# PROVIDER REFERENCE MANUAL

2022

TEACO PROVIDER NETWORK, L.L.C.

VAN LANG, IPA, L.L.C.

## Contents

# 1 INTRODUCTION

## 1.1 Summary of Network

Van Lang IPA, LLC (VL), TEACO Provider Network, L.L.C. (TPN), TECQ Foundation (TF), and TEACO Health LLC (TH).

Each Network is either an Independent Practice Association (IPAs) or Clinically Integrated Network (CIN). TPN/VL/TF/TH all have a select network of Providers in Texas with Hospital Coverage that will serve populations which qualify for Medicare Advantage Part C for any of these products; Health Maintenance Organization (HMO), Dual Special Needs Plan (DNSP), Chronic Special Needs Plans (CNSP), Medicare Medicaid Plans (MMP), and Preferred Provider Organization (PPOs).

## 1.2 Board Authority

TPN oversees each Network through an Executive Board for Utilization Management (UM), Quality Improvement (QI), Credentialing and Peer Review, Finance, and Provider Network activities. The Networks are partnered with TECQ Partners Inc., serving as the Managed Service Organization (MSO) that is contracted to provide administrative and operational functions to our clients. TECQ Partners is located in Houston, Texas.

TECQ Partners management team and staff have years of extensive experience and expertise working with local partners such as physicians, hospitals, and key partnerships with national health plans. Our goal is to ensure our patients/members consumers are getting high quality services timely, and physicians are being appropriately reimbursed by health plans. TECQ Partners provides medical management, provider network, claims, and customer services for our providers and members.

## 1.3 Committees

### Utilization Management Committee

The UM Committee provides overall direction for the Utilization Management process and oversees those activities are consistent with the organizations and affiliates strategic goals and priorities and aligned with regulatory and controlling agencies and standards. Oversees the UM activities of the Networks to support efforts that members have appropriate access preventive services, treatment of acute diagnosis and care for chronic conditions. Supports compliance with regulatory and licensing requirements and accreditation standards for Utilization Management and related Quality Improvement Projects, Activities, and Initiatives. Assesses, monitors, and guards against over and under- utilization of services provided to members of our affiliated networks. Makes certain that UM decisions are made based on sound clinical evidence and approves procedures for appropriately applying the criteria. Monitors, evaluates, and acts on the care and services members are provided to promote appropriate utilization of resources.

Quality Improvement Committee

The QI Committee provides overall direction for the continuous improvement process and oversees those activities are consistent with the Network's strategic goals and priorities. Promotes an interdisciplinary approach to driving continuous improvement and make certain that adequate resources are committed to the program. Supports compliance with regulatory and licensing requirements and accreditation standards related to Quality Improvement projects, activities, and initiatives. Monitors, evaluates, and acts on the care and services members are provided to promote quality of care outcomes

Credentialing/Peer Review Committee

The Credentialing Committee provides overall direction for the Credentialing and Recredentialing activities and oversees that those activities are consistent with state and federal regulations and support the Plan's strategic goals and priorities. Promotes timely review of peer review activities including but perhaps not limited to review of new applicant's practice history and potential quality issues (PQIs) as identified through the Quality Improvement and Grievance processes. Provides ongoing review of potential or actual peer review when issues are identified, conducts mid-cycle recredentialing reviews when indicated based on egregious peer review findings. Supports compliance with regulatory and licensing requirements and accreditation standards related to Credentialing, Recredentialing, and Peer Review activities

Compliance Committee

The Compliance Committee develops strategies to promote compliance and the detection of any potential violations. Reviews and approves compliance and fraud, waste, and abuse (FWA) training, and making certain that training and education are effective and appropriately completed. Assists with the creation and implementation of the compliance risk assessment and of the compliance monitoring and auditing work, and in the creation, implementation, and monitoring of effective corrective actions. Develops innovative ways to implement appropriate corrective and preventative actions and reviews the effectiveness of the system of internal controls designed to support compliance with Medicare regulations in daily operations. Supports the compliance officer's needs for sufficient staff and resources to carry out his/her duties and makes certain that there are appropriate, up-to-date compliance policies and procedures. The committee reviews and supports the system for employees and first tier, delegated, and related entities (FDRs) to ask compliance questions and report potential instances of Medicare program noncompliance and potential FWA confidentially or anonymously (if desired) without fear of retaliation. Makes certain that this is a method for members to report potential FWA and reviews and addresses reports of monitoring and auditing of areas in which the sponsor is at risk for program

noncompliance or potential FWA and ensuring that corrective action plans are implemented and monitored for effectiveness. The Committee provides regular and ad hoc reports on the status of compliance with recommendations to the governing body.

Finance Committee

The Finance Committee addresses financial results including but not limited to gains, losses, financial short/long-term planning, managed care agreements and provider network arrangements. Team evaluates value-based risk arrangements making recommendations to organizational stakeholders.

### 1.4 Updates to the Provider Manual

The Provider Manual is updated periodically and reviewed at least annually to reflect the most current policies and procedures related to the associated Networks. The Provider Manual is available on TECQ's website www.tecqpartners.com.

## 2 CONTACT INFORMATION

### 2.1 Important numbers – At a Glance

| Department | Telephone | E-mail |
|---|---|---|
| Utilization Management | (888) 319-0777, ext. 699 | clinical@tecqpartners.com |
| Claims | (888) 319-0777, ext. 899 | claims@tecqpartners.com |
| Compliance Hotline | (888) 319-0777, ext. 999 | Compliance@tecqpartners.com |
| Provider Relations | (888) 319-0777, ext. 799 | provider-support@tecqpartners.com |
| Credentialing | (888) 319-0777, ext. 969 | credentialing@tecqpartners.com |
| Member Services | (888) 319-0777, ext. 599 | |

#### 2.1.1 Utilization Management

For emergency admissions and services at any facility other than Memorial Hermann, please call Van Lang within 24 hours of admission.

Medical Management Department including Utilization Management and Care Navigation (for post-discharge care coordination) activities: (888) 319-0777, ext. 699

For emergency admissions at Memorial Hermann facilities, please call Anthem/Amerigroup within 24 hours of admission.

#### 2.1.2 Claims

Claims should be submitted electronically through SDS Clearinghouse ("SDS"). Van Lang's payer ID with SDS is "77036".

Providers may also send electronic claims via an Online Submission.

In the event paper claims are necessary, please submit to the following address for payment:

Van Lang IPA
% TECQ Partners
P.O. Box 211406
Eagan, MN 5512

For inquiries related to your electronic claim submission to Van Lang IPA please contact our Claims Team: claims@tecqpartners.com

Claims for Amerigroup MMP, PPO and Medicaid patients should be billed to Amerigroup directly. Van Lang does not pay claims for MMP, PPO or Medicaid. Van Lang does not accept faxed claims.

### 2.1.3 Compliance

Detecting and preventing Fraud Waste and Abuse (FWA) is the responsibility of everyone affiliated with TECQ Partners and affiliated Networks. All providers and staff who suspects FWA or other Compliance concerns may use the Compliance Hotline at 1-888-319-0777, ext. 999 for anonymous reporting of any suspected FWA or submit to compliance@tecqpartners.com.

### 2.1.4 Provider Relations

Provider inquiries can be made via the following number: (888) 319-0777, ext. 799 from 8:30 to 5:00pm CST.

## 2.2 Health Plan Information

| Plan | Contact | Contact |
|---|---|---|
| Amerigroup | Ameriadvantage Part B, contact Provider Services department 1-866-805-4589 Option 5, from 8:00 a.m. to 8:00 p.m. | Ameriadvantage Part D, contact Express Scripts Provider Services at 1-800-338-6180 24 hours a day, 7 days a week. |

## 2.3 Additional resources

Centers for Medicare and Medicaid Services: For verification of eligibility for Medicare patients and managed care members, call the toll-free line at:

(800) MEDICARE or (800) 633-4227. Medicaid at (800) 925-9126.

HHSC Ombudsman Office – Contact the Ombudsman Office if you have health and human services-related complaints or issues.

