Provider Policies and Procedures Manual

…….Your Partners for Good Health

The purpose of these policies and procedures is to offer specific explanations for provisions contained in Health Partners of Kansas provider contracts.

MISSION STATEMENT

To serve our members and providers with courtesy, respect, responsibility, honesty and accuracy.

To strive for quality in all areas of service at all times.

To steadily improve, enhance and expand our services.

To support our community by providing comprehensive healthcare benefits within an extensive professional network.

ABOUT US

Founded in 1987, Health Partners of Kansas (HPK) celebrates being in business for more than 20 years. Located in Wichita, HPK is a Kansas statewide provider network, which offers administrative services to employer groups, third party payers and insurance companies to assist in the development of health plans. While other networks and payers contract with Wesley Medical Center, HPK prides itself in being the only network both affiliated and owned by Wesley.

Administrative services offered include network lease, provider contracting, provider credentialing, and provider servicing. The strength and success of HPK is, in a large part, due to the hospital/physician relationships that have been developed as well as the commitment to customer service excellence. HPK is committed to meeting the demands of the marketplace by providing a balance of cost, access and quality within a health care delivery system.

HPK STAFF

Gaylee Dolloff……..President

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CONTACT US

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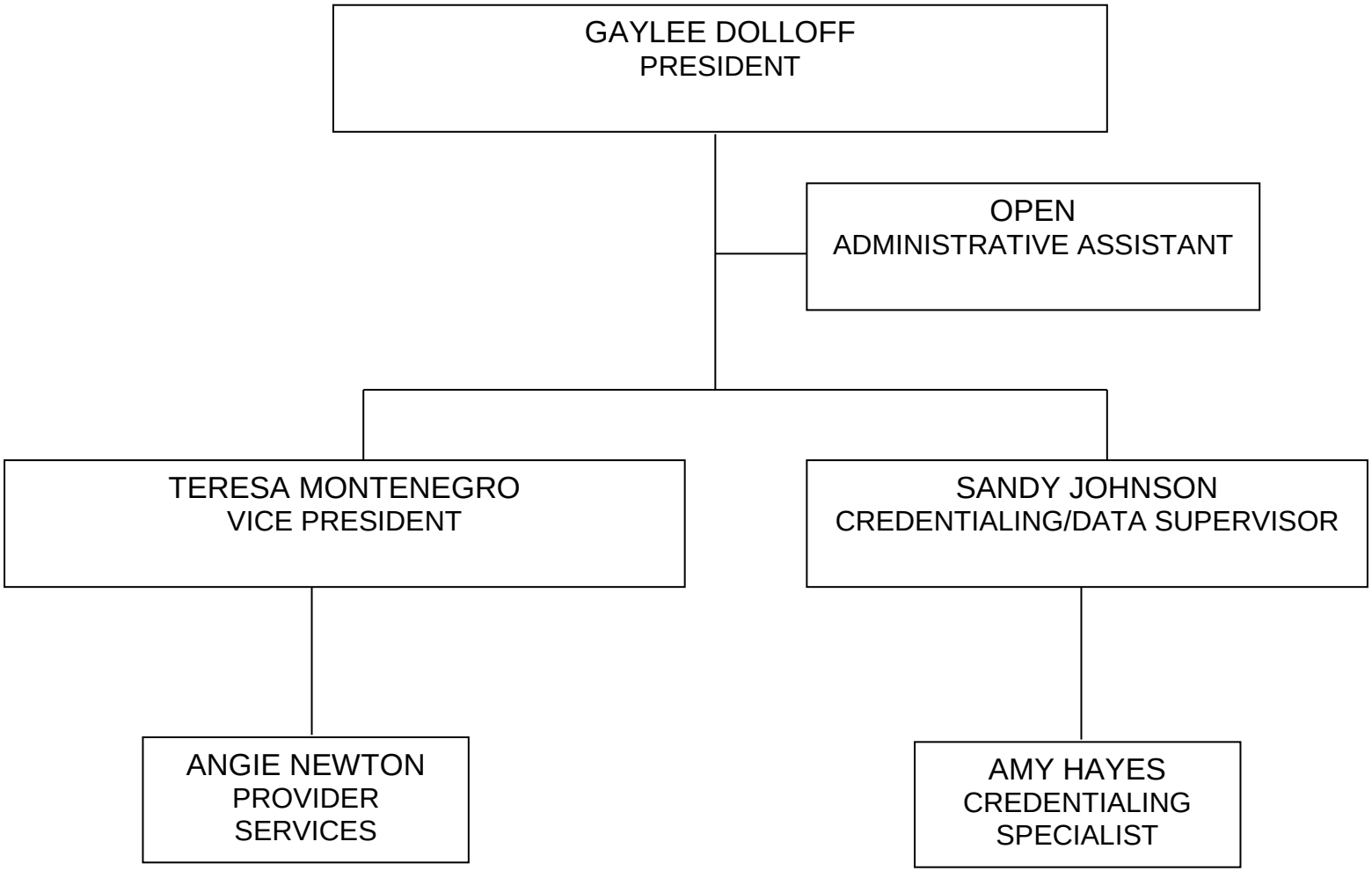
HEALTH PARTNERS OF KANSAS, INC
ORGANIZATIONAL CHART



