PROVIDER MANUAL

Physicians Group of Texas

PGT Medical Group Inc. is an affiliate of Kelsey-Seybold Clinic. This PGT Provider Manual is an extension of your Provider Agreement and a reference tool that provides information on the guidelines and procedures applicable to our contractual relationship. The manual can be used as a day-to-day reference for answering questions and solving problems and as a training tool for new employees. Many of these same principles are also included in your Provider Agreement. Periodic updates will be available by referring to our website at www.kelsey-seybold.com. If, at any time, you have a question or concern about the information outlined in this Section of the Provider Manual, you can reach our Provider Relations Department by calling 713-442-9528.

Updated August 2025

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Physicians Group of Texas

INTRODUCTION AND ONBOARDING

CONTACT INFORMATION

Department	Responsible for the following inquiries:
Provider Services **713-442-5440** 866-535-8343 – Toll Free	• Member Eligibility and Benefits • Referrals and Authorizations • Claims and Reconsiderations / Appeals
Provider Relations **713-442-9528** 713-442-2775 – Fax affiliateproviders@kelsey-seybold.com	• Contract related inquiries • Notifications regarding demographic and practice changes • Resolving high level issues
Utilization Management **713-442-5339** 713-442-3648 – STAT Line 713-442-5333 – Fax	• Review and issuing all authorization referral requests • Case Management / Disease Management Programs
Credentialing kelseycredentialing@kelsey-seybold.com or networkcredentialing@kelsey-seybold.com	• Maintain credentialing and re-credentialing information • Credentialing application status

KELSEY-SEYBOLD CLINIC (KSC)

PGT Medical Group, Inc., a Kelsey-Seybold Medical Group, PLLC affiliate and accepts contractual health care insurance risk for contracted providers servicing identified patient populations.

PROVIDER MANUAL

The PGT Medical Group, Inc. (PGT) Provider Manual is an extension of your Provider Agreement and a reference tool that provides information on the guidelines and procedures applicable to our contractual relationship. The manual can be used as a day-to-day reference for answering questions and solving problems and as a training tool for new employees. Many of these same principles are also included in your Provider Agreement. Periodic updates will be available by referring to our website at www.kelsey-seybold.com.

As per your PGT Provider Agreement, all Providers are to comply with Centers for Medicare & Medicaid Services (CMS) and health plan policies and procedures, including, but not limited to, those listed herein, as applicable. Please refer to the applicable **health plan provider manual** for specific policies and procedures. Any requirements under applicable law, regulation or governmental agency guidance that are not expressly set forth in this manual shall be incorporated herein by this reference and shall apply to Providers where applicable. Providers are responsible for complying with all

applicable state and federal laws and regulations. **Please be aware that existing Provider contracts may supersede some policies stated in this manual.**

CREDENTIALING

All Providers go through a credentialing process to ensure that the PGT credentialing criteria are met. Initial credentialing may include but is not limited to a written application, education, training, verification of licensure or certification from primary sources, disciplinary status, eligibility for payment under Medicare, if applicable, and site visits as appropriate. As a provider being credentialed by PGT, you have the right during the credentialing process to review the information collected during the process, to correct erroneous information obtained during the process as well as the right to be informed of the status of the application, upon request. Providers must notify PGT if a new provider is added and/or is no longer with the practice. Notices can be emailed to: affiliateproviders@kelsey-seybold.com.

Every Provider will be re-credentialed no later than thirty-six (36) months from the initial credentialing or re-credentialing date in accordance with CMS guidelines and health plan policy. The credentialing process updates information obtained during initial credentialing, considers performance indicators such as those collected through quality improvement programs, utilization management systems, handling of grievances and appeals, enrollee satisfaction surveys, and other plan activities, and includes an attestation of the correctness and completeness of the new information. Non-compliance with a recredentialing request can result in termination and/or suspension of the provider agreement.

If a Provider renews any licenses, certifications, or accreditations between the Credentialing cycle, this information must be forwarded to the Group or the applicable Credentialing department.

Term and Termination: Please refer to your PGT agreement for information specific to terminations.

Please note that referrals cannot officially be made until the credentialing process is complete.

PROVIDER PORTAL

Kelsey-Seybold's Provider Portal is Kelsey CareLink. Kelsey CareLink is the "user-friendly" web- based application that provides secure and easy access to real-time patient information.

All Providers are required to utilize the Kelsey CareLink secure provider portal to check eligibility/coverage, claim status and referral status.

Direct Login Link - Kelsey CareLink **Login**
Kelsey CareLink Info Page - Kelsey CareLink
Find A Claim (no login required) – Find A Claim Kelsey CareLink
Verify Eligibility (no login required) - Verify Eligibility Kelsey CareLink

Kelsey CareLink Highlights:

- Ability to check the status of eligibility, claims and/or referrals/authorizations
- Help Guide which provides detailed instructions
- User Access Request Form
- Enroll in Provider EFT/ERA payments (ECHO)

Obtain access by completing the **Access Request Form** for the designated user(s). As part of the terms and conditions of usage, users must not share their User ID and/or password to ensure compliance with HIPAA guidelines.