Texas Health and Human Services Commission
Office of the Ombudsman, MC H-700
P O Box 13247
Austin, TX 78711-3247Phone: 1-877-787-8999 (Toll-Free)
Texas Relay: 7-1-1 or 1-800-735-2989 (Toll-Free) For the deaf or hearing impaired
Online: Online Submission Form
Fax: 1-888-780-8099 (Toll-Free)

## 3 CREDENTIALING AND RECREDENTIALING

The credentialing department makes certain that all practitioners and providers are properly credentialed and re-credentialed to the IPA and meet the standards for professional qualifications in accordance with TECQ Partners Credentialing policies and procedures and the National Committee for Quality Assurance (NCQA). Credentialing is a routine process that requires providers to complete a Texas Standardized Credentialing Application, which is used to verify provider's relevant education, training and experience and current competence and is presented to the IPA Credentialing Committee for review. The Credentialing Committee reviews each provider's credentialing and recredentialing application and makes determinations whether to approve or reject a provider from joining the IPA.

The following provider types are covered under the scope of the credentialing program:

- Physicians (MD, DO)
- Psychologists (PhD, PsyD)
- Advanced Practice Registered Nurses (APRN)
- Physician Assistants
- Podiatrists (DPM)
- Licensed independent practitioners including Behavioral Health and Allied Health
- Hospital and Ancillary providers

Additionally, Primary Care Physicians participating in Medicaid and/or Medicare/Medicaid managed care may be subject to a passing facility site review conducted by oversight Plan.

Continued participation with the Network is dependent upon successfully completing the recredentialing process that takes place every thirty-six (36) months.

The following documents are required for the initial credentialing and recredentialing processes:

Providers must maintain a current CAQH profile, complete with current documents located in the CAQH document repository and maintain a current attestation no older than 90 days at the time of the application submission.

For providers who are not on CAQH, the following are required:

- A complete Texas Standardized Credentialing Application (pages 1-20), including an explanation for adverse responses to the disclosure questions and gaps in work history.
- Copy of current professional liability insurance policy face sheet, showing expiration dates, limits, and applicant's name.
- Copy of IRS W-9s for verification of each tax identification number used (signed & dated within the last 12 months).
- Copy of current DEA registration.
- Copy of CLIA certifications, if applicable.
- Copies of radiology certifications, if applicable.
- Copy of DD214, record of military service, if applicable.

In addition to the above, the following criteria are incorporated into the recredentialing process:

- Member complaints.
- Information from quality improvement activities.
- Member satisfaction.
- Provider Status Change.

IPA requires provider notification of any provider status change 30 days prior to the change, or in cases of emergency, within 14 days of the change.

Any planned change in status such as an address or phone number change, malpractice insurance coverage or staffing changes, must be reported immediately to TECQ Partners Credentialing Department. (Refer to Provider Change Notification Form in the Forms Section of this Manual). You can also send an email to credentialing@tecqpartners.com.

Required Reporting

IPA must file a report with the Medical Board of Texas or other licensing board, and a report with the National Practitioner Data Bank within 15 calendar days after the effective date of the action, if any of the following events occurs:

The provider's application for IPA participation status (credentialing) is denied or rejected for a medical disciplinary cause or reason.

- The provider's participation status is terminated or revoked for a medical disciplinary cause or reason.
- Restrictions are imposed or voluntarily accepted for a cumulative total of 30 days or more for any 12month period for a medical disciplinary cause or reason.
- The provider resigns or takes a leave of absence from IPA.
- IPA participation status changes following notice of any impending investigation based on information indicating medical disciplinary cause or reason.

The provider will be notified in writing of any adverse action taken. A contracted physician may request a fair hearing if there has been a reduction, termination, or suspension of the provider's contractual relationship.

Provider Rights

Applicants have the right to:

A. Review information submitted to support their credentialing application, including information obtained from outside sources such as malpractice insurance carriers and state licensing boards.
B. Correct erroneous information. Corrections can be submitted through the electronic CAQH application process and may be submitted from the original time of submission up through the time of the credentialing decision. The applicant will be notified prior to the final credentialing decision should additional information be needed or if existing information requires clarification.
C. Receive the status of their credentialing or recredentialing application, upon request. You may contact the Credentialing Department at any time to request the status of your application, processing time, and anticipated date of decision. You may contact the Department through the email credentialing@tecqpartners.com and phone at (888) 319-0777, ext. 969.

# 4 PHYSICIAN RESPONSIBILITIES

## 4.1 Provider Information

All providers are responsible for informing the Network and TECQ Partners of any changes to their practice. This is important to make certain that providers receive important

information from the Network. It is critical that demographic information is up to date. This includes but is not limited to:

- Provider/Network name or Tax ID number (W 9 required)
- Provider/Network practice address, zip code, telephone, or fax numbers
- Provider/Network billing address (W 9 required)
- Email addresses and contact information

To update your information, please send to:

PSU-Support@Tecqpartners.com or mail to:

TECQ Partners

8278 Bellaire Blvd., Suite B

Houston, TX 77036

## 4.2 Appointment and Services

The following are standards and requirements for appointments and services rendered by Primary Care Physicians as required by Health Plan, CMS and/or other regulatory agencies including the Texas Health and Human Services Commission (THHSC) and Texas Department of Insurance (TDI).

| Type of Appointment and Services | Access Standards and Requirements |
|---|---|
| Availability of the PCP | • PCP must be available by telephone 24hours per day/ seven days per week.<br>• If the PCP is unable to provide on-call services, arrangements must be in place to cover the PCP after hours and on weekends; covering physician must be credentialed by IPA |
| Appointment Systems | Providers should use an efficient and effective written or computerized appointment making system, which includes follow-up on broken appointments. |
| Waiting Time in the Office | The waiting time for scheduled appointments must be 30 minutes or less. |
| Appointments for Urgent and Routine Primary Care Services | • For **urgent primary care services**, PCPs are required to triage and provide **same-day appointment** for his/her members.<br>• For Routine primary care services, the timeline for appointments are as follows: |

| Type of Appointment and Services | Access Standards and Requirements |
|---|---|
| | Physical exam and routine preventive services – 4 work weeks.<br>Routine ambulatory visits – 7 business days maximum for an appointment. |
| Appointments for Routine Physician Consultation and Specialty Referral | Specialist physicians are expected to schedule an appointment for a non-urgent, properly authorized referral within 10 business days. |
| 90-day<br>Initial Health Assessment (IHA) and annual wellness exam | Each newly enrolled MA member is expected to receive an IHA within 90 days of enrollment. Use of the "Annual Physical Exam Form" provided is acceptable. PCPs are also required to see MA members on annual basis and perform a complete annual wellness exam |

4.3 Specialty Care Practitioners

Specialty care physicians provide referral services consistent with industry standard medical practices, to IPA members upon request by the PCP with authorization from the IPA. The Specialist is responsible for communicating results and findings back to the member's PCP for continuity and/or coordination of care. The Specialist is responsible for the following:

- Provide IPA authorized medically necessary specialty care
- Work in conjunction with PCP to assure continuity of patient care
- Specialist will make authorization requests through the referring PCP
- Submit treatment plans to PCP and IPA for continued specialty care
- Assist PCP/IPA in coordinating ancillary services and hospitalization
- Arrange for practice coverage by another IPA contracted/participating physician for times or extended periods Specialist is unavailable (i.e., vacation, jury duty, holidays, illness, etc.)
- Provide and arrange for 24 hour, 7 days per week on-call coverage for all managed care members
- Participate in respective UM/QM committees and programs as may be required under contract

NOTE:

Specialists can only submit referral authorization requests through the PCP for additional continued care or treatment of members and cannot refer members to other specialists. Unauthorized services will not be reimbursed.

The Network must be notified to arrange for a Memorandum of Understanding to be in place if a non-participating physician is scheduled to take calls for you or assist you with a service or procedure.

USE OF A CALL ANSWERING MACHINE IS NOT AN ACCEPTABLE FORM OF ON-CALL COVERAGE.

