PIEDMONT
COMMUNITY HEALTH PLAN

Provider Manual

Revised November 30, 2022

Piedmont Community Health Plan Provider Manual (Manual), as may be amended from time to time, is incorporated by reference into the Agreement. The Manual is designed for use by, and applicable to, all Piedmont Participating Providers. The Manual is intended to be interpreted in a manner that is consistent with all applicable state and federal laws and regulations. Updates to this Manual may be necessary or required from time to time to ensure consistency with changes in applicable federal and state laws and regulations.

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PURPOSE AND INTRODUCTION

ABOUT PIEDMONT COMMUNITY HEALTH PLAN

Mission

Our mission is to provide comprehensive quality healthcare coverage to the residents of Central Virginia and neighboring communities in partnership with those who share a commitment of access to medical care that represents the highest standards for quality and efficiency.

Vision

Our vision is to provide efficient and quality healthcare coverage to the local community through a network of providers and hospitals. By doing so, we help hold down healthcare costs through medical management efforts and lower administration costs. Superior customer service, account management, and claims administration will be key components of success.

Values

- **We are committed.** We conduct ourselves in a manner that adheres to compliance and organizational integrity and promotes both the letter and spirit of Piedmont's Code of Conduct (The Code). We encourage you to review this document, which is attached as an addendum to this manual.
- **We are dedicated.** We learn the laws and regulations that govern our business and are diligent in keeping current on regulatory changes.
- **We are honest.** We comply with laws and regulations and monitor actions for reasonableness, necessity, accuracy**,** appropriateness and completeness.
- **We use good judgment.** We do not engage in any activity that might create a conflict of interest for ourselves or the company.
- **We are courageous.** We speak up for what is right. We report wrongdoing when we see it including illegal or unethical conduct, fraud, waste, and abuse.
- **We are responsible.** We accept the consequences of our actions. We admit our mistakes and quickly fix them. We don't retaliate against those who try to do the right thing by asking questions or raising concerns.
- **We are trustworthy.** We protect the privacy of our Members and the confidentiality of sensitive business information about Piedmont.
- **We treat others with respect.** We value our Members, colleagues, and community and maintain fairness in all relationships. We are open and transparent in our communications with each other.

As part of the Centra Health System, we operate on the principles that a personal physician should manage the healthcare of our Members – not out-of-town insurance administrators – and that there should be close cooperation between local healthcare providers, patients, and employers.

Provider networks for our HMO plans include providers in Lynchburg, Virginia and the four surrounding counties of Amherst, Appomattox, Bedford, and Campbell. Provider networks for our POS and PPO plans include providers throughout Virginia, plus Duke University Medical Center. Exceptions may be granted for POS and PPO Members who reside/receive care outside of Virginia. Our plan documents provide details.

Commercial - We offer three basic plan designs to local large and small employers: Preferred Provider Organization (PPO), Health Maintenance Organization (HMO), and Health Maintenance Organization-Point of Service (HMO-POS) plans. These plan designs are offered through a choice of funding arrangements. Fully insured arrangements are provided through our wholly owned subsidiary, Piedmont Community HealthCare. Self-insured arrangements are provided through the parent company, Piedmont Community Health Plan ("Company"). Networks may vary.

Exchange – We offer individual Marketplace plans in accordance with the Affordable Care Act, with competitive rates and the required benefits set forth by the ACA on our individual and family health plans. Members may choose between Gold, Silver, or Bronze plans.

Piedmont Advantages

Piedmont Community Health Plan is Central Virginia's only locally headquartered healthcare insurance carrier. We offer real advantages to Members and employers including:

- ***A community-based organization accessible to its Members.***
- ***Management with knowledge and understanding to make the most informed decisions.***
- ***Staff empowered to serve each employer and their covered employees.***
- ***A medical management program designed to promote the concept that your physician will manage your care.***

Contact Information

Piedmont Community Health Plan
2316 Atherholt Road
Lynchburg, Virginia 24501
Phone: 434-947-4463
Office hours: 8:30 a.m. to 5:00 p.m. EST, Mon-Fri (except holidays)

Provider & Client Relations Department

Sherri Wagurak, Associate Manager – sherri.wagurak@pchp.net
Barb Schlesinger-Nash, Director – barb.schlesinger-nash@pchp.net
Melanie Matherly, Coordinator – melanie.matherly@pchp.net
Betty Walters, Vice President, Network Development and Provider Relations – betty.walters@pchp.net

CVS Caremark
1-800-966-5772

Visit Piedmont's provider portal log-in page by clicking here - Provider Portal - or visit www.pchp.net to view benefits, claims, eligibility, participating providers, and formularies.

PROVIDER RESPONSIBILITIES

General Provisions

Participating Provider and Piedmont agree to abide by the following General Provisions:

Assignment. The Agreement or any part, articles or sections thereof may not be assigned during the term of the Agreement by any of the parties without the prior written consent of the other party(s), except (i) as may otherwise be provided for in the Agreement and (ii) each party may at any time assign its rights and obligations under the Agreement to any corporation controlled by, in control of or under common control of the assigning party provided, however, it provides the non-assigning party(s) with thirty (30) days prior to written notice of said assignment.

Compliance. The parties agree to comply with all applicable federal and state laws and rules including, but not limited to (i) Title VII of the Civil Rights Act of 1964; (ii) The Age Discrimination Act of 1975; (iii) The Rehabilitation Act of 1973; (iv) The Americans With Disabilities Act; (v) other laws applicable to recipients of Federal funds; (vi) Medicare laws, regulations and Centers for Medicare and Medicaid Services (CMS) instructions; (vii) Patients' bill of Rights in accordance with OPM; (viii) the Genetic Information Nondiscrimination Act of 2008; (ix) Health Insurance Portability and Accountability Act of 1996 (HIPAA); 42 CFR Part 2; and all other applicable laws and rules. Furthermore, Participating Provider hereby warrants and represents that it shall comply and shall be responsible for requiring any party that it may subcontract with to furnish services to Members to comply with Piedmont's policies and procedures and all other terms and conditions of the Agreement. Additionally, it is hereby disclosed that payments made by Piedmont to related entities, contractors and subcontractors are, in whole or in part, from federal funds received by the Piedmont through its contracts with the Centers for Medicare and Medicaid Services.

Entire Agreement/Amendments/Multiple Originals. The Agreement, together with any attachments, exhibits, or applicable Provider Manual(s), as amended from time to time, set forth the entire Agreement between the parties with respect to the subject matter. Any prior purchase orders, agreements, promises, negotiations, or representations, whether oral or written, not expressly set forth in the Agreement, are of no force or effect. The Agreement shall be executed in multiple originals, one for Participating Provider and the other for Piedmont. The parties agree that the Agreement shall be automatically amended to comply with applicable federal and state laws and regulations; otherwise, the Agreement may not be amended except in writing, signed by the parties.

Exhibits. All exhibits within the Agreement are incorporated by reference and made part of the Agreement as if they were fully set forth in the text of the Agreement.

Governing Law. The Agreement shall be deemed to have been made and shall be

construed and interpreted in accordance with the laws of the Commonwealth of Virginia, and the parties hereto agree to the jurisdiction of the Commonwealth of Virginia.

Indemnification. Participating Provider and Piedmont agree to protect, indemnify, and hold harmless the other party(s) from and against any and all loss, damage, cost and expense (including attorneys' fees) which may be suffered or incurred under the Agreement as a result of the negligent or intentional acts of the indemnifying party, its employees, agents, consultants or subcontractors. Said indemnity is in addition to any other rights that the indemnified party may have against the indemnifying party and will survive the termination of the Agreement.

Insurance. Each party agrees to maintain, at its own cost and expense, insurance coverage as necessary and reasonable to insure itself and its employees and agents in connection with the performance of its duties and responsibilities under the Agreement. Upon request, the parties agree to provide one another with a Certificate of Insurance evidencing said insurance coverage. Participating Provider shall notify Piedmont within ten (10) days of the cancellation or material alteration of such coverage.

Notices. All notices and communications hereunder shall be in writing and deemed given, when personally delivered to or upon receipt when deposited with the United States Postal Service, certified or registered mail, return receipt requested, postage prepaid; a nationally recognized overnight courier, with all fees prepaid; or e-mail addressed as set forth on the first page of the Agreement or to such other person and/or address as the party to receive may designate by notice to the other.

Notification of Incidents. The parties agree to notify the other party(s) within twenty-four (24) hours after the discovery of any incidents, occurrences, Claims or other causes of action involving the Agreement. Upon receipt of discovery by any party of any incident, occurrence, Claim (either asserted or potential), notice of lawsuit or lawsuit involving the Agreement, said party agrees to immediately notify the other party(s). The parties hereto agree to provide complete access, as may be provided by law, to records and other relevant information as may be necessary or desirable to resolve such matters. This Section shall survive the termination of the Agreement.

Other Parties. The Agreement is solely between the parties hereto and is not intended to be enforceable by any other party or to create any express or implied rights hereunder of any nature whatsoever in any other party.

Partial Invalidity/Interpretation. If any term or provision of the Agreement is determined to be invalid or unenforceable, the remainder of the Agreement will not be affected thereby. The section headings in the Agreement are solely for reference purposes. Participating Provider acknowledges that portions of the Agreement are subject to review by Governmental Agencies and/or their designated representatives, as applicable, and in the event that such Governmental Agencies and/or their designated representatives require any material change to the terms and conditions of the Agreement, Participating Provider agrees to renegotiate the affected terms and conditions upon being notified of such required change by Piedmont.

