

## Section 1:

### PRIMARY CARE PROVIDER RESPONSIBILITIES

- The Provider will provide a comprehensive range of primary care services including assessment, diagnosis and treatment of conditions not requiring a specialist.
- The Primary Care Provider will provide case management services, which include making appropriate referrals for specialty and inpatient care. Case management also includes follow up on all specialty treatment with an emphasis on continuity of care.
- The Primary Care Provider will not make fee-for-service referrals to other primary care physicians (i.e. general practice, family practitioners, pediatricians, internists) or primary care clinics except for obstetrical or gynecological services.
- The Primary Care Provider has the responsibility to identify specialist Medicaid providers for each instance when such services are determined to be necessary for the enrollee.
- The Primary Care Provider shall provide health screening examinations, diagnostic and treatment services for enrollees in accordance with the Child/Teen Health Program standards, and a behavioral health screening for all members, as appropriate.
- Primary Care Providers shall not seek or accept additional or supplemental payment from the enrollee or his family. Services shall be provided to enrollees of this plan in the same manner as any other patients receiving services from the Provider.
- The Provider may not bill the enrollee for any services covered by Managed Care Plan, except for applicable co-pays, co-insurance or permitted deductibles.
- The Primary Care Provider will maintain a comprehensive, current medical record, which shall be subjected to confidentiality restrictions.
- The Provider will implement a system to record and report health care services provided to enrollees on an encounter basis. These encounter records will be submitted monthly. In addition, the Provider will provide semi-annual reports of women who receive obstetrical care, and the number of Child/Teen Program services provided.
- The Primary Care Provider will obtain complete current information concerning a diagnosis, treatment and prognosis in terms the member can be expected to understand. When it is not advisable to give such information to the enrollee, the information is to be made available to an appropriate person acting on the enrollee's behalf.
- The Primary Care Provider will provide information to members as necessary to give informed consent prior to the start of any procedure or treatment.
- The Primary Care Provider shall maintain 24 hour, 7 day-a-week telephone coverage to advise enrollees of procedures to obtain emergency medical and health care services. **Medicaid enrollees must have access to a live voice for after hours care.**

- If a provider's license, certification or registration is revoked or suspended by the state, the provider will be terminated from the plan. (see section \_\_\_\_\_ PCP Terminations).
- Provider's that are sanctioned by the Department of Health's Medicaid Program will be excluded from the participation in the plan.
- Provider must develop policies and procedures to assure confidentiality of HIV related information which include:
  1. Initial and annual in-service education to staff and contractors
  2. Identification of staff allowed to access and limits of access
  3. Procedure to limit access to trained staff (including contractors)
  4. Protocol for secure storage (including electronic storage)
  5. Procedures for handling requests for HIV related information
  6. Protocols to protect persons with or suspected of having HIV infection from discrimination
- Providers must educate their enrollees about the risk and prevention of sexually transmitted disease (STD). Providers must screen and treat members for STDs and report cases to the Local Public Health Agency and cooperate in contact investigation, in accordance with existing state and local laws and regulations.
- Providers must comply with lead poisoning screening and follow up.
- Providers must follow the appointment and availability standards which are as follows:
  - For emergency care: immediately upon request at a service delivery site.
  - For urgent care: within 24 hours of the request
  - Non-urgent sick visits: within 48-72 hours of the request, as clinically indicated
  - Routine non-urgent, preventive appointments: within 4 weeks of request
  - Adult baseline and routine physicals: within 12 weeks from enrollment in managed care plan.

***Please note: Gold Choice members with appointments shall not routinely be made to wait more than one hour.***

## Section 2: Referrals and Authorization

**2a) Referred Services** means those services that are coordinated by Gold Choice and require authorization by Gold Choice or the PCP.