### 4.4 Primary Care Practitioners (PCP)

The following services are the responsibilities of Primary Care Physicians (PCP) unless special arrangements have been made with the IPA. Please refer to your Primary Care Provider Agreement with the IPA for more details regarding coverage provisions. Covered Medical Services include all of the services a PCP customarily makes available to patients of his or her practice, including but not limited to the services listed below:

- Maintain office accessibility to members at least 4.5 days per week. All PCPs are required to provide and arrange for 24 hour, 7 days per week on-call coverage for all managed care members unless previous arrangements have been made with IPA.
- First point of contact care for persons with previously undifferentiated health concerns.
- Office Visits and Examinations (diagnosis and treatment of illness or injury).
- Adult health maintenance.
- Periodic health appraisal examination, including all routine tests performed in PCP's office.
- Routine gynecological examinations including pap smears.
- Venipuncture and administration of injections and injectables.
- Minor office surgical procedures, including repair of simple lacerations to areas other. than the face, ear lavage, I&D of superficial soft tissue abscess, EKG, visual acuity testing, trigger point injections, arthrocentesis, etc.
- Specimen collection.
- Nutritional counseling.
- Interpretation of laboratory results.
- Miscellaneous supplies related to treatment in PCP's Office (i.e., bandages, arm slings, splints, suture trays, gauze, tape, and other routine medical supplies).
- Telephone consultations.
- Well-Child Care, including screening and testing for vision and hearing.
- Coordination of other health care services as they relate to a Plan Member's care.
- Immunizations, for adults and children, in accordance with accepted medical practice in the community.
- Health education in disease prevention, exercise, and healthy living practices.

The following listed services are generally considered primary care services. The PCP must have received appropriate training, within the limitations of scope of practice, and consistent with State and Federal rules and regulations. These guidelines are based on routine uncomplicated cases where care is ordinarily provided by a PCP. This list only provides guidelines, is not intended to be all inclusive, and should be used with clinical discretion.

| Allergy | |
|---|---|
| • Treat seasonal allergies<br>• Treat hives<br>• Treat chronic rhinitis<br>• Allergy history<br>• Environmental counseling | • Minor insect bites/stings<br>• Asthma, active with or without co-existing infection<br>• Allergy testing and institute immunotherapy - if appropriately trained<br>• Administer immunotherapy |
| **Adult Cardiology** | |
| • Perform electrocardiograms<br>• Interpret electrocardiograms<br>• Evaluate chest pain<br>• Evaluate and treat coronary risk factors, including smoking, hyperlipidemias, diabetes, hypertension | • Evaluate and treat uncomplicated hypertension, CHF, stable angina, non-life-threatening arrhythmias<br>• Evaluate single episode syncope (cardiac)<br>• Evaluate benign murmurs and palpitations |
| **Dermatology** | |
| • Treat acne - acute and recurrent<br>• Treat painful or disabling warts with topical suspensions, electrocautery, liquid nitrogen<br>• Diagnose and treat common rashes including contact dermatitis, dermatophytosis, herpes genitalis, herpes zoster, impetigo, pediculosis, pityriasis rosea, psoriasis, scabies, seborrheic dermatitis, and tinea versicolor<br>• Screen for basal or squamous cell carcinomas | • Diagnose and treat common hair and nail problems and dermal injuries<br>• Common hair problems include fungal infections, ingrown hairs, virilizing causes of hirsutism, or alopecia as a result of scarring or endocrine effects<br>• Common nail problems include trauma, disturbances associated with other dermatoses or systemic illness, bacterial or fungal infections, and ingrown nails |

| | |
|---|---|
| • Biopsy suspicious lesions, if trained may do biopsy of suspicious lesions for cancer or others such as actinic keratoses<br>• Punch biopsy<br>• Incisional biopsy | • Dermal injuries include minor burns, lacerations, and treatment of bites and stings<br>• Counsel patients regarding removal of cosmetic (non-covered) lesions<br>• Identify suspicious moles |
| Endocrinology | |
| • Diabetic management, including Type I and Type II for most patients<br>• Patient education<br>• Supervision of home (SBGM) testing<br>• Medication management<br>• Manage DKA<br>• Manage thyroid nodules (testing, scans, ultrasound) | • Diagnose and treat thyroid disorders<br>• Identify and treat hyperlipidemia<br>• Diet instruction<br>• Exercise instruction<br>• Provide patient education for osteoporosis risk factors<br>• Identify and treat lipid disorders with diet and/or at least 2 medications for a minimum of 6 months |
| Gastroenterology | |
| • Diagnose and treat lower abdominal pain<br>• Diagnose and treat acute diarrhea<br>• Occult blood testing<br>• Perform flexible sigmoidoscopy<br>• Diagnose and treat heartburn, upper abdominal pain, hiatal hernia, acid peptic disease<br>• Evaluate acute abdominal pain | • Diagnose and treat uncomplicated inflammatory bowel disease<br>• Diagnose jaundice<br>• Diagnose and treat ascites<br>• Diagnose and treat symptomatic, bleeding, or prolapsed hemorrhoids<br>• Manage functional bowel disease<br>• Manage diagnosed malabsorption syndrome<br>• Manage mild hepatitis A |
| General Surgery | |
| • Evaluate and follow small breast lumps in teenagers<br>• Order screening mammograms<br>• Aspirate cysts<br>• Foreign body removal | • Laceration repairs (minor)<br>• Local minor surgery for hemorrhoids<br>• Minor surgical procedures<br>• Diagnose gallbladder disease<br>• Manage inguinal hernia |

| | |
|---|---|
| Geriatrics | |
| • Diagnose and treat impaired cognition (dementia)<br>• Be familiar with effects of aging on drug distribution, drug metabolism, and drug-drug interaction | • Management of advanced illness including the use of alternative levels of care<br>• Recognition of elder abuse |
| Gynecology / OB | |
| • Perform routine pelvic exams and PAP smears<br>• Perform lab testing for sexually transmitted diseases<br>• Wet mounts<br>• Diagnose and treat vaginitis and sexually transmitted diseases<br>• Contraceptive counseling and management<br>• Normal pregnancy (if physician privileged to deliver) | • Evaluate lower abdominal pain to distinguish gynecological from gastrointestinal causes<br>• Diagnose irregular vaginal bleeding<br>• Diagnose and treat endometriosis with hormone therapy<br>• Manage premenstrual syndrome with non-steroidal anti-inflammatory hormones and symptomatic treatment |
| Neurology | |
| • Diagnose and treat all psychophysiological diseases, headaches, low back pain, myofascial pain syndromes, neuropathies, radiculopathies, and central nervous system disorders<br>• Diagnose and treat tension and migraine headaches<br>• Order advanced imaging procedures (MRI or CT scan at an appropriate anatomic level after an appropriate clinical evaluation and trial of conservative therapy | • Diagnose and management of syncope<br>• Treat seizure disorders<br>• Manage degenerative neurological disorders with respect to general medical care (i.e., Parkinson's)<br>• Manage stroke and uncomplicated TIA patients<br>• Lumbar puncture<br>• Treat myofascial pain syndromes |
| Ophthalmology | |
| • Perform thorough ophthalmologic history including symptoms and subjective visual acuity | • Remove corneal foreign bodies (except metallic)<br>• Treat corneal abrasions<br>• Perform tonometry |

