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Provider Manual

REVISED
DECEMBER 2014

ABOUT THIS MANUAL

This manual is a reference tool which describes, in general, GlobalHealth's policies and procedures and is designed to assist you as a participating Provider in the GlobalHealth network. GlobalHealth will keep you informed of important changes in our policies, procedures, and benefits. The Provider Manual is available on the Provider Tab of the GlobalHealth site, www.globalhealth.com. Annually, Providers will be notified of Provider Manual updates. The notification may be delivered to you by direct mail, facsimile, e-mail, or through on-site visits.

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DISCLAIMER

This Provider Manual is intended for use by GlobalHealth, Inc. ("GlobalHealth") participating Providers and Practitioners only and is incorporated by reference as a part of your contract with GlobalHealth. Therefore, your reimbursement may be affected by your compliance with the contents herein. The information contained in this Provider Manual is strictly confidential and proprietary to GlobalHealth and may not be copied in whole or part or distributed without the express written consent of GlobalHealth, Inc.

1. GLOBALHEALTH CONTACT LIST

Commercial Customer Care

Phone	(405) 280-5600
Fax	(405) 280-2960
Toll Free	(877) 280-5600
TTY/TDD/Voice	(800) 722-0353 or 711
Email	CommercialAnswers@globalhealth.com

Marketplace Customer Care

Phone	(405) 280-5583
Fax	(405) 280-2960
Toll Free	(877) 280-5583
TTY/TDD/Voice	(800) 722-0353 or 711
Email	MarketplaceAnswers@globalhealth.com

Medicare Customer Care (Hours 8:00 AM – 8:00 PM)

Phone	(405) 280-5774
Fax	(405) 280-2960
Toll Free	(877) 280-5774
TTY/TDD/Voice	(800) 722-0353 or 711
Email	MedicareAnswers@globalhealth.com

Utilization Management

Phone	(405) 280-5300
After Hours	(405) 819-7574
Toll Free	(866) 277-5300
Authorization Fax	(405) 280-5398
Email	um@globalhealth.com

Medical Director

Phone (Direct)	(405) 280-5577
Phone	(405) 280-5300
Toll Free	(866) 277-5300

Provider Relations, Contracting and Credentialing

Phone	(405) 280-5300
Toll Free	(866) 277-5300
Fax	(918) 878-7350
Provider Relations Email	provider.relations@globalhealth.com
Credentialing Email	ghcredentialing@globalhealth.com

Quality Improvement

Phone	(405) 280-5600
Email	quality@globalhealth.com

Compliance

Phone	(405) 280-5852
Toll-Free Hotline	(877) 280-5852
Email	compliance@globalhealth.com

Claims Processing (Closed 12:00 PM – 1:00 PM Daily)

Phone	(405) 280-5300
Toll Free	(866) 277-5300
Email	ediclaims@globalhealth.com

Benefits, Eligibility & Enrollment (Hours 7:30 AM – 4:30 PM)

Phone	(405) 280-5300
Toll Free	(866) 277-5300
Fax	(405) 280-5881
Email	edienrollment@globalhealth.com

Pharmacy

Phone	(405) 280-5300
Toll Free	(866) 277-5300
Fax	(405) 280-5613
Email	gh.pharmacy@globalhealth.com

Main Office*
701 NE 10th Street, Suite 300
Oklahoma City, OK 73101-2383

Tulsa Office*
6120 South Yale Ave, Suite 925
Tulsa, OK 74136-4216

Claims Submission
GlobalHealth, Inc.
ATTN: Claims
P.O. Box 2328
Oklahoma City, OK 73101-2383

Appeals
GlobalHealth, Inc.
ATTN: Appeals
P.O. Box 2393
Oklahoma City, OK, 73101-2393

Generations Claims Submission
Generations Healthcare HMO
ATTN: Claims
P.O. Box 1747
Oklahoma City, OK 73101-1747

Visit the GlobalHealth website at: **www.globalhealth.com**

*OFFICE HOURS: Monday - Friday 9:00 AM - 5:00 PM CT

2. GLOBALLINK™ INFORMATION

GlobalLink is an online tool available to all contracted providers. GlobalLink is provided by GlobalHealth to allow providers to:

Verify Eligibility
Review Member Demographics
View Benefit Information
Review and Create Referrals
Check Claim Status
Communicate with GlobalHealth, Inc.

You may access information about GlobalLink™ on our website at:

http://www.globalhealth.com/globallink.aspx

Providers can submit an application request for access to GlobalLink™ on our website at:

http://www.globalhealth.com/globallink_terms.aspx

You may access a PDF version of the GlobalLink™ Training Manual on our website at:

http://www.globalhealth.com/docs/forms/GlobalLink_Training.pdf

3. NETWORK/MEMBERSHIP

Summary

GlobalHealth, Inc. ("GlobalHealth") is fully licensed by the State of Oklahoma as a health maintenance organization ("HMO"). Individuals who receive benefits through GlobalHealth are referred to as "Members."

GlobalHealth Provider Network

The GlobalHealth network includes participating hospitals, Primary Care Physicians, specialists, and other health care Providers throughout Oklahoma.

Website: www.globalhealth.com

We continually update our website. Check here often for important information!

Identification

Every GlobalHealth Member has an identification card, which must be presented each time the Member seeks care from a participating Provider. If a GlobalHealth Member fails to present an identification card, please contact us to verify the Member's eligibility.

It is essential to verify Member Eligibility because:

- Employer groups may change benefit plans
- Member benefits may change
- Copayments must be determined
- Fraudulent use may occur

Note: The Member ID card does not guarantee coverage or entitlement to benefits.

Eligibility Verification

Eligibility can be verified by contacting Benefits, Eligibility & Enrollment between the hours 7:30 AM and 4:30 PM Central Time Monday through Friday.

Please be careful to note the following items on Member identification cards:

- Be sure the patient's name matches the name listed on the card.
- Be sure the card has a coverage ID number, current effective date, and group number (items 1 and 2 identified below)
- The physician listed on the card is the Member's Primary Care Physician ("PCP").

Example: Member Identification ("ID") Card

Front of Card

1. Coverage ID
2. Group identification number
3. Member ID Number
4. The selected Primary Care Physician
5. PCP phone number
6. PCP effective date
7. Relationship code to Subscriber
8. Copayment and benefit Information

Back of Card

1. What to do in case of a life-threatening emergency
2. Routine and urgent care information
3. How to reach GlobalHealth's Customer Care Department including phone number, office hours, and claims address

> **IMPORTANT!**
> **The PCP shown on the card must approve in advance all non-Emergency medical services provided to the Member in order for the Member to be covered by GlobalHealth.**
>
> **Physicians should not see Members for primary care services if they are not listed as the PCP on the Member's card, unless GlobalHealth has authorized the visit or service in advance.**

Special Needs

Language, Vision, Hearing, or Physically Challenged

If you have a Member who requires the services of an interpreter or who has special language needs (e.g., is visually and hearing impaired or who is physically disabled), contact Customer Care. Please refer to the contact list on page 5 for the appropriate Customer Care phone number.

4. PRIMARY CARE PHYSICIANS ("PCP")

Definition

The Primary Care Physician, or PCP, is the Member's first contact for all his or her health care needs. The PCP manages the Member's total health care program by providing a broad range of services and arranging for specialty care when necessary.

A contracting PCP must practice in one of the following fields: Family practice, pediatrics, general practice or internal medicine. Internal medicine physicians must spend ninety percent (90%) of their time practicing family medicine to be eligible to contract with GlobalHealth as a PCP.

A "Practitioner" is a professional who provides health care services. Practitioners are licensed as required by law.

A "Provider" is a physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional, or health care facility licensed, certified, or accredited as required by state law. "Provider" may also refer to an institution or organization that provides services for health plan Members (such as hospitals and home health agencies).

Responsibilities of the PCP

1. Manage the Member's total health care program. This includes health supervision, basic treatment, initial diagnosis, management of chronic conditions, and preventive health and wellness service.
2. Educate Members regarding their health care needs.
3. Communicate freely with patients about their treatment, regardless of benefit coverage limitations.

4. Coordinate health care with specialists or health care facilities when such care is needed, including obtaining authorization from GlobalHealth for medically necessary referrals. (The PCP should always refer Members to GlobalHealth participating Providers and facilities, unless the services are not available within the GlobalHealth network.)
5. Provide medically necessary services in accordance with the GlobalHealth contract, the applicable benefit plan, GlobalHealth policies and procedures, and requirements in the Provider Manual.
6. Discuss all treatment alternatives, risks, and benefits with Members, including the risks/benefits of receiving no treatment, recognizing that the Member makes the final decision concerning his or her preferred treatment option.
7. Provide complete information on authorized care or services to the referred specialist.
8. Provide medical care coverage for assigned patient panel 24-hours per day, seven days per week within GlobalHealth's established network of Providers.
9. Participate in and cooperate with GlobalHealth's Utilization Management and Quality Improvement Programs and activities.
10. Allow GlobalHealth to use Practitioner performance data.
11. Maintain accurate medical records that include complete documentation for all services provided to Members. Notify GlobalHealth promptly if any of the following information changes:
    - Tax ID number
    - NPI
    - Address
    - Telephone or fax number
    - Name change
    - Limitations/Restrictions to practice
    - Adding or deleting a physician from a group practice
12. Shall not discriminate in the delivery of health care services and shall accept for treatment any Member in need of the health care services they provide.