- Cell phone numbers are required for two-factor authentications, as well as a 4-digit PIN (any numbers)
- For assistance with Kelsey CareLink login issues, contact the Kelsey IT Help Desk at (713) 442-4357

PROVIDER ADDS / TERMS / UPDATES

In order for PGT and its delegated entities to maintain accurate participating Provider directories and for reimbursement purposes, all changes to address or other practice information should be reported in writing at least 30 days prior to effective date of change but no later than 10 days after change to PGT.

Changes that require notice to PGT may include, but are not limited to, the following:

- **Tax Identification Number (TIN)***
- Address
- Telephone or Fax number
- Practice name
- Limitations to practice or services offered not previously reported
- **Adding a Provider – Provider joining practice/group****
- **New (additional) locations*****
- Provider deletions – Provider no longer participating with the practice/group
- Medicare numbers

* Changes in Tax ID numbers may require an amendment or new contract depending on the reason for the change. Please contact a Provider Relations representative.

** If adding a physician or other health care Provider, the new physician/Provider must first be credentialed before rendering treatment to any Member.

*** New locations are subject to the Group's credentialing policies. Providing this information in writing in a timely manner facilitates credentialing and inclusion in respective Provider Directories.

CHANGING PANELS

A Provider may desire to change their panel status (i.e., open to new patients, open to existing Members only or close). Such requests must be submitted in writing to the PGT, Inc at least sixty (60) days prior to the effective date indicating the reason for the request. The Provider shall continue to serve current Members during the sixty (60) day notice period. Approval is at the discretion of PGT, and the Provider will be notified in writing of the decision. To re-open their panel, the physician must notify PGT in writing.

Please send notices of Adds / Terms / Updates to:

Preferred notification method via email to: affiliateproviders@kelsey-seybold.com	If mailing the notice, send to: Provider Relations 11511 Shadow Creek Parkway Pearland, TX 77584

PROVIDER STANDARDS

Requirements apply to each Provider and are part of the contractual requirements and must be upheld for the duration of the agreement. Each Provider's office must:

1. Have visible sign and title listing the names of all providers practicing in the office.
2. Have all areas accessible to all members, including, but not limited to, its entrance, parking lot and bathroom.
3. Have a clean, properly equipped, and accessible patient toilet and hand-washing facility.
4. Have a waiting room sufficient to accommodate members.
5. Have at least two examining rooms that are clean, properly equipped, and private.
6. Require a medical assistant to attend sensitive examinations (for example, gynecological exams), unless member declines assistant's presence. A person of the same sex as the member, if available, will be provided upon request.
7. If immunization services are offered, follow the vaccine safety and refrigeration guidelines in the U.S. Centers for Disease Control (CDC) Vaccine Storage and Handling Toolkit.
8. Have an infection control and prevention program that operates in accordance with nationally recognized standards (e.g., CDC). The program should include provisions to report unexpected events and to have regular staff training on appropriate hand hygiene and injection safety protocols.
9. Keep controlled substances in locked cabinets.
10. Have appropriate protocol immediately available to treat medical emergencies. Must have documented medical emergency procedures addressing treatment, transportation, and disaster evacuation plans for member's safety.
11. Follow ADA guidance on accessibility of your office; the method you or your staff use to communicate with members with disabilities; and training of your staff to learn and implement these guidelines.

HIPAA PRIVACY REGULATIONS

All PGT policies and procedures include information to enable PGT complies with the Health Insurance Portability and Accountability Act (HIPAA) regulations and the Gramm-Leach-Bliley Act. You will make individual medical records available to patients or their legally designated representative upon request and at no cost. **PGT requires that physicians provide access to medical records when requested as part of Quality Improvement, Credentialing, or other health plan activities.** In addition, you will abide by all Federal and State laws regarding confidentiality and disclosure of medical records or other health and enrollment information.

PGT employees are required to understand their responsibilities under these privacy regulations. Throughout its departments, PGT has incorporated measures to make sure potential, current and former Members' protected health information (PHI), patient identifiable health information (PII), and personally identifiable financial information are maintained in a confidential manner, whether that information is in oral, written, or electronic format. PGT employees may use and disclose this information only for those purposes permitted by federal legislation (for treatment, payment, and health care operations); by the Member's written request; or if required to be disclosed by law, regulation, or court order.

Hospitals and Providers subject to HIPAA are required to understand their responsibilities under these privacy regulations. Providers must establish procedures to safeguard the privacy of any information that identifies a PGT Member; release information from, or copies of, records only to only authorized individuals; ensure that unauthorized individuals cannot gain access to or alter Member records; release original medical records in accordance with Federal and State laws, court orders, or subpoenas; maintain the records and information in an accurate and timely manner; ensure timely access by Members to the records and information that pertain to them; and abide by all Federal and State laws regarding confidentiality and disclosure for mental health records, medical records, other health information and Member information.

PGT will only release protected health information for a Member if it has received a release form signed by the Member or their authorized representative. To be compliant Providers should make reasonable efforts to restrict access and limit

routine disclosure of PHI/PII to the minimum necessary to accomplish the intended purpose of the disclosure of patient information.

MEMBER HOLD HARMLESS

Members may not be balanced billed for any reason for covered services. Members can only be billed for coinsurance/copayment amounts and for services that are not covered under their insurance plan, provided the member has signed a waiver accepting financial responsibility prior to services being rendered (i.e., cosmetic procedures). You may not balance bill a member for charges that are in dispute between you and PGT for contractual discounts.

