PRIMARY CARE PHYSICIANS (PCP) SCOPE OF RESPONSIBILITIES

Plan members are strongly encouraged to select a contracted Primary Care Physician (PCP) as their main provider of health care services at the time of enrollment.

The PCP’s scope of practice includes the development and supervision of the member’s treatment and care plan, which includes being available to the member 24 hours a day, 7 days a week. The PCP serves as the primary provider of a member’s health care services.

The PCP provides routine, preventive and urgent care services to their patients. They should also ensure the member receives appropriate specialty, ancillary, emergency and hospital care when needed. PCPs must be accessible to their patients for urgent medical situations 24 hours a day, 7 days a week, via phone, pager or through a call group consisting of other in-network primary care physicians.

PCPs should be willing and able to provide detailed information to the member or legal representative of the member about the member’s illness, the planned course of treatment, and prospects for recovery in terms the member can understand.

PCP responsibilities include providing or arranging for:

- Routine and preventive health care services
- Emergency care services
- Hospital services
• Ancillary services
• Referrals for Specialty Care Services
• Interpreter services
• Coordination with care coordinators to ensure continuity of care for members

PCPs coordinate care with clinic services, such as therapeutic, rehabilitative or palliative services for outpatients. PCPs must cooperate with any court-ordered services.

Referrals

As a gatekeeper for the Covered Individual’s health care needs, the PCP has agreed to refer their patient’s to specialty care providers or facilities who participate in the Anthem Healthy Indiana Plan when medically indicated. If the Network does not have the necessary specialist in-network, the utilization management department may authorize services to a non-network provider. In situations such as this, the Covered Individual will receive maximum benefits. Out-of-network authorizations can only be approved by the appropriate utilization management unit.

All PCPs

• Are expected to refer members to specialists or specialty care, behavioral health care services, health education classes and community resource agencies when appropriate
• Must contact the Plan to obtain authorizations for any out-of-network referrals when an in-network provider of the specialty in question is not available in the Geographical area.
• Are responsible for screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.
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- Must document referrals, including referrals to carved-out services.
- Should assist Members with scheduling appointments with other providers and health education programs.
- Must coordinate with the Women, Infants and Children (WIC) program to provide medical information necessary for WIC eligibility determinations; such as a height, weight, hematocrit or hemoglobin
- Are expected to track and document appointments, clinical findings, treatment plans and care received by members referred to specialists, other health care providers or agencies to ensure continuity of care.

Specialty referrals to in-network providers do not require prior authorization from the Plan.

Interpreter Services

Providers should notify members of the availability of Anthem Healthy Indiana Plan’s interpreter services and discourage the use of minors, friends and family members to act as interpreters at medical appointments. Refer to the Interpreter Services Including Services for Members with Hearing Loss section in the Provider Resources chapter for provider responsibilities for after-hours linguistic access and how to update language capabilities.

The Plan appreciates the need for good communication between providers, patients, and the Plan, and offers the linguistic tools needed to result in satisfying and effective medical encounters.
Transitioning Members Between Facilities or Home

PCPs initiate or assist with the discharge or transfer of:

- Members from an inpatient facility to the appropriate level of care facility (skilled nursing facility, intermediate rehabilitation facility) or back to the Member’s home whichever is medically appropriate.

- Members who are hospitalized in an out-of-network facility to an in-network facility, or to home with home health care assistance (within benefit limits) when medically indicated. The coordination of member transfers from non-contracted out-of-network facilities to contracted in-network facilities is a priority that may require the immediate attention of the PCP. Contact the Plan’s utilization nurse to assist in this process.

PCPs are expected to abide by all of the provider responsibilities as outlined in this manual.
SPECIALIST SCOPE OF RESPONSIBILITIES

Specialty Care Physicians (SCPs), licensed with additional training and expertise in a specific field of medicine, treat Plan members to supplement the care provided by Primary Care Physicians (PCPs).

PCPs refer members to Plan-contracted network specialist physicians for conditions beyond the PCP’s scope of practice that are medically necessary. Specialists diagnose and treat conditions specific to their area of expertise. Specialist care is limited to Plan benefits.

In-network referrals to Specialty Care Providers do not require authorization from the Plan.

