to evaluate requests for coverage.
- All utilization review decisions to deny coverage are made by qualified, licensed physicians, or when appropriate and when allowable by law, by licensed health care professionals with expertise in the specialty for which services are being requested.
- GMG does not compensate individuals conducting utilization review for issuing denials of coverage, and it does not provide financial incentives for UM decision-makers to encourage denials of appropriate coverage.
- Financial incentives for utilization review do not encourage decisions that result in underutilization.
- UM decision-making is based on medical necessity, applicable coverage guidelines and appropriateness of care and service.

Medical Necessity Guidelines

GMG determines benefit coverage for the benefits described in each patient's health plan product description by using Medical Necessity Guidelines (MNGs) to determine the medical necessity and appropriateness of health care services under the applicable health benefit plan. These utilization review MNGs are:

- Developed in accordance with standards adopted by national accreditation organizations and regulatory and government entities.
- Reviewed on an annual basis and updated as new treatments, applications and technologies are adopted as generally accepted professional medical practice.
- Evidence-based
- Applied in a manner that considers the individual health care needs of the member and characteristics of the local delivery system.
- Evaluated at least annually for the consistency with which those involved in utilization review apply the MNGs in the determination of coverage.
- GMG also utilizes some commercially purchased criteria. The use of these criteria is also reviewed in the manner described above.
- MNGs are used by providers when making coverage determinations for Managed Care patients. MNGs can be made available to the requesting provider by calling GMG Referrals Department at (210) 921-3801. A printed copy of coverage determination can be sent to the requestor by mail, fax or email upon request.
- Ensuring that you provide the correct and complete clinical information at the correct time when requesting a medical necessity review when clinical information is needed.
- If the information provided does not support medical necessity, the service cannot be approved under Medicare law. Please provide the necessary information to justify the services you are requesting at the time of the request to allow for an appropriate decision to be made. Any service determined to require a clinical review will be processed in accordance with:
    - Section 1861(a)(1)(A) of the Social Security Act, which states that Medicare payment can only be made for services/items that are medically necessary and reasonable.
    - Section 1833(e) of the Social Security Act, which states that Medicare payment can be made only when the documentation supports the service/item.

Timeliness of UM Decisions

UM review decisions will be made in a timely manner. The decision will be made as expeditiously as the enrollee's health condition requires, but no later than the time periods outlined below. Both the determination and notification to the patient and requesting provider must occur within the defined time periods.
Timeframes are as follows:

- **For standard, non-urgent preservice decisions**, determination must be made within 14 calendar days of receipt of the request.
    - GMG may extend the time frame up to 14 calendar days
    - This extension is allowed to occur if the patient requests the extension or if GMG justifies a need for additional information and documents how the delay is in the interest of the patient (for example, the receipt of additional medical evidence)
    - GMG must notify the patient, in writing, of the reasons for the delay, and inform the patient of the right to file a grievance if he or she disagrees with the decision to grant an extension.
- **For expedited, urgent pre-service decisions**, determination must be made within 72 hours of receipt of the request.
    - A patient, or any physician may request an expedited determination when they believe that waiting for a decision under the standard time frame could place the patient's life, health, or ability to regain maximum function in serious jeopardy.
    - If unable to make a decision due to lack of necessary information, the decision can be extended once for up to 48 hours.
    - GMG must notify the patient or their authorized representative what specific information is necessary to make the decision.
- **For urgent concurrent review decisions**, the determination and notification (patient and requesting provider) will be made within 24 hours of receipt of the request.
- **For post service/retrospective decisions**, the determination and notification (patient and requesting provider) will be made within 30 days of receipt of the request

Denials/Unfavorable UM Determinations

The requesting service practitioners are given the opportunity to discuss UM denial decisions with an appropriate reviewer: senior physician, other appropriate reviewer, behavioral healthcare reviewer or pharmacist reviewer. The Referral staff is responsible to document in the record that practitioners are provided the opportunity to discuss UM denial determinations with an appropriate reviewer. Contact information of the reviewing provider will be provided upon request for denial review discussion or a “peer to peer” discussion. This applies to non-BH, BH (Behavioral Healthcare), and Pharmacy reviews.

Thank you for contracting with Gonzaba Medical Group!