MEMBER RESPONSIBILITIES

- Utilize in-network providers to receive the highest benefit level. Utilizing out-of-network providers will decrease benefit level and could possibly result in the entire charge amount being denied and the member held responsible
- Present ID card at the time of service
- Pay copayment at the time of services
- Comply with the medical advice and orders of your provider
- Understand and abide by your benefit plan's coverage and exclusions
- Inform your employer if you have any eligibility changes
- Inform your Payer if you have additional healthcare coverage

MEMBER RIGHTS

- To receive high quality medical care
- To be treated with courtesy and respect
- To maintain the right of privacy regarding your medical care
- To view medical records through your healthcare provider
- To receive full and understandable answers to your questions

PROVIDER REFERENCE GUIDE

General Information

- Patients may also be known as a Member, Subscriber or Insured.
- Members should be referred to providers that participate in the Health Partners of Kansas network.
- Photocopy the front and back of the Member's ID card each visit .
- Pre-certify as required by the Member's benefit plan.
- Plan benefit designs vary by group. Call the information number on the back of the Member's ID card for benefit information. This should be the number for the Health Plan or Insurance Co.

Appeals Procedure

If a Provider or Member wishes to appeal a decision made by the Payer, they should follow the appeal process located on the Explanation of Benefits. All medical information and viewpoints from the provider and member will be researched and reviewed in the appeals process before a final financial determination is made.

Coinsurance and Copayments:

Copayments are generally fixed amounts rather than a percentage and are due at the time services are rendered. These amounts are usually identified on the member's identification card. The amounts will vary depending on the insurance plan.

Coinsurance is a provision of each insurance plan by which the insured shares the cost of various covered expenses on a percentage basis. These too will vary by plan. The carrier will pay their percentage of the maximum allowable amount set forth in the negotiated fee schedule, the insured will be responsible for the remaining percentage (e.g., carrier pays 80%; member pays 20%.

Content of Service/Incidental Services

Content of service/Incidental service refers to those procedures and/or services that are considered to be an integral part of another procedure and/or services. This may also include procedures and/or services determined by the Payer that were unbundled.

Coordination of Benefits:

When an insured has two plans covering costs for the member, the benefits are coordinated between the two plans. You should contact the claims administrator directly in order to verify the rules used to determine the benefit payment. Note: If Payer is other than the primary Payer, then reimbursement to participating providers from Payer shall not exceed the amount allowed from Health Partners of Kansas fee schedule.

Deductibles:

Amounts and type of deductibles will vary by plan. These amounts may be obtained by calling the benefit verification number on the member's identification card.

Explanation of Benefits (EOB):

An explanation of benefits statement will be issued to the physician each time medical expenses are submitted and plan benefits are assigned to the provider of medical services. This statement will identify HPK, (or contracted Payer i.e.; CIGNA) the member, date of service, procedure(s) considered, amount charged, allowable amount, percentage of coverage, applicable co-payment/coinsurance and deductibles applied, and the member's financial responsibility. **Please note that you may not collect the difference between your charged amount and the maximum allowable amount from the member.**

Laboratory/X-Ray Procedures:

Laboratory and x-ray procedures may be done in your office or at any participating Health Partners of Kansas provider/facility.

Member Benefits/Coverage Limitations:

The Payer is obligated to cover only those services, which are specified in the certificate of coverage. It is important to note that some plans may exclude certain pre-existing conditions and may have either annual or lifetime dollar maximum benefit coverage limits. Any questions about covered benefits or coverage limitations should be directed to the Health Plan at the phone number listed on the member's ID card.

Member ID Card:

When a member calls for an appointment, they should be requested to bring their insurance information, ID card, and if required, specific claim form. The ID card contains all key phone numbers and addresses you will need regarding benefits and eligibility, authorizations, and claims payment. However, the member possessing the ID card does not guarantee his or her eligibility for benefits.

Photocopy both sides of the ID card for the member's file or record the following important information from the ID card:

- Insured/Employee Name
- Insured/Employee ID Number
- Group Name
- Group Number
- Claims Office Address
- Claims Office Telephone Number

You will need this information to complete the claim form when you bill the Payer.

Health Partners of Kansas, HPK, the HPK logo or that of contracted Payer, i.e.; CIGNA, should be clearly identified on the ID card to designate that the member/patient is to access the HPK provider network, **IT DOES NOT INDICATE HPK AS RESPONSIBLE FOR MEDICAL MANAGEMENT, REFERRALS AND/OR AUTHORIZATIONS OF CLINICAL SERVICES**. Please contact the member's benefit plan for these services.

Pre-certification and Utilization Review:

Life threatening emergencies should always go to the nearest facility providing the appropriate level of care.

Prior to any elective hospitalization, make sure you call the appropriate utilization review company (located on the member's identification card) to pre-certify the procedure. Failure to pre-certify an admission may result in denial of claims for payment related to the admission. Hospitalized members may be subject to concurrent review with regard to medical appropriateness, level of in-patient care, length of a hospital stay or other parameters deemed medically appropriate by the claims administrator.

In addition to hospitalization, other services (e.g. MRIs, CT, PET scans, genetic testing, certain out-patient procedures, etc) may require pre-certification. Refer to the member's ID card for pre-certification requirements.

When calling for pre-certification, please be prepared to provide the following information:

- Member's name and date of birth
- Insured's information; name, Social Security number, address, policy ID number, employer, and home telephone number
- Physician's information; name, tax ID number, address and telephone and fax number
- Admitting hospital's information; name, address and telephone number
- Patient's symptoms and duration
- Results of physical exam, lab tests, and/or x-rays
- Medical and/or surgical treatment plan
- Admitting diagnosis

Referrals to Participating Physicians and Hospitals:

The member/patient's benefit plan determines the need for written referrals and/or authorizations. Please be aware that HPK does not perform Utilization Review (UR), authorizations and referrals for members accessing the HPK network.

In accordance with plan design, benefits will be decreased or denied for using providers outside of the HPK network. Please ensure all laboratory and radiological services are provided within the HPK network. If unsure about providers participation please consult HPK's web site at www.hpkansas.com, or call HPK Provider Services at (316) 652-1327 or (800) 633-9917.

Refund/Overpayment Policy

In the event an overpayment or underpayment is made to any Participating Provider, a correction shall be made by the appropriate party by issuing a refund or additional payment for such overpayment or underpayment to the other party within thirty (30) days of receipt of written notification of same as long as written notification is within one year of the date of service.

PROVIDER RIGHTS

Providers have the right to review and correct any erroneous information used to evaluate the application during the credentialing verification process. Verification sources may include the state licensing board, regulatory agencies such as the NPDB and OIG, malpractice insurance carriers, and other peer-review protected information. HPK Credentialing staff shall notify the provider in writing when information is in question during the application assessment process. The HPK written notification will: 1) Identify what information is in question; 2) Identify what documentation and/or response is expected; 3) Identify who the provider's response is to be sent to; and, 4) State the date the information is due HPK. The provider shall be accorded thirty (30) days from the date of the letter to reply. The letter will also inform the provider that if response is not received within thirty (30) days, the application will be suspended and no further credentialing will occur and a new application may be required. When the information is received from the provider, the HPK credentialing staff will date and document the provider's corrections to the application.

Providers also have the right to be informed about the status of the application process. Requests may be submitted to HPK through written or verbal communication. Written communication may include letters, fax, or e-mails. If the request is made verbally, the communication shall be documented noting the date, name of provider or designated spokesperson, topic of discussion, expected outcome, and signature of the credentialing staff. Documentation shall be made and maintained in the provider paper file and/or electronic record. HPK response to written or verbal requests shall be completed within seven (7) business days of the request.

Providers are advised of the right to review and correct erroneous information in the credentialing application and the right to be informed about the status of the credentialing application on the HPK Statement of Attestation and in the HPK Provider Manual available on the HPK website.

NONDISCRIMINATORY CREDENTIALING DECISIONS

Health Partners of Kansas shall not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, age, sexual orientation, type of procedures performed, or the types of patients cared for by the applicant. Members of the MAC shall sign an annual agreement affirming that credentialing decisions are made in a nondiscriminatory manner and that any complaints alleging discrimination shall be diligently investigated.

DEFINITIONS

Benefit Plan: means those individual and group health benefit contracts, policies of insurance, or other health care coverage arrangements or plans of a Payer which are subject to Health Partners of Kansas participating provider agreements and pursuant to which a Member is eligible to receive Covered Services.

Covered Services: means the medically necessary health care services provided pursuant to a benefit plan. Services shall not be deemed to be covered services unless they have been determined to be medically necessary as determined by the Payer or party delegated by Payer pursuant to the applicable benefit plans.

Emergency Services: means Medically Necessary health services for the treatment of acute illness or injury requiring immediate medical attention and which involve placing the health of a patient in serious jeopardy; or serious dysfunction of any bodily organ or part; and which may preclude the Member from seeking such care from or through a Participating Provider.

Fee Schedule: means a schedule of maximum reimbursement amounts set forth, which a Payer shall pay Participating Provider to provide Covered Services.

Managed Care Programs: means one of the following programs offered through Health Partners of Kansas Network: Preferred Provider Organization (PPO), Point-of-Service (POS), Work Comp (Occ Health), under which a Member is eligible to receive Covered Services through a Benefit Plan.

Medically Necessary: means Covered Services or supplies, which under the terms and conditions of this Agreement, and the applicable Benefit Plan, are determined to be appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition of Member; provided for the diagnosis or direct care and treatment of the medical condition of Member; within standards of hospital and medical practice within the community, and, are not primarily for the convenience of the Member, the Member's physician or another provider.

Member: means a person who is eligible to receive Covered Services pursuant to a Benefit Plan.

Member Charges: means co-payment, coinsurance, deductibles, charges associated with exhausted benefits and similar charges. If any, applicable to Covered Services which are to be paid by the Member pursuant to a Benefit Plan.

Participating Provider: means any physician, physician group, ancillary provider, practitioner, or hospital entity, which has entered into an agreement with Health Partners of Kansas to provide Covered Services to eligible members and/or their beneficiaries.

Payer: means any insurance company, employer, third party administrator, risk-bearing entity, or other entity, which has contracted with Health Partners of Kansas (HPK), or an HPK contracting partner to arrange for the provision of Covered Services to Members pursuant to one or more Managed Care Programs.