



# **Provider Manual 2011/2012**

# WELCOME TO PALMETTO PHYSICIAN CONNECTIONS

Palmetto Physician Connections is a South Carolina Medical Home Network. Palmetto Physician Connections will execute a primary care case management program featuring a dedicated clinical focus on care coordination, case management and disease management for your Healthy Connections Program patients. Palmetto Physician Connections works to accomplish this goal by partnering with the primary care providers (PCP) who oversee the healthcare of Palmetto Physician Connections members. Palmetto Physician Connections will serve our members consistent with our core philosophy that quality healthcare is best delivered locally.

Simply stated, Palmetto Physician Connections stands ready to partner with providers to fully execute and deliver on care coordination to members and execute on the goals of the Medical Homes Network program, which are:

- 1) Accessible, comprehensive, family centered, coordinated care.
- 2) Provide a medical home with a primary care provider -
  - manage the patient's health care,
  - perform primary and preventive care services,
  - arrange for any additional needed care, and,
  - focus on the physician-patient relationship.
- 3) Patient access to a "live voice" 24 hours a day, 7 days a week to ensure appropriate care.
- 4) Patient education regarding preventive and primary health care, utilization of the medical home and appropriate use of the emergency room.

At Palmetto Physician Connections, we strive to provide our members with improved health status and outcomes. We strive to improve member and provider satisfaction in a medical home environment.

All of our programs, policies and procedures are designed with these goals in mind. We hope that you will assist Palmetto Physician Connections in reaching these goals and look forward to your active participation.

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## PALMETTO PHYSICIAN CONNECTIONS VALUES

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### **Relationships**

Members are the reason we are in the business of health care in a partnership with providers, government officials & leaders and community based stakeholders/organizations. Providers, government officials & leaders and community based stakeholders/organizations are our partners in the service to our members.

### **Respect**

All associates must act in good faith and show consistent levels of respect and demonstrate a high level of integrity that earns the trust of internal and external customers.

### **Responsibility**

All associates must act in good faith and be responsible for the commitments made to members, providers, government officials & leaders, community based stakeholders/organizations and fellow associates.

### **Results**

We must produce positive results and get things done for our members, providers, government officials & leaders and community and community based stakeholders/organizations.

## PALMETTO PHYSICIAN CONNECTIONS SUMMARY

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Based in Greenville, S.C., Palmetto Physician Connections is a patient centered **South Carolina Medical Home Network** (MHN) that executes primary care case management program featuring a dedicated clinical focus on care coordination, case management and disease management for South Carolina's Healthy Connections Choices beneficiaries.

The company utilizes an information system to manage and share comprehensive patient information among and between all participants along the patient care spectrum. The challenge for MHNs is consolidating data and transforming it into something that is meaningful to everyone involved in a patient's care -- this is what Palmetto Physician Connections does. It facilitates a proactive, collaborative approach that links care to nationally recognized best practices and tracks outcomes to established quality measures.

By enabling the collection, organization and sharing of actionable patient information in a format that is appropriate for each end user, Palmetto Physician Connections ensures that every participant in the program who interacts with a patient is connected to the data they need, when they need it. This is particularly important for rapid response when care gaps or status changes are identified.

Palmetto Physician Connections also realizes that eliminating administrative hassles for providers helps them focus on what they do best – providing optimum care to their patients and our members. Therefore we offer our providers:

- Shared Savings,
- Case Management Fee Per Member per Month,
- No network requirements for referrals,

- No additional prior authorization,
- No copayment for pregnant women, children under 19 years of age, for emergency services, institutionalized individuals, members receiving hospice, or members of a federally recognized Indian tribe Integrated case and disease management programs,
- Claims processed by the SC Dept. of Health and Human Services (SCDHHS)/SC Medicaid,
- Local, accessible and dedicated provider relations personnel, and,
- EFT/Direct Deposit.

Palmetto Physician Connections makes it possible for the healthcare system to move toward a patient-centric model like, where care is integrated across all participants, including primary care providers, hospitals, delegated vendors, pharmacists and payers.”

It is the policy of Palmetto Physician Connections to conduct its business affairs in accordance with the standards and rules of ethical business conduct and to abide by all applicable federal and state laws.

Palmetto Physician Connections takes the privacy and confidentiality of our members’ health information seriously. We have processes, policies and procedures to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and state privacy law requirements.

## **PALMETTO PHYSICIAN CONNECTIONS AT A GLANCE**

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For your ease, we have included this reference guide to assist you in the day-to-day operations of your office.

**PALMETTO PHYSICIAN CONNECTIONS**  
**531 South Main Street, Suite 307**  
**Grenville, South Carolina 29601**  
**Toll Free (888) 781-4371**  
**Fax (888) 781-4316**  
**info@palmettophysicianconnections.com**  
**www.palmettophysicianconnections.com**

<b>DEPARTMENT</b>	<b>TELEPHONE NUMBER</b>	<b>FAX NUMBER</b>
Member Services	(888) 781-4371 (888) 357-7188 (TDD/TTY)	(888) 781-4316
Case Management	(888) 781-4371 (888) 357-7188 (TDD/TTY)	(888) 781-4316
Nurse Response (24/7 Availability)	(888) 781-4371	N/A

# PROVIDER RESPONSIBILITIES

## **PRIMARY CARE PROVIDER (PCP)**

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The primary care provider (PCP) is the cornerstone of Palmetto Physician Connections. The PCP shall serve as the member's initial and most important point of interaction with Palmetto Physician Connections' provider network. The medical home concept assists in establishing a member-provider relationship, supports continuity of care, leads to elimination of redundant services and ultimately more cost effective care and better health outcomes.

The PCP responsibilities shall include, at a minimum:

- 1) Managing the medical and health care needs of members to assure that all medically necessary services are made available in a timely manner;
- 2) Monitoring and follow-up on care provided by other medical service providers for diagnosis and treatment, to include services available under Medicaid fee-for-service;
- 3) Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services that may be available through Medicaid fee-for-service; and
- 4) Maintaining a medical record of all services rendered by the PCP and other referral providers.

## **PCP AVAILABILITY**

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Availability is defined as the extent to which Palmetto Physician Connections contracts with the appropriate type and number of PCPs necessary to meet the needs of its members within defined geographical areas. Palmetto Physician Connections has implemented several processes to monitor its network for sufficient types and distribution of PCPs.

PCP availability is analyzed annually by the Palmetto Physician Connections' Provider Relations (PR) Department. At least annually, the PR department computes the percentage of PCPs with panels open for new members versus those PCPs accepting only members who are already-existing patients in their practice. The Member Services Department analyzes member surveys and member complaint data to address SCDHHS and federal requirements regarding the cultural, ethnic, racial, and linguistic needs of the membership. The Quality Improvement Department tracks and trends member and provider complaints quarterly and monitors other data (such as appointment availability audits, after hours use of the member hotline and member and provider satisfaction surveys) that may indicate the need to increase network capacity.

## **PCP ACCESSIBILITY**

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Accessibility is the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment, if applicable. The Plan monitors access to services by performing access audits, tracking applicable results of the Healthcare Effectiveness Data and Information Set/Consumer Assessment of Health Plans Survey (HEDIS/CAHPS), analyzing member complaints regarding access, and reviewing telephone access.

## 24-HOUR ACCESS

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Each PCP is responsible to maintain sufficient facilities and personnel to provide covered physician services and shall ensure that such services are available as needed twenty-four (24) hours a day, 365 days a year. PCPs must provide members with an after-hours telephone number. The after-hours number must connect the member to an answering service, a call center system, a recording that directs the caller to another number to reach the PCP or PCP-authorized medical practitioner, or a system that automatically transfers the call to another telephone line that is answered by a person who will contact the PCP.

A hospital may be used for the 24-hour telephone coverage requirement if the 24-hour access is not answered by the emergency department staff. The PCP must establish a communication and reporting system with the hospital and the PCP must review the results of all hospital-authorized services.

Palmetto Physician Connections will monitor physicians' offices through scheduled and unscheduled visits through our Provider Relations staff.

## APPOINTMENT ACCESS STANDARDS

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The following schedule should be followed regarding appointment availability:

- **Routine sick care** visits should be scheduled within 3 days of presentation or notification
- **Routine well care** visits should be scheduled within 45 days of presentation or notification (15 days if pregnant)
- **Urgent non-emergent** visits should be scheduled within forty-eight (48) hours
- **Urgent care** visits should be performed within 48 hours of presentation or notification at the delivery site
- **Emergency care** visits should be performed immediately upon presentation or notification at the delivery site

Palmetto Physician Connections will monitor appointment and after-hours availability on an ongoing basis through its Quality Improvement Program.