Promotional Materials. Participating Provider consents to Piedmont's use of its name, address and the names and professional designations of its healthcare professionals in membership and marketing materials. The parties hereto agree not to use the name of or any trademark, service mark or design registered to the other parties or their affiliates or any other party in any additional publicity, promotional or advertising material, unless review and written approval of the intended use shall first be obtained from the releasing party(s) prior to the release of any such material. Said approval shall not be unreasonably withheld by any of the parties.

Relationship Among Parties. The parties hereto expressly acknowledge and agree that: (i) Piedmont's duties and responsibilities under the Agreement apply solely to Piedmont Members; (ii) in its capacity as third-party administrator, Company's duties and responsibilities under the Agreement apply to Members of an Employer- Sponsored Program; and (iii) with the exception of (ii) of this Section, Company's duties and responsibilities under the Agreement apply to Company Members. Each party hereto shall be considered independent entities with respect to each other. None of the provisions of the Agreement are intended to create nor shall be deemed or construed to create any relationship between the parties other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of the Agreement. Neither the parties nor any of their respective agents or employees shall be construed to be the agent, employee, joint Employer or representative of the other. The parties shall not have any express or implied rights or authority to assume or create any obligation or responsibility on behalf of or in the name of the other, except as may be otherwise set forth in the Agreement.

Release of Information. The provisions of the Agreement are confidential and protected from disclosure to any other party unless: (i) otherwise provided for in the Agreement; (ii) disclosure is required by Piedmont, an Employer or Participating Provider to meet any federal, state, or local rule, law or regulation; or (iii) any party hereto engages a third party for purposes such as quality assurance or auditing.

Unforeseen Circumstances. In the event either party's operations are substantially interrupted by war, fire, insurrection, pandemic, the elements, earthquakes, acts of God or, without limiting the foregoing, any other cause beyond the control of the affected party (including the Piedmont no longer meeting all material requirements imposed on Piedmont by Federal or State law resulting in a significant impact on Piedmont's operations), the affected party shall be relieved of its obligations only as to those affected portions of this Agreement for the duration of such interruption. In the event that the performance of the affected party hereunder is substantially interrupted pursuant to such event, the other party shall have the right to terminate this Agreement upon ten (10) days' prior written notice to the affected party.

Waiver. Failure of a party to complain of any act or omission on the part of another party shall not be deemed to be a waiver. No waiver by a party of a breach of the Agreement will be deemed a waiver of any subsequent breach. Acceptance of partial payment will be deemed a part payment on account and will not constitute an accord and satisfaction.

Appointment Standards

These requirements assume that the receiving facility has both the capability and capacity to provide the required services. Emergent referrals for both primary and specialty care are expected immediately and will occur in accordance with all EMTALA standards when an Emergency Department is involved. It is expected that emergent referrals to a specialty clinic receive the appropriate medical screening, stabilization, treatment, and referral to a higher level of care when necessary. Urgent referrals are expected to be evaluated within 24 hours for both primary and specialty services. Routine primary care referrals are expected to have an appointment scheduled within 7 business days, and specialty appointments within 14 business days, and preventive health exams within 30 days. Behavioral health has different parameters for timeliness. Again, these referral standards assume the clinic that is referred to has the capability and capacity to meet these standards. When a clinic is unable to meet these standards, the Member should be informed and given the option to be referred to a different clinic if they are unable or unwilling to wait.

PCP Wait Times

Waiting time standards for PCPs require that Members, on average, should not wait at a PCP office for more than thirty (30) minutes for an appointment for routine care. On rare exceptions, if a physician encounters an unanticipated urgent visit or is treating a Member with a difficult medical need, the waiting time may be expanded to one hour. Piedmont monitors compliance with appointment and waiting time standards and works with providers to ensure that these standards are met.

Infection Control Measures

Piedmont wants to ensure providers exercise approved and effective infection control practices. The Guide to Infection Control Prevention for Outpatient Settings: Minimum Expectations for Safe Care, produced by the Centers for Disease Prevention can be found at http://www.cdc.gov/HAI/pdfs/guidelines/standatds-of-ambulatory-care-7-2011.pdf.

Quality Management Plan

Piedmont's mission is to provide comprehensive quality healthcare coverage to the residents of Central Virginia and neighboring communities in partnership with those who share a commitment of access to medical care that represents the highest standards for quality and efficiency. Piedmont supports the overall mission of Centra. The Piedmont Quality Management Plan provides the structure and processes for continuously monitoring, analyzing, and improving the clinical care and services provided under Piedmont products to further that mission.

For a copy of the complete Quality Management Plan, contact Piedmont's Quality Improvement Department.

REFERRALS

Direct Access and Self-Referrals

The following services do not require a referral from the PCP:

1. Vision (only if for routine; if medical in nature, may require authorization)
2. Dental (only if for routine; if medical in nature, may require authorization)
3. Obstetrical and Gynecological (OB/GYN) services
4. Chiropractic services
5. Physical, occupational and speech therapy services

Please Note: To be self-referred, the Member must obtain these self-referred services from Piedmont's Network.

Family Planning Services do not require Prior Authorization or referral. Members may access Family Planning Services from any qualified provider. Family Planning Services include, but are not limited to:

- Health Education
- Counseling necessary to make an informed choice about contraceptive methods
- Pregnancy testing and breast and cervical cancer screening services
- Contraceptive supplies such as prescribed birth control pills and sterilization procedures
- Diagnostic screens, biopsies, cauterizations, cultures, and assessments

Members have direct access to OB/GYN services and have the right to select their own OB/GYN provider; this includes nurse midwives participating in Piedmont's Network. They can obtain maternity and gynecological care without prior approval from a PCP. This includes:

- Selecting a provider to give an annual well-woman gynecological visit
- Primary and preventive gynecology care
- PAP smear and referrals for diagnostic testing related to maternity and gynecological care, and Medically Necessary follow-up care
- Perinatal and Postpartum maternity care

If a new pregnant Member is already receiving care from an Out-of-Network OB-GYN SCP at the time of enrollment, the Member may continue to receive services from that SCP throughout the pregnancy and postpartum care related to the delivery. In such cases, please notify Medical Management to ensure your record is appropriately notated.

Substance Abuse and Behavioral Health Referrals

Many behavioral health disorders such as depression, anxiety and substance abuse often occur in Members who present for medical care. PCPs and all non-behavioral health practitioners are encouraged to recommend behavioral health services to Members when

deemed appropriate. Substance abuse and behavioral health services, when appropriate authorizations are obtained, are available to all Piedmont Members through the Member's local county mental health services and/or other Network providers.

UTILIZATION MANAGEMENT PROGRAM AND CRITERIA

Participating Providers are reminded that utilization criteria and the utilization program description are available upon request. Participating Providers may request a copy of the applicable criteria as part of the utilization decision phone conversation, by fax or U.S. mail, or through discussion with the respective Medical Director. Criteria can be requested in writing from the Medical Management Department, Attention: Director of Medical Management, 2316 Atherholt Road, Lynchburg, Virginia 24501.

Utilization Management (UM) Terms and Definitions

1. **Pre-service Review.** Review for Medical Necessity that is conducted on a health care service or supply prior to its delivery to the Covered Individual.

2. **Initial Request/Continued Stay Review (continuation of services).** Review for Medical Necessity during initial/ongoing inpatient stay in a facility or a course of treatment, including review for transitions of care and discharge planning.

3. **Pre-certification/Pre-authorization Request.** For UM team to perform Pre-service Review, the provider submits the pertinent information as soon as possible to Piedmont UM prior to service delivery.

4. **Pre-certification/Pre-authorization Requirements.** List of procedures that require Pre-service Review by UM prior to service delivery.

5. **Business Day.** Monday through Friday, excluding designated company holidays.

6. **Notification.** The telephonic and/or written/electronic communication to the applicable health care Providers, Facility and the Covered Individual documenting the decision, and informing the health care Providers, Facility and Covered Individual of their rights if they disagree with the decision.

Prior Authorizations (Precertification)

Precertification is Piedmont's response to information presented relating to a request for specified health care services. Precertification does not guarantee a Member's coverage or Piedmont payment. A Member's coverage is pursuant to the terms and conditions of coverage set forth in a Member's applicable benefit document.

A Member is not financially responsible for a Participating Provider's failure to:

(i) obtain precertification, or
(ii) provide required and accurate information to Piedmont.

Copayments are the financial responsibility of the Member, when applicable.

A complete list of services requiring Prior Authorization is available online at PCHP.net.

General Rules for Pre-Certification

Not all health plans offer the same benefits. Always confirm benefits that may be available for the Covered Individual at the time of service either online through the PCHP website or by calling Customer Service at the phone number on the Covered Individual's health plan ID card. **Please note:** Customer Service cannot provide pre-certification for services. Providers still must call the pre-certification line phone number on the Covered Individual's health plan ID card.

Pre-certification, or the requirement for it, is not a guarantee of benefits. Once pre-certification is obtained, to facilitate timely and accurate processing of claims, the ordering provider must verify the Covered Individual's eligibility within two (2) business days before providing services.

For services obtained from non-participating providers, benefits may not be available, Covered Individual financial responsibility may increase or reimbursement to providers may be reduced, depending on the Covered Individual's Health Benefit Plan. If a non-participating provider is delivering services, Piedmont strongly advises that the Covered Individual and the non-participating provider call Customer Service at the phone number on the Covered Individual's health plan ID card to confirm available benefits and to clarify financial responsibility, which may make it possible to avoid any applicable financial penalties.

