



## Provider Manual

### Table of Contents

Purpose .....	2
Provider Relations .....	3
Affirmative Statements .....	4
Participating Provider Responsibilities .....	4
Verifying Eligibility.....	6
Verifying Eligibility with CMS .....	6
Copays and Coinsurance .....	6
Non-Covered Services .....	6
Claims Submissions .....	7
Medicaid .....	7
Contracted Providers – Call Coverage .....	8
Referrals to Contracted Providers .....	8
Pharmacy Services .....	8
Enrollee Direct Access Services.....	8
Cultural Competency and Language Assistance .....	9
Non-Discrimination .....	9
Provider Administrative Dispute Resolution.....	9
UTILIZATION MANAGEMENT .....	10
Medical Necessity Guidelines .....	11
Timeliness of UM Decisions .....	11
Denials/Unfavorable UM Determinations .....	12



## Purpose

The Provider Manual serves as a reference guide and educational resource for physicians, ancillary providers and their staff. It is a source for answers to some of the most common questions that providers have about working with GMG. It expands upon and explains some of the GMG policies and procedures referenced in your provider agreement.

This provider manual is made available to all providers digital format, email or fax.

Please be advised that nothing in this provider manual or the GMG provider agreement is intended to or shall be interpreted to discourage or prohibit a participating provider from discussing with a member treatment options or providing other medical advice or treatment deemed appropriate by a participating provider.

**Please Note:** If any provision of this Provider Manual comes in conflict with state or federal law or the terms of your provider agreement, the current federal law or state law as applicable takes precedence. The policies and procedures described in this manual are subject to modification, addition and/or deletion. All updates will be incorporated into the online Provider Manual; in some instances providers may receive additional communication in one of the various formats including, but not limited to; newsletters, mailings, fax blasts, web postings and/or manual revisions that will be incorporated into the online provider manual.



## Provider Relations

As a Medical Group, it is our aim to make it easy for providers to do business with us. We hope you find we simplify our processes, give you reliable information and are responsive to you and your staff.

- Our Credentialing team can assist you with any Credentialing issues. We can also assist with updating demographic information and directory information.
- Our Network team will be available to assist with any contract questions. Responsibilities include educating and servicing physicians, and their office staff. We are here to assist with resolving more complex issues you may have related to reimbursement and quality programs.
- Our Referral Staff can assist with Referral and prior authorization submission process, verifying member eligibility, helping you to obtain UM criteria, etc.  
8:00 AM – 5:00 PM Monday through Friday;
- Claims are paid on behalf of Gonzaba Medical Group by Innovista Health Solutions.

Department	Phone	Fax	Email
GMG Referrals	(210) 921-3801	(210) 334-2862	---
GMG Case Management	(210) 890-4441	(210) 334-2864	---
GMG Claims CS line	(210) 201-0489	---	<a href="https://eznet.innovistaportal.com">https://eznet.innovistaportal.com</a>
Provider Relations	(210) 540-7033	(210) 334-2862	Josephx.flores@gonzaba.com
Credentialing	(210) 395-3646	(210) 334-2851	Credentialing@gonzaba.com
Contracting	(210) 903-8819	(210) 921-5763	Frances.ortiz@gonzaba.com
Medical Records	(210) 905-4519	(210) 334-2861	Lupe.maldonado@gonzaba.com



Reviewed 8.10.2020

## Affirmative Statement

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

## Participating Provider Responsibilities

1. Manage the medical and health care needs of health plan members/patients, including monitoring and following up on care provided by other providers, providing coordination necessary for services provided by specialists and ancillary providers (both in and out-of-network), and maintaining a medical record meeting GMG standard.
2. Provide coverage 24 hours a day, 7 days a week; regular hours of operation should be clearly defined and communicated to health plan members/patients
3. Provide all services and treat all patient ethically, legally and in a culturally competent manner, and treat patient disclosures and records confidentially, giving patients the opportunity to approve or refuse their release
4. Work to meet the unique needs of health plan members/patients with special health care needs
5. Participate in systems established by GMG to facilitate the sharing of records, subject to applicable confidentiality and HIPAA requirements and with all applicable federal and state laws regarding the confidentiality of patient records.
6. Make provisions to communicate in the language or fashion primarily used by his or her patients
7. Provide hearing interpreter services upon request to health plan members/patients who are deaf or hard of hearing
8. Participate in and cooperate with GMG in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established by GMG.
9. Help foster open communication and cooperation with QI activities. Support / cooperate with GMG Quality Improvement program initiatives.
  - Cooperate with QI activities, including collection of performance measurement data and participation in the GMG's clinical and service measure QI programs.
  - Allow GMG to use provider performance data for quality improvement activities, as outlined contractually.
  - Allow the Plans as specified in Exhibit D of the Participating Provider Agreement to use their performance data.



10. Comply with Medicare laws, regulations and CMS instructions, agree to audits and inspections by CMS and/or its designees, cooperate, assist and provide information as requested, and maintain records for a minimum of 10 years
11. Participate in and cooperate with the GMG appeal and grievance procedures
12. Agree to not balance bill health plan members/patients for monies that are not their responsibility or that should be paid for by another carrier.
13. Continue care in progress during and after termination of a health plan member/patient's contract for up to 60 days, or such longer period of time required by state laws and regulations, until a continuity of service plan is in place to transition the health plan member/patient to another network provider in accordance with applicable state laws and regulations
14. Develop and have an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood-borne pathogens
15. Establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act of 1990 (ADA)
16. Inform GMG if a health plan member/patient objects to the provisions of any counseling, treatments or referral services for religious reasons
17. Provide health plan members/patients complete information concerning their diagnosis, evaluation, treatment and prognosis and give them the opportunity to participate in decisions involving their health care, except when contraindicated for medical reasons
18. Advise health plan members/patients about their health status, medical care or treatment options, regardless of whether benefits for such care are provided under the program and advise them on treatments that may be self-administered
19. When clinically indicated, contact health plan members/patients as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings
20. Have a policy and procedure to ensure proper identification, handling, transport, treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
21. Agree to maintain communication with the appropriate agencies such as local police, social services agencies and poison control centers to provide high-quality patient care
22. Provide advanced notification to health plan members/patients of services that are not covered by the plan or Medicare in accordance with Medicare requirements. Please refer to Provider Obligations — Precertification.



## Verifying Eligibility

The Health Plan record is always considered the primary source for a member's eligibility. A provider should verify their enrollee's eligibility directly with the applicable health plan, either through their secure portal, or through contacting the provider customer service department. It is a provider's responsibility to verify member eligibility at the time of service.

## Verifying Eligibility with CMS

Providers may verify eligibility directly with CMS for any Medicare Advantage Plan (MAP). If member eligibility cannot be verified with the applicable health plan, CMS can verify if the member is enrolled in an MAP plan or not.

To verify eligibility through CMS, please contact:

Medicare Eligibility:

Texas IVR: 1-855-252-8782

For other Medicare related questions visit <http://www.cms.gov/> or call

Medicare Provider Service:

Texas: 1-800-633-4227

## Copays and Coinsurance

It is the provider's responsibility to collect co-payments and co-insurance directly from the patient at the time services are rendered.

**Copayment** – a fixed amount charged to a MA enrollee on a per service basis.

**Co-insurance** – percentage of allowed charges for which the enrollee is responsible.

Contracted providers must not bill or collect any amount in excess of the maximum allowable except for the applicable co-payments and co-insurance.

## Non-Covered Services

Providers may charge GMG patients for non-covered services. However, such charges must be the usual and customary fee that the provider charges all other enrollees. The patient must agree in writing to accept responsibility for the non-covered service prior to receiving that service. Providers must utilize the Advance Beneficiary Notice of Noncoverage for this purpose.



## Claims Submissions

GMG is responsible to pay claims for **Amerigroup** patients that we send to you for healthcare services, effective **DOS 9/1/2019**. **Amerigroup** patients under GMG have been issued new ID cards. Note that “**Gonzaba Medical Grp**” appears on the front of the ID card, under the PCP information. This will help Network staff to identify the patients under the GMG contract. The card includes the claims address information on the back, detailed below.



- **Claims should be submitted electronically to PayerID: GMGSA**  
Electronic submission is preferred, but you are also able to submit paper claims via [mail](#).

**GMG Claims**  
**PO Box 7997**  
**Westchester IL 60154**

- **EZNET portal** is available to allow Network staff to inquire online about authorizations, claims status, payment, or even to enter referral requests. **Contact GMG Provider Relations to obtain EZ NET login/password.**

## Medicaid

Medicaid is the program that provides access to health care for low-income families and individuals. Medicaid also assists aged and disabled people with the costs of nursing facility care and other medical expenses. Eligibility for Medicaid is usually based on the families or individual's income and assets. Many dual eligible patients (those that have Medicare and Medicaid) enrolled in a Medicare Advantage Plan will have no co-payments or co-insurance.



If you are uncertain as to an enrollee's Medicaid eligibility, you may contact Texas Medicaid & Healthcare Partnership (TMHP) for additional information:

**Texas:**

**1-800-925-9126**

[www.tmhp.com](http://www.tmhp.com)

## Contracted Providers – Call Coverage

Contracted physicians are contractually required to make on-call after-hours coverage arrangements with other contracted and credentialed physicians when they are temporarily unavailable due to vacation, conferences, illness or leave of absence. Each covering physician will bill under their own GMG agreement.

In some instances, a GMG Network Provider may need to make call coverage. In this case we ask that you contact the GMG Network team /Provider Relations so we can perform required compliance reviews.

## Referrals to Contracted Providers

Physicians are required to refer enrollees within the GMG contracted network. Occasionally, it may be necessary to refer to an out-of-network provider when a service is required that is not available within the network. All out-of-network services require Prior Authorization: 210-921-3800

## Pharmacy Services

### **Part D Medications**

Physicians are asked to prescribe medications that are listed on the applicable health plan formulary unless medical necessity dictates otherwise. Any requests for drugs not on the health plan's formulary require completion and submission of the health plan non-formulary exception request form by the prescribing physician.

You can find out if a drug has any additional requirements or limits by looking at the pharmacy formulary information on the applicable health plan's website.

## Enrollee Direct Access Services

Enrollees have direct access to the following services without going through their PCP:

- Annual Well Woman Exam
- Annual Mammogram
- Disease Management programs





- Hearing exam (coverage varies by benefit plan)
- Influenza Vaccines (Flu)
- Optometry – Annual eye exam and glasses (coverage varies by benefit plan)
- Out-of-area dialysis

## Cultural Competency and Language Assistance

GMG strives to provide services in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds by providing a culturally diverse provider network. We gather information from providers concerning languages other than English that are spoken in each office.

Providers are encouraged to deliver care in a manner that is sensitive to the cultural background and language of the enrollee. It is required by law and the responsibility of the provider to obtain and pay for interpreters for language interpretation other than English, as well as for visually impaired, hearing/vision impaired, hard of hearing and speech disabled enrollees. At a minimum this involves arranging for a language interpreter for enrollees who do not speak English.

## Non-Discrimination

GMG employed and contracted providers maintain a policy of non-discrimination to all enrollees and does not exclude, deny delivery of services to, or otherwise discriminate against any person on the basis of any of race, color, national origin, disability, sex, sexual orientation or sexual identity, marital status age, mental or physical disability or medical condition, such as ESRD, religion, claims experience, medical history, or genetic information. In accordance with Title VI of the Civil Rights Act of 1964, et seq., Section 2000d Rules and Regulations or as otherwise provided by law or regulation.

## Provider Administrative Dispute Resolution

GMG defines the provider dispute resolution process to ensure that all provider complaints, grievances and concerns are handled appropriately and in compliance with the contract, CMS, State Regulatory and health plan requirements. This resolution process is available to all participating providers.

GMG encourages its providers to express any concern or dispute in the form of a written complaint. If a provider complaint is received verbally, the provider will be encouraged to file a written account of the complaint. The written account should include:

- Provider/Organization name, address, Tax ID
- Description of the Dispute



- Expected Outcome
- Contact Name, Title, phone, Fax, email
- Any additional information or documents

Once completed, the written account should be submitted for review and processing to the Compliance Department at the following address:

**Gonzaba Medical Group**  
Attn: Compliance Officer  
720 Pleasanton Rd  
San Antonio, TX 78214

Administrative disputes will be reviewed within 30 days of the receipt of the original request. A final written communication will be sent to the provider addressing the concerns and explaining the outcome/resolution.

## UTILIZATION MANAGEMENT

GMG Utilization Management Program includes the evaluation of requests for coverage by determining the medical necessity, appropriateness and efficiency of the health care services under the applicable health benefit plan. UM services will be provided where licensed or permissible under state and federal law, or other regulatory authority.

The Chief Medical Officer (CMO) has senior level executive responsibility for UM and reports directly to the President and Chief Executive Officer (CEO).

GMG adheres to the following guidelines when administering its UM Program:

- It is the responsibility of the PCP/attending provider to make clinical decisions regarding medical treatment. These decisions must be made consistently with generally accepted principles of professional medical practice and in consultation with the patient.
- It is the responsibility of GMG to determine benefit coverage based on the patient's health plan benefits. GMG uses medical necessity guidelines/utilization review criteria, if applicable, to evaluate requests for coverage.
- All utilization review decisions to deny coverage are made by qualified, licensed physicians, or when appropriate and when allowable by law, by licensed health care professionals with expertise in the specialty for which services are being requested.
- GMG does not compensate individuals conducting utilization review for issuing denials of coverage, and it does not provide financial incentives for UM decision-makers to encourage denials of appropriate coverage. Financial incentives for utilization review do not encourage decisions that result in underutilization. UM decision-making is based on medical necessity, applicable coverage guidelines and appropriateness of care and service.



## Medical Necessity Guidelines

GMG determines benefit coverage for the benefits described in each patient's health plan product description by using Medical Necessity Guidelines (MNGs) to determine the medical necessity and appropriateness of health care services under the applicable health benefit plan. These utilization review MNGs are:

- Developed in accordance with standards adopted by national accreditation organizations and regulatory and government entities
- Reviewed on an annual basis and updated as new treatments, applications and technologies are adopted as generally accepted professional medical practice
- Evidence-based, if such evidence is available
- Applied in a manner that considers the individual health care needs of the member and characteristics of the local delivery system
- Evaluated at least annually for the consistency with which those involved in utilization review apply the MNGs in the determination of coverage
- GMG also utilizes some commercially purchased criteria. The use of these criteria is also reviewed in the manner described above.
- MNGs are used by providers when making coverage determinations for Managed Care patients. MNGs can be made available to the requesting provider by calling GMG Referrals Department at (210) 921-3801. A printed copy of coverage determination can be sent to the requestor by mail, fax or email upon request.
- Ensuring that you provide the correct and complete clinical information at the correct time when requesting a medical necessity review when clinical information is needed.
- If the information provided does not support medical necessity, the service cannot be approved under Medicare law. Please provide the necessary information to justify the services you are requesting at the time of the request to allow for an appropriate decision to be made. Any service determined to require a clinical review will be processed in accordance with:
  - Section 1861(a)(1)(A) of the Social Security Act, which states that Medicare payment can only be made for services/items that are medically necessary and reasonable.
  - Section 1833(e) of the Social Security Act, which states that Medicare payment can be made only when the documentation supports the service/item.

## Timeliness of UM Decisions

UM review decisions will be made in a -timely manner. The decision will be made as expeditiously as the enrollee's health condition requires, but no later than the time periods outlined below. Both the determination and notification to the patient and requesting provider must occur within the defined time periods.

Timeframes are as follows:



- For standard, non-urgent preservice decisions, the determination must be made within 14 calendar days of receipt of the request.
  - GMG may extend the time frame up to 14
  - This extension is allowed to occur if the patient requests the extension or if GMG justifies a need for additional information and documents how the delay is in the interest of the patient (for example, the receipt of additional medical evidence)
  - GMG must notify the patient, in writing, of the reasons for the delay, and inform the patient of the right to file a grievance if he or she disagrees with the decision to grant an extension.
- For expedited, urgent pre-service decisions the determination must be made within 72 hours of receipt of the request.
  - A patient, or any physician may request an expedited determination when they believe that waiting for a decision under the standard time frame could place the patient's life, health, or ability to regain maximum function in serious jeopardy. If unable to make a decision due to lack of necessary information, the decision can be extended once for up to 48 hours.
  - GMG must notify the patient or their authorized representative what specific information is necessary to make the decision.
- For urgent concurrent review decisions, the determination and notification (patient and requesting provider) will be made within 24 hours of receipt of the request.
- For post service/retrospective decisions the determination and notification (patient and requesting provider) will be made within 30 days of receipt of the request

## Denials/Unfavorable UM Determinations

GMG gives requesting service practitioners the opportunity to discuss UM denial decisions with an appropriate reviewer: senior physician, other appropriate reviewer, behavioral healthcare reviewer or pharmacist reviewer. The Referral staff is responsible to document in the record that practitioners are provided the opportunity to discuss UM denial determinations with an appropriate reviewer. Contact information of the reviewing provider will be provided upon request for denial review discussion or a "peer to peer" discussion. This applies to non-BH, BH (Behavioral Healthcare), and Pharmacy reviews.

***Thank you for contracting with Gonzaba Medical Group!***