## OFFICE WAIT TIMES

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PCPs must adhere to the following standards for office wait times:

- Waiting times should not exceed forty-five (45) minutes for scheduled appointment of a routine nature.
- Walk-in patients with non-urgent needs should be seen within 2 hours if possible or scheduled for an appointment consistent with written scheduling procedures.

- Walk-in patients with a life-threatening emergency needs should be seen immediately upon presentation.

## **HOSPITAL ADMITTING PRIVILEGES**

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PCPs must establish and maintain hospital admitting privileges or enter into a formal arrangement with another physician or group practice for the management of inpatient hospital admissions of Palmetto Physician Connections members. This requirement must be met prior to the PCP providing medical services to members. An attestation must be signed by the PCP attesting that a formal arrangement exists. By signing the attestation, the physician/group agrees to accept responsibility for admitting and coordinating medical care for the member throughout the member's inpatient stay.

The following arrangement is acceptable:

- A physician, a group practice, a hospital group, a physician call group (not necessarily a MHN provider) that is enrolled with the South Carolina Medicaid program, and has
- Admitting privileges or formal arrangements at a hospital that is within 30 miles or 45 minutes drive time from the PCP's office. If there is no hospital which meets this geographic criteria, the closest hospital to the PCP practice is acceptable.
- Hospital admitting agreements with unassigned call doctors are unacceptable.
- Exceptions may be granted in cases where it is determined the benefits of a PCP's participation outweighs the PCP's inability to comply with the admitting privileges requirement.

## **REFERRALS AND AUTHORIZATIONS**

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Coordination of care is an essential component of the MHN. PCPs are contractually required to either provide medically necessary services or authorize a referral to another provider to evaluate and/or treat the member. If a member has failed to establish a medical record with the PCP, the

CSO, in conjunction with the PCP, should arrange for authorization on any existing referral (s). Referral authorization is the responsibility of the PCP/CSO, not SCDHHS. In some cases, the PCP may choose to authorize a referral retroactively. Some referrals do not require authorization. (Refer to the list of exempt services in this section). All referral authorizations and consultations, including referrals authorized retroactively, are at the discretion of the PCP. The process for referring a member to a specialist can be made by telephone or in writing. The referral should include:

- The number of visits being authorized
- The extent of the diagnostic evaluation.

If the PCP authorizes multiple visits for a course of treatment specific to the diagnosis, the specialist does not need to obtain additional authorizations for each treatment visit. The same authorization referral number may be used for each treatment visit. It is the PCP's responsibility to provide any further diagnosis, evaluation or treatment not identified in the scope of the original referral or to authorize additional referrals.

If the specialist receives authorization to evaluate and/or treat a member and then needs to refer the member to a second specialist for the same diagnosis, the member's PCP must be contacted

for referral authorization. Referral authorization is not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. However, the physician component for inpatient services does require referral authorization. The hospital should contact the PCP for authorization within 48 hours of the member's admission.

Specialist referrals for follow-up care after discharge from a hospital also require PCP authorization.

In addition to MHN authorization, prior approval (PA) may be required by SCDHHS to verify medical necessity before rendering some services. PA is for medical approval only. Obtaining referral authorization does not guarantee payment or ensure beneficiary eligibility on the date of service.

Claims submitted for reimbursement must include the **PCP's referral authorization Number**.

Referrals for the following services must be authorized by the PCP:

- 1) Inpatient hospital<sup>1</sup> services except newborn DRGs, Residential Treatment Facilities and Institutions for Mental Disease;
- 2) Outpatient hospital services except lab and x-ray<sup>2</sup>;
- 3) All other physician services except family planning services and services performed by an obstetrician and/or gynecologist; Podiatry and Chiropractic;
- 4) All services provided by Nurse Practitioners and Nurse Midwives except family planning services;
- 5) Services provided by DHEC Clinics except family planning and communicable diseases related services;
- 6) Services provided by Ambulatory Surgical Centers (except family planning services);
- 7) Services provided by FQHCs and RHCs except family planning services (unless the FQHC/RHC is the member's MHN PCP);
- 8) Home Health; and,
- 9) Durable Medical Equipment.

<sup>1</sup>FQHCs/RHCs that provide inpatient hospital services under a separate provider number (not the FQHC/RHC number) must enter a preauthorization number on the claim form or the claim will reject.

<sup>2</sup>FQHCs/RHCs that provide lab and x-ray services under a separate provider number (not the FQHC/RHC number) must enter a preauthorization number on the claim form or the claim will reject.

## **REFERRALS FOR A SECOND OPINION**

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MHN PCPs are required to refer a member for a second opinion, at the request of the member, when surgery is recommended.

## **REFERRALS INTO THE WOMEN, INFANTS, AND CHILDREN (WIC) PROGRAM**

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MHN PCPs are required to refer potentially eligible members to the WIC program.

## REFERRAL DOCUMENTATION

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All referrals must be documented in the member's medical record. The CSO and the PCPs should review the monthly referral data to ensure that services rendered to their members were authorized, have been documented and recorded accurately in the member's medical record. It is the PCP's responsibility to review the referral data validity, accuracy and report inappropriate/unauthorized referrals to the CSO. The CSO is responsible for investigating inappropriate/unauthorized referrals and notifying SCDHHS should Medicaid fraud or abuse be suspected.

## EXEMPT SERVICES

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Members may obtain the following from Medicaid providers without first obtaining referral authorization from their PCPs:

- Ambulance
- Dentistry, Pedodontics, Oral Surgery (Dental only)
- Dialysis/End Stage Renal Disease Services
- Emergency Room Services billed by the Hospital or EMTALA services billed by a hospital-based Urgent Care Clinic
- Family Planning Services
- Home and Community Based Waivers
- Independent Lab and X-ray<sup>1</sup>
- Medical Transportation
- Nursing Home
- Obstetrics and Gynecology
- Optician
- Optometry
- Pharmacy
- Medicaid services provided by state agencies, including: Department of Mental Health, Continuum of Care, Department of Alcohol and Other Drug Abuse Services, Department of Disabilities and Special Needs, Department of Juvenile Justice, Department of Social Services.
- Speech and Hearing Clinic services
- Developmental Evaluation Center services
- BabyNet services
- Children's Rehabilitative services
- Sickle Cell Anemia services
- Early Intervention services

<sup>1</sup> FQHCs/RHCs that provide lab and x-ray services under a separate provider number (not the FQHC/RHC number), must enter a preauthorization number on the claim form or the claim will reject.

Some services still require a prescription or doctor's order. Physicians should refer to the appropriate Medicaid Provider Manual for more detailed information and/or requirements or contact the SCDHHS Program Manager.

Some services may be sponsored by a state agency and require a referral from that agency's case manager. The state agency case manager should coordinate with the PCP and the Network Care Coordinator to insure continuity of care. These services include, but are not limited to, the following:

- Audiology
- High/Moderate Management Group Home services
- Occupational Therapy
- Physical Therapy
- Psychology
- Speech Therapy
- Therapeutic Foster Care

## **OBSTETRICAL REGISTRATION FORM**

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**Submit completed OB Registration Form (Attachment A) for expectant mothers within 5 days of first prenatal visit via fax at (888) 781-4316 or email at [Care@PalmettoPhysicianConnections.com](mailto:Care@PalmettoPhysicianConnections.com).**

## **PROVIDER TERMINATION**

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Providers should refer to their Palmetto Physician Connections contract for specific information about terminating provider agreement.

# **MEDICAL RECORDS**

## **MEDICAL RECORDS**

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Palmetto Physician Connections providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to members. They will also enable Palmetto Physician Connections to review the quality and appropriateness of the services rendered. To ensure the member's privacy, medical records should be kept in a secure location. Palmetto Physician Connections requires providers to maintain all records for members for at least ten years for adult patients and at least thirteen years for minors. See Member Rights section of this manual for policies on member access to medical records.

## **REQUIRED INFORMATION**

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Medical records means the complete, comprehensive member records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the

member's participating primary care physician or provider, that document all medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable SCDHHS rules and regulations, and signed by the medical professional rendering the services.

Providers must maintain complete medical records for members in accordance with the following standards:

- Member's name, and/or medical record number on all chart pages;
- Personal/biographical data is present (i.e. employer, home telephone number, spouse, next of kin, etc.);
- All entries must be legible;
- All entries must be dated and signed, or dictated by the provider rendering the care;
- Significant illnesses and/or medical conditions are documented on the problem list;
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA is documented;
- An up-to-date immunization record is established for pediatric members or an appropriate history is documented in adult members' charts;
- Evidence that preventive screening and services are offered in accordance with Palmetto Physician Connections' practice guidelines;
- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the history and physical;
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses;
- Working diagnosis is consistent with findings;
- Documented treatment prescribed, therapy prescribed and drug(s) administered or dispensed;
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns;
- Signed and dated required consent forms;
- Unresolved problems from previous visits are addressed in subsequent visits;
- Laboratory and other studies ordered as appropriate;
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the primary care provider (PCP) to signify review;
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere;
- Health teaching and/or counseling is documented;
- For members ten (10) years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for members seen three or more times, a substance abuse history should be queried);
- Documentation of failure to keep an appointment;
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed;

- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem;
- Confidentiality of member information and records protected;
- Evidence that an advance directive has been offered to adults 18 years of age and older;
- Pre-birth selection form.

