



**GlobalHealth**  
PROVIDER NETWORKS

# **GlobalHealth Provider Networks**

## **Provider Policy and Procedure Manual**

MANUAL NUMBER \_\_\_\_\_

EFFECTIVE JANUARY 2008

## **ABOUT THIS MANUAL**

This manual is to be used as a tool to assist in the daily operations of member care. Please make sure it is kept in a common area, available to all staff members.

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### ***GlobalHealth Updates***

GlobalHealth will keep you informed as policies, procedures, or benefits change. Updates to the PPPM will be delivered to you by mail, facsimile, Internet, or on-site visits.

### ***Provider Manual Limitations***

If there is an inconsistency between the information contained in the Provider Manual and the contractual agreement(s) and/or Medical Group contract(s) between you and GlobalHealth or between you and the GlobalHealth Provider Networks (GHPN), the terms of your contractual agreement with GlobalHealth or the agreement held between GHPN and GlobalHealth shall govern. If there is an inconsistency between the Provider Manual and the contract under which the Member derives his/her coverage (“Evidence of Coverage, employer Group Agreement and/or Member Handbook”), that contract will govern.

**PROVIDER POLICY**

**AND**

**PROCEDURE MANUAL**

DISCLAIMER

The Provider Policy and Procedure Manual is intended for use by GlobalHealth Provider Networks contracted providers and practitioners only. This Manual is component of your contract with GHPN. Therefore, your reimbursement may depend on your compliance with these policies and procedures. This Manual is to be used only by employees or other personnel acting on behalf of GlobalHealth Provider Networks or its contracted providers and practitioners who are responsible for administering or authorizing benefits as part of their employment or contract responsibilities. The information contained within this Manual is strictly confidential and proprietary to GlobalHealth Provider Networks. The information is not to be copied in whole or part; nor is the information to be distributed without express written consent of GlobalHealth Provider Networks.

## **1. GLOBALHEALTH CONTACT LIST**

### Medical Director

Charles Lunn, MD (405) 280-5473

### Customer Service\*

#### **Local Numbers:**

Phone Number (405) 280-5600  
Fax (405) 280-8506

#### **Toll Free Numbers:**

(Outside the Oklahoma City metropolitan area): 1-877-280-5600  
TTY/TDD/Voice 1-800-522-8506  
Fax Number 1-877-280-2951

### Utilization Management\*

#### **Local Numbers:**

General Number (405) 230-8725  
Authorization Fax Number (405) 230-8732  
After Hours – Cell Number (405) 642-9969

#### **Toll Free Number:**

Utilization Management 1-866-277-5300

### **Director of Health Services**

Becky Anderson, RN (405) 230-8781  
Pager (405) 978-0052  
Fax (405) 230-6110

### **Case Managers**

Regina Smiley (405) 230-8792  
Eddie Foster (405) 230-8780  
Victoria Dickman (405) 230-8746

### **Health Services Coordinators**

Pam Stowe (405) 230-8793  
Aris Jackson (405) 230-8771

### Provider Relations\*

Angela Neal, Director (405) 230-8770  
Wesley Bamberg (405) 230-8727  
Lavone Foster (405) 230-8790

General Number (405) 280-5774  
(Outside the Oklahoma City metropolitan area): 1-877-280-5774  
Fax (405) 230-8713

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**GlobalHealth  
701 NE 10<sup>th</sup> St.  
Oklahoma City, OK 73104\*5400**

**PO Box 1747  
Oklahoma City, OK 73101-1747**

**Visit our website at:  
[www.globalhealth.cc](http://www.globalhealth.cc)**

**\*OFFICE HOURS – MONDAY THROUGH FRIDAY – 8:00 AM - 5:00 PM**

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## **2. NETWORKS/MEMBERSHIP**

### *Summary*

Use the information in this section to become familiar with GlobalHealth. This section also details Membership information and how to determine eligibility.

GlobalHealth is fully licensed by the State of Oklahoma as a health maintenance organization (HMO). GlobalHealth offers two HMO products at this time:

- GlobalHealth – the health plan for members who are covered through commercial employer groups

Generations Healthcare – the health plan for individual members who are eligible Medicare beneficiaries that meet the requirements for coverage as a Medicare Advantage (formerly Medicare +Choice) enrollee

**Note:** All members will be referred to as GlobalHealth throughout this document.

GlobalHealth will not prohibit or restrict a healthcare professional acting within the lawful scope of their practice, from advising or advocating on behalf of a Member regarding the Member's health status, medical care, or treatment options.

GlobalHealth and its network providers accept assignment of a Member and will not discriminate against eligible enrollees in the delivery of healthcare services consistent with the benefits covered in their policy because of race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment. This expectation applies to all personnel, both clinical and non-clinical, in their dealings with each Member.

### ***GlobalHealth Network***

The GlobalHealth network includes contracting GlobalHealth Provider Network's participating physicians, health care providers, and facilities.

### ***Website ([www.globalhealth.cc](http://www.globalhealth.cc))***

The following information Member and Provider information is available on the GlobalHealth website and may be updated from time to time:

- Prescription Formulary
- Member Materials
  - Summary of Benefits
  - Evidence of Coverage
  - Member Handbook

- Clinical Practice Guidelines
- Covered Services
- Provider Directory

## ***Identification***

Every GlobalHealth Member has an identification card, which must be presented each time he/she seeks care from a participating provider. If a GlobalHealth Member fails to present an identification card, GlobalHealth should be contacted to verify the Member's eligibility.

It is essential to verify Member Eligibility because:

- Employer Groups may change benefit plans
- Benefits may change
- Co-payments must be determined
- Fraudulent use may occur

The Member ID card is provided for the purposes of convenience and does not guarantee a Member's eligibility (Sample ID cards are attached). A Member must present their copy of the ID card at the time of the visit. This card is needed for medical, hospital and other covered services.

Presentation of the ID card will identify Members to you and your office staff and provide quick access to pertinent information. Members will have a member ID card for themselves and each covered member of their family. This information is necessary in coordinating Pre-Authorization or Authorization of specific services and in filing claims. However, possession of an ID card does not guarantee the patient's eligibility at the time services are rendered.

### **Eligibility can be verified:**

Providers are instructed to verify eligibility for each patient encounter by contacting Global Health or Generations Healthcare Customer Service Department during normal business hours, Monday through Friday, 8:00am to 5:00pm Central Standard Time. The number is printed on the back of the member ID card or you may call 1-877-280-5600. GlobalHealth Provider Networks will not be responsible for payment of services to ineligible members.

### **Please note the following items on Member identification cards:**

- The patient seen must be the person listed on the card.

- The physician listed on the card is the Member's Primary Care Physician (PCP). The listed PCP must approve in advance all non-emergency medical services provided to the Member for him/her to be covered by GlobalHealth, except self-referral services to a participating provider. Physicians should not see Members for primary care services if they are not listed as the PCP on the card, unless the contracting GHPN and/or GlobalHealth give approval or authorization in advance.

**Your Generations Healthcare ID Card**

{IDCARDFRONT}

<p align="center"><b>Pre-authorization required.</b> <b>Seeback of card for instructions.</b></p>		<p><b>Emergency Services</b> - Based on your symptoms arising from any injury, illness, or condition such that a reasonable and prudent layperson could expect the absence of medical attention would result in serious impairment to bodily function, dysfunction of any body organ or part, or jeopardize your health, go to the nearest hospital emergency room or call 911. Call your Primary Care Physician (PCP) within 48 hours.</p> <p><b>Healthcare Providers</b> - This card is for member identification and does not guarantee eligibility. Other than emergency care, non-PCP providers must have</p>				
<p>OFFERED BY GLOBALHEALTH MEMBER ID* <b>J 2345678901 2</b></p>						
MEMBER NAME	MEMBER DOB	01/01/2005				
<b>DOE,JOHN</b>						
PRIMARY CARE PHYSICIAN (PCP)	PCP EFFECTIVE DATE	01/01/2005				
<b>DOCTOR.THE</b>						
PCPTELEPHONE	<b>4Q5-555-2550</b>					
GROUP*	PCP / SPEC / ERCOPAY	CVG EFFECTIVE DATE				
PLAN* .....	<b>\$. / » . / \$.</b>	<b>01/01/2005</b>				
<p align="center"><b>Card must be presented at time services are requested **</b></p>						
		<p align="center"><b>{ ID CARD BACK }</b></p> <p>specific advance authorization from GlobalHealth and/or the PCP for each service to be rendered.</p> <p align="center"><b>Customer Service</b></p> <table border="1"> <tr> <td>Generations Healthcare 405.280.5400 (LOCAL) www.generationshealthcare.ee</td> <td>GlobalHealth, Inc. 405.280.5600 (LOCAL) www.globalhealth.ee</td> </tr> <tr> <td>1.877.280.5600 (TOLL-FREE)</td> <td>1.800.522.8506 (TTY/TDD/VOICE)</td> </tr> </table> <p align="center"><small>Send claims or other inquiries to PO Box 1747 • Oklahoma City, OK 73101-1747</small></p>	Generations Healthcare 405.280.5400 (LOCAL) www.generationshealthcare.ee	GlobalHealth, Inc. 405.280.5600 (LOCAL) www.globalhealth.ee	1.877.280.5600 (TOLL-FREE)	1.800.522.8506 (TTY/TDD/VOICE)
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**GNMEMID08 - MMYY**

**GlobalHealth Member Identification Card**  
Your GlobalHealth ID Cards

{FRONT}

**GlobalHealth**  
INCORPORATED  
A World of difference

Pre-authorization required. See back of card for instructions.

MEMBER ID # **4015555501**  
MEMBER DOB **01/01/2005**

MEMBER NAME  
**DOE, JOHN**  
PRIMARY CARE PHYSICIAN (PCP)  
**DOCTOR, THE**  
PCP TELEPHONE **405-555-2550**  
GROUP # **1010010** PLAN # **491003**

PCP EFFECTIVE DATE **01/01/2005**  
CVG EFFECTIVE DATE **01/01/2005**

**Gold Network Cost Sharing Information**  
PCP \$20 SPEC \$30 ER \$50  
Rx Retail: GENERIC \$20 BRAND \$30  
See Summary of Benefits for Silver Network Cost Sharing

EXPRESS SCRIPTS<sup>®</sup> RxGRP KCC A  
RxBIN 003858  
RxPCN A4

PPO Oklahoma CCN  
First Health Networks

CARD ISSUANCE: 01/01/2005

{BACK}

**Healthcare Providers** - This card is for member identification and does not guarantee eligibility. Other than emergency care and urgently needed care, non-PCP and non-plan providers must have specific advance authorization from GlobalHealth and/or plan PCP for each service to be rendered.

**Emergency Services** - Based on your symptoms arising from any injury, illness, or condition such that a reasonable and prudent layperson could expect the absence of medical attention would result in serious impairment to bodily function, dysfunction of any body organ or part, or jeopardize your health, go to the nearest hospital emergency room or call 911. Call your Primary Care Physician (PCP) within 48 hours.

**Customer Service**  
1.800.522.8506 (TTY/TDD/VOICE)  
1.877.280.5600 (TOLL-FREE)

**GlobalHealth, Inc.**  
405.280.5600 (LOCAL)  
www.globalhealth.cc

**Generations Healthcare**  
405.280.5400 (LOCAL)  
www.generationshealthcare.cc

Send claims or other inquiries to:  
PO Box 1747  
Oklahoma City, OK 73101-1747

Members: 1.866.804.7650  
Pharmacists: 1.800.824.0898  
TDD: 1.800.899.2114

Submit Pharmacy claims to:  
PO Box 66773  
St. Louis, MO 63166

{FRONT}

**GlobalHealth**  
INCORPORATED  
A World of difference

Pre-authorization required. See back of card for instructions.