The Primary Care Provider is responsible for the referral and authorization of the following services:

1. Specialty physician services (including OB/GYN, radiology and ophthalmology services).
2. Specialty clinic services
3. Laboratory services – (except Alcohol & Drug toxicology testing protocols)
4. Radiological Services (physician and clinic)
5. Inpatient service in any licensed general hospital
6. Podiatry
7. Certified home health services (all services provided by a Certified Home Health Agency).
8. Durable medical equipment (Home Health Agency Supply and Equipment (0261), Personal Care Agency Supply and Equipment (0262), prosthetic and orthotic devices, hearing aids.
9. Services provided by physical, occupational and speech therapist.
10. Therapies such as speech, occupational, physical or rehabilitative services provided by independent therapist, clinic, or certified home health agency
11. Audiology.
12. Outpatient surgical procedures.
13. Outpatient diagnostic testing

Should any provider render family planning and reproductive health services they do so as a Medicaid Fee-For-Service practitioner.

Specialist bill Medicaid fee-for-service for the services listed above.

An enrollee diagnosed as having a life-threatening condition or disease or degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time is eligible for a specialist to serve as the member's PCP. (Requires agreement of PCP, MCO, specialist, pursuant to a treatment plan).

An Enrollee must be diagnosed as having a life-threatening condition or disease, a degenerative and disabling condition or disease either of which requires specialized medical care over a prolonged period of time may ask their primary care doctor for a **standing referral**. A standing referral may be good for a long period of time, not just one or two visits. (Requires agreement of PCP, MCO, specialist, pursuant to a treatment plan).

Members may self refer to public health agency facilities for the diagnosis and treatment of tuberculosis.

## **2b) Specialist billing information**

Referral forms must contain the following information (form attached):

- Medicaid Client Name
- Date of Birth
- Clients current address and telephone number.
- Medicaid Client Identification Number (CIN).
- Date of Referral
- Diagnosis
- Procedure or expected treatment
- Name of Primary Care Physician
- Name of referred provider (physician or clinic) consultant.
- MMIS number of the referring physician. (the specialist will need this information to receive payment from Medicaid).

The provider may also give a verbal authorization and/or use a script as a referral as long as the above information is included.

If you need more referral forms please contact provider relations at 898-6224.

## **2c) Non-Covered Services**

The following are non-covered services and do not require a referral or authorization by the Primary Care Provider:

1. Prescriptions
2. Dental Care
3. Outpatient mental health/alcohol & substance abuse services
4. Optometrist, including glasses
5. Routine transportation for medical services
6. Personal care services
7. Mental retardation services
8. Methadone maintenance treatment
9. Health related or skilled nursing services
10. Comprehensive medical case management
11. Family planning/reproductive health services

*In addition: Enrollees will have unrestricted access to full range of HIV pre-test and post-test counseling and testing.*

*Please Note: Should any PCP render family planning and reproductive health services, they should do so as a Fee-For-Service Medicaid Practitioner.*

### Section 3: Emergency Services

“Emergency Medical Condition” means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (b) serious impairment to such person’s bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

The primary care provider shall main coverage 24 hours a day, 7 days a week.

Enrollees must have access to a live voice for after hours PCP emergency consultation and care. If the provider uses an answering machine, the message must direct the enrollee to a live voice to advise enrollees of procedures for accessing emergency medical conditions and for accessing services for urgent medical conditions. (This includes emergency consultation and care for pregnant enrollees after hours).

**Emergency Services are not subject to prior approval.**

## Section 4: Billing

### 4) Medicaid Recipients Cannot be Billed

When a provider accepts Medicaid recipient as a patient and agrees to bill Medicaid for the services provided, the provider is prohibited from requesting any monetary compensation from that individual, or his/her responsible relative, except for Medicaid co-payments, if such co-payments are applicable.

If, for example, the provider sees a patient, advises him/her that the Medicaid card is valid and eligibility exists for the date of service and then treats the individual, the provider may not change his/her mind and bill the patient for that service or any part of that service. A provider may charge a Medicaid recipient for services only when both parties have agreed prior to the rendering of the service that the recipient is being seen as a private pay patient; this must be a mutual and voluntary decision. It is suggested that the provider maintain the patient's signed consent to be treated as private pay in the patient record.

Further, a Medicaid recipient must not be referred to a collection agency for unpaid medical bills when the provider has accepted the individual as a Medicaid recipient. Similarly, the provider must not bill the individual in cases where he/she was treated as a Medicaid recipient, but the provider failed to submit a claim to Computer Sciences Corporation (CSC) for payment within the required timeframes or submitted a claim which was subsequently denied for reasons other than recipient ineligibility. The policies in this article do not apply to Medicaid co-payments. Providers may use any legal means to collect applicable unpaid Medicaid co-payments.

If a problem arises as a result of submitting a claim, the provider should first contact CSC. If CSC is not able to resolve the issue because some action must be taken by the recipient's local Department of Social Services, such as providing the claiming address of a health insurance company or terminating a closed health insurance policy, the local Department of Social Services should be contacted for resolution.

It is important to emphasize a hospital's responsibilities in the treatment of a Medicaid patient. A hospital that accepts a Medicaid patient for treatment accepts the responsibility of making sure that the patient receives all medically necessary care and services. Other than for legally established co-payments, a Medicaid recipient should never be required to have any out-of-pocket expenses for medically necessary inpatient services or medically necessary services provided in a hospital based emergency room (ER), unless arrangements for private payment have been mutually agreed upon prior to the service(s) being rendered. Because of the acute nature of an ER visit, it is unlikely that prior mutual agreement between the Medicaid patient and provider can occur in an ER.

NOTE: The above noted policy applies regardless of whether the individual practitioner treating the individual in the facility is enrolled in the Medicaid Program.

Provider shall hold Gold Choice enrollees harmless from liability, and shall not bill enrollees under any circumstances for the costs of covered services rendered.

#### 4b) Compensation

You will be paid a monthly capitation rate minus an administrative fee of 9% for each enrollee on your roster. Only if the New York State Department of Health increases the Capitation rates, will an increase be passed down to the provider otherwise the rates will remain unchanged during the term of this agreement.

This Capitation rate will compensate for the provision of all services required to be performed by the provider and includes all primary care services and case management services, including referral and authorization. C/THP examination provided in accordance with C/THP periodicity schedule are included in the capitation rate. Administration of immunizations for children 18 years or younger are also included under the capitation rate. Vaccine is available without charge through the New York Vaccines for Children Program (VFC). For VFC information and registration forms call the NYS Immunizations Program at 1-800-KID-SHOT (543-7468). Vaccines for adults age 19 years or older will be reimbursed under current fee-for-service.

You will receive a monthly enrollment verification listing, which will include current and new enrollee's names and client identification numbers, numbers of enrollees in each actuarial class, and reimbursement calculations based upon actuarial capitation rates.

## PRIMARY CARE PARTIAL CAPITATION PROVIDERS BENEFIT PACKAGE

CPT Code Number	Title	Description
10060	Incision and Drainage	Incision and drainage of Abscess-Multiple and/or complicated
10061	Incision and Drainage	Incision and drainage of Abscess-Multiple and/or complicated
12020	RepairCSimple	Treatment of superficial wound dehiscence; simple closure
16000	Burns, Local Treatment	Initial treatment, first degree burn, when no more than local treatment is required
16020	Burns, Local Treatment	Without anesthesia, office or hospital, small
20550	Introduction or Removal	Injection, tendon sheath, ligament, trigger points, or ganglion cyst
26010	Hand and Fingers-Incision	Drainage of finger abscess; simple
46221	Excision	Hemorrhoidectomy, by simple ligature (e.g. rubber band)
46230	Excision	Excision of external hemorrhoid tags and/or multiple papillae
81000	Urinalysis	Urinalysis Stick/Reagent For Etc; Non-Auto Wo Mic
81002	Urinalysis	Urinalysis Stick or Tab Any Constituents W/Micro
81015	Urinalysis	Urine; Microscopic Only
81025	Urinalysis	Urine Pregnancy Test Visual Color Compare
85007	Hematology and Coagulation	Blood Count; Manual Diff Wbc Etc
85013	Hematology and Coagulation	Blood Count; Spun Microhematocrit
85018	Hematology and Coagulation	Blood Count; Hemoglobin
85021	Hematology and Coagulation	Blood Count; Hemogram, Auto Etc.
85022	Hematology and Coagulation	Blood Count: Auto And Manual Dif Wbc Etc
85041	Hematology and Coagulation	Blood Count Rbc only
85048	Hematology and Coagulation	Blood Count; Wbc
85651		Sed Rate Erythrocyte; Non-Automated
85652		85661; Automated
86485	Immunology	Skin Test; Candida
86490	Immunology	Skin Test; Coccidioidomycosis
86510	Immunology	Skin Test; Histoplasmosis
86580	Immunology	Skin Test; Tuberculosis, Intradermal
86585	Immunology	Skin Test; Tuberculosis, Tine Test
86586	Immunology	Skin Test; Unlisted Antigen, Each
87082		Cult, Presump, Path Org. S/O, Comm Kit;1 Organism
90700-90745	Immunization Injections	
90748-90749	Immunization Injections	
90799	Therapeutic or Diagnostic	Unlisted therapeutic or diagnostic injections
92551-92568	Audiologic Function Test with medical diagnostic evaluation	
94010	Pulmonary	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurements
94060	Pulmonary	Thoracic gas volume
94150	Pulmonary	Vital Capacity Test
94640	Pulmonary	Non-pressurized inhalation treatment for acute airway obstruction
94664	Pulmonary	Aerosol or vapor inhalation for sputum mobilization,

		bronchodilation, or sputum induction for diagnostic purposes; initial demonstration and/or evaluation
94665	Pulmonary	Aerosol or vapor inhalation-subsequent
95000-95078	Allergy and Clinical Immunology Allergen	
99201-99210	New Patient	Office Visits or other outpatient visits
99211-99215	Established Patient	Office Visits or other outpatient visits
99218-99220	Initial Observation Care New or Established Patient	Initial observation care
99221-99239	Initial Hospital Care	Initial hospital care
99240-99275	Consultations	Office or Outpatient Consultations; Initial Inpatient Consultations; Follow-up Consultation; Confirmatory Consultations
99281-99285	Emergency Department Services	New or Established Patients emergency department visits
99291-99292	Critical Care Services	Critical Care, evaluation of management
99381-99385	Child Teen/Health Program	Periodic prevention, evaluation, etc Established patient
99391-99395	Child Teen/Health Program	Periodic prevention, reevaluation, etc Established patient
99396-99430	Preventive Medicine Services	Periodic preventative medicine reevaluation and management of an individual including comprehensive history, comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures established patient; 40-64 years; 65 years and over
99398-99430	Preventive Medicine Services	Counseling and/or Risk Factor Reduction Intervention
99431	Newborn Care	History and examination of the normal newborn infant, initiation of diagnostic and treatment programs and preparation of hospital records. (This code should also be used for birthing room deliveries).
99433	Newborn Care	Subsequent hospital care, for the evaluation and management of a normal newborn, per day.
99440	Newborn Care	Newborn resuscitation: provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output.
J0120-J7675	Injections	
W5001	PPAC Physician/Nurse Prac Office Visit	Well child examinations and developmental checks-Healthy newborns and children under 18 years old.
W5002	PPAC Physician/Nurse Prac. Office Visit	Well child examinations and developmental checks-Healthy newborns and children under 18 years old.
W5004	PPAC Physician/Nurse Prac. Office Visit	Children under 18 with problems in the following areas: muscle, skeletal, nutritional, ear, nasopharynx, respiratory, gastrointestinal, skin infections and injuries
W5005	PPAC Physician/Nurse Prac. Office Visit	Visits where sole purpose is to administer a drug, i.e. vaccinations, inhalants, allergy shots, etc. (except chemotherapy) or renew a prescription with concomitant brief encounter assessment.

W5006	PPAC Physician/Nurse Prac. Office Visit	Well adult examinations and health education visits- Healthy adults over 17 years of age
W5008	PPAC Physician/Nurse Prac. Office Visit	Children under 18 with problems in the following areas: muscle, skeletal, nutritional, ear, nasopharynx, respiratory, gastrointestinal, skin infections and injuries
W5012	PPAC Physician/Nurse Prac. Office Visit	Visits by women under 21 for annual GYN examination
W5500	PPAC	Hospital Visits
W5501	PPAC	Residential Health Facility Visit
W5502	PPAC	Adult Home Visit
W5503	PPAC	Home Visit
W5504	PPAC	Emergency Room Visit
W7200	Managed Care	Hospital Visit
W7201	Managed Care	Residential Health Facility Visit
W7202	Managed Care	Adult Home Visit
W7203	Managed Care	Home Visit
W7204	Managed Care	Emergency Room Visit

## Section 5:

### 5a) Medical Record Standards

All medical records must contain the following patient information:

- If relevant, all information pertaining to C/THP, STD's and lead screening
- Date of Birth and Sex
- All levels and management of care must be noted, including initial physical and all mental health and chemical dependency diagnosis
- Current medications and problems identified
- All allergies and adverse reactions notes and prominently displayed
- A history of all labs ordered and results
- All patient referrals
- All Consultant summaries
- Plans of action consistent with findings and diagnosis
- All previous unresolved problems must be addresses including a follow up plan
- A review of all ER visits and inpatient hospitalizations
- Entries must be dated, legible and signed

A list of currently enrolled members who have had at least two PCP visits within the past 12 months is generated using encounter data. From this pool, selection is driven predominantly by provider site. In order to avoid multiple records from one provider or provider site, once a client is randomly selected from a given site, all other clients from that site in the pool of potential clients are deleted to ensure that multiple clients from any given site are not selected.

The providers of members who are randomly selected are sent a Physician Self-Assessment (PSA) tool with the Gold Choice medical record standards. They are asked to audit their own charts and return the PSA within 10 business days.

#### 5b) Standards and Performance Goals for Participating Providers

Providers are rated on the Medical Record Review Standards with the following performance goals:

1. 100% compliance—fully compliant with standards
2. 80% compliance—significant compliance
3. Below 80% compliance requires a corrective action plan

Providers with non-compliant medical records are required to adhere to a Corrective Action Plan developed by the medical director within 30 days of notice. The results are reviewed by the Quality Assurance Committee and kept in the providers' files for future credentialing review consideration.

#### 5c) Gold Choice Process for Improving Medical Records (including any actions it has taken).

Any provider below 80% compliance with these Medical Records Standards will require corrective action. Corrective action includes but is not limited to:

1. Letters sent to providers that included specific deficiencies identifying the compliance issues and a suggested action plan for improvement.
2. Suggested models of records such as forms, problem lists or medication allergies documentation forms.
3. Re-education information highlights of best practices or blinded records that meet Gold Choice standards particularly well.

Subsequently, ten percent (10%) or 2 charts will be requested for an in house audit to check the validity of the physician self-assessment (PSA). Gold Choice utilizes a medical record review staff to conduct onsite follow up reviews. Providers and their office staff receive verbal feedback and education, which includes, but is not limited to, the Plan's requirements, various Department of Health reporting requirements, medical record documentation and member education. Providers receive a written report card following the onsite review.

In order to assure provider compliance, those who have been deemed non-compliant will be audited again within 6 months of the original audit.