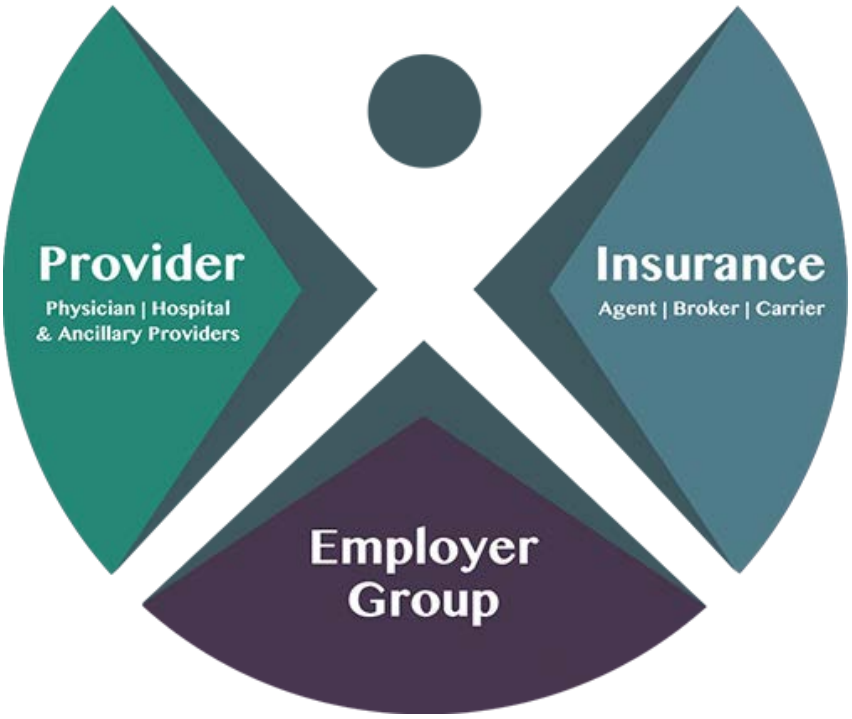
WPPA, INC.

ProviDRs Care



2018

Provider Manual

WPPA, INC.

ProviDRs Care

Contents

Introduction

How to Use This Manual

The ProviDRs Care Manual is published to assist healthcare providers and office staff in developing and maintaining a high quality working relationship with ProviDRs Care. Updates and revisions to this manual are available at **www.ProviDRsCare.net** and can also be provided electronically.

When questions arise regarding programs and plans associated with ProviDRs Care, we ask that you please check the appropriate section of the manual prior to calling customer service. If you are unable to find the answer, please check our website or contact the Provider Relations Department.

In addition, we are always searching for ways to improve service for our Providers. If you have any suggestions regarding improvement to this manual, please contact the Provider Relations Department.

About WPPA, Inc. dba ProviDRs Care

Our Mission is...

- To sustain a comprehensive statewide network of physicians, hospitals and ancillary providers dedicated to delivering high-quality and cost effective medical care to covered members at a reasonable fee.
- To maximize the benefits of employee health care plans while controlling health care costs by partnering with insurance carriers, employers and our network of providers and facilities.

ProviDRs Care works in partnership with insurance agents, brokers and carriers to provide cost-effective, quality health care coverage to individuals, employers and groups ranging from 2 to 20,000 members. Our extensive network of physicians, health care providers and medical facilities helps employers maximize their plan benefits and gain control of their costs.

How to Contact ProviDRs Care

Phone Number: (316) 683 4111 or (800) 801-9772
Fax Numbers: General (316) 683-6255 or Claims (316) 683-1271

Business hours are Monday through Friday, 8:30 am to 5:00 CST.

	Phone Extension	Email Address
Provider Relations & Contracting	(800) 801-9772 Option 4	**ProviderRelations@ProviDRsCare.net**
Claims Dept	(800) 801-9772 Option 3	**Claims@ProviDRsCare.net**

Provider Responsibilities

Introduction

This section of the Provider Manual addresses the respective responsibilities of Participating Providers.

ProviDRs Care does not prohibit or restrict Network Providers from advising or advocating on behalf of a Participating Member about:

(1) The Participating Member's health status, medical care or treatment options (including alternative treatments that may be self-administered), including providing sufficient information to Participating Member to provide an opportunity to decide among all relevant treatment options;

(2) The risks, benefits and consequences of treatment or non-treatment; and

(3) The Participating Member's right to refuse treatment and express preferences about future treatment decisions. An Ancillary Provider must provide information regarding treatment options in a culturally competent manner, including the option of no treatment. A Provider must ensure that individuals with disabilities are presented with effective communication on making decisions regarding treatment options.

Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

A Provider's responsibility is to provide or arrange for Medically Necessary Covered Services for Participating Members without regard to race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment. A Physician is further responsible to render Medically Necessary Covered Services to Participating Members in the same manner, availability and in accordance with the same standards of the profession as offered to the Provider's other patients.

Primary Care Physician (PCP) Responsibilities

The following is a summary of responsibilities specific to Primary Care Physicians who render services to Plan Members:

- Coordinate, monitor and supervise the delivery of health care services to each Participating Member who has selected the PCP for Primary Care services.
- Assure the availability of Physician services to Participating Members in accordance with Physician Availability & Accessibility.
- Arrange for on-call and after-hours coverage.
- Ensure Members utilize network Providers. If unable to locate a participating Provider for services required, contact Provider Relations for assistance.
- A Physician/Provider will consider Member input into proposed treatment plans.

Specialists Responsibilities

Specialists are responsible for communicating with the PCP in supporting the Medical Care of a Member.

Responsibilities of All Plan Providers

The following is an overview of responsibilities for which all Plan Providers are accountable. Please refer to your contract, or contact your Provider Relations Representative for clarification of any of the following:

- All Providers must comply with the appointment scheduling requirements as stated in the Appointment Scheduling Section.
- Provide or coordinate health care services that meet generally recognized professional standards in the areas of operations, clinical practice guidelines, medical quality management, customer satisfaction and fiscal responsibility.
- Use Physician extenders appropriately. Physician Assistants (PA) and Advanced Practice Registered Nurse (APRN) may provide direct Member care within the scope or practice established by the rules and regulations of the State of Kansas and Payor guidelines.
- The sponsoring Physician will assume full responsibility to the extent of the law when supervising PA‘s and APRN‘s whose scope of practice should not extend beyond statutory limitations.
- PA‘s and APRN’s should clearly identify their titles to Members, as well as to other health care professionals.