| | |
|---|---|
| • Perform common eye related services<br>> Distant/near testing<br>> Color vision testing<br>> Gross visual field testing by confrontation<br>> Alternate cover testing<br>> Direct fundoscopy without dilation<br>> Extraocular muscle function evaluation<br>> Red reflex testing in pediatric patients | • Diagnose and treat common eye conditions<br>> Viral, bacterial, and allergic conjunctivitis<br>> Blepharitis<br>> Hordeolum<br>> Chalazion<br>> Subconjunctival hemorrhage<br>> Macrocystis' |
| Orthopedics | |
| • Treat low back pain and sciatica without neurological deficit<br>• Treat sprains, strains, pulled muscles, overuse symptoms<br>• Treat acute inflammatory conditions<br>• Chronic knee problems<br>• Manage chronic pain problems | • Diagnose and treat common foot problems: ingrown nails, corns/calloses, bunions<br>• Closed emergency reduction of dislocation: digit, patella, shoulder<br>• Treatment of minor fractures<br>• Arthrocentesis |
| Otolaryngology | |
| • Treat tonsillitis and streptococcal infections<br>• Perform throat cultures<br>• Evaluate and treat oropharyngeal infections<br>> Stomatitis<br>> Herpangina<br>> Herpes simplex<br>• Treat acute otitis media<br>• Treat effusion | • Evaluate tympanograms/audiograms<br>• Treat acute and chronic sinusitis<br>• Treat allergic or vasomotor rhinitis<br>• Remove ear wax<br>• Treat nasal polyps<br>• Diagnose and treat acute parotitis and acute salivary gland infections<br>• Treat nasal obstruction (including foreign body)<br>• Treat simple epistaxis |
| Physical Medicine and Rehabilitation | |
| • Coordinate care for patients recovering from major trauma or CNS injury by appropriate use of various rehab professionals including PT, OT, ST, and physiatrist | • Basic understanding of effective use of common orthotic and prosthetic devices including wrist splint for CTA, AFO for foot drop |

| Psychiatry **(*)** | |
|---|---|
| • Perform complete physical and mental status examinations and extended psychosocial and developmental histories when indicated by psychiatric or somatic presentations (fatigue, anorexia, over-eating, headaches, pains, digestive problems, altered sleep patterns and acquired sexual problems | • Diagnose physical disorders with behavioral manifestation<br>• Provide maintenance medication management after stabilization by a psychiatrist or if longer-term psychotherapy continues with a non-physician therapist<br>• Diagnose and manage child, elder, dependent adult abuse, and domestic violence victims |

**(*)** Only for Medicaid Managed Care, this is a "carve-out" service and PCP is only responsible for H&P for patients/members before inpatient mental health admissions and for assessment and referral to County Mental Health Department for outpatient mental health services.

**(*)** For some Medicare Advantage/Medicaid HMOs, this is a "carve-out" service and PCP should refer to these HMOs for Mental Health Network for all services.

| Pulmonology | |
|---|---|
| • Diagnose and treat asthma, acute bronchitis, pneumonia<br>• Diagnose and treat chronic bronchitis<br>• Diagnose and treat chronic obstructive pulmonary disease | • Manage home aerosol medications and oxygen<br>• Work up possible tuberculosis or fungal infections<br>• Treat opportunistic infection<br>• Order chest x-rays, special views, and CT scans |
| Rheumatology | |
| • Diagnose and treat non-articular musculoskeletal problems:<br>> Overuse syndromes<br>> Injuries and trauma<br>> Soft tissue syndromes<br>> Bursitis or tendonitis<br>• Provide steroid injections<br>• Manage osteoarthritis unless there is a significant functional impairment despite treatment | • Diagnose crystal diseases<br>• Perform arthrocentesis<br>• Diagnose and treat rheumatoid arthritis<br>• Diagnose and treat inflammatory arthritic diseases<br>• Diagnose and treat uncomplicated collagen diseases |

| | |
|---|---|
| Urology / Nephrology | |
| • Diagnose and treat initial and recurrent urinary tract infections<br>• Provide long term chemoprophylaxis<br>• Diagnose and treat urethritis<br>• Explain hematospermia<br>• Initiate evaluation of hematuria<br>• Evaluate incontinence<br>• Evaluate male factor infertility and impotence and treat readily correctable factors | • Diagnose and treat epididymitis and prostatitis<br>• Differentiate scrotal or peri testicular masses from testicular masses<br>• Evaluate prostatism and prostatic nodules<br>• Manage urinary stones<br>• Evaluate and treat renal failure<br>• Placement of urinary catheters<br>• Evaluate impotence<br>• Evaluate male infertility |
| Vascular Surgery | |
| • Diagnose abdominal aortic aneurysm<br>• Diagnose and treat venous diseases<br>• Treat stasis ulcers | • Manage intermittent claudication<br>• Manage transient ischemic attacks<br>• Manage asymptomatic bruits |
| Other | |
| • Basic life support<br>• Advanced life support<br>• Heimlich maneuver | • Endotracheal intubation<br>• Tracheostomy (emergency) |

## 4.5 Telephone services

PCP or office staff must return any nonurgent phone calls within 24 hours. Urgent and emergent calls are to be handled by the primary care physician, immediately, 24 hours a day, 7 days a week unless other arrangements have been made with IPA.

## 4.6 Services for members with disabilities

Primary and Specialty Care Physicians must comply with all the provisions of the Americans with Disabilities Act including a handicapped bathroom or alternative access which is equipped with handrails in the bathroom, handicapped access ramp, handicapped water fountain or alternative provisions, an elevator when applicable, and at least one handicapped parking space.

## 4.7 Hospital Admissions

Primary Care Physicians (PCPs) should have admitting privileges to at least one of the contracted hospitals. The Admitting Team should always be notified by the PCP for assistance and coordination of care whenever IPA member needs to be admitted. Refer to MSO Inc. of Southern California and IPA Medical Director for notification and follow-up. If a PCP does not have admitting privileges to one of the contracted hospitals, PCP should notify the UM Department upon contracting so arrangements could be made for admission of members assigned to PCP.

## 4.8 Initial Health Assessments (IHA)

The CMS Medicare Advantage requires an IHA to be performed on all assigned Medicare members within 90 to 120 days of the effective date of enrollment. This visit can also serve as the annual wellness visit.

The IHA will help PCPs identify patients in need of health education, counseling, and other medical and social services. The PCP is responsible for the following:

- Assessing whether the member has had a complete physical exam in the last year. If the member has had a physical exam by another physician, the member should sign a medical record release to request the exam and incorporate into the member's chart.
- Documenting all findings into the medical record.

Unless deemed inappropriate by the physician, or refused by the member, health assessments should include:

- Health history
- Unclothed physical examination
- Assessment of nutritional status
- Inspection of ears, nose, mouth, throat, teeth, and gums
    - Noting that if dentures are in use the appliance is well fitting to support nutrition
- Vision screening
    - Noting if glasses are used that the prescription is adequate
- Tuberculin testing and laboratory tests appropriate to age and sex, including test for anemia, diabetes, and urinary tract infections
- Testing for sickle cell trait where appropriate
- Immunizations appropriate to age and health history necessary to make status current

- Health education appropriate to age and health status, including harmful effects of the use of tobacco products and exposure to secondhand smoke

Please Note: If the member refuses to give this information, this should be documented in the medical record.

## 4.9 Medical Records

Periodically, the Network may request medical records and conduct medical chart reviews to retrieve evidence for compliance with HEDIS monitoring, evaluate practice patterns, to identify opportunities for medical chart improvement, and to support compliance with quality standards and documentation. Well documented medical records facilitate the retrieval of clinical information necessary for the delivery of quality of care. Providers should adhere to compliance with professional standards and should take steps to safeguard member confidentiality.

The Physician is responsible for maintaining a legible, detailed, confidentially stored, easily retrievable medical record for each patient for ten (10) years, as required and mandated by Centers for Medicare and Medicare (CMS). The medical record of a patient is a confidential document used by the physician to maintain a systematic record of the patient's continuing medical care.

Release of medical information and records will be in accordance with Federal, State, and local statutes. (Refer to the Forms Section for the Medical Record Release Form).

Medical records will be stored in an area of the medical practice, with access limited to authorized staff only. All staff members must sign a Confidentiality Statement that assures that the access to medical records and the information therein is confidential, and that this information may not be released without permission, nor can it be sold in total or any part thereof.

All patient information is confidential and must be protected from disclosure to unauthorized personnel in accordance with the Health Insurance Portability and Accountability Act and the regulations promulgated thereunder (HIPAA) and applicable State privacy and medical record laws. Patient information includes the patient’s name, address, telephone number, social security number or Medicaid identification number.

Medical Record Standards

All medical records must comply with applicable Federal and State laws and applicable payor requirements. The following requirements apply to ALL Medical Records:

- A separate medical record is maintained for each patient.