Billing Deadline	Unless otherwise specified in your contract, claims must be submitted within 95 days of the date of service and must also include a valid PGT issued referral number for services rendered. Claims submitted for surgical procedures must include an operative report when more than one procedure is performed during a single operative session.
Duplicate Claims	A provider may not submit a duplicate claim prior to the 46th day for non-electronic claims and the 31st day for electronic claims after the original claim is presumed to have been received.
Fee Schedule	Refer to the Provider Agreement for specific information.
Refund Requests	PGT may request a refund from providers due to overpayments or audits. A Provider may appeal a refund request by providing written notice of disagreement no later than 45 days after receipt of the refund notice for overpayments and no later than 30 days after notification for audits unless stipulated otherwise in the Provider Agreement.
Ancillary Services	All laboratory and diagnostic radiology services must be performed at Kelsey-Seybold Clinic, unless otherwise specified in your provider agreement or approved by the PGT Utilization Management Department prior to services being rendered.

MANAGED CARE CONTRACTUAL ARRANGEMENTS (Capitated)

CAPITATED HEALTH PLANS (HMO and EPO)

PGT In, is contracted with multiple health plans and provides services for multiple lines of business: Commercial, Marketplace/Individual Exchange and Medicare Advantage Plans. For more information regarding plan specific benefits, access the health plan's website or contact the Provider Relations Department.

- The Kelsey-Seybold Clinic PCP is responsible for directing care of the patient including referrals to specialty care providers.
- Patients normally have a copayment or a coinsurance due at the time of service; the Provider is responsible for collecting applicable cost-share at the time of the office visit.
- Pre-certification/authorization is required for elective hospitalizations, surgeries, and other procedures.
- Pre-certification/authorizations are valid for 30-90 days depending on the type of authorization requested.

COMMERCIAL

Participation with the following plans can change at any time, the list is not all inclusive, and subject to change.

- ERS HealthSelect of Texas (Blue Cross Blue Shield)
- TRS Active Care
- Blue Essentials HMO
- KelseyCare powered by Cigna
- KelseyCare Aetna
- Cigna SureFit
- Individual Marketplace (IFP) – UHC Kelsey-Seybold Copay Focus plans (only) (Global Cap – **KSC pays all claims)**

MEDICARE ADVANTAGE

Participation with the following health plans can change at any time. Please visit www.kelsey-seybold.com/MA for an up-to-date list of MA plans accepted.

- **KelseyCare Advantage (KCA)**
  - Capitated (Global)
  - Delegated for all services
- **Aetna Medicare Advantage**
  - Capitated (Professional)
  - Delegated for Claims and UM - HMO plans only
- **United Healthcare Medicare Advantage (only specific HMO plans)**
  - Capitated (Professional)
  - NOT Delegated for Claims and UM
- **Wellcare/Texan Plus Medicare Advantage**
  - Capitated (Professional)
  - Delegated for Claims and UM - HMO plans only

Dual Eligible Medicare Advantage Members are not financially responsible for any cost-sharing for their Medicare services.

NOTE: To avoid claim processing errors and payment delays, please submit claims according to the information listed on the back on the member's ID card.

- **Professional claims** for authorized, covered services provided to eligible, capitated members assigned to PGT or Kelsey-Seybold Clinic are to be submitted to PGT/Kelsey-Seybold for processing and payment. *(Except UHC/Wellmed Medicare Advantage claims)*
- **Facility claims** for authorized services are to be submitted to the members health plan as indicated on the back of the ID card.
- **Facility and professional claims for KCA and United Healthcare-Kelsey Seybold ACA (Marketplace)** members are to be submitted to Kelsey/PGT for processing.

Kelsey Seybold/PGT will not process claims submitted for ineligible members or for members who are not assigned to Kelsey Seybold/PGT at the time of service.

Claims Type	File Electronically Through Availity	Send Paper Claims
Professional Claims	**KELSE**	Kelsey/PGT PO Bo 31031 Tampa, FL 33631
Institutional Claims	**KELSI**	

IDENTIFYING A CAPITATED KSC ASSIGNED HMO or EPO MEMBER

Kelsey-Seybold assigned HMO and EPO patients are issued ID cards identifying Kelsey-Seybold as their Primary Care Provider (PCP). These capitated patients require referral/authorization from the Kelsey-Seybold UM Department prior to services being rendered.

The Kelsey-Seybold UM Department will issue an Authorization Summary Report for each Provider of all approved and denied requests on a regular basis via email. The patient also receives notification of authorization updates.

If your office has not received a Kelsey-Seybold referral/authorization on a patient, contact Kelsey- Seybold UM Department at (713) 442-5339. If a patient presents as a Kelsey-Seybold referral with an ID card indicating a non-Kelsey-Seybold PCP, contact the health plan using the customer service phone number on the member's ID card to verify benefits and PCP selection.

If Kelsey-Seybold has been selected as the patient's PCP the patient's ID Card should include one of the following under the section "Primary Care Physician/PCP" and/or "Network":

- A Kelsey-Seybold physician's name
- A Kelsey-Seybold physician's phone number (generally begins with 442 prefix, i.e., 713-442-0000)
- A Kelsey-Seybold Clinic name (i.e., Main Campus, West Clinic, etc.)