Authorization Required for Payment

Any service, with or without an authorization, rendered by a Participating Provider and determined to be clinically inappropriate by the Medical Director will be paid at an appropriate alternate level of care or payment will be denied completely. Medical Director determinations are in accordance with individual Member's needs, characteristics of the local delivery system, applicable medical criteria and clinical expertise. At the time of a medical management denial, the Participating Provider is verbally notified of the option to speak with a Medical Director regarding such payment denial. The Provider Appeal process is also available to Participating Providers for claims payment issues.

Precertification Determination and Communication

Precertification of services may be required and will be performed by Piedmont Medical Management staff, or through delegated vendor relationships. Delegated vendors may review services such as, but not be limited to, pharmacy requests.

Precertification staff, which includes appropriate practitioner reviewers, utilizes nationally recognized medical guidelines as well as internally developed medical benefit policies, individual assessment of the Member, and other resources to guide precertification, Concurrent Review, and Retrospective Review processes in accordance with the Member's eligibility and benefits.

Preferred Modes of Data Submission to Piedmont Medical Management

Piedmont prefers contracted providers utilize our iExchange platform to submit authorization requests and attach clinical information needed to conduct prior authorization.

Please note: Do not send the entire chart. Only send the applicable information such as admission history and physical, pertinent lab and test information, physician progress notes, etc.

Provider may also fax a request for services to 434-947-4465.

Urgent requests can also be called into Piedmont's Medical Management Department at 434-947-4463.

Please note: Piedmont is available to accept authorization requests during off hours via fax, iExchange, or voicemail.

How to Obtain Pre-Certification

Please have the following information available when you request pre-certification:

- Covered Individual's name, identification number, and date of birth
- Diagnosis including ICD-10 code, scheduled procedure including CPT codes, and date of admission or expected date of service
- Name of the referring provider and referring to provider or facility
- The Covered Individual's medical records. (Please have them in front of you because you will be asked specific questions about the Covered Individual's past treatment and ongoing medical condition. In some cases, you may be asked to submit additional information in writing.)

Upon receipt of the pre-certification request, Piedmont's medical management department staff will:

- Confirm Covered Individual eligibility
- Verify the Covered Individual's insurance coverage.
- Evaluate Medical Necessity

Upon submission of required information, the precertification staff will provide the Member, the requesting provider and the prescribing provider with notification of the determination of coverage as expeditiously as the Member's health condition requires, or at least orally, within the standard or expedited required timeframe, unless additional information is needed.

Piedmont will make standard requests for services within 15 days of receipt or prior to the date of service if date is sooner than 15 days after receipt. For expedited urgent requests, Piedmont will provide a decision within 72 hours. For concurrent review, decisions will be made within 24 hours of the receipt of information. Notification will be made to providers and Members within the above allotted timeframes as well. Piedmont may request additional information and take an extension when the extension will be in the best interest of our Member.

On-Site Review

If Plan maintains an on-site Initial Request/Continued Stay Review program, the Facility's UM program staff is responsible for following the Covered Individual's stay and documenting the prescribed plan of treatment, promoting the efficient use of services and resources, and facilitating available alternative outpatient treatment options. Facility agrees to cooperate with Piedmont and provide Piedmont with access to Covered Individual's medical records, and access to the Covered Individual in performing on-site Initial Request/Continued Stay Review and discharge planning related to, but not limited to, the following:

- Emergency and/or maternity admissions
- Ambulatory surgery
- Case management
- Pre-admission testing (PAT)
- Inpatient Services, including Neo-Natal Intensive Care Unit (NICU)
- Focused procedure review Discharge Planning
- Observation stays

Discharge planning includes the coordination of medical services and supplies, medical personnel, and family to facilitate the Covered Individual's timely discharge to a more appropriate level of care following an inpatient admission.

Urgent/Emergency Services

PCP authorization is not required for Emergency Services. PCPs agree to have health care services available and accessible to Members, twenty-four (24) hours per day, and seven (7) days per week. When the PCP is not available and accessible to Member, the PCP is responsible for ensuring appropriate arrangements are made for another PCP to provide Health care services to Member, in accordance with Piedmont Access and Availability Standards.

PCPs can utilize the following to ensure Members have access to medical direction or care:

- PCP can utilize an answering service that forwards callers (i.e., Members) directly to the PCP or a designated covering PCP for medical direction or care during PCPs non-business hours.
- PCP can utilize any other delivery method that would provide the Member with direct access to the PCP or designated covering PCP with medical direction or care during PCPs non-business hours.

Participating Provider's specialty services immediately following a non-contracted or out-of-network facility emergency department discharge or an inpatient hospital discharge, whether in or outside the mandatory post-operative period, excluding direct access services, require a Referral Form issued by the Member's PCP for HMO and some POS plans. Please contact CS if there are questions about necessity based on Member's plan.

Behavioral Health and Substance Abuse Services

Piedmont encourages all health care providers to be cognizant of the impact that behavioral health problems may have on physical health, to treat the Member accordingly and to refer to, and coordinate with, a behavioral health specialist when necessary. Providers are encouraged to be holistic in their approach and to promote the integration of behavioral health and physical health services in their Member's care. All contact with behavioral health providers needs to be conducted in accordance with state and federal privacy policies in effect at the time.

Coordination of care with behavioral health providers is strongly encouraged and especially important for Members who present with physical health problems in addition to:

- Chronic history of depression, anxiety or substance abuse/dependence.
- Multiple psychotropic medications.
- New prescriptions for atypical anti-psychotics and/or antidepressants when Member is taking medication for a medical condition.
- Those with a substance abuse problem and prescribed potentially addictive medication.
- Pregnant women who require medication to manage a behavioral health condition.
- Other conditions which may warrant this same coordination and collaboration of care between Piedmont providers and behavioral health providers.

Cooperation between Participating Providers and behavioral health practitioners is critical to the provision of effective and appropriate care. Participating Providers are expected to:

- Refer Members to appropriate behavioral health provider.
- Be available for consultation with the Member's behavioral health practitioner.
- Seek release of information in cases of known behavioral health provider involvement.

- Abide by all applicable privacy and confidentiality laws and regulations governing the sharing of Protected Health Information and other confidential information, including but not limited to Virginia's Health Information Privacy Act, HIPAA and 42 CFR Part 2.
- Assess all pregnant Members for depression, substance abuse and other behavioral health problems, as well as nicotine dependence.
- Closely monitor any Members with diagnosis of diabetes and schizophrenia with special attention to LDL-C and HbA1c.
- Coordinate and collaborate with behavioral health providers for those Members with chronic medical conditions such as, but not limited to, CAD, CHF, COPD, Diabetes, etc.

Experimental/Investigational or Unproven Services

Experimental, investigational or unproven services are any medical, surgical, psychiatric, substance abuse or other health care technologies, supplies, treatments, diagnostic procedures, drug therapies or devices that are determined by Piedmont to be:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use, or not identified in the American Hospital Formulary Service as appropriate for the proposed use, and are referred to by the treating Health Care Provider as being investigational, experimental, research based or educational;
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II, or III clinical trial set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight; or
- The subject of a written research or investigational treatment protocol being used by the treating Health Care Provider or by another Health Care Provider who is studying the same service.

If the requested service is not represented by criteria listed above, Piedmont reserves the right to require demonstrated evidence available in the published, peer-reviewed medical literature. This demonstrated evidence should support:

- The service has a measurable, reproducible positive effect on health outcomes as evidenced by well-designed investigations, and has been endorsed by national medical bodies, societies or panels with regard to the efficacy and rationale for use;
- The proposed service is at least as effective in improving health outcomes as are established treatments or technologies or is applicable in clinical circumstances in which established treatments or technologies are unavailable or cannot be applied;
- The improvement in health outcome is attainable outside of the clinical investigation setting;
- The majority of Health Care Providers practicing in the appropriate medical specialty recognize the service or treatment to be safe and effective in treating the particular medical condition for which it is intended; and

- The beneficial effect on health outcomes outweighs any potential risk or harmful effects.

Piedmont reserves the right to make judgment regarding coverage of experimental, investigational and/or unproven procedures and treatments. Participating Providers are encouraged to contact the Medical Management Department for precertification review if the service could potentially be experimental/investigational or potentially unproven services.

Failure to Comply with Utilization Management Program

Provider and Facility acknowledge that the Plan may apply monetary penalties such as a reduction in payment, as a result of Provider's or Facility's failure to provide notice of admission or obtain Pre-service Review on specified outpatient procedures, as required under this Agreement, or for Provider's or Facility's failure to fully comply with and participate in any cost management procedures and/or UM programs.

Peer-to-Peer Review Process

Providers can initiate a peer-to-peer request if he/she is the attending, treating or ordering physician, Nurse Practitioner, or Physician Assistant who provides the care for which any adverse Medical Necessity determination is made. In compliance with nationally recognized accrediting body guidelines. Provider or his/her designee may request the peer-to-peer review. Others such as hospital representatives, employers and vendors are not permitted to do so.

Audits/Records Requests

At any time, Piedmont may request on-site, electronic or hard copy medical records, utilization review sheets and/or itemized bills related to Claims for the purposes of conducting audits and reviews to determine Medical Necessity, diagnosis and other coding and documentation of services rendered.

