

# **PROVIDER MANUAL**

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## **Introduction**

Podiatry Network of Florida, Inc. (PNF) is a nonprofit IPA that contracts with established podiatric providers to provide high quality, cost-effective podiatric care to patients covered by managed health care plans. It is the goal of PNF to more than meet the needs of its customers: patients, payors, and participating providers.

This Provider Manual will supplement the terms of your Provider Participation Agreement (PPA). Your PPA sets forth the responsibilities of PNF and all Participating Providers and, therefore, should be reviewed by and kept handy for all providers and staff. It is important to remember that Participating Providers must comply with the terms of your PPA and the terms of PNF's contract with the associated payors.

Updates to your PPA and this Manual will be provided as necessary. If you have questions regarding either document, feel free to contact us at anytime.

## **Participating Providers**

Interested podiatric physicians must complete a PNF application, meet approved credentialing criteria, and sign a PNF PPA. By doing so, participating providers agree to cooperate and comply with the rules, regulations, policies, and procedures of PNF and the contracted payors.

PNF requires that providers be credentialed upon application, re-credentialed at least every 3 years, members of the American Podiatric Medical Association, and either Board Certified or Board Eligible with the American Board of Podiatric Surgery. Exceptions to these criteria may be made under extenuating circumstances. Please note that PNF contracted payors may have additional requirements.

Providers may participate in any number of PNF's contracts with payors. Participation depends on provider, PNF, and payor interest/need, and varies due to membership volume, locations, and particular needs. PNF evaluates their networks on an annual basis or at the request of a contracted payor and strives to offer a minimum of 2 providers in each county, a minimum of 1 provider in major population areas in each county, access to urban members within 30 minutes, access to rural members within 45 minutes, and access to providers who can meet the cultural needs (e.g., language) of members.

PNF will offer Participating Providers a specific Fee Schedule Exhibit to sign if they are selected for a payor. If the Exhibit is signed, PNF will provide specific contract, benefit, and procedure information prior to the effective date of the specific payor.

Participating Providers must make available all podiatric services and supplies normally done in their office which a member is entitled to receive pursuant to their plan benefits and meeting the definition of medical necessity.

### **Participating Provider Responsibilities**

In accordance with generally accepted professional standards, Participating Providers are required to:

1. Provide care and make sure their staff provides care within the scope of practice established by local, state, and federal rules and regulations.
2. Provide treatment to all members in need of podiatric services.
3. Refer members to other participating providers, except in the case of an emergency, when the services needed are outside the scope of their practice. An authorization from a member's PCP or health plan may be required depending on their benefit plan.
4. Prescribe generic drugs or drugs included on the payor's formulary, whenever available and appropriate.
5. Treat all member records confidentially, require appropriate consent for their release, and release them promptly.

6. Inform PNF immediately of any change in license, credential, or insurance that might affect ability to participate with PNF or its contracted payors.
7. Inform PNF as soon as possible of any change in demographic information.
8. Not bill, charge, collect a deposit from, seek compensation from, or have any recourse against members other than for copayments, coinsurance, deductibles, and non-covered services. Prior to rendering a non-covered service, Providers must obtain the member's informed written consent that includes their financial responsibility.
9. Obtain appropriate business, laboratory, and radiology licenses.
10. Maintain appropriate, safe equipment and office that meets all local, state, and federal rules and regulations.
11. Participate in all disease management, risk management, quality assurance, case management, and corrective action activities as requested by PNF or payor. PNF will take appropriate action when instances of non-cooperation and/or sub-optimal quality are identified.
12. Not discriminate for any reason including payor source, race, ethnicity, national origin, sex, sexual orientation, age, religion, place of residence, health status, mental or physical disability, claims experience, medical history, evidence of insurability, and genetic information.
13. Disclose ALL treatment options available.
14. Offer members access to after-hours care 24 hours a day, emergent care immediately (if medically indicated, refer to ER), urgent care within one day, and routine "sick" care within one week.