MEMBER ID # **4015555501**  
MEMBER DOB **01/01/2005**

MEMBER NAME  
**DOE, JOHN**  
PRIMARY CARE PHYSICIAN (PCP)  
**DOCTOR, THE**  
PCP TELEPHONE **405-555-2550**  
GROUP # **1010010** PLAN # **491003**

PCP EFFECTIVE DATE **01/01/2005**  
CVG EFFECTIVE DATE **01/01/2005**

**Cost Sharing Information**  
(Health)  
PCP \$20 SPEC \$30 ER \$50  
(Prescription - Retail)  
GENERIC \$20 BRAND \$30

EXPRESS SCRIPTS<sup>®</sup> RxGRP KCC A  
RxBIN 003858  
RxPCN A4

PPO Oklahoma CCN  
First Health Networks

CARD ISSUANCE: 01/01/2005

{BACK}

**Healthcare Providers** - This card is for member identification and does not guarantee eligibility. Other than emergency care and urgently needed care, all providers other than the PCP listed on the front of this card must have specific advance authorization from GlobalHealth and/or plan PCP for each service to be rendered.

**Emergency Services** - Based on your symptoms arising from any injury, illness, or condition such that a reasonable and prudent layperson could expect the absence of medical attention would result in serious impairment to bodily function, dysfunction of any body organ or part, or jeopardize your health, go to the nearest hospital emergency room or call 911. Call your Primary Care Physician (PCP) within 48 hours.

**Customer Service**  
1.800.522.8506 (TTY/TDD/VOICE)  
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PO Box 66773  
St. Louis, MO 63166

**Special Needs**

Language, Vision, Hearing, or Physically Challenged

If you have Member(s) who require the services of an interpreter or who have special language needs (i.e., visually and hearing impaired) or who are physically disabled, contact GlobalHealth at 1-877-280-2990.

### **3. PRIMARY CARE PHYSICIANS**

#### ***Definition***

The Primary Care Physician (PCP) is the patient's first contact for all health needs. The PCP manages the patient's total health care program by providing a broad range of services and arranging for specialty care when necessary.

A contracting Primary Care Physician must practice in one of the following fields: Family Practice, Pediatrics or Internal Medicine. Internal Medicine physicians must spend ninety 90 percent of their time practicing family medicine to be eligible to contract as a PCP.

#### ***Responsibilities of the PCP***

1. Manage the patient's total health care program. This includes health supervision, basic treatment, initial diagnosis, management of chronic conditions, and preventive health services.
2. Educate patients regarding their health needs and share findings of the member's medical history and physical examinations.
3. Coordinate health care with specialists or institutions when such care is needed, including authorization of appropriate referrals.
4. Render medically necessary services in accordance with the GlobalHealth contract, the applicable benefit plan, GlobalHealth's policies and procedures and other requirements set forth in the Provider Manual; however, provider shall also openly discuss treatment options, risks and benefits with Members without regard to coverage issues. Recognize that the member has the final say in the course of action to take among clinically acceptable choices.
5. Provide complete information on authorized care or services to the referred specialist.
6. Provide coverage for patients 24-hours per day, seven days per week by a participating network provider.

## ***PCP Panel Status***

### **Open**

Physician will accept all GlobalHealth Members new or established.

### **Established Members Only**

Physician may close his/her practice to new Members by notifying GlobalHealth that he/she will accept established Members only. This option allows only patients currently seeing the Physician to select him/her as a PCP. If a Member selects an Established Members Only Physician inaccurately, the PCP must notify GlobalHealth immediately. GlobalHealth will assist the Member in selecting an available PCP.

### **Not Accepting Any Members (Closed)**

Physicians who have a full practice may close to all new GlobalHealth Members. Physicians who request to be listed as “not accepting any members” will not be assigned new GlobalHealth Members.

## **4. SPECIALISTS**

### ***Specialist Physician Responsibilities***

- Accept and treat GlobalHealth Members with an authorization from the Member's PCP.
- Provide only those services authorized by the Member's Primary Care Physician. If additional medically necessary treatment or tests are needed beyond those initially authorized, Specialists will seek further authorization from the GlobalHealth and/or its delegated Medical Group(s).
- Educate patients regarding their health needs, share findings of the member's medical history and physical examinations.
- Render medically necessary services in accordance with the GlobalHealth contract, the applicable benefit plan, GlobalHealth's policies and procedures and other requirements set forth in the Provider Manual; however, provider shall also openly discuss treatment options, risks and benefits with Members without regard to coverage issues.
- Recognize that the member has the final say in the course of action to take among clinically acceptable choices.
- Comply with precertification requirements.
- Use only GlobalHealth participating providers and participating facilities for services for the Member.
- Submit claim forms for all services rendered to GlobalHealth Members or where applicable to the Medical Group/IPA.
- Cooperate with GlobalHealth utilization review, peer review, quality assurance, and quality improvement programs to promote high standards of medical care.
- Provide a written report of services provided to the Member's Primary Care Physician for inclusion in the Member's medical record within 10-days of completing the source of treatment and/or consultation or sooner if medically indicated.
- Maintain office records to document all services provided to Members in accordance with GlobalHealth standards.
- Assist GlobalHealth in determining coordination of benefits with other carriers.

## **5. BILLING AND REIMBURSEMENT**

### ***Monthly Member List***

Each Medical Group/PCP will receive a Member list at the beginning of each month, showing GlobalHealth Members who have been assigned to that PCP. The Member's ID number, name, age, sex, beginning GlobalHealth coverage date, group number, plan type, office co-payment and pharmacy co-payment are included in this report. The PCP should check this list prior to seeing a GlobalHealth Member to be sure the Member is assigned to that PCP. GlobalHealth should be contacted to verify eligibility of any Member who does not appear on the list.

### ***Time Limits for Filing Claims***

All providers are required to submit to GlobalHealth Clean claims must be filed within thirty (60) calendar days from date of service. The Provider agrees to waive charges for claims received by GlobalHealth Provider Networks after sixty (60) days or such other timeframe as specified in the provider's Hospital or ancillary Services Agreement.

Accordingly, if a provider fails to submit clean claims to GlobalHealth within the foregoing timeframes, GlobalHealth reserves the right to deny payment for such claim(s). Claim(s), which are denied for untimely filing, **cannot** be billed to a member. For claims that have been misdirected by Provider that fall within timely filing limit please refer to Claims Appeals Section of this manual.

GlobalHealth's timely filing requirements are consistent with industry practices for the submissions of claims and enable GlobalHealth to manage information pertaining to costs of health care services provided to members. GlobalHealth reimburses contracted facilities and facility providers in accordance with the established contract rates.

Inpatient stay charges must be submitted once the member has been discharged.

#### **Required Elements of a Clean Claim**

A provider submits a clean claim by providing the required data elements as specified in this section along with any attachments and additional elements, or revisions to data elements, of which the provider has been properly notified, and any coordination of benefits or non-duplication of benefits information if applicable.

## ***Claims Submission***

Claims must be submitted to the following address:

GlobalHealth Provider Networks  
Attention: Managed Care Claims  
P.O. Box 1747  
Oklahoma City, OK 73101-1747

## ***Claims Adjudication***

GlobalHealth reviews and evaluates all claims submissions for medical necessity and the possibility of billing irregularities. The review relies on and complies with the American Medical Association guidelines and the CPT system coding standards. GlobalHealth may decline benefits payments consistent with the evaluation findings.

Payments for services will be made based on current CPT codes. GlobalHealth's Fee-Schedule utilizes the Medicare Resource-Based Relative Value System (RBRVS) units for most services.

## ***Approved Forms:***

- CMS 1500
- UM 92
- OR OTHER FORMS APPROVED BY GLOBALHEALTH PROVIDER NETWORKS

## ***Claims Reimbursement***

For each authorized claim submitted in a timely manner for eligible members specified by the contract or statutory guidelines GlobalHealth will pay the contracted basis of payment and reimbursement rate due to the hospital or ancillary facility specified in the Provider Services Agreement.

## ***About Payment***

- GlobalHealth's payments to its Contracted Providers will be at the rates set forth in the applicable Services Agreement.

- Copayments payable by a Member will be deducted from the reimbursement made to a provider.
- Providers will receive an Explanation of Payment (EOP) detailing how each service was processed within the statutory time limit.
- Claims that have to be reviewed longer than the statutory claims payment period will be processed according to the statutory guidelines.

## ***Reasons for Payment Delays***

It is very important for the GlobalHealth Provider Networks (GHPN) to be able to process your claims as expeditiously as possible. To do so, it is essential that you accurately submit a complete claim.

Common mistakes made when submitting claims are:

- No Employer or Group Number
- No Authorization Number
- Failure to submit written documentation in accordance with GHPN and/or HCFA Guidelines.
- Inaccurate diagnosis
- No or Wrong Tax ID Number

When these common mistakes are made, there is a delay in payment or non-payment of claims.

## ***Covered Services***

GlobalHealth will provide to participating providers information regarding Covered Services. This information will be distributed through various methods such as written communication, provider newsletters or Internet ([globalhealth.cc](http://globalhealth.cc)). Provider may contact GlobalHealth Provider Relations to obtain information.

## ***Copayments/Coinsurance***

A copayment/coinsurance is a fee paid by the member at the time of service. Members are required to pay a copayment/coinsurance for some GlobalHealth/Generations benefits.

- Copayments should be collected when services are rendered.
- Coinsurance should not be collected at the time of service but rather billed to the member once the coinsurance amount is specified from GlobalHealth/Generation's Explanation of Payment sent to the provider.

Some copayment amounts are listed on the member's identification card. However, all copayment/coinsurance amounts may be confirmed by utilizing one of the confirmation mechanisms.

## ***Collection of Copayments***

Providers are responsible for the collection of applicable copayments in accordance with the applicable member benefits. The member ID card should be checked to verify the copayment. Commercial members and Generations members may have copayments for emergency room services. Inpatient copayments may also vary depending on the plan and service type.

Member materials instruct the member to pay their copayments at the time of each visit. Emergency room copayments should be collected at the time of the service, but if the member is admitted, the provider may waive the emergency room copayment. Refer to the member's specific benefits of a determination. If not paid at the time of service, members may be billed for copayments.

## ***Nonpayment of Copayment***

When a member cannot pay the applicable copayment before the services are provided, Provider has the following options:

- Reschedule the appointment (unless an urgent/emergent visit).
- Bill the member.

## ***Claims Status and Follow Up***

GlobalHealth Provider Networks, Customer Service staff are available Monday through Friday, 8:00 am to 5:00 pm, Central Standard Time, should you have any questions concerning claims you have submitted, how to file a claim, understanding the explanation of payment detail, etc. GlobalHealth Provider Networks Customer Service Department can be reached by calling 1-877-280-5668.

## ***Balance Billing***

GlobalHealth members shall not be subject to balance billing by a Contracted Provider. Contracted Providers may not look to GlobalHealth members for payment for covered services beyond the member's copayment.

## ***Remittance Advice***

Each check received from GlobalHealth Provider Networks is accompanied by a "Remittance Advice" (RA). The RA summarizes your claims and explains how benefits were applied.

You can use the RA to determine how a claim was paid including non-allowed amounts and adjustments. The RA will note any appropriate non-covered services, deductible and co-insurance amounts that are the responsibility of the member. The RA lists and explains all codes used in processing each claim.

## ***General Claim Information***

### **Contractual Obligations**

#### *Right of Offset*

This right allows GlobalHealth and its delegated Medical Group(s) to retract overpayment amounts, which will be subtracted from your future payments. You will be notified of any offset amount, the name of the Member/patient for whom an overpayment was made in error, and the relevant dates of service. This information will be noted on the detail of remittance.