- A request by a Member to be seen by a Physician, rather than a Physician extender, must be honored at all times.
- Admit Members only to participating Hospitals, Skilled Nursing Facilities (SNF's) and other inpatient care facilities, except in an emergency.
- Respond promptly to Network or Payor requests for medical records in order to comply with regulatory requirements, and to provide any additional information about a case in which a Member has filed a grievance or appeal.
- Not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against any Participating Member, other than for patient responsibility in accordance with benefit plan.
- Treat all Member records and information confidentially, and not release such information without the written consent of the Member, except as indicated herein, or as needed for compliance with State and Federal law.
- Apply for a Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable. Maintain quality medical records and adhere to all Network policies governing the content of medical records as outlined in the quality improvement guidelines. All entries in the Member record must identify the date and the Provider.
- Maintain an environmentally safe office with equipment in proper working order in compliance with city, state and federal regulations concerning safety and public hygiene.
- Communicate clinical information with treating Providers timely.
- Preserve Member dignity, and observe the rights of Members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimen.
- Not to discriminate in any manner between Participating Members and non-Participating Members.
- Fully disclose to Members their treatment options and allow them to be involved in treatment planning.
- A Physician/Provider will consider Member input into proposed treatment plans.

Physician Access & Availability

Providers agree to make necessary and appropriate arrangements to ensure the availability of services to Members on a 24-hour per day, 7-day per week basis, including arrangements for coverage of Members after hours or when the Physician is otherwise unavailable.

In the event participating Providers are temporarily unavailable to provide care or referral services to Plan Members, they should make arrangements with another network contracted and credentialed provider to provide these services on their behalf.

Additionally, Physicians are to establish an appropriate appointment system to accommodate the needs of Participating Members, and shall provide timely access to appointments to comply with the following schedule:

- Urgent Care within 2 days of an illness;
- Sick care within 1 week of an illness; and
- Well visit within 2 months of an appointment request.

Appointment Scheduling

The following criteria comply with access standards:

1. Primary Care Providers should:
    - Provide medical coverage 24-hours a day, seven days a week;
    - Scheduled appointments should be seen within 30 minutes;
    - Schedule urgent care within 2 days;
    - Schedule routine care within one 30 days; and
    - Schedule preventive care within 60 days.

2. Specialty Care Providers should:
    - Schedule urgent care within 2 days;
    - Schedule routine care within 30 days;

ProviDRs Care may collect and perform an annual analysis of access and availability data, and measures compliance to required thresholds. The analysis can include access to:

- well visit;
- sick care;
- urgent care; and/or
- after hours care.

After-Hours Services

The Primary Care Physician or covering Physician should be available after regular office hours to offer advice and to assess any conditions, which may require immediate care.

To assure accessibility and availability, the Primary Care Physician should provide one of the following:

- 24-Hour answering service;
- Answering system with an option to page the Physician; or
- An advice nurse with access to the PCP or on-call Physician.

Provider Information Changes

30 day prior notice to our Provider Relations Department is required for any of the following changes:

- Tax identification number
- Group name or affiliation
- Physical or billing address
- Telephone or facsimile number

Updates can be sent to **ProviderRelations@ProviDRsCare.net** by completing the online form available at **http://providrscare.net/wp-content/uploads/2015/11/Provider-Changes.pdf**.

Contracting

Eligible Providers

The following providers are eligible for membership in the ProviDRs Care Network:

Physicians
Physician Assistants
Podiatrists
Occupational Therapists
Oral Surgeons
Optometrists
Physical Therapists
Psychologists
Psychiatrists
Chiropractors
ARNP (Nurse Practitioners)
LSCSW (Clinical Social Workers)
LCP (Licensed Clinical Psychotherapist)
LPC (Licensed Professional Counselor)
LCMFT (Licensed Marriage & Family Therapist)
LMFT (Licensed Marriage Therapist)
LAC (Licensed Addiction Counselor)
LCAC (Licensed Clinical Addiction Counselor)
LMLP (Licensed Master Level Psychologist)
LP (Licensed Psychologist)
BA (Behavior Analyst)
SLP (Speech & Language Pathologists)
AuD (Audiologists)
RD (Registered Dietician)

RDN (Registered Dietician Nutritionist)
CRNA (Nurse Anesthetists)
Behavior Health Specialists
Hospitals & Specialty Hospitals
Hospices
Laboratories
Ambulatory Surgery Centers
Minor Emergency Centers
Radiological Facilities
Home Health Care Agencies
Outpatient Mental Health Facilities
Durable Medical Equipment
Infusion Therapy Companies
Specialty Pharmacies
Diabetic Supply Companies

Credentialing

All providers must be credentialed prior to participating in the ProviDRs Care network

A. GOVERNANCE STRUCTURE

The Network Board of Directors (Network Board) has ultimate authority on matters of credentialing policy. The Board has charged the Membership and Peer Review Committee (Membership Committee) with the development of policies and procedures that are consistent with Board policy, that are sensitive to consumer needs and that maintain strict confidentiality. These policies and procedures will be used by the Membership and Peer Review Committee in making credentialing decisions regarding providers for Network's provider panel.

B. PURPOSE OF THE CREDENTIALING PLAN

The purpose of this Credentialing Plan is to assure a systematic approach to the non-discriminatory selection, evaluation, monitoring, disciplining and separation of members of the Network.

Together the screening and credentialing activities will allow the Network to:

Screen applicants to determine if the applicant meets the pre-application requirements, if the applicant is needed for the network, and if the provider should be invited to apply to the Network for membership.

Invite applicants to apply as panel participants if screening criteria are met.

Obtain and maintain provider professional information (all information received or discovered during credentialing or recredentialing will be maintained with strict confidentiality at all times).

Approve qualified physicians including MD's, DO's, DPM's, DDS's.

Approve qualified allied health professionals to be listed in the directory.

To ensure providers are provided the opportunity to review and correct information used in the credentialing process.

Enable due process of those providers who do not meet criteria.

Establish membership disciplinary procedures.

Assist in the continuous quality improvement of the provider Network.

C. CONFIDENTIALITY, DISCRIMINATION, AND CONFLICT OF INTEREST

The Network requires that all members of the Membership and Peer Review Committee maintain the strictest of confidence regarding information presented and discussed during the credentialing procedures. Credentialing decisions will be conducted in a non-discriminatory manner. Decisions will not be based on race, ethnic/national identity, gender, age, sexual orientation, patient type (e.g. Medicaid)type of practice, etc. Additionally, the Membership and Peer Review Committee on an annual basis will monitor and avoid any discrimination or conflict of interest issues. If Committee Chair observes behavior that may potentially be considered discriminatory or a conflict of interest, they will discuss this with the Committee Member and determine resolution, which may include a report submitted the Network Board.

The Membership and Peer Review Committee members are required to sign a Confidentiality / Discrimination Conflict of Interest Agreement.

D. MEMBERSHIP AND PEER REVIEW COMMITTEE

The Network Board of Directors has delegated the credentialing and peer review function to the Membership and Peer Review Committee. The purpose, committee membership, and committee rules which address the credentialing function are as follows:

PURPOSE

The purposes of the Membership and Peer Review Committee are to:

1. Conduct peer review of providers applying or reapplying for membership in the Network, using information that is no more than one hundred eighty (180) days old.

2. Recommend to the Board acceptance or rejection of provider applications based on minimum professional standards and peer review.

3. Provide reconsideration and/or appeal opportunity for invited providers who have been denied participation or continuation in the Network.

4. Recommend to the Board actions/discipline for continuation in Network for providers who:
    a) breach contract provisions;
    b) exhibit inappropriate utilization;
    c) demonstrate quality of care inconsistent with community standards; or
    d) have excessive complaints and grievances; or
    e) have more than two (2) sanctions in a given year.

5. Advise the Board of Directors on credentialing policy issues; and

6. Review annually and recommend needed revisions of the Credentialing Plan to the Network Board of Directors.

COMMITTEE MEMBERSHIP

Membership and Peer Review Committee members shall be comprised of at least six (6) voting members (composed of physicians representing multiple specialties) appointed by the Network Board President, and up to two (2) representatives of the Network Managed Care Department.

COMMITTEE RULES

The Network Membership and Peer Review Committee conducts meetings using the following rules of order in performing the credentialing function. The Committee will be chaired by a physician who is responsible for carrying out the duties of the Membership Committee and will act as a liaison for the Board of Directors. In addition, such physician will lead the implementation of the credentialing program according to the Credentialing Plan and its associated policies and procedures.

1. Not more than four (4) physician members from the Board of Directors.

2. Remainder, Non-Board member physicians.

3. Peer Review is conducted by physicians.

4. The Committee will meet at least monthly for a total of no less than twelve (12) meetings per year. Meetings may be scheduled more frequently, if necessary.

5. Procedures are voted on by the Committee.

6. Policy changes in the Credentialing Plan must be approved by the Network Board.

7. A simple majority of voting committee members present (at least three) is required for approval of participation status, policy and procedure changes.

8. Confidential minutes are taken.

9. Every applicant is reviewed by the Membership and Peer Review Committee, using information that is no more than one hundred eighty (180) days old.

10. All Committee members must execute confidentiality/conflict of interest agreements.

11. Committee may vote by unanimous consent in writing or by phone.

12. Members receive indemnification by Network.

13. Additional rules to be developed as needed.

E. PRACTITIONER RIGHTS

The practitioner has the right to review information submitted to support their credentialing application. The practitioner will be notified in writing within thirty (30) days of any information obtained during the credentialing process that varies substantially from information provided to the organization by the practitioner. The practitioner will then have thirty (30) days to submit corrections or explanations of discrepancies to WPPA, ProviDRs Care via email, fax or mail prior to Membership Committee review of the file. The practitioner has the right to request status during the credentialing process and receive a written response within thirty (30) days. Each practitioner shall be entitled, upon request, to information obtained by WPPA, ProviDRs Care to evaluate the practitioner's credentialing application from outside sources such as state licensing boards and malpractice carriers. WPPA, ProviDRs Care may at its discretion, provide redacted copes or summaries of information if required to protect an individual's confidentiality. If a practitioner believes upon review of the information, that any information contained therein is misleading and/or erroneous, the practitioner may submit a corrective statement, which WPPA, ProviDRs Care shall place in the practitioner's credentialing file. The foregoing does not require WPPA, ProviDRs Care to alter or delete any information contained in the practitioner's credentialing file, nor does it require WPPA, ProviDRs Care to disclose to a practitioner references, decisions, or other peer review protected information.

F. PEER REVIEW AND USE OF CRITERIA

Peer Review is the review of an applicant's professional behavior, educational background and experience as a physician or practitioner.

The use of explicit criteria during peer review is to avoid discrimination during the selection process, to approve physicians who have demonstrated their commitment to quality and who have the requisite background for Network's needs. Criteria are to be used in conjunction with the judgment and experience of the Membership Committee. The committee may waive any criteria when in the best interest of Network and patient care, except criteria regarding current licensure, DEA, liability limits and an attested application.

G. APPEALS BOARD/FAIR HEARING PROCEDURES

MEMBERSHIP of the Appeals Board

A panel of at least five (5) physicians (with no more than one on the Membership and Peer Review Committee), one of whom is designated as chairman, is appointed by the Network Board of Directors. The purpose, membership rules and appeal procedures are as follows:

PURPOSE

The purposes of the Appeals Board/ Fair Hearing Process are to:

1. Provide a fair hearing for providers with the purpose of addressing adverse decisions regarding disciplinary action and/or termination resulting from a credentialing or recredentialing review.

2. Review all information submitted by the Membership Committee, Board of Directors and the Appellant.

3. Render a decision which is supported by all rules and regulations regarding educational background and training, experience, professional behavior and appropriate utilization of resources in providing high quality patient care.

APPEALS BOARD RULES

The Network Appeals Board follows the following rules of order:

1. The Appeals Board has ultimate authority to hear and respond to appeals.

2. Any physician in direct competition with an applicant may render clinical opinion, but shall be excused from the meeting for voting.

3. The Board will notify the applicant of the Appeals Board review process.

4. Within two weeks after receiving an appeal, the Appeals Board will schedule a hearing at a time and place mutually agreed on by both parties.

5. The right to a hearing is forfeited if the provider fails, without good cause, to appear for the Appeals Board hearing.

6. The applicant may be represented by an attorney or other person of the physician's choice.

7. The applicant is entitled to the following rights:
    a. To have a record made of the proceedings;
    b. To call, examine and cross-examine witnesses;
    c. To present evidence determined to be relevant by the Appeals Board, regardless of its admissibility in a court of law;
    d. To submit a written statement at the close of the hearing;
    e. To receive the written recommendation of the Appeals Board, including a statement of the basis for the recommendations; and
    f. To receive a written decision from Network, including a statement of the basis for the decision.

8. The Appeals Board will submit a written response to the appeal within 60 days after receiving the appeal, specifying the findings and the decision.

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CREDENTIALING - RECREDENTIALING CRITERIA

A. PHYSICIAN PRE-APPLICATION SCREENING CRITERIA

License	MD, D.O., D.P.M., D.D.S. with current, unrestricted license to practice medicine in state in which the network is established.
Hospital Privileges	Has or is applying for privileges at a Network Hospital or meets acceptable exception criteria (rural area, non-hospital based specialty, etc.).
Malpractice	Current professional liability coverage with no history of denial or cancellation.
Recommendations	From one peer, non-economic relationship.
Network Panel Status	Meets specific Network panel membership need as documented in the current board resolution on panel status.

B. GENERAL PHYSICIAN SELECTION CRITERIA

Application and Attestation	Application with attestation as to completeness and correctness. Incomplete applications will be returned. Complete applications will include name; degree; date of birth; specialty; board certifications; address and phone; TIN; work history for the past five years; license state, number and expiration date; answers to all professional questions and health status questions; education institution, degree and graduation date; training institution(s), specialty(s), and dates; certificate of insurance with a current expiration date; hospital privileges; DEA, BNDD number and expiration date; original application signature and original release signature no more than 180 days prior to receipt of application.
State License	Verified, current and unrestricted license in the states in which network is established. Providers with a Federal Active License will be reviewed by the Membership Committee for consideration to participate or continue participation in the network.

Education

MDs and DOs:
Graduation from medical school.
Successful completion of a residency except:

1. General Practitioners who graduated from medical school prior to 1985 or

2. The lack of a panel physician would create a public health hardship in a specific community.

DDSs:
Graduation from dental school and completion of specialty training as applicable.

DPMs:
Graduation from podiatry school and completion of a residency, as applicable.

Board Certification

Board Certification from the specialty board recognized by ABMS, AOA, American Board of Oral and Maxillofacial Surgery, American Board of Podiatric Medicine or American Board of Foot and Ankle Surgery for the practice specialty or meet one of the following exceptions:

1. Have graduated from medical school prior to 1985, or

2. Have graduated from medical school and completed a residency or fellowship in the practicing specialty within the past 5 years, or

3. The lack of a panel physician would create a public health hardship in a specific community as determined by the Board, or

4. The Board waives the requirement for the individual in question based on information provided by the applicant or knowledge of the applicant's medical skills. If either of these measures is unavailable, the Committee may request additional information from known and reputable resources.

DEA

Verified, Current Federal Drug Enforcement Administration Certificate (DEA #) or a valid explanation of the lack thereof for practitioners practicing in a non-prescribing specialty (e.g. optometry, pathology, radiology).

State BNDD	Verified, Current state BNDD if applicable
Current Liability Coverage	Maintain at least the minimal amount of professional liability insurance as required by the state law with no history of denial or cancellation.
Malpractice History	1. No pattern of suits over a five year period of time based on incident date, or 2. No more than two lawsuits filed with incident dates during one calendar year, or 3. No more than two payments or settlements of $30,000 or more per suit with incident dates in one calendar year, or 4. No cases resulting in permanent disability or death, in which payment of over $30,000 was made, or 5. No pending cases, which in the view of the Committee, could result in failure to meet malpractice history criteria.
Privileges	1. Current unrestricted admitting privileges consistent with the licensure in a Network hospital, or 2. Physician is in a specialty which does not traditionally admit patients and has courtesy or consulting privileges at a network hospital, e.g., Anesthesiology, Dermatology, Pathology, DPM or Radiology, or 3. Physician is in a specialty or subspecialty frequently used as a consultant, and has consulting privileges at a Network hospital, e.g., Psychiatrist or 4. Physician has a transfer agreement with a panel physician with admitting privileges at a Network hospital, or 5. The lack of a panel physician would create a public health hardship in a specific community.

Impairment	Absence of any condition that impairs judgment or performance of essential functions of practice with or without accommodation (including mental, substance abuse, or other health problems) currently or over the past 5 years.
Suspension or Probation	Absence of or valid justification of: 1. Probation or suspension from professional medical societies, or 2. Loss or limitations of hospital privileges, or 3. History of loss of license, or 4. Medicare or Medicaid Sanctions.
Work History	Included with the application, five (5) consecutive years history, or length of practice if less than 5 years, with no gaps of six (6) months or more, or, in the case of a gap, an explanation via email, fax or mail from the provider regarding that time period.
Criminal Indictment	No felony conviction or indictment including a plea of no lo contendre.

C. <u>ADDITIONAL CRITERIA FOR NON PHYSICIAN BEHAVIORAL HEALTH PROVIDERS</u>

State License or Certification	Verified, current and unrestricted license as a psychologist, social worker, professional counselor, or clinical nurse specialist/psychiatric and mental health nurse practitioner in the state in which network is established or certified as a substance abuse counselor in the state in which the network is established or possessing a master's degree in the health sciences field along with three (3) years experience in providing substance abuse services. Each provider licensure must meet the requirements of the state regulatory board.
Education	Provider must have degree in appropriate fields from an accredited university program recognized by the appropriate certifying body: 1. Licensed Clinical Social Worker (LSCSW) –Masters or doctoral degree in social work with emphasis in clinical social work. 2. Licensed Professional Counselor (LPC) – Masters or doctoral degree in counseling or education with counseling field of study (doctoral in Divinity does not meet criteria).

3. Licensed Clinical Professional Counselor (LCPC) - Masters degree in counseling or meet same qualifications.

4. Licensed Clinical Professional Counselor (LCPC) - Masters degree in counseling or meet same qualifications.

5. Licensed Clinical Psychotherapist (LCP) – Master's degree in psychology.

6. Licensed Psychologist (LP) - Doctoral degree in field of psychology 2 years of supervised work experience.

7. Licensed Master Level Psychologist (LMLP) – Master's degree in field of psychology.

8. Licensed Marriage & Family Therapist (LCMFT) – Masters or Doctoral degree in Marriage and Family Therapy or related field of study.

9. Licensed Marriage Family Therapist (LMFT) - Masters or Doctoral degree in Marriage and Family Therapy OR a related field which contained coursework considered to be equivalent to the Marriage and Family therapy program

10. Clinical Nurse Specialist/Psychiatric and Mental Health Nurse Practitioner – Master's degree in nursing with specialization in psychiatric and mental health nursing and certified by American Nurses Association (ANA) in psychiatric nursing.

11. Clinical Psychologist – Doctoral degree

12. Licensed Addiction Counselor (LAC) - Baccalaureate degree in addiction counseling or a related field.

13. Licensed Clinical Addiction Counselor (LCAC) - Masters degree in addiction counseling or a masters degree in a related field.

14. Behavior Analyst (BA) - Bachelor's or graduate degree and completed course work for licensure as a behavior analyst.

Experience	Provider must comply with state guidelines regarding clinical experience in each counseling specialty. The experience must be completed in an appropriate mental health or chemical dependency treatment facility.
Practice Patterns	Emphasis on the following: 1. Outpatient therapy. 2. Short-Term problem focused therapy instead of long-term insight-oriented therapy. 3. Availability of 24 hour crisis intervention. 4. Willingness to participate in utilization management, quality assurance, credentialing and sanctioning processes.

D. <u>CREDENTIALING CRITERIA FOR APRN (NP, CNM) and PA</u>

State License APN	Valid and current RN license by the state in which the provider practices. Valid and current document of recognition (certification type) as required by the state in which the provider practices.
State License PA	Valid and current PA license by the state in which the provider practices.
DEA	Verified, Current Federal Drug Enforcement Administration Certificate (DEA #) or a valid explanation of the lack thereof for practitioners practicing in a non-prescribing specialty (e.g. optometry, pathology, radiology).
Education and Certification	Graduation from a training program and appropriate post-graduate training program resulting in licensure and certification (current or expired): 1. NP – certification program accredited by The National Commission for Certifying Agencies (NCCA) such as ANCC, PNCB, AANP. 2. CNM – certification by the National Certification Corporation of OB/GYN and Neonatal Nursing, American College of Nurse Midwives, or American Midwifery Certification Board.

3. NP must be certified by National Psychiatric and Mental Health Nursing Practice if performing psychotherapy.

4. PA – certification by the National Commission of Certification of Physician's
   Assistants in the applicable specialty.

5. If the lack of a panel NP or PA would create a public health hardship in a specific community as determined by the Board, the Board may waive the certification requirement.

6. The ProviDRs Care Board of Directors waives the certification requirement for the NP or PA based on information provided by the applicant or knowledge of the applicant's medical skills. If either of these measures is unavailable, the Committee may request additional information from known and reputable resources.

Grandfather Clause

1. Current participating network APRN providers that have chosen not to obtain certification will be considered for continuing participation if the provider graduated before 1976. In addition to standard recredentialing process, providers are required to submit two letters of reference from peer with non-economic relationship. All letters of reference will be reviewed to determine network eligibility.

2. Current participating PA providers will be considered for continuing participation. In addition to standard recredentialing process, providers are required to submit two letters of reference from peer with non-economic relationship. All letters of reference will be reviewed to determine network eligibility.

Privileges

May be required to have Allied privileges with a Network hospital.

Supervision Agreement

Must be supervised and employed by at least one (1) Network Physician who abides by the APRN Supervision Policy, works under a written Network approved protocol and is currently licensed as a physician in the states in which network is established and practices in a specialty appropriate to the NP or CMN,.

E. CREDENTIALING CRITERIA FOR AuD, SLP, RD and RDN's

State License	Valid and current license by the state in which the provider practices. Valid and current document of recognition (certification type) as required by the state in which the provider practices.
Education and Certification	Graduation from a training program and appropriate post-graduate training program resulting in licensure and certification (current or expired):

1. AuD– Master's degree or equivalent from an educational institution with standards consistent with those of the state universities or accredited by ASHA. For providers who possess at least a doctorate degree or equivalent in audiology from an educational institution won or after January 1, 2012 and any individual who possesses at least a master's degree or equivalent in audiology prior to January 1, 2012, shall be deemed to have met the educational requirement.

2. SLP- Master's degree or equivalent from an educational institution with standards consistent with those of accredited state universities or accredited by ASHA.

3. RD – Baccalaureate degree or equivalent from an educational institution with standards with those of accredited state universities or approved by the Academy of Nutrition and Dietetics.

4. RDN - Bachelor's degree or equivalent from an educational institution with standards with those of accredited state universities with course work approved by the Academy of Nutrition and Dietetics' Accreditation Council for Education in Nutrition and Dietetics.

I. POLICIES & PROCEDURES

A. RE-CREDENTIALING PROCEDURE FOR PROFESSIONAL PROVIDER

Once a provider has become a member of the Network, he or she is re-credentialed at least every three (3) years or earlier as determined by the Membership Committee during initial credentialing. The recredentialing application follows the same procedures as an initial provider. Providers with

watch status are recredentialed annually or sooner depending on the decision of Membership Committee.

B. ONGOING MONITORING OF SANCTIONS, COMPLAINTS, AND ADVERSE EVENTS

Policy

Ongoing Monitoring of Sanctions, Complaint, and Adverse Events will be performed on participating providers, and, when appropriate, action on important safety, care or service issues will be taken according to the Disciplinary Procedures outlined in Section G. Reports from the following sources shall be reviewed for the presence of any providers participating in the Network within thirty (30) calendar days of its release:

1. Medicare and Medicaid sanction reports
2. Licensing boards
3. Complaints
4. Adverse Events

C. MALPRACTICE HISTORY DEVELOPMENT

Policy

Network will review the past five years of malpractice history provided by the applicant and obtained through the National Practitioner Data Bank to assist in the decision to grant or continue participation status to providers. Refer to Network Credentialing Criteria for details regarding satisfactory malpractice history.

D. IMPAIRED PROVIDERS (due to chemical dependency)

Policy

Network shall not grant participation status or will revoke existing status if there is evidence of impaired judgment or performance due to chemical dependency.

Applicants with a history of chemical dependency within the past five (5) years must meet the advocacy requirements of the appropriate medical association.

E. IMPAIRED PROVIDERS (due to physical and mental health)

Policy

Applicants over the age of 70 will submit an annual written report from their physician confirming their mental and physical health.

Network shall not grant participation status or will revoke existing status if there is evidence of impaired judgment or performance due to a physical or psychiatric health condition.

F. PROVIDER PRACTICING WITHOUT BOARD CERTIFICATION

Policy

Network providers are to meet the Board Certification requirements in Section II-B. Exceptions to this policy are identified for two categories of providers:

1. Board Certified providers who are practicing in a subspecialty without subspecialty Board Certification. (Ex. Oncologist practicing pediatric oncology)

   Procedure: Under the direction of the Chairman of the Membership and Peer Review Committee, the Network Staff will send each current and each previous hospital a letter requesting privileging information regarding the applicant.

   If the privileging is granted by the hospitals, the applicant will be recommended for participation status.

   If the privileging is not granted by the hospitals, the applicant will not be granted participation status for the subspecialty.

2. Board Certified providers, whose practice is in a different primary specialty without Board Certification. (Surgeon practicing Emergency Medicine).

   Procedure: Applicant must meet requirements stated in Section II-B.

G. DISCIPLINARY PROCEDURES

Providers who provide medically unnecessary care, who are not accountable for pre-certification review, who engage in inappropriate utilization of health care resources, are in breach of contract provisions, or who demonstrate poor judgment, quality of care, unprofessional conduct,

questionable competence or other inappropriate actions as determined by the Board of Directors, may lose their participation status with the Network.

The following Table illustrates the categories and the disciplinary process applied to each level of infraction:

DISCIPLINARY PROCEDURES

Category	1st	2nd	3rd	4th
Failure to participate with UR	Warning by phone	Warning by phone	Warning in writing	QAC review
Unnecessary Care	Warning by phone	Warning by phone	Warning in writing	QAC review
Cont. Breach	Warning by phone	Warning in writing	QAC review	NA
Quality Breach	Warning in writing	Warning in writing	QAC review	NA

Infractions are noted in writing in the provider credentials record and are reviewed on a twelve month basis. The Network presents the record of infractions to the Membership Committee as specified in the Table.

If, in the opinion of the Membership Committee, a provider does not meet minimal criteria or accumulates excessive warnings, the Network's Board of Directors will notify the provider by registered mail of the decision to place on probation for a designated period of time, restrict privileges or terminate the Network participation contract. The right and procedures to appeal the decision are provided in the notification. Flagrant violations may be reviewed by the committee immediately and appropriate action taken.

The Appeal process for this action is the same as for denial or termination as a result of credentialing/recredentialing.

Any action to restrict, suspend or terminate a provider's clinical privileges or plan participation, which is based on professional competence or professional conduct, for more than 30 days will be reported to the state licensing board and/or National Practitioner's Data Bank.

Within 15 calendar days of the effective date of the final action, the Manager responsible for credentialing reports the action to the following authorities:

- All appropriate state licensing agencies
- National Practitioner Data Bank (NPDB)

A letter is then written to the appropriate state licensing boards describing the adverse action taken, the practitioner it was taken against and a copy of the NPDB report is attached to the letter. This letter is sent certified to the appropriate state licensing boards within 24-hours of receiving the final NPDB report. A copy of this letter is filed into the Practitioner's credentials file.

Actions that are not reportable to the NPDB or licensing board are those that, in general, do not reduce, restrict, suspend, revoke, deny, or fail to renew clinical privileges or membership. Furthermore, actions that are not based on a physician's professional competence or behavior do not have to be reported.

The following are not reportable to the state licensing board and/or NPDB:

1. Censures, reprimands, or admonishments that do not adversely affect a physician's clinical practice or privileges.

2. A requirement that a physician have consultations on certain cases, retrain, receive additional training or attend continuing education classes.
3. Any withdrawal of an application for appointment or participation before the board takes final action.

4. Administrative suspensions such as those given to physicians for failing to meet reporting and other administrative requirements.

5. A voluntary relinquishing of participation as long as the physician is not under investigation for professional competence or conduct (but not if participation is relinquished in return for canceling an investigation).

6. Leaves of absence to enter a drug, alcohol, or psychiatric rehabilitation.

H. APPEALS/DUE PROCESS

If an invited provider has been denied participation with Network, practitioner will be notified in writing the reasons of denial including the appeals process, reconsideration and an appeal process are available to the provider. In the event an applicant pursues legal recourse, and the case is

decided in favor of Network, the applicant is responsible for all attorney fees. The following outline represents these processes.

Responsibility	Action
Network Staff	Notifies provider in writing reasons of denied participation decision including a summary of the appeals process.
Network Staff	Action will be reported within 30 days of the Membership Committee to the NPDB and to the Kansas Board of Healing Arts or the appropriate licensing board.
Provider	May request reconsideration from the CC within 30 days. Provider must provide clarification of or additional, new information.
Membership Committee	May recommend a reversal of the non-participation decision based on additional information, or may uphold the non-participation decision.
Network Board	Approves or denies a reversal.
Network Staff	Notifies provider in writing of Membership Committee's decision to uphold or Board decision regarding reversal.
Provider	If non-participation decision is upheld, the applicant may appeal to the Board of Directors within 30 days of the denial.
Network Board	Notifies applicant of the Appeals Board review process.
Appeals Board	Conducts the Appeals Board hearing and makes a final determination.
Appeals Board	Notifies provider in writing of final status within 60 days.
Network Staff	Updates system and produces a revised delegated provider profile.

I. DELEGATED CREDENTIALING TO OTHER ENTITIES

The credentialing process may be delegated by contract to a contracted IPA or group medical practice. The Network Staff and/or Membership Committee will review the external entity's provider application and credentialing plan to ensure compliance with NCQA standards and Network's application, criteria, policies and procedures. The external entity's plan must conform to the Network credentialing plan and the credentialing criteria must meet or exceed the Network credentialing criteria in order to be approved by the Membership Committee. The entity's Credentials Committee must be constructed to meet state and federal requirements for Peer Review. The entity must agree to permit Network and NCQA access to credentialing files and Credentials Committee minutes, or a written summary of such minutes.

Network's Membership Committee will provide the criteria to the external entity and will assist the entity in developing a satisfactory credentialing plan.

Network's Membership Committee has the ultimate authority for credentialing providers. The Network retains the right to approve new providers and to terminate or suspend individual providers. The Membership Committee, at its discretion, will review any credentialed provider as well as all exceptions granted by the external entity. The entity must notify the Network within 5 working days of any changes in status of the providers, including but not limited to termination, resignation, changes in privileges, probation, or other disciplinary action.

The Network Membership Committee will review the entity's credentialing and reappointment or recertification processes at least annually. This will include a review of the credentialing plan, including criteria, as well as at least five percent (5%) or fifty (50) credentialing files, whichever is more.

Review of the provider files will include the following to determine file adequacy:

Orderly, consistent format and organization

1. Completed, legible application

2. Signed attestation

3. Copies of Primary Source verification of the following:
   a) board certification
   b) education, if not board certified
   c) appropriate license(s)
   d) malpractice claims history
   e) copies of DEA certificate, BNDD certificate, privilege status at primary admitting facility, and malpractice coverage.

4. Copies of Provider Authorization/Release and Delegation Release.

5. Report of work history.

6. Documentation of adverse professional actions, e.g. Hospital suspensions or limitations, Medicare/ Medicaid suspension, DEA investigations/actions, state licensing investigations/ actions.

7. Documentation and appropriateness of disciplinary actions.

8. Documentation of Recredentialing conducted at least every three years with Primary Source verification as prescribed and QA/QI information provided by NETWORK Quality Management.

9. Evidence of Peer Review and due process.

10. Review of Credentialing Plan and Credentials Committee minutes.

If audit findings indicate discrepancies of credentialing criteria, the Membership Committee may rescind the delegation and conduct internal credentialing. The committee will routinely monitor and evaluate the delegated credentialing process.

If deficiencies are found during the audit, WPPA, ProviDRs Care may develop a corrective action plan for the delegated entity, to correct deficiencies in its credentialing process. WPPA, ProviDRs Care may conduct an independent investigation into the credentials and/or professional conduct of any application or participating provider. Delegated entities shall permit WPPA, ProviDRs Care timely and reasonable access to all credentialing documents and related files.

J. Facility Required Credentialing Criteria

ProviDRs Care requires hospitals, home health agencies, skilled nursing facilities, DME suppliers, long term care facilities, ambulatory surgical centers, behavioral health care facilities providing mental health or substance abuse services in an inpatient, residential, ambulatory facility based outpatient and laboratories to be qualified, competent and meet the standards for performance and delivery of high quality clinical care and service.

All facilities requesting participation with ProviDRs Care must complete the credentialing process and be approved for participation before entering into a contractual agreement.

ProviDRs Care confirms network facilities are in good standing with state and federal regulatory and/or accrediting bodies at least every three years thereafter (excluding DME suppliers and laboratories).

ProviDRs Care facility credentialing guidelines are based on the standards set by the National Committee for Quality Assurance (NCQA).

Facility applicants must provide the following in order to be considered for network participation:

1. Active, unencumbered state license to operate if applicable

2. A CMS or state review less than three years old at the time of application. The report from the institution must show evidence of substantial compliance or an acceptable corrective action plan with current state regulatory requirements or;
3. Accreditation by one of the following accrediting bodies:

Facility Type	Acceptable Accrediting Bodies
Hospitals, Behavioral Health Facilities	JCAHO, AOA, AAAHC, CMS or State Agency review or certification
Skilled Nursing Facility, Nursing Home	CARF, CHAPS, JCAHO, CMS or State Agency review of certification
Home Health Care Agencies	CHAPS, JCAHO, ACHC, CMS or State Agency review or certification
Ambulatory Surgery Centers	AAAASF, AOA, AAAHC, JCAHO, CMS or State Agency review or certification
Laboratories	CLIA and State Agency review or certification

Maintain at least the minimal amount of professional liability insurance as required by the state law with no history of denial or cancellation.

Organizations Not Accredited or Certified: If the Organization is not accredited or certified by an agency listed above, a site visit of the organization by the credentialing staff is required before making a recommendation for participation to the Board of Directors. A Site visit will include assessment of environment, policies, medical records, safety issues and access. Credentialing staff will present results and recommendations to the Board of Directors for decision and action.

Verification of Credentials Process: ProviDRs Care completes primary verification of credentials using recognized sources in the following areas:

1. Current state license in the state where the facility provides care to WPPA, ProviDRs Care members via the state's department of health and human services website or a current copy of the facility license as displayed to the public included in the application.
2. Copy of professional liability insurance coverage current at the time of committee decision, with minimal amount of professional liability insurance as required by the state law with no history of denial or cancellation, or, evidence of federal or state tort immunity included in the application.
3. Verification Review of sanctions or exclusions from Medicare/Medicaid, or other Federal Healthcare Programs via query of The Office of the Inspector General (OIG) and NPDB online.
4. Copy of accreditation by an approved Accredited bodies included in the application.

WPPA, INC.
PROVIDRS CARE

ProviDRs Care Network Directory Listing

Upon becoming a participating provider with ProviDRs Care Network, the provider's demographic information will be listed in provider directories made available online.

ProviDRs Care Network Reimbursement Policies

The ProviDRs Care Network allowances are designed to reimburse our ProviDRs appropriately while remaining competitive with other network reimbursements. Mid-level practitioners are reimbursed at 85% of physician reimbursement. Providers rendering services at the following Places of Service are subject to a site differential:

- Inpatient Hospital (POS code 21);
- Outpatient Hospital (POS code 22);
- Emergency Room-Hospital (POS code 23);
- Ambulatory surgical center (ASC) (POS code 24);
- Skilled Nursing Facility (SNF) (POS code 31);
- Hospice – for inpatient care (POS code 34);
- Ambulance – Land (POS code 41);
- Ambulance – Air or Water (POS code 42);
- Inpatient Psychiatric Facility (POS code 51);
- Psychiatric Facility -- Partial Hospitalization (POS code 52);
- Community Mental Health Center (POS code 53);
- Psychiatric Residential Treatment Center (POS code 56); and
- Comprehensive Inpatient Rehabilitation Facility (POS code 61).

Modifiers

The following modifiers may affect the repricing of your claims. The discounts derived from these modifiers are subject to network guidelines and cannot be billed to the patient.

Modifier:	Description:	Repricing Methodology:	Applies to:
-22	Increased Procedural Service	115% of allowable.	Surgical procedures
-26	Professional Fee Only	Professional allowable will be used.	Non-surgical services
-50	Bilateral	1½ times the Allowable.	Surgical procedures

	Procedure		
-51 -59	Multiple Procedure	100% of allowable for the first procedure (which should not be marked with the modifier), 50% for the second procedure and 25% for the third and following procedures.	Surgical procedures
-52	Reduced Service	50% of allowable.	Surgical procedures
-53	Discontinued Services	50% of allowable.	All procedures
-54	Surgical Care Only	70% of allowable.	Surgical procedures
-55	Postoperative Management Only	15% of allowable.	Surgical procedures
-56	Preoperative Management Only	15% of allowable.	Surgical procedures
-62	Co-surgeons	125% of the Allowable is to be divided between the two surgeons. Each surgeon is to indicate what percent of the surgery he/she performed. When no indication is provided, ProviDRs Care will apply a default of 50/50.	Surgical procedures
-73	Discontinued Outpatient Hospital/ASC Procedure prior to anesthesia	60% of allowable.	Facility Fees
-74	Discontinued Outpatient Hospital/ASC Procedure after anesthesia	60% of allowable. (Anesthesiologists should bill indicating time and should be reimbursed according to standard Anesthesia guidelines)	Facility Fees
-80 -81 -82 -AS	Assistant Surgeon	25% of the calculated allowable for approved assistant surgeon charges and approved assistant surgeons.	Surgical procedures
-TC	Technical Component	The technical allowable will be used.	Non-surgical services

Multiple Surgeries

- The order of surgery reductions are determined using the RVU weight of the billed codes in combination with modifier 51 when applicable.

- Multiple surgery reductions apply even when the surgeries are billed on separate claims

- Add-on Codes and Modifier 51 Exempt Codes do not receive multiple surgery reductions
- Multiple units should be considered multiple surgeries
- Multiple Surgery reductions only apply to surgical procedures with an established allowable. Do not apply multiple surgery reductions on a surgical CPT Code that does not have an established allowable.

Claims Edits

Accurate coding and reporting of services are critical aspects of proper billing. To promote national correct coding methodologies and to control improper coding leading to inappropriate payment, ProviDRs Care, consistent with industry standards, applies claim edits defined under the CMS National Correct Coding Initiative Guidelines (NCCI).

Wrong Surgical or Other Invasive Procedures

Providers will not be reimbursed for surgical or other invasive procedures that are erroneously performed by a healthcare provider. This policy applies to both UB-04 and CMS-1500 claim forms.

Erroneous procedures include:

- Surgical procedure performed on the wrong side or body part
- Surgical procedure performed on the wrong person
- The wrong surgical service or other invasive procedure rendered to a patient

In addition, Medica will not reimburse for services associated with the erroneous procedure. Associated services include:

- All services provided in the operating room that are related to the error
- Services provided by all providers in the operating room when the error occurred, who could bill individually for their services
- All related services provided during the same hospitalization in which the error occurred.

Providers may not balance bill the member for costs associated with erroneous procedures.

The following services (if covered) will be reimbursed regardless of whether or not they are related to the erroneous procedure:

- Services provided following discharge

- Performance of the correct procedure

ProviDRs Care follows CMS coding and billing guidelines:

Hospital Inpatient Claims
Hospitals are required to submit two UB-04 claims:

- A no-pay claim (Type of Bill 110) for all services associated with the erroneous procedure
- A separate claim for services unrelated to the erroneous procedure

Hospital Outpatient, Ambulatory Surgery Center (ASC), and Professional/1500 Claims
Outpatient, ASC, and practitioner claims must have one of the following modifiers appended to the surgical procedure code:

- PA: Surgical or other invasive procedure on wrong body part
- PB: Surgical or other invasive procedure on wrong patient
- PC: Wrong Surgery or other invasive procedure on patient

For claims billed on both the UB-04 and CMS-1500 form, one of the following diagnoses must be reported on the claim to identify the type of error that occurred:

ICD-10-CM on or after 10/1/2015:

- Y65.51 - Performance of wrong procedure (operation) on correct patient
- Y65.52 - Performance of procedure (operation) on patient not scheduled for surgery
- Y65.53 - Performance of correct procedure (operation) on wrong side/body part

Note: For the UB-04 claim type, the ICD-10-CM diagnosis codes listed above must be reported in diagnosis position 2-9.

Provider Services

Provider Communication

ProviDRs Care publishes an annual update to inform our providers of any changes in administration and policies. Information may also be found on our website. Updates affecting participating providers will also be communicated via the ProviDRs Care Connect newsletter. To enroll in the ProviDRs Care Connect email distribution list, please send requests to **ProviderRelations@ProviDRsCare.net**.

All provider applications are available online at **http://providrscare.net/providers/**. Providers may also verify their contracting status via our online directories at **http://providrscare.net/find-a-doctor/**.

Provider Relations Customer Service Center

Our Provider Relations staff is available to assist your contracting and credentialing needs Monday through Friday from 8:30 am to 4:30 pm CST. Providers in the Wichita, KS area should call (316) 683-4111; all other callers may use (800) 801-9772.

Claim Status Inquiries

ProviDRs Care Claims Repricing Department is available to assist with repricing status requests and problematic claims resolutions. Claims staff members are available Monday through Friday from 8:30 am to 4:30 pm Central Time. Providers in the Wichita, KS area should call (316) 683-4111; all others callers may use (800) 801-9772.

For your convenience, you may check claim repricing status online by clicking the link below:
CLAIMS.ProviDRsCare.Net

Please note that ProviDRs Care does not pay claims and will not have information available regarding benefits or payment. For status of claims payment, please refer to the patient's identification card for the payer's telephone number. For more information on our prompt pay policy, see "Payment Turnaround Time".

Providers are not required to call prior to submitting an appeal or request for assistance on a problematic claim. Requests may be sent via mail to Attn: Appeals, ProviDRs Care Network, 1102 S Hillside, Wichita, KS 67211 or via fax to (316) 683-1271.

Examples of problematic claims include:

- Claims paid with incorrect ProviDRs Care Network allowance.
- Claims paid showing a participating provider as out-of-network in error, and vice-versa.

Member Identification

ProviDRs Care partners with a variety of employers, carriers and third party administrators (TPA) throughout the state of Kansas. The health identification card is used to identify patients accessing the ProviDRs Care Network. The member's identification card will list the name ProviDRs Care Network and/or the company logo (see upper right hand corner of page). Additionally, the

explanation of benefits (EOB) will also indicate ProviDRs Care Network. The below ProviDRs Care logos below will appear on the member's ID card.

ProviDRs Care Select Network is a select part of our provider network that is customized specific to meet the employer's needs. The Select Network may carve out certain provider types that are not be subject to contracted PPO network rates. The ProviDRs Care Select logo below will appear on the member's ID card and will identify which providers are carved out from the ProviDRs Care PPO network and subject to allowances determined by employer.

Although each identification card may be slightly different, the following information is commonly found on each identification card:

- *Member Name, Group Number and Member Date of Birth*
- *Summary of Key Member Co-pay/Co-insurance Responsibilities*
- *How to Contact the payer for Eligibility, Benefits, Precert and Utilization Management*
- *Claims Submission Information (electronic and postal address)*
- *Pharmacy and Behavioral Health Services contacts*

Claims Filing & Collecting

Collection of co-Payment and Co-Insurance

Providers may collect co-payments and co-insurance at the time services are rendered. Providers are expected to assist the patient in determining an appropriate co-insurance amount that considers the expected allowance and patient remaining out-of-pocket expenses.

Timely Filing

Claims must be submitted within ninety (90) days from the last day of the month in which services occurred. Keep in mind; however, the quicker the claim is filed, the quicker the payment can be received. Some self-funded plans have timely filing limits that prohibit claims payments that fall outside of the contract period. For this reason, it is critical to file claims as soon as possible after services are rendered.

Corrected claims should be filed within sixty (60) days after receipt of payment explanation from Group. If the claim is not filed promptly, the claim may be denied due to the plan limitations. At no time is the rendering provider allowed to balance bill the patient for denied claims filed after sixty (60) days.

Assignment and Claims Routing

As a ProviDRs Care Network participating provider, you have agreed to accept assignment and file claims for all services rendered to eligible patients.

Claims filing addresses vary by claim administrators. To ensure claims are filed to the accurate location, please refer to the patient's health identification card. You may also request a copy of our Payer/Client Repricing Report to assist you in determining the location for claims submissions. These requests may be sent to Claims@ProviDRsCare.Net.

Claims repriced by ProviDRs Care may be submitted via mail, fax or electronically. For more information on electronic submissions, see the next section; paper filing information is as follows:

Mailing address: 1102 S Hillside
Wichita KS 67211

Fax Number: (316) 683-1271

Electronic Claims Filing

Electronic claims submission can significantly increase productivity within your practice. Not only will this reduce paper costs, but it also improves the repricing turnaround of your claims and improves

accuracy by minimizing the chance of conversion errors. Please reference the list of Electronic Data Interchange (EDI) clearinghouses/vendors below for the most up-to-date status of connectivity with ProviDRs Care.

http://providrscare.net/edi-vendor-connectivity-list/

If you cannot locate your clearinghouse/vendor on the list, please contact **NikkiSade@ProviDRsCare.Net** to request a connection.

Claims Service Locations

All claims filed (paper or electronic) should include the Service Facility location where services are rendered. On occasion, ProviDRs Care administers repricing for groups with benefit plans designed to increase continuity of care. To facilitate these plan designs, all providers participating in ProviDRs Care Network are required to provide the location of where the services were rendered. This also ensures the provider collects the proper co-pay and is reimbursed accordingly from the group. The following information is required:

Paper Claims HCFA: Box 32 (Service Facility Location)

Electronic Claims Professional v5010: Loop 2310C (Service Facility Location) is required when the location is different than the location in Loop 2010AA (Billing Provider).

Corrected Claim Submission

HCFA/Professional Claims

ELECTRONIC SUBMISSION: To submit a corrected HCFA claim electronically, please include a 7 (Replacement of prior claim) in the CLM05 Claim Frequency Type Code (AKA Claim Submission Reason Code).

PAPER SUBMISSION: To submit a corrected HCFA claim via paper:

- Option 1: Please include a 7 (Replacement of prior claim) in Box 22 (Resubmission Code).
- Option 2: Mark or Stamp “Corrected Claim” in a clear identifiable location on the paper claim.

UB/Institutional Claims

ELECTRONIC SUBMISSION: To submit a corrected UB claim electronically, please include a 7 (Replacement of prior claim) in the CLM05 Claim Frequency Type Code (AKA The third position of the Bill Type Code).

PAPER SUBMISSION: To submit a corrected UB claim via paper:

Option 1: Please include a 7 (Replacement of prior claim) as the third position of the Bill Type Code.

Option 2: Mark or Stamp "Corrected Claim" in a clear identifiable location on the paper claim.

Payment Turnaround Time

Your payments will come from two sources: the payer and/or the patient. Contracting groups are required to pay or deny clean claims within thirty (30) business days of receiving the claim. In the event the claim cannot be processed timely, the group is required to issue a statement explaining the reason for the pending status.

For claims where payment, denial or statement of pending status has not been received timely, the provider may request to have a prompt pay penalty applied to the claim. The provider may submit a request to rescind the network savings in writing via fax (316-683-1271) or mail:

Attn: Claims-Prompt Pay
ProviDRs Care Network
1102 S Hillside
Wichita KS 67211

The correspondence should include original date of claim submission, dates of resubmissions and copies of any correspondence sent or received. ProviDRs Care Network will contact the payer in an effort to reach a resolution within five (5) business days.

REQUESTS FOR MEDICAL RECORDS/OPERATIVE REPORTS

On occasion, ProviDRs Care will need to review a portion of the medical record to assure fair and accurate repricing. ProviDRs Care only requests records when necessary and is only used for purposes stated on the records request.