ELIGIBILITY & BENEFIT COVERAGE VERIFICATION (Capitated)

Providers must verify a member's eligibility and benefit coverage on each date of service. The number to call for eligibility verification is located on the back of the Member's ID card.

- Ask the Member about changes – Eligibility should be verified on each date of service.
- Ask to see the Members ID Card
- KelseyCare Advantage member eligibility can be verified via Kelsey CareLink
- Call the Health plan – Eligibility can be verified by calling the number on the back of the Member ID Card.
- Collect the applicable copayment or coinsurance

Changes with eligibility do occur, the presence of an ID Card itself does not guarantee the Member is eligible for services.

Specifically related to ACA, Individual and Family Marketplace plans – Retro termination of coverage does happen for various reasons, the most common being failure to pay monthly premiums when the member receives a subsidy from the Government. Kelsey/PGT may have authorized services, and you may have treated a member and then the member is retro terminated. The member is responsible for any charges associated with services rendered if it turns out they did not have coverage at that time. Please refer to your PGT agreement for language related to our standard recoupment process.

NON-MANAGED CARE ARRANGMENTS (FFS, Non-Capitated)

IDENTIFYING NON-CAPITATED HEALTH PLANS AND PPO PLANS

- Your medical practice must be listed as a participating provider in the health plan's network for patients to receive the highest level of benefits.
- The initial authorization from Kelsey-Seybold covers only services stated in the referral. For any additional services, your medical practice must obtain pre-certification and/or authorization from the member's health plan.
- The members' health plan will be responsible for processing these claims. PGT Inc. is **not** responsible for processing these claims.
- The provider's office must file these claims with the health plan.

ELIGIBILITY & BENEFIT COVERAGE VERIFICATION (FFS) (NON-CAPITATED PLANS)

Providers must verify a member's eligibility through the members health plan directly (i.e.., Availity, health plan portal etc.)

UTILIZATION MANAGEMENT

REFERRAL PROCESS – (Capitated HMO'S)

If a member is referred to your practice a referral will be generated by the patient's PCP and/or a Kelsey-Seybold specialist. If the referral is approved then the patient, the referring provider and you will receive a notification authorization letter. Please note an authorization is not a guarantee of payment. The following are some examples of referrals your office may receive:

INITIAL CONSULTATIONS

- The notification authorization letter will contain the approved office visit/consultation codes and the provider/member information.
- Consultation referrals are valid for one (1) visit within the requested timeframe or as specified on the notification. This is contingent on the member eligibility being current and the member is assigned to Kelsey-Seybold Clinic. Providers may include up to 5 additional follow-up visits with appropriate coding if they wish that to be reviewed in addition to the consult.
- If additional testing is needed beyond the initial consultation that was authorized, the provider must call the Kelsey-Seybold UM Department at (713) 442-5339 or fax a completed Prior Authorization form to be found at Affiliate Provider | Kelsey-Seybold Clinic . This can be faxed to the Kelsey-Seybold UM Department at (713) 442-5333. Failure to obtain authorization may result in claims being denied.
- After the members visit, the rendering provider must send a dictated or written report of the findings/recommendations to the patient's primary care physician or referring specialty care physician.
- We recommend the rendering provider also follow-up with a phone call to the referring physician to confirm receipt of the dictated report.

ROUTINE VISITS

- The notification authorization letter will include patient demographic information and an authorization number for approved requested services.
- Affiliate providers should verify eligibility each time a member arrives at your office for services.

- The number to call for eligibility verification is located on the member's ID card. Payment will not be made for services rendered to an ineligible member. Refer to the "Eligibility Verification" section of this manual.
- The consultation and the number of office visits noted in the notification authorization letter must occur within the approved timeframe of the authorization dates or additional authorization will be required.
- No additional testing (lab, x-rays, EKG, etc.) is authorized unless specified KS Medical Group agreement.
- Emergency approvals will not be given for routine follow-up visits. Patients will be asked to reschedule.
- The Provider should send a written report to the PCP after seeing the patient. The report should be sent to the physician's clinic address. Kelsey-Seybold location addresses can be found at Locations | Kelsey-Seybold Clinic | Houston, TX Doctors.

SURGICAL PROCEDURES

- The "CPT Procedure Code(s)" table on the notification authorization letter identifies the surgical procedure code(s) that have been authorized by Kelsey-Seybold. Information regarding the facility where services are to be performed, and the referral type are indicated within the notification as well.
- Claims submitted for surgical procedures must include an operative report when more than one procedure is performed during a single operative session (we do not require this when sending EDI claims).
- Verification of eligibility with the member's health plan a day prior to surgery is recommended. Payment will not be made for services rendered to an ineligible member. Refer to the "Eligibility Verification" section of this manual.
- Surgery must be performed within the start and end of the authorization dates.
- Pre-op testing must be performed at Kelsey-Seybold Clinic. Non-emergency pre-op laboratory testing cannot be performed at a hospital facility unless authorized by the Kelsey-Seybold UM Department prior to services being rendered.
- Member must be admitted on the day of surgery unless approval for early admission is obtained from the Kelsey-Seybold UM Department.
- Follow-up visits for a surgical procedure are payable in accordance with current Centers for Medicare & Medicaid Services guidelines. Post surgical follow-up visits do not require additional authorization provided the follow-up visit(s) are rendered within the CMS surgical global period for that procedure. However, if the global period has expired, the post-surgical visit will require authorization from the Kelsey-Seybold UM Department prior to services being rendered.
- The Affiliated Provider treating a member referred by Kelsey-Seybold is responsible for securing authorization for surgical procedures and/or other diagnostic testing beyond that which is stipulated in the original referral from Kelsey-Seybold. To request such approval, providers must fax a completed Authorization Form to (713) 442-5333.
- Lead time is required for pre-certification of elective surgical procedures. Please allow enough time to secure the approval prior to scheduling the procedure.

EMERGENCY REFERRALS

Emergency referrals are made after regular working hours, on weekends and for urgent care cases.

If an urgent care case is referred to you during regular working hours, you should contact the Utilization Management Department at (713) 442-5339 for an authorization number. Alternatively, you may fax a prior authorization request using the PA form found online at Affiliate Provider | Kelsey-Seybold Clinic. After a determination is rendered an authorization notification letter of approval or denial will be sent to you using the fax number on file. If you do not have a working fax number, the authorization notification letter will be mailed.

If you are contacted by a Kelsey-Seybold physician after hours or on weekends and are requested to provide care to a Kelsey-Seybold member, you must notify the Kelsey-Seybold UM Department by fax or phone using the contact information below:

1. Telephone: (713) 442-5339
2. Fax: (713) 442-5333

Please submit the prior authorization request the next working day, with the following information included:

1. Name of the patient and date of birth
2. Name of the Kelsey-Seybold referring physician
3. Date of service, diagnosis, and procedure (if performed)
4. Relevant codes
5. Patient's health plan, if known
6. Name of physician rendering care

This process will facilitate prompt payment of your claims. Failure to follow this procedure may result in delay of payment or denial of payment for your services.

PRIOR AUTHORIZATIONS & PRE-CERTIFICATIONS (Capitated HMO's)

When a Kelsey-Seybold HMO patient is referred to you, additional requests for authorization/pre-certification are the provider responsibility. Contact the patient's primary care physician or UM Department at (713) 442-5339 for assistance. You may also complete the Prior Authorization form and fax it to UM to request additional services or visits. The form can be found at Affiliate Provider | Kelsey-Seybold Clinic

Kelsey-Seybold UM will process authorization/pre-certification requests for many services including the following items on capitated HMO, POS and EPO patients:

- CT scans, MRI's & PET scans
- Chemotherapy/Radiation Therapy
- All Hospital Admissions, including surgical procedures
- All outpatient surgical procedures
- Referrals to non-Kelsey-Seybold physicians
- Any diagnostic testing not allowed through your provider agreement with Kelsey-Seybold.

Kelsey-Seybold does not provide any incentive to any of its physicians or employees that are based on the quantity or type of denial decisions rendered.

To obtain authorization/pre-certification for any of the services on the previous page, the following steps are to be followed:

- Complete a Prior Authorization form outlining the proposed treatment plan and/or surgical procedure requested and fax to Utilization Management at (713) 442-5333. Please include all relevant codes and other information on the form.
- Lead time is required for pre-certification of elective surgical procedures. Please allow enough time to secure the approval prior to scheduling the procedure.
- The requesting provider is responsible for submitting the appropriate paperwork to secure an authorization from Kelsey-Seybold.
- Extension of referral dates, additional tests, procedures, or referrals to other physician cannot be performed unless approval has been obtained from the Kelsey-Seybold UM Department.

The UM Department will verify eligibility and review the appropriate authorization/pre-certification for you. **Your office will receive an Authorization Notification of approval or denial, along with the patient and the referring provider.** If you

do not follow these requirements, we may deny claims. In that case, you cannot bill the member. Prior authorization is valid only for the date of service or date range listed on it.

In the event a request is denied for medical necessity, the requesting provider will receive (via fax and phone) initial notification of the impending denial. At that time, the requesting provider wishing to discuss impending denial or review the criteria used may call the Kelsey-Seybold UM Department at (713) 442-5339. You should ask to speak with a physician reviewer.

URGENT REQUESTS

The Kelsey-Seybold UM Department can take a request for urgent approval/authorizations over the telephone at (713) 442-5339. Be prepared to provide the following information:

- Patient's name and date of birth and Kelsey MRN, if available
- Diagnosis and medical necessity
- Procedure/testing being requested
- Date of procedure and facility where services are to be rendered

The nurse reviewer will verify eligibility and obtain appropriate information to secure approval. Your request will be reviewed and a determination rendered within the required timeframe.

Requests for urgent authorization may also be faxed to the Kelsey-Seybold UM Department at (713) 442-5333 using the PA form found online. Please note on the fax that it is "URGENT."

Physicians wishing to discuss a pending utilization review decision or review the criteria used may call the Kelsey-Seybold UM Department at (713) 442-5339. You should ask to speak with a physician reviewer.

REFERRAL PROCESS – (Non-Capitated PPO'S, EPO'S, FFS)

You must be a participating provider in the health plan's network in order to provide services to these members and receive in-network reimbursement. Any referrals required would be coordinated through the members health plan.

PRIOR AUTHORIZATIONS & PRE-CERTIFICATIONS – (Non-Capitated PPO'S, EPO's, FFS)

Your office is responsible for following the pre-certification process in accordance with your agreement with the member's health plan. We recommend verification of eligibility prior to each member's visit.

Services that normally require authorization/pre-certification by the various PPO/EPO plans include:

- All hospital admissions, including elective surgical procedures
- All outpatient surgical procedures
- CT scans, MRI's & PET scans
- Chemotherapy/Radiation Therapy
- Durable Medical Equipment (see Ancillary Service section)
- Home Health Care (see Ancillary Service section)
- Emergency room visits

All claims are billed to the address on the member's ID card.

MEDICAL RECORDS DOCUMENTATION

DOCUMENTING MEDICAL RECORDS

PGT requires medical records to be maintained in a manner that is current, detailed, and organized and permits effective and confidential patient care and quality review. The medical record must contain the following minimum requirements:

1. Patient information is entered into the medical record in a timely manner.
2. All entries must contain author identification and professional title.
3. All entries must be dated.
4. Documented identification of all Providers participating in care and information on services furnished.
5. An up-to-date problem list, including significant illnesses and medical/psychological conditions.
6. Each note must describe presenting complaints, diagnoses, and treatment plans.
7. A medication list containing prescribed medications with dosage, and dates of initial or refill prescriptions.
8. Documentation on allergies and adverse reactions (or notation that patient has no known allergies and adverse reactions).
9. Documentation of past medical history, physical examinations, necessary treatments, and possible risk factors for the Member relevant to a particular treatment.
10. Information on Advance Directives or notation of discussion whereby the Member does not have or wish to have an Advance Directive.

CONFIDENTIALITY

Medical Records are considered confidential and protected health information (PHI). Providers must comply with all state and federal laws concerning confidentiality of health and other information about PGT Members. This confidentiality also applies to PGT's trade secrets and other proprietary documents that contain other non-public information.

PGT Members have the right to access their medical records; therefore, each provider must have a mechanism in place to provide this access. Appropriate communication of medical record information between treating providers is essential to promoting continuity and coordination of care. Should a Member change his/her Primary Care Physician (PCP), he/she may request a transfer of their medical records or copies of medical records. Providers are responsible for obtaining all legally required consents and authorizations necessary to release a patient's health information, including but not limited to pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, and communicable disease information to other medical providers, PGT and its affiliates, as defined by HIPAA and/or applicable laws.

COOPERATION WITH QUALITY IMPROVEMENT (QI) AND PATIENT SAFETY ACTIVITIES

Providers must follow our QI and patient safety activities and programs, including:

- Timely responses to queries and/or completion of improvement action plans during quality-of-care investigations
- Participation in quality audits, including site visits and medical record standards reviews, and Healthcare Effectiveness Data and Information Set (HEDIS) record review
- Allowing use of practitioner and health care provider performance data
- Notifying us when you become aware of a patient safety issue or concern

ACCESS STANDARDS

You agree to provide Covered Medical Services in a manner consistent with professionally recognized standards of health care. There are established mechanisms to promote Member accessibility medical necessary health care services. These standards are reviewed and updated as needed. The following are considered minimum access standards:

Type of Service	Commercial Plans – Managed Care Standards	Medicare Advantage Plan Standard
Emergent	Please refer to specific health plan access standard requirements	Immediate
Urgent		Immediate
Not emergent or urgent, but requires medical attention		Within 7 days
Routine and Preventive Health Services		Within 30 days
Access to After Hours Care		24-hour access, 7 days per week

ANCILLARY SERVICES

LABORATORY TESTING

Providers should direct capitated members to Kelsey-Seybold Clinic for lab services.
PPO/FFS members can be directed to an in-network laboratory as applicable.

DIAGNOSTIC RADIOLOGY

Unless otherwise specified in your contract, all diagnostic radiology studies must be performed at Kelsey-Seybold Clinic for capitated plans.

HOME HEALTH CARE

All home health care requests should be directed to the medical management department of the patient's health plan. (Refer to the back of the member's ID care for the telephone number). However, requests for home health care for members of:

- CHI St. Luke's Health System
- Kelsey-Seybold Clinic
- UHC Kelsey-Seybold Marketplace ACA
- KelseyCare Advantage

These should be directed to Kelsey-Seybold UM Department for authorization.

DURABLE MEDICAL EQUIPMENT (DME)

All requests for DME should be directed to the medical management department of the patient's health plan. (Refer to the back of the member's ID care for the telephone number). However, requests for DME for members of:

- CHI St. Luke's Health System
- Kelsey-Seybold Clinic
- UHC Kelsey-Seybold Marketplace ACA
- KelseyCare Advantage

These should be directed to Kelsey-Seybold UM Department for authorization. The DME vendor is responsible for contacting Kelsey-Seybold UM Department for prior authorization.

Do not dispense durable medical equipment from your office stock unless you are an approved DME provider for the patient's health plan. If you do so, you may not be reimbursed for the equipment by the health plan. The patient's health plan will direct you to an approved DME supplier.

BEHAVIORAL MEDICINE

Patients should call the phone number on the back of their ID card for a list of the Behavioral Medicine Providers participating in their health plan.

CLAIMS AND PAYMENT ADMINISTRATION

CLAIMS SUBMISSION

Please reference the Claims Submission instructions located on the Kelsey-Seybold Clinic website for up-to-date information:

Follow link for Claims Submission instructions - Kelsey Seybold clinic

All claims for authorized, covered services provided to eligible, Kelsey-Seybold assigned HMO and EPO members must be submitted on a CMS 1500 form, a UB 04, or in an electronic format, as applicable. **Timeliness standards are outlined in the PGT Provider Contract.** Claims submitted with 'Unlisted Procedure Codes' must include documentation supporting the use of that code for payment consideration. If necessary to determine if the claim is payable, Kelsey-Seybold may within thirty (30) days of receipt of a clean claim, request additional information from the treating provider. A physician or provider may not submit a duplicate claim for payment before the 46th day after the date the original claim was submitted.

Claims Type	Send Electronically Through Availity	Send Paper Claims To:
Professional Claims	**KELSE**	Kelsey/PGT PO Bo 31031 Tampa, FL 33631
Institutional Claims	**KELSI**	

CLINICAL LABORATORY IMPROCEMENT AMENDMENTS REQUIREMENTS

We only reimburse for laboratory services that you are certified to perform through the federal Clinical Laboratory Improvement Amendments (CLIA). You must not bill our members for any laboratory services and respective procedure codes if you do not have the applicable CLIA certification.

CORRECTED CLAIM SUBMISSION GUIDELINES

Corrected claim submissions should be minimal. We urge providers to submit claims once all charges are documented to reduce claim processing errors and duplicate filing. **Corrected claims must still be filed within the timely filing deadlines.** Note, a correction to a prior claim may not be submitted until the original claim has been processed and provider has been notified of the claim status. All accurate line items from the original submission must appear on the replacement claim along with the line items requiring a correction to avoid unintended refund or overpayment requests. All corrected claim submissions should contain the original claim number or the Document Control Number.

CLAIM RECONSIDERATION / APPEALS

If you disagree with the outcome of a processed claim (payment or denial), you may request a Dispute/Reconsideration by submitting a written request. If a claim you submit is denied and additional information is not requested as part of the denial, you may submit a Dispute/Reconsideration. All submissions must include an explanation as to why the payment decision should be reviewed. Written Dispute/Reconsideration requests must be submitted within the timeframe specified in your Agreement.

All requests must be submitted with a completed Provider Claims Reconsideration & Dispute Request Form. The form is available at www.kelsey-seybold.com under the Affiliate Directory. Supporting documentation relevant to the request must also be included. Incomplete requests or those missing a clear statement of intent will be dismissed and will not be reviewed.

Please submit Dispute/Reconsideration requests to:

Claims Type	Send To:
Professional & Institutional Claims	Kelsey/PGT Attn: Provider Disputes Unit PO Box 841649 Pearland, TX 77584 Fax Number: (713) 442-9536

You may inquire about claims dispute/appeals status by calling Provider Services at (713) 442-5440.
Contracted providers must adhere to requirements for prior authorization of covered services as outlined in the Prior Authorization & Pre-Certifications section in this document.

20 OR MORE CLAIMS (RESEARCH REQUEST)

If you have a request to reconsider 20 or more paid or denied claims for the same administrative issue, please contact Provider Relations at the contact information provided in this document.

EXPLANATION OF PAYMENT OR REMITTANCE ADVICE

The Explanation of Payment (EOP) or Remittance Advice (RA) is an adjudication summary of the claims submitted for payment consideration by a specific Provider. It reflects an individual summary of the services billed and a determination on how the claim was adjudicated for payment consideration. (i.e., Member information, claim information, Member's cost share and payment information.) For additional questions regarding the EOP or RA, contact Provider Services.

OVERPAYMENTS/UNDERPAYMENTS AND OFFSETS

Should a Provider request reconsideration of or dispute payment or payments made by PGT under this Agreement, Provider must notify PGT in writing of the dispute within one hundred and eighty (180) calendar days of the date of the original claim adjudication. Provider acknowledges that PGT may consider that Provider's failure to submit such disputes within the above referenced time period as Provider's waiver of any such dispute and PGT original adjudication may be considered final without further appeal options.

In the event PGT determines that a claim was overpaid, they may seek correction of the payment within one hundred eighty (180) calendar days from the date of the overpayment unless the overpayment is related to fraud or material misrepresentation. Provider may appeal the refund request within forty-five (45) calendar days of receipt of refund request. If after appeal, the overpayment determination is maintained, Provider will repay PGT the overpayment amount within ten (10) calendar days of notice of the outcome of the appeal. If Provider fails to refund overpayment, Provider agrees that PGT may recover overpayment through offsets against future payments. Provider will report promptly any credit balance that it maintains with regard to any claim overpayment and will return such overpayment to PGT within forty-five days (45) calendar days after posting it as a credit balance. Provider must refund an overpayment from a Member in the amount of the overpayment to the Member not later than the 30th day after date the Provider determines that an overpayment has been made.

Send refunds to:
Kelsey-Seybold/PGT
P.O. Box 845209
Dallas, TX 75284-5209

Include documentation that shows the overpayment, including the claim number, member's name, health plan ID number, date of service and amount paid. If possible, also include a copy of the provider remittance advice (PRA) that corresponds with our payment. If the refund is owed because of COB with another carrier, provide a copy of the other carrier's EOB/remittance advice with the refund.

COMPLAINTS

There are certain dispute resolution provisions in the PGT agreement. In addition to these, providers are urged to contact Provider Relations when there is an administrative question, problem, complaint or claims issue. Complaints received are tracked and trended and the data is reviewed on an annual basis to identify opportunities for improvement.

Provider Relations	(713) 442-9528 Affiliateproviders@kelsey-seybold.com
Utilization Management decisions may be formally appealed by phone or fax. To appeal a UM medical necessity determination contact:	(713) 442-5339 Phone (713) 442-5333 Fax
TDI Complaints	Texas Department of Insurance PO Box 149104 Austin, TX 78714-9104 Fax: (512) 474-1771 www.tdi.texas.gov

COMPLIANCE

You agree to comply with PGT quality assurance, quality and compliance investigations, peer review process, quality improvement, accreditation, risk management, utilization review, utilization management, and other administrative policies and procedures established and revised by PGT.

CODE OF CONDUCT

PGT compliance program includes our Code of Conduct (Code) which is part of the Corporate Compliance Program of PGT and all its affiliated entities. It is intended to advise PGT, personnel including healthcare providers and contractors of situations that could possibly result in non-compliance with applicable laws, rules, or regulations.

FRAUD, WASTE AND ABUSE (FWA)

PGT is committed to detecting, preventing, and correcting any Fraud, Waste, and Abuse and comply with all federal and state rules, laws, and regulations. PGT strives to provide our members the highest quality of care while at the same time protect the integrity of the healthcare fund and we take allegations seriously.

As part of our health care delivery system all our business partners should be committed to conducting themselves in an ethical, legal, and above-board manner, including detecting, preventing, and correcting fraud, waste, and abuse.

EXAMPLES OF POTENTIAL FRAUD, WASTE AND ABUSE

- Failure to provide medically necessary services to a Member
- Incorrect coding for the services provided, such as up-coding
- Improper formulary decisions when costs take priority over clinical criteria and appropriateness
- Payments for excluded drugs, drugs that are not for medically accepted indications, and improper formulary decisions
- Submissions of false claims
- Multiple billings for the same Part C or Part D services (if applicable)
- Billing for services which were not provided
- Mishandling of appeals when a beneficiary is denied their rights
- Prescription forging or altering
- Fraudulent cost reports
- Faxed requests to our clinics requesting Physician authorization or signature for DME, Diabetic supplies, or prescriptions that are not legitimately required by patients

PGT will promptly and confidentially investigate any reported potential violations of federal or state rules, laws, regulations, or any other policies and procedures. Report an actual or potential violation of FWA, as appropriate, and when reported in good faith will not result in any action.

EXCLUSING CHECKS / EXTERNAL RELATIONSHIPS

Prior to hiring or contracting with Providers, PGT will review federal and state exclusion lists, as applicable. Monthly reviews of the exclusion lists will occur and any exclusion or event that makes an individual ineligible to perform work directly or indirectly on federal health care programs will be subject to termination.

Providers agree to disclose any all-external relationships they or their family may be associated with and be a potential conflict with their responsibilities to PGT.

KELSEY COMMUNITY NETWORK PRIMARY CARE NETWORK PCP'S

The Kelsey Seybold Primary Care Community Network is made up of a limited number of individual Primary Care Physicians located in the Houston and surrounding area. These Community Primary Care Physicians have been identified by Kelsey Seybold Medical Group and must meet credentialing and contracting criteria.

PRIMARY CARE PHYSICIAN SELECTION

- Each Member participating in a Capitated plan must select a Primary Care Physician (PCP) from the list of participating primary care physicians in the Provider directory.
- Kelsey-Seybold Clinic Providers are listed at Find a Doctor.
- Kelsey Community Network Primary Care Providers are included in some of the PGT/KSC agreements and rosters.
- If you are a contracted KCP provider, refer to your PGT agreement to confirm which products you are participating in.

PCP RESPONSIBILITY

- Verifying a member's eligibility
- Assessing the health care needs of each Member
- Delivering care to all members in need of assistance, even if the member never established care
- Delivering primary care services
- Guiding the member through the healthcare system by arranging for specialty and ancillary care as needed
- Maintaining and providing pertinent documentation in medical records that support clinical determinations and medical necessity
- Submitting electronic referrals for the member to enable them to see another network physician, if the benefit plans require
- Advocate for additional programs such as care management and supportive care services based on patients' eligibility
- Coordinating the Member's overall health care and originating all Member communication and information exchange among the Member's various Providers.

KCP Primary Care providers shall provide or arrange for medical care 24 hours a day, seven days a week for any Members whom they are assigned to, including having back-up for absences. This coverage cannot be provided by an emergency room.

MEMBER DISMISSALS FROM PRIMARY CARE PROVIDERS

In the event that a KCP Provider refuses to treat or continue to treat a Member under any circumstances, Provider shall notify Provider Relations in writing in accordance with the notice provision of the PGT Agreement of such refusal and the reasons, therefore.