- The medical record is to be stored in a secured place.
- Each medical record will contain at a minimum the following demographics:
    - Complete patient name
    - Date of birth
    - Gender
    - Marital Status
    - Home address and phone number
    - Employer address and phone number (if applicable)
    - Insurance and member identification number
    - Signature on file for consent to treatment
    - Member's Primary Language indicated in writing
- All pages in the medical record must contain the patient's name or identification number.
- Allergies are predominately displayed.
- Advance Directive or refusal of Advance Directive is clearly identified.
- All entries are dated and signed by the author. Full signature with title is required.
- All entries must be dated and signed or initialed by the Provider.
- The medical record must be legible to others besides the provider and their staff.

A notation must be made for each visit in the medical record and must include:

- Date of visit
- Chief complaint
- A documented physical exam relevant to the complaint
- Diagnosis / Impression
- Medication list includes medication history as well as current medications
- Medication allergies, adverse reactions, or the absence of known allergies are noted in a consistent fashion
- Problem list includes medical conditions and significant illnesses and surgeries
- A comprehensive health history is documented for patients seen three or more times.
- Use of tobacco, alcohol, and substance abuse are documented for patients seen more than three times
- Progress notes which must document:
    - Height, weight, vital signs
    - Chief complaint and unresolved problems from previous visits
    - Physical exam consistent with chief complaint
    - Working diagnosis

  - Tests, referrals, consult, and plan of treatment consistent with working diagnosis
  - Prescribed medications include name of drug, dosage, and administration frequency, and duration
  - Follow up plan and date of return visit or PRN
  - Health education and preventative care
- Telephone advice is documented noting date, time, and name with credentials of person providing the advice
- The physician initials and dates consultant summaries, laboratory, and other diagnostic reports. Consultant summaries and abnormal lab and diagnostic test results have a chart entry including a follow-up care plan
- Immunization records appropriate to age are initiated on all patients
- Preventive screening and health education services are offered
- Problems lists are updated with each visit and unresolved problems are addressed at the next visit
- Missed appointments are to be documented in the medical record. At a minimum, three attempts will be made to determine the cause of the missed appointment
- Documentation includes a notation of the time and method used to contact the member
- Refusal to have a translator outside of family and or friend must be documented
- Any access to care problems is to be documented in the medical record

### 4.10 Vaccine and immunization administration

Vaccines for Medicare Advantage HMO members shall be the sole responsibility of the PCP if PCP chose to administer them. Please refer to the PCP Agreement for reimbursement information. Some vaccines (such as influenza) can be administered by pharmacies contracted with the health plans and PCP may direct the members accordingly.

## 5 ENCOUNTER DATA AND CLAIMS SUBMISSION

Encounter data is used to report medical services for patients under capitated contracts. The encounter data is very similar to the information submitted on a fee for service form, but no service-related reimbursement occurs.

Encounter data must be submitted weekly and on a CMS 1500, or when applicable UB92. Health Plans imposes significant financial penalties for lack of, or inadequate submission, of Encounter data. Providers who are on fee-for service do not have to submit encounter data, only claims as described below.

Encounter data plays an integral role in providing evidence to support compliance with access to preventive care and maintenance of chronic conditions when measuring completion of HEDIS specification requirements.

# 6 HIERARCHICAL CONDITION CATEGORY CODING (HCC) AND RISK ADJUSTMENT FACTOR (RAF)

HCCs, or Hierarchical Condition Categories, are sets of medical codes that are linked to specific clinical diagnoses. Since 2004, HCCs have been used by the Centers for Medicare and Medicaid Services (CMS) as part of a risk-adjustment model that identifies individuals with serious acute or chronic conditions. This allows Medicare to project the expected risk and future annual cost of care. Each HCC represents diagnoses with similar clinical complexity and expected annual care costs.

HCCs are used to calculate payments to healthcare organizations for patients who are insured by Medicare Advantage (MA) plans, Accountable Care Organizations (ACOs), some Affordable Care Act (ACA) plans and many more. Clinicians add HCCs to a patient's medical record along with supporting documentation as required by CMS.

A Risk Adjustment Factor, known as a RAF score, is a measure of the estimated cost of an individual's care based on their disease burden and demographic information. The RAF score is then used to calculate payments to healthcare organizations. Each HCC associated with a patient is assigned a relative factor that is averaged with any other HCC code factors and a demographic score.

The resulting score is then multiplied by a predetermined dollar amount to set the per-member-per-month (PMPM) capitated reimbursement for the next period of coverage. The PMPM is the payment amount a provider receives for a patient enrolled in an MA plan regardless of services provided. Healthier patients will have a below average RAF while sicker patients will have a higher one, which impacts the calculated payment amount. Scores are calculated on an annual basis.

HCCs directly impact the amount of money received by healthcare organizations from the largest single payer in healthcare, CMS. Patients with high HCCs are expected to require intensive medical treatment, and clinicians that enroll these high-risk patients are reimbursed at higher rates than those with enrollees who have low HCCs.

# 7 ENROLLMENT AND ELIGIBILITY

## 7.1 Eligibility Verification

Patient eligibility must be verified before providing any service. Possession of a membership card DOES NOT guarantee eligibility.

Providers are encouraged to check eligibility of Medicare members by calling TECQ Partners or the Health Plan directly (claim contact information is provided on members ID card).

Always try to find the member's name on the most recent IPA Eligibility List. Member eligibility is available electronically through the provider portal.

### 7.2 Eligibility List (Refer to the Eligibility Verification Form)

The Eligibility list provides monthly information on member enrollment for each Health Plan by product for Medicare Advantage assigned members

### 7.3 Capitation Report (when applicable)

The Capitation Report provides monthly information on capitation payment for each member. Capitation is mailed out to providers approximately 5 working days from receipt of capitation payment from the contracted health plans.

### 7.4 Member Disenrollment

For Medicare Advantage HMO members, the member is locked into the Plan of choice for a period of 12 months, after open enrollment occurs. DSNP members can make enrollment changes quarterly.

### 7.5 Provider Status Change

Any planned change in status such as an address or phone number change, malpractice insurance coverage or staffing changes, must be reported immediately, and at least sixty (60) days prior to the change, to the Credentialing Department at TECQ Partners.

## 8 INTERPRETER SERVICES

Interpretation services may be accessed through the service provided by the members enrolled Health Plan. Please refer to the members membership card for specific details. Interpreter services are provided at no cost to the member.

Primary and Specialty Care Physicians are required to offer interpretive services to members in order to provide quality health care services.

If a member declines the interpretive services, the provider must note this in the member’s medical records.

# 9 UTILIZATION MANAGEMENT (UM)

## 9.1 Referral Authorization Process and Guidelines

The following guidelines are provided to support providers when submitting a Referral for prior authorization:

1. PCPs are responsible for submitting a Referral when referring a member for any specialty services members require outside of the PCP office.
2. Specialists are responsible for submitting a Referral when additional services are required after an initial specialty consultation.
3. Providers should use contracted providers and facilities for member care.
4. If members require services from a non-contracted provider or facility, the requesting provider, completes the Referral form, either paper or TECQ Partners Provider Portal, includes clinical information to support the rationale for the request and submits to TECQ Partners for review and approval.
5. Use of the TECQ Partners Referral form is required and should include clinical information to support request for care or service (electronic submission will result in a quicker turnaround time)
    a. Providers with access to the TECQ Partners Provider Portal submit their Referrals via the Portal.
    b. Providers without access to the TECQ Partners Provider Portal, utilize the paper Referral form and can submit via FAX or mail:

        FAX #:

            +1 (833) 585-5298

            (Please include +1 before fax number. FAX will FAIL if +1 is not entered)

        Mail to:

            TECQ Partners

            8278 Bellaire Blvd. Suite B

            Houston, TX 77036

## 9.2 Auto Authorization

The complete list of Services that do not require prior authorization is available on the TECQ Partners Provider Portal. A copy of the current Auto-Auth list is provided to the physician at the time of contracting and orientation.

The list is updated on an ongoing basis and the most recent list is available on the IPA website.