CASE MANAGEMENT

The purpose of Piedmont's Complex Case Management Program is to ensure that medically necessary care is delivered in the most cost-efficient setting, utilizing the most appropriate provider(s), and in the most cost-efficient manner and timeframe for Members who require extensive or ongoing services. The program is focused on improving access to needed resources for Members with complex and chronic care issues.

Proactive clinical and administrative processes are implemented to identify, coordinate, and evaluate appropriate high-quality services that may be delivered on an ongoing basis. The

Complex Case Management Program is evaluated, updated, and approved annually along with the Utilization Management Program.

The Complex Case Management process is directed at coordinating resources and creating appropriate cost-effective alternatives for catastrophically, chronically ill or injured Members on a case-by-case basis to facilitate the achievement of realistic treatment goals. Medical Directors assist in making decisions of medical appropriateness for the Complex Case Management process.

Qualified and appropriately licensed health professionals are involved in the Complex Case Management Program. Case managers coordinate individual services for Members whose needs include ongoing medical care, home health and hospice care, rehabilitation services and preventive services. The case managers work collaboratively with those involved in the Member's care, including discharge planners, care managers, and/or care navigators at hospitals, SNFs, other healthcare facilities, and ambulatory settings (e.g., PCMH). Piedmont may conduct hospital rounds for utilization review and discharge planning at our local hospitals including having staff on-site to meet with Members, caregivers, and attending physicians to assist in the care of our Members. The medical directors and Utilization Management Committee members are substantially involved in these case management functions.

The goal of Complex Case Management is to help Members regain optimum health or improved functional capability in the right setting and in a cost-effective manner. It involves comprehensive assessment of the Member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow up. Complex Case Management differs from other health plan interventions in that the:

- degree and complexity of illness or condition is typically severe
- level of management necessary is typically intensive
- resources required for Member to regain optimal health or improved functionality is typically extensive

Case managers work in collaboration with the primary care physician to manage patients with complex co-morbid conditions. The case manager completes a comprehensive assessment and prioritizes the patient's needs that allow the provider, Member and/or Member representative, and case manager to develop a patient-centric action plan of care and self-management. Post discharge transitions of care are integral to this patient-centered model and include medication reconciliation, confirmation that services such as home health, durable medical equipment, and adequate social support, are in place, as appropriate. For advanced illnesses, case managers will facilitate palliative care, home health and hospice referrals.

To refer a Member to a Case Management/Disease Management Program or to learn more about a specific Case Management/Disease Management Program, providers should visit Piedmont's Provider Information Center at www.pchp.net or contact the Case Management

Department at (434) 947-4463 or toll free (800) 400-7247, Monday through Friday from 8:30 a.m. to 5:00 p.m.

DISEASE MANAGEMENT PROGRAM DEVELOPMENT

The Case Management Department conducts an analysis of the disease under consideration prior to the development of a Case Management/Disease Management program. The following criteria are evaluated:

- Disease prevalence
- Disease complexity
- Potential for reducing complications, improving quality
- Current cost of managing the disease
- Existence of an evidence-based clinical guideline to assist practitioners in the management of the disease
- Value to the Participating Provider, Member and Piedmont if the program is implemented

Case Management leadership determines the need for a specific Case Management/Disease Management program based upon the criteria listed above and submits a proposal to Piedmont's Quality Improvement Committee for review and approval. Actively practicing practitioners are participating members of Case Management/Disease Management teams and they assist in the development, implementation, and monitoring of new and established Case Management/Disease Management programs.

Practitioner Program Content

The design of all Case Management/Disease Management programs may include but is not limited to: evidence-based clinical guidelines, Member identification, passive or active enrollment, stratification, interventions based on stratification level, practitioner decision support and evaluation of program effectiveness.

Evidence-based clinical guidelines are a core component of Piedmont medical management programs. Board certified SCPs and/or PCPs are involved in the review and approval of evidenced-based guidelines.

Clinical guidelines are reviewed at least every two years or when the appropriate guideline team, Piedmont's Utilization Management Committee and/or the Quality Improvement Committee make recommendations. Identified PCPs and SCPs are involved in the development and review of new Case Management/Disease Management programs.

Piedmont's Case Management Department and the accompanying teams are responsible for program content that is consistent with current clinical practice guidelines.

Evidence-based guidelines are posted online at www.pchp.net and announcements are made in the provider newsletter. Printed copies or electronic PDF files are available upon request.

Identification of Members who benefit from Case Management/Disease Management programs is accomplished through Claims analysis using standard clinical specifications from criteria such as the Health Plan Employer Data & Information Set (HEDIS®). Member identification is also facilitated by direct referrals from PCPs, SCPs, family members, or from various Piedmont departments including Medical Management, Customer Service, Appeals, and Quality Improvement.

Enrollment and Patient Participation

All Members with a disease-specific diagnosis are identified by claims analysis and/or HEDIS® criteria.

All Members receive disease-specific informational newsletters quarterly to increase their knowledge of disease self-management. The newsletters also encourage Members to become "active" participants in the disease management program.

A Member can be enrolled in the appropriate disease management program by contacting Piedmont's Case Management Department directly or by referral from a Health Care Provider or a Piedmont department, or by accepting an invitation extended by Piedmont's Case Management Department (through disease-specific Member newsletters or direct Member invitation by letter or phone as the result of claims analysis information).

A Case Manager/Health Manager reviews the referral information and contacts the Member to either schedule an office appointment with the Case Manager or to arrange to routinely communicate with the Member telephonically. After the Member's verbal and/or written consent for participation is obtained, the Member is actively enrolled in the appropriate program. Members may choose to "opt out" by contacting Piedmont's Case Management Department.

Risk Stratification

Case Managers/Health Managers stratify active Members based on clinical criteria according to low, moderate or high risk. For example, Members with diabetes are stratified using glycosylated hemoglobin (A1c) control and the presence of risk factors.

Interventions

The degree of intervention is based on the Member's risk stratification. For example, a Member classified as low risk receives a minimum of one (1) program informational newsletter on a quarterly basis, self-management education, a plan of care, and one or more follow-up office or phone appointments. A Member with a high-risk stratification receives these interventions *plus* more frequent office/phone visits and referrals for necessary specialty or case management services.

Practitioner Decision Support

Case Managers are key to providing collaborative "real time" decision support to PCPs. Case Managers follow internally developed education Care Paths (Algorithms) that complement the clinical guidelines. The education Care Paths (Algorithms) provide a

framework for self-management education, the recommended laboratory/diagnostic studies, and targeted clinical goals.

The plan of care includes information regarding the Member's self-management of their condition, barriers, special considerations or exceptions, review of medical test results, management of co- morbidities, collaborative goal-setting and problem-solving, medication review, plans for follow-up, and preventive health monitoring. The plan of care may be reviewed and discussed by the PCP and/or SCP and the Case Manager in person, by phone, or through an electronic medical record messaging process.

The involvement of the practitioner is integral in the design of program content for all Case Management/Disease programs. Practitioner participation ensures program content is appropriate for the actively practicing PCP. All PCPs are surveyed annually to elicit feedback regarding the program(s).

Evaluation of Program Effectiveness

Program effectiveness is measured by conducting a pre- and post-analysis of pertinent clinical measures, annual Member/practitioner program satisfaction surveys and pre- and post-comparisons of services utilized by Members in the programs.

Practitioner's Rights

Practitioners who care for Members have the right to:

- Obtain information regarding Case Management/Disease Management programs and services in conjunction with Piedmont as outlined herein;
- Obtain information regarding the qualifications of the Case Management staff;
- Obtain information regarding how the Case Management staff facilitates interventions via treatment plans for individual Members;
- Know how to contact the Case Managers responsible for managing and communicating with their patients;
- Request the support of the Case Manager to make decisions interactively with Members regarding their health care;
- Receive courteous and respectful treatment from Case Management Staff at all times; and
- File a Complaint when dissatisfied with any component of the Case Management/Health Management programs by contacting the Case Management Department at **(434) 947-4463, toll free at (800) 400-7247**, or the Customer Service Department at the number listed on your patient's insurance card.

PROGRAM EXCEPTION PROCESS

Participating Providers may request coverage for items or services that are included under the Member's benefit package. Participating Providers may also request an exception for services or items that exceed limits on the fee schedule if the limits are not based in statute or regulation. These exceptions should be requested in advance of providing services. To request program exceptions, Participating Providers must follow the Piedmont Prior Authorization process.

ADVANCE DIRECTIVES

The Patient Self-Determination Act of 1990, effective December 1, 1991, requires providers of services and health maintenance organizations under the Medicare and Medicaid programs to assure that individuals receiving services will be given an opportunity to participate in and direct health care decisions affecting themselves and be informed of their right to have an advance directive. An advance directive is a legal document through which a Member may provide directions or express preferences concerning his or her medical care and/or to appoint someone to act on his or her behalf. Advance directives are used when the Member is unable to make or communicate decisions about his or her medical treatment. Advance directives are prepared before any condition or circumstance occurs that causes the Member to be unable to actively make decisions about his or her medical care.

In Virginia, there are two types of advance directives:

- Living will or health care instructions
- Appointment of a Health Care Power-of-Attorney

Providers are required to comply with federal and state laws regarding advance directives (also known as health care power of attorney and living wills), as well as contractual requirements, for adult Members. In addition, Piedmont requires that providers obtain and maintain advance directive information in the Member's medical record. Requirements for providers include:

- Maintaining written policies that address a Member's right to make decisions about their medical care, including the right to refuse care
- Providing Members with written information about advance directives
- Documenting the Member's advance directives or lack of one in his or her medical record
- Communicating the Member's wishes to attending staff in hospitals or other facilities
- Not discriminating against a Member or making treatment conditional based on his or her decision to have or not have an advance directive
- Providing staff education on issues related to advance directives

Piedmont provides information about advance directives to Members in the Member Handbook, including information about the Member's right to make decisions about their medical care, how to obtain assistance in completing or filing a living will or health care power-of-attorney, and general instructions.