## **6. AFFILIATE PCP LAB INFORMATION**

### ***No Lab Onsite:***

If your practice does not have a lab on site but your staff can draw the specimen, you must complete the necessary and appropriate Diagnostic Laboratory Of Oklahoma (DLO) form, then contact DLO at (405) 609-2000 option 3 and have them pick up the specimen. You may bill the GlobalHealth Provider Networks for the lab draw using the code G0001.

***PLEASE*** make sure that you write the referring physician's name and fax number on the DLO form so that you will receive the results in a timely manner. If you need to call for a result, that number is 405-609-2000 option 2.

If you need to send the member to a DLO draw station you may send them to the nearest DLO draw station to them with the appropriate DLO form.

### ***Lab Onsite:***

If your practice does have a CLIA Waive lab on site, you are able to still provide those tests. Attached is a list of the waived tests that can be performed at your location and billed to the GlobalHealth Provider Networks.

All other test(s) would be drawn and you will need to complete the necessary and appropriate Diagnostic Laboratory Of Oklahoma (DLO) form. ***PLEASE*** make sure that you write the referring physician's name and fax number on the DLO form so that you will receive the result in a timely manner. If you need to call for a result, that number is (405) 609-2000 option 2. Then call DLO at (405) 609-2000 option 3 for a pick-up.

<b>Approved In-Office Lab Procedures <sup>(1)</sup></b>	
<b>TEST/PROCEDURE DESCRIPTION</b>	<b>CPT CODE(S)</b>
Routine Venipuncture	G0001
Urinalysis	81000-81005, 81007
Urine Pregnancy Test	81025
Acetone/other ketone bodies, serum quantitative	82010
Amines, Vaginal Fluid, qualitative	82120
Occult Blood Feces Screening	82270-82273
Creatinine; other source	82570
Blood, reagent strip	82948
Hemoglobin, copper Sulfatem non-automated	83026
PH, body fluid, except blood	83986
Phenylalanine (PKU), blood	84030
Blood counts	85007-85048
Prothrombin time	85610
Sedimentation rate, erythrocyte; non-automated	85651
Heterophile antibodies; screening	86308
Particle agglutination; screen each antibody	86430
Skin tests	86485-86585
Smear tests for bacteria, fungi or cell types	87205; 87210-87220
Streptococcus, Group A	87430, 87880
Cell counts and crystal identification	89050-89060
Duodenal intubations and aspiration	89100-89105
Nasal smear	89190
Semen analysis	89300-89320
Sperm evaluation	89329-89330
Sweat collection by iontophoresis	89360

**Note: (1) This list is reviewed on a periodic basis and is subject to change.**

## **7. UTILIZATION MANAGEMENT PROGRAM**

### *Summary*

The Utilization Management (UM) program at GlobalHealth is designed to assist the health care provider with obtaining the most appropriate setting of care and the most appropriate course of treatment for the patient. The goal of this program is to ensure that our Members receive high quality health care. Our trained professionals work together with the provider and/or the patient.

This section describes your rights and responsibilities as a participating provider in the GlobalHealth UM program. UM activities, including delegated UM activities are defined and procedures are explained.

### *GlobalHealth and its Delegated Medical Group(s) Responsibilities*

1. Utilization Management (UM) staff are properly trained, qualified, and supervised by a licensed health care practitioner.
2. The UM Medical Director holds an unrestricted license to practice.
3. Determinations not to precertify an admission, medical services, or extension of stay based on medical necessity will be made by the Medical Director.
4. Clinical review decisions are based on existence of coverage and established clinical review criteria developed with input from actively participating providers. Clinical review criteria are effective in determining appropriate care/service and are updated at least on an annual basis.
5. A mechanism is available to providers to appeal UM denials.
6. Patient-specific information is kept confidential.
7. All information obtained is used solely for the purpose of improving Member care through Utilization Management, Quality Management, and discharge planning.
8. GlobalHealth (and its delegated Medical Group(s)) does not reward practitioners or other individuals for issuing denials of coverage or services. No financial incentives are provided to Utilization Management decision makers that would encourage decisions that result in underutilization. All staff that makes utilization decisions is encouraged to make appropriate decisions and to be aware of underutilization.

### ***Provider Responsibilities***

1. Supply complete and detailed clinical information to allow GlobalHealth and/or its delegated Medical Group(s) to make an informed decision.
2. Obtain prior written authorization from GlobalHealth and/or its delegated Medical Group(s) for all non-emergent hospital admissions, outpatient surgeries done in an outpatient surgery center, and non-emergent services that cannot be provided within the physician's office (special scans MRI, CT, Nuclear Medicine, etc.)
3. Verify a referral authorization for services.
4. Contact GlobalHealth and/or its delegated Medical Group(s) to extend written authorization for services.
5. Refer Members to the Case Management program as needed.

### ***Definition of Emergency***

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a reasonable and prudent layperson could expect the absence of medical attention to result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to body functions or serious dysfunction of any body organ or part. Members are asked to call their Medical Group/PCP within 48-hours of seeking emergency care.

### ***Definition of Urgent Care***

Urgent Care is the treatment for an unexpected illness or injury that is not an emergency, but which is severe enough or painful enough to require treatment within 24-hours. Examples include but are not limited to:

1. High fever
2. Severe vomiting and diarrhea
3. Pulled muscle

A PCP should respond to an urgent care case within 24-hours of the Member's call to the PCP. If the PCP is unable to see the Member, a referral should be made to an appropriate provider or facility.

## ***When Services are Not Medically Necessary***

Unless a proper written waiver signed by the Member acknowledging the Member's financial responsibility has been obtained, providers may not collect charges from GlobalHealth and/or GHPN(s) or the Member for services that have been determined not medically necessary by the Medical Director.

## ***Written Notification to GlobalHealth Members***

There may be situations where a GlobalHealth Member disagrees with your decision about a request for a service or course of treatment. At each patient encounter with a GlobalHealth Member, the Member should be notified of his/her right to receive from GlobalHealth, upon request, a detailed written notice regarding the Member's services. Participating practitioners must provide GlobalHealth Members information about how to contact GlobalHealth.

## ***What is Precertification?***

Preadmission Certification (precertification) and Admission Certification are processes used to review hospital admissions and certain outpatient services to examine the medical necessity of services and whether they are provided in an appropriate setting.

## ***Utilization Management Criteria***

Utilization management determinations are based upon criteria provided by Milliman USA. Physicians may obtain copies of criteria for review. Requests for criteria should be made to GlobalHealth by contacting GlobalHealth Customer Service .

1. The Utilization Management Program plan will include the effective processing of prospective, concurrent and retrospective review determinations by qualified personnel. The areas of review will include:
  - 1.1. Emergency Department authorizations – Approvals by Medical Director and/or the UM RN based on ER criteria.
  - 1.2. Inpatient hospitalizations – Milliman USA criteria reviewed by Case Manager, Medical Director, physician designee, or Patient Care Committee. Daily inpatient hospitalization reviews by RN Case Managers.
  - 1.3. Outpatient surgeries – Milliman USA Criteria reviewed by Case Manager, Medical Director, physician designee, or Patient Care Committee
  - 1.4. Outpatient services – Case Manager, Medical Director, physician designee, or Patient Care Committee
  - 1.5. Rehabilitation services – Case Manager based on evaluation, Medical Director, physician designee, or Patient Care Committee

- 1.6. Ancillary services – Case Manager reviewed by Medical Director, physician designee, or Patient Care Committee

### ***Delegation of Precertification***

GlobalHealth may delegate utilization management to entities that meet the standards, requirements and policies and procedures of GlobalHealth. The delegated entity is then responsible for precertification and authorizing all medically appropriate referrals and hospital admissions, with oversight and monitoring by GlobalHealth.

### ***When is Precertification Required?***

Admission certification is required for all obstetric and emergency admissions. Preadmission certification (precertification) is required for all other inpatient admissions and outpatient procedures/surgeries.

### ***Who is Responsible for Obtaining Precertification?***

As coordinator of health care for GlobalHealth Members, the Primary Care Physician has the responsibility to obtain precertification.

Specialists or facilities treating a GlobalHealth Member should verify precertification with the PCP or appropriate Medical Group prior to treatment.

### ***How to Request Precertification?***

Medical Groups that have delegated UM should have a precertification request forwarded directly to GHPN. If you are unsure who to call for precertification, GlobalHealth can direct your call to the appropriate UM department.

### ***Recertification***

If a precertified admission is expected to extend beyond the initially assigned length of stay, the admission is subject to concurrent review and must be recertified. Recertification must be completed on or before the last day of the assigned stay. The recertification process is the same as precertification.

### ***Precertification Does Not Guarantee Payment for Services Rendered***

Precertification will only determine if a service is medically necessary. Precertification does not determine if the Member is enrolled or if the service is a benefit for the Member. We recommend that you call the GlobalHealth Customer Service Department to inquire about Member enrollment and benefit coverage.

## ***When is a Referral Required?***

The Member's designated PCP is required to authorize or perform all medically necessary services.

## ***How to Obtain an Authorization***

### **Medical Group/PCP**

Each PCP should follow GlobalHealth and/or its delegated Medical Group(s) guidelines for referrals.

### **Specialist Requests**

Each Specialist should follow GlobalHealth and/or its delegated Medical Group(s) guidelines for referrals.

## ***Referral Authorization Guidelines***

The following referral authorization process will apply to all Health Plans with which GHPN is contracted and is delegated to perform the utilization management activities for Members assigned to an GHPN Primary Care Physician and its Affiliates, including but not limited to:

### **Commercial Health Plans**

GlobalHealth HMO

### **Medicare Advantage Health Plans**

Generations Healthcare, offered by  
Global Health

Authorization can be obtained by completing the appropriate request form, which can be faxed to the UM Department 280-5329. Approval requires adequate documentation on the form. Please keep in mind that this should be a "stand alone" document that includes sufficient information and documentation that allows a physician reviewer with no previous knowledge of the patient to determine that the service requested is medically necessary. GHPN is not responsible for payment of claims for non-authorized services.

Referrals are authorized for the current month only. Referrals for more than thirty (30) days in advance will be held until the month services are to be provided.

## ***Provider Responsibilities***

### **Primary Care Physician (PCP)**

The PCP bears the responsibility for authorizing a referral when necessary. The PCP also is responsible for supplying complete information regarding the authorized treatment and procedures to the referral specialist.

### **Specialist Physician and Facilities**

The referral specialist or facility may only perform the services specified on the authorization. The specialist or facility furnishing a referral service should report appropriate information to the referring or attending physician. The attending physician will need to authorize any additional services.

If the specialist decides the Member needs additional services, or services from another specialist, **it is the responsibility of the referring specialist to submit the authorization for additional services.**

### ***Inappropriate Patient Request for a Referral***

If a Member requests a referral that you believe is inappropriate, you are not obligated to authorize the referral. The patient has the right to file an appeal. Please inform the patient of this right and advise him/her to call GlobalHealth Customer Service Department.

### ***Self- Referral Services***

#### **Well Woman/Well Man Visits**

GlobalHealth Members may self-refer once every year for a wellness check. Women may self-refer to a participating gynecologist who is a contracted women's health specialist for a pap smear, breast exam, and pelvic exam. Men may self-refer for a prostate exam only. All other services including a PSA test and mammogram require a referral from the PCP.

Generations Healthcare Members may also self-refer once every year for a Wellness check. Women may self-refer to a participating gynecologist who is a contracted women's health specialist for a Pap smear, breast exam and pelvic exam. Women may also self-refer to a participating provider for a mammography screening.

Generations Healthcare Members may also self-refer to their PCP's for influenza vaccinations.

### ***Routine Office Visit Referrals***

Defined, as all other service not having been identified as emergent or urgent.

We recommend verification of eligibility the day prior to the office visit.

The referral will state office visit. The number of office visits will be stated and must occur within a 60-day time frame from the date of the referral.

If the referral covers more than one (1) *office visit*, the provider must verify eligibility at the time of each visit. Payment will not be made for services rendered to an ineligible member.

No ancillary testing is allowed, unless otherwise stated on the referral. (Exception: fracture care where fracture x-rays is allowed before and after casting during the global period.)

Do not schedule appointments unless you have received an authorization letter at your office. **RETRO REFERRALS** are **NOT** given for routine office visits/follow-ups. If a provider renders service to a patient without prior authorization, that provider may submit an appeal for a retrospective review. At GHPN's sole discretion, determination for authorization will be retrospectively approved or denied. Such decision will take into consideration that provider did not consciously circumvent the prior authorization requirement. Repeated violations may be subject to suspension from GHPN's participating provider network.

The provider is required to send a written/dictated response to the patient's primary care physician with his/her findings/recommendations within a week of seeing the patient.

### ***Retro Referrals***

Retro referrals will not be made for services rendered by contracted providers who do not receive prior approved authorizations, except as outlined in emergency authorizations.

### ***Urgent Referrals***

If an Urgent Care case is referred to a specialist during regular business working hours, the UM Department will contact the specialist's office and provide them with an authorization number and the limitations of the referral. The approved referral will be faxed to the specialist's office the next day. The specialist provider must see the patient within twenty-four (24) hours.

### ***Emergency Referrals***

If a specialist provider is contacted by a GHPN provider, after hours or on weekends and is requested to provide care to a GHPN managed care member, the Specialist provider must notify the UM Department at (405) 280-5300.

The following information must be provided:

Name of patient and date of birth

Name of GHPN referring physician

Date of Service, diagnosis and procedure (if performed)

The provider is required to send a dictated or written response of his/her findings/recommendations to the patient's PCP.

In order to provide timely service to our patients, a follow-up phone call to the patient's primary care physicians is appreciated.

The UM Department will complete an authorization form. This will facilitate prompt payment of claims. Failure to follow this procedure may result in delay of payment for provider services. The approved referral will be faxed to the provider's office.

### ***Response Time Urgent/Emergent Referrals***

Same day if received by UM Department before 5:00 PM, or noon next day if received after 5:00 PM, if no additional information is required from Provider.

### ***Cases that May Require Special Care***

Conditions that may require Case Management intervention include, but are not limited to:

- AIDS, HIV, infection and related diagnoses
- Amputations
- Asthma
- Burns (Severe)
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Coma (after three days' duration)
- Crohn's Disease
- Cystic Fibrosis
- Diabetes
- Eating Disorders
- Hospital admission greater than the expected LOS
- Head injuries
- Hemophilia
- IV Therapy (Long-term)
- Muscular/Neurological Disorders (Traumatic and degenerative such as ALS, MS, MD or Paralysis)
- Neonates with high risk complications or congenital anomalies
- Pre-term labor
- Rehabilitation (Long-term)
- Rheumatoid Arthritis (Severe)

- Spinal cord injury
- Terminal Illness – Hospice candidates
- Transplant candidates
- Trauma (Major)
- Ulcerative Colitis
- Ventilator dependent

All cases are subject to evaluation by appropriate staff for Case Management intervention.

### ***What is Case Management?***

Case Management is a program that helps maintain and improve the health and quality of life of our Members with catastrophic or chronic illnesses. In this program, Case Managers work with providers and Members to coordinate care and develop alternative treatment plans to ensure appropriate coverage of medically necessary care and to enhance the treatment of complex or chronic conditions.

### ***How Does Case Management Work?***

The Case Managers review potential cases to determine if Case Management could have a positive impact on the Member. The Case Managers consider the Member's admission history, present diagnosis, comorbidity issues, current setting, any need for multiple providers or services, placement and discharge planning issues and claims history.

The Case Manager may identify an appropriate alternative care setting, such as a skilled nursing facility or the patient's home.

### ***Who Can Make a Case Management Referral?***

Referrals can be made by any medical care personnel, a member or the member's family.

### ***How to Submit a Case Management Referral***

To make a referral to the Case Management Department, please call the Member's PCP at the phone number listed on the Member's ID card.

Case Management activities are implemented only after the Case Manager consults with the physician, patient, patient's family and the proposed provider of care.

## ***Non – Approval of Referrals***

Non-authorized referrals should not be interpreted as a barrier to patient care or a questioning of physician judgment. They represent a request for additional information from provider, medical records, or offer alternative treatment plans, before authorizing the requested procedure.

## ***Utilization Management Appeals***

There are two types of appeals available to providers – Expedited and Standard.

### **Expedited Appeals**

You may pursue an expedited appeal if the patient is actually receiving services or is scheduled to receive services; and when the attending physician and/or the Member believes that the determination warrants immediate attention due to the patient's condition or health status. For this reason, expedited appeals may be submitted by telephone. Expedited appeals offer peer-to-peer review opportunities.

#### ***Appeal***

1. Call GlobalHealth at 1-877-280-5600.
2. Have all related clinical information available regarding the denied services including:
  - Patient name
  - Member ID number
  - Name of facility where services are being rendered, if applicable

#### ***Decision***

Decisions concerning expedited appeals are made as expeditiously as the medical condition requires, but no later than 72-hours after the review commences.

### **Standard Appeals**

You may pursue a standard appeal if there are no ongoing services requiring review or the determination does not require immediate attention due to the patient's condition or health status. You may pursue a standard appeal for denied services or claims.

### *Appeal*

1. Submit the appeal in writing to:  
GlobalHealth  
Attn: Appeals  
PO Box 1747  
Oklahoma City, OK 73101-1747
2. Include all related clinical information available regarding the denied services including:
  - Patient name
  - Member ID number
  - Name of facility where services are being rendered, if applicable

### *Written Response*

A written response of a standard appeal is sent no later than 30 business days after receipt of all clinical information, provided UM has received all the necessary documentation.

## *Physician Review*

A Physician Reviewer is available to discuss any denial decisions.

Only the Medical Director (or Physician Designee) makes medical necessity denial decisions.

Only physicians discuss medical necessity denial decisions with the Medical Director. Members may contact their health plan to file a grievance/appeal concerning any denial decisions.

GHPN UM Program Medical Director is Charles Lunn, M.D.

Dr. Lunn may be reached at (405) 280-5473, Monday through Friday, (8:00am to 5:00pm Central Standard Time).

**If a medically necessity denial decision is made outside of normal business hours, the Physician Reviewer is available through the on-call UM staff.**

## **8. QUALITY ASSURANCE/QUALITY IMPROVEMENT PROGRAM**

### ***Quality Improvement Process***

*GlobalHealth approaches quality improvement activities with a methodology incorporating the following elements:*

- Assessment of Key Customer Expectations. To be successful, GlobalHealth must understand what its key customers are seeking and assess on a continuous basis whether it is meeting those expectations. GlobalHealth's key customers include enrollees, those who purchase health benefits for enrollees (employers and government), and providers.
- Identification of Opportunities. The process which gives rise to current performance is analyzed and potential opportunities for improvement are identified.
- Setting Goals. Expectations are translated into measurable performance targets/goals which are attainable and which meet or exceed those which are offered by its competitors or others in the market.
- Process Change. Interventions are offered which seek to change process so as to attain the desired results.
- Assessment of Impact. Results of GlobalHealth's improvement activities are measured, and these results used to guide the next cycle of improvement.

To facilitate quality improvement, GlobalHealth utilizes the following tools:

- Annual Quality Plan. On an annual basis, a plan for the coming year is developed to address all product lines. The plan sets forth the measurable performance targets/goals, which are anticipated and the related activities needed to accomplish those targets/goals.
- Activity Plan. For each activity, a detailed statement as to what needs to occur is developed. Such statements identify the key individuals responsible and the major milestones of the activity.
- Quarterly and Annual Reports. Each quarter, and at the end of each year, a summary of results and activities is prepared and reported to the Quality Improvement Committee.

### ***Performance Target/Goal Setting***

The performance targets/goals of the Quality Improvement Program are set annually in view of the principles set forth below. In general, program targets/goals incorporate the following indicators:

- The scope of the program is comprehensive in nature, focusing on the expectations of key customers. The scope encompasses a broad spectrum of activities, including

processes and outcomes of clinical care, member services and satisfaction, monitoring of physician performance by way of re-credentialing, provider satisfaction and efficiency of resource use.

- They are measurable indicators of some aspect of performance, either clinical or service
- They relate to an area which is of importance to key customers
- They involve clinical quality improvement initiatives consistent with the scope of services relevant to the population served.

### ***Annual Quality Plan***

The annual Quality Plan is the document through which GlobalHealth defines specific quality- related activities to be accomplished in the coming year. The document defines short-term targets/goals, the timeframes in which the targets/goals are to be accomplished, and the individual(s) responsible for overseeing the activity.

Each year, the Quality Plan is developed in collaboration with input from the various Work Groups (see below). It is reviewed, revised, and approved by the Quality Improvement Committee. The annual Quality Plan is then submitted for review and approval to GlobalHealth Board of Directors.

### ***Organizational Structure / Roles and Responsibilities***

GlobalHealth Board of Directors has the final authority and responsibility for all GlobalHealth products and for the Quality Improvement Program. GlobalHealth's management, reporting to the Chief Executive Officer, has managerial responsibility for the products. GlobalHealth's Quality Improvement Committee has oversight responsibility for the Quality Improvement Program as delegated by the Board of Directors, which requires reporting of its activities to the Board of Directors on a quarterly basis. The QIC includes Work Groups for Customer Service Appeals/Grievances, Credentialing/Peer Review, Pharmacy and Therapeutic, and Technology Assessment.

The Quality Improvement Committee implements the program through its designated Work Groups.

### ***Members Rights and Responsibilities***

GlobalHealth is committed to ensuring that its Members are treated in a manner that respects their rights as individuals entitled to receive health care services. By the same token, GlobalHealth holds forth certain expectations of Members, which respect to their relationship to GlobalHealth and their individual health care providers. These rights and responsibilities are reinforced in member materials. GlobalHealth provides a copy of the

Rights and Responsibilities Statement to its participating providers in this Provider Manual.

Various components of the Quality Improvement Program incorporate elements of member rights. In part, they include:

- The policy on inquiries, complaints/grievances
- The policy on appeals
- The policy on quality of care concerns
- Access standards

### ***Peer Review and Risk Management Activity***

The GlobalHealth quality improvement process includes a mechanism for reviewing potential risk cases to identify quality related concerns. GlobalHealth personnel and the participation and cooperation of its delegated entities are responsible for identifying, reporting and documenting risk management and potential Quality of Care (QOC) issues. GlobalHealth's Medical Director is responsible for overseeing the QOC process including case identification, investigation, tracking and trending of issues, and preparing documentation.

In addition to the QOC process, GlobalHealth is committed to ensuring that it is monitoring the performance of its providers through the following activity:

Review of all (or a random sample) of cases involving surgical complications:

1. Retrospective mortality review -
  - Review of all deaths shall be performed on a quarterly basis for accuracy of diagnosis and adequacy of treatment considering the given circumstances.
2. Surgical complication review –
  - Review of all (or a random sample) of cases involving surgical complications
3. Review of repeat admissions
  - Review of repeat admissions to an acute hospital stay within 60 days following discharge from an acute hospital stay
4. Review of quarterly quality of care issues, e.g. member complaints, provider grievances and QOC cases.

### ***Medical Access Standards***

The following access standards are monitored for compliance.

- Routine health evaluation appointments are available within 30 working days.

- Sick non-urgent appointments (illness which does not have a sudden onset of symptoms) are available within five working days. After-hours, physicians are available 24-hours per day, seven days per week with physicians to return patients' phone calls within one hour.
- Urgent appointments (sudden onset of symptoms) are available within 24-hours or the patient is referred to urgent care services. After hours, physicians are available 24-hours per day, seven days per week with physicians to return patients' phone calls within one hour.
- In an emergency situation, Members should seek care from the nearest facility and call their Medical Group/PCP within 48-hours of the incident to arrange for follow-up care. (GlobalHealth defines emergency care as treatment for any injury, illness, or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in serious jeopardy to the Member's health; serious impairment to bodily function; or serious dysfunction of any body organ or part.)
- For chronic condition follow-up, an appointment must be available within 30-days.
- For an initial specialist care referral, an appointment must be available within 14-working days.
- For an urgent specialist care referral, an appointment must be available within 24-hours.
- Clinic waiting time should be no longer than one hour. Wait time is measured at the start of the scheduled appointment.

### ***Mental Health and Substance Abuse Access Standards***

The following access standards are monitored for compliance.

- Non-urgent appointment (depression and anxiety without profound symptoms) is available within 5 to 10 working days.
- Urgent appointment (affective disorder, which may include homicidal or suicidal ideations) is available within 24 to 48 hours.
- Immediate treatment is available in an emergency situation. An emergency situation may be defined as a drug overdose; threat or plan to harm self, or others; or a psychotic disorder.
- Non-life threatening emergency treatment is available within six hours.
- Clinic waiting time should be less than 30-minutes. Wait time is measured at the start of the scheduled appointment time.
- An average of no more than two therapy patients per hour should be treated.
- Outpatient follow-up after hospitalization within 14-days.

## ***Medical Record Keeping and Documentation Standards***

Since consistent and complete documentation of medical records is an essential component of quality patient care, a practitioner office review includes assessment of medical record keeping practices, and medical record documentation. Individual records should be organized in a manner to provide quick and easy access to information. Additionally, confidentiality/security of medical information must be maintained. GlobalHealth has identified the following essential medical record components:

- There is an organized medical record filing system.
- Every page in the record contains patient's identification.
- All entries are dated.
- All entries include author identification (signed or initialed by practitioner).  
Electronic signatures are acceptable, provided authorization for its use is included in the signature line.
- Personal/biographical data includes the date of birth, sex, marital status, address, employer, and home and work telephone numbers.
- Family/social history is noted in the record.
- Advance Directive documents or a notation that none exist.
- The record is legible to the reviewer.
- Medication allergies, adverse reactions, or "no known allergies" are prominently noted in the record.
- A current medication list including initial prescription and refill dates.
- A current problem list notes significant illnesses and medical conditions.
- Immunization records are current, or a note indicates up-to-date immunizations.
- Person health history includes complete medical and behavioral health history.
- For a patient seen three or more times, the past medical history should be noted including serious accidents, operations, and illnesses. For Members 18 years old or younger, past medical history should include prenatal care, birth, operations, and childhood illnesses.
- For patients 12 years and older who have been seen three or more times, the use of cigarettes, alcohol, and any substance abuse is noted.
- Visit notes include reason for visit, history and description of presenting problems, including precipitation factors, mental status evaluation, physical status evaluation if appropriate, psychosocial history including an appropriate developmental history for children and adolescents, risk assessment of severity and possibility of potential harm to self or others accompanied by a referral to a level of care which is appropriate to the level of risk, and appropriate diagnostic tests.
- Notes indicate all services provided by practitioner, all referrals for diagnostic or therapeutic services, services and tests ordered, follow-up care/plans including dates of subsequent appointments, and when applicable, a completed discharge plan.

- Treatment Plan is consistent with diagnoses and includes measurable objectives, estimated time frames, and prevention efforts, community resources utilization, and current caregivers contacted or involved in treatment (or, if not, so stated in the record).
- Unresolved problems are addressed in subsequent visits.
- Consult, ancillary services, lab, and imaging study reports are initialized by the practitioner.
- If hospitalized, the record includes an admit report, operative report (if applicable) and hospital discharge summary.
- Working diagnoses are consistent with findings and appropriate DSM-IV diagnoses are documented.
- There is evidence of continuity and coordination of care between primary and specialty practitioners including mental health practitioners.
- Notes indicate preventive screenings and services that are offered in accordance with GlobalHealth's Preventive Health Guidelines.

### ***Credentialing/Appointment***

The selection and retention of providers who are committed to quality and efficiency is one of the most important elements of the Quality Improvement Program. A high quality panel of providers provides several advantages to GlobalHealth including positive marketing to employer groups and members, potential providers and effective risk management. Members of the Quality Improvement Committee must ensure that the health plan retains qualified health care providers who will provide quality services to GlobalHealth members. In the selection of insitutional and ancillary providers GlobalHealth requires evidence of accreditation by a recognized accrediting agency, or if there is not such an agency, other indication that the provider meets acceptable standards of quality. See Section 8.

### ***Re-credentialing/Re-appointment***

To remain in the network, each practitioner must be recredentialled every three (3) years. The Quality Improvement's peer review activities assist GlobalHealth in determining which providers to retain in its network.

### ***Delegation – Delegated Programs***

As a function, GlobalHealth delegates Utilization Management, Claims Processing and Payment and Credentialing/Re-Credentialing, Network Management and some Quality Improvement activities to delegated entities meeting GlobalHealth applicable standards.

## ***Monitoring of Delegated Activities***

At the time of delegation, GlobalHealth will execute a mutually agreed upon document which clearly defines the performance expectations for the delegated entity. At a minimum, the document:

- Defines the delegated entity's specific duties and responsibilities
- Describes the delegated entity's activities
- Describes the requirements for the delegated entity's reporting to GlobalHealth
- Defines the process by which GlobalHealth will evaluate the delegated entity's performance
- Specifies the remedies available to GlobalHealth, including revocation of the delegations, in the event the delegated entity does not fulfill its obligations.

## ***Scope and Content of the Program***

The scope of GlobalHealth's Quality Improvement Program is designed to objectively and systematically improve the quality of care for members. The program process is as follows:

- Identify improvement opportunities-assessment of process variance from average compliance to different standards of identifying opportunities for improvement. This will be accomplished by various methods: surveys of customers, monitoring studies, leadership perceptions, etc. Develop a comprehensive list of improvement opportunities for prioritization.
- Prioritize and select improvement opportunities.
- Develop an operational definition for the opportunity improvement.
- Organize a team. The team will be functional and interdisciplinary.
- Analyze and study the opportunity for improvement.
- Identify root causes.
- Develop intervention strategies.
- Implement strategy.
- Assess improvements.
- Hold the gains by periodically and continuously monitoring process of the "improved" process using indicators.
- Disseminate the results by reporting using various means.

## ***Sources of Information***

The Quality Improvement Program will routinely collect and interpret information from all parts of the organization, to identify areas of clinical concern, health delivery system issues, and issues in member services. Types of information that will be reviewed may include:

- Population Information - Data on enrollee characteristics relevant to health risks or utilization of clinical and non-clinical services, including age, sex, race/ethnicity/language, and disability or functional status.
- Performance Measures - Data on the organization's performance as reflected in standardized measures, including local, state, or national information on performance of comparable organizations.
- Other Utilization, Diagnostic, and Outcome Information - Data on utilization of services, procedures, medications and devices; admitting and encounter diagnoses; adverse incidents (such as deaths, avoidable admissions, or readmissions); and patterns of referrals or authorization requests.
- External Data Sources - Data from outside organizations, including Medicare, data from other managed care organizations, and local or national public health reports on conditions or risks for specified populations.
- Enrollee Information on Their Experiences With Care - Data from surveys (such as the Consumer Assessment of Health Plans Study, or CAHPS), information from the grievance and appeals processes, and information on disenrollments and requests to change providers.
- Providers/Practitioners – The credentialing/re-credentialing process initiates collection of provider information. Additional information may be collected through member grievances, provider surveys and site reviews.

### ***Corrective Action***

GlobalHealth continuously monitors the performance of individual practitioners, its delegated entities and other entities through numerous quality indicators. These indicators are measured and trended over time to provide a historical perspective of performance. When a potential performance issue is identified, GlobalHealth then schedules a meeting to jointly formulate and document a written plan for corrective action, which is submitted to the QIC for approval or denial. The process is a collaborative effort between GlobalHealth and the entity or individual provider designed to improve performance with its focus being educational and consultative, rather than punitive, in nature.

### ***Quality Improvement Committee***

The GlobalHealth Quality Improvement Committee (QIC) is a multidisciplinary, plan-wide committee that retains operational accountability for the design and implementation of the QI Program. QIC will also be responsible for performing all activities to evaluate, monitor and improve the quality of care of the plan's membership. The QIC is accountable to the Board of Directors.

**Functions and Responsibilities:** Performance responsibilities include but are not limited to the following:

- Design, implementation and overall direction of the QI Program
- Review, evaluate and make appropriate modifications to the QI Program Description, QI Program Evaluation and QI Work Plan on an annual basis
- Develop and directly oversee the UM Program Description and the UM Work Plan
- Analyze data to identify clinical quality of care issues and recommend appropriate action
- Review, approve and monitor clinical and service studies and initiatives. Develop benchmarks and/or performance goals for clinical and service indicators.
- Develop strategies to prevent adverse clinical outcomes.
- Develop and approve preventive health and practice guidelines.
- Review and monitor demographics and health risks of the enrolled population annually
- Approve administrative standards such as the member rights and responsibilities and access availability standards
- Develop and implement strategies that promote safety of clinical care
- Review, approve and monitor delegated functions
- Review, approve and monitor delegated credentialing and re-credentialing activities
- Review and monitor provider grievances for improvement opportunities
- Review and monitor trends for improvement opportunities in customer service
- Review trends of member complaints, grievances and appeals
- Review and monitor trends related to pharmacy services
- Review and monitor trends related to behavioral health care services
- Review and monitor for potential under and over utilization of health care services
- Review findings and recommendations from QI work groups
- Identify and develop strategies to reduce adverse outcomes
- Review, monitor, recommend and/or approve corrective action plans
- Identify areas requiring focused review
- Review/audit delegated entities on a semi-annual basis for policy and procedure compliance

**Composition of Committee:** GlobalHealth is committed to the integration of quality improvement activities throughout the organization. The committee serves as a forum for evaluating services and operations, and integrating, coordinating and communicating ongoing activities across the Plan. Collaboration is achieved through broad representation of committee membership. Members include but are not limited to the following:

- Medical Director - Chairperson
- Chief Executive Officer
- Director of Quality

- Compliance Officer
- Ad Hoc Members as determined necessary

**Frequency of Meetings:** The QIC meets quarterly with a minimum of four meetings per year.

**Reporting Relationship:** The QIC is accountable to the GlobalHealth Board of Directors.

## **9. PHYSICIAN CREDENTIALING**

### ***Requesting an Application***

To contract with GlobalHealth or its delegates, physicians must complete and submit an application with all required documentation. Applications are valid for up to 180-days from the date of the physician's signature. Please contact GlobalHealth at 1-405-280-5600 or 1-877-280-5600.

Practitioners have the right to review information submitted to support their application, to correct erroneous information and to be informed of the status of their application upon request.

### ***Primary Care Physician Credentialing Criteria***

To be considered a Primary Care Physician (PCP), the applicant must meet the following criteria:

- Specialize in Internal Medicine, Family Practice, or Pediatrics.
- Ninety percent (90%) or more of the applicant's office practice must be within one of the four listed PCP specialties.

#### **PCP Credentialing Requirements:**

1. Submit a complete application with original signature (no signature stamps).
2. Current unrestricted Oklahoma license.
3. Graduation from a school of medicine or osteopathy that is accredited by the Liaison Committee on Medical Education and completion of residency. Graduates of foreign medical schools must be certified by the Educational Commission for Foreign Medical Graduates. For other practitioners, graduation from an appropriate accredited professional school and/or completion of a formal training program.
4. A current DEA certificate and Controlled Dangerous Substance certificate, if applicable.
5. Board certification or Board eligibility.
6. Current and unrestricted admitting privileges in good standing at a GlobalHealth contracted hospital.

7. Current professional liability insurance minimum: \$1,000,000 per occurrence and \$1,000,000 aggregate.
8. Absence of history of involvement in malpractice suit, arbitration, or settlement; or in the case of an applicant with such history, evidence that the history does not demonstrate probable future sub-standard professional performance.
9. Absence of history of denial, suspension, restriction, or termination of hospital privileges; or in the case of an applicant with such history, evidence that this history does not currently affect applicant's ability to perform professional duties for which the applicant contracted, or does not demonstrate probable future sub-standard performance.
10. Absence of a history of disciplinary actions affecting applicant's professional license, DEA or other required certifications; or, for applicants with such history, evidence that this history does not currently affect applicant's ability to perform professional duties for which the applicant contracted, or does not demonstrate probable future sub-standard performance.
11. Absence of history of felony convictions; or for an applicant with such history, evidence that the nature of the conviction does not affect applicant's current ability to perform the professional duties for which applicant contracted, or does not demonstrate probable future sub-standard care.
12. Absence of history of sanctions by regulatory agencies, including Medicare/Medicaid sanctions; or for an applicant with such history, evidence that applicant is not currently sanctioned or prevented by a regulatory agency from participating in any federal or state sponsored programs.
13. Absence of chemical dependency/substance abuse; or for those applicants who have such history, evidence that the applicant is participating in, or has completed, a prescribed, monitored treatment program and that no current chemical dependency or substance abuse exists that would affect applicant's ability to adequately perform the professional duties for which applicant is contracted.
14. Absence of physical or mental condition that would impair the ability to competently and safely perform the professional duties for which applicant is contracted.
15. Evidence of the capability to provide twenty-four (24) hour, seven (7) day a week coverage.
16. Ability to work cooperatively with others.
17. Appropriate and complete work history for at least the past five years.

18. Successful completion of an office survey for PCP's and OB/GYN physicians, which includes a structured review of the office site and evaluation of the medical record keeping system and practices. Scores of 85% for the site evaluation and 80% for a detailed medical records review for re-credentialing are required.

*Note: GlobalHealth, or its delegated entity(s) shall not discriminate in the selection of providers for reimbursement, race, religion, age, etc.*

## **10. MEMBER RIGHTS AND RESPONSIBILITIES**

### ***HMO Member Rights and Responsibilities Statement***

As a partner with your health plan, your physician and other health care professionals who may be involved in your care, you or your legal designee have the right to:

- Ask questions about any medical advice or prescribed treatment if you need an explanation or want more information in order to make an informed consent or refuse a course of treatment providing you accept the responsibility and consequences of such a decision.
- Participate actively in decisions regarding your medical care. Having participated and agreed to a treatment plan, you have a responsibility to follow the treatment plan.
- Appeal any unfavorable medical or administrative decisions by following the established appeal or grievance procedures of your health plan.
- The names and titles of all physicians and other health care professionals involved in your medical treatment.
- Completely understand your medical condition, health status and the medications prescribed for you - what they are, what they are for, how to take them properly and possible side effects.
- Know how your health plan operates – as stated in your Member Handbook and Evidence of Coverage.
- Timely access to your primary care physician and referrals to specialists when medically necessary.
- Use emergency services when you, as a prudent layperson acting reasonably, believe that an emergency medical condition exists.
- Receive urgently needed services.
- Be treated with dignity and respect and to have your right to privacy recognized.
- Confidential treatment of all communications and records pertaining to your health care and the care of other patients. With written permission, you or your representative have the right to access your medical records. The Plan must provide timely access to your medical records or other health and enrollment information that pertains to you.
- Complete an Advance Directive, Living Will or other directive to a contracting medical provider.
- Information about our contracted physician payment agreements, as well as explanations for any bills for non-covered services, regardless of payment source.
- Be advised if a physician proposes to engage in experimental or investigational procedures affecting your care or treatment. You have the right to refuse to participate in such research projects.
- Voice complaints and appeals about GlobalHealth the care provided without discrimination and expect problems to be fairly examined and appropriately addressed.

You are also entitled to exercise these rights regardless of gender, sexual orientation, marital status or culture, economic, educational or religious background.

You or your legal designee has the responsibility to:

- Identify yourself by presenting your health plan ID card (to physicians, laboratory, hospital, etc.) when receiving medical services.
- Provide your current primary care physician with all previous medical records as well as providing accurate and complete medical information to all physicians and other health care professionals involved in the course of your treatment.
- Be on time for all appointments and to notify your physician's office as far in advance as possible if you need to cancel or reschedule an appointment.
- Notify your health plan within forty-eight (48) hours, or as soon as possible, if you are hospitalized or receive emergency or out-of-area urgent care.
- Pay all required co-payments at the time you receive health care services.
- Provide to the extent possible, physicians, health care professionals and contracting providers the information needed in order to care for you.
- Do your part to improve your own health condition by following treatment plans, instructions and care that you have agreed on with your physicians(s).
- Participate, to the degree possible, in understanding your behavioral health problems and developing mutually agreed upon treatment goals.
- Adhere to behavior that reasonably supports your treatment plan and the recommendation of your primary care physician or other contracting medical provider.
- Review information regarding Covered Services, policies and procedures as stated in your Member Handbook or Evidence of Coverage booklet. Accept the financial responsibility associated with services received while under the care of a physician or while a patient at a facility.
- Ask questions of your contracting physician or GlobalHealth/Generations Healthcare.

You have the right at any and all times to contact the Customer Service Department for assistance with issues regarding your health plan.

## ***Generations Healthcare Member Rights and Responsibilities Statement***

As a Generations Healthcare Member, you have the **right** to:

### **Timely, Quality Care**

- A choice of a qualified Contracting PCP. (Note: We can let you know if a specific physician is not accepting new patients at this time. Your physician will discuss with you the hospital that best fits your needs in the event of needing hospital services.)
- A discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- Timely access to your PCP and referrals to specialists when medically necessary.
- Timely access to all covered services, both clinical and non-clinical.
- Access to emergency services without prior authorization when you, as a prudent layperson, acted reasonably, believing that an emergency medical condition existed. Payment would not be withheld in cases where you sought emergency services.
- Actively participate in decisions about your own health and treatment options.
- Receive urgently needed services when traveling outside the Plan's service area or in the Plan's service area when unusual or extenuating circumstances prevent you from obtaining care from your contracting medical provider.

### **Treatment with Dignity and Respect**

- Be treated with dignity and respect and to have your right to privacy recognized.
- Exercise these rights regardless of your race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or your national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for your care. Expect these rights to be upheld by both the Plan and contracting providers.
- Confidential treatment of all communications and records pertaining to your care. You have the right to access your medical records. We must provide timely access to your records and any information that pertains to them. Except as authorized by State law, we must get written permission from you or your authorized representative before medical records can be made available to any person not directly concerned with your care or responsible for making payments for the cost of such care.
- Extend your rights to any person who may have legal responsibility to make decisions on your behalf regarding your medical care.
- Refuse treatment or leave a medical facility, even against the advice of physicians (providing you accept the responsibility and consequences of the decision).
- Be involved in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment.
- Complete an Advance Directive, living will or other directive to your Contracting Medical Providers.

### **Generations Healthcare Information**

- Information about Generations Healthcare and covered services.
- Know the names and qualifications of physicians and health care professionals involved in your medical treatment.
- Receive information about an illness, the course of treatment and prospects for recovery in terms you can understand.
- Information regarding how medical treatment decisions are made by the contracting Medical Group or Generations Healthcare, including payment structure.
- Information about your medications -- what they are, how to take them and possible side effects.
- Receive as much information about any proposed treatment or procedure as you may need in order to give an informed consent or to refuse a course of treatment. Except in cases of emergency services, this information shall include a description of the procedure or treatment description, the medically significant risks involved, any alternate course of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.
- Reasonable continuity of care and to know in advances the time and location of an appointment, as well as the physician providing care.
- Be advised if a physician proposes to engage in experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.
- Be informed of continuing health care requirements following discharge from inpatient or outpatient facilities.
- Examine and receive an explanation of any bills for non-covered services, regardless of payment source.
- General coverage and plan comparison information.
- Utilization control procedures.
- Statistical data on grievances and appeals.
- The financial condition of Generations Healthcare.
- Summary of provider compensation agreements.

### **Solving Problems Timely**

- Make complaints and appeals without being discriminated and expect problems to be fairly examined and appropriately addressed.
- Responsiveness to reasonable requests made for covered services.

As a Member of Generations Healthcare, you have the responsibility to:

- Provide your physicians or other health care providers the information needed in order to care for you.
- Do your part to improve your own health condition by following treatment plans, instructions and care that you have agreed on with your physician(s).
- Behave in a manner that supports the care provided to other patients and the general functioning of the facility.
- Accept the financial responsibility for any co-payment or coinsurance associated with covered services received while under the care of a physician or while a patient at a facility.
- Accept the financial responsibility for any premiums associated with membership in Generations Healthcare.
- Review information regarding covered services, policies and procedures as stated in your Evidence of Coverage or Member Handbook.
- Ask questions of your PCP or Generations Healthcare. If you have a suggestion, concern, or a payment issue, we recommend you call the Generations Healthcare Customer Service Department.

## **11. HOSPITAL CARE**

**INPATIENT** hospital care must be provided at St. Anthony's Hospital or a participating hospital located outside of Oklahoma County, except for emergencies or in pre-authorized special circumstances.

### ***Participating Hospitals:***

#### **Caddo County:**

The Physicians' Hospital of Anadarko

#### **Cleveland County:**

Moore Medical Center

#### **Johnston County:**

Johnston Memorial Hospital

#### **Lincoln County:**

Stroud Regional Medical Center  
Prague Municipal Hospital

#### **Logan County:**

Logan Medical Center

#### **Pottawatomie County:**

Unity Health Center

#### **Rogers County:**

Claremore Hospital

#### **Seminole County:**

Seminole Medical Center

#### **Tulsa County:**

Southcrest Hospital  
Orthopedic Hospital of Oklahoma

## ***Hospital & Ancillary Compliance***

The hospital and ancillary providers must participate, cooperate and comply with all operational aspects of GlobalHealth's Utilization Management Programs with respect to health care services provided or arranged for by the hospital, hospital providers, and ancillary providers.

Complying with GlobalHealth's UM Program includes, but is not limited to the following:

- Responding to requests from GlobalHealth regarding medical management activities.
- Maintaining accurate, timely, and consistently formatted medical records.
- Making available Medical Records pertaining to GlobalHealth members, as requested.
- Assisting GlobalHealth's UM Staff in Case Management and Discharge Planning
- On-site access to GlobalHealth members while in the hospital and access to member's medical records.

The Hospital & ancillary allows GlobalHealth or its agents, including but not limited to its delegated utilization management and case management personnel, hospitalist or other reviewers, on-site and telephonic access for the purpose of conducting Utilization management and Case management. Hospital & ancillary Providers will render covered services at the most appropriate level of service (including levels of acute care as intensive care unit services or regular acute medical and surgical services as determined by the clinical status of the member) that can safely be provided to the member.

## **Utilization Decision**

GlobalHealth ensures that qualified health professionals are utilized to conduct reviews and assess clinical information. In addition, appropriately licensed health professionals supervise all review decisions.

All utilization decisions (including prior authorization, concurrent review or retrospective review) are supported by relevant clinical information appropriate to each case (such as medical records, lab/x-ray results, ER treatment records, etc.) and consulting with the treating physician, as needed. Board Certified practitioners and/or clinical peers from appropriate specialty areas are utilized to assist in making determinations of medical appropriateness as indicated.

Decisions are made in a timely manner to accommodate the clinical urgency of the situation. GlobalHealth has policies that outline specific timeliness requirements for prior authorization

(pre-certification), concurrent review and retrospective review. Policies also outline the requirements for timeliness of decision notification to members and practitioners.

### ***Reporting Requirements***

Hospital & Ancillary providers are required to adhere to the operational processes and reporting requirements established by GlobalHealth as documented in the next sub section titled Daily Reporting.

### ***Daily Reporting***

The following reports are required to be faxed daily to the GlobalHealth Utilization Management Department:

- Census report for all GlobalHealth/Generation members
- Discharge report
- Outpatient surgeries and skilled nursing facility admissions

***The following information must be included on the report:***

- Member name
- Member ID number
- Date of birth
- Admitting and/or attending physician
- Facility
- Room number
- Admit date
- Admit type
- Bed type
- Diagnosis (ICD-9)
- Procedures
- Anticipated discharge date
- Actual discharge date
- Discharge disposition

## ***Concurrent Review Requirements for All Admissions***

GlobalHealth performs concurrent review from the day of admission through discharge to assure the medical necessity of each day, that services are provided at the appropriate level of care, and that all discharge arrangements have been made. Any stay that indicated the member might be transferred to a lower level of care or alternative treatment setting will be discussed with the admitting physician. If a discrepancy occurs between the admitting physician and GlobalHealth, GHPN Medical Director will be contacted to discuss the member's clinical status and treatment plan.

The hospital and hospital providers will cooperate with GlobalHealth by:

- Providing telephonic concurrent review
- Allowing GlobalHealth's onsite concurrent review staff to participate in the concurrent review/discharge planning process, including access to medical records, patient's family, and patient.
- Provide admission and discharge notification 24 hours/day 7 days/week

Failure to comply with GlobalHealth's concurrent review process may result in a post-service review and/or non-payment of hospital and provider services for applicable days and charges.

## ***Elective Admissions***

All prior authorized elective admissions are reviewed from the day of admission through discharge. Subsequent reviews will be performed as the member's condition indicates or as requested by GlobalHealth or its designee until the member is discharged. GlobalHealth will review each admission for appropriate level of care.

## ***Emergency Admissions***

GlobalHealth must be notified of all emergency admissions the same day of admission. GlobalHealth will obtain review information on the first business day following admission. Subsequent reviews will be performed as the member's condition indicated or until the member is discharged. GlobalHealth will review each admission for appropriate level of care.

## ***Notification***

In order to maintain an effective Utilization Management Program, GlobalHealth requires the prior notification of all GlobalHealth member admissions, as well as patient status and discharge dates.

## ***Discharge Planning***

Discharge planning is the coordination of a patient's continued care needs when discharged from the inpatient setting. Care Coordination is the coordination of discharge needs for the more complex members, end of life, frail and elderly. The initial evaluation for discharge planning begins at the time of notification of inpatient admission. A comprehensive discharge plan includes assessment of needs, plan development, and plan implementation and evaluation of effectiveness.

The facility is responsible for discharge planning. GlobalHealth's assistance in the discharge planning process will vary from facility to facility. The assistance may be on-site or telephonic. Discharge planning responsibilities include:

- Assessing patient's potential discharge requirements beginning day of or day following admission
- Completing multiple elements to patient assessment, including evaluation of available support and assistance, financial needs, skilled services and/or durable medical equipment (DME)
- Arranging multidisciplinary meeting as appropriate to include patient and family, if necessary
- Involving social service in discharge planning, as appropriate
- Coordinating discharge needs to include DME, home Health (HH), skilled nursing facility (SNF), transportation, medications
- Obtaining authorizations for necessary post-discharge services
- Documenting and communication the discharge plan
- Ensuring patient understanding of discharge orders, follow-up care required
- Making referrals to Utilization Management
- Delivering the Written Notice of Non-coverage

Early identification of any social or financial problems, which may delay or complicate discharge, is essential in the discharge planning process. The hospital discharge planner or social services personnel should become involved at the very earliest possible opportunity.

## ***Discharge Planning Requirements***

Discharge Planning begins prior to admission when possible or at a minimum within 24 hours following admission. The admitting physician is required to facilitate discharge planning by documenting the anticipated discharge disposition (home, SNF, other) and any other services the member may require. GlobalHealth's Utilization staff will coordinate with the hospital case manager to arrange for any needed services and assist in monitoring the patient throughout the hospital stay.

## **12. APPEALS & GRIEVANCES – GLOBALHEALTH**

In accordance with state and federal guidelines, GlobalHealth maintains Member grievance and appeals processes. The processes are as follows:

### **Member Grievances**

#### **POLICY**

In order to maintain a high level of Member satisfaction, GlobalHealth shall provide mechanisms and implement procedures to assure timely resolution of Member grievances and implement corrective actions as needed. If a Member grievance also contains an appeal, the case shall be processed separately but simultaneously.

#### **DEFINITION:**

Appeal: any of the procedures that deal with the review of a) adverse organizational determinations of the health care services an enrollee is entitled to receive or b) any amount the enrollee must pay for a service. If GlobalHealth does not provide or pay for a requested service, the Member may appeal the decision.

Grievance: Any Member expression of dissatisfaction with care or service that does not involve a Standard Organization determination.

Standard Organization Determination: the first decision by GlobalHealth regarding service to be furnished to the Member or claims to be paid on the Member's behalf for services already furnished to the Member.

#### Customer Service Representative (CSR):

The CSR will attempt to resolve all oral Member complaints within 48 hours. If the complaint cannot be resolved the CSR will assist the Member in initiating the formal grievance procedure.

1. The Director of Customer Service has responsibility for oversight of the Grievance process.
2. Each department manager is responsible for responding in a timely and professional manner to requests for information regarding grievances.
3. Each delegated entity is responsible for responding in a timely and professional manner to requests for information regarding grievances.
4. The CSR is responsible for communicating with providers regarding information needed from them regarding complaints and grievances.

PROCEDURE:

- 1) A complaint or grievance is received either by phone or in writing/fax.
- 2) If someone other than a Member initiates the complaint or grievance, the CSR seeks an Appointment of Representative form (Attachment A) or other legally binding document before proceeding.
- 3) If the grievance is verbal the CSR will log in the data system.
- 4) If received in writing the CSR will date stamp written communication upon receipt, log information regarding the contact into system.
- 5) Attempt to resolve the issue on first contact.
  - a) If the issue cannot be resolved on first contact, ask the Member who calls to state the grievance in writing and send it to the attention of the CSR.
  - b) If the complaint is in writing, the CSR reviews the complaint and attempts to resolve it on first contact.
- 6) Immediately determine whether the complaint is a grievance, appeal or both.
  - a) If grievance only (see definition above), handle according to this policy and procedure
  - b) If both a grievance and appeal, handle grievance according to this policy and procedure and handle appeal according to policy and procedure. Process concurrently.
  - c) If appeal only (see definition above), handle according to appeal policy and procedure.
- 7) If the grievance raises issue(s) regarding quality of care, refer it to Utilization Management (UM) within 48 hours for the review simultaneously. The Customer Service log for that call remains open until closure is confirmed by UM. UM documents findings and recommendations in the system and returns the grievance to the CSR prior to the expiration of 20 days from receipt of the grievance. The CSR communicates in writing with the Member within three business days of resolution (not to exceed 30 days from receipt of request).
- 8) If medical records are needed to resolve the issue, request a Release of Medical Records from the Member or authorized representative. Request records from the provider(s) upon receipt of the signed release(s).
- 9) Refer medical records and a copy of the summary of the case to UM for review.
- 10) UM documents its findings and recommendations and returns the grievance to the CSR within three business days (not to exceed 30 days from receipt of the request). The CSR communicates in writing with the Member within three business days of resolution (not to exceed 30 days from receipt of request).
- 11) If the Member is dissatisfied with the determination, he/she may request a review by the Customer Service Director. All decisions of the Director are final.
- 12) The CSR logs and tracks grievances for purposes of reporting to Members upon request, for reporting to QIC for quality improvement purposes and for the reporting of quality of care grievances to CMS.

## **Member Appeals**

### **POLICY:**

In compliance with federal law, GlobalHealth shall maintain Member appeal procedures in which a person(s), who was not involved in the initial determination, makes a decision. Members shall have the right to appeal any decision about GlobalHealth's payment for, or failure to arrange or continue to arrange for, what the Member believes are Covered Services (including non-Medicare covered benefits) under GlobalHealth. Appeals procedures pertain to disputes involving a standard organization determination with which the Member (or an authorized representative) is dissatisfied. All appeals shall be processed directly by GlobalHealth, not through providers. If a Member appeal also contains a grievance, the cases shall be processed separately but simultaneously.

Examples of decisions that may be appealed include, but are not limited to:

- Payment for emergency services, urgently needed services, or post-stabilization care.
- Payment for health services furnished by a non-contracting provider or facility that the Member believes should have been arranged for, or reimbursed by GlobalHealth.
- Discontinuation of a service, if the Member disagrees with the determination that the service is no longer medically necessary.
- Referrals to specialty care, if the Member disagrees with the determination that the specialty care is not medically necessary.

### **DEFINITIONS:**

Appeal: any of the procedures that deal with the review of a) adverse organizational determinations of the health care services an enrollee is entitled to receive or b) any amount the enrollee must pay for a service. If GlobalHealth does not provide or pay for a requested service, the Member may appeal the decision.

Grievance: any complaint or dispute other than one involving an organizational determination.

Standard Organization Determination: the first decision by GlobalHealth regarding service to be furnished to the Member or claims to be paid on the Member's behalf for services already furnished to the Member.

Reconsideration: See Appeal.

- 1) The CSR is responsible for handling Member appeals.
- 2) The appropriate delegated entity is responsible for providing medical review of cases related to service denials.

- 3) The Claims Department is responsible for providing copies of denial letters and supporting documentation related to claim denials.

**PROCEDURE:**

- 1) Member submits a written, signed and dated request for appeal within 60 days of notice of initial decision to GlobalHealth.
- 2) Appointment of Representative: Someone else may file a written, signed and dated appeal on behalf of the Member if the Member appoints the individual to act on his/her behalf. If a Member appoints a representative other than an attorney, obtain a written statement (Attachment A) to this effect from the Member, which is signed by the individual appointee. Members may write a Statement of Appointment naming the representative. Statement must include:
  - a) Member name
  - b) Member ID number
  - c) A statement, which appoints an individual as the representative such as, “ I (Member name) appoint (name of representative) to act as my representative in requesting an appeal from GlobalHealth and/or CMS regarding denial or discontinuation of medical service.”
  - d) Dated signature of the representative unless he/she is an attorney
  - e) Dated signature of the Member
- 3) If a representative submits the appeal, the Statement of Appointment must be included with the appeal.
- 4) A non-contracted physician or other provider may submit an appeal on behalf of the Member if he/she completes and submits a waiver of payment statement that says he will not bill the Member regardless of the outcome of the appeal.
- 5) After a Member or authorized representative has initiated an appeal, there are 5 stages that may be available in the standard appeal process. These stages are listed in chronological order below:
  - a) Review by GlobalHealth
  - b) Review by Independent Review Entity (IRE)
  - c) Administrative Law Judge (ALJ) hearing (upon request)
  - d) Departmental Appeals Board (DAB) hearing (upon request)
  - e) Judicial review (upon request)
- 6) If the appeal involves a quality of care component, the CSR addresses the issue as a grievance concurrently but separately.
- 7) Throughout the appeal process, the CSR monitors requests that may need processing sooner than regulatory or organizational timeframes require due to the Member’s health status. If information from the Member’s treating physician, medical records or other sources indicates the Member’s health may be jeopardized by a delay in receipt of health care, the CSR will immediately review the appeal with the Medical Director or designee.

**Stage 1: Internal Review - GlobalHealth**

- 1) Date stamp written communication upon receipt and log into data system. Open file, initiate case chronology and continue to develop throughout case.
- 2) Access the system and/or contact appropriate delegated entity to acquire denial letter, Notice of Non-Coverage/Notice of Denial from issuing department.
- 3) CSR sends written acknowledgment to Member within 3 working days of receiving a written request and seeks Release of Medical Records as necessary.
- 4) Maintain tickler to track return of: (Appointment of Representative Statement &/or (2) Release of Medical Records &/or (3) Waiver of Payment. If forms are not returned one week after mailing, call Member/Representative to seek return.
- 5) CSR sends signed medical record release(s) request(s) to provider(s) within one working day of receipt of release(s). Maintain tickler for return of medical records.
- 6) If records are not received within five business days contact the provider by phone to request immediate release of records. Extend review by 14 days if non-contracted provider and of benefit to the Member.
- 7) The CSR prepares the file for review as soon as medical records and all other supporting documentation is available (initial adverse determination, appeal request from Member, medical records, etc.) or as soon as the Member's health requires, not to exceed 30 days from the date the appeal was received.

**GlobalHealth Review of Service Denials:** The Medical Director/designee and Appeals Committee review the initial determination (service denial and supporting documentation) and reach a decision as expeditiously as the Member's health requires, but no later than 30 calendar days from receipt of the Member's appeal request. Extend this timeframe up to 14 calendar days if it meets criteria in the section on extensions.

- 1) If the reconsideration of an adverse organization determination is based on "lack of medical necessity", it must be made by a physician who has appropriate expertise in the field of medicine appropriate for the services at issue.
- 2) The Member or authorized representative may present or submit relevant facts and/or additional evidence for review in person or in writing to GlobalHealth.
- 3) If the decision is made fully in favor of the Member, provide or authorize the service within 30 calendar days from the date the written appeal was received. Notify the Member and provider in writing within three days of the decision, not to exceed 30 days from receipt of request.

**GlobalHealth Review of Claim Denials:** CSR reviews the initial determination (claim denial and supporting documentation) brings information to the Appeals Committee within 60 days from receipt of the Member's appeal request. The Member or authorized representative may present or submit relevant facts and/or additional evidence for review in person or in writing to GlobalHealth.

- 1) If the decision is made fully in favor of the Member, authorize the payment and make payment within 60 calendar days of the date the written request was received.

- 2) CSR notifies the Member and provider in writing within three days of the decision, not to exceed 60 days from receipt of request.

If a request for an appeal is upheld in part or in whole, the CSR forwards the entire file to the Independent Review Entity (IRE). IRE is CMS's independent contractor for appeal reviews involving Medicare+Choice managed care plans.

For service denials: forward the file to IRE within 30 calendar days of receipt of the request for appeal

For claim denials: forward the file to IRE within 60 calendar days of receipt of the request for appeal.

CSR notifies the Member, in writing, within three days of the decision (and not to exceed 30/60 days from receipt of request), that the file has been forwarded to IRE for reconsideration

### **Stage 2: Review by the IRE**

- 1) CSR sends the complete file to IRE, including IRE forms and following directions provided by IRE, the Member's appeal letter, medical records and all other supporting documentation.
- 2) CSR retains a copy of the file for GlobalHealth reference.
- 3) CSR responds to requests for additional information and retains copies of all information supplied in the GlobalHealth copy of the file.
- 4) IRE has 60 days to respond to standard appeals and will notify the Member in writing of its decision and copy GlobalHealth on the decisions and reason(s) for the decision.
- 5) If IRE upholds a GlobalHealth decision, the notice will inform the Member of his/her right to a hearing before an Administrative Law Judge (ALJ) if the amount in dispute is \$100.00 or more.
- 6) If IRE overturns a GlobalHealth **service denial** decision, GlobalHealth must authorize the service within 72 hours of the date it receives notice from IRE reversing the determination or provide the service as expeditiously as the Member's health condition requires, but no later than 14 calendar days from that date.
- 7) If IRE overturns a GlobalHealth **claims denial** decision, the claim must be paid within 30 calendar days of the date it receives the notice from IRE.

### **Stage 3: Administrative Law Judge Hearing**

- 1) Member may request an Administrative Law Judge review within 60 days of the date of IRE's determination notice. The request may be submitted to GlobalHealth, CMS, or the Social Security Administration.
- 2) IRE notifies GlobalHealth and the Member in writing of the Member's the request for an Administrative Law Judge hearing and the date the hearing will be held.
- 3) A management representative of GlobalHealth and/or another designated representative will attend the hearing to testify on behalf of GlobalHealth. The GlobalHealth representative or designated representative is not required to answer any medical questions but, rather, will explain plan benefits and the reason or reasons

for the denial.

- 4) Either the Member or GlobalHealth may request a review of the ALJ decision by the Departmental Appeals Board, which may either review the decision or decline to review.

**Stage 4: Departmental Appeals Board Review**

- 1) If either the Member or GlobalHealth is not satisfied with ALJ decision, either party may request a review by the Departmental Appeals Board of the Social Security Administration. The DAB may either review the decision or decline to review.

**Stage 5: Judicial Review**

- 1) If the amount in controversy is \$1000.00 or more, either the Member or GlobalHealth may request that the decision reached by the Administrative Law Judge or Departmental Appeals Board be reviewed by a Federal District Court.

Any initial or reconsidered decision made by GlobalHealth, IRE, the ALJ or the DAB can be reopened by any party (a) within 12 months (b) within four years for cause or (c) at any time for clerical correction of an error or in cases of fraud.

## **APPENDIX A – ER CRITERIA**

Emergency health care services are covered inpatient and outpatient services provided by contracting or non-contracting providers that are needed to evaluate or stabilize an emergency medical condition. Our Members are instructed that they have the right to access emergency health care services without prior authorization when an enrollee's medical condition manifests acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual, serious impairment to bodily functions, or serious dysfunction of an organ or body part. We may enforce appropriate use of emergency services through retrospective payment denials where enrollees did not act as prudent laypersons, as described above.

**The following are recommendations for conditions that may require treatment in the ER setting:**

- Abdominal or flank pain, acute (severe distress) abdominal rigidity, nausea and vomiting, melena
- Ascites
- Acute appendicitis, pancreatitis, incarcerated hernia
- Alcohol withdrawal, with impending DT's
- Anaphylaxis
- Arrhythmia, including tachycardia and bradycardia; heart rate <60 or >110 with symptoms of decompensation or malfunction, pacemaker
- Asthma, severe acute episode
- Back pain, severe
- Bleeding/hemorrhage (vomitus, major wound, possible incomplete abortion, history of Coumadin use, hemophilia)
- Blindness sudden (glaucoma, retinal detachment, or any acute episode)
- Burns (second or third degree major/chemical)
- Cardiac/Respiratory Arrest
- Cerebrovascular accident (CVA/Stroke/TIA)
- Chest Pain
- Choking
- Cold or pulseless extremity
- Coma or near coma
- Dehydration, severe, accompanied by an electrolyte imbalance
- Diabetic ketoacidosis/coma/insulin reaction
- Dislocation of joint
- Drug overdose/reaction
- Eye injury/illness causing partial or complete loss of vision; penetrating foreign body
- Fracture, open or closed, with displacement/visible deformity (excluding toes)
- Gallbladder, acute attack

- Gastroenteritis, acute symptoms and onset
- Head trauma, recent with episodes of decreased level of consciousness, slurred speech, abnormal behavior, blurred vision, nausea, vomiting
- Headache, severe acute, associated with neurologic symptoms
- Heatstroke/sunstroke (dehydration, fever, electrolyte imbalance)
- Hypertensive crisis (diastolic 110) kidney stone, severe symptoms loss of consciousness, fainting, syncope
- Major trauma, blunt head, abdomen, chest; gunshot wound; penetrating head, abdominal, chest, or back wound; amputation; major eye trauma; spinal injury
- MVA
- Mental status change, acute delirium (e.g., speech loss, uncontrollable hysteria, severe anxiety, panic attack, and disruptive violent behavior)
- Myocardial Infarction (actual or suspected)
- Obstetric complications; suspected miscarriage; acute swelling; headache/abdominal pain; vaginal bleeding, with pregnancy and post-therapeutic abortion; postpartum bleeding; placenta previa; abruptio placenta; eclampsia; pre-eclampsia; ruptured ectopic pregnancy; hyperemesis
- Pain, severe
- Penetration/imbedded or ingested foreign body
- Pleurisy
- Pneumothorax
- Pneumonia
- Pneumonitis
- Poisoning, any type
- Pyelonephritis
- Pyelitis, acute with pain or bleeding
- Renal dialysis patient with clotted shunt or infection
- Respiratory obstruction, distress, severe shortness of breath, flared nostrils, sternal retractions, tripod positioning air hunger, cyanosis
- Seizures, acute onset or status epilepticus
- Sexual assault
- Shock, Hypotension
- Sickle cell crisis
- Snake bite
- Suicide Attempt
- Urinary retention, acute
- Vomiting, severe, accompanied by electrolyte imbalance
- Weakness, acute unilateral

**Conditions which may require treatment in the ER Urgent Care Center, or PCP's office depending on availability of services:**

- Abdominal pain, non-acute
  - Chronic with no changes
  - Treated and seen without change
- Mild GI upset
- Abrasions/bruises/contusions
- Allergies or urticaria for more than 24-hours, non progressive
- Back pain, chronic (without re-injury)
- Burns, minor
  - First degree burns
  - Sunburns
  - Cellulitis or abscess
- Chronic, with no changes
  - Cold/flu symptoms earache, sore throat
  - Epistaxis/nosebleed, uncontrolled
  - Eye infections
- Eye injury:
  - Superficial foreign body corneal abrasion
- Fever
  - 103° temperature in children less than 3 years old
  - 101 ° in infants less than 3 months of age
  - Seizure activity
- Dehydration
- Fracture/dislocation, closed, with minimal deformity
- Jaundice
- Joint pain without trauma lacerations
- Migraine headaches mild/chronic headache
- Motor vehicle accidents, with delayed symptoms
- Puncture wounds
- Rash
- Thrombophlebitis

## **APPENDIX B – DIRECTORY INFORMATION**

### *Directory Information*

<i>Provider's Last Name and Degree (ie MD, DO, etc.)</i>	<i>Provider's First Name and Middle Initial</i>
<i>Languages Spoken (Other than English)</i>	<i>Board Certification (specify name of certifying board)</i>
<i>Office Phone/Fax Number</i>	<i>Gender</i> <input type="checkbox"/> <i>Male</i> <input type="checkbox"/> <i>Female</i>
<i>Provider Office Address (City State County and Zip Code)</i>	
<i>Provider Tax Identification Number</i>	
<i>IF, PCP – Panel Status for New Patient Assignment (Open, Existing Patient Only, Closed)</i>	
<i>Restrictions or Limitations, if any (age, etc.)</i>	
<i>Provider ID Number (List all 12 digits)</i>	
<i>Provider Signature and Date</i>	

	<i>Beginning Hours</i>	<i>AM/PM</i>	<i>Ending Hours</i>	<i>AM/PM</i>
<input type="checkbox"/> <i>Monday</i>				
<input type="checkbox"/> <i>Tuesday</i>				
<input type="checkbox"/> <i>Wednesday</i>				
<input type="checkbox"/> <i>Thursday</i>				
<input type="checkbox"/> <i>Friday</i>				
<input type="checkbox"/> <i>Saturday</i>				
<input type="checkbox"/> <i>Sunday</i>				

<i>Information Verified By</i>	
<i>Loaded to System By</i>	<i>Date</i>

*If any of this information changes, please notify GlobalHealth by calling 280-5600 (local) or 1-877-280-5600 toll free.*