It is the responsibility of the contracted provider office to maintain current list of services that do not require prior authorization.

## 9.3 Referrals Requiring Review:

Any services not specifically listed on the Auto-Auth List requires completion of the Referral Authorization form either hard copy and faxed to TECQ Partners or electronically completed and submitted via TECQ Partners Portal.

The online TECQ Partners Provider Portal is used for Referral submission. Access and

training on use, is provided to Provider offices upon completion of contracting and

credentialing.

Refer to the Forms Section for a copy of the Referral Authorization Form

The Requesting Provider Use the TECQ Partners Referral Form in written or electronic form and submits the Referral to the TECQ Partners UM Department for review.

To avoid unnecessary delays, the following information is included in ALL Referrals:

Type of referral: Urgent or Routine

- Member's Name
- Member ID Number
- Specialist or Requested Provider Name
- Type of service being requested including CPT codes
- Reason for referral, including diagnosis with ICD-10 codes
- Provide all pertinent progress notes which may include diagnostic test results, medications or treatments tried with response to previous treatments
- Number of visits requested including CPT codes

## 9.4 Review Standards

All review determinations are based on review of the requested services, comparing member specific clinical information to established clinical criteria.

The approved TECQ Guidelines for Review are based on CMS, state, Health Plan and industry recognized clinical practice guidelines, such as MCG. The requesting provider may request a copy of any specific criteria or guidelines by contacting the UM Department.

Upon review for Medical Necessity, if the information provided on the referral form is not sufficient to determine medical necessity, the UM Department will make a number of attempts to collect the additional information, including sending a letter to the Requesting Provider with a specific outline of the missing information including:

- Lab or other diagnostic test results
- Additional family or personal health history
- Consultation or progress notes from the PCP or Specialist
- Conservative treatment provided and response to treatment

In addition to the Medical Necessity review, the following elements are applied to every Referral submitted to ensure appropriate management of the referral process:

- Member eligibility at the time of request
- Services as a covered benefit
- Service being the responsibility of the Primary Care Provider

9.5 Member and Provider Notification of Outcomes of Review:

Member are notified in writing of all UM Determinations.

Written notifications are completed utilizing the health plan required letter templates and timeframes to ensure timely notification.

Providers receive notification via the TECQ Partner's Provider Portal. When Providers do not have access to the TECQ Partner's Provider Portal, such as a non-contracted provider, they are notification of the outcome of the review determination via fax.

9.6 Review Priority

There are two levels of priority when submitting a request for prior authorization review:

Medicare Advantage Turn Around Time (TAT) Guidelines

A. URGENT or Expedited Referrals The patient's care must be expedited on an urgent basis.

Turn-around time is 24 to 72 hours.

B. ROUTINE Referrals non-urgent/non-emergent requests for care/service

Waiting for the 14 calendar days for the approval and appointment will not compromise member care outcomes.

Turn-around time of a maximum 14 calendar days following the submission of a COMPLETE referral form including all supporting documentation.

URGENT Referrals

If members require care or service urgently, the provider submits the Referral for prior authorization review to the UM department and notes in the Referral Type as: URGENT

For a Referral to be considered as Urgent, the care being requested must meet the following definition of Urgent:

Care that should be provided promptly to prevent impairment of the member's health and the standard turn-around time of 14 calendar days may jeopardize prevention of impairment

Routine Referrals

Care and services requiring approval where the 14-calendar day approval timeframe will not compromise member care outcomes are considered as Routine Referrals.

## 9.7 Emergency Room Utilization and Management

A medical Emergency is defined as a sudden injury or onset of illness that, if immediate care is not provided, may result in permanent damage or cause loss of life or limb to patient.

The Primary Care Physician or his/her on-call physician is responsible for determining the medical necessity of an Urgent Care or Emergency Room visit. After hours Urgent Care Referrals should be directed to the contracted Urgent Care Centers.

If a member contacts the PCP office at any time day or night, it is the PCPs responsibility to assess the situation and decide as to the emergent nature of the care being needed.

Based on the assessment of the member's described issue, the PCP can:

- Decide during normal business hours:
    - Instruct the member come to the PCP office for care
    - Instruct the member to go to the contracted Urgent Care Center
    - Instruct the member to go to the ED for treatment

If/when the PCP is notified of a member in an Emergency Room, the is responsible for immediately responding to the call from the emergency room.

The member automatically will receive a medical screening exam (MSE) in the Emergency Room. This is required by law and is automatically paid.

When the PCP is notified of the member being in the Emergency Room the PCP should evaluate the situation and give the specific orders to the ER staff.

- If the member requires ER level of care, the PCP should approve the ER visit
    - If the member can be treated and released with no further treatment, the ER should be instructed to treat the member and instruct the member to receive all follow up care with the PCP, NOT THE EMERGENCY ROOM.
- If the member requires additional treatment, such as admission and the PCP is contacted, the PCP should authorize the admission
- PCP with hospital privileges at the hospital, admit and manage the member
- PCP without admitting privileges at the hospital, the Admitting Physician should be called.

The PCP is responsible for notifying the UM Department via fax at (833) 585-5298 via phone at: (888) 319-0777, ext. 699 of any emergency room visit or emergency inpatient admission by the following business day.

In the event the PCP is unaware of an inpatient admission, the UM department will notify the PCP as soon as the information comes forward.

The Emergency Room MUST NOT be utilized in lieu of the Primary Care Physician's office.

## 10 CLAIMS SUBMISSION

Claims must be submitted no later than 95 days, from when care was rendered. Claims will be processed, and payments made in accordance with timeliness guidelines as outlined in your Participating Provider Agreement (PPA). Claims should be submitted for those services that are performed by the physician that are not covered under capitation (if applicable) and/or according to the contract.

In order for the Network to accurately adjudicate claims and ensure timely processing and payment for services rendered to IPA members, it is imperative that all the required information on the CMS 1500 is provided.

For a complete submission, the following minimum information must be on all CMS 1500 claims to be considered a “clean claim” or encounter data submissions*, otherwise the claim may be pending or denied:

- Patient's name and date of birth*
- Patient's Insurance identification number*
- Patient's complete address*

- Date of onset of illness or injury or Last Menstrual Period (where applicable) *
- ICD10 Code and Diagnosis and Procedure and modifier code(s) (CPT or HCPCS) * - ALL PERTINENT ICD-10 AND CPT CODES PERFORMED DURING EACH VISIT
- Referring physician
- Rendering physician NPI*
- Date of service, place of service, type of service, quantity/unit of service(s), and normal charge(s)*
- Authorization Number in Box 23 of CMS-HCFA 1500 Form (when required)
- The Physician's Federal Tax ID number, Medicaid, or Medicare Provider number, UPIN number (where applicable) *
- Name and address of facility where services were rendered
- Name, address, zip code and phone number of Physician submitter*
- Attached OR, procedure, or ER notes and Medical Reports for E&M codes billed as complex or severe
- A copy of the authorized referral attached to the claim
- EOMB or EOB attached if other coverage (COB) applies

Claims processing for Van Lang will change beginning 01/01/2022. There are **important clearinghouse and claims processing changes,** as noted below**.** We accept electronic and paper claims. Faxed claims are not accepted. A valid Provider rendering NPI is required for claims processing.