For more information or to file Complaints regarding noncompliance with advance directive requirements, you may contact:

Virginia's Office of the Attorney General
202 North Ninth Street
Richmond, Virginia 23219
Phone: (804) 786-2071.

PHARMACY SERVICES

The information in this section applies to Piedmont Members with our prescription drug coverage. Piedmont has a variety of prescription drug benefit designs. A Member's cost is usually lower for a generic drug than for a brand-name medication.

Pharmacy Benefit Drugs Requiring Authorization

Piedmont Pharmacy is committed to helping Piedmont's Members manage their health care benefits. Prior authorization, quantity limits, step therapy and dose optimization are approved by Caremark's National Pharmacy and Therapeutics Committee to ensure that Members' benefits provide them with access to safe, appropriate and effective medications.

- **Prior authorization** may require a Member to obtain approval before receiving benefits to cover the medication.
- **Step therapy** may require a Member to use another medication first before receiving benefits for the requested medication.
- **Quantity limits** may affect the quantity of a certain medication for which a Member can receive benefits each month.
- **Dose optimization** (or dose consolidation) usually involves converting from a twice-daily dosing schedule to a once-daily dosing schedule. A once-daily dosing schedule may increase compliance and decrease expenses for the Member and Piedmont.

To request prior authorization for a drug, call CVS Caremark's pharmacy prior authorization help desk at 855-582-2022.

Mail Order Pharmacy Program

Piedmont Members can enroll in the Caremark Mail Order Pharmacy Program for up to a ninety-day (90-day) supply of maintenance medications (those used to treat chronic health conditions). Many of Piedmont's prescription drug plans include discounted coinsurance payments for a mail order 90-day supply wherein the Member pays coinsurance for the equivalent of a 60-day supply, thus lowering the cost to the Member.

We recommend initial prescriptions for maintenance medications of no more than a thirty-day (30-day) supply to minimize waste should the drug or dosage need to be changed. Once the correct drug and dosage are established, if medically appropriate, we recommend using Caremark's Mail Order Pharmacy Program for a 90-day fill for better compliance and cost savings to the Member.

Specialty Medications

Specialty medications must be obtained through Piedmont's contracted Specialty Pharmacy (Caremark or a limited distribution pharmacy provider). The list of specialty medications is subject to change. We encourage you to use Caremark's Specialty Pharmacy to fill specialty prescriptions for your Piedmont patients. It's a full-service specialty pharmacy that delivers specialty drugs to more than one (1) million people nationwide and provides case management services to patients taking specialty medications. Piedmont prescription benefit plans require certain specialty medications be filled only by Caremark's Specialty Pharmacy.

Caremark's Specialty Pharmacy offers you and our Members these personalized services and resources:

- A team of nurses, pharmacists and care coordinators who offer personal support related to the Member's specialty medications and associated health care concerns
- Care coordinators who remind patients when it's time to refill their prescriptions and coordinate delivery as requested
- A clinical case management team that understands our Members' needs and provides helpful information about their condition to support your treatment plan

To use Caremark's Specialty Pharmacy to fill specialty medications for your Piedmont patients (self-administered medications), you have two options:

1. Call toll free at 800-237-2767 and provide the requested information to a care coordinator. Care coordinators are available from 7:30am to 9pm EST, Mon – Fri.

   OR

2. Fax the prescription and a copy of the Member's health plan ID card to Caremark's Specialty Pharmacy toll-free at 800-323-2445.

Pharmacy Benefit Management and Drug List/Formulary

Development and management of drug formularies is an integral component in the pharmacy benefit management (PBM) services. Piedmont partners with CVS Caremark to provide this service. Formularies have two primary functions: 1) to help the health plan provide pharmacy care that is clinically sound and affordable for plans and their plan Members; and 2) to help manage drug spend through the appropriate selection and use of drug therapy.

Underlying principles of the CVS Caremark Formulary Development and Management Process include the following:

- Commitment to providing a clinically appropriate formulary.
- Decisions on formulary are made by a committee of independent, unaffiliated clinical pharmacists and physicians.
- The physician always makes the ultimate prescribing determination of the most appropriate course of therapy.

The formulary development process is based on nearly two decades of experience as well as extensive clinical pharmaceutical management resources. The formulary is developed and managed through the activities of the CVS Caremark National Pharmacy and Therapeutics (P&T) Committee and Formulary Review Committee (FRC).

Piedmont has multiple formulary/drug lists on our website at www.PCHP.net. Please select the appropriate drug list when searching for covered medications.

Additions/deletions to the Piedmont's drug list/formulary currently occur four (4) times a year. For Piedmont Members to receive their highest level of benefits, all Providers and Facilities should use the drug list/ formulary when prescribing medications. A copy of the drug list/formulary is available online on our website at www.PCHP.net.

REIMBURSEMENT & CLAIM SUBMISSION

This section of the Provider Manual has been created for use by all Plan practitioners/providers and their staff to:

- Provide information about Piedmont's claim submission requirements.
- Reduce the number of claim rejections and/or claim re-submissions because of initial claim errors.
- Facilitate timely payment of claims.

GENERAL PAYMENT GUIDELINES

To ensure accurate and timely processing of claims, Piedmont follows CMS claim submission required fields and guidelines. CMS required fields and guidelines can be found in the Medicare Claims Processing Manual.

Claims must be submitted in one of these formats:

- Electronic Claims Submission using ASC X12 837I (institutional) or 837P (professional). HIPAA Standard Implementation Guides should be used when submitting electronic claims.
- CMS 1500 Form
- UB04 Form

Member Eligibility Verification

Piedmont issues ID cards to each Member. Prior to rendering or billing for services, providers should verify each Member's eligibility for benefits through our online provider portal or call Piedmont's Customer Service at 800-400-7247.

Provider Claim Submission

Although Piedmont accepts both electronic and manual Claims submission, Piedmont encourages providers to submit claims electronically whenever possible for the most efficient, accurate, and timely processing. When submitting claims electronically, use **Payer ID 55768**.

Balance Billing

In accordance with Virginia law, effective January 1, 2021, Piedmont Members may be protected from "balance billing" when they receive emergency services from an out-of-network hospital, or an out-of-network provider at an in-network hospital. The balance billing protection also apply to non-emergency surgical or ancillary services from an out-of-network lab or health care professional at an in-network hospital, ambulatory surgical center, or other health care facility.

In-Network Providers may only bill Piedmont Members for their applicable copayments, coinsurance, deductible and non-covered services. Additional legal requirements can be found at Va. Code § 38.2-3445.01.

Timely Submission of Claims

Piedmont encourages providers to submit all claims – paper and electronic – as soon as possible after the date of service to facilitate prompt payment and avoid delays that may result from expiration of timely filing requirements.

Unless otherwise stated in your Agreement, providers must submit clean claims to Piedmont within 365 days from the date of service. The start date for determining the

timely filing period is the “from” date reported on a CMS-1500 or 837P and the “through” date used on the UB-04 or 837I for institutional claims.

Unless prohibited by federal law or CMS, Piedmont may deny payment of any claim that fails to meet Piedmont’s submission requirements for clean claims or failure to timely submit a clean claim to Piedmont.

Claims received more than 365 days from the date of services will be denied as a Late Claim Submission.

Paper Claim Submissions

Paper claims should be completed in their entirety, including but not limited to the following elements, as applicable:

- The Patient’s name and their relationship to the Plan Subscriber name
- The Patient name, address, birthdate, and sex
- Piedmont’s subscriber name, address, ID #, plan name, group number, date of birth, sex
- Other insurance name, policy #, group #, and payment information
- Workers’ compensation information including name of Workers’ compensation payer, Case #, and date of accident
- Motor vehicle accident information including name of auto insurance company, policy number, and date of accident
- Other accident information including any liability insurance, policy number, date of accident
- Federal Tax ID #
- Name, address, and NPI # of Facility
- Name, address, and NPI # of Billing Provider
- Name and NPI # of Rendering Provider
- Name and NPI # of Referring Provider
- Name and NPI # of Attending Provider (if applicable)
- Name and NPI # of Other Provider (if applicable)
- Signature of physician or supplier or accept assignment indicator
- Patient Control or Account #
- Value codes and amounts
- Date of illness, injury or pregnancy (LMP)
- Prior authorization number, referral number
- Treatment authorization codes
- Document control number, resubmission code, original reference number, original claim number (for corrected claims)
- Type of Bill or place of service
- Statement Covers Period from and through dates, admit date
- Hospital dates related to current services, dates of service
- Condition codes
- Occurrence codes and dates
- Diagnosis codes (ICD-9 or ICD10), ICD indicator, patient reason diagnosis code, admit diagnosis code, diagnosis pointer
- Revenue codes, revenue code descriptions, HCPCS, CPT codes, principal procedure codes, procedure codes, procedure modifiers, NDC codes for drug therapy
- Days or units, service units
- Line billed charges, total billed charges

Piedmont Community Health Plan paper claims should be mailed to:

Piedmont Community Health Plan
P.O. Box 21406
Eagan, MN 55121

Follow these guidelines for faster paper claims processing:

- Do not submit hand-written forms. These will be returned to you to submit electronically or on a CMS 1500 form in typed format.
- Do not use script fonts
- Use a black bold font
- Do not use highlighter or other markings on the claim to emphasize any boxes
- Do not enter information outside the designated boxes within each form
- Do not enter information in the wrong box or in the wrong order
- Do not include non-HIPAA-compliant information
- Accurately complete all required fields

Common Claims Filing Errors

Piedmont adheres to national and local payment policy requirements to ensure proper payment of claims. Common types of errors that result in claim denials include:

- Billing/data entry errors
- Noncompliance with coverage policy
- Billing for services that are not medically necessary
- Incorrect Member ID number
- Invalid/missing Diagnosis code, Healthcare Common Procedure Coding System (HCPCS) or revenue codes, procedure modifiers, quantity/units/time
- Past timely filing requirements
- Missing or invalid National Provider Identifier (NPI)

Rejected Claims

Rejected claims are not processed claims and the provider will receive a letter that the claim was rejected. There are NO APPEAL rights – the claim must be corrected and resubmitted for further consideration.

