Section 4
Practitioners

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Section 4

Role of the Primary Care Physician (PCP)

Upon joining a CDPHP HMO, government programs, or POS plan, each member must choose a doctor from the participating practitioner/provider directory to be his/her primary care physician (PCP). Members that select the PPO or EPO products are not required to select a PCP nor are they required to obtain a referral/authorization for specialist visits. PCPs may be chosen from the specialties of internal medicine, family practice, general practice, and pediatrics. Each member of a family may select a different PCP, and women may also choose an OB/GYN physician. For Medicaid-Select Plan and Medicaid-HARP, a member may choose a primary care provider from a behavioral health clinic the member already uses if that clinic also provides primary care services.

The member's PCP is responsible for coordinating the patient's health care services. Specifically, the PCP is responsible for the following:

- Coordinates care by arranging for services of participating specialists, adjunct, and ancillary practitioners/providers;
- Provides for primary medical evaluation and treatment on a 24-hour basis;
- Works cooperatively with CDPHP's resource coordination (RC) department to coordinate medically necessary care outside the network when an in-network provider is unavailable; (see Policy: Out-of-Network Care 1370/20.000145)
- Provides for initial access for each new problem or new episode of a problem;
- Consults with specialists to determine appropriate treatment(s) and place(s) of service(s);
- Consults and coordinates with member(s) regarding specialists' recommendations;
- Maintains a comprehensive medical record on each member for whom he/she is the designated PCP.
- Uses a formal assessment instrument to identify members needing mental health and chemical dependence services, and determines the types of services that should be furnished.

Appointment Wait Time

The contract CDPHP has with the New York State Department of Health to manage the care of Medicaid beneficiaries (both Select Plan and HARP) requires monitoring of appointment wait times. The contract states that "enrollees with appointments shall not routinely be made to wait longer than one hour." CDPHP currently monitors wait time through the member complaint process. A specific question regarding wait times is included in our member satisfaction survey.

Role of the Authorized Specialist

The authorized specialist is a physician who practices in any non-primary care discipline. The specialist acts as a consultant, and performs the services within his/her expertise which could not otherwise have been rendered by the PCP. The specialist is authorized by the PCP to render specific services. If the specialist feels additional services are medically appropriate, the specialist must consult with the PCP.

In addition to complying with the above, the authorized specialist agrees to:

- Maintain medical records on each CDPHP member treated by the specialist;
- Provide 24-hour coverage with another participating specialist;
- Respond to the PCP in writing of his/her findings and develop a treatment plan with the PCP.

On the following pages are tip sheets for you to use as a handy reference tool.

Coordination of Care

CDPHP monitors continuity and coordination of care between primary care physicians and specialists; between settings and across transitions of care; and within the medical and behavioral health delivery systems

Behavioral Health

Coordination between behavioral health and medical providers is a key aspect of care and exchange of information among health care practitioners is essential. It can be as simple as a phone call or documentation using progress notes, discharge summaries, or the CDPHP *Exchange of Information Form*, which is available as a writeable PDF under "Forms" in the Provider section of www.cdphp.com.

Obstetrical Care

CDPHP guidelines support continuity and coordination of obstetrical care for members per New York State Department of Health. Detailed information is available in Section 13 of this manual.

Inpatient Admissions/Role of the PCP and Hospitalist

It is essential that the primary care physician or other treating physician maintain communication with the admitting/attending physician any time a member is being admitted to a hospital or other facility by a hospitalist or another speciality physician. Physicians who choose to use hospitalists continue to be responsible for the management of their patients and should take the initiative to contact the hospitalist or other admitting physician when sending a patient to the hospital for admission. This avoids delays in initiating care and unnecessary duplication of services. It is the responsibility of the hospitalist to assure that communication back to the PCP or other treating physicians takes place when there is an unexpected change in the patient's condition and at discharge. This will improve the ongoing care of the patient and reduced complications and readmissions.

Sexually Transmitted Disease (STD) Reporting

New York State Department of Health Communicable Disease Reporting Requirements

Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (10NYCRR 2.10).

The primary responsibility for reporting rests with the physician; however, laboratories (PHL 2102), school nurses (10NYCRR 2.12), day care center directors, nursing homes/hospitals (10NYCRR 405.3d), and state institutions are also required to report communicable diseases.

For more information, and a list of communicable diseases and NYS reporting form, go to:
http://www.health.ny.gov/professionals/diseases/reporting/communicable/

6 Wellness Way • Latham, NY 12110

TIP SHEET FOR PRIMARY CARE PHYSICIANS

Contact Information

Resource Coordination . . . . . (518) 641-4100
Resource Coordination Toll-Free 1-800-274-2332
Provider Services (PS) . . . . . (518) 641-3500
PS Toll-Free 1-800-926-7526
Electronic Data Interchange (EDI) Team . (518) 641-4EDI
EDI E-mail address . . . . E_Transaction_Help@cdphp.com
Member Services (for Member Inquiries) . . (518) 641-3700
Behavioral Health Services 1-888-320-9584
To order claim forms, waivers, etc. . . . . (518) 641-3500
Credentialing and Provider File Maintenance . . (518) 641-3321

CDPHP website: www.cdphp.com

Member Eligibility

These suggestions are not a guarantee of coverage.

Please remember to:

- Verify eligibility of all patients by checking the member's ID card or accessing CDPHP's secure online network through www.cdphp.com. For further assistance, please call the provider services department.
- Collect the applicable copayment for services rendered at the time of the visit.
- Deductibles and coinsurance should be collected after receipt of the CDPHP payment.

Referrals/Authorizations

- Refer **ONLY** to participating physicians and providers. Consult "Find-A-Doc" on our website, your *Directory of Participating Practitioners and Providers*, or call the provider services department. Check the member's benefit plan coverage to be sure referrals are issued to providers that participate in the member's program.
- Utilize CDPHP's preferred laboratory and radiology network.
- It is the responsibility of the authorizing practitioner to determine the length of treatment.
- You may utilize the PCP/OB-GYN *Patient Treatment Waiver* if you are not designated as the member's PCP.
- After seeking services from a specialist, if a member requests another referral to a different physician of the same specialty, the PCP will issue another referral.
- Contact the resource coordination department for prior authorization of services from non-participating physicians/providers.
- Some CDPHP products provide coverage for non-participating physician/provider services without the prior authorization requirement. These services may increase the member's out-of-pocket responsibility.
- The most up-to-date policies can be accessed by logging into the secure area of www.cdphp.com.
- A complete list of services that require prior authorization is available by logging into the secure area of www.cdphp.com.

Admissions

- Inpatient facilities should contact CDPHP's resource coordination department within 24 hours or the next business day when a CDPHP member is admitted.
- CDPHP no longer requires its physicians to notify us in advance of a hospital admission.

Continued ▶

Claims

Not following these instructions may result in a delay in payment or a claim denial.

Please remember to:

- Submit all claims within established filing limits from the date of service to CDPHP, P.O. Box 66602, Albany, NY 12206-6602.
- Submit all COB claims within the established filing limits from the date of the primary carriers EOP.
- Complete the following sections of the CDPHP claim form:
    1. CDPHP member ID# (include suffix number), name, and date of birth.
    2. CDPHP provider name, address, and tax ID#.
    3. Your national provider identification number (NPI).
    4. Valid CPT-4 / HCPCS procedure code(s) and description.
    5. Valid ICD-9 diagnosis code(s) (as of October 1, 2015, ICD-10) and description.
    6. Date(s) of service.
    7. Itemized charges.
    8. Place of service code(s).
- If submitting a paper claim, ensure the claim is clear and legible with a font size of 10 or greater.
- Do not highlight anything on the claim form or Provider Review Form.
- We recommend you include your specific patient account number in field #26 of the CMS 1500 form, when submitting paper or electronic claims. If billed, the information will appear on your weekly explanation of payment for account reconciliation purposes.
- Include a copy of the operative report when billing for multiple surgical procedures and extensive or unusual procedures, or any unlisted procedure ending in "99."
- Check your CDPHP *Payment Vouchers* or 835 transactions weekly to determine the disposition of claims submitted.
- When submitting electronic claims, check your reject reports, make necessary corrections, and resubmit within established claim filing limits.
- Please allow for the claim to appear as a paid or denied claim on your voucher before resubmitting the claim, to avoid duplicate claims in the system.
- Locum tenens (LT) are required to bill for services under the practice's supervising physician's identification number.
- You have six months from the adjudication date of a claim to request a claim appeal. All claim appeals should be submitted on a fully completed Provider Review Form with additional supporting documents attached to CDPHP, Provider Services Department, 6 Wellness Way, Latham, NY 12110.
- Calling the provider services department to obtain the status of a claim is not considered acceptable follow-up. It is necessary to either provide additional information verbally that was not initially available or additional supporting documentation via the Provider Review Form to be considered acceptable follow-up within six months.
- Access CDPHP's secure online network to obtain the status of a claim and call the provider services department with any questions.

This tip sheet provides an overview of the claims process.
Refer to Section 9 of this *Provider Office Administrative Manual* for additional information.

Capital District Physicians' Health Plan, Inc.
Capital District Physicians' Healthcare Network, Inc.
CDPHP Universal Benefits, Inc.

6 Wellness Way • Latham, NY 12110

TIP SHEET FOR OB/GYN PHYSICIANS

Contact Information

Resource Coordination . . . . . (518) 641-4100	Member Services (for Member Inquiries) . . (518) 641-3700
Resource Coordination Toll-Free 1-800-274-2332	Behavioral Health Services 1-888-320-9584
Provider Services (PS) . . . . . (518) 641-3500	To order claim forms, waivers, etc. . . . . (518) 641-3500
PS Toll-Free 1-800-926-7526	Credentialing and Provider File Maintenance . . (518) 641-3321
Electronic Data Interchange (EDI) Team . (518) 641-4EDI	
EDI E-mail address . . . . E_Transaction_Help@cdphp.com	

CDPHP website: www.cdphp.com

All consultations, laboratory testing, and treatments must be communicated back to the primary care physician (PCP).

Member Eligibility

These suggestions are not a guarantee of coverage.

Please remember to:

- Verify eligibility of all patients by checking the member's ID card or accessing CDPHP's secure online network through www.cdphp.com. For further assistance, please call the provider services department.
- Collect the applicable copayment for services rendered at the time of the visit.
- Deductibles and coinsurance should be collected after receipt of the CDPHP payment.

Referral/Authorizations

- Refer **ONLY** to participating physicians and providers. Consult "Find-A-Doc" on our website, your *Directory of Participating Practitioners and Providers* or call the provider services department. Check the member's benefit plan coverage to be sure referrals are issued to providers that participate in the member's program.
- Utilize CDPHP's preferred laboratory and radiology network.
- Contact the resource coordination department for prior authorization of services from non-participating physicians/providers.
- Some CDPHP products provide coverage for non-participating physician/provider services without the prior authorization requirement. These services may increase the member's out-of-pocket responsibility.
- The most up-to-date policies can be accessed by logging into the secure area of www.cdphp.com.
- A complete list of services that require prior authorization is available by logging into the secure area of www.cdphp.com.

Admissions

- Inpatient facilities should contact CDPHP's resource coordination department within 24 hours or the next business day when a CDPHP member is admitted.
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Claims

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- Submit all COB claims within the established filing limits from the date of the primary carriers EOP.
- Complete the following sections of the CDPHP claim form:
    1. CDPHP member ID# (include suffix number), name, and date of birth.
    2. CDPHP provider name, address, and tax ID#.
    3. Your national provider identification number (NPI).
    4. Valid CPT-4 / HCPCS procedure code(s) and description.
    5. Valid ICD-9 diagnosis code(s) (as of October 1, 2015, ICD-10) and description.
    6. Date(s) of service.
    7. Itemized charges.
    8. Place of service code(s).
- If submitting a paper claim, ensure the claim is clear and legible with a font size of 10 or greater.
- Do not highlight anything on the claim form or Provider Review Form.
- We recommend you include your specific patient account number in field #26 of the CMS 1500 form, when submitting paper or electronic claims. If billed, the information will appear on your weekly explanation of payment for account reconciliation purposes.
- Include a copy of the operative report when billing for multiple surgical procedures and extensive or unusual procedures, or any unlisted procedure ending in "99."
- Check your CDPHP *Payment Vouchers* weekly to determine the disposition of claims submitted.
- When submitting electronic claims, check your reject reports, make necessary corrections, and resubmit within established claim filing limits.
- Please allow for the claim to appear as a paid or denied claim on your voucher before resubmitting the claim, to avoid duplicate claims in the system.
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TIP SHEET FOR SPECIALISTS

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- Collect the applicable copayment for services rendered at the time of the visit.
- Deductibles and coinsurance should be collected after receipt of the CDPHP payment.

Referrals/Authorizations

- Upon scheduling an appointment with the patient, remind him/her that a referral may be needed from his/her PCP.
- Utilize CDPHP's preferred laboratory and radiology network.
- Contact the resource coordination department for prior authorization of services from non-participating physicians/providers.
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    1. CDPHP member ID# (include suffix number), name, and date of birth.
    2. CDPHP provider name, address, and tax ID#.
    3. Your national provider identification number (NPI).
    4. The name and NPI of the referring physician.
    5. Valid CPT-4 / HCPCS procedure code(s) and description.
    6. Valid ICD-9 diagnosis code(s) (as of October 1, 2015, ICD-10) and description.
    7. Date(s) of service.
    8. Itemized charges.
    9. Place of service code(s).
    10. Use the "ET" modifier on your claim when billing for one follow-up visit when the member has been referred from the emergency room or urgent care center. (This visit must occur within 10 business days of the emergency visit.)
- If submitting a paper claim, ensure the claim is clear and legible with a font size of 10 or greater.
- Do not highlight anything on the claim form or Provider Review Form.
- We recommend you include your specific patient account number in field #26 of the CMS 1500 form, when submitting paper or electronic claims. If billed, the information will appear on your weekly explanation of payment for account reconciliation purposes.
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