Anthem Healthy Indiana Plan members may choose to seek services from Specialty Care Provider without a referral from their PCP. As long as the Specialist is a participating provider and the services rendered are considered covered services under the Anthem Healthy Indiana Plan, the claims for the services will be processed as in-network and paid at the in-network level.

Services rendered by a non-participating provider without an out-of-network Anthem authorized referral, will be denied as Member’s responsibility. The Anthem Healthy Indiana Plan does not cover unauthorized out-of-network services.

Specialists must follow all provider responsibilities as outlined in this manual.
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HOSPITAL SCOPE OF RESPONSIBILITIES

PCPs refer members to Plan-contracted network hospitals for conditions beyond the PCP’s scope of practice that are medically necessary. Hospital care is limited to Plan benefits.

Hospital professionals diagnose and treat conditions specific to their area of expertise.

Hospital professionals must follow all provider responsibilities as outlined in this manual.

Notification of Admission and Services

The hospital must notify the Plan or the review organization of an admission or service at the time the member is admitted or service is rendered. If the member is admitted or a service is rendered on a day other than a business day, the hospital must notify the Plan of the admission or service during the morning of the next business day following the admission or service.
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Notification of Decision

If the hospital has not received notice of precertification review determination at
the time of a scheduled admission or service, as required by the Utilization
Management Guidelines and the Hospital Agreement, the hospital should contact
the Plan and request the status of the determination.

Any admission or service that requires precertification review, as discussed in the
Utilization Management Guidelines and the Hospital Agreement, and has not
received the appropriate review, may be subject to post-service review denial.
Generally, the physician is required to perform all precertification review functions
with the Plan; however, the hospital may ensure, before services are rendered, that
such has been performed, or risk post-service denial. Refer to the Utilization
Management chapter for precertification review time frames.
ANCILLARY SCOPE OF RESPONSIBILITIES

The Plan has a network of various participating health care professionals and facilities. Health care professionals provide medically necessary services when a licensed physician or licensed health care professional orders the services and are in accordance with the applicable benefit agreement and Ancillary Agreement. All services provided by the health care professional, and for which the health care professional is responsible, are listed in the Ancillary Agreement. Health care professionals agree that all medical services they provide or arrange for are included in the rates, as described in the Ancillary Agreement.

PCPs and specialists refer members to Plan-contracted network ancillary professionals for conditions beyond the PCP’s or specialist’s scope of practice that are medically necessary. Ancillary professionals diagnose and treat conditions specific to their area of expertise. Ancillary care is limited to Plan benefits.

Ancillary professionals must follow all provider responsibilities as outlined in this manual.
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RESPONSIBILITIES APPLICABLE TO ALL PROVIDERS

Eligibility Verification

All providers must verify member eligibility immediately before providing services, supplies, or equipment. Eligibility may change frequently so a member eligible on the last day of the month may not be eligible on the first of the following month. The Plan is not responsible for charges incurred by ineligible persons.

Providers should verify Anthem Healthy Indiana Plan eligibility in one of the following ways:

• Log in to the Indiana’s MyAnthem secure website: [www.anthem.com](http://www.anthem.com)

• Customer Service Phone number: 800-553-2019  TDD: 800-758-1769

• Eligibility Verification Systems (EVS) will provide the following eligibility information for HIP members:
  • The member is eligible for HIP
  • The member’s insurer and telephone contact information for member’s benefits

• Log in to Indiana’s secure website Web interChange at [https://interchange.indianamedicaid.com/Administrative/logon.aspx](https://interchange.indianamedicaid.com/Administrative/logon.aspx)

• Use the Indiana Health Coverage Program (IHCP) Automated Voice Response (AVR) System: 800-738-6770 or 317-692-0819 (Indianapolis area)
IHCP Enrollment

All providers must be participating Medicaid Providers in order to participate in the Healthy Indiana Plan network. All services must be provided in-network since there are no out-of-network benefits for HIP. No coverage for out-of-network services in accordance with 42 CFR 438.206(b)(4) with the exception of family planning and emergency medical services. Anthem intends to target existing Anthem-contracted Hoosier Healthwise and Anthem Medicare Advantage participating providers for participation in the Healthy Indiana Plan network.

Prospective providers should be aware that in all referral or emergency situations, in order for the service to be a covered service under Healthy Indiana Plan, and in order to obtain reimbursement for such services, all providers must as a prerequisite be enrolled in IHCP and agree to accept Healthy Indiana Plan reimbursement as payment in full. Absent IHCP enrollment, the service will be deemed non-covered and no reimbursement will be made under the Healthy Indiana Plan. Providers seeking to retain their existing patient base and/or obtain reimbursement for referral or emergency services are encouraged to enroll in IHCP.

Precertification Reviews

Providers must request precertification review and obtain authorization from the Plan’s Utilization Management Department for the following services:

- Elective Admissions
- Emergency Admissions (Anthem requires notification within 24 hours)
- Inpatient Skilled Nursing Facility (SNF)
- Long Term Care Facility (LTAC)
- Rehabilitation Facility admission
- Inpatient Hospice Respite Care
- Bariatric Surgery
- Radiology Services: Nuclear Cardiology, CT Scan, MRI, MRA, MRS, PET Scan
• Human Organ and Bone Marrow/Stem Cell Transplants (Predetermination of Benefits is required)
  • Inpatient Admissions for ALL solid organ and bone marrow/stem cell transplants
  • All outpatient services for Stem Cell/Bone Marrow Transplant (with or without myeloablative therapy)
  • Donor Leukocyte Infusion
• Out-of-Network referrals (MAY be authorized based on network availability and/or medical necessity)
• Inpatient Mental Health and Substance Abuse Care including:
  • Inpatient Admissions
  • Intensive Outpatient Program (IOP)
  • Partial Hospitalization Program (PHP)
  • Residential Care

Providers submit precertification review requests directly to the Plan’s Utilization Management department according to the utilization review process.

An emergency medical service to triage and stabilize a member does not require precertification review, but the provider must notify the PCP that services were rendered.

Collaboration

The provider shares the responsibility of giving considerate and respectful care and working collaboratively with Plan affiliates, members and their families, specialty care providers, hospitals, ancillary providers and others for the goal of providing timely, medically necessary and quality health care services. Providers must permit members to participate actively in decisions regarding medical care, including, except as limited by law, their decision to refuse treatment. The provider must also facilitates interpreter services when necessary.
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Communication for Continuity of Care

The PCP should maintain frequent communication with the specialist physician, hospital and/or ancillary provider to ensure continuity of care. The Plan encourages physicians, hospitals and providers to maintain open communication with their patients regarding appropriate treatment alternatives, regardless of their benefit coverage limitations. The PCP is responsible for providing an ongoing source of primary care appropriate to the member’s needs. The Plan does not penalize physicians, non-physician practitioners, or other health care providers for discussing medically necessary or appropriate patient care.

The Plan established comprehensive and consistent mechanisms to ensure continued access to care for members when physicians terminate from the Plan. Under specified circumstances, members may finish a course of treatment with the terminating physician. For more information, refer to the Access Standards and Access to Care chapter.

Confidentiality

PCPs must ensure their members’ medical, behavioral health and personal information are kept confidential as required by state and federal laws. They must prepare and maintain all appropriate records in a manner that permits prompt retrieval of information on members receiving covered services through their office.

Obtaining Signed Consent

All Physicians, Hospitals, Ancillary Providers, Facilities and other Health Care Providers are required to obtain signed consent forms prior to providing services.

Medical Records Documentation and Access to Medical Records and Information

Providers are responsible for ensuring that member medical records are organized and complete, and include documentation from specialists, hospitals, ancillary providers, carved-out services, and community services when applicable. The PCP
must record the use of any and all interpreter services. Documentation must be signed, dated, legible and completed in a timely manner. Medical records must be stored in a secured location.

Providers must provide the Plan with prompt access, upon demand, to medical records or information for quality management or other purposes, including utilization review, audits, reviews of complaints or appeals, Health Plan Employer Data and Information Set (HEDIS®) and other studies. Physicians and any other provider of medical services must provide all medical records and information, at no cost to Plan, as required within the timeframe established in the request for records.

Providers must supply the Plan or its external quality review organization (EQRO) access to office sites for facility or medical records reviews upon the Plan’s request. Mandated time limitations for the completion of reviews and studies require the cooperation of the provider to deliver medical records expeditiously. Providers must have procedures in place for timely access to medical records in their absence.

For public health communicable disease reporting, providers must provide all medical records or information as requested and within the time frame established by state and federal laws.

**Mandatory Reporting of Abuse**

Providers ensure that office personnel have specific knowledge of local reporting requirements, agencies, and procedures to make telephone and written reports of known or suspected cases of abuse. All health care professionals must immediately report actual or suspected child abuse, elder abuse or domestic violence to the local law enforcement agency by telephone. Providers must submit a follow-up written report to the local law enforcement agency within the time frames as required by law.
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Notifying the Plan of Changes

Providers must notify Anthem Healthy Indiana Plan when any of the following occur:

• Change in professional business ownership
• Change in the practice tax identification number
• Change in business address or the location where services are provided
• Change in any demographic data (for example, phone numbers, open/closed practice status, or office hours)
• New physician/provider joins the practice
• A current physician/provider leaves the practice
• Any changes with a Group or Individual National Provider Identifier (NPI)
• Legal or governmental action initiated against a health care professional, including, but not limited to, an action for professional negligence, for violation of the law, or against any license or accreditation which, if successful, would impair the ability of the health care professional to carry out the duties and obligations under the Provider Agreement
• Any other problem or situation that impairs the ability of the health care professional to carry out the duties and obligations under the Provider Agreement

Use the Provider Maintenance Form (PMF) to notify the Plan of changes. The Plan prefers providers to complete the PMF on-line. The on-line form is located under the Answers@Anthem tab on the Provider Home Page.

In the event the Plan determines the quality of care or services provided by a health care professional is not satisfactory, as may be evidenced by or in member satisfaction surveys, member complaints or grievances, utilization management data, complaints or lawsuits alleging professional negligence, or any other quality of care indicators, the Plan may terminate the Provider Agreement.
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Health care professionals agree to be bound by and comply with Plan policies, procedures and rules.

Members’ Rights and Responsibilities

All Plan PCPs actively support the Members’ Rights and Responsibilities Statement as written in the Member Rights and Responsibilities chapter.

Office Hours

To maintain continuity of care, all PCPs must be available to provide services for a minimum of 24 hours each week. The PCP must be available 24 hours a day by telephone or have an on-call physician take calls in case of urgent or emergency situations. Physicians must post their office hours at each practice location. For specific hours of operation and after-hours requirements, refer to the Access Standards and Access to Care chapter.

The provider must inform members of the provider’s availability at each site.

After Hours

Those providers contractually obligated to provide “after hours” coverage for members shall not bill members for such coverage. Providers may only bill members for applicable coinsurance, copayments and deductibles.

Licenses and Certifications

Providers must maintain all licenses, certifications, permits, accreditations or other prerequisites required by the Plan and federal, state and local laws to provide medical services. Copies of the licenses, certifications, permits, evidence of accreditations or other prerequisites may be requested and verified during the Plan’s Credentialing Process and should be made available upon request by plan.
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Prohibited Activities

All providers are prohibited from:

• Balance billing eligible members for covered services
• Segregating members in any way from other persons receiving similar services, supplies or equipment
• Discriminating against Plan members

Open Clinical Dialog/Affirmative Statement

Nothing within the provider’s Participating Provider Agreement or this Provider Manual should be construed as encouraging providers to restrict medically necessary covered services or to limit clinical dialog between the providers and their patients.

Providers can communicate freely with members regarding the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

Provider Terminations

When a participating provider or a participating provider group notifies the Plan of their intent to terminate their provider agreement and exit the Plan’s provider network, the Plan will make best efforts to notify any members who may be impacted by the termination. In the event the terminating provider is a Primary Care Physician, the Plan will notify the physician’s assigned members and have them choose a new PCP. The notification will advise the members that any future services they receive from the provider after the effective date of the termination will be deemed ‘out of network’ and will be considered not covered under the benefit plan.
Providers wishing to terminate their participation agreement must submit written notification to the Plan at least 90 calendar days prior to the effective date of the termination.

Cross-References

- Eligibility Verification
- Utilization Management
- Continued Access to Care / Continuity of Care for Anthem Healthy Indiana Plan Members
- Health Services and Programs
- Facility Site and Medical Record Reviews
- Access Standards and Access to Care