PCP Panel Status

Open

Physician will accept any GlobalHealth Member, whether new or established.

Established Members Only

Physician may close his/her practice to new Members by notifying GlobalHealth. This option allows only patients currently seeing that physician to select him/her as a PCP. If a Member incorrectly selects an "established Members only"

physician, the PCP must notify GlobalHealth as soon as possible. GlobalHealth will then assist the Member in selecting an available PCP.

Not Accepting Any Members (Closed)

Physicians who have a full practice may close their practice to all new GlobalHealth Members. Physicians who request to be listed as "not accepting any Members" will not be assigned new GlobalHealth Members.

PCP Member List

PCP's may access their respective Member lists at any time by logging in to their GlobalLink™ account.

Termination of a Member by a PCP

There may be an occasion where a PCP wishes to terminate a Member from his or her panel. Reasons for such termination may include non-compliance or threatening or disruptive behavior by the Member. If a PCP plans to terminate a Member, the PCP must notify GlobalHealth. Additionally, the PCP must notify the Member in writing of the termination and continue to provide coverage for the Member for a minimum of thirty (30) days or until the Member obtains a new PCP.

Exception: A PCP may not terminate a Member if such termination would be detrimental to the Member's health (e.g., a third trimester or complicated pregnancy, a hospitalized patient, a patient receiving treatment for a degenerative and disabling condition or disease, or life-threatening or terminal illness, etc.) until the Member's condition is stabilized and another PCP has assumed care or through six weeks of post-delivery care.

PCP Voluntary Termination from the GlobalHealth Network

A PCP may choose to voluntarily discontinue participation in the GlobalHealth network by providing at least a ninety (90) day written notice of the disaffiliation. During the 90-day period, GlobalHealth will notify affected Members and assign them to another network PCP.

5. SPECIALISTS

Specialist Physician Responsibilities

1. Accept and treat GlobalHealth Members referred by their PCP and authorized by GlobalHealth.
2. Provide only those services authorized by the Member's PCP and GlobalHealth. If additional medically necessary tests or treatments are needed beyond those initially authorized, specialist may seek additional authorization from GlobalHealth and notify the Member's PCP.
3. Educate patients regarding their health needs and share findings of the Member's physical exam and treatments with the PCP.
4. Communicate freely with patients about their treatment, regardless of benefit coverage limitations.
5. Provide medically necessary services in accordance with the GlobalHealth contract, the applicable benefit plan, GlobalHealth policies and procedures, and requirements specified in the Provider Manual or Member Schedule of Benefits.
6. Discuss all treatment alternatives, risks, and benefits with Members; including the risks/benefits of receiving no treatment, recognizing that the Member makes the final decision concerning his/her preferred treatment option.
7. Comply with all GlobalHealth pre-certification requirements.
8. Use only GlobalHealth participating Providers and facilities for services for the Member.
9. Submit claim forms to GlobalHealth for services rendered to GlobalHealth Members.
10. Participate in and cooperate with GlobalHealth's Utilization Management and Quality Improvement Programs activities.
11. Allow GlobalHealth to use Practitioner performance data.
12. Provide a written report to the Member's PCP within ten (10) days of completing the consultation/treatment/procedure – or sooner if medically indicated.
13. Maintain accurate medical records that include complete documentation for all services provided to Members.
14. Assist GlobalHealth in determining Coordination of Benefits ("COB") issues with other carriers or payers.
15. Notify GlobalHealth promptly if any of the following information changes:
    - Tax ID number
    - NPI
    - Address

- Telephone or fax number
- Name change
- Limitations/Restrictions to practice
- Adding or deleting a physician from a group practice

16. Shall not discriminate in the delivery of health care services and shall accept for treatment any Member in need of the health care services they provide.

Specialist Voluntary Termination from the GlobalHealth Network

A specialist may choose to voluntarily discontinue participation in the GlobalHealth network by providing at least a ninety (90) day written notice of the disaffiliation. During the 90-day period, GlobalHealth will permit a Member to continue an ongoing course of treatment with the specialist during a transitional period of up to 90 days from the date of notice to GlobalHealth of the physician's disaffiliation. GlobalHealth will notify affected Members.

6. HOSPITALS AND FACILITIES

Hospital/Facility Provider Responsibilities

1. Provide covered health services to GlobalHealth Members twenty-four (24) hours a day, three-hundred and sixty-five (365) days a year.
2. Obtain necessary authorizations from GlobalHealth for hospital admissions and continued inpatient stays.
3. Assure hospital/facility and its personnel are duly licensed, certified, and authorized to provide covered health care services to GlobalHealth Members.
4. Provide advance written notice to GlobalHealth of any significant changes in the ability to provide covered health care services to GlobalHealth Members.
5. Assist GlobalHealth in proper Coordination of Benefits ("COB") with other insurance carriers or third-party payers.
6. Remain in compliance with applicable state and federal requirements, Medicare Conditions of Participation, and The Joint Commission ("TJC") accreditation standards or equivalent.
7. Participate in and cooperate with GlobalHealth's Utilization Management and Quality Improvement Programs and activities.
8. Allow GlobalHealth to use Provider performance data.
9. Submit timely claims for reimbursement of covered health care services.

10. Notify GlobalHealth promptly if any of the following information changes:
    - Tax ID number
    - NPI
    - Address
    - Telephone number
    - Name change
    - Change in license status
    - New Location

7. BILLING

Time Limits for Filing Claims

Providers must submit Clean Claims* to GlobalHealth within the timely filing period specified in the Provider's contract in order to receive payment. If the Provider fails to submit a Clean Claim within the required timeframes, GlobalHealth expressly reserves the right to deny payment for such claim(s). Claim(s) denied for untimely filing **cannot** be billed to a Member.

** A **"Clean Claim"** is defined as a claim for medically necessary, covered health care services that is timely submitted and includes all the information necessary to adjudicate the claim for payment. A Clean Claim has no defect or impropriety, includes all substantiating documents, and requires no special treatment or development prior to adjudication.*

Claims Submission

Claims must be submitted electronically or mailed to the following address:

GlobalHealth, Inc.
ATTN: Claims
P.O. Box 2328
Oklahoma City, OK 73101-2328

Generations Healthcare HMO
ATTN: Claims
P.O. Box 1747
Oklahoma City, OK 73101-1747

A list of clearing houses utilized can be found on the GlobalHealth website.

Claims Adjudication

GlobalHealth reviews and evaluates claims for:

(1) Correct coding (ICD-9, CPT-4®, or other required coding as applicable).
(2) Correct billing (UB-04 or CMS-1500 format).
(3) Coverage criteria.
(4) Medical necessity.

Approved Forms:

- CMS 1500
- UB-04
- Electronic Filing

Claims Reimbursement

GlobalHealth will pay timely filed claims in accordance with contractual agreements and applicable statutory requirements less any applicable copayments, coinsurance, and/or deductibles owed by the Member.

Should GlobalHealth fail to pay a claim within the required timeframe, GlobalHealth will pay interest in accordance with contractual and State regulatory requirements.

Providers will receive a Remittance Advice ("RA") detailing how each service was processed.

Reasons for Payment Delays

It is our goal to process your claims as expeditiously as possible. In order to do so, it is essential that you submit complete and accurate claims. Common mistakes that delay your payment include:

- No employer or group number
- No authorization number
- Failure to submit required additional documentation
- Inaccurate or questionable diagnosis or procedure coding
- Missing or incorrect Tax ID Number
- Missing Provider name and/or NPI

When such mistakes are made, your payment may be delayed.

Covered Services

GlobalHealth will provide information on covered services to participating Providers through written communication or the GlobalHealth website.

Copayments/Coinsurance

A copayment or coinsurance is an amount due from the Member at the time of service. Members are required to pay a copayment or coinsurance for certain benefits.

- Copayments should be collected when services are rendered. Copayment amounts are generally listed on the Member's GlobalHealth ID card.
- Coinsurance should not be collected at the time of service but billed to the Member after the coinsurance amount due is indicated by GlobalHealth through the Explanation of Payment (EOP) sent to the Provider.

Collection of Copayments

Providers are responsible for the collection of applicable copayments. The Member's ID card should be checked to verify the copayment amount due. Member materials instruct Members to pay their copayments at the time of each visit or service. If a copayment is due but was not paid at the time of service, the Provider may bill the Member for the copayment.

Emergency room copayments should be collected at the time of the service. However, if the Member is admitted to the hospital, the hospital may waive the Emergency room copayment.

Claims Status and Follow Up

Claim status can be checked by using GlobalLink™. See page 7 of this Provider Manual for information regarding the use of GlobalLink™. GlobalHealth's Claims representatives are available Monday through Friday, 9:00 AM to 5:00 PM Central Time, should you have questions concerning claims you have submitted, how to file a claim or the explanation of payment detail, etc.

Balance Billing

A contracted or participating Provider accepts the GlobalHealth reimbursement as payment in full and may NOT "balance bill" a GlobalHealth Member. In other words, the Provider may not look to a GlobalHealth Member for payment for covered services beyond the Member's applicable deductible, copayment and/or coinsurance amounts. Balance billing is a violation of the Provider Agreement with GlobalHealth and may result in termination of the Provider from the GlobalHealth network.

Remittance Advice ("RA")

Each check received from GlobalHealth is accompanied by a Remittance Advice ("RA"). The RA summarizes the Provider's claims and explains how benefits were applied.

You can use the RA to determine how a claim was paid including non-allowed amounts and adjustments. The RA will note any appropriate non-covered services, deductibles and coinsurance amounts that are the responsibility of the Member. The RA lists and explains all codes used in processing each claim.

Right of Offset

This allows GlobalHealth to recoup overpayment amounts by subtracting such amounts from a Provider's future payments. You will be notified of any offset amount, the name of the Member for whom an overpayment was made, and the relevant dates of service. This information will be noted on your RA.

8. LABORATORY TESTING

If your practice has a CLIA-approved lab on site, you may provide and bill for those tests that you are approved to perform. All other test(s) must be performed at a facility that is contracted with GlobalHealth.

If your practice does not have a lab onsite, you may either refer the patient to a GlobalHealth contracted laboratory facility or, draw and send the lab specimen to a GlobalHealth contracted laboratory.

9. UTILIZATION MANAGEMENT ("UM") PROGRAM

Summary

GlobalHealth's Utilization Management ("UM") program is designed to assist Providers in obtaining the most appropriate setting and the most appropriate course of treatment for their patients. Our goal is to ensure that our Members receive the highest possible quality health care at the lowest cost to the Member.

GlobalHealth's Responsibilities

1. GlobalHealth's UM employees are properly trained, qualified, and supervised by a licensed physician Medical Director.

2. UM decision making is based only on appropriateness of care and service and existence of coverage.
3. Determinations not to authorize an admission, extension of a hospital stay, medical treatment, diagnostic or therapeutic service, or other procedure based on medical necessity are made by the Medical Director.
4. Clinical review decisions are based on published standard clinical review criteria and/or internal policies that are developed with input from actively participating physicians.
5. Providers may appeal UM denials in accordance with GlobalHealth policies and applicable regulatory requirements.
6. GlobalHealth does not reward Practitioners or other individuals for issuing denials of coverage. No financial incentives are provided to UM decision makers that would encourage determinations that result in underutilization or denial of medically necessary services.
7. GlobalHealth reports Practitioner suspension or termination to the appropriate authorities.

Provider Responsibilities

1. Provide complete and detailed clinical information, so that GlobalHealth can make the right coverage and payment determination.
2. Obtain prior written authorization from GlobalHealth for all non-emergent hospital admissions, outpatient surgeries performed in an ambulatory/outpatient surgery center, and non-emergent services that cannot be provided within the physician's office (e.g., specialized scans, MRI, CT, nuclear medicine, etc.)
3. Verify a referral authorization for services.
4. Contact GlobalHealth to extend written authorizations for services, if necessary.
5. Refer Members to GlobalHealth's Case Management program if needed.

Utilization Management Decisions

GlobalHealth ensures that qualified health professionals conduct utilization reviews. All UM decisions (including prior authorizations and concurrent reviews) are supported by current, clinical information relevant to each case. Board-certified Practitioners or

clinical peers from appropriate specialty areas may be used in determinations of medical appropriateness of care.

Decisions are made in a timely manner to accommodate the clinical urgency of the particular patient's situation. Our goal is to complete utilization review determinations for urgent requests within 24 hours and non-urgent requests within five (5) business days. Frequently, determinations are made the same day as requested.

GlobalHealth accepts non-urgent requests by written submission, phone, GlobalLink (electronic submission) and fax (not monitored after business hours).

Utilization Management Criteria

UM determinations are based upon standard, published criteria and medical guidelines adopted by GlobalHealth (e.g., Milliman Care Guidelines®, Hayes, Inc.®, Center for Medicare and Medicaid, etc.) A Member or Provider may request a copy of the criteria used by contacting Customer Care or the UM Department.

Elective Hospital Admissions

ALL INPATIENT hospital care **must** be provided at a GlobalHealth network participating hospital, except for Emergency admissions or when pre-authorized by GlobalHealth under special circumstances.

GlobalHealth reviews every inpatient admission, including those that were prior authorized, for appropriate level of care beginning on the day of admission through discharge.

GlobalHealth reviews every outpatient observation claim greater than twenty-four (24) hours to determine appropriate level of care and utilization of services.

Providers are required to notify GlobalHealth of every inpatient or observation admissions within 48 hours of admit. When admissions occur on a Friday, GlobalHealth must be notified by the following Monday.

Emergency Admissions*

GlobalHealth must be notified of all Emergency admissions on the day of admission. GlobalHealth will obtain clinical information from the hospital on the first business day following admission. Subsequent reviews are performed as the Member's condition

warrants or until the Member is discharged. GlobalHealth reviews all Emergency admissions for appropriate level of care.

> ***Definition of Emergency**
> *A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a reasonable and prudent layperson could expect the absence of medical attention to result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to body functions or serious dysfunction of any body, organ or part. Members are asked to notify their PCP within 48-hours of seeking Emergency care.*

Discharge Planning

Discharge planning begins at the time GlobalHealth is notified of an admission and continues throughout the discharge process and includes the coordination of a patient's continued care needs both in and out of the inpatient setting. A comprehensive discharge plan includes assessment of needs, plan development, plan implementation and evaluation of effectiveness.

The admitting physician should facilitate discharge planning by documenting the anticipated discharge date, disposition (e.g., home, SNF, rehabilitation, etc.), and any post-discharge services the Member may require. GlobalHealth's UM staff will coordinate with the hospital case manager to arrange for any needed services. GlobalHealth's participation in the discharge planning process will vary based on the individual patient's circumstances and may occur by telephone or through on-site reviews.

Discharge planning activities include:

- Assessing patient's potential discharge requirements beginning on the day of admission.
- Completing evaluation of available support and assistance, including financial needs.
- Arranging multidisciplinary meetings to include patient and family members, as appropriate.
- Involving social services in discharge planning, as appropriate.
- Coordinating discharge needs such as DME, home health, Skilled Nursing Facility ("SNF"), transportation, medications, etc.
- Obtaining authorization from GlobalHealth for necessary post-discharge services.
- Documenting and communicating the discharge plan.
- Ensuring patient understanding of discharge orders and follow-up care required.
- Making other referrals as needed.
- Delivering a written notice of non-coverage, if applicable.

Early identification of any social or financial problems that might delay or complicate the patient's discharge is essential in the discharge planning process. The hospital discharge planner or social services personnel should become actively involved at the earliest possible opportunity.

Concurrent Review Requirements for All Admissions

GlobalHealth performs concurrent review from the day of admission through discharge to assure the medical necessity of each day, that services are provided at the appropriate level of care, and that necessary discharge arrangements have been made. Indications that a Member might be transferred to a lower level of care or alternative treatment setting are discussed with the admitting physician. If a dispute occurs between the admitting physician and GlobalHealth policy, the GlobalHealth Medical Director is contacted to review the Member's clinical status and treatment plan.

Contracted Providers should cooperate with GlobalHealth by:

- Providing concurrent review status reports by telephone.
- Allowing GlobalHealth's UM staff to conduct on-site concurrent reviews.
- Including access to medical records, the Member, and Member's family.
- Providing admission and discharge notifications 24 hours/day, 7 days/week.

NOTE: Failure to comply with GlobalHealth's concurrent review process may result in a post-service review and/or non-payment of claims.

Daily Reporting

The following reports are required to be provided daily to GlobalHealth's UM Department:

- Census report for all GlobalHealth Members
- Discharge report
- Outpatient surgeries and skilled nursing facility admissions, if applicable

The following information must be included on the report:

- Member name
- Member ID number
- Date of birth
- Admitting and/or attending physician
- Facility
- Admit date
- Admit type

- Bed type
- Diagnosis (ICD-9)
- Procedures
- Extraordinary items and services requiring authorization
- Anticipated discharge date
- Actual discharge date
- Discharge disposition

When Services are Not Medically Necessary

Provider may not collect payment from a GlobalHealth Member for services that have been determined not medically necessary by the GlobalHealth Medical Director unless a proper written waiver (1) was signed by the Member, (2) acknowledges the Member's financial responsibility, and (3) was obtained by the Provider prior to the service being rendered.

What is Pre-certification?

"Pre-certification" is the process of confirming and collecting information prior to inpatient admissions and selected ambulatory procedures and services. There are two components to pre-certification: "Notification" and "Coverage Determination."

1. **"Notification"** is the process of recording a coverage request for services or supplies included. Notification is only a data-entry process and does not require judgment or interpretation for benefit coverage.
2. **"Coverage Determination"** requires the review of treatment plan documents and clinical information concerning the service or supply in order to determine whether clinical guidelines and criteria for coverage are met.

When is Pre-certification Required?

Pre-certification is required prior to any inpatient admission or outpatient procedure/surgery other than for Emergency and obstetrical admissions. Admission certification is required following all obstetric and Emergency admissions.

Who is Responsible for Obtaining Pre-certification?

The Member's PCP has the responsibility to obtain necessary authorizations or pre-certifications.

Specialists or facilities treating a GlobalHealth Member should verify authorization or pre-certification with the PCP prior to treatment. In addition to the inpatient and/or outpatient procedures, the authorization or pre-certification must also include office visits and testing.

How to Request Pre-certification

Pre-certification can be requested three (3) ways from GlobalHealth's UM department:

- GlobalLink™ (www.globalhealth.com)
- Fax (405) 280-5398
- Telephone (405) 280-5300

Re-certification

If a pre-certified admission is expected to extend beyond the initially assigned length of stay, the admission is subject to concurrent review and must be re-certified. Re-certification must be completed on or before the last day of the pre-approved hospital stay. The re-certification process is the same as pre-certification.

Pre-certification Notification Does Not Guarantee Payment for Services Rendered

Pre-certification notification will only determine if a service is medically necessary. Pre-certification does **not** determine if the Member is enrolled or if the service is a covered benefit for the Member. We recommend that you call the GlobalHealth's Customer Care Department to verify Member enrollment and benefit coverage.

When is a Referral Required?

The Member's designated PCP must authorize or perform all medically necessary services. A referral is needed for services not performed by the PCP.*

* Exception: if the service is specifically listed in the Member's benefit plan as not requiring a PCP referral (e.g., mammogram, well-woman visit, etc.).

How to Obtain an Authorization

Authorizations can be requested three (3) ways from GlobalHealth's UM department:

- GlobalLink™ (www.globalhealth.com)
- Fax (405) 280-5398*

- Telephone (405) 280-5300

*An authorization can be obtained via fax by downloading the appropriate request form from www.globalhealth.com, completing the form and faxing it to GlobalHealth's UM Department.

Approval requires complete and accurate documentation on the form. Please keep in mind that this should be a "stand alone" document that includes sufficient information and documentation that allows a physician reviewer with no previous knowledge of the patient to determine that the service requested is medically necessary.

Referrals are authorized for the current month only. Referrals for services to be provided more than thirty (30) days in advance will be held until the month services are to be provided.

Provider Responsibilities for Referral Authorizations

Primary Care Physician (PCP)

The PCP is responsible for submitting a referral request when necessary and for supplying complete clinical information concerning the referral to the receiving specialist or Provider.

Specialist Physicians and Facilities

The referral specialist or facility may only perform the services specified on the authorization. The specialist or facility providing the referred service should report the approriate clinical information to the referring PCP. The PCP or specialist will need to authorize any additional services.

If the specialist decides the Member needs additional services, or services from another specialist, **it becomes the responsibility of the referring specialist to submit the the authorization for additional services**.

Inappropriate Member Request for a Referral

If a Member requests a referral that you as the Provider believe is inappropriate, you are not obligated to authorize the referral. The Member has the right to file an appeal. Please inform the Member of this right and advise him/her to call the GlobalHealth Customer Care Department.

SERVICES THAT REQUIRE PRIOR AUTHORIZATION

NOTE: This list is not all-inclusive. Other infrequently requested or highly-specialized services not listed below may require prior authorization. By requesting prior authorization, the contracting Provider is representing that the proposed covered health care services are medically necessary.

1. **Inpatient Care, Inpatient Rehabilitation and Observation Stays:**
   All inpatient care, inpatient rehabilitation and observation stays require prior authorization by the contracted facility.
2. **Skilled Nursing and Long-Term Acute Care:**
   All skilled nursing and long-term acute care facility ("LTCH") care require prior authorization by the contracted facility.
3. **Emergency and Urgent Care:**
   Emergency services do not require prior authorization if the services meet the definition of Emergency care as provided in this Agreement, Member Handbook or Evidence of Coverage. Notification to GlobalHealth by the contracted Provider is required by the next business day following the date of service.
4. **Ambulance:**
   Scheduled ambulance transport from one facility to another location requires prior authorization.
5. **Hospital Transfers:**
   All scheduled hospital transfers require prior authorization prior to transfer. All emergent hospital transfers require notification to GlobalHealth the next business day following the date of service.
6. **Outpatient Hospital / Ambulatory Surgery:**
   Procedures performed in an outpatient hospital (place of service 22) or ambulatory surgery center (place of service 24) requires prior authorization.
7. **Audiology Services:**
   Audiology services, speech/language therapy and hearing aids require prior authorization.
8. **Home Health Care and Hospice Care:**
   All home health care, including home infusion therapy, and hospice care services require prior authorization.
9. **Durable Medical Equipment (DME), Prosthetics and Orthotics:**
   DME, prosthetics and orthotics require prior authorization. In general, basic equipment and supplies or equipment ancillary to covered health care procedures do not require prior authorization. All other DME, prosthetics and orthotics (Revenue

Codes 274 through 278), including enhanced or specialty equipment or supplies, require prior authorization.

10. **Therapies and Rehabilitation:**
    All physical, occupational, and speech therapy, cardiac rehabilitation and pulmonary rehabilitation services require prior authorization.

11. **Behavioral Health:**
    All behavioral, mental health, substance abuse and psychological testing services require prior authorization. GlobalHealth delegates all behavioral health functions to NCQA accredited MHNet. For behavioral or mental health prior authorizations, contact MHNet at 1-866-904-5234

12. **Diagnostic Services:**
    Other procedures and testing that require prior authorization include:

    - Infertility testing and services.
    - Organ transplant services; transplant evaluations, organ donor services, transplant procedures.
    - Stereotactic radiosurgery (e.g. gamma-ray radiosurgery, gamma knife, etc.).
    - Cardiac stress tests, nuclear cardiac testing and coronary computed tomography angiography, EKG, ECG, other cardiographs.
    - Neurology and neuromuscular diagnostic testing, including EEG, EMG, NCV and sleep studies.
    - Bone densitometry studies.
    - Non-invasive diagnostic testing including vascular, pulmonary and voiding cysto-urethrogram.
    - CT scans, nuclear scans/tests, MRI, MRA, PET scan and gamma camera.
    - Dialysis, epoetin, and laboratory services rendered in conjunction with dialysis.
    - Outpatient radiation therapy and chemotherapy.
    - Maternity care, maternal support services, fetal monitoring, threatened and premature labor treatment.
    - Elective facility-based invasive diagnostic testing.
    - Hyperbaric treatment.
    - Blood transfusions and all infusion therapies/services.

13. **Pharmacy:**
    Certain injectable medications require prior authorization. Certain formulary drugs may be preferred agents or may require prior authorization. Specific prior authorization criteria are available by contacting the Pharmacy Department.

Approved Self- Referral Services

Well Woman / Well Man Visits

- GlobalHealth Members may self-refer once each year for a wellness check.
- Women may self-refer to a participating gynecologist or family physician who is a contracted women's health specialist for a well woman exam..
- Women may self-refer for a screening mammogram once every twelve (12) months.
- Men may self-refer for a prostate exam beginning at age forty (40) if there is a "high risk" history and at age fifty (50) and older for routine screening.

Specialist Office Visit Referrals

A specialist office visit is one that is not defined as urgent or emergent.

1) We recommend verification of eligibility the day prior to the office visit.
2) The referral will state "office visit" along with the number of office visits that are approved.
3) The approved office visit(s) must occur within a sixty (60) day time frame from the date of the referral.
4) If the referral covers more than one (1) office visit, the Provider must verify eligibility at the time of each visit. Payment will not be made for services rendered to an ineligible Member.
5) No ancillary testing is allowed, unless otherwise indicated on the referral.
6) <u>Do not schedule</u> appointments unless you have received an authorization letter at your office.
7) **Retro referrals are NOT approved** for routine office visits/follow-ups. If a Provider renders services to a Member without prior authorization, that Provider may submit an appeal for a retrospective review. At GlobalHealth's sole discretion, authorization will be retrospectively approved or denied. Such decision will take into consideration that Provider did not consciously circumvent the prior authorization requirement. Repeated violations of the referral process may result in suspension from GlobalHealth's network.
8) The receiving referral Provider is required to send communication to the patient's PCP with his/her findings and recommendations within ten (10) days of seeing the Member.

Urgent Referrals

If an Urgent Care case is referred to a specialist during GlobalHealth's regular business hours, the UM Department will contact the specialist's office and provide an authorization number and the limitations of the referral. The approved referral will be faxed to the specialist's office the next day. The specialist must see the patient within twenty-four (24) hours.

Definition of Urgent Care

"Urgent Care" is the treatment for an unexpected illness or injury that is not an Emergency, but which is severe enough or painful enough to require treatment within 24-hours. Examples include, but are not limited to:

- High fever
- Severe vomiting and diarrhea
- Pulled muscle with pain or swelling

The PCP should respond to an Urgent Care case within 24-hours of the Member's call to the PCP. If the PCP is unable to see the Member, a referral should be made to another network Provider or facility.

Emergency Referrals*

If GlobalHealth's UM Department is contacted after-hours or on weekends by a specialist who is requesting to provide care to a GlobalHealth Member, the specialist must provide the following information:

- Patient's name and date of birth
- Referring physician
- Date of service
- Diagnosis
- Procedure (if applicable)

The UM Department will complete the referral authorization form and fax the approval to the specialist's office. Failure to follow this procedure may result in delay of payment.

Please note: The specialist is required to send a dictated or written note of his/her findings and recommendations to the patient's PCP within ten (10) days or less. A follow-up phone call to the patient's PCP is also appreciated.

***Definition of Emergency**
A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a reasonable and prudent layperson could expect the absence of medical attention to result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to body functions or serious dysfunction of any body organ or part. Members are asked to notify their PCP within 48-hours of seeking Emergency care.*

Response Time Urgent/Emergent Referrals

If no additional information is needed, urgent/emergent referrals are approved the same day when received by the UM Department before 5:00 PM, and by noon the next day for referrals received after 5:00 PM, Monday through Friday.

Non-Approval of Referrals

The fact that a referral is not approved, should not be interpreted as a barrier to patient care or questioning of a physician's judgment. It may indicate the need for additional information from the Provider, or consideration of alternative treatment plan options, before authorizing the request.

Case Management

"Case Management" is the coordination of care and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

The goal of complex Case Management is to help Members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the Member's condition, determination of available benefits and resources, and development and implementation of a case management plan with performance goals, monitoring and follow-up.

How to enroll:

If a Member is diagnosed with a chronic disease and would like assistance, the Member's PCP may refer the Member for Case Management by contacting the Utilization Management Department or calling the Customer Care Department and asking to speak to someone about a Case Management referral. Please refer to the contact list on page 5 for the appropriate Customer Care phone number.

A Member may self-refer for Case Management by going to our website, www.globalhealth.com, then clicking on "Case Management Support" under the "Resources" tab. Or, a Member may call Customer Care and ask for Case Management assistance.

Cases that May Require Special Care

Conditions that may require Case Management intervention include, but are not limited to:

- AIDS, HIV, infection and related diagnoses
- Amputations
- Asthma
- Burns (severe)
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Coma (after three days' duration)
- Crohn's Disease
- Cystic Fibrosis
- Diabetes
- Eating disorders
- Hospital admission greater than the expected length of stay (LOS)
- Head injuries
- Hemophilia
- IV therapy (long-term)
- Muscular/neurological disorders (traumatic and degenerative such as ALS, MS, MD or paralysis)
- Neonates with high risk complications or congenital anomalies
- Pre-term labor
- Rehabilitation (long-term)
- Rheumatoid arthritis (severe)
- Spinal cord injury
- Terminal illness – hospice candidates
- Transplant candidates
- Trauma (Major)
- Ulcerative Colitis
- Ventilator dependent

All cases are subject to evaluation for Case Management intervention.

How Does Case Management Work?

GlobalHealth case managers review the Member's admission history, present diagnosis, comorbidity issues, current setting, any need for multiple Providers or services, placement and discharge planning issues and claims history to determine the need for Case Management intervention. Case managers may identify an appropriate alternative care setting, such as a skilled nursing facility or the patient's home.

Who Can Make a Case Management Referral?

Referrals can be made by any medical care personnel, a Member or the Member's family.

Pharmacy Management Procedure Information

GlobalHealth communicates in the "Drug Formulary":

- A list of pharmaceuticals and tiers including restrictions and preferences.
- How to use the pharmaceutical management procedures.
- An explanation of limits or quotas.
- How prescribing Practitioners must provide information to support an exception request. GlobalHealth considers exceptions based on the medical necessity for requested non-preferred pharmaceuticals.
- GlobalHealth's process for generic substitution and step-therapy protocols.

GlobalHealth communicates in the "Schedule of Benefits" on "GlobalLink™" and on the Member's GlobalHealth ID card:

- Copayment and coinsurance requirements and the pharmaceuticals or classes or tiers to which they apply.

Pharmaceutical management materials and procedures are available on the GlobalHealth website under the Provider tab\Tools and Resources\Prescription Information.

Pharmaceutical Patient Safety Issues

- Express Scripts (ESI), the Pharmacy Benefit Manager (PBM) delegate for GlobalHealth, identifies and notifies Members and prescribing Practitioners affected by a Class II recall or voluntary drug withdrawals from the market for safety reasons within thirty (30) calendar days of the FDA notification.
- ESI utilizes an expedited process for prompt identification and notification of Members and prescribing Practitioners affected by a Class I recall.

- ESI is enrolled in an Emerging Therapeutic Issues (ETI) program which reaches out to Members and physicians by mail when appropriate.
- A link to access current drug recalls at www.fda.gov is posted on the GlobalHealth website.

10. DISEASE MANAGEMENT & WELLNESS PROGRAMS

Disease Management

GlobalHealth actively works to improve the health status of its Members with chronic conditions, supporting the patient-doctor relationship. A critical aspect of care is ongoing communications between the Member and physician. Adherence to treatment, including health lifestyle choices, is equally important. We invite our Members with the following diseases to enroll in our disease management programs.

Targeted diseases include:
- COPD
- Congestive Heart Failure
- Coronary Artery Disease

How to Enroll a Member in the Disease Management Program
You may refer a Member by contacting the Utilization Management Department or Customer Care Department. Ask to speak with someone about referring your patient for disease management services. Please refer to the contact list on page 5 for the appropriate Customer Care phone number.

A GlobalHealth Member may also self-refer and enroll by going to our website, www.globalhealth.com, and clicking on “Case Management Support” under the “Resources” tab or by contacting our Customer Care Department.

Behavioral / Mental Health Disease Management
For behavioral or mental health referrals, contact MHNet at 1-866-904-5234.

Medication Therapy Management
GlobalHealth Members taking multiple medications for chronic conditions can receive support from our medication therapy management program. The goal of this program is to help eliminate duplicate drug therapies, reduce potential for negative drug interactions and/or side effects, and optimize Member benefits by providing information on the lowest cost medication alternatives. Enrollment is automatic for qualified Members. Benefits include personalized service from registered pharmacists and staff.

Wellness Program

Information on GlobalHealth's Wellness Program is available on our website under the "Wellness" tab. You may also contact Customer Care and request printed materials.

11. QUALITY IMPROVEMENT ("QI") PROGRAM

Quality Improvement

GlobalHealth is committed to providing quality health care and the preservation of good health for our Members. GlobalHealth furthers that commitment through a comprehensive Quality Improvement ("QI") Program, competent Provider network and highly responsive operational functions. GlobalHealth works diligently to meet the standards and guidelines established by the National Committee for Quality Assurance ("NCQA") and the Center for Medicare and Medicaid Services (CMS).

GlobalHealth develops an annual Quality Improvement Plan ("QIP") to ensure quality patient care services and to verify appropriate follow-up is conducted on any identified areas needing improvement. We are committed to an objective, multidisciplinary approach that manages the quality of care and services provided to Members.

The annual Quality audit update, which includes a summary of HEDIS® preventive care measures, may be found on the GlobalHealth website under the Provider Tab.

Information is available upon request about our QI Program through our website, or by calling Customer Care.

HEDIS®

Each year, GlobalHealth selects and examines a sample of medical records to ensure quality care is being provided to our Members. These quality studies, Healthcare Effectiveness Data and Information Set (HEDIS®), are part of a nationally recognized quality improvement initiative. HEDIS® is used by the Center for Medicare & Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA) for monitoring the performance of managed care organizations. Data is collected for measures related to preventive care. GlobalHealth is pleased to participate in these studies, and appreciates the support of our Provider and Practitioner community in continuously improving our scores and the quality of care rendered to our Members. Primary Care Physicians (PCP) and OB/GYNs are the primary participants. However, if the data is not found in these medical records, additional medical record reviews may be required.

GlobalHealth is a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You do not need a separate authorization from the patient to release the medical record information for purposes of these quality studies. The annual audit is quite short in duration thus we would recommend the medical requests are processed in your office and not sent to a third party for processing to ensure your high quality care is represented in the national rankings.

CAHPS®

GlobalHealth uses The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) anonymous survey. The survey is distributed annually to a random sample of GlobalHealth Members and measures Member satisfaction with the quality of care.

Survey questions include:

- Access to timely care
- Preventive counseling
- Discussion of treatment options – including pros and cons
- Understandability of physician explanations
- Physician listened, showed respect, and spent enough time with Member
- Follow-up of test results with Member
- Medication review with Member
- Ease of access to specialists
- Smoking cessation discussion / counseling
- Annual flu vaccine
- Aspirin use, including risk/benefit, to prevent MI/stroke

HEDIS® and CAHPS® results show our Members how well our Practitioners provide needed care. It is essential that Practitioners work with GlobalHealth to provide the highest quality of care. In addition to your help, we anticipate improving HEDIS® and CAHPS® results through Member and Provider education, analytical monitoring and intervention and enhanced data collection. Please view the Provider Tab of the GlobalHealth website, www.globalhealth.com to access additional resources.

Provider Satisfaction Survey

In order to improve upon plan services, GlobalHealth will conduct an annual Provider Satisfaction Survey. The survey identifies the Providers level of satisfaction of:

- GlobalHealth overall
- Case Management/Referral Department
- Complex Case Management

- Provider Relations Department
- Claims Department

Medical and Behavioral Health Access Quality Standards

GlobalHealth standards for Practitioner office or facility Member appointment wait time:

- Less than 1 hour from time of arrival for scheduled appointment.
- Wait time standard applies when Member timely in appointment arrival.

GlobalHealth standards and performance goals for appointment availability of Practitioners include:

Primary Care Regular and Routine care Appointments

- Routine evaluation – Appointments within 30 working days
- Sick non-urgent – Appointments within 5 working days
- Urgent care – Appointments within 24 hours
- Chronic condition follow-up – Appointments within 30 working days
- Emergent care – Appointment immediately
- After-hours Care – Nurse triage of call or call coverage with Practitioner response within 1 hour

High Volume Specialist

- Initial referral - within 14 working days
- Urgent Care - within 24 hours
- Emergent care - immediate
- After hours – nurse triage of call or call coverage with Practitioner response within 1 hour

Behavioral Health Practitioner

- Emergent services
- Life threatening – Immediate
- Care for a non-life threatening emergency – within 6 hours
- Urgent Care – within 48 hours
- An appointment for a routine office visit – within 10 working days
- Out-patient follow-up after inpatient stay – within 14 working days

Medical Recordkeeping and Documentation Standards

Because complete and accurate documentation in medical records is an essential component of quality patient care, GlobalHealth conducts periodic Practitioner office reviews to assess medical recordkeeping practices and medical record clinical documentation.

Essential medical record components include:

- An organized medical record filing system with patient medical records stored in a systematic, secure, and confidential manner.
- Each page in the record contains the patient's name or identification number – both front and back sides.
- Each record contains appropriate, updated biographical/personal data.
- All entries are dated.
- All entries are signed by the author. Transcribed notes are initialed or signed by the author. All signatures should include the credentials of the author. Note: an electronic signature is acceptable, provided authorization for its use is included in the signature line. Stamped signatures will not be accepted.
- Physician Assistant's notes are co-signed by physician.
- Personal/biographical data including date of birth, sex, marital status, address, employer, and home and work telephone numbers.
- Family/social history is noted in the record.
- Advance Directive documents or a notation that none exist.
- The record is legible to the reviewer or someone other than the writer.
- Medication allergies, adverse reactions, or "no known allergies" is prominently noted in the record. Location is consistent throughout patient charts.
- A current medication list including drug name, dosage, frequency and duration, initial prescription and refill dates. Medication list is updated each visit.
- Injections are documented and include drug name, dosage, route, and site as well as the NDC number.
- Notation is made in record when sample drugs are provided.
- A current problem list notes significant illnesses and medical conditions.
- Immunization records are current, or a note indicates up-to-date immunizations.
- Past medical and social history is present and identifies serious accidents, surgeries, illnesses and important family information. Personal health history includes complete medical and behavioral health history.
- For Members twenty (20) years old or younger, past medical history includes prenatal care, birth, operations, and childhood illnesses.
- For Members eleven (11) years and older (or younger if appropriate) who have been seen three (3) or more times, the use of cigarettes, alcohol, and any substance abuse is noted. Documentation of family/household tobacco history is also noted.
- Pertinent history and physical exam is documented for visits, including reason for visit, history and description of presenting problems, including precipitating factors, mental status evaluation, physical status evaluation if appropriate, psychosocial history including an appropriate developmental history for children and adolescents, risk assessment of severity and possibility of potential harm to self or others accompanied by a referral to a level of care which is appropriate to the level of risk, and appropriate diagnostic tests.

- Notes indicate all services provided by Practitioner, all referrals for diagnostic or therapeutic services, services and tests ordered, follow-up care plans including dates of subsequent appointments, and when applicable, a completed discharge plan.
- Lab and other studies ordered as appropriate for diagnosis.
- Preventive and screening services are offered consistent with national and GlobalHealth practice guidelines.
- Diagnosis noted in the medical record is consistent with symptoms and physical exam or other diagnostic findings.
- Evidence of patient teaching as appropriate.
- Treatment plan is consistent with diagnoses and includes measurable objectives, estimated time frames, and prevention efforts, community resources utilization, and current caregivers contacted or involved in treatment (if no caregiver is involved, so stated in the record).
- Follow-up plans and dates for return visits are clearly documented.
- Unresolved problems are addressed in subsequent visits.
- Consultations, ancillary services, lab, and imaging study reports are initialed by the Practitioner.
- If hospitalized, the record includes an admit report, operative report (if applicable) and discharge summary.
- Working diagnoses are consistent with findings and, if applicable, appropriate DSM-IV diagnoses are documented.
- There is evidence of continuity and coordination of care between primary and specialty Practitioners including mental health Practitioners.
- Phone calls to and from patient are documented, including phone calls notifying the patient of diagnostic test results or related to prescription refills.
- Requests for prescription refills are documented to include the pharmacy name, medication name, dosage, administration directions, and number of refills allowed.

Clinical Practice Guidelines & Preventive Care Recommendations

GlobalHealth recognizes the following Practice Guidelines:

Clinical Practice Guidelines

- GlobalHealth supports and encourages Providers to use research based clinical practice in an effort to improve health care quality and reduce unnecessary variation in care.
- The GlobalHealth Quality Improvement Committee has reviewed and approved the following medical and behavioral health evidence-based clinical practice guidelines presented by the National Guideline Clearinghouse supported by the

AHRQ (Agency for Health Care Research and Quality) and the U.S. Department of Health and Human Services.

- These medical and behavioral health conditions were chosen because of identified prevalence in our Member population.

Master List of Clinical Practice Guidelines

Preventive Clinical Practice Guidelines

- Obesity Assessment)
- Breast Cancer)
- Colorectal Cancer)
- Hypertension)

Medical Conditions - Non-Preventive Clinical Practice Guidelines

- Diabetes Mellitus (DM)
  Management of Microvascular Complications
  Nutritional Management
- Congestive Heart Failure (CHF)
  Diagnosis and Evaluation
  Management of chronic heart failure in adults in primary and secondary care
- Chronic Obstructive Pulmonary Disease (COPD)
  Diagnosis and Management of Acute Exacerbations
  Diagnosis and Management of Stable COPD
  Pulmonary Rehabilitation
- Coronary Artery Disease (CAD)
  CAD Clinical Practice Guidelines

Behavioral Health Clinical Practice Guidelines

- Depression
  The Treatment and Management of Depression in Adults.

- Attention Deficit Hyperactivity Disorder (ADHD)
  ADHD Assessment and Management

Preventive Care Recommendations

GlobalHealth promotes the use of evidence-based preventive health guidelines to support health. The following recognized sources provide preventive health information based on developmental age.
US Preventive Services Task Force
American Academy of Pediatrics
Recommended Childhood Immunization Schedule: American Academy of Pediatrics

Centers for Disease Control and Prevention
Life Stages: Centers for Disease Control and Prevention

Perinatal Care
Pregnancy: Centers for Disease Control and Prevention
Prenatal: American Academy of Pediatrics
Guidelines for Vaccinating Pregnant Women: Centers for Disease Control and Prevention

Children 0-24 years
Infants and Toddlers (Approximate Ages 0-3): Centers for Disease Control and Prevention
Baby (0-12 months): American Academy of Pediatrics
Toddler (1-3 years): American Academy of Pediatrics

Children 2-19 years old
Infants and Toddlers (Approximate Ages 0-3): Centers for Disease Control and Prevention
Toddler (1-3 years): American Academy of Pediatrics
Children (Ages 4-11) - Milestones and Schedules: Centers for Disease Control and Prevention
Preschool (3-5 years): American Academy of Pediatrics
Grade school (5-12 years): American Academy of Pediatrics
Teens (Approximate Ages 12-19): Centers for Disease Control and Prevention
Young Adult (18-21 years): American Academy of Pediatrics

Adults 20-64 years old
Healthy Aging: Centers for Disease Control and Prevention
Young Adult (18-21 years): American Academy of Pediatrics

Adults 65 years and older
Healthy Aging: Centers for Disease Control and Prevention
Health Information for Older Adults : Centers for Disease Control and Prevention
Team Up to Stay Healthy: CDC, AARP and Medicare

For more information, contact our Quality Improvement Department.

Quality and Provider Credentialing

The selection and retention of Providers that are committed to quality and efficiency is one of the most imporant elements of our Quality Improvement Program. In the selection of institutional and ancillary providers, GlobalHealth requires evidence of accreditation by a recognized accrediting agency, or if there is not such an agency, other indication that the Provider meets equivalent standards of quality. [See next section.]

12. PROVIDER CREDENTIALING

Any Practitioner or Provider that wishes to participate in the GlobalHealth network(s) must be credentialed by GlobalHealth or its delegated credentialing agent.

Requesting an Application

To contract with GlobalHealth, physicians and Practitioners must complete and submit an application with all required documentation. Applications are valid for up to 180 days from the date of the physician's signature.

Physicians/Practitioners have the right to review information submitted to support their application, to correct erroneous information and to be informed of the status of their application upon request.

Primary Care and Specialist Physician Credentialing Criteria

To be considered a Primary Care Physician ("PCP"), the applicant must specialize in internal medicine, general practice, family practice, or pediatrics. Internal medicine physicians must devote ninety per cent (90%) of their time to family medicine to be credentialed as a PCP.

Credentialing Requirements:

1. Submit a complete application with original signature (no signature stamps).
2. Current unrestricted Oklahoma license.
3. Graduation from a school of medicine or osteopathy that is accredited by the Liaison Committee on Medical Education and completion of residency. Graduates of foreign medical schools must be certified by the Educational Commission for Foreign Medical Graduates (ECFMG certificate). For other Practitioners, graduation from an appropriate accredited professional school and/or completion of a formal training program.
4. A current DEA certificate and Controlled Dangerous Substance certificate, if applicable.
5. Board certification or Board eligibility.
6. Current and unrestricted admitting privileges in good standing at a GlobalHealth contracted hospital.
7. Current professional liability insurance minimum: $1,000,000 per occurrence and $1,000,000 aggregate, unless otherwise agreed to.

8. Absence of history of involvement in malpractice suit, arbitration, or settlement; or in the case of an applicant with such history, evidence that the history does not demonstrate probable future substandard professional performance.
9. Absence of history of denial, suspension, restriction, or termination of hospital privileges; or in the case of an applicant with such history, evidence that this history does not currently affect applicant's ability to perform professional duties for which the applicant contracted, or does not demonstrate probable future substandard performance.
10. Absence of a history of disciplinary actions affecting applicant's professional license, DEA or other required certifications; or, for applicants with such history, evidence that this history does not currently affect applicant's ability to perform professional duties for which the applicant contracted, or does not demonstrate probable future sub-standard performance.
11. Absence of history of felony convictions; or for an applicant with such history, evidence that the nature of the conviction does not affect applicant's current ability to perform the professional duties for which applicant contracted, or does not demonstrate probable future sub-standard care.
12. Absence of history of exclusions or sanctions by regulatory agencies, including Medicare/Medicaid sanctions; or for an applicant with such history, evidence that applicant is not currently sanctioned or prevented by a regulatory agency from participating in any federal or state sponsored programs.
13. Absence of chemical dependency/substance abuse; or for those applicants who have such history, evidence that the applicant is participating in, or has completed, a prescribed, monitored treatment program and that no current chemical dependency or substance abuse exists that would affect applicant's ability to adequately perform the professional duties for which applicant is contracted.
14. Absence of physical or mental condition that would impair the ability to competently and safely perform the professional duties for which the applicant is seeking.
15. Evidence of the capability to provide twenty-four (24) hour, seven (7) days per week coverage.
16. Work history for at least the past five years.
17. Cooperation with office surveys, which includes a structured review of the office site and evaluation of the medical recordkeeping system and practices. Scores of 85% for the site evaluation and 80% for a detailed medical records review for re-credentialing are required.

Midlevel Credentialing Criteria

To be credentialed as a midlevel Provider, the applicant must be licensed as a Nurse Practitioner (“NP”) or Physician’s Assistant (“PA”) in Oklahoma and provide the following:

1. A complete application with original signature (no signature stamps).
2. Current unrestricted Oklahoma license.
3. Graduation from an appropriate accredited professional school and/or completion of a formal training program.
4. Current professional liability insurance minimum: $1,000,000 per occurrence and $1,000,000 aggregate.
5. Absence of history of involvement in malpractice suit, arbitration, or settlement; or in the case of an applicant with such history, evidence that the history does not demonstrate probable future substandard professional performance.
6. Absence of a history of disciplinary actions affecting applicant’s professional license, or other required certifications; or, for applicants with such history, evidence that this history does not currently affect applicant’s ability to perform professional duties for which the applicant contracted, or does not demonstrate probable future sub-standard performance.
7. Absence of history of felony convictions; or for an applicant with such history, evidence that the nature of the conviction does not affect applicant’s current ability to perform the professional duties for which applicant contracted, or does not demonstrate probable future sub-standard care.
8. Absence of history of exclusions or sanctions by regulatory agencies, including Medicare/Medicaid sanctions; or for an applicant with such history, evidence that applicant is not currently sanctioned or prevented by a regulatory agency from participating in any federal or state sponsored programs.
9. Absence of chemical dependency/substance abuse; or for those applicants who have such history, evidence that the applicant is participating in, or has completed, a prescribed, monitored treatment program and that no current chemical dependency or substance abuse exists that would affect applicant’s ability to adequately perform the professional duties for which applicant is contracted.
10. Absence of physical or mental condition that would impair the ability to competently and safely perform the professional duties for which an applicant is seeking.
11. Evidence of the capability to provide twenty-four (24) hour, seven (7) days per week coverage, if applicable.
12. Work history for at least the past five years.

Credentialing of Hospitals and Facility Providers

To be credentialed as a hospital or facility within the GlobalHealth network, the entity must be licensed in good standing with state and federal regulatory bodies. Additionally, the entity must be accredited by an approved accrediting body such as The Joint Commission ("TJC") or equivalent. If the entity is not accredited, GlobalHealth will conduct an on-site review to ensure the entity meets quality standards established by TJC and GlobalHealth. GlobalHealth will confirm the entity continues to be licensed and in good standing with state and federal bodies at least once every three (3) years.

Hospital and facility Providers must provide the following:

1. Submit a completed GlobalHealth "Ancillary & Facility Application" along with the necessary attachments.
2. Evidence of Medicare certification.
3. Copy of accreditation approval letter (e.g., TJC).
4. If an organization is not accredited, the entity must provide current copies of its DEA certification, CLIA/CAP certification, and any other relevant certifications held by the organization.
5. If an organization is not accredited, GlobalHealth will conduct an on-site review. Any deficiencies identified during the on-site visit are communicated to the entity with a request for corrective action plan within fifteen (15) business days of the date received. Failure to timely correct deficiencies may result in a determination not to credential the organization. (Survey results provided by a regulatory agency may be accepted in place of a site visit at GlobalHealth's sole discretion.)
6. Entities that are not accredited must also have an acceptable malpractice claims history as approved by GlobalHealth. The entity must provide the number and facts of each legal action brought against it in the three (3) years prior to the application and the resolution of such action (e.g. withdrawn, dismissed, judgment, or settlement), including the amounts of settlements and judgments.
7. The entity must submit a copy of its Quality Assurance/Quality Improvement ("QA/QI") and Risk Management Plans and a copy of its medical staff roster.

Recredentialing

To remain in the GlobalHealth network, ALL Providers must be re-credentialed, at a minimum, every three (3) years.

GlobalHealth (including its delegated entity/entities, if applicable) does not discriminate in the selection of Providers based on race, religion, age, ethnicity or gender factors.

Practitioner Appeal Process

GlobalHealth will:

- Provide written notification when a professional review action has been brought against a Practitioner, reasons for the action, and a summary of the appeal rights and process.
- Allow Practitioners to request a hearing and provide the specific time period for submitting the request.
- Allow at least thirty (30) calendar days after the notification for Practitioners to request a hearing.
- Allow Practitioners to be represented by an attorney or another person of their choice.
- Appoint a hearing officer or a panel of individuals appointed by GlobalHealth to review the appeal. This panel will include, at a minimum, the GlobalHealth Medical Director, or designated MD or equal Practitioners, and one network Practitioner to participate in the appeal.
- Provide written notification of the appeal decision that contains the specific reason for the decision within 10 days.
- Follow all applicable state law requirements.

13. MEMBER RIGHTS AND RESPONSIBILITIES

As a partner with GlobalHealth, you should be aware of our Member Rights and Responsibilities.

Our Members have the right to:

a) Receive information about GlobalHealth, its services, Practitioners and Providers, and Member rights and responsibilities.
b) Be treated with respect and recognition of his/her dignity and right to privacy.
c) Ask questions about any medical advice or prescribed treatment in order to make an informed consent or refuse a course of treatment.
d) A candid discussion of all appropriate, medically necessary treatment options that are recommended, regardless of the cost or benefit coverage.
e) To participate in decisions regarding medical care, to completely understand his/her medical condition, health status, and the medications prescribed (including why the medication is being prescribed, how to take it properly, and possible side effects).

f) Voice complaints or grievances about GlobalHealth or the care the Member received without discrimination, retaliation, or adverse effect.
g) Appeal any unfavorable medical or administrative decisions by following GlobalHealth's established appeals and grievances procedures. Members have the right to an external or expedited review of an adverse determination when applicable.
h) Timely access to his/her PCP and referrals to specialists when medically necessary or urgent.
i) Use Emergency services when the Member, acting as a prudent layperson, has a reasonable belief that an Emergency medical condition exists.
j) Confidential treatment of individual identifiable or protected health information as required by federal and state laws.
k) Receive information about contracted physician payment agreements, explanations of benefits and claims processing determinations.
l) Expect problems to be fairly examined and appropriately addressed.
m) Exercise Member rights regardless of race, national origin, gender, sexual orientation, marital status, or cultural, economic, educational or religious background.

Our Members have the responsibility to:

a) Identify himself/herself as a GlobalHealth Member by presenting a Member ID card to the Provider of services.
b) Provide, to the extent possible, information and medical records needed by the Provider in order to render appropriate care.
c) Do their part to improve their own health condition by following treatment plans and instructions
d) Be on time for appointments and notify the Provider in advance as possible if the Member needs to cancel or reschedule an appointment.
e) Notify their PCP within forty-eight (48) hours, or as soon as possible, if hospitalized or if Emergency or out-of-network Urgent Care was received.
f) Pay all required copayments.
g) Review their Member Handbook and Schedule of Benefits and ask questions if they do not understand health benefits or coverage information.

14. CONFIDENTIALITY, PRIVACY, & SECURITY

GlobalHealth takes all reasonable steps and uses best efforts to comply with applicable laws and regulations pertaining to patient confidentiality and privacy and security of protected health information ("PHI"), including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health ("HITECH"), and similar federal and state laws.

As a contracted Provider in the GlobalHealth network, you are also expected to comply with these laws and regulations.

For a current copy of GlobalHealth's Notice of Privacy Practices ("NPP"), please visit our website or contact Customer Care and request a hard copy.

To report a possible privacy violation or breach, please contact the GlobalHealth Compliance and Privacy Officer at (405) 280-5711 (direct phone) or 1-877-280-5852 (recorded hotline), email privacy@globalhealth.com, or write to:

ATTN: Privacy Officer
GlobalHealth, Inc.
701 NE 10th
Suite 300
Oklahoma City, OK 73104-5403

15. APPEALS & GRIEVANCES

GlobalHealth complies with all applicable state and federal regulations for processing Member grievances and appeals.

Member Grievances

A GlobalHealth Member has the right to complain or file a written grievance when the Member is dissatisfied. All written Member grievances are acknowledged within five (5) business days of receipt by GlobalHealth, investigated, and responded to within thirty (30) days.

Member Appeals

A GlobalHealth Member who is dissatisfied with an adverse determination made by GlobalHealth has the right to request an appeal of that determination. Appeal requests must be received within 180 days of the date of the initial denial by GlobalHealth. Appeal requests must be submitted in writing to:

GlobalHealth, Inc.
ATTN: Appeals
P.O. Box 2393
Oklahoma City, OK 73101-2393

All Member appeal requests are acknowledged within five (5) business days of GlobalHealth's receipt of the request. An individual who was not involved in the

initial adverse determination will conduct a full and independent review. A written appeal determination is mailed to the Member within thirty (30) days of receipt of the request. If the adverse determination is upheld on appeal, the Member is provided with any additional appeals rights, as applicable.

Provider Appeal of UM Denial or Adverse Determination

Standard Appeal

You may request a standard appeal for denied services or claims where the patient is not currently receiving treatment or treatment is already scheduled and the patient's condition is not such that an expedited appeal is warranted.

Submit the appeal in writing to:

GlobalHealth, Inc.
ATTN: Appeals
P.O. Box 2393
Oklahoma City, OK 73101-2393

Include all related information available concerning the denied services including:

- Patient name
- Member ID number
- Name of facility where services are being rendered, if applicable
- Medical necessity, or basis of appeal

Written Response to Appeal

A written response to a standard appeal is sent no later than thirty (30) days after receipt of the appeal request and supporting documentation.

Expedited Appeal

You may request an expedited appeal if the Member is actually receiving services or is scheduled to receive services and the attending physician and/or the Member believes that the determination warrants immediate attention due to the patient's condition or health status.

1. Call GlobalHealth - please refer to the contact list on page 5 for the appropriate contact information.
2. Have all related clinical information available regarding the denied services including:
    - Patient name
    - Member ID number
    - Name of facility where services are being rendered, if applicable
    - Medical necessity information, or basis of appeal

Expedited Appeal Decision

Decisions concerning expedited appeals are made as expeditiously as the medical condition requires, but no later than 72-hours after the review commences. Providers are notified by telephone followed by written determination.

Physician Review of Medical Necessity Denials

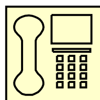
Only the Medical Director (or other physician designee) makes medical necessity denial determinations. The Medical Director is available to discuss denial decisions with a Provider. The Medical Director can be reached Monday through Friday, (9:00 AM to 5:00 PM Central Time).

16. COMPLIANCE PROGRAM

GlobalHealth has a written Compliance Program that incorporates the following elements:

- A designated Chief Compliance Officer
- Written Code of Conduct
- Auditing and monitoring, including methods for detecting fraud and abuse
- Education and training
- Hotline for reporting compliance concerns*
- Policies and procedures
- Remediation / corrective action when problems are identified

All participating Providers are expected to adhere to the GlobalHealth Compliance Program, including the Code of Conduct. A current copy of the Code of Conduct is available on the GlobalHealth website. For any question concerning the Compliance Program, or to report a concern, contact our Compliance Officer at (405) 280-5711 (direct number), or call our toll-free anonymous reporting line described below and leave a message.



*To anonymously report a compliance or privacy concern,

call our 24-hour toll-free Compliance Line at

1-877-280-5852

*All calls or reports are timely and thoroughly investigated by the Compliance Officer. GlobalHealth will not retaliate against anyone who, in good faith, reports an actual or potential violation of any federal or state law or regulation or GlobalHealth policy.

You may also contact our Compliance Officer in writing at:

ATTN: Compliance Officer
GlobalHealth, Inc.
701 NE 10th
Suite 300
Oklahoma City, OK 73104-5403

17. REIMBURSEMENT

GlobalHealth will reimburse for covered services that are provided to Members according to the rates set forth in the Provider contract, reduced by applicable copayments, coinsurance, and deductibles and subject to any other applicable contractual reductions. Unless otherwise specified, GlobalHealth follows Centers for Medicare and Medicaid Services (CMS) coding guidelines including; ICD-9, CPT-4®, and HCPCS.

Hospital Facility Reimbursement – General

1. **Inpatient Acute Care Services**
These services are reimbursed based upon the negotiated percentage of the current Medicare Severity Diagnosis Related Group ("MS-DRG") reimbursement methodology, as defined by CMS, in effect on the date of service based on MS-DRG price data then available. Such rates are updated annually, or in accordance with CMS changes, and include Medicare transfer and outlier payment guidelines. The amount to be paid is the sum of the hospital-specific base rate plus capital component. The compensation for inpatient acute care services does not include any Indirect Medical Education ("IME"), Graduate Medical Education ("GME"), disproportionate share or nursing and allied health education costs.

2. **Ambulatory Payment Classification ("APC") Outpatient Hospital Services**
These services are reimbursed at a rate equal to the negotiated percentage of the current Medicare APC reimbursement in effect on the date of service, subject to Medicare's multiple procedure reductions, and subject to applicable Medicare coverage criteria for medical necessity. Rates are determined based on the APC price data then available.

3. **Outpatient Radiology Services** (CPT-4® Codes 70000 - 79999)
Services which are not directly related to the performance of a surgical procedure are reimbursed at an all-inclusive rate equal to the negotiated percentage of the current

Medicare reimbursement schedule in effect on the date of service, subject to medical necessity or other coverage limitations. Outpatient radiology services which are directly related to the performance of and/or an integral part of a surgical procedure are not separately reimbursed.

4. **Non-APC Outpatient Hospital Services**
   These services are reimbursed at an all-inclusive rate equal to the negotiated percentage of the Medicare fee schedule payment methodology in effect on the date of service, subject to Medicare CPT-4™ and HCPCS coding policies, medical necessity and any other coverage limitations.
5. **Outpatient Hospital Services not subject to Medicare APC or Medicare Fee Schedule** These services are not reimbursed unless specifically described in the Provider contract or Member schedule of benefits.

Physician Reimbursement – General

1. **Primary Care Physician Services**
   These services are reimbursed at the negotiated percentage of the Oklahoma Adjusted Medicare Physician Fee Schedule ("MPFS") allowable amount in effect at the date service is rendered to the Member.
2. **Specialist Services**
   These services are reimbursed at the negotiated percentage of the Oklahoma Adjusted Medicare Physician Fee Schedule ("MPFS") allowable amount in effect at the date service is rendered to the Member.
3. **Diagnostic / Other Therapeutic Services**
   These services are reimbursed at the negotiated percentage of the Medicare allowable for diagnostic and other therapeutic services that are separately reimbursable and have an established Medicare fee schedule. Reimbursement is subject to medical necessity and coverage limitations. For services that do not have a Medicare allowable reimbursement amount, no payment shall be made unless specifically described in the Provider contract or Member Schedule of Benefits.

Situations That May Affect Hospital Reimbursement

Reimbursement for inpatient services may be affected in certain situations described below.

1. **Hospital Acquired Condition Not Present on Admission**
   GlobalHealth does not provide additional reimbursement for complications and co-morbidities related to hospital acquired conditions not present on admission as defined by the Centers of Medicare and Medicaid Services (CMS).

2. **Hospital Readmissions**
GlobalHealth does not make additional, separate DRG payments for readmissions that are foreseeable and the result of a quality of care issue or premature discharge. GlobalHealth applies standardized criteria such as the Centers for Medicare and Medicaid Services (CMS) guidelines, Milliman Care Guidelines® and other applicable industry guidance in determinations not to reimburse for a subsequent hospitalization.

3. **Never Events**
GlobalHealth does not reimburse for charges that are related to "Never Events" as defined by the Centers for Medicare and Medicaid Services (CMS).

18. FRAUD, WASTE, AND ABUSE / CLAIMS AUDITING

GlobalHealth is committed to an effective Fraud, Waste, and Abuse ("FWA") Program to detect, correct, and prevent FWA. Examples of potential FWA include, but are not limited to:

- Submission of false or fraudulent claims by a Provider.
- Submission of claims for services that are not medically necessary.
- Submission of claims for services that are not properly documented.
- Failure to provide medically necessary services to a Member which adversely affects the Member.
- Payments made for excluded drugs or drugs that were not for medically accepted indications.
- Multiple billings for the same services.
- Altered or forged documentation

GlobalHealth will promptly investigate any reported potential violations of federal or state laws, regulations or other policies. Reports of actual or potential FWA should be reported to the GlobalHealth Compliance Officer at (405) 280-5711 or the toll-free reporting line at 1-877-280-5852.

Education on FWA is available on the GlobalHealth website. Additionally, the GlobalHealth Compliance Officer will provide FWA and other compliance-related training to Providers upon request.

GlobalHealth reserves the right to audit paid claims in order to determine payment accuracy and as part of its program to detect FWA. Such audits may be conducted at random or selected based on data analysis. Certain claims present higher risk for payment errors and may be subject to pre- or post-payment audits.

Such claims include, but are not limited to:

- Inpatient short stays

- Outpatient observation greater than twenty-four (24) hours
- Inpatient high-severity DRG
- Readmissions within thirty (30) days
- High dollar claims
- Multiple units billed
- Targeted areas identified by the Office of the Inspector General ("OIG"), the Centers for Medicare and Medicaid Services ("CMS") or other entity as being high risk for error.

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