



November 30, 2007

Dear Provider:

In order to keep your Delaware Physicians Care, Inc. (DPCI) Provider Manual as up-to-date as possible, we will occasionally mail you packets of replacement pages. Enclosed please find current updates to the DPCI Provider Manual. The chart below provides detail on applicable sections affected by the current update as well as the page numbers you are asked to replace.

| Section Number | Replace the Following Pages | Explanation of Updates |
|---|------------------------------------|--|
| Section II | Page 8 | Replaced Access Standards for Members Grid with updated Grid |
| Section V – Primary Care Providers & Maternity Care | Page 29 | Updated Appointment Guidelines and Office Wait Times for PCP and Maternity Care providers |
| Section VI – Specialist Physicians | Pages 35-36 | Updated Appointment Guidelines and Office Wait Times for Specialist Physicians |
| Section VII – Referral Procedures | Pages 39-42 | Updated Referring and Receiving Provider’s Responsibilities, and Referrals to Maternity Care Professionals |
| Section XI – Behavioral Health Services & Benefits | Page 53 | Updated Appointment Guidelines and Office Wait Times for Behavioral Health providers |

The updated DPCI Provider Manual is also available on our website, www.DelawarePhysiciansCare.com. As always, do not hesitate to contact your Provider Relations Representative with questions. Thank you for your continued support and dedication to our members.

Sincerely,

Mike McGarrigle
 Director, Provider Relations

Access Standards for Members

| Appointment Standard | | | | | |
|--|---|---|--|---|---|
| Primary Care | Specialty Care | OB/GYN | Behavioral Health | EPSDT | SHCNs Foster Care |
| Emergency Services – Available twenty-four (24) hours a day, seven (7) days a week | Emergency Services – Immediate | Emergency Services – Immediate | Emergency Services – Within twenty-four (24) hours of request. Immediate treatment for a potentially suicidal individual | Early and Periodic Screening Diagnosis and Treatment (EPSDT) Screening – Available no more than two (2) weeks after the initial request | DFS Suspects Physical and/or Sexual Abuse – Within twenty-four (24) hours |
| Emergency Primary Care Provider (PCP) – Available same day | Urgent Care – Available within two (2) calendar days | Initial Prenatal Care – First Trimester – Within three (3) weeks of first request | Routine Care – Within seven (7) calendar days of request | Initial Visit for Newborns – Newborn physical exam | DFS – All Other Cases – Within five (5) days of notification that the child was removed from home |
| Urgent Care PCP – Available within two (2) calendar days | Routine Care – Available within three (3) weeks of member request | Initial Prenatal Care – Second Trimester – Within seven (7) calendar days of first request | Urgent Care – Available within two (2) calendar days | Preventive Pediatric Visit – According to the American Academy of Pediatrics periodicity schedule up to age twenty-one (21) | DFS – Child Access to Screening Tool – Within thirty (30) days of notification the child was removed from home; whenever possible should be completed within five (5) days time frame |
| Routine Care – Available within three (3) weeks of member request | After Hours – Available twenty-four (24) hours a day, seven (7) days a week | Initial Prenatal Care – Third Trimester – Within three (3) calendar days of first request | Non-Life Threatening Emergency – Available within six (6) hours | | |
| After Hours – Available twenty-four (24) hours a day, seven (7) days a week | | Initial Prenatal Care – High Risk – Pregnancies Within three (3) calendar days of identification of high risk | After Hours – Available twenty-four (24) hours a day, seven (7) days a week | | |
| Non-Life Threatening Emergency – Available within twenty four (24) hours | | Routine Care – Available within three (3) weeks of member request | | | |
| | | Urgent Care – Available within two (2) calendar days | | | |
| | | Non-Life Threatening Emergency – Available within twenty four (24) hours | | | |
| | | After Hours – Available twenty-four (24) hours a day, seven (7) days a week | | | |

DPCI engages in a program that observes appointment availability with provider. Random phone calls are placed to provider's offices requesting appointments to assume compliance with the guidelines as outlined in the manual.

- Have an office adequately equipped with equipment and supplies necessary to provide EPSDT services.
- Utilize clinical encounters to address EPSDT services to avoid missed opportunities and assess the immunization status of all children during each encounter.
- Report all EPSDT encounters on the required claim (CMS 1500) form using correct CPT/EPSDT/HCPCS codes.
- Abide by the DPCI pediatric and minimum medical record standards and practice according to the standards for pediatric immunization practices.
- Refer to DPCI -EPSDT Provider Reference Guide for details in providing quality care to all DPCI Members under twenty-one (21) years of age. (See Section 15).
- Participate in an annual review to assure compliance with DPCI medical record standards, pediatric standards and EPSDT program services, which includes chart reviews.
- Approximate immunizations if it is determined at the time of screening an immunization is needed. (See Appendix for immunization schedule).

Appointment guidelines and Office Wait Times

PCPs/Maternity Care Professionals are responsible for providing members with:

- Office visits during regular office hours
- Office visits, home visits or other appropriate visits during non-office hours as determined medically necessary, and
- Response to phone calls within a reasonable time, on a twenty-four (24) hours a day, seven (7) days per week basis.

PCPs/Maternity Care Professional should schedule or arrange time-specific appointments and referral appointments for members such that the request-to-appointment time meets the following guidelines:

- Emergency services are available twenty-four (24) hours a day, seven (7) days a week.
- Emergency services by Maternity Care Professional are available immediately.
- Emergency appointments are available the same day (e.g. high temperature persistent vomiting or diarrhea, symptoms which are of sudden or serve onset, but which do not require emergency room services.)
- Urgent care appointments are available within two (2) calendar days (e.g., persistent rash, recurring high-grade temperature, nonspecific pain, fever)
- Routine care appointments available within three (3) weeks of a member request (e.g., well-child exams, routine physical exams); (this does not apply to appointment for routine physical examinations or regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every three (3) weeks.
- A member's waiting time at the PCP's/Maternity Care Professional's office shall not exceed sixty (60) minutes, unless the member is late and/or the PCP is unavailable due to an emergency.
- After hours and non-life threatening emergency services are available twenty-four (24) hours a day, seven (7) days a week.

DPCI engages in a program that observes appointment availability with providers. Random phone calls are placed to provider's offices requesting appointments to assume compliance with the guidelines as outlined in this manual.

- PSP shall comply with federal regulations of the Occupational Safety and Health Administration including, with limitation, the regulations concerning Bloodborne Pathogens Standards at 29 C.F.R. Part 1910.1030, which became effective January 1, 1992.
- PSP is responsible for bringing referred members into compliance with medical treatment plans. DPCI will work with PSP to facilitate appointment scheduling.
- PSP shall comply with the Patient Self-Determination Act, which became effective December 1, 1991.
- PSP will abide by and follow DPCI's Policies, including quality management and utilization management.
- PSP shall identify and bill other third-party carriers or insurers first.
- PSP shall continue to provide services to a member transitioning to another provider and/or health plan until such time that member is safely transferred; cooperating with the receiving provider and/or health plan in transferring relevant records within ten (10) business days of the request.
- Members with disabling conditions or chronic illnesses may request that their primary care physicians be specialists.
- Providers must maintain compliance with Title II of the Americans with Disabilities Act.

Checklist for a Specialist Office Visit

When providing services to DPCI members, the following steps should be taken:

- Verify the member's enrollment via DPCI Member Solutions or web site prior to initiating services and before rendering subsequent services.
- Check the member's DPCI ID card each time the member presents for service and verify against secondary identification (with photo, if possible).
- Obtain Referral from Referring Physician. (See Section 8)
- Obtain Prior Authorization if required. (See Section 9) The authorization number should be indicated on the claim form. (See Section 13)
- Under federal law, DPCI is the payor of last resort. Identify and bill all appropriate third party payors first. (See Section 13)

Appointment Guidelines and Office Wait Times

PSPs are responsible for providing to members **(a)** office visits during regular office hours **(b)** office visits, home visits or other appropriate visits during non-office hours as determined medically necessary and **(c)** response to phone calls within thirty (30) minutes on a twenty-four (24) hour per day, seven (7) days per week basis.