## **MEDICAL RECORDS RELEASE**

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All member medical records shall be confidential and shall not be released without the written authorization of the covered person or a responsible covered person's legal guardian. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis.

Written authorization is required for the transmission of the medical record information of a current Palmetto Physician Connections member or former Palmetto Physician Connections member to any physician not connected with Palmetto Physician Connections.

## **MEDICAL RECORDS TRANSFER FOR NEW MEMBERS**

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All PCPs must transfer the member's medical record to the receiving provider upon the change of the member's PCP and as authorized by the member within 30 days of the date of the request.

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned Palmetto Physician Connections members. If the member or member's guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers then this should also be noted in the medical record.

# **PALMETTO PHYSICIAN CONNECTIONS CASE AND DISEASE MANAGEMENT**

## **CASE MANAGEMENT INTRODUCTION**

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Case Management at Palmetto Physician Connections is done in conjunction with the Disease Management program. Individuals not meeting the identified disease entities (i.e. Cardiovascular Disease, Diabetes, Asthma, HIV/AIDS and Cancer) are placed in the Case Management Program. Disease Management is a comprehensive, integrated approach to care and reimbursement based on a disease's natural course (population based, disease focused). The

*Case Management Society of America* defines Case Management as a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates options and services to

meet an individual's health needs through communications and available resources to promote quality, cost effective outcomes.”

Health care issues commonly placed in case management include but are not limited to:

- High Risk OB
- Children with Special Needs
- Sickle Cell Anemia
- Behavioral Health
- Chronic Debilitating Illnesses
- Transplants
- Renal Failure
- Spinal Cord Injuries

These diagnoses will be evaluated on an individual basis to identify the need for case management. Not all diagnosed patients will require case management. An expand program description of each disease state follows at the end of this section.

## **CASE MANAGEMENT PROGRAM**

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The goals of the Case Management Program are to:

- Facilitate the delivery of individualized, coordinated care
- Process ongoing or future service needs
- Empower our members
- Identify, assess, design, control and manage the care of our members to ensure optimum outcomes

## **COMPONENTS OF CASE MANAGEMENT**

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The identification and monitoring of members needing case management includes:

- Intake and Screening
- Assessment and Reassessment
- Care Plan Development
- Care Coordination of services
- Monitoring outcomes
- Ongoing Documentation/Communication

## **DISEASE MANAGEMENT INTRODUCTION**

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Disease Management at Palmetto Physician Connections is a program aimed at:

- Understanding the course of identified diseases
- Targeting members most likely to benefit from our interventions
- Cost containment
- Prevention
- Member education.

The goal of disease management is to identify a member's illness or condition to prevent the exacerbation of that disease and the corresponding need for high cost resources. Warren Todd, in his book Disease Management, A Systems Approach to Improving Patient Outcomes, defines disease management as a comprehensive, integrated approach to care and reimbursement based on a disease's natural course. In contrast to case management with its emphasis on individualized patient management, the impetus for disease management is a population-based, disease focused, preventative approach.

## **DISEASE MANAGEMENT STATES**

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At Palmetto Physician Connections, we have identified the following four disease states as the most prevalent to address in this population:

- Asthma/COPD
- Diabetes
- Cardiovascular Disease
- HIV/Oncology

Each disease state is managed by a licensed professional that is responsible for establishing, updating and maintaining their disease management program and identifying their population base. To assist our disease case managers in the managing of patients, we have developed applicable assessment tools, are utilizing extensive patient education literature, the most current clinical guidelines and are continually working to establish the necessary community and health care relationships. An expanded program description of each disease state follows at the end of this section.

## **DISEASE MANAGEMENT PROGRAM**

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Our program aims to identify individuals at risk or suffering from specific disease states and stratify them by severity of illness or their health risk. Once identified, members are evaluated to assess their specific needs and deficits. There are four (4) acuity levels that a member may be placed in depending on the severity of illness:

- Level I – Member is receiving preventative services, member is functioning independently.
- Level II – Member is receiving home health care services, continuous or special order DME, or requiring consistent monitoring of needs.
- Level III – Member is in an inpatient setting, high-cost, high utilization of resources, and/or noncompliant.
- Level IV – Catastrophic use of resources, multiple admission, multiple use of emergency services, and/or noncompliant.

The assessment tools used are disease specific so Disease Managers can readily identify what a member will need. Clinical guidelines from the Agency for Healthcare Research and Quality's National Guideline Clearinghouse and the Evidenced Based Medicine Resource Center will be adopted to ensure that members are doing all the necessary things to keep them at an optimum level of health. Clinical guidelines adopted by Palmetto Physician Connections include but are not limited to:

- *Asthma*
- *Cholesterol*
- *Hypertension*
- *Obesity*
- *HIV*

The Disease Management program strives to ensure that there is open team dialogue between the Disease Manager, patient, Primary Care Physician, and Specialist (as needed). This collaborative relationship helps the patient to take an active part in their care and allows the other team members to assist the patient to participate in care plan development and compliance.

The members move through a continuum of care and can be discharged from disease management. Members can be discharged for the following reasons:

- Member is disenrolled
- No response from the member after multiple phone and outreach attempts
- Member expired
- Criteria not met for placement in the program
- Goals met and no further targets are needed
- Member declines services
- Member is non-compliant after exhausting all avenues.

We have developed outcome measures to evaluate our program and measure the effects of our disease management. Outcome measures are under development for each disease state managed. Some examples of outcome measures are:

- Hospital Admission/ Readmissions
- Medication Compliance
- Emergency Room Visits
- Blood Pressure Screening
- Annual Eye Examination
- Annual Podiatry Examination
- Annual Physical Examination
- Annual Dental Examination
- Annual Lipid Profile
- Semi-annual CD4 count
- Semi-annual HBA1c
- Compliance with the Care Plan
- Verbalizes Understanding of Disease Condition
- Appropriate DME in the Home
- Verbalizes Understanding of DME usage

To track these outcomes and patient encounters, the Disease/Management Database is utilized.

## **CASE AND DISEASE MANAGEMENT PROCESS**

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**Submit completed Disease/Case Management Request form (Attachment B) via fax at (888) 781-4316 or email at Care@PalmettoPhysicianConnections.com for any of your Palmetto Physician Connections that you would like to be enrolled into a case or disease management program.**

### **Referrals to Case or Disease Management**

Case Managers will act on the receipt of all appropriate external and internal referrals to the Case Management Program. Referrals for case management can be made directly to the Medical Management Department via telephone or the Case Management Referral Form.

Internal referrals may be received from:

- Providers
- Nurse Advice Line
- Palmetto Physician Connections Members
- Outreach Department
- Utilization Review Nurses
- Quality Management Department
- Customer Services

External referrals may be received from:

- Primary Care Providers
- Provider Specialists
- Social Workers
- Community Organizations
- Hospital
- Outpatient Clinics
- Government Agencies

### **Admission to Case or Diseases Management**

***Once the member has been accepted into the Case or Disease Management Program, the Case Manager will:***

- Verify member eligibility
- Determine if the member has been a part of case management previously, if not, create a new chart
- Enter member data into Case Management database.
- Determine current medical status through medical record review, PCP, therapist, or skilled nursing assessment.
- Contact member/member representative (parent, guardian, etc.).

- Obtain verbal permission to be entered into case management and document consent/refusal in chart.
- Complete case management assessment.
- Identify problem areas or needs.
- Determine how the case management team can manage the case to improve outcomes in cost and quality of care.

## **PREVENTIVE AND CLINICAL PRACTICE GUIDELINES**

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The Care Management staff at Palmetto Physician Connections will apply the National Guideline Clearinghouse™ (NGC) evidence-based clinical practice guidelines criteria. Online access to guidelines is at <http://www.guideline.gov/index.aspx>. The NGC guidelines will be used in efforts to execute on case and disease management and will also be used in decisions to limit or reduce referrals.

The Medical Director may refer cases to peer reviewers or other physician specialist to assist in decision-making process.

All requests not meeting NGC criteria, or when criteria do not exist for that category of services, will be referred to the Medical Director for review

Palmetto Physician Connections will have the link to the National Guidelines Clearinghouse (NGC) website on its company website in efforts for providers to access the guidelines or providers can go directly to the NGC site at <http://www.guideline.gov/index.aspx>.

# **ROUTINE, URGENT AND EMERGENCY SERVICES**

## **ROUTINE, URGENT AND EMERGENCY CARE SERVICES DEFINED**

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Members are encouraged to contact their PCP prior to seeking care, although it is not required in an emergency.

The following are definitions for **routine**, **urgent**, and **emergency services**.

**Routine** - Services to treat a condition that would have no adverse effects if not treated within twenty-four (24) hours or could be treated in a less acute setting (e.g., physician's office) or by the patient. Examples include treatment of a cold, flu, or mild sprain.

**Urgent** - Services furnished to treat a medical condition that requires attention within forty eight (48) hours. If the condition is left untreated for 48 hours or more, it could develop into an emergency condition.

**Emergency\* Medical Condition** - An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy or serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Services area covers inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services under this title; and (2) needed to evaluate or stabilize an emergency medical condition.

An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms.

\*Emergency Care is not subject to prior authorization or pre-certification. Urgent care provided in an urgent care facility **does** require authorization. Emergency Services must be provided by a qualified Provider regardless of network participation. The PCP plays a major role in educating Palmetto Physician Connection members about appropriate and inappropriate use of hospital emergency rooms. The PCP is responsible to follow up on members who receive emergency care from other providers.

## ELIGIBILITY AND ENROLLMENT

### ELIGIBILITY FOR THE PALMETTO PHYSICIAN CONNECTIONS PROGRAM

The State of South Carolina has the sole responsibility for determining eligibility for Medicaid for all coverage groups except for Supplemental Security Income (SSI). The Social Security Administration (SSA) determines eligibility for SSI.

### VERIFYING ELIGIBILITY

Providers are responsible for verifying eligibility every time a member schedules an appointment, and when they arrive for services. PCPs should also verify that a member is their assigned member.

**Call 1-888-781-4371 to reach Member Services for eligibility verification**

**Or check online at:**

**<https://webclaims.scmehcaid.com/>**  
**(Must have provider login and password from SCDHHS)**

## **ENROLLMENT/MARKETING GUIDELINES FOR PALMETTO PHYSICIAN CONNECTIONS PROVIDERS**

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Palmetto Physician Connections' contract with SCDHHS defines how the MHN and its providers market and advertise the program. Accordingly, providers may not include any reference to their affiliation with SCDHHS or Palmetto Physician Connections, in their marketing or advertising without prior approval from Palmetto Physician Connections and SCDHHS. SCDHHS requires providers to submit to Palmetto Physician Connections samples of any marketing materials they intend to distribute, and to obtain state approval prior to distribution or display. Palmetto Physician Connections Provider Relations staff will submit these materials to SCDHHS within five (5) business days of receipt, and will send providers written notice of approval or of any changes required by SCDHHS within five (5) business days of receiving notice from SCDHHS

Palmetto Physician Connections Provider Relations staff will give an overview of the marketing plan to all network physicians and their staff and present them with the SCDHHS MHN Policy and Procedure Guidelines on General Marketing and Enrollment. This will define what a provider may or may not do in regards to marketing to our members.

Provider communication tools will include brochures, directories, booklets, handbooks, newsletters, letters and videos. Some specific examples of the tools Palmetto Physician Connections might use include:

- Provider orientation meetings/town hall meetings
- Provider newsletters
- Provider manual
- Provider directory
- Informational letters, flyers and other mailings
- Interactive Web portal

## **NON-COMPLIANT ENROLLEES**

### **NON-COMPLIANT ENROLLEES**

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There may be instances when a PCP feels that a member should be removed from his or her panel. A PCP may request a member be transferred to another practice for any of the following reasons:

- Repeated disregard of medical advice
- Repeated disregard of member responsibilities
- Personality conflicts between physician and/or staff with member

Examples of reasons that a PCP may request to remove a member from their panel could include, but not be limited to:

A member is disruptive, unruly, threatening, or uncooperative to the extent that the member seriously impairs the provider's ability to provide services to the member or to other members and the member's behavior is not caused by a physical or behavioral condition.

All requests to remove a member from a panel must be made in writing, contain detailed documentation and must be directed to:

**Palmetto Physician Connections**  
**Attention: Customer Service Manager**  
**531 South Main Street, Suite 307**  
**Greenville, SC 29601**

Upon receipt of such request, Member Services may:

- Interview the provider or their staff that are requesting the disenrollment, as well as any additional relevant providers
- Interview the member
- Review any relevant medical records
- Involve other Palmetto Physician Connections departments as appropriate to resolve the issue

A PCP should **never** request a member be disenrolled for any of the following reasons:

- Adverse change in the members health status or utilization of services which are medically necessary for the treatment of a member's condition
- On the basis of the member's race, color, national origin, sex, age, disability, political or religion

## **NURSE RESPONSE<sup>®</sup>**

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Our members have many questions about their health, their primary care provider and access to emergency care. Our health plan offers a nurse line service to encourage members to talk with their physician and to promote education and preventive care.

Nurse Response is our 24-hour nurse line for members. The registered nurses provide basic health education, nurse triage and answer questions about urgent or emergency access, all day long. The staff often answers questions about pregnancy and newborn care. In addition, members with chronic problems, like asthma or diabetes, are referred to case management for education and encouragement to improve their health.

Members may use Nurse Response to request information about providers and services available in your community after the health plan is closed. Providers can use it to verify eligibility any time of the day. The Nurse Response staff is conversant in both English and Spanish and can offer the Language Line for additional translation services. The nurses document their calls in a web-based data system

We provide this service to support your practice and offer our members access to an RN every day. If you have any additional questions, please call Care Management or Nurse Response at 1-888-781-4371.

## NON-EMERGENCY TRANSPORTATION SERVICES

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Palmetto Physician Connections members may need transportation to or from a Medicaid covered service to receive medically necessary care. Non-emergency transportation is only available to eligible recipients who cannot obtain transportation on their own through other available means, such as family, friends or community resources.

South Carolina Medicaid Transportation program provides non-emergency transportation for members. If a member needs to schedule a ride for non-emergency reason, the member is to call SCDHHS Call Center at 1-888-549-0820 to find out which transportation broker (Logisticare or MTM) services their county. They will schedule the ride for the member. The member can also call the Member Services Department at 1-888-781-4371 if they are having difficulty scheduling their ride for a medical appointment. Member Services can assist the member in contacting the transportation broker to arrange transportation.

## EPSDT

### SOUTH CAROLINA EPSDT SERVICES AND STANDARDS

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The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, is a program of comprehensive preventive health services available to Palmetto Physician Connections recipients through the month of their 21<sup>st</sup> birthday. The program is designed to maintain health by providing early intervention to discover and treat health problems. EPSDT is a preventive program that combines diagnostic screening and medically necessary follow-up care for dental, vision and hearing examinations for eligible members.

EPSDT services include:

- Outreach and informing
- Screening in accordance with the SCDHHS periodicity schedule
- Tracking compliance with EPSDT requirements
- Diagnostic and treatment services

Standards for providing EPSDT services are described and are included in the state MHN Policies and Procedures Manual.

**PCPs are required to perform EPSDT medical check-ups in their entirety and at the required intervals.** All components of exams must be documented and included in the medical record of each EPSDT eligible member. Initial well-child exams are to be completed within ninety (90) days of the initial effective date of membership and within twenty-four (24) hours of birth for all newborns.

The components of these visits are as follows:

- *Comprehensive health and developmental history* -- (including assessment of both physical and mental health development);
- *Comprehensive unclothed physical exam;*

- *Appropriate immunizations* -- (according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines);
- *Laboratory tests* -- including blood level assessments appropriate for age and risk factors;
- *Anticipatory Guidance/Health Education* -- Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and/or dental screening provides the initial context for providing health education. Health education and counseling to both parents (or guardians) and children is required and is designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention;
- *Vision Screening* – Vision should be assessed at each screening. In infants, the history and subjective findings of the ability to regard and reach for objects, the ability to demonstrate an appropriate social smile, and to have age appropriate interaction with the examiner is sufficient. At ages four and above, objective measurement using the age-appropriate Snellen Chart, Goodlite Test, or Titmus Test should be done and recorded. If needed, a referral should be made to an ophthalmologist or optometrist;
- *Dental Screening* – A general assessment of the dental condition (teeth and/or gums) is obtained on all children, including fluoride treatments. As indicated and beginning at age 2 years old a referral should be made to a dentist;
- *Hearing Screening* – A hearing test is required appropriate to the child's age and educational level. For the child under age four, hearing is determined by whatever method is normally used by a provider, including, but not limited to, a hearing kit. For the child over age four, an audiometer, if available is recommended. If needed, an appropriate referral should be made to a specialist. It is recommended that high-risk neonates be evaluated with objective measures, such as brain stem evoked response testing, prior to discharge from the hospital nursery;
- *Other Necessary Healthcare* – States must provide other necessary healthcare, diagnosis services, treatment, and other measures described in section 1905(a) of the Social Security Act to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services.

**Periodic Screening** - EPDST beneficiaries are eligible to receive 20 screenings in 21 years of life. Screening ranges are determined according to age of the child and, in some circumstances, when last screened. The following is a general guide for the ranges in which screenings should occur (refer also to **Attachment \_ EPSDT Periodicity Schedule**):

- Neonatal exam (identified from hospital claim and not billable as an EPSDT screening)
- Birth to 1 month
- 1 month through 2 months
- 3 months through 4 months
- 5 months through 7 months
- 8 months through 11 months
- 12 months through 14 months
- 15 months through 17 months
- 18 months through 20 months
- 21 months through 24 months (when the child passes age 2, another screening is not due until age 3)
- 3 years through month of 21<sup>st</sup> birthday (screenings are recommended annually)

Note: The codes for reporting screening services for new and established patients are as follows:

- 99381 - New Patient under one year
- 99382 - New Patient (ages 1-4 years)

- 99383 - New Patient (ages 5-11 years)
- 99384 - New Patient (ages 12-17 years)
- 99385 - New Patient (ages 18-39 years)
- 99391 - Established patient under one year
- 99392 - Established patient (ages 1-4 years)
- 99393 - Established patient (ages 5-11 years)
- 99394 - Established patient (ages 12-17 years)
- 99395 - Established patient (ages 18-39 years)
- 99431 - Newborn care (history and examination)
- 99432 - Normal newborn care

Screenings for children 17 years and under should be billed with Diagnosis code V20.2 and for children 18-21 V70.0

Preventive health is a major principal on which managed care organizations are based, *measured and held accountable*. Palmetto Physician Connections supports its PCPs to encourage their Palmetto Physician Connections patients to participate in the State of South Carolina preventive care program, EPSDT. Palmetto Physician Connections will send reminders of the need for a well-child examination to all EPSDT eligible members. For newborns, parents/guardians will receive a letter explaining the EPSDT schedule through 2 years old. For the child's second birthday, an EPSDT reminder postcard will be sent advising of the two suggested exams before the child turns three. For ages 3 through 20, reminders will be sent annually based on the month of the birth. Providers must demonstrate compliance with the EPSDT periodicity schedule and screening requirements (including blood lead screening) for at least 80% of their eligible members, in accordance with the methodology prescribed by the Centers for Medicare and Medicaid Services.

## **IMMUNIZATIONS**

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Children must be immunized during medical checkups according to the EPSDT Routine Immunization Schedule by age and immunizing agent.

Palmetto Physician Connections encourages all members under the age of 18 to be immunized by their PCP unless medically contraindicated or against parental religious beliefs. Providers shall report all immunizations to the State Immunization Information System (SIIS) administered by the South Carolina Department of Health and Environmental Control (DHEC), effective with the implementation of SIIS.

Since immunizations are a required component of EPSDT screening services, an assessment of the child's immunization status should be made at each screening and immunizations administered as appropriate. If the child is due for an immunization, it must be administered at the time of the screening. However, if illness precludes immunization, the reason for delay should be documented in the child's record. An appointment should be given to return for administration of immunization at a later date.

Immunization of children should be provided according to the guidelines recommended by the Department of Health and Environmental Control (DHEC), the Centers for Disease Control (CDC), the Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics, and South Carolina State Law.

PCPs should participate with the Vaccine for Children Program (VFC). If a provider does not routinely administer immunizations as part of his/her practice, they should refer the child to the county health department but must maintain a current record of the child's immunization status.

## BLOOD LEAD SCREENING

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Palmetto Physician Connections EPSDT guidelines include Blood Lead Level Screenings for children from the ages of nine months through 72 months. A Lead Screening Questionnaire should be completed at the time of each routine office visit for children in this age group.

All Medicaid children are considered at increased risk for having elevated blood lead levels (BLLs). A blood lead test must be used when screening Medicaid-eligible children. An elevated BLL is considered anything  $\geq 10$  ug/dl. A blood lead test result equal to or greater than 10 ug/dl obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample. According to CMS policy, all Medicaid children require a screening blood lead test at 12 and 24 months of age. Children between the ages of 36 and 72 months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning.

## BILLING AND CLAIMS

### GENERAL BILLING GUIDELINES

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Services provided under the MHN program are all paid on a FFS basis. As such, all claims are submitted to and processed by SCDHHS. Benefits offered in the MHN program mirror those offered in FFS with the following exceptions:

- All beneficiaries, regardless of age, receive unlimited ambulatory visits
- No copayment for pregnant women, children under 19 years of age, for emergency services, institutionalized individuals, members receiving hospice, or members of a federally recognized Indian tribe.

For additional information concerning core services and limitations, please refer to the MHN Policy and Procedures manual, or provider manuals for the applicable area (Physicians, Hospitals, etc.)

For claims inquiries, payment issues and general billing questions, please call the SC Medicaid Provider Service Center at 1-888-289-0709.

## QUALITY IMPROVEMENT

### QUALITY IMPROVEMENT PROGRAM

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Palmetto Physician Connections has designed a provider centric system and quality-based program for the support of the provider network and the monitoring and evaluation of proper quality and utilization of services. This program is the Quality Improvement Plan (QIP) and is also designed to comply with applicable quality standards, including those of the Centers for Medicare and Medicaid Services' (CMS) *Quality Improvement System for Managed Care (Q/SMC)*, and the need and requirements of Federal and State authorities that conduct oversight.

The purpose of the QIP is to develop a systematic process to monitor and evaluate provider service utilization and progress on the Medical Homes Network program. In addition, the QIP will identify quality indicators, monitor, measure, evaluate, and then provide a quantitative basis for continuous improvement of outcomes and the care process through which these outcomes are achieved.

The QIP seeks to define the quality of services by assessing the following components deemed integral to the quality of all healthcare services:

- Appropriateness and Necessity of Services
- Access to and Availability of Care
- Timeliness of Service
- Case and Disease Management
- Utilization Management / Use of Services
- Health Education for Members
- Preventative Services
- Health Care System Stability
- Prudent Management of Healthcare Resources
- Member and Provider Satisfaction

## **QUALITY IMPROVEMENT PROGRAM STRUCTURE**

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To ensure continuity of operations within Palmetto Physician Connections and ensure the execution of the QIP, the following guidelines apply:

- The President's appointment by the Board of Directors will be reflected in the Board of Director's proceeding and minutes
- The Board of Directors will be apprised of the absences of the President in writing and the temporary appointment of a designee as the acting President for Palmetto Physician Connections.
- The Medical Director shall be licensed in South Carolina. Through participation as chairman of the Quality Management and its subcommittees, the Medical Director will demonstrate active participation in the development of related policies and procedures.
- In the absence of the Medical Director, a duly licensed physician, authorized to practice in South Carolina will be designated in writing to fulfill the role and obligations of the Medical Director with the approval of the President and the Board of Directors.
- The Quality Management Committee and all subordinate committees will perform under the supervision of the Medical Director.

## **QUALITY IMPROVEMENT PROGRAM GOALS AND OBJECTIVES**

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- To provide and maintain the highest standard and quality of healthcare.
- To assure compliance with all local, federal, and contractual regulations.
- To continuously identify new areas for improvement of the delivery of healthcare and services for our members.

- To assess the impact of Case and Disease Management and health education on the quality of life for our members as well as sound resource management practices for Palmetto Physician Connections.
- To ensure that the quality of care and healthcare services provided meets professionally recognized standards of practice.
- To promote the advancement of quality management and delivery of services through continued analysis, education, and resource management.
- To provide a systematic approach for monitoring the appropriateness of the delivery of care so as to ensure that the healthcare provided results in optimal outcomes for the members of Palmetto Physician Connections.
- To assess the medical necessity of all care as well as ensuring optimal utilization practices.
- To evaluate and ensure significant community, consumer, and provider confidence and satisfaction.
- To communicate the results of our quality activities with the employees and providers of Palmetto Physician Connections.
- To assess the impact of wellness programs and preventative care on the prevention of disease and resource management.
- To identify member specific needs, taking into consideration unique demographics, assessed special and cultural needs, and preference.
- To evaluate and improve accessibility and timeliness of all care and services provided to Palmetto Physician Connections members.

## **QUALITY IMPROVEMENT PROGRAM SCOPE**

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The Quality Improvement Program is integrated into clinical and non-clinical services involved with care for Palmetto Physician Connections patients. The QIP will assess the impact of Case and Disease Management and health education on the quality of life for our members as well as sound resource management practices for Palmetto Physician Connections patients, health care providers and affiliated providers. The program is designed to monitor, evaluate, and continually improve all care and services delivered by Palmetto Physician Connections providers. These services include:

- Primary Care Services
- Specialist Physicians
- Advanced Practice Nurses
- Pharmacy Services
- Home Health Services
- EPSDT
- Pregnancy Related services (all family planning, prenatal, perinatal and postpartum care)
- Case Management Services
- Diabetes Care Services
- Dental Services for Adults

- Dental Services for Children
- Inpatient Hospital Services
- Outpatient Hospital Services
- Diagnostic Testing
- Laboratory Testing
- Nursing Facility Services
- Outpatient Rehabilitation Services
- Inpatient Rehabilitation Services
- Dialysis
- Blood and Blood Products
- Mental Health Services
- Substance Abuse Services
- Emergency Services
- Services for speech, language, and hearing for children less than 21 years old
- Oral Surgery
- Health Education Programs
- Transportation Services (non-emergency and emergency)
- Podiatry Services
- Vision Services
- Day Treatment Services
- Personal Care Services
- Durable Medical Equipment (DME)
- Disposable Medical Supplies (DMS)
- Hospice Services
- Cosmetic Surgery (when determined to be medically necessary)
- Long Term Care Services
- Transplants

## **PRACTITIONER INVOLVEMENT**

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Palmetto Physician Connections recognizes the integral role practitioner involvement plays in the success of its quality improvement program. Practitioner involvement in various levels of the process is highly encouraged through provider representation. Palmetto Physician Connections encourages PCP, Behavioral Health, Pediatrics, OB/GYN representation on key quality committees and select ad-hoc committees.

## **HEALTH CARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)**

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HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of the SCDHHS contract. SCDHHS holds Palmetto Physician Connections accountable for the timeliness and quality of healthcare services (acute, preventive, mental health, etc) delivered to its diverse membership.

HEDIS consists of 20+ Effectiveness of Care type measures as well as Access to Care and Use of Services measures for which the health plan contractually reports rates to the State of South Carolina based on claims and/or medical record review data.

As both the State and Federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider as well. State purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a Health Insurance Company's ability to demonstrate an improvement in Preventive Health outreach to its members. Physician specific scores are being used as evidence of preventive care from primary care office practices. The rates then serve as a basis for physician incentive programs such as 'pay for performance' and 'quality bonus funds'. These programs pay providers an increased premium based on scoring of such quality indicators used in HEDIS.

#### **How are HEDIS rates calculated?**

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim or encounter data submitted to the health plan. Measures typically calculated using administrative data include: annual mammogram, annual Chlamydia screening, annual Pap test, treatment of pharyngitis, treatment of URI, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data reduces the necessity of medical record review. Measures typically requiring medical record review include: comprehensive diabetes care, control of high-blood pressure, immunizations, prenatal care, and well-child care.

#### **What can be done to improve my HEDIS scores?**

Understand the specifications established for each HEDIS measure.

Submit claim/encounter data for each and every service rendered. All providers must bill (or report by encounter submission) for services delivered, regardless of contract status. Claim/encounter data is the most clean and efficient way to report HEDIS. If services are not billed or not billed accurately they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation. Chart documentation must reflect the services provided.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact Palmetto Physician Connections' Quality Improvement Department at 1-888-781-4371.

## **CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS) SURVEY**

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This is a member satisfaction survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to members by an NCQA certified survey vendor. The adult CAHPS survey provides information on the experiences of Medicaid members with the MHN services and gives a general indication of how well the MHN meets members' expectations. Global rating questions reflecting overall satisfaction include rating of personal doctor and rating of specialist seen most often. Composite scores summarize responses in key areas such as getting care quickly, getting needed care, how well doctors communicate, and shared decision making. The child CAHPS survey looks at the same global and composite areas

but provides information on parents' experience with Palmetto Physician Connections services. Member responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability.

## **PROVIDER SATISFACTION SURVEY**

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Palmetto Physician Connections conducts an annual provider satisfaction survey which includes questions to evaluate provider satisfaction with our services such as claims, communications, utilization management, and provider services. The survey is conducted by an external vendor. Participants are randomly selected by the vendor, meeting specific requirements outlined by Palmetto Physician Connections, and the participants are kept anonymous. We encourage you to respond timely to the survey as the results of the survey are analyzed and used as a basis for forming provider related quality improvement initiatives.

## **AUTHORITY AND RESPONSIBILITY**

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The Palmetto Physician Connections Compliance Officer has overall responsibility and authority for carrying out the provisions of the compliance program.

Palmetto Physician Connections is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

The Palmetto Physician Connections provider network must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.

These are the primary agencies to which incidents or practices of abuse and/or fraud are to be reported:

**PALMETTO PHYSICIAN CONNECTIONS**  
**Attention: Manager, Compliance**  
**531 South Main Street, Suite 307**  
**Greenville, SC 29601**  
**1-888-781-4371**

**SCDHHS**  
**Department of Fraud**  
**P.O. Box 8206**  
**Columbia, SC 29202-8206**  
**1-888-364-3224**

# MEMBER SERVICES

## MEMBER SERVICES

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Palmetto Physician Connections is committed to providing its members with information about the health benefits that are available to them through the Palmetto Physician Connections program. Palmetto Physician Connections encourages members to take responsibility for their healthcare by providing basic information to assist with making decisions about their healthcare choices. Other functions of the member services department:

- Provide additional information about Palmetto Physician Connections providers,
- Facilitate referrals to providers; and
- Assist in the resolution of service and/or medical delivery concerns or problems.

Palmetto Physician Connections has developed targeted programs to address the needs of its members. Members receive specific disease management bulletins and treatment updates, appointment reminder cards, and informational mailings.

As a provider for Palmetto Physician Connections, please remember that it is your obligation to identify any member who requires translation or interpretation language services. Palmetto Physician Connections will pay for these services whenever you need them to effectively communicate with a Palmetto Physician Connections member. Palmetto Physician Connections

members are not to be held liable for these services. To arrange for any of the above services, please call the Palmetto Physician Connections Member Services Department at:

**1-888-781-4371**

## MEMBER MATERIALS

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Members will receive various pieces of information from Palmetto Physician Connections through mailings and through face-to-face contact. The Member Handbook is printed in English and Spanish and can be requested in other languages identified by the state. These materials include:

- Quarterly Newsletters
- Targeted Case and Disease Management Brochures
- Provider Directory
- Nurse Response Information
- Emergency Room Information
- Member Handbook which includes:
  - Member rights and responsibilities

Providers interested in receiving any of these materials may contact:

**Member Services Department**  
**1-888-781-4371**  
**Fax 1-888-781-4316**  
**TDD/TTY 1-888-357-7188**  
[www.palmettophysicianconnections.com](http://www.palmettophysicianconnections.com)

## **MEMBER RIGHTS & RESPONSIBILITIES**

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Members are informed of their rights and responsibilities through the Member Handbook. Palmetto Physician Connections providers are also expected to respect and honor member's rights.

Palmetto Physician Connections members have the following rights and responsibilities:

- ◆ To be treated with respect and dignity at all times
- ◆ To have your privacy protected.
- ◆ To take part in decisions about your health care.
- ◆ To refuse treatment.
- ◆ Restraint or seclusion will not be used as a way to force or punish you or for the convenience of any provider.
- ◆ To ask for and get a copy of your medical records.
- ◆ To ask that they be changed or corrected if you find a mistake.
- ◆ To receive health care services that are easy to get and do what they are supposed to do.
- ◆ To receive services that are right for you.
- ◆ To not be denied services just because of diagnosis, type of illness, or medical condition.
- ◆ To get information in a way that you can easily understand.
- ◆ To get help from both SCDHHS and your doctor in understanding your health plan.
- ◆ To get oral interpretation services free of charge if you don't speak English.
- ◆ To be told that oral interpretation is available and how to get those services.
- ◆ To get information on the program's services, to include, but not limited to:
  - ✓ Benefits and how to get them.
  - ✓ Authorization requirements.
  - ✓ Any co-pays.
  - ✓ Service area.
  - ✓ Information on doctors that speak a language other than English.
  - ✓ Any limits on your freedom to choose a doctor.
  - ✓ Doctors not taking new patients.
  - ✓ Benefits not offered and how to get them.
- ◆ To get a copy of your disenrollment rights at least once a year.
- ◆ To be told about any big changes in your Benefits.
- ◆ To get information on the Grievance, Appeal and Fair Hearing procedures.
- ◆ To get information on emergency and after-hours coverage, to include, but not limited to:
  - ✓ What emergency medical condition, emergency services, and post-stabilization services are.
  - ✓ That Emergency Services do not need prior authorization.
  - ✓ How to get Emergency services.
  - ✓ Where to go for emergency services.
  - ✓ Your right to use any hospital or other setting for emergency care.

- ✓ Post-stabilization care services rules.
- ◆ To get the **MEDICAL HOMES** policy on referrals for services not provided by your doctor.
- ◆ To exercise these rights without fear of being treated differently.

## **MEMBER GRIEVANCES**

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A **grievance** is an expression of dissatisfaction about any matter other than an “action” with any aspect of Palmetto Physician Connections or a provider’s operation.

Examples:

- Quality of care issues
- Rudeness of a provider or employee
- Failure to respect the member’s rights

Who has the authority to file?

- A member or member’s authorized representative
- A provider, acting on behalf of the member and if the state permits the provider to act as the member’s authorized representative in doing so.

Grievances may be filed either orally or in writing with Palmetto Physician Connections. Palmetto Physician Connections will notify the member or authorized representative that the grievance has been received in writing within 10 business days of receipt of the grievance. Members or their authorized representative may file a grievance by contacting Member Services at 1-888-781-4371 or fax 1-888-781-4372 or by submitting written notification to:

**Palmetto Physician Connections  
Appeals/Grievances Coordinator  
531 South Main Street, Suite 307  
Greenville, SC 29601**

Palmetto Physician Connections will respond to all issues raised by members as soon as possible but at least within **sixty (60) calendar days** of receipt of the grievance. Should Palmetto Physician Connections (with approval of SCDHHS) or the member request additional time to resolve the grievance, Palmetto Physician Connections will extend the resolution timeframe to 14 additional calendar days for resolution of the grievance.

## **APPEALS**

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An appeal is the request for review of an “action”. An “action” is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service; the failure to provide services in a timely manner. The review may be requested in writing or orally, however oral requests for appeals within the standard timeframe must be confirmed in writing within 30 days of the date of the Notice of Action, unless the member or the provider requests expedited resolution. Members may request that Palmetto Physician Connections review the Notice of Action to verify if the right decision has been made.

Who may file an Appeal?

- Palmetto Physician Connections members
- Authorized representative of an Palmetto Physician Connections member
- Provider acting on behalf of member

Requests for an Appeal must be made within **ninety (90) calendar days** from the date of the Notice of Proposed Action. Under certain circumstances, members have the right to request, within 10 days of the date of the Notice of Action, that benefits be continued while an appeal is pending. Palmetto Physician Connections will send a written decision within **thirty (30) calendar days** after the request for an appeal is received by Palmetto Physician Connections, subject to an authorized extension of up to 14 days.

## **EXPEDITED RESOLUTION OF APPEALS**

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If a decision on an appeal is required immediately due to the member's health needs which cannot wait with the standard resolution time, an expedited appeal may be requested. Palmetto Physician Connections' decision on the expedited resolution will be provided within **72 hours** of receipt of the request for the review.

## **CONTINUATION OF BENEFITS**

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Palmetto Physician Connections members may continue receiving services or items until a decision is made about his/her grievance, appeal or fair hearing process if the member was receiving ongoing services that were suspended, reduced or terminated.

Palmetto Physician Connections must continue the member's benefits if:

- The member or the provider files the appeal timely
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- The services were ordered by an authorized provider

## **ASSISTANCE AND CONTACTING PALMETTO PHYSICIAN CONNECTIONS**

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Palmetto Physician Connections' Appeals and Grievance Coordinator is available to assist members who need help in filing a grievance or request for appeal or in completing any element in the grievance or appeal process. Members may seek assistance or initiate a grievance or request for appeal by calling 1-888-781-4371 (or TDD/TTY 1-888-357-7188).

## **MEMBERS RIGHT TO STATE FAIR HEARING**

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If the member has exhausted the Palmetto Physician Connections level appeal procedures, the member may request a State Fair hearing within 30 days from the date of the notice of resolution.

A member or member's authorized representative may request in writing a State Fair Hearing within thirty (30) calendar days of the date the Notice of Adverse Action is mailed by Palmetto Physician Connections. The parties to the State Fair Hearing shall include Palmetto Physician Connections as well as the member, Member's Authorized Representative, or representative of a deceased member's estate. A provider can, with written consent from the member, request a State Fair Hearing on behalf of a member. The request for the State Fair Hearing should be mailed to:

**South Carolina Department of Health and Human Services  
Division of Appeals and Hearings  
P.O. Box 8206  
Columbia, SC 29202-8206  
1-803-898-2600**

## **INTERPRETER/TRANSLATION SERVICES**

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Palmetto Physician Connections is committed to ensuring that staff and subcontractors are educated about, remain aware of, and are sensitive to the linguistic needs and cultural differences of its members. In order to meet this need, Palmetto Physician Connections is committed to the following:

- Providing Language Line services that will be available twenty-four (24) hours a day, seven (7) days a week in 140 languages to assist providers and members in communicating with each other when there are no other translators available for the language
- Providing TDD/TTY access for members who are hearing impaired through 1-888-357-7188.
- Palmetto Physician Connections medical advice line, Nurse Response, provides 24 hour access, seven days a week for interpretation of Spanish or the coordination of non-English/Spanish needs via the Language Line
- Providing or making available Member Services and Health Education materials in alternative formats as needed to meet the needs of the members, such as language translation; all alternative methods must be requested by the member or designee

Providers must call Member Services at 1-888-781-4371 if interpreter services are needed. Please have the member's ID number; date/time service is requested and any other documentation that would assist in scheduling interpreter services.

## **PROVIDER RELATIONS ASSISTANCE**

### **PROVIDER RELATIONS DEPARTMENT**

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The Provider Relations Department at Palmetto Physician Connections is designed around the concept of making your experience with Palmetto Physician Connections a positive one by being your advocate within Palmetto Physician Connections. Provider Relations is responsible for providing the services listed below which include but are not limited to:

- Contracting
- Maintenance of existing Palmetto Physician Connections Provider Manual
- Eligibility distribution
- Development of alternative reimbursement strategies
- MPPM and shared savings updates/status

- Network performance profiling
- Individual physician performance profiling
- Physician and office staff orientation
- Ongoing provider education, updates, and training

The goal of this department is to furnish you and your staff with the necessary tools to provide the highest quality of healthcare to Palmetto Physician Connections enrolled membership. To contact the provider relations specialist for your area contact:

**Provider Relations Department  
1-888-781-4371**

Provider Relations staff is available to you and your staff to answer questions, listen to your concerns, assist with members, and respond to your Palmetto Physician Connections inquiries.

## PHARMACY

### COVERED PHARMACY SERVICES

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Prescription drug benefits are managed and administered through SCDHHS.

#### **Monthly Prescription Limit Override Criteria for Adult Beneficiaries**

Pharmacists may utilize an override code to exceed the monthly prescription limit for adult Medicaid beneficiaries if the prescription limit override criteria are met. A total of three overrides per beneficiary per month is allowed.

Pharmacists should submit the prescription limit override code, a **“5” in the Prior Auth Type Code (PATC) field, if all of the following criteria are met.** Adult Medicaid beneficiaries are entitled to four prescriptions per month and up to three overrides for prescriptions that meet the following criteria. Pharmacists should submit the prescription limit override code on the claim if:

1. The monthly prescription limit has been met, and
2. The adult patient has one of the following conditions, and
3. The prescription is for an essential drug used in the adult patient’s treatment plan for one of these conditions:

- Acute sickle cell disease
- Behavioral health disorder
- Cancer
- Cardiac disease (including hyperlipidemia)
- Diabetes
- End stage lung disease
- End stage renal disease (ESRD)
- HIV/AIDS
- Hypertension
- Life-threatening illness (not otherwise specified)
- Organ transplant
- Terminal stage of an illness

*“If a pharmacist is uncertain as to the appropriateness of a prescription limit override for a particular medication, the pharmacist should contact the prescriber to obtain additional clinical information so that an informed Medicaid coverage decision may be made”.*

# Attachments

Attachment A – Obstetrical Registration Form

Attachment B – Disease/Case Management Request Form

Attachment C – WIC Referral Form

Attachment D – Medical Record Release

Attachment E – Complaint Form

Attachment F – Member Primary Care Provider Transfer

Attachment A – Obstetrical Registration Form



**Obstetrical Registration Form** (please fax or email)

**Instructions**

1. Complete the demographics section.
2. Complete the clinical/social section. Check the trimester a condition or risk identified by the provider office (an unchecked box indicates that the risk was not identified).
3. Fax or Email to Care Management Dept at **(888) 781-4316** or **care@PalmettoPhysicianConnections.com**

531 South Main Street, Suite 307  
Greenville, SC 29601

Phone: (888)781-4371 Fax: (888) 781-4316

Member/Enrollee Name (First, Middle, Last)		Provider Name (First, Last)	
Date of Birth	Member/Enrollee ID#	NPI or Provider Number	
Home Phone	Alternate Phone	Phone # Fax #	
Language Spoke			
Date of 1st Prenatal Visit	Gestational age wks	Gravida	Para TAB Live Births
EDC	Hospital/Birthing Center for Delivery		

Past OB Complications	Current Risk Factors	Trimester			Current Risk Factors	Trimester		
		1st	2nd	3rd		1st	2nd	3rd
Gestational Diabetes <input type="checkbox"/>	2 <sup>nd</sup> /3 <sup>rd</sup> trimester bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia Hb <10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incompetent cervix <input type="checkbox"/>	Abnormal placenta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIUGR <input type="checkbox"/>	Gestational diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preeclampsia/Eclampsia <input type="checkbox"/>	Missed Prenatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Premature ROM <input type="checkbox"/>	Perinatal depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Clotting disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preterm delivery <32 wks <input type="checkbox"/>	Oral problems: _____ Dental visit past 6 mos? Y <input type="checkbox"/> or <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preterm delivery 32-36 wks <input type="checkbox"/>	Weight gain Poor <input type="checkbox"/> Excessi <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preterm labor <32 wks <input type="checkbox"/>	Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obese BMI>30,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous C-Section <input type="checkbox"/>	Premature ROM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Overweight BMI>25,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prior fetal loss (1 <sup>st</sup> )(2 <sup>nd</sup> )(3 <sup>rd</sup> ) <input type="checkbox"/>	Preterm dilation of cervix (>1.5cm)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Underweight BMI<19	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infant or child death <input type="checkbox"/>	or Preterm Labor <32 weeks)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Renal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Previous delivery within 1 year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	STI _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Preeclampsia/Eclampsia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Cessation Services Offered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Domestic violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Street / Rx drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	History of chronic depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Current Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Depression screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other medical issues:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Housing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Teen pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	List Referrals Made by Provider			
	Head of Household Aware	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	WIC Y <input type="checkbox"/> N <input type="checkbox"/>			
	Transportation problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Others:			
	Other risks:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			

Attachment B – Disease/Case Management Request Form



531 South Main Street, Suite 307  
Greenville, SC 29601

Phone: (888)781-4371 Fax: (888) 781-4316

## Disease/Case Management Request

### Instructions

1. Complete the demographics section.
2. Complete the clinical section.
3. Fax or Email to Care Management Dept at -  
(888) 781-4316 or care@PalmettoPhysicianConnections.com

*The Care Management Department depends on referrals to Disease/Case Management (DM/CM) in order to enroll members into the DM/CM program. A referral may be made by any physician, a family member, facility/hospital, Palmetto Physician Connections employee, vendor, etc. The Request form should be completed in its entirety and submitted to Care Management Dept. The Disease/Case Manager will assess the member for DM/CM needs within the specified guidelines.*

**Please Fax or Email to the Palmetto Physician Connections Care Management Dept. at -  
(888) 781-4316 or care@PalmettoPhysicianConnections.com**

Member Name: \_\_\_\_\_

Member ID: \_\_\_\_\_

Member DOB: \_\_\_\_\_

Date of Referral: \_\_\_\_\_

Member Address \_\_\_\_\_

Member Phone Number \_\_\_\_\_

Reason for Referral/Clinical information: \_\_\_\_\_

B/P: \_\_\_\_/\_\_\_\_ HR \_\_\_\_ Glucose: \_\_\_\_ Peak flow: \_\_\_\_ HbA1C: \_\_\_\_

LABS: \_\_\_\_\_

Other (include medications): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Referred to (please check CM/DM program requested):

- |  |  |   |
|--|--|---|
| Asthma <input type="checkbox"/>          | Diabetes <input type="checkbox"/>                      | Cardiovascular <input type="checkbox"/> |
| OB/High Risk OB <input type="checkbox"/> | HIV/AIDS <input type="checkbox"/>                      | Oncology <input type="checkbox"/>       |
| Special Needs <input type="checkbox"/>   | Mental Health/Substance Abuse <input type="checkbox"/> |   |
| Other <input type="checkbox"/>           | _____  |   |

Referred By: (Department/Provider/Vendor Name)

\_\_\_\_\_

Contact information (fax/phone):

\_\_\_\_\_

Do you require feedback after Disease/Case Management Assessment?  
YES  NO

Attachment C – WIC Referral Form

**WIC REFERRAL FORM**

**PL103-448, §204(e) requires States using managed care arrangements to serve their Medicaid beneficiaries to coordinate their WIC and Medicaid Programs. This coordination should include the referral of potentially eligible women, infants, and children and the provision of medical information to the WIC Program. To help facilitate the information exchange process, please complete this form and send it to the address listed below. Thank you for your cooperation.**

**Name of Person being referred:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

The following classifications describe the populations served by the WIC program. Please check the category that most appropriately describes the person being referred:

- \_\_\_\_\_ Pregnant woman
- \_\_\_\_\_ Woman who is breast feeding her infant(s) up to one year postpartum
- \_\_\_\_\_ Woman who is non-breast feeding up to six months postpartum
- \_\_\_\_\_ Infant (age 0-1)
- \_\_\_\_\_ Child under age 5

States may consider using this space to either include specific medical information or to indicate that such information can be provided if requested by the WIC Program.

**Provider's Name:** \_\_\_\_\_

**Provider's Phone:** \_\_\_\_\_

I, the undersigned, give permission for my provider to give the WIC Program any required medical information.

\_\_\_\_\_  
(Signature of the patient being referred or, in the case of children and infants, signature and printed name of the parent/guardian)

**Send completed form to:**

WIC Program Contact  
Address  
Phone Number

Please go to <http://www.scdhec.gov/health/mch/wic/map.htm> for the WIC Program Contact name, address and phone number for the Regional WIC site in your area.

**MEDICAL RECORD RELEASE**

I, the undersigned, give permission for my provider, acting on my behalf, to refer my name for WIC services and to release necessary medical record information to the WIC agency.

**Signature** \_\_\_\_\_  
*(Signature of patient being referred or, in case of children and infants, the signature and printed name of the parent/guardian)*

**Date** \_\_\_\_\_



# SC MHN COMPLAINT FORM

(page 2)

Palmetto Physician Connections staff reviews all complaints that come to our office. We take each complaint seriously and have a process in place for addressing each one. It is not necessary for us to use your name when investigating a complaint. However, it is more effective to have your name when describing the concern to the provider. Therefore, we have included a place to sign your name on this form that will let us use your name when investigating your complaint. **Please do not sign both statements.**

**1. If you agree to allow us to use your name in investigating this complaint, please sign the following:**

I give the SC MHN Managed Care staff permission to use my name when sharing my complaint with the Primary Care Provider (PCP) named in my complaint. The PCP has my permission to respond to the SCMHN staff concerning my complaint and release medical records regarding the patient when necessary.

\_\_\_\_\_  
Signature of Complainant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient/Parent/Legal Guardian

\_\_\_\_\_  
Date of Birth

**OR**

**2. If you would like your name to remain confidential and you do not want us to use your name in the investigation of this complaint, please sign below:**

\_\_\_\_\_  
Signature of Complainant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient/Parent/Legal Guardian

\_\_\_\_\_  
Date of Birth

If you have any questions regarding the use of this form or the MHN Complaint Process, please contact the Palmetto Physician Connections office at Toll-free (888) 781-4371. Thank you for giving us this opportunity to serve you better.

**Please Do Not Write Below This Line**

MHN PCP Name: \_\_\_\_\_ MHN PCP#: \_\_\_\_\_

MHN Practice Name: \_\_\_\_\_ Location: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

Attachment F – Member Primary Care Provider Transfer



## Member Primary Care Provider Transfer

*(please fax or email)*

### Instructions

1. For Provider Use Only
2. Please complete form and provide documentation to support your request to transfer PCP.
3. Fax or Email to the Palmetto Physician Connections Member Services Department at:  
**(888) 781-4316** or **info@PalmettoPhysicianConnections.com**

531 South Main Street, Suite 307

Greenville, South Carolina 29601

Phone: (888)781-4371 Fax: (888) 781-4316

The member is enrolled with the following practice: \_\_\_\_\_

The member(s) listed are to be transferred to Primary Care Provider: \_\_\_\_\_

List reason for transfer: \_\_\_\_\_

PRINT NAME OF EACH FAMILY MEMBER TO BE TRANSFERRED	DOB	MEDICAID NUMBER	IS MEMBER AWARE OF TRANSFER?

Family Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone number: (\_\_\_\_) \_\_\_\_\_

Member Signature: \_\_\_\_\_ (MEMBER MUST SIGN IF PRESENT)

Provider Name: \_\_\_\_\_ Medicaid Provider number: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Title: \_\_\_\_\_

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_