

## PHYSICIAN SERVICES

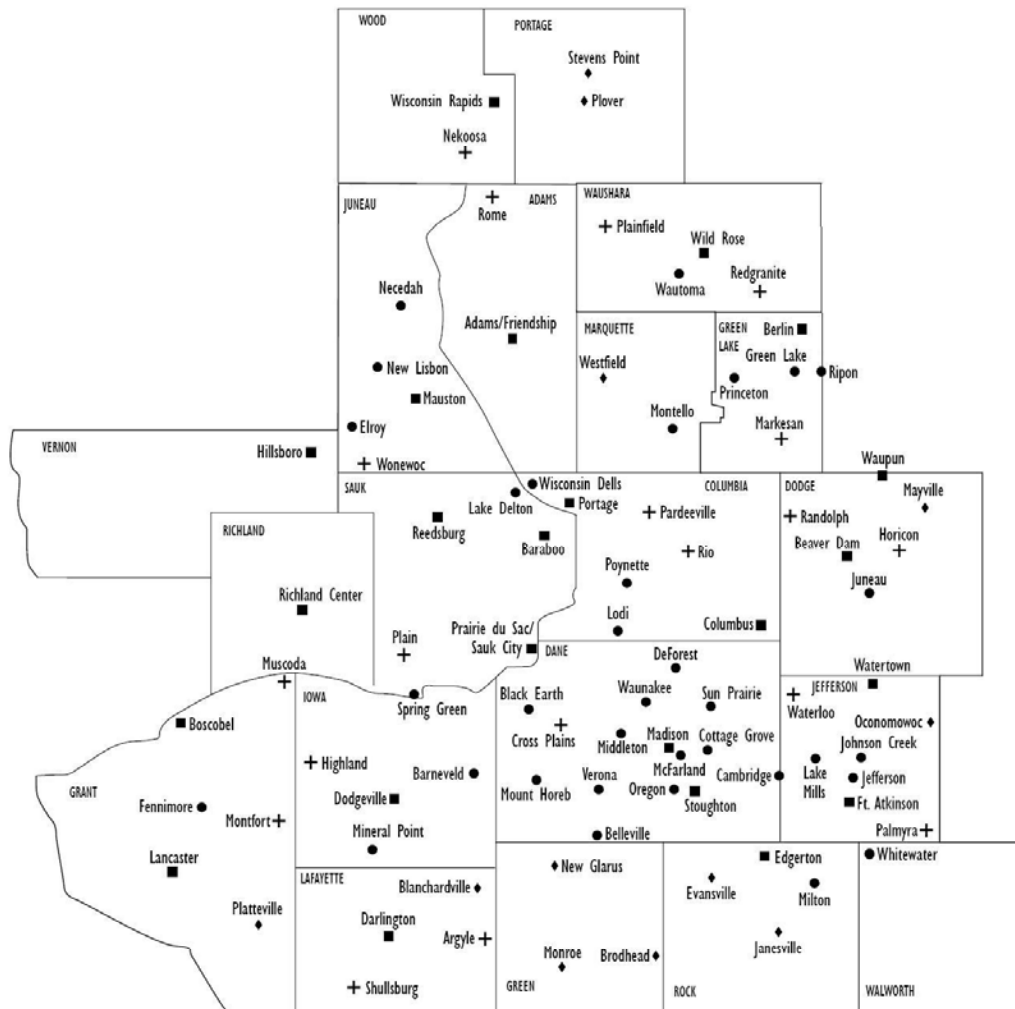
Physicians Plus is structured as a network model managed care organization, which contracts with large multi-specialty groups and independent practice physicians. The Physicians Plus provider network includes more than 3,500 physicians and 25 hospitals serving a 21-county area. This network of services ensures Physicians Plus members that their medical needs will be provided for in a continuous and coordinated manner in the hands of skilled physicians and well-established hospitals.

This section includes a map of the Physicians Plus service area.

Physicians Plus produces a Provider Directory that lists all participating providers by city and specialty. The alphabetical listing of our providers is in the back of the Provider Directory, which provides the user with an easy-to-use reference. At a glance, the user can determine whether a provider is part of the Physicians Plus network. The directory is available to Physicians Plus members to assist with physician selections. A provider directory is also available at our website at [www.HealthyChoicesBigRewards.com](http://www.HealthyChoicesBigRewards.com). This online tool allows users to search for providers in many ways and is updated weekly.

**Physician Services/Plan Providers Section**

**South Central Wisconsin  
2009 Provider Service Area**



- + PCP
- PCP, Specialist & Hospital
- PCP & Specialist
- ◆ Specialist only
- \* Specialist & Hospital

## **ROLE OF THE PRIMARY CARE PHYSICIAN**

Definition	<p>The Primary Care Physician (PCP) is the provider responsible for managing the health care of his/her assigned members. PCPs include Family Practitioners, Internists, Pediatricians and, in some cases Obstetricians/Gynecologists. When a PCP determines that care should be rendered by a specialty provider or other provider of service, the PCP will assist the member with coordinating services.</p> <p>Members are required to choose a PCP at the time of enrollment. PCPs may see a list of members assigned to them through our online provider GO-TO system. Members are required to contact Physicians Plus to change their PCP.</p>
Status & Demographic Change	<p>PCPs who wish to change their status with regard to accepting patients may do so with written notification to Physicians Plus. PCPs are expected to see the members assigned to them prior to any change in status, even though they may be new patients. Written notification must also be sent when a provider moves, adds a new location, or leaves practice. Changes should be sent to the Provider Network Management Department.</p>
Availability	<p>It is the PCP's responsibility to have in place effective procedures to provide for the availability and accessibility of medically necessary care 24 hours a day, 7 days a week.</p>
Responsibilities	<ul style="list-style-type: none"><li>• Establish member eligibility and benefit coverage.</li><li>• Ensure that requested hospitals and referral physicians are participating providers.</li><li>• Evaluate medical necessity, proposed place of treatment and treatment plan.</li><li>• Review and confirm the specialist treatment plan.</li></ul>

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- When necessary and appropriate, coordinate transfer of members both into and within the network of participating providers and hospitals.
- Cooperate and coordinate with the Physicians Plus Case Management Programs and Prior Authorization Policies and Procedures.
- Provide Information to and cooperate with Physicians Plus to facilitate coverage decisions.

## **ROLE OF THE SPECIALIST**

Definition	The specialist and PCP should work together to coordinate the best care for the member.
Demographic Change	Written notification must be sent to the Physicians Plus Provider Network Management Department when a provider moves, adds a new location, or leaves practice.
Responsibilities	<p>The specialist should remember the following:</p> <ul style="list-style-type: none"><li>• Verify that prior authorization has been obtained before rendering services, if required.</li><li>• Services rendered without prior authorization may result in denied claims.</li><li>• The specialist should always verify member's eligibility before rendering services.</li><li>• Specialists should not refer to other specialists. Members should be referred back to their PCP.</li><li>• Physicians Plus advises the specialist maintain Continuity of Care with the PCP.</li></ul>

## **Privacy and Confidentiality of Protected Health Information (PHI)**

Insurance companies and Health Maintenance Organizations are required to collect and store information regarding our members, your patients. Much of this information, such as Social Security Numbers, medical histories, and claims information, is highly sensitive and confidential. Physicians Plus maintains the highest standards to ensure information is released only with authorization or in accordance with state and federal statutes. We were one of the first insurers in Wisconsin to utilize a random, eleven digit member number in lieu of using members' Social Security Numbers.

Physicians Plus expects all participating providers to maintain similar standards regarding the confidentiality of patient information. Medical records must be maintained and stored in a designated area away from public access. Medical records should be released only with authorization or in accordance with state and federal statutes. Additionally, providers must have a written policy and procedure that addresses confidentiality of patient information that is distributed to all employees.

### **HIPAA**

HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996. HIPAA is a federal law that covers health plans, providers and clearing houses. The Center for Medicaid and Medicare Services (CMS) formally known as the Health Care Finance Administration is responsible for implementing various unrelated provisions of HIPAA.

One provision of HIPAA that impacts healthcare organizations is the Administrative Simplification Act. The Administrative Simplification provisions are intended to reduce the costs and administrative burdens of health care by making possible standardized, electronic transmission of many administrative and financial transactions that are currently carried out manually on paper. Also, included in the administrative simplification section, is the establishment of standards for the privacy of individually identifiable health information.<sup>1</sup>

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<sup>1</sup> 45 C.F.R. § 160.103

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### Transactions and Code Sets Overview

As of October 16, 2003, entities covered by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 are required to process electronic transactions in formats compliant with HIPAA. CMS has taken proactive steps to help covered entities achieve compliance and to communicate key concepts and requirements contained in HIPAA. The final rule published in February of 2003 made some important changes to the HIPAA electronic transactions and code sets standards that were originally published in August 2000. These changes are detailed in documents called “addenda.” The original implementation guides were known as version 4010, the subsequent addenda are referred to as version 4010A. The addenda also adopt modified standards for two transactions that were not included in the proposed modifications rule – Premium Payments and Coordination of Benefits.

HIPAA defines a “transaction” as the “exchange of information between two parties to carry out financial or administrative activities related to health care.”

The following are the required standard transactions:

1. Claims or equivalent encounter information
2. Payment and remittance advice
3. Claim status and inquiry response
4. Eligibility inquiry and response
5. Referral certification and authorization inquiry and response
6. Enrollment and dis-enrollment in a health plan
7. Health plan premium payments
8. Coordination of benefits

Electronic Data Interchange (EDI) can eliminate the inefficiencies of handling paper documents. It reduces administrative burden, lowers operating costs and improves overall data quality.<sup>2</sup> For further detailed information about HIPAA, log onto the CMS HIPAA web-site at <http://www.cms.hhs.gov/hipaa/hipaa2/regulations>.

### Privacy Overview

The Privacy Rule became effective on April 14, 2003. Most health plans and health care providers that are covered by the new rule must comply with the new requirements by April 2003. Compliance with HIPAA’s privacy regulations requires the addition of, or change to, numerous administrative processes at a health care organization. Under HIPAA, all covered entities must designate a privacy officer, create policies and procedures for handling protected health information, train employees, and sanction employees and business partners for non-compliance. The design and implementation of your plan should be reasonably developed based on the size of your organization and complexity for complying with the privacy regulations of HIPAA.

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<sup>2</sup> Source: CMS HIPAA Information Series

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### Security Overview

The security standards work in concert with the final privacy standards adopted by HHS. The two sets of standards use many of the same terms and definitions in order to make it easier for covered entities to comply. Security standards for HIPAA were published on February 20, 2003 and providers were required to comply with the standards by April 21, 2005. Under this rule, health plans, payers, clearinghouses, and certain health care providers must have established procedures and mechanisms to protect the confidentiality, and integrity and availability of electronic Protected Health Information (PHI).

### Unique identifiers requirements

HIPAA also requires the use of unique identifiers to clearly identify entities within the health care delivery system. The Provider Identifier Standard Final Rule also known as the National Provider Identifier or NPI has been approved. The primary purpose of the NPI is to uniquely identify health care providers as “health care providers” in HIPAA Standard transactions. The NPI will replace all other identifiers assigned to health care providers such as those assigned by health plans, government programs and health care purchasers for purposes of conducting these business transactions. For information on how the NPI should be used when submitting claims to Physicians Plus, see section K1 of this manual.

For any questions or comments regarding Physicians Plus standards of privacy and compliance, please feel free to contact Karen Mayes, Compliance and Privacy Officer at 608-260-7045 or e-mail: [karen.mayes@pplusic.com](mailto:karen.mayes@pplusic.com).