PSPs should schedule or arrange time-specific appointments and referral appointments for members such that the request-to-appointment time meets the following guidelines:

- Urgent care available within two (2) calendar days.
- Routine care available within three (3) weeks of member request

- Emergency care on an immediate basis, at the nearest facility available, regardless of contracted arrangements.
- A member's waiting time at the PSP's office shall not exceed sixty (60) minutes, unless the Member is late and/or the PSP is unavailable due to an emergency.
- After hours are available twenty-four (24) hours a day, seven (7) days a week

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Referral Procedures

Types of Referrals

It may be necessary for a DPCI member to be referred to another provider for medically necessary services that are beyond the scope of the member's PCP. There are two types of referrals:

- Participating providers (particularly the member's PCP) may refer members for specific covered services to other health-care professionals or medical specialists, allied health-care professionals, medical facilities, or ancillary service providers.
- Members may self-refer to certain medical specialists for specific services if allowed under DMMA. (See Section 8)

Referral Process

Participating providers are expected to refer members to DPCI network providers if the required service is available within the network in the member's region. Except for certain services in which members may be referred to nonparticipating providers (such as family planning services), members should only be referred to out-of-network providers if the services required are not available within the DPCI network and if DPCI prior authorizes the referrals. Failure to comply with this policy may result in denial of reimbursement.

Referrals must meet the following conditions:

- The referral must be requested by a participating provider and be in accordance with the requirements of the member's benefit plan.
- The member must be enrolled in DPCI on the date(s) of service and eligible to receive the service.
- The service requested must be a covered benefit for the member.

Both referring and receiving providers must comply with DPCI policies, documents, and requirements that govern referrals (paper or electronic) including prior authorization, if applicable. (See Section 8 on prior authorization requirements related to referrals). Failure to comply may result in delay of a member's care, delay or denial of reimbursement or costs associated with the referral being charged to the referring provider.

Referrals are a means of communication between two providers servicing the same member. Although DPCI encourages the use of its referral form, it is recognized that some providers use telephone calls and other types of communication to coordinate the member's medical care. This is acceptable to DPCI, as long as the communication between providers is documented and maintained in the members' medical records.

Referring Provider's Responsibilities

It is the responsibility of the referring (primary or treating) provider to:

- Confirm that the required service is covered under the member's benefit plan.
- Confirm that the receiving provider is a network participant, if required.
- Obtain prior authorization, if required, for the needed service, specialty area, or nonparticipating provider.
- Complete a referral form and mail or fax the referral to the receiving provider, if applicable. (See Appendix for referral form.) Other means of communication is acceptable if kept and documented in the member's medical records.
- Refer pregnant members to a Maternity Care Professional, if applicable, immediately after confirming the pregnancy and send a copy of the referral to the DPCI Case Management Department.
- Monitor the progress of the member's care and see that the member is returned to the PCP's care as soon as medically appropriate.

Receiving Provider's Responsibilities

Providers may provide services to DPCI members upon receipt of a referral from the member's primary care or treating provider or at the request of DPCI. It is the receiving provider's responsibility to:

- Schedule and deliver the needed services in compliance with DPCI's requirements and standards governing frequency of visits and time frames, as follows:
 - Emergencies are to be seen on the same day as the referral
 - Urgent care appointments are to be seen within forty-eight (48) hours of the referral.
 - Routine care is to be scheduled within three (3) weeks of the referral.
- Verify that the member is enrolled and eligible on each date of service.
- Verify that the service is covered under the member's benefit plan.
- Verify that the referring provider has obtained the applicable prior authorization and include the Prior Authorization number on the claim when submitted for payment.
- Obtain prior authorization for any ancillary services or tests, procedures, or treatments provided beyond the initial consultation and two follow-up visits, unless specifically exempted by contract or other policy.
- Inform the referring provider of the consultation or service by sending a report and applicable medical records to allow the referring provider to continue the member's care.

Period of Referral

Unless otherwise stated in a participating provider's contract or DPCI documents a referral is valid for three (3) visits or sixty (60) days from the date it is signed and dated by the referring provider (if paper). This is contingent upon the member being enrolled on each date of service. Following are exceptions:

- Exceptions prior authorized by the Prior Authorization Department on a case-by-case basis
- Referrals for hematology/oncology continuing care, oncology radiation, and orthopedic continuing care (valid for 120 days)

- Referrals for obstetrical services (valid through delivery or termination of pregnancy plus 90 days of postpartum care)

Referrals to Maternity Care Professionals

Referrals to Maternity Care Health Professionals may occur in two ways:

- A pregnant DPCI member may self refer to any Maternity Care Health Professional within the DPCI network or
- Primary Care Physicians (PCPs) will refer pregnant members to a Maternity Care Health Professional within the network. The referral does not require Prior Authorization, however, a referral form must be completed and submitted to DPCI.

Maternity Health Care Professionals who provide care to members must provide copies of the completed Perinatal Care and Risk Assessment Form and a Smart Start Referral form (if applicable) to the Prior Authorization Department either by mail or fax to the following address:

Delaware Physicians Care, Inc. (DPCI)
Case Management Department
252 Chapman Rd, Suite 250
Newark, DE 19702
FAX: (302) 731-7369

Failure to provide the completed Perinatal Care and Risk Assessment form to the Prior Authorization Department will result in the denial of claims.

When the completed Perinatal Care and Risk Assessment form is received by DPCI, the Prior Authorization Department will assign a global authorization number and contact the Maternity Care Health Professional's office to provide the assigned number.

The completed Perinatal Care and Risk Assessment forms are forwarded to Perinatal Case Management for processing. All identified pregnant members are contacted and assessed by a Perinatal Case Manager. DPCI's Perinatal Case Management program supports the Maternity Health Care Professional's services and is linked closely with the Smart Start Program.

Maternity Health Care Professionals will:

- Coordinate the members maternity care needs until completion of the postpartum visits.
- Schedule a minimum of one (1) postpartum visit at approximately six weeks postpartum.
- Refer when necessary members to other health professionals in accordance with DPCI's Referral policies and procedures.
- Schedule return visits for members with uncomplicated pregnancies consistent with the American College of Obstetrics and Gynecology (ACOG) standards:
 - Through twenty-eight (28) weeks of gestation – every four weeks
 - Between twenty-nine (29) and thirty-six (36) weeks gestation – every two (2) weeks
 - After the thirty-sixth (36) week – once a week
 - High-risk pregnancies – according to the Member's individual need
- Schedule first-time appointments within the required time frames:
 - Members in first trimester – within seven (7) calendar days
 - Members in second trimester – within seven (7) calendar days

- Members in third trimester – within three (3) calendar days
- High-risk Members – within three (3) calendar days of identification or immediately if an emergency condition exists.

Ancillary Referrals

All providers are to utilize contracted Ancillary providers. (See Section 9).

Member Self-Referrals

Under the DMMA program, DPCI members are allowed to self-refer to participating providers for the following covered services:

- Family planning services (See Section 3)
- Women’s routine and preventive health cares services provided by a women’s health specialist within DPCI’s network.
- Behavioral Health services

Participating providers to whom a member self-refers are responsible for ensuring that all the requirements are met for a receiving provider as described above.

Prior Authorization Requirements related to Referrals

The following prior authorization requirements apply to referrals from a participating provider to other providers. Note that in certain cases, prior authorization may not be required for the initial referral, but is required for services or procedures provided by the receiving health-care professional or provider. For more in-depth information of prior authorization requirements, please see Section 9 and Section 11.

- Rendering services to members who are diagnosed as having human immunodeficiency virus (HIV) in the same manner and to the same extent as other members under the compensation terms set forth in your contract.
- Identifying and billing other third-party carriers or insurers first. DPCI has a third party liability (TPL) unit that will assist in verifying primary insurance. A provider relations representative can assist in contacting the TPL unit.
- Continuing to provide services to a member transitioning to another provider until such time that the member is safely transferred; cooperating with the receiving provider in transferring relevant records.

Appointment Guidelines and Office Wait Times

Behavioral health providers must be able to provide appointments as follows:

- Emergency within twenty-four (24) hours of request
- Routine within seven (7) calendar days of request
- Urgent Care within two (2) calendar days
- After Hours – available twenty-four (24) hours a day, seven (7) days a week
- Non-life Threatening Emergency – available within six (6) hours

Members with appointments must not routinely be made to wait longer than one hour, unless there is an emergency.

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Office Visit Checklist

When providing services to DPCI members, the following steps should be taken:

- 1) Verify the member's enrollment by contacting DPCI Member Solutions Department or by visiting the DMAP web site prior to initiating services and before rendering subsequent services.
- 2) Check the member's DPCI ID card each time the member presents for service and verify against secondary photo identification.
- 3) Verify that Prior Authorization has been obtained, if needed, prior to providing services. The authorization number should be indicated in the appropriate box on the submitted claim. (See Section 13 for billing procedures).
- 4) Bill all services provided to a DPCI Member on a HCFA-1500, UB92, or via electronic means (in an HIPAA compliant format). Refer to Section 13 for billing procedures.
- 5) Send all relevant medical information to the member's PCP.