15. Utilize a Participating Provider to cover members when not available or obtain prior written approval from PNF to utilize an alternate provider as a covering physician. Covering physicians must meet PNF's credentialing criteria and agree to abide by all PNF, payor, and CMS rules and policies including payment for services.
16. Be the member's advocate and help them understand their rights and responsibilities.
17. Provide culturally and linguistically appropriate clinical and non-clinical services.

### **Participating Provider Appeals Procedure**

It is PNF's goal to meet the needs of all of its customers. Should they not be met, the complainant should contact PNF via phone, mail, fax, or email. They will gather and review documents and speak with appropriate parties as necessary. Once an appropriate response is determined, it is communicated in writing to all interested parties within 30 days. If the complainant is not satisfied, the situation is reviewed by the UM Committee. All grievance documentation is filed in the participating provider's file

If the complainant is not satisfied, the provider may appeal directly to the payor.

Providers with a claim issue(s) who have completed the entire payor appeal process have the right to request a review by the Florida Provider and Managed Care Organization Claim Dispute Resolution Program.

## **Member Eligibility**

Possession of a member identification card does not guarantee eligibility or coverage of services. Eligibility should be verified on all members, but know that eligibility may change retroactively.

## **Member Rights and Responsibilities**

Florida law requires that health care providers recognize member rights while receiving medical care and that members respect the health care provider's right to expect certain behavior on the part of patients. A summary of the Florida law follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.

- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

## **Member Appeals Procedure**

Participating Providers should try to resolve all issues directly with the member. If the member is not satisfied, the member (or provider on their behalf) can contact PNF with the specifics of the complaint. PNF will contact the appropriate parties to gather information and will work with PNF's UM Committee and the payor, as necessary, to determine the appropriate response. The response will be communicated in writing to all interested parties within 30 days. All appeal/grievance documentation is filed in the Participating Provider's file.

If the complainant is not satisfied, the member may appeal directly to their payor. Members who have completed the entire payor appeal process may consider filing a grievance with:

Subscriber Assistance Program  
Agency for Health Care Administration  
Bureau of Managed Care  
2727 Mahan Drive, Ft. Knox #1, Suite 339  
Tallahassee, FL 32308  
**1-888-419-3456**  
850/921-5458  
850/413-0900 Fax  
[spsap@ahca.myflorida.com](mailto:spsap@ahca.myflorida.com)

## **Claims Process**

Participating Providers should send their claims to PNF electronically. Please contact our office with questions about setting this up. If after contacting us, you are unable to do so and must mail your claims on a CMS 1500 form, send them to:

Podiatry Network of Florida  
2835 West DeLeon St., Suite 101  
Tampa, FL 33609

A separate claim for each date of service should be submitted. Claims must be received by the 15<sup>th</sup> of the month following the service month to be considered for payment. At the end of each service month, all claims are adjudicated and an Explanation of Benefits Report (EOB) is generated for each Participating Provider. Each Participating Provider's EOB and associated check is sent out by the 15<sup>th</sup> of the next month.

Patient eligibility, benefits, and, if appropriate, referrals/authorization are checked for each claim. The claims are then adjudicated according to established UM policies. These policies are established by the UM Committee and are based on current guidelines and standards of care from the American Medical Association, American Podiatric Medical Association, CMS, First Coast Service Options, Codingline, and many payors. The UM Committee reviews and approves changes as needed. Participating Providers

may request a copy of PNF's general adjudication guidelines and guidelines for accepted payors.

Claims will be pended if there are questions about the service(s) provided, their documentation, or their coding. Requests for additional information such as progress or operative notes are made via fax and/or telephone. Once the information is received and reviewed, the claim will be released and processed.

Claim appeals are due within 30 days after the claim appears on an EOB. Appeals will be handled according to the Participating Provider Appeals Procedure.

Remember, if a member is covered by more than one payor, primary responsibility should be determined and the claim should be sent to the primary payor first. If a balance remains, the original claim and a copy of that payor's EOB should be sent to PNF for them to consider reimbursement under the secondary plan.

Remember, patients may not be billed for:

1. The difference between actual charges and the amount reimbursed.
2. Services denied due to late filing or for lack of information.
3. Services requiring authorization that was not obtained.
4. Non-covered services when the member was not notified prior to.