In some cases, additional documentation may be required for the claim to complete adjudication. After Piedmont receives the additional information, the claim can be adjusted or corrected.

Appeals

Any disputed denied claim must be appealed within 180 days from the claim decision date. Appeals can be submitted via our provider portal, fax, email, or USPS mail. Refer to the Provider Appeals and Disputes section of this manual for additional information.

Corrected Claims

All requests for corrected claims must be received within 365 days from the date of explanation of payment. Corrected claims received after 365 days from the date of service will be denied for untimely filing.

Coordination of Benefits

Piedmont will coordinate payment of Covered Services in accordance with the terms of a Member's benefit plan, applicable state and federal laws, and CMS guidance. Providers should bill primary insurers for items and services they provide to a Member before they submit a secondary claim for the same items or services to Piedmont. The secondary claim must include information verifying the payment amount received from the primary insurer and/or an explanation of benefits from the primary payer or Medicare.

Worker's Compensation/Accident-Related Claims

Any claim with an injury diagnosis code for a patient will be reviewed. Piedmont communicates with the Member to determine if the injury is work-related or for some plans if a third party is involved for Subrogation. Piedmont will automatically send a letter to the Member requesting information about their injury.

Claim Edits

Providers are subject to Piedmont's coding and editing policy. The coding and editing policy is intended to ensure that providers are reimbursed based on the code or codes that accurately describe the health care services provided. A copy of the policy can be found on Piedmont's website at www.pchp.net.

CREDENTIALING

Credentialing Scope

A. Professional Practitioners:

1. Practitioner Types: Piedmont credentials the following health care practitioners when an independent relationship exists between Piedmont and the Practitioner, or the individual Practitioner is listed individually in Piedmont's provider network directory; and exclusions in section 2 (see below) do not apply:

    - Medical Doctors (MD)
    - Doctors of Osteopathic Medicine (DO)
    - Doctors of Podiatry
    - Chiropractors
    - Optometrists providing Health Services covered under the Health Benefits Plan
    - Oral and Maxillofacial surgeons
    - Psychologists who are state-certified or licensed and have doctoral or master's level training
    - Clinical social workers who are state-certified or state-licensed and have master's level training
    - Psychiatric nurse practitioners who are nationally or state certified or state licensed or behavioral nurse specialists with master's level training
    - Other behavioral health care specialists who are licensed, certified or registered by the state to practice independently
    - Telemedicine practitioners who have an independent relationship with Piedmont and who provide treatment services under the Health Benefits Plan
    - Medical therapists (e.g., physical therapists, speech therapists, and occupational therapists)
    - Licensed Genetic Counselors who are licensed by the state to practice independently
    - Audiologists who are licensed by the state to practice independently
    - Certified nurse midwives
    - Nurse Practitioners in certain circumstances. (See Section II Criteria for Selecting Practitioners, D. Participation Criteria and Exceptions for Certified Nurse Midwives and Nurse Practitioners.

2. Practitioners with whom we have a contractual relationship do not require credentialing when the Practitioner:

    - Practices exclusively in an inpatient setting and provides care for Piedmont Covered Individuals only because Covered Individuals are directed to the hospital or another inpatient setting; OR

- Practices exclusively in free-standing facilities and provides care for Piedmont Covered Individuals only because Covered Individuals are directed to the facility.

  Examples of this type of Practitioner include, but are not limited to:
  - Pathologists
  - Radiologists
  - Anesthesiologists
  - Neonatologists
  - Emergency Room Physicians
  - Hospitalists
  - Pediatric Intensive Care Specialists
  - Other Intensive Care Specialists

3. The following behavioral health practitioners are not subject to professional conduct and competence review under Piedmont's credentialing program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:

   - Certified Behavioral Analysts
   - Certified Addiction Counselors
   - Substance Abuse Practitioners

   Note: an individual who is contracted and practices in the office setting must be credentialed when that practitioner meets criteria in section 2 of this Credentialing Policy, above.

B. Health Delivery Organizations (HDOs):

1. Piedmont credentials the following Health Delivery Organizations:

   - Hospitals
   - Home Health Agencies
   - Skilled Nursing Facilities
   - Ambulatory Surgical Centers
   - Behavioral Health Facilities providing mental health and/or substance abuse treatment in inpatient, residential or ambulatory settings, including:
     - Adult Family Care/Foster Care Homes
     - Ambulatory Detox
     - Community Mental Health Centers (CMHC)
     - Crisis Stabilization Units
     - Intensive Family Intervention Services
     - Intensive Outpatient – Mental Health and/or Substance Abuse
     - Methadone Maintenance Clinics

    - Outpatient Mental Health Clinics
    - Outpatient Substance Abuse Clinics
    - Partial Hospitalization – Mental Health and/or Substance Abuse
    - Residential Treatment Centers (RTC) – Psychiatric and/or Substance Abuse
- Birthing Centers
- Convenient Care Centers/Retail Health Clinics/Walk-In Clinics
- Intermediate Care Facilities
- Urgent Care Centers
- Federally Qualified Health Centers (FQHC)
- Home Infusion Therapy when not associated with another currently credentialed HDO
- Rural Health Clinics

2. The following Health Delivery Organizations are not subject to professional conduct and competence review under Piedmont's credentialing program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

    - Clinical laboratories (a CMS-issued CLIA certificate or a hospital-based exemption from CLIA)
    - End Stage Renal Disease (ESRD) service providers (dialysis facilities)
    - Portable x-ray Suppliers
    - Home Infusion Therapy when associated with another currently credentialed HDO

Credentials Committee

The decision to accept, retain, deny or terminate a practitioner's participation in a Network or Plan Program is conducted by a peer review body, known as Piedmont's Medical Affairs Committee.

The Medical Affairs Committee will meet at least once every other month and ad hoc as needed. The presence of a majority of voting of the Medical Affairs Committee members constitutes a quorum. The chair must be a state or regional lead medical director, or a Piedmont medical director of business also represented by the chair. The Medical Affairs Committee will include at least five, but no more than ten external providers representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the medical director). At least two of the provider committee members must be credentialed for each line of business (Commercial, Exchange) offered within the geographic purview of the Medical Affairs Committee.

The Medical Affairs Committee will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation, or to terminate a practitioner from participation in one or more Networks or Plan Programs, require a majority vote of the voting members of the Medical Affairs Committee attendance, the majority of whom are Network practitioners.

During the credentialing process, all information that is obtained is highly confidential. All Medical Affairs Committee meeting minutes and practitioner files are stored in highly secured electronic data system and can only be seen by appropriate Credentialing staff, medical directors, and Medical Affairs Committee members.

Documents in these files may not be reproduced or distributed, except for confidential peer review and credentialing purposes; and peer review protected information will not be shared externally.

Practitioners and HDOs are notified that they have the right to review information submitted to support their credentialing applications. This right includes access to information obtained from any outside sources with the exception of references, recommendations or other peer review protected information. Providers are given written notification of these rights in communications from Piedmont's credentialing verification office, which initiates the credentialing process. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, the credentialing verification office will contact the practitioner or HDO within thirty (30) calendar days of the identification of the issue. This communication will specifically notify the practitioner or HDO of the right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the specific process for submission of this additional information, including where it should be sent. Depending on the nature of the issue in question, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue(s) in question, including copies of the correspondence or a detailed record of phone calls, will be clearly documented in the practitioner's credentials file. The practitioner or HDO will be given no less than fourteen (14) calendar days in which to provide additional information. Upon request, applicant will be provided with the status of his or her credentialing application. Written notification of this right may be included in a variety of communications from Piedmont which includes the letter which initiates the credentialing process, the provider web site or Provider Manual. When such requests are received, providers will be notified whether the credentialing application has been received, how far in the process it has progressed and a reasonable date for completion and notification. All such requests will be responded to verbally unless the provider requests a written response.

Piedmont may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The Medical Affairs Committee will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

Nondiscrimination Policy

Piedmont will not discriminate against any applicant for participation in its Networks or Plan Programs on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Piedmont will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities that are provided to the Covered Individuals to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners/HDOs require additional individual review by the Medical Affairs Committee are made according to predetermined criteria related to professional conduct and competence as outlined in Piedmont Credentialing Program Standards. Medical Affairs Committee decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process.

Initial Credentialing

Each practitioner or HDO must complete a standard application form when applying for initial participation in one or more of Piedmont's Networks or Plan Programs. This application may be a state-mandated form or a standard form created by or deemed acceptable by Piedmont. For practitioners, the Council for Affordable Quality Healthcare (CAQH), a Universal Credentialing Data source is utilized. CAQH built the first national provider credentialing database system, which is designed to eliminate the duplicate collection and updating of provider information for health plans, hospitals and practitioners. To learn more about CAQH, visit their web site at www.caqh.org.

Piedmont will verify those elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. Piedmont may use an external credentialing verification organization for source information. Final determination is made by Piedmont. All verifications must be current and verified within the one hundred eighty (180) calendar day period prior to the Medical Affairs Committee making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Piedmont will review verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating Covered Individuals.
Hospital admitting privileges at a TJC, NIAHO or AOA accredited hospital, or a Network hospital previously approved by the committee.
DEA/CDS and state-controlled substance registrations a. The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating Covered Individuals. Practitioners who see Covered Individuals in more than one state must have a DEA/CDS registration for each state.
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

Verification Element
Accreditation, if applicable
License to practice, if applicable
Malpractice insurance
Medicare certification, if applicable
Department of Health Survey Results or recognized accrediting organization certification
License sanctions or limitations, if applicable
Medicare, Medicaid or FEHBP sanctions

Recredentialing

The recredentialing process incorporates re-verification and the identification of changes in the practitioner's or HDO's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess

whether practitioners and HDOs continue to meet Piedmont's credentialing standards.

During the recredentialing process, Piedmont will review verification of the credentialing data as described in the tables under Initial Credentialing unless otherwise required by regulatory or accrediting bodies. Piedmont may use an external credentialing verification organization for source information. Final determination is made by Piedmont. These tables represent minimum requirements.

All applicable practitioners and HDOs in the Network within the scope of Piedmont Credentialing Program are required to be recredentialed every three (3) years unless otherwise required by contract or state regulations.

Health Delivery Organizations

New HDO applicants will submit a standardized application to Piedmont for review. If the candidate meets Piedmont's screening criteria, the credentialing process will commence. To assess whether Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and recredentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail in Piedmont's Credentialing Program Standards, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Piedmont may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HDO.

Recredentialing of HDOs occurs every three (3) years unless otherwise required by regulatory or accrediting bodies. Each HDO applying for continuing participation in Networks or Plan Programs must submit all required supporting documentation.

On request, HDOs will be provided with the status of their credentialing application. Piedmont may request, and will accept, additional information from the HDO to correct incomplete, inaccurate, or conflicting credentialing information. The Medical Affairs Committee will review this information and the rationale behind it, as presented by the HDO, and determine if a material omission has occurred or if other credentialing criteria are met.

Ongoing Sanction Monitoring

To support certain credentialing standards between the recredentialing cycles, Piedmont has established an ongoing monitoring program. Credentialing performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listings/reports within thirty (30) calendar days of the time they are made available from the various sources including, but not limited to, the following:

- Office of the Inspector General (OIG)
- Federal Medicare/Medicaid Reports
- Office of Personnel Management (OPM)
- State licensing Boards/Agencies
- Covered Individual/Customer Services Departments
- Clinical Quality Management Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
- Other internal Piedmont Departments
- Any other verified information received from appropriate sources

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response including, but not limited to: review by the Medical Affairs Committee of Piedmont, review by the Piedmont Medical Director, referral to the Medical Affairs Committee, or termination. Piedmont's credentialing departments will report practitioners or HDOs to the appropriate authorities as required by law.

Appeals Process

Piedmont has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of Piedmont's Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Piedmont may wish to terminate practitioners or HDOs. Piedmont also seeks to treat Network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating participation in Piedmont's Networks for professional competence and conduct reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB). Additionally, Piedmont will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is the intent of Piedmont to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of Piedmont's Networks or Plan Programs and those denials of request for initial participation which are reported to the NPDB that were based on professional competence and conduct considerations. Immediate terminations may be imposed due to the practitioner's or HDO's suspension or loss of licensure, criminal conviction, or Piedmont's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Covered Individuals. A practitioner/HDO whose license has been suspended or revoked has no right to informal review/reconsideration or formal appeal.

Reporting Requirements

When Piedmont takes a professional review action with respect to a practitioner's or HDO's participation in one or more of its Networks or Plan Programs, Piedmont may have an obligation to report such to the NPDB. Once Piedmont receives a verification of the NPDB report, the verification report will be sent to the state licensing board. The credentialing staff will comply with all state and federal regulations in regard to the reporting of adverse determinations relating to professional conduct and competence. These reports will be made to the appropriate, legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

I. Eligibility Criteria

Health care practitioners:

Initial applicants must meet the following criteria to be considered for participation:

A. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP; and

B. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he/she provides services to Covered Individuals; and

C. Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Covered Individuals; the DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Covered Individuals. Practitioners who see Covered Individuals in more than one state must have a DEA/CDS registration for each state.

Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the CC:

A. For MDs, DOs, DPMs, and oral and maxillofacial surgeons, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Podiatric Surgery (ABPS), American Board of Podiatric Medicine (ABPM), or American Board of Oral and Maxillofacial Surgery (ABOMS)) in the clinical discipline for which they are applying.

B. Individuals will be granted five years or a period of time consistent with ABMS

board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.

C. Individuals with board certification from the American Board of Podiatric Medicine will be granted five years after the completion of their residency to meet this requirement. Individuals with board certification from the American Board of Foot and Ankle Surgery will be granted seven years after completion of their residency to meet this requirement.

D. If one or more of the following exceptions apply, Piedmont may choose to waive the board certification requirement for participation in the Network.

1. The provider requesting in-network status services a county or city medically under-served in the Piedmont network area.
2. Language, ethnic understanding or other cultural barriers are considered when determining access of care.
3. Community perception of access and consumer sentiment will be considered by Piedmont in making determinations regarding geographic and transportation impediments to access of health care services.
4. The provider is Board Eligible by virtue of recent completion of training and/or other requirements for certification by a recognized medical specialty board.
5. A provider who has been in active medical practice for at least ten (10) years in their present or previous medical community and for whom there is documented evidence that the provider is in good standing in that medical community as evidenced by unrestricted hospital privileges for two (2) years, as applicable, and two (2) acceptable letters of recommendation from their peers. In addition, the provider must have a lack of significant malpractice issues and meet all other Piedmont Credentialing Standards for network participation with the exception of Board Certification.
6. The provider has an illness that prevents him or her from completing the requirements for Board certification.
7. Providers, who have met prior period Piedmont Board Waiver Criteria and continue to meet current waiver criteria, shall be eligible to participate in the network.
8. A provider who is currently in Piedmont's Network when Piedmont's Board certification standards change is eligible to be Grandfathered as in network. Upon recredentialing, all criteria for providers that are not board certified will need to be met.

E. For MDs and DOs, the applicant must have unrestricted hospital privileges at The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (NIAHO), an AOA accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem

hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.

II. Criteria for Selecting Practitioners

A. New Applicants (Credentialing)

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations;
2. Application attestation signed date within one hundred eighty (180) calendar days of the date of submission to the CC for a vote;
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;
4. No evidence of potential material omission(s) on application;
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Covered Individuals;
6. No current license action;
7. No history of licensing board action in any state;
8. No current federal sanction and no history of federal sanctions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report);
9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Covered Individuals. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Covered Individuals. Practitioners who treat Covered Individuals in more than one state must have a valid DEA/CDS registration for each applicable state.
10. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions;
11. No history of or current use of illegal drugs or history of or current alcoholism;
12. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
13. No gap in work history greater than six (6) months in the past five (5)

years except those related to parental leave or immigration where twelve (12) month gaps will be acceptable. Other gaps in work history of six to twenty-four (6 to 24) months will be reviewed by the Chair of the CC and may be presented to the CC if the gap raises concerns of future substandard professional conduct and competence. In the absence of this concern the Chair of the CC may approve work history gaps of up to two (2) years.

14. No history of criminal/felony convictions or a plea of no contest;
15. A minimum of the past ten (10) years of malpractice case history is reviewed.
16. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Piedmont's Provider Directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
17. No involuntary terminations from an HMO or PPO;
18. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
    a. investment or business interest in ancillary services, equipment or supplies;
    b. voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    c. voluntary surrender of state license related to relocation or nonuse of said license;
    d. a NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria.
    e. non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    f. previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five (5) year post residency training window;
    g. actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    h. history of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

Note: The CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

Practitioners who meet all participation criteria for initial or continued participation and whose credentials have been satisfactorily verified by the Credentialing department may be approved by the Chair of the CC after review of the applicable credentialing or recredentialing information. This information may be in summary form and must include, at a minimum, practitioner's name and specialty.

B. Currently Participating Applicants (Recredentialing)

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed and dated within one hundred eighty (180) calendar days of the date of submission to the CC for a vote;
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;
4. No evidence of potential material omission(s) on re-credentialing application;
5. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP. If, once a Practitioner participates in Piedmont's programs or provider Network(s), federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the Practitioner will become immediately ineligible for participation in the applicable government programs or provider Network(s) as well as Piedmont's other credentialed provider Network(s).
6. Current, valid, unrestricted license to practice in each state in which the practitioner provides care to Covered Individuals;
7. *No current license probation;
8. *License is unencumbered;
9. No new history of licensing board reprimand since prior credentialing review;
10. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
11. Current DEA/CDS registration and/or state-controlled substance certification without new (since prior credentialing review) history of or current restrictions;
12. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; OR for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a Network HDO who provides inpatient care to Covered Individuals needing hospitalization;

13. No new (since previous credentialing review) history of or current use of illegal drugs or alcoholism;
14. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
15. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
16. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five (5) years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
17. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
18. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
    a. investment or business interest in ancillary services, equipment or supplies;
    b. voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    c. voluntary surrender of state license related to relocation or nonuse of said license;
    d. an NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    e. nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    f. previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five (5) year post residency training window;
    g. actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    h. history of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.
19. No QI data or other performance data including complaints above the set threshold.
20. Recredentialed at least every three (3) years to assess the practitioner's continued compliance with Piedmont standards.

    *It is expected that these findings will be discovered for currently credentialed Network practitioners and HDOs through ongoing sanction monitoring.

Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: The CC will individually review any credentialed Network practitioners and HDOs that do not meet one or more of the criteria for recredentialing.

C. Additional Participation Criteria and Exceptions for Behavioral Health Practitioners (Non-Physician) Credentialing

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type:
   a. Master or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education (CSWE) or the Canadian Association on Social Work Education (CASWE).
   b. Program must have been accredited within three (3) years of the time the practitioner graduated.
   c. Full accreditation is required, candidacy programs will not be considered.
   d. If master's level degree does not meet criteria and practitioner obtained PhD training as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet the criteria, the doctoral program must be accredited by the American Psychological Association (APA) or be regionally accredited by the Council for Higher Education Accreditation (CHEA). In addition, a Doctor of Social Work from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.

2. Licensed professional counselor (LPC) and marriage and family therapist (MFT) or other master level license type:
   a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
   b. Master or doctoral degrees in divinity do not meet criteria as a related field of study.
   c. Graduate school must be accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, Council for Accreditation of Counseling and Related Educational Programs (CACREP), or Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) listings. The institution must have been accredited within three (3) years of the time the practitioner graduated.
   d. Practitioners with PhD training as a clinical psychologist can be reviewed. To meet criteria this doctoral program must either be

accredited by the APA or be regionally accredited by the CHEA. A Practitioner with a doctoral degree in one of the fields of study noted will be viewed as acceptable if the institution granting the degree has regional accreditation from the CHEA and;

e. Licensure to practice independently.

3. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
   a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing. Graduate school must be accredited from an institution accredited by one of the Regional Institutional Accrediting Bodies within three (3) years of the time of the practitioner's graduation.
   b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
   c. Certification by the American Nurses Association (ANA) in psychiatric nursing. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner.
   d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Covered Individuals.

4. Clinical Psychologist:
   a. Valid state clinical psychologist license.
   b. Doctoral degree in clinical or counseling, psychology or other applicable field of study from an institution accredited by the APA within three (3) years of the time of the practitioner's graduation.
   c. Education/Training considered as eligible for an exception is a practitioner whose doctoral degree is not from an APA accredited institution, but who is listed in the National Register of Health Service Providers in Psychology or is a Diplomat of the American Board of Professional Psychology.
   d. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.

5. Clinical Neuropsychologist:
   a. Must meet all the criteria for a clinical psychologist listed in C.4 above

and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN).

b. A practitioner credentialed by the National Register of Health Service Providers in Psychology with an area of expertise in neuropsychology may be considered.

c. Clinical neuropsychologists who are not Board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:

i Transcript of applicable pre-doctoral training, OR

ii Documentation of applicable formal one (1) year post-doctoral training (participation in CEU training alone would not be considered adequate), OR

iii Letters from supervisors in clinical neuropsychology (including number of hours per week), OR

iv Minimum of five (5) years of experience practicing neuropsychology at least ten (10) hours per week

6. Licensed Psychoanalyst:
   a. Applies only to Practitioners in states that license psychoanalysts.
   b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Credentialing Policy (e.g. psychiatrist, clinical psychologist, licensed clinical social worker).
   c. Practitioner must possess a valid psychoanalysis state license.
      i. Practitioner shall possess a master's or higher degree from a program accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, CACREP, or the COAMFTE listings. The institution must have been accredited within 3 years of the time the Practitioner graduates.
      ii. Completion of a program in psychoanalysis that is registered by the licensing state as licensure qualifying; or accredited by the American Board for Accreditation in Psychoanalysis (ABAP) or another acceptable accrediting agency; or determined by the licensing state to be the substantial equivalent of such a registered or accredited program.
         (a) A program located outside the United States and its territories may be used to satisfy the psychoanalytic study requirement if the licensing state determines the following: it prepares individuals for the professional practice of psychoanalysis; and is recognized by the appropriate civil authorities of that jurisdiction; and can be appropriately verified; and is determined by the

licensing state to be the substantial equivalent of an acceptable registered licensure qualifying or accredited program.

(b) Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.

(c) Meet examination requirements for licensure as determined by the licensing state.

D. Participation Criteria and Exceptions for Certified Nurse Midwives and Nurse Practitioners. Piedmont does not credential Physician Assistants and they are not included in Piedmont's Provider Directory.

1. Process, Requirements and Verifications – Nurse Practitioners with current Autonomous licenses:
    a. Applicant will submit the appropriate application and supporting documents as required of any other Practitioner with the exception of differing information regarding education, training and board certification.
    b. Applicant will have completed the equivalent of at least 5 years of full-time clinical experience and submitted an attestation from his/her patient care team physician(s) stating (i) that the patient care team physician has served as a patient care team physician on a patient care team with the nurse practitioner pursuant to a practice agreement; (ii) that while a party to such practice agreement, the patient care team physician routinely practiced with a patient population and in a practice area included within the category for which the Nurse Practitioner was certified and licensed; and (iii) the period of time for which the patient care team physician practiced with the Nurse Practitioner under such a practice agreement.
    c. Applicant will undergo the standard credentialing process outlined in Piedmont's Credentialing Policies. Nurse Practitioners are subject to all requirements of the Credentialing Policies including, but not limited to, the requirement for Committee review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
    d. Upon completion of the credentialing process, Nurse Practitioners may be listed in Piedmont provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
    e. Nurse Practitioners will be clearly identified as such:
        i. on the credentialing file;
        ii. at presentation to the Credentialing Committee; and
        iii. on notification to Network Services and to the provider database.

2. Process, Requirements and Verifications – Certified Nurse Midwives:
    a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other Practitioner with the exception of differing information regarding education, training and board certification.

    b. The required educational/training will be at a minimum that required for licensure as a Registered Nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.

    c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.

    d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested, and primary source verified via normal company procedures. If there are in force adverse actions against the DEA, the applicant will be notified, and the applicant will be administratively denied.

    e. All CNM applicants will be certified by either:
        i. The National Certification Corporation for Ob/Gyn and Neonatal Nursing; or
        ii. The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes.

    This certification must be active and primary source verified. If the state licensing board primary source verifies one of these certifications as a requirement for licensure, additional verification by Piedmont is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic Credentialing Committee.

    f. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, the CNM must not

raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. Should the CNM provide only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.

g. The CNM applicant will undergo the standard credentialing process outlined in Piedmont's Credentialing Policies. CNMs are subject to all the requirements of these Credentialing Policies including (but not limited to): the requirement for Committee review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

h. Upon completion of the credentialing process, the CNM may be listed in Piedmont provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.

i. CNMs will be clearly identified as such:
    i. On the credentialing file;
    ii. At presentation to the Credentialing Committee; and
    iii. On notification to Network Services and to the provider database.

III. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Piedmont may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. Non-accredited HDOs are subject to individual review by the CC and will be considered for Covered Individual access need only when the CC review indicates compliance with Piedmont standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are recredentialed at least every three (3) years to assess the HDO's continued compliance with Piedmont standards.

General Criteria for HDOs:

1. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Covered Individuals. The license must be in good standing with no sanctions.
2. Valid and current Medicare certification.
3. Must not be currently federally sanctioned, debarred or excluded from

participation in any of the following programs; Medicare, Medicaid, or FEHBP. Note: If, once an HDO participates in the Piedmont's programs or provider Network(s), exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider Network(s) as well as the Piedmont's other credentialed provider Network(s).

4. Liability insurance acceptable to Piedmont.
5. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Piedmont's quality and certification criteria standards have been met.

MEDICAL FACILITIES

Facility Type (MEDICAL CARE)	Acceptable Accrediting Agencies*
Acute Care Hospital	CIQH, CTEAM, DNV/NIAHO, HFAP, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC
Birthing Center	AAAHC, CABC
Clinical Laboratories	CLIA, COLA
Convenient Care Centers (CCCs)/Retail Health Clinics (RHC)	DNV/NIAHO, UCAOA, TJC
Dialysis Center	CMS Certification, TJC
Federally Qualified Health Center (FQHC)	AAAHC
Free-Standing Surgical Centers	AAAASF, AAPSF, HFAP, IMQ, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, CTEAM , DNV/NIAHO, TJC
Home Infusion Therapy (HIT)	ACHC, CHAP, CTEAM, HQAA, TJC
Hospice	ACHC, CHAP, TJC
Intermediate Care Facilities	CTEAM
Portable x-ray Suppliers	FDA Certification
Skilled Nursing Facilities/Nursing Homes	BOC INT'L, CARF, TJC
Rural Health Clinic (RHC)	AAAASF, CTEAM, TJC
Urgent Care Center (UCC)	AAAHC, IMQ, TJC, UCAOA

BEHