Health First Network, Inc.

Moving Healthcare Forward

PROVIDER MANUAL

2015

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1. HFNI WHO WE ARE	Health First Network is an integrated, comprehensive network of physicians dedicated to improving the health care experience and quality of life of people in our community.
2. HFNI RELATIONSHIPS WITH HEALTH PLANS	Health First Network enters into contractual agreements with Health Plans on behalf of their members. Financial arrangements may be on a fee-for-service or capitated (risk) basis. In some instances, HFNI provides utilization management, medical management and claims/encounter payment and processing services. Other agreements, primarily PPO plans, provide utilization management and claims services through the Health Plan. Contractual negotiation and provider relations' services are provided by or coordinated through HFNI in all HFNI agreements. Participating Physicians are included in all risk agreements that Health First enters into. Participation under HFNI negotiated non-risk agreements is elective on the part of the physician and the Health Plan. Many Health Plans require that physicians already directly individually contracted are not eligible for participation under a subsequently negotiated contract with HFNI. You will receive a notification letter offering you the opportunity to select to participate in the non-risk contract(s) entered into by HFNI. Contact the Provider Relations Department, if you have any questions.
3. CONTRACT LISTING	Current agreements exist with: • Coventry Health Care • WellCare Medicare Advantage • HealthSpring Medicare Advantage • Humana Medicaid • Staywell Kids Medicaid • Sunshine Health Plan (Medicaid) • Clear Choice Alliance (Medicaid HIV/AIDS) Current **(PPO)** agreements exist with: • Evolution Healthcare • Evolutions Prime Care • Interplan Health Care Contractual relationships are subject to change. Contact the Provider Relations Department for the most current contract status information or with questions regarding your participation.
4. HFNI SERVICE AREA	Currently, the Health First Network primary service area includes Escambia, Santa Rosa, Okaloosa and Walton Counties in Florida. Today, more than 680 Health First Network physicians serve most of Northwest Florida.

5. OVERVIEW OF MEMBER SERVICES BY HEALTH PLANS	Member Services functions are managed by each of the contracted health plans. **Health First Providers should direct questions involving the member to the member's health plan.** Examples include, member changing primary care physicians, member grievances, member identification cards, etc.
6. OVERVIEW OF PROVIDER RELATIONS SERVICES	The Provider Relations Department is multi-faceted and is here to serve the needs of the HFNI providers. The Provider Relations staff will provide assistance to you and your office staff as a liaison with HFNI contracted health plans, assisting in recruitment and enrollment of new providers into the IPA, staff education and contractual issues. Responsibilities of this department include, but are not limited to: • Physician Education and Office Visitation - providing physician and/or staff with information on HFNI policies and procedures as well as coordinating the education regarding health plan policies and procedures. • Ongoing updates and educational materials are provided regularly through Health First Network EConnect Newsletter. The newsletter is updated and sent out electronically on a monthly basis. • Physician Contractual Issues - assisting physician and staff with questions or concerns that may arise regarding their provider contractual issues. • Coding Assistance; changes in fee schedules notification. • HFNI will notify providers at least 30 days in advance of any fee schedule changes, and/or changes to contracting provisions. • Availability and distribution of provider manuals. • Encouraging input and committee participation from Practitioners about how the Provider Network can best serve consumers.
7. UTILIZATION / QUALITY MANAGEMENT FUNCTION OVERVIEW	The goal of Health First Network, Inc.'s (HFNI) Utilization Management program is to provide cost-effective, quality care to HFNI members. The structure of HFNI's UM Program includes a multispecialty UM/QM Committee which oversees the development and implementation of the UM Program and QM Program. The UM Committee reports to the HFNI Board of Directors. The Board of Directors monitors the UM Program with a view toward determining whether HFNI is providing cost-effective, quality care to HFNI members. The scope of the UM Program includes pre-authorization, concurrent, and retrospective review of specialty referrals, inpatient and outpatient services. Outpatient services include emergency care services; urgent care services, surgeries, and procedures. Inpatient services are subject to prospective, concurrent, and retrospective review, as well as discharge planning assistance. Contractual agreements with the Health Plans and HFNI determine the role of HFNI in the inpatient process. For assistance with UM activities, referral issues, concurrent review or case management, contact the HFNI Health Services Department at 850-438-0818.

8. SUMMARY OF GUIDELLINES	Information on the following topics is included in the Provider Operations Manual: A Provider Handbook is available to all providers by accessing the Health First Network Website at www.hfni.com. This handbook is updated on a regular basis to comply with State and Federal Laws. Upon request a hardcopy will be provided at no charge. • Utilization Management Committee Functions • Primary Care Physician Responsibilities • Referral Care Physician Responsibilities • Covering Physician Guidelines • Primary Care Physician Tip Sheet • Referral Care Physician Tip Sheet • Referral Authorization Form • Referral / Authorization Process • Services Requiring Prior Authorization and Pertinent Medical Records • Emergency and Urgent Care Services • Out-Of-Plan Referrals • Service Denials and Appeals • Hospital Admissions • Case Management • Quality Management • Policy on UM Decision Making • Grievance Procedures A copy of Health First Network Policies and Procedures, UM criteria and Utilization Management Program Description is available upon request.
9. OVERVIEW OF CLAIMS FUNCTION (If Applicable)	The claim services department is responsible for: • Processing and adjudication of all claims submitted to HFNI. • Coordination of benefits. • Working with the Finance Department to coordinate check runs on timelines determined by HFNI Executive Management. Checks runs are completed every Friday of each week.
10. OVERVIEW OF CUSTOMER SERVICE (If Applicable)	The Customer Service Department is here to assist the HFNI Providers in the following areas: • Verifying member eligibility and benefits. • Responding to questions regarding claims payment, co-pay and claims status. • Confirming status of referrals and or authorizations. • Assisting the providers in other HFNI areas. Customer service representatives are available from 7:30 am – 4:30 pm CST Monday – Friday to answer your questions.

11. PROVIDER AND MEMBER APPEALS (If Applicable)	When the medical necessity of a service or procedure can not be determined, the authorization or referral will be denied. The physician requesting the service and/or the member may appeal the decision. The physician may appeal by notifying HFNI verbally or in writing, and forwarding additional information to HFNI within 45 days from the date on which the services were denied. The request for appeal and supporting information should be forwarded to the following address: Health First Network, Inc P.O. Box 11427 Pensacola, FL 32524-1427 Attention: Appeals If denials are a non-delegated activity on behalf of a health plan, any denial issued will be issued directly from the health plan. The physician requesting the service will be notified of the reason for the denial directly from the health plan. The notification of denial will provide the requesting provider with the appeals process. The member may appeal by contacting their health plan. Members and Providers (acting on behalf of members) have the right to request an expedited appeal and review of an adverse determination if they feel that waiting the standard grievance procedure time frame could jeopardize life, health, or ability to regain maximum function of the member. A request for an expedited appeal may be submitted verbally or in writing to the member's health plan.
12. EDUCATION	The HFNI Provider Relations Department is responsible for providing or coordinating education and orientation meetings. All new HFNI physicians are required to attend an orientation prior to their effective date. HFNI Physician Bulletins are published in conjunction with the Medical Department to provide information on changes, new policies or general information to the Provider and Staff. This Provider Operations Manual is an integral component of the education process. It is available to all providers by accessing the Health First Network Website at www.hfni.com. This handbook is updated on a regular basis to comply with State and Federal Laws. However, if you have a question regarding HFNI or specific health plan policies and/or procedures; please contact the HFNI Provider Relations Department.
13. PROVIDER SERVICE VISITATION	The HFNI Provider Relations Department is committed to the following visitation program: • Primary Care Physician Offices — Once Quarterly • Referral Care Physician Offices — Twice Annually The above criteria are a minimum. If you have any questions or concerns, please contact the HFNI Provider Relations Department to arrange a mutually convenient time for a meeting.

14. PARTICIPATION WITH HFNI CONTRACTED HEALTH PLANS	By following the procedures outlined in this provider manual and any contracted health plan provider manual, your participation will be in compliance with your contractual obligations. However, upon occasion, contractual obligations may be inadvertently overlooked thereby creating non-compliance. The HFNI Provider Relations Department staff is committed to assisting you in meeting the obligations of your contract in order to maintain the integrity of the managed care network. If you have any problem complying with the terms of any component of your contract and the programs included, please contact the HFNI Provider Relations Department.
15. PROVIDER SATISFACTION ISSUES	Health First Network is committed to ensure that the same high level quality and service is provided to all health plan members of HFNI and to set forth a process to monitor, evaluate and continuously improve the quality and effectiveness of care and service provided by HFNI providers. All calls and emails are responded to with-in 24 hours of receipt.
16. PROVIDER COMPLAINTS	All provider complaints should be directed through the HFNI Provider Relations Department. Complaints will be addressed promptly then forwarded to the UM/QM Department for tracking and reporting to the UM/QM Committee and HFNI Board of Directors. These HFNI Committees are structured to improve processes and facilitate the flow of information to contracted health plans and providers.
17. RESIGNATION AND TERMINATION PROCEDURES	To resign as a participating physician, written notice must be sent to HFNI giving required notice as specified in the HFNI Provider Contract. A confirmation letter will be sent to you from HFNI acknowledging receipt of your termination.
18. TERMINATION WITHOUT CAUSE	Either party may terminate physician contracts without cause by giving the required notice to the other party as specified in the Provider Contract.
19. TERMINATION WITH CAUSE	Situations can arise which require HFNI to terminate a physician's provider contract for cause. Please refer to your Provider Contract for specific situations.
20. PCP PANEL CLOSURE PROCEDURES	In order for a physician to close his/her panel to new members, ninety-day (90) written notice must be sent to Health First Network. Please refer to the Physician Contract for information concerning the minimum number of members a provider should have prior to attempting to close his/her panel. A confirmation letter will be sent to you from HFNI acknowledging receipt of and acceptance of your panel closure.
21. PCP CHANGES	In order for a member to change his/her Primary Care Physician, the member must contact his/her appropriate health plan Member Service Department. The telephone number may be found on the member's ID card.
22. ABUSIVE AND UNCOOPERATIVE MEMBERS	Occasionally, a physician may encounter a patient who is abusive or uncooperative. Examples of this are missed appointments without cancellation, minor disruptive behavior, abusive language, failure to follow the physician's orders and failure to remit his/her office visit co-payment(s) three

	times. The physician and his/her office staff should attempt to work with the patient to resolve the problem. However; should any of the above occur and the physician is uncomfortable treating the patient, the physician can request that the member select another physician. The physician must do this in writing to Health First Network and a copy to the Health Plan.
23. TRANSFER OF UNCOOPERATIVE OR ABUSIVE MEMBERS	Document the incident and the physician's unwillingness to continue the physician-member relationship in a letter. Allow the patient thirty-days (30) to select another physician. You must be available to the member for emergency care during this period. Send letter certified mail to the patient and copy HFNI and the health plan.

24. CREDENTIALING	The physician credentialing process is an integral part of any quality improvement program. Collecting, verifying, and reviewing specific information during the credentialing and re-credentialing review processes maintains the integrity of Health First Network. Implementation of the credentialing and re-credentialing programs enables HFNI to enter into delegated credentialing agreements with Health Plans. Delegated credentialing agreements eliminate the physicians need to submit credentialing data to numerous Health Plans. HFNI currently has delegated agreements with the following health plans:
	
	• Coventry Health Care
	• Wellcare Medicare Advantage
	• HealthSpring Medicare Advantage
	• Humana Medicaid
	• Staywell Kids Medicaid
	• Sunshine State Health Plan
	• Clear Choice Alliance
	
	To be credentialed, all providers are required, at a minimum, to:
	• Complete an application (hardcopy or CAQH)
	• Provide current copies of Current Curriculum Vitae or summary of education and work
	• History to include:
	  o Medical School Name and graduation date
	  o Complete work history for past five (5) years
	  o Location and completion dates of internships,
	  o Residencies and fellowships
	• Florida Medical License
	• Drug Enforcement Agency License
	• Specialty Board Certificate
	• Certificate of Insurance
	• Current W-9
	• Signed Contract

25. CREDENTIALING DECISION	HFNI submits all applications to the Credential Committee, along with other required documentation for review and evaluation. The HFNI Credential-Committee will make credentialing decisions based on network needs as specified by the HFNI Network Design Committee. Letter of the Board's decision regarding Credentialing and Contracting status will advise applicants within 10 business days of the determination.
26. RECREDENTIALING	Recredentialing of participating providers will be performed per HFNI's credential- policies, which requires submission of updated information at least every three years. The HFNI Credentials Committee will review all required information and a decision regarding continued participation will be determined and the provider notified.
27. PROVIDER SITE VISITS	A prospective provider office on-site visit report is required of any new non-hospital based office. The visit includes a medical record review, structured physical plant review, clear goals or standards, and a standard review form. HFNI will review a model medical record and discuss office documentation practices with the practitioners or office staff. At time of recredentialing, site visits are made to non-hospital based offices.
28. MEMBER ENROLLMENT PROCESS INFORMATION	Payers market health insurance to employer groups and individuals. All prospective members receive enrollment materials including a marketing brochure explaining the health benefits, costs and a provider directory of the available physicians. Interested employees/individuals become "subscribers" and complete an enrollment application for themselves and any dependents they wish to enroll. A primary care physician (PCP) is then designated by the subscriber on the enrollment application that is sent to the health plan for processing. The subscriber and eligible dependents receives an identification card from the health plan identifying the member number, effective date, primary care physician and copay. Subscribers and their dependents are known as members. Each primary care physician receives an eligibility list of members assigned to him/her. Verification of the member's eligibility should take place before rendering service. This is for the financial protection of the HFNI physician. Member eligibility can be verified by calling the health plan Customer Service Department for assistance. The health plan Customer Service phone number is located on the member's I.D. Card.
29. HEALTH PLAN MEMBER IDENTIFICATION CARD	The card serves as an identification tool for medical, prescription drug and other supplemental benefits. It displays useful information such as the effective date of coverage, the subscriber's ID number, the group number, assigned PCP, co-payment amounts and the plan's code. Please refer to the specific health plan manuals and/or websites for copies of the actual member card. **Identification cards should not be used solely to verify coverage.** Inquire what type of insurance the member has and ask for a copy of his/her insurance card. Copy insurance card for member's chart. Each health plan has distinctive differences in the member number.

30. MEMBER GRIEVANCES (If Applicable. Health Plans may require Grievances to be addressed directly to the Health Plan.)	Patients may have complaints regarding aspects of their treatment, the attitude of the physician or his/her office staff, eligibility problems or a delinquent claim. Patients are encouraged to deal directly with their physician to resolve the issue. If a satisfactory resolution is not achieved, the patient may file a complaint with the health plan. These formal complaints are referred to as "Grievances." Sometimes health plans will request a written response from HFNI. HFNI is required by contract to respond to grievances from the member's health plan within five working days. Health First Network Provider Relations Department is responsible for handling provider complaints. These complaints can be received by telephone, email, regular mail, and in person. All complaints are addressed within a 24 hour period. Health First Network provides a written notice of outcome to the provider.
31. RESPONDING TO A GRIEVANCE	A copy of the grievance is forwarded to the member's PCP or specialist if appropriate. The PCP or specialist must formulate a written response within five working days, or respond verbally to the Health Plan Quality Assurance Manager. If requested, forward the patient's medical records along with the formalized response to HFNI's Medical Director. Each member upon enrollment, signs on his/her application a "Release of Medical Records." No additional authorization to release records is required. Any resolution offered by the health plan to the patient will be forwarded to the physician upon receipt by HFNI.
32. GRIEVANCE PROCEDURE	The grievance procedure is as follows: PCP/RCP and his/her office staff work with member to resolve issue. If the issue is not resolved, the Member may file a formal complaint with the health plan. The health plan will provide notification of the grievance to HFNI. HFNI will forward a copy to the PCP and/or specialist for response as appropriate. The PCP and/or specialist must submit a written response within 5 days. HFNI will then forward a copy of the response to the health plan after it is reviewed by the Medical Director. The Health plan will inform the member of its resolution.
33. RENDERING SERVICES	Services shall be rendered after eligibility has been confirmed and the office staff has inquired if the member has other health insurance coverage. Government regulating agencies insist that health plan enrollees are treated the same as private patients. **Discrimination of health plan members is not acceptable. Negative comments regarding a health plan, HFNI, or payments should be directed to HFNI, not the member. Negative statements to members may jeopardize HFNI contracts with our health plans as well as may jeopardize the provider's contract with HFNI.**

34. CLAIMS ENCOUNTER GENERAL GUIDELINES (If Applicable)	Federal law requires health plans to report services provided to their members. Contractual agreements between HFNI and its health plans also require this information. The encounter is the interaction between the patients and provider. HFNI uses encounter data to pay PCPs for non-capitated services, aggregate and bill for reinsurance, and formulate statistics for use in contract negotiations with health plans. If a member must return to the office for follow-up or other diagnostic tests as a result of an earlier encounter on the same day, it <u>will not</u> be considered as a separate encounter. **NOTE**: Encounter forms (HCFA 1500) must be completed for all services including inpatient visits.
35. CO-PAYMENT COLLECTION	When a member visits his/her PCP or a Specialist (RCP), he/she is required to pay an out-of-pocket expense called a **co-payment** for professional services. The amount varies for each benefit plan set by the health plan. The co-payment amounts are typically indicated on the member's identification card. It may also be verified by contacting the Customer Service for assistance. The co-payment needs to be collected on the day the service is rendered. The specialist (RCP) can determine the member's co-payment from HFNI's confirming authorization for the visit or from the member's identification card.
36. ENCOUNTER (CLAIM) PROCESS	<u>Be sure to:</u> • Verify eligibility/authorization. • Collect Co-Payment. • Inquire if Patient has other insurance coverage. If so, determine primary carrier for appropriate order of claims submission. • Submit Encounter (HCFA-1500 Claim) form to appropriate health plan.
37. ELECTRONIC CLAIMS / ENCOUNTER DATA SUBMISSION	HFNI currently does not process medical claims for any payers.
38. ELECTRONIC CLAIM SUBMISSION TURN-AROUND TIMES	HFNI currently does not process medical claims for any payers.
39. CLAIMS SUBMISSION	Some claims cannot be submitted electronically. Claims that must be submitted on industry-standard paper forms are: • Claims requiring additional supporting documentation, such as operative or medical notes.

	• Claims for provider payment disputes • Services with zero amount billed (except Ambulatory Surgical Claims) • Unlisted CPT procedures that require explanations or descriptions. Paper claims should be mailed to the address provided by each Health Plan and specified in the "Payor Summary" document provided by HFNI.
40. CLAIMS PROCESSING	HFNI currently does not process medical claims for any payers.
41. CONTESTED CLAIMS	HFNI currently does not process medical claims for any payers. Health First Network is not delegated at this time to respond to authorization request. This service is provided by the health plan. Providers with questions, complaints, or concerns can reach a member of Provider Relations Staff between the hours of 7:00 a.m. – 6:00 p.m. Central Standard Time, Monday – Friday excluding state holidays.
42. COORDINATION OF BENEFITS (COB)	A physician may be entitled to collect additional moneys from the patient if he/she has other coverage. Coordination of benefits between health plans may enable the physician to bill the second carrier for services rendered. Instruct the office staff to inquire if the member has other coverage and document the information in his/her chart. Determine which plan is the primary and secondary payor when coordinating benefits between two health insurance plans. There are established rules to determine the primary payor. Coverage through the member's employer or directly purchased by the member is always primary. **<u>Coordination of Benefits</u>** When a member has coverage through more than one health plan, Health First Network providers should observe the following rules to determine which plan has the primary obligation to provide benefits: • If the patient is covered by more than one health plan at the time of service and the HFNI contracted plan is the secondary insurer, do not take a cost sharing amount up front. Submit the claim to the private carrier as the primary insurer, then submit the claim with the primary insurer's explanation of benefits (EOB) to the secondary insurer. • If a cost-sharing amount is due, it will appear on your Statement of Account (SOA) at the time of payment, and you may then bill the patient. Whether HFNI's contracted health plan is the primary or secondary insurer, the Member must follow plan procedures to receive benefits. • If a claim is submitted stating that other coverage exists, the corrected claim must also be submitted. Submit the claim no more than 90 days after the EOB is received. The health plan is responsible for identifying and coordinating benefits. Questions regarding coordination of benefits may be directed to the health plan Customer Service Department.

	Filing Limit for Coordination The filing limit for claims submission in the case of multiple insurance carriers is 90 days from the date of the primary insurer's explanation of benefits (EOB). The EOB from the primary insurer must be submitted with the claims when Health First Network's contracted health plan is the secondary payer. **Coordination of Benefits Adjustments** If submitting for coordination of benefits (COB) adjustments, do not send a new claim unless one was not initially submitted. Instead, send a copy of the explanation of benefits, the primary carrier's EOB and the *Provider Appeals Form.* The original claim will be adjusted accordingly.
43. SUBROGATION	If an HFNI member is injured through an act or omission of another individual, the physician still must provide medical care. Yet, if the member is entitled to recovery, the member shall agree in writing to reimburse the physician one hundred percent of his/her usual and customary fees immediately upon collection of damages. The physician is contractually obligated to report all third party payments to HFNI. If a member is receiving a settlement through his/her insurance company, then this is not a Third Party Liability case. The member is therefore, entitled to keep those moneys and neither HFNI nor the health plan can make the member sign a lien. **Motor Vehicle Accidents (No-Fault or PIP Coverage)** The health plan coordinates on its own behalf with the Personal Injury Protection (PIP) and/or Medical Payment (Medpay) benefits on claims for services rendered as a result of a motor vehicle accident (MVA). Members should not be billed or required to pay up front for services as a result of a MVA, other than applicable cost-sharing amounts. For motor vehicle accident claims, providers should bill the motor vehicle carrier directly. The motor vehicle insurer is primary for the full PIP coverage and /or any available MedPay coverage. After receiving the insurer's statement or check, if further payment is requested, providers must bill the health plan within the contracted filing limit from the date the statement or check was issued. Note: Under your Health First Network contract, once the Member's PIP and MedPay benefits are exhausted, you cannot balance bill the Member or file a lien against the Member's third party settlement or judgment.
44. APPEAL PROCESS	A method to appeal a denied claim for service(s) rendered exists and is defined in each health plan contract. Each claims payment appeal must consist of a letter explaining why the provider is requesting the appeal, documentation supporting their request and a copy of the corrected claim. **This must be submitted within 45 days from the date of the original denial. No Faxed or verbal requests will be accepted.**

	Requests for an appeals on denied claims must be done in writing and mailed to the claims appeals address for the appropriate health plan.
45. APPEAL FORM	**RESERVED**
46. REIMBURSEMENT	**RESERVED**
47. REIMBURSEMENT DISPUTES	Providers who disagree with the reimbursement or adjudication of a claim can submit an administrative appeal to the Medical Review address for the appropriate health plan:
48. UTILIZATION MANAGEMENT COMMITTEE FUNCTIONS AND RESPONSIBILITIES	The HFNI UM/QM Committee oversees the development and implementation of comprehensive, systematic, continuous medical management processes which make the HFNI Utilization Management Program effective in the delivery of high quality health care to members in the most cost-effective manner. The UM Committee monitors quality, continuity and consistency with standard medical practices and coordination of care as well as over-utilization and under-utilization of services. HFNI providers, staff, and ultimately the UM/QM Committee effectively manage the entire scope of care, beginning with an initial encounter to the member's return to a healthy state. Evidenced-based clinical treatment guidelines that lead to the best health status outcomes are reviewed and approved by the UM/QM Committee and communicated to HFNI providers.
49. PRIMARY CARE PHYSICIAN RESPONSIBILITIES	The Primary Care Physician (PCP) is responsible for providing or overseeing comprehensive healthcare services for HFNI members. The responsibilities of the PCP are defined for the purpose of assisting the HFNI staff and providers in understanding the scope of the primary care practice within the HFNI. **Scope:** The following scope of work describes, in general, the role of the primary care physician. • The PCP serves as the provider and general manager (commonly referred to as the "gatekeeper") of the member's care. As the focal person of contact, the PCP functions as a resource and consultant for all healthcare services provided to the member. • The PCP provides for, or arranges for 24 hour/seven days per week coverage for the PCP's primary care practice. • The PCP evaluates specialist consult summaries and determines (with specialist provider input) whether additional specialty services are needed. The involvement of the PCP helps to ensure continuity of care while eliminating duplication of services. • During a member's hospitalization, skilled nursing facility or home healthcare, the PCP continues to monitor the medical necessity of services being provided and facilitates the appropriate transfer of the member to the next lower level of care at the earliest opportunity. Alternately, an attending physician or hospitalist may be responsible for monitoring the member's care.

	• The PCP provides medical expertise and direction concerning the member's Healthcare needs while promoting the success of HFNI. • The PCP works with the HFNI Medical Director, the HFNI UM/QM Committee and the HFNI Medical Department, collaborating in the referral authorization process to provide appropriate services to contracted health plan members. Established descriptions of PCP responsibilities may be reviewed and revised per HFNI protocol. **Responsibilities:** • Routine office visits, related physician care and after-hours care of uncomplicated medical problems. • Periodic health evaluations as appropriate and timely for all adults and children who are members of the PCP's practice. • Immunization/injections for adult and children members. • Well-child care. • Twenty-four hour on-call coverage. • Consultation time to manage the member's care. • Visits and examinations in the emergency room, hospital, skilled nursing facility, or extended care facility. • Supervision of any required skilled home healthcare regimens. • Referral of members to appropriate specialty providers or ancillary services as medically necessary and according to HFNI approved practice guidelines for referrals. • PCP's shall admit members with emergency situations to a participating hospital unless stated otherwise under the member's contract with the health plan. For example, an appropriate bed or service is unavailable or the member is out of the service area. The contracted Primary Care Physician agrees to comply with the HFNI's Utilization Management Program. Primary Care Physicians are notified of their responsibilities in the contractual service agreement that they sign to become a provider of HFNI. Any changes will be handled through the HFNI's governance structure as described in the agreement.
50. CLINICAL CRITERION FOR USE IN UTILIZATION REVIEW (If Applicable)	HFNI utilizes InterQual®, health plan-defined, Medicare and/or Medicaid criteria to make medical necessity determinations based on the member's specific healthplan.
51. REFERRAL CARE PHYSICIAN RESPONSIBILITIES	The Referral Care Physician (RCP) is responsible for providing specialty healthcare services for HFNI members. The responsibilities of the RCP are defined for the purpose of assisting the health plan staff and providers in understanding the RCP's role and the scope of the referral care practice within HFNI. Established descriptions of Referral Care Physician responsibilities may be reviewed, updated, approved, and utilized by HFNI.

	Responsibilities: • The RCP provides non-emergency covered services to eligible members after receiving a prior authorization to treat the member from the responsible Primary Care Physician. • The RCP will submit a written report to the Primary Care Physician having responsibility for the ongoing care of a particular member regarding the plan of treatment proposed by the RCP, including any proposed hospitalization or surgery, within fourteen (14) days of examination of the member. • The RCP and the responsible Primary Care Physician shall agree on the plan of treatment proposed by the RCP prior to implementation of that plan of treatment. • The RCP works with the responsible primary care physician, HFNI's Medical Director or designee, and / or HFNI's Utilization Management Committee to justify the authorization of appropriate services for HFNI members. • The RCP or an HFNI approved referral care physician provides covered services for the RCP's specialty practice. • The RCPs will have someone on-call to see HFNI members in the service area. • RCP's shall admit members with emergency situations to a participating hospital unless stated otherwise under the member's contract with the health plan. For example, an appropriate bed or service is unavailable or the member is out of the service area. The contracted Referral Care Physician agrees to comply with the HFNI's Utilization Management Program. Referral Care Physicians are notified of their responsibilities in the contractual service agreement that they sign to become a provider of HFNI. Any changes will be handled through HFNI's governance structure as described in the agreement.
52. COVERING PHYSICIAN GUIDELINES	If an HFNI primary care physician (PCP) or referral care physician (RCP) is, for any reason, from time to time unable to provide contracted services, the PCP or RCP may secure the services of a qualified covering physician who shall render services otherwise required of the PCP or RCP. The responsibilities of the covering physicians are the same as the PCP or RCP who secured the services of the covering physician. **Guidelines:** • The covering physician must be a physician approved by HFNI to provide services to HFNI members. • The PCP or RCP shall be solely responsible for securing the services of the covering physician and paying the covering physician for those services provided to HFNI members. • An authorization for non-capitated services rendered by the covering physician is required. The PCP or RCP shall insure that the covering physician: • Looks solely to the PCP or RCP for compensation;

	• Is made aware of capitated and non-capitated services; • Complies with the specific "Description of Responsibilities;" • Complies with HFNI's Utilization Management Program; • Accepts HFNI's peer review procedures; • - Not directly bill members for services; • -Prior to all elective hospitalizations obtain authorization in accordance with HFNI's Utilization Management program.
53. PRIMARY CARE PHYSICIAN (PCP)	Before you call: Direct member to a HFNI Specialist (RCP). Be sure to have the correct member number for the patient. Have correct ICD-9 diagnosis codes and CPT-4 procedure codes. Be prepared to fax clinical notes on procedures requiring pre-authorization. Do not schedule a procedure until an approval authorization number has been obtained. Know at which facility a procedure will be performed. Allow sufficient time for the medical review process. **WHEN YOU CALL:** Provide the following information: • Member Number • Date of Service • Diagnosis Code (ICD-9) • Provider Name (Specialist's name if an office visit, facility name if an outpatient procedure) • Procedure Code (CPT-4) • Number of Office Visits (If a referral to a specialist) • Name of Provider for Ancillary Service • Place of Service for Procedure **OUT OF AREA** **HealthSpring Medicare Advantage Call HealthSpring 1-800-962-3018** For referral of a patient to a tertiary care center, prior to scheduling the visit, contact HFNI for the appropriate tertiary care center for the members' contracted health plan. Please provide complete information, including: • Physician's Name • Address • Telephone Number • Physician's Specialty **IF THERE IS A CHANGE OF FACILITY OR DATE OF SERVICE, PLEASE NOTIFY HEALTH FIRST NETWORK**.

54. REFERRAL CARE PHYSICIAN (RCP)	Before you call: Be sure you have a current office visit referral from the primary care physician. Have the correct member number for the patient. Have correct ICD-9 diagnosis code and CPT-4 procedure codes. Know at which facility a procedure will be performed. Do not schedule a procedure or service until an approval authorization number has been obtained. **WHEN YOU CALL:** Provide the following information: • Member Number • Date of Service • Diagnosis Code (ICD-9) • Name of Physician Performing Outpatient Procedure • Current PCP Referral Number • Facility Name • Procedure Code (CPT-4) • Name of Provider for Ancillary Service • Allow sufficient time for medical review **IF THERE IS A CHANGE OF FACILITY OR DATE OF SERVICE, PLEASE NOTIFY HEALTH FIRST NETWORK**
55. REFERRAL AND AUTHORIZATION PROCESS	The Utilization Management process entails the following review process: Referral Prior Authorization, Concurrent and Retrospective (Post-service) Review. The goal is that the referral procedure will ensure appropriate utilization of services and accurate payment of claims to contracted providers for health care services. All payments are contingent upon the member's benefit coverage. The contracted health plan will be included in the referral authorization process. The health plan will receive reports of all authorizations and denials. Referrals are requests submitted by the member's Primary Care Physician (PCP) for the member to be evaluated by a specialty physician. Referrals require an authorization to ensure payment for services; documentation is not required for purpose of medical necessity unless the specialty physician is out of network. Prior authorizations are requests submitted by the member's PCP or RCP prior to services being rendered for review to establish medical necessity, appropriateness of setting/level of care, benefit coverage and appropriateness of specialty provider. Clinical documentation is required. These services can include inpatient and/or outpatient services (i.e. hospitalization, elective surgical procedure, wound care, home health services, or rehabilitative services, etc.). Concurrent Review activities required evaluation of a members acute or sub acute admission or acute rehabilitative stay for medical appropriateness. The

	clinical documentation is reviewed to determine appropriateness of setting, level of care and coordination of discharge planning. Receipt of an authorization is not a guarantee of reimbursement. Reimbursement is subject to benefit coverage and patient eligibility at the time service is rendered.
56. REFERRAL AND AUTHORIZATION PROCESS - PCP RESPONSIBILITIES	**Primary Care Physician Responsibilities:** At the point of encounter, the PCP should: • Evaluate the patient • Render care according to the HFNI PCP responsibilities • Determine if a referral is necessary If a referral to a RCP is necessary, the HFNI referral process is initiated by the PCP as follows: • Asking to see the patient's identification card at each visit to be sure that the member has not changed benefit plans or insurance companies. • Confirming the patient's eligibility • A sample Referral Authorization Form is included in this Manual and should be completed as follows: o Patient name o Patient's health plan identification number o Patient's date of birth o Patient's address o Services which are required as a result of an accident listing the other insurance for example, auto work related, or other o Patient's telephone number o Primary Care Physician name o Primary Care Physician telephone number o Referral Care Physician name o Authorization number o Referral Care Physician address o Date of Appointment o Number of visits authorized o Expiration date o Referral Care Physician telephone number o Type of Service o Reason for Referral - o Diagnosis and ICD-9 Code o Requested care, procedure or test with CPT 4 Code o Clinical history/findings which justify the requested procedure • Phoning, faxing, or mailing the authorization request to HFNI along with clinical documentation. • Providing the RCP with the appropriate information upon approval of the requested service. • Referral request may be entered directly into eINFOsource.

57. REFERRAL AND AUTHORIZATION PROCESS - RCP RESPONSIBILITIES	**Referral Care Physician Responsibilities:** • Confer with the PCP to establish a continuing treatment plan. • Communicate all results of consultations, tests, procedures, and recommendations for ongoing care to the PCP either by phone, fax, mail, or electronically.
58. REFERRAL AND AUTHORIZATION PROCESS - GENERAL GUIDELINES	**General Guidelines** The services listed on the Authorization Matrix may require a Referral or Pre-Service review. Services with an asterisk (*) indicate that clinical documentation must be submitted. These services are reviewed by licensed clinical staff. Authorizations are typically good for 180 days unless otherwise specified. If an extension is needed, such a request should be submitted by copying the original request with the authorization number written on the form, and under "other requests," it should be noted "time extension needed." The PCP should initiate referrals to RCPs. Most referrals to a Specialist are approved for 12 visits. RCPs may request authorization for services that they intend to provide (e.g., surgery, procedures, imaging studies) after receiving an initial consult from the PCP and PCP approval.
59. REFERRAL AND AUTHORIZATION PROCESS - RETROSPECTIVE REQUESTS	Retroactive referral authorizations include services that have been rendered without an authorization from HFNI. Retroactive referral authorizations for ambulatory care will be reviewed to determine whether the request should be approved. The request will be researched to determine the reason for retroactive authorization. The determination will be coordinated with the member's PCP. Retroactive requests will be considered for a period of three months (90 days) past the date of service.
60. REFERRAL AND AUTHORIZATION PROCESS	Physicians who function as both PCP and RCP may "self-refer" for specialty care only after submitting a request for authorization -as previously described herein.
61. REFERRAL AND AUTHORIZATION PROCESS - GLOBAL OB POLICY	Pregnancy (global authorizations) require authorizations approved through the health plan.
62. REFERRAL AND AUTHORIZATION PROCESS ROUTINE/ANNUAL GYN SERVICES AND MEDICALLY NECESSARY FOLLOW-UP	See attached Authorization Lists for procedures and services that require referral pre-authorization and medical review. The annual well-woman exam, in accordance with regulatory guidelines does not require a referral if performed by an HFNI OB/Gyn. Should follow-up intervention be required the referral/ authorization process as outlined below will be followed.

63. REFERRAL AND AUTHORIZATION PROCESS - MEMBER DIRECTED SELF-REFERRAL SERVICES	In accordance with state and regulatory guidelines, members are entitled to seek care from some providers without a PCP Referral. The following is a list of such services: • Annual Well Woman Examinations by an HFNI OB/GYN. • Annual Diabetic Retinal Examinations by an HFNI Ophthalmologist. • Five Dermatology visits, annually, to an HFNI dermatologist. • Podiatry visits per contract benefit. • Chiropractor visit per contract benefit.
64. POLICY AND PROCEDURES (If Applicable)	**Purpose:** The Utilization Management Committee oversees the referral/authorization process. The process is evaluated, revised as necessary and approved annually by the Utilization Management Committee. **Policy:** Determinations are being based on medical necessity and reflect application of appropriate clinical decision – making criteria. **Procedure:** HFNI's UM/ QM Committee will determine how strict the referral process will be in regard to authorization of services, in accordance to member contract. For example, whether all referrals from the PCP to a specialist require authorization, or if only follow-up specialist visits and certain specialist referrals need to be authorized, or if only follow-up visits require authorization. Similarly, if the UM Committee determines that certain services will be automatically authorized, a list of those services and criteria will be made available to the UM staff and providers. The HFNI UM/QM Committee may set referral guidelines, which are coordinated with the member's healthplan, and they should comply with the members contract. The member's healthplan will determine the accrediting entity (i.e. NCQA or AAAHC) or ERISA timeliness standards will be followed.
65. PRIOR AUTHORIZATION LIST (If Applicable)	**SEE ATTACHED AUTHORIZATION LIST** Health First Network Provider Relations Department submits a file of all network providers in addition to New Providers, updates and terminations by the 10th of each month.
66. EMERGENCY AND URGENT CARE SERVICES - PCP Responsibilities (If Applicable)	The PCPs may remind the member to contact them to coordinate care before being seen at an emergency room. If the situation involves the need for immediate emergency care, the PCP will advise the member to go to the nearest emergency facility and to call his/her PCP within 48 hours of the emergency room visit. The PCPs should remind their patients that visits to an Urgent Care Center require authorization and that the PCP should be contacted prior to seeking care.
67. ER AND URGENT CARE SERVICES - Policy and Procedures (If Applicable)	See policy and procedures provided here. **Purpose** The UM staff will assist providers to follow the proper Emergency and urgent care service utilization process which is aimed at the appropriate utilization of these services.

MANAGEMENT OF EMERGENCY and URGENT CARE SERVICES (If Applicable)	Urgently needed services are covered services provided when an enrollee is temporarily absent from the service area (or, under unusual and extraordinary circumstances, provided when the enrollee is in the service area but the Plan's provider network is temporarily unavailable or inaccessible). **Policy**: An emergency will be defined as a medical condition manifesting itself by 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 or, in case of a pregnant woman, the health of the woman or her unborn child. • Serious impairment to bodily functions or serious dysfunction of any bodily organ or part. Utilization management staff will provide guidance to providers regarding urgent care service utilization. The UM staff will obtain and document urgent care service information for the authorization process. **Urgent Care Services** The UM staff may receive (or place) calls regarding urgent care service authorizations from HFNI providers and health plans. These calls may be made regarding service authorizations at a participating facility or at a non-participating facility.
68. OUT-OF-PLAN, OUT OF AREA REFERRALS	Emergency situations - See above guideline for Emergency and Urgent Care Services. All other out of plan, out of area referrals require prior authorization.
69. SERVICE DENIAL AND APPEAL PROCESS (If Applicable)	If HFNI is unable to authorize a requested service(s), the primary care physician, the physician requesting the service, and the health plan will be timely notified of the reasons for denial. HFNI practitioners will also be instructed on appeal and expedited appeal procedures. The physician requesting the service and / or the member may appeal the decision. The physician may appeal by notifying HFNI and forwarding additional information to HFNI within 45 days from the date on which the services were denied. The request for appeal and supporting information should be forwarded to the following address: Health First Network, Inc. P.O. Box 11427 Pensacola, Florida 32524-1427 The member may appeal by contacting their health plan. Further information is available in the HFNI UM Policy and Procedure Manual.

70. EXPEDITED APPEAL PROCESS (If Applicable)	Members and Providers acting on behalf of members have the right to request an expedited appeal and review of an adverse determination if they feel that waiting the standard grievance procedure time frame would jeopardize life, health, or ability to regain maximum function. For an expedited appeal, a determination will be made within 72 hours of receiving all appropriate, additional clinical documentation to support the request. A written response will be sent within two (2) days.
71. UTILIZATION RELATED DECISIONS - Purpose and Procedure (If Applicable)	Purpose: It is the policy of Health First Network to inform practitioners, providers and staff who make utilization-related decisions of the need for special concern about the risks of under-utilization. HFNI will maintain a policy and distribute a statement to all its practitioners, providers and employees (also to health plan members if HFNI has member services delegation) which affirms that: UM decision-making is based only on appropriateness of care and service. HFNI does not compensate practitioners or other individuals conducting utilization review for denials of coverage or service. HFNI does recognize the skill, knowledge, expertise, and time constraints of Physician consultants. As a Provider Organization, HFNI does compensate UM consultants for their time and expertise in performing a review. This compensation is at the rate of $25.00 per 15-minute review increment. This compensation is provided to a HFNI UM Consultant/Specialist for the time spent on the review, and is not related to the determination made. Financial incentives for UM decision-makers do not encourage denials of coverage or services. HFNI and its contracted payers will adhere to the policy listed above.
72. CASE MANAGEMENT (If Applicable)	HFNI has an active and effective Case Management Department and several Disease Management Programs to assist Physicians with the exceptional quality care for their members. Physicians may contact the Medical Management Department at 850-434-6087 for information or to refer a member for Case Management/Disease Management Services. Note: Health First Network Infectious Disease providers are all specialized in HIV care and treatment.
73. QUALITY MANAGEMENT (If Applicable)	It is the responsibility of the physician's office and HFNI staff to identify and report quality related issues to the health plan. Please refer to the health plan's provider manual. Health First Network's UM/QM Committee oversees the Quality Management Program within HFNI. For any questions about the HFNI UM/QM Program description, or its review and evaluation activities, contact the HFNI Medical Services Department at 850-434-6087.
74. QUALITY IMPROVEMENT (If Applicable)	Each participating physician has contractually agreed to cooperate with contract Health Plans in the review of quality care administered to Members. Quality Improvement Programs are generally included in each Health Plan's Provider Manual. If any adverse changes occur the health plan is notified within 4 days of the change.

75. PHARMACY FORMULARIES	Compliance unless medical necessity dictates otherwise, with pharmaceutical formularies developed and/or adopted by HFNI and contracted Health Plans is contractual. Please refer to the HFNI Provider Relations Department or Health Plan Provider Manual for specific formularies.
76. CREDENTIALING DISPUTE RESOLUTION	a) The dispute resolution mechanism is available to any participating provider who wishes to initiate it; b) The methods to initiate such a mechanism is to submit formally a letter to the Director of Network Development. c) This will go before a PEER review by the HFN Credentialing Committee. d) The participating provider may present relevant information; e) A determination will be made by the PEER review. f) A letter will be sent to the provider with the determination within 5 days along with the reconsideration and/or appeals process. g) The provider must respond to this within 30 calendar days from the date of the notice. (policy available upon request).