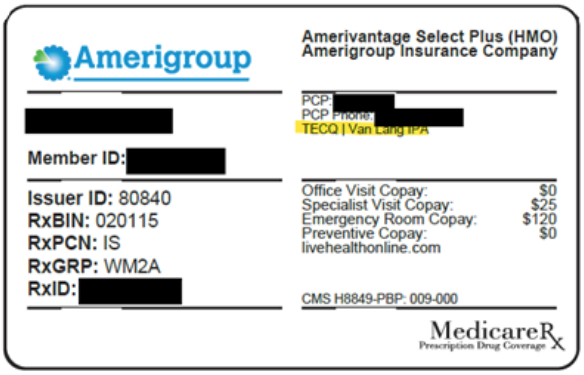
**Electronic Payment**

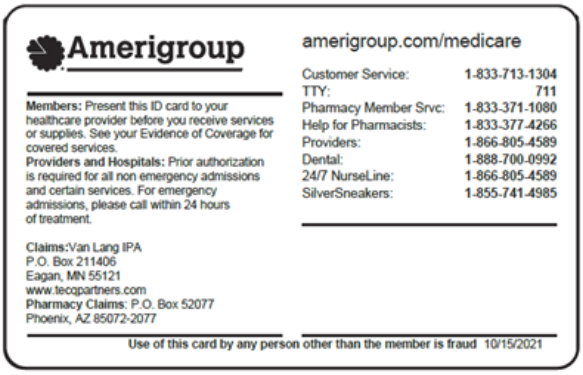
To receive electronic claims payment, you can start to enroll immediately for electronic fund transfer (EFT) by registering at https://www.tecqpartners.com/go/eft. Payment via electronic fund transfer is applicable only for claims submitted to Van Lang after the date of service of 1/1/2022. Fees may be associated with EFT payments. Consult with your financial institution about specific rates.

| Dates | Department | Activity | Action Steps for your practice |
|---|---|---|---|
| **Available Now** | Claims | Electronic Claims Payment Registration is Required for electronic payment | Enroll **NOW** electronic payment at **www.tecqpartners.com/Go/EFT** |

| | | | |
|---|---|---|---|
| **01/01/2022** | Claims | Please do NOT change your billing process until **1/1/2022** | Beginning 1/1/2022 send claims to SDS Clearinghouse Payer ID: **77036** |
| | Claims | Online processing | Check www.tecqpartners.com periodically for updates |
| | Claims | ERA 835 replaces the paper version of the EOR (explanation of reimbursement) | Check www.tecqpartners.com periodically for updates for accessing 835 files electronically |
| **01/01/2022** | Pre - authorization | Submit and track pre-authorization electronically. | Check www.tecqpartners.com periodically for updates |
| **01/01/2022** | Credentialing & Recred | Keep your CAQH profile updated & attestation current. | Check www.tecqpartners.com periodically for updates |

**Member ID - Amerigroup - Effective Jan 1, 2022**




**About EFT**

EFT payment transactions are reported in a CCD+, NACHA Automated Clearing House (ACH) corporate payment format. Your financial institution must be able to receive NACHA files for EFT payment. Fees may be associated with EFT payments. Consult with your financial institution for specific rates.

**About ERA**

The ERA (electronic remittance advice) replaces the paper version of the EOR (explanation of reimbursement).

For questions regarding this transition change, please contact:

| Department | Name | Email | Phone |
|---|---|---|---|
| Claims | Claims Customer Service | claims@tecqpartners.com | 888.319.0777 ext 899 |
| Provider Services | | provider-support@tecqpartners.com | 888.319.0777 ext 799 |
| | Jeff Ngo | jeff.ngo@tecqpartners.com | 888.319.0777 ext 750 |
| | Tiffany Dao | tiffany.dao@tecqpartners.com | 888.319.0777 ext 751 |

**Notice of Amerigroup as the payor for all Reference Labs**
(CPL, QUEST, Labcorp)
**EFFECTIVE 1/1/2022**

Beginning 1/1/2022, Amerigroup will be the payor for all Reference Labs (CPL, QUEST, Labcorp). Van Lang will no longer be paying for reference labs. If you have any patients with billing questions related to Laboratory Services, please contact *Amerigroup Customer Service at 1-833-713-1304 as listed on the back of the Member ID card.*

As a provider, there is no action needed from you. This is a courtesy reminder of a change that Amerigroup will be the payor for all reference labs beginning 1/1/2022. Van Lang will no longer be the payor for Amerigroup patients.

**HOW TO SUBMIT A CLAIM**

**Electronic claims submission (effective after 1/1/2022):**

- Van Lang's preferred claims clearinghouse is SDS Clearinghouse.
  - The payer ID is **77036**
  - Claims for Amerigroup HMO & DUAL members/patients are paid by TECQ Partners, administrator for Van Lang.
    - Claims for Amerigroup MMP, PPO and Medicaid patients should be billed to Amerigroup directly. Van Lang does **not** pay claims for MMP, PPO or Medicaid.
  - SDS Clearinghouse website is https://sdata.us/

- Providers may send electronic claims via an Online Submission. Contact claims@tecqpartners.com for additional information.
- Providers also may file a claim by EDI through the clearinghouse of their choice. Some clearinghouses and vendors charge a service fee. Contact the clearinghouse for information.
- Filing deadline for claims must be submitted as stipulated in the provider agreement.
- If a claim is submitted in error to a carrier or agency other than Van Lang IPA, the timely filing period begins on the date the provider was notified of the error by the other carrier or agency.

**Paper claims (effective after 1/1/2022):**

**Van Lang IPA**
**% TECQ Partners**
**P.O. Box 211406**
**Eagan, MN 55121**

**Online Capabilities at www.tecqpartners.com**

- Claims status is available 24/7 via our IVR (interactive voice response) system.
- Prior authorization (PA) requests are available via our online portal.
- Provider portal with checking member eligibility, prior authorization status, payment information (ERA remittances) and referral trends.
- Patient portal with ability to check explanation of benefits.

**CLAIMS QUESTIONS AND ASSISTANCE**

| Claims Department Quick Reference | |
|---|---|
| Payer ID for SDS Clearinghouse | TECQ |
| Claims Clearinghouse: SDS | https://sdata.us |
| Paper Claims Address | Van Lang % TECQ Partners |
| | P.O. Box 211406 |
| | Eagan, MN 55121 |
| Claims Status via IVR 24/7 | Pending update on 1-1-2022 |
| Claims Department | claims@tecqpartners.com |
| Claims Department | 888.319.0777 ext. 899 |

## 11 NON-COVERED PROGRAM SERVICES

Check with each individual Plan Program's Covered Benefits and Evidence of Coverage to determine if services are covered.

## 12 LINKED AND CARVED-OUT MEDICARE SERVICES

Below are some of the examples of services that are linked or carved out of the members Health Plan benefits, for Medicare Programs. IPA and Plan will help coordinate these services with the Provider and the appropriate health care setting.

For Medicare Advantage Managed Care Program:

- Adult Day Health Care Services
- Custodial Care (Dual Eligible Managed Care shall defer to member's Medicaid Plan)
- Dental Services
- Optometry Benefits
- Prescription Drugs – Medicare Part D

## 13 MEMBER HEALTH EDUCATION

All affiliated Health Care Providers are responsible for providing and/or arranging for culturally and linguistically appropriate health education, prevention, and counseling services to Medicare managed care members, and to encourage members to take increased responsibility for their personal health.

Documentation of health education provided to managed care members in medical records should include:

- Date
- Health education relative to the diagnosis and/or presenting problem
- Any support materials given to or presented to the Patient (e.g., "patient viewed asthma video" or "patient given brochure on diabetes.")
- Patient's understanding of the education provided
- Any follow up needed or that is appropriate (e.g., completed referral form, attended class, revisit scheduled)
- Referral to health education services
- Signature and title of all staff providing health education
- Health education activity rendered (i.e., one-on-one consultation, class, support Network session)
- Health education resources provided (e.g., brochure, newsletter, videotape, audiotape)

## 14 ADVANCE DIRECTIVES

An Advance Directive is a formal document, written in advance of an incapacitating illness or injury in which once can assign decision making for future medical treatment. Texas legally recognizes the Durable Power of Attorney for Health Care (DPAHC) as Advance Directive for adults.

The responsibility of the PCP is as follows:

- Provide all members 18 years old and above with the Patient Rights Brochure. A copy must be provided to the member at the initial encounter with their PCP.
- Provide the member with the pamphlet, which addresses Advance Directives, surrogate decision making and the forgoing of life sustaining procedures.
- The PCP may assist members who have questions about an Advance Directive; however, he/she may not influence the member in making the decision regarding the member's health care.
- Documentation in the medical record must be entered when the member has been informed of his/her right to an Advance Directive and/or whether the member has executed an Advance Directive.
- When the member executes an Advance Directive, a signed copy must be in the medical record.
- If the patient does not have a written Advance Directive but expresses his/her intentions regarding future medical care, the PCP shall clearly document all communications regarding the Advance Directive issue in the medical record. This information must be available to alternate decision-makers for the member in the event subsequently becomes incapable of directing his/her care.

The requirements for advance directives, to include psychiatric advance directives, vary from state to state. Specific forms that meet compliance with each state can be found on the state's official website. Psychiatric advance directive information may be found at the following website: https://www.nrc-pad.org/states/texas/.

TECQ Partners will provide a copy of the Advance Directive Form to the provider upon request.

## 15 COMPLAINTS AND GRIEVANCES

### 15.1 The Member complaint and grievance process.

Will apply when a member or provider files a complaint that does not involve a determination of coverage. Grievances may be filed for issues regarding quality of care, termination, adequacy of facilities, waiting times, or interpersonal problems with providers. Please keep the following in mind:

- Members must be informed of their right to complain and may submit complaints orally or in writing to the health plans
- Members may be directed to call the Health Plans' Member Services Department to file a grievance.
- Members can obtain a complaint form, either from their provider's office, or the Health Plan (Refer to the Forms Section for a copy of the grievance form)
- IPA and Health Plan are required to acknowledge a member's complaint within fifteen (15) working days and resolve the member's complaint within forty-five (45) working days.
- Members can call the Plan and/or the Texas Department of Health Services (TDHS, if the complaint is not resolved to their satisfaction.
- Most common grievances result from:
    - Length of time required to see the physician or schedule appointments
    - Difficulty in obtaining referral
    - Lack of courteous treatment on the part of physician's personnel
    - Crowded or cluttered waiting room conditions
    - Member feels that the physician is not giving the member what he/she wants versus the physician providing what is needed

### 15.2 Physician Complaints

- Physicians and other health care providers are encouraged to aid in the overall quality improvement efforts of the provider network by bringing forth issues that affect member's care, operational issues, or other service problems.
- Physicians and other health care providers with provider issues can submit a grievance to the IPA or MSO's QM Department by telephone, fax or via mail.
- Quality Management staff will assist in resolving the issue and will forward the complaint or problem to the health plans.
- Physicians will receive written confirmation of the outcome of the grievance investigation and the QM Committee's findings. Administrative and operational issues will be resolved within 5 business days. Providers will receive written confirmation of the outcome of the grievance.

### 15.3 Member and Provider Satisfaction Surveys

- In order to measure the overall satisfaction of individual physicians and members, TECQ Partners and IPA requests that physician participate in data collection regarding satisfaction.
- Physician Satisfaction are recommended to be completed at least once a year.

- [Attached forms 13.9 and 13.10 are provided for the purpose of gaining information regarding satisfaction. The IPA asks that Primary Care Physicians give these to members to fill out. Members may fill the form out and return it to the PCP or, if needed, office staff can assist the member in completion.
- Is the Member Satisfaction Form – for Member
- Is Physician Satisfaction Form – For PCP
- Both forms should be faxed back to the identified number at the bottom of the forms.

## 16 COMPLIANCE

### 16.1 Fraud – Waste – Abuse (FWA)

Anyone who suspects inappropriate FWA behavior is to report the suspicion to the Compliance Department. FWA reporting can be done by telephone, email, or mail.

- Compliance Hotline at 1-888-319-0777, ext. 999 for anonymous reporting of any suspected FWA. The hotline is monitored exclusively by the Chief Compliance Officer.
- Concerns may also be sent via email to Compliance@tecqpartners.com

Your anonymity will be protected and there is never any retaliation for reporting a suspected or actual compliance concern.

Detecting and preventing Fraud Waste and Abuse (FWA) is the responsibility of everyone affiliated with TECQ Partners or affiliated CIN, Medical Group, or Network for a Medicare Advantage product, including employees, members, providers, FDRs, and agent/brokers. TECQ Partners Compliance Program strives to improve the quality, productivity and efficiency of our operations while significantly reducing the probability of improper conduct and legal liability, including reducing FWA. TECQ Partners is committed to meeting rigorous compliance requirements by specifically:

- Providing a mechanism that brings the employees, providers, and members together to reach mutual goals of reducing fraud and abuse.
- Educating employees, providers, and members regarding beneficial practices in the prevention, detection, measurement, enforcement, and reporting of potential fraud and abuse.
- Strengthening awareness of compliance to all appropriate departments and business partners, and provide oversight and guidance in the prevention, detection, enforcement, and reporting of potential fraud and abuse.

- Enhancing existing and developing new internal controls to assure compliance with regulatory and internal guidelines.
- Enhancing the communications system to encourage employees, members, and business partners to report suspected misconduct.
- Reacting quickly and accurately to reports of potential fraud and abuse, effectively target resources to address those reports.
- Assessing employee and contractor behavior relating to fraud and abuse in order to develop performance improvement plans that will strengthen knowledge of compliance and correct inappropriate performance behaviors.
- Utilizing fraud and abuse resources to specifically target the inclusion, but not limited to, embezzlement & theft, underutilization, double billing and improper coding for prevention, detection, measurement, enforcement, and reporting of potential fraud and abuse.

## 16.2 Privacy, Confidentiality, and Security (including HIPAA)

The very nature of the Company's business and products involves the receipt, creation, maintenance, and transmission of patients' individually identifiable health information, most of which is considered "protected health information" (or "PHI") under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Company is often a Business Associate of its Covered Entity customers, such as home health agencies and health plans, and is therefore subject to certain provisions of HIPAA and of the Company's contracts with those customers.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Secretary of the U.S. Department of Health and Human Services (HHS) to develop regulations protecting the privacy and security of certain health information. HHS published what are commonly known as the

- HIPAA Privacy Rule
- HIPAA Security Rule

The Privacy Rule, or Standards for Privacy of Individually Identifiable Health Information, establishes national standards for the protection of certain health information. The Security Standards for the Protection of Electronic Protected Health Information (the Security Rule) establish a national set of security standards for protecting certain health information that is held or transferred in electronic form. The Security Rule operationalizes the protections contained in the Privacy Rule by addressing the technical and non-technical safeguards that organizations called "covered entities" must put in place to secure individuals' "electronic protected health information" (e-PHI).

The Security Rule requires covered entities to maintain reasonable and appropriate administrative, technical, and physical safeguards for protecting e-PHI.

Specifically, your office must:

- Protect the confidentiality, integrity, and availability of all e-PHI they create, receive, maintain, or transmit.
- Identify and protect against reasonably anticipated threats to the security or integrity of the information.
- Protect against reasonably anticipated, impermissible uses or disclosures.

It is the Provider's responsibility to make certain office staff comply with both privacy and security rules.

The Security Rule defines "confidentiality" to mean that e-PHI is not available or disclosed to unauthorized persons. The Security Rule's confidentiality requirements support the Privacy Rule's prohibitions against improper uses and disclosures of PHI. The Security rule also promotes the two additional goals of maintaining the integrity and availability of e-PHI. Under the Security Rule, "integrity" means that e-PHI is not altered or destroyed in an unauthorized manner. "Availability" means that e-PHI is accessible and usable on demand by an authorized person.

## 17 MANDATORY PROVIDER EDUCATION

Each calendar year each provider serving the Medicare population must attest to the completion of mandatory training.

- Complete the Centers for Medicare and Medicaid Services (CMS) for Fraud, Waste, and Abuse (FWA).

  Under Title 42, Code of Federal Regulations (CFR), Sections 438.206(c)(2), 438.330(b)(4), 438.242(b)(2) Van Lang IPA is required to document completed training which is satisfied by submitting this attestation along with the completed "Certificate of Completion"

- Medicare Pars C and D General Compliance Training

  https://www.cms.gov/Outreach-and-Education/MLN/WBT/MLN3995723-MLNPartsCD/FWA/story.html

- Combatting Medicare Parts C and D Fraud, Waste, and Abuse

www.cms.gov/Outreach-and-Education/MLN/WBT/MedicareFraudandAbuse/FraudandAbuse/story.html

Additional CMS MLN Web-Based Training is available at:

www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining