Part I Section 3

CCHCA Physician Responsibilities

CCHCA PHYSICIAN RESPONSIBILITIES

Responsibilities of the Primary Care Physician (PCP)

Patient members of CCHCA contracted health plans are required to select a primary care physician from the CCHCA primary physician panel. Family members may select different primary care physicians.

The PCP is responsible for:

1. Assuring reasonable access and availability to primary care services,
2. Making referrals to specialists and other plan providers,
3. Providing 24 hour coverage for advice and access to care, and
4. Communicating authorization decisions to the health plan member.

Members may require services that go beyond the scope of their PCP. When this occurs the PCP refers the member to an appropriate CCHCA specialist using the Specialty Consultation Referral Form.

In the event the Medical Group does not have a needed consultant, the PCP must request prior authorization from the Utilization Management Department to use an out-of-network specialist. In emergencies, authorization from the Medical Group should be obtained on the next working day following the emergency.

Responsibilities of Specialist Physicians

When a member has been referred to a specialist, the specialist is responsible for diagnosing the member's condition and/or managing treatment of the condition, up to four visits in a calendar year for the same diagnosis. Further visits beyond the four visits will require prior authorization from the Utilization Management Department. The scope of services rendered is limited to those related to the clinical condition or problem for which the PCP referred the member and medically necessary services related directly to the condition or problem. Note: OB/GYN specialists may see female members without referral from a PCP consistent with California law.

When providing specialty care, the physician is responsible for:

1. Informing the PCP of the member's general condition with problem written consult reports.
2. Obtaining PCP concurrence and/or prior authorization from the Utilization Management Department for subsequent referrals for tests, hospitalizations or additional covered services.
3. Notifying the PCP when the member requires services of other specialists or ancillary providers for further diagnosis, specialized treatment, or if the member requires admission to a hospital.

4. Providing on-call 24 hour emergency coverage.

Responsibilities of All CCHCA Physicians

1. **Mid-level Practitioner's Services**

Physicians who employ mid-level practitioners such as nurse practitioners, physician assistants, or those who have licensed providers like physical therapists, optometrists, etc., must adhere to the following requirements:

- All mid-level practitioners and/or licensed providers rendering care to CCHCA patients must be credentialed.
- Services provided by mid-level practitioners or licensed providers must be billed using their individual National Provider Identifier (NPI) number.
- Only services provided by a CCHCA physician can be billed under the physician's name and NPI.

The credentialing process includes a request for the names and license numbers of health professionals employed by CCHCA physicians. To ensure CCHCA is compliant in this area, please make sure that all health professionals in your office have been credentialed. If you are not sure whether all health care practitioners in your office have been credentialed, please contact CCHCA.

2. Verifying Member Eligibility

Physician offices are responsible for verifying member eligibility before rendering services. Eligibility must be verified every time prior to services being rendered. Because member eligibility and co-payments are subject to change, physician offices should contact the applicable health plan/insurance company directly to get the most updated information on member eligibility, benefits, or co-payments. All health plans offer online eligibility verification on their website. Physicians should contact the health plans for information on accessing online eligibility and benefits.

Sample member identification (ID) cards are located in this handbook in the sections specific to each health plan. Please ask patients to present their ID card each time they require services. The ID card is not proof of eligibility. It is for identification purposes only, however it contains information to assist you in verifying eligibility on each plan's website.

3. Collecting Co-payments

CCHCA's contracted health plans and programs utilize a co-payment system. Co-payments should be collected from the patient by the physician offices at the time of service. When a claim is paid, the co-payment is deducted from the payable amount. Your CCHCA Remittance Advice (RA) accompanying each payment will note the applicable deduction.

Patients are obligated to pay the applicable co-payment, but are not obligated beyond the co-payment for services rendered. CCHCA physicians may not expect greater than the allowed amount for services rendered, and may not bill the patient for further amounts. Any payments received from a patient in excess of the allowed amounts of co-payments needs to be returned to the patient.

There is no office visit co-payment for maternity visits. If a member who is pregnant has an inpatient hospital copayment, the hospital will collect the inpatient hospital co-payment.

There is no co-payment for most preventive care services. Physicians are expected to review a patient's chart to determine if and when they need these important services and encourage patients to complete the preventive services. Preventive services covered without co-payments are those recommended by the United States Preventive Services Task Force (USPSTF). For the most up-to-date information, please go to: http://www.uspreventiveservicestaskforce.org

4. Documenting Language Assistance

CCHCA Physicians must document the language preference of patients who are Limited English Proficient (LEP) in their medical records. Refer to Section 12 for complete details on your responsibility in notifying and documenting an LEP member's right to language assistance.

5. Notification of Authorization Approvals

Decisions to approve service authorization requests for authorization requested prior to, or concurrent with the provision of health care services shall be communicated by the Utilization Management Department to the requesting provider within 24 hours of the decision. It is the responsibility of the requesting provider to communicate to the member the specific health care service(s) that was approved and document that the approved service was communicated to the member. Patients may be notified by telephone, written notice, email or in person.

6. Providing Members with Grievance Information

If a patient is dissatisfied with a decision made by CCHCA, their HMO, or CCHCA physician, CCHCA Physicians must inform patients of their right to file a grievance and offer to provide members with a copy of their HMO's member grievance and appeal form. Copies of the form are located in this handbook in the sections specific to each health plan.

7. Fraud, Waste and Abuse Training Requirements for Physicians and Staff

All health care providers and staff, as well as pharmacies and vendors who render care to Medicare Advantage members or interact with Medicare members in any capacity, including data related to them, must participate in fraud, waste and abuse (FWA) training annually. This is a mandatory training, required by the Centers for Medicare and Medicaid Services (CMS) for all individuals and entities involved with the administration of Part C Medicare Advantage Plans (MA) and Part D Medicare Prescription Drug Plans (PDP).

Such individuals and entities are required to meet minimum training requirements. In accordance with these CMS stipulations, CCHCA requires providers and vendors participating in Chinese Community Health Plan's (CCHP) Medicare Advantage programs to train employees annually in Fraud, Waste and Abuse.

To meet this requirement, CCHCA provides an online FWA training program on our Web site as a PowerPoint presentation. To access the training, go to http://www.cchca.com/compliancetraining.php

It is understood that many providers participate in more than one health plan's Medicare network. **Providers will only need to take the training once a year to satisfy the requirement for all the plans with which they contract. If you have already completed the FWA training provided by another Medicare Advantage Plan, you can use that training to satisfy this requirement**.

You must document the names of the individuals who received training, the date of the training and the source of the training and keep it on file in the event of an audit by CMS. Documentation of annual training will be reviewed during CCHCA site review visits or recredentialing.

Physicians who do not provide adequate attestation showing their completion of the required FWA training, will not be eligible to receive their withhold payments (based on contracted fee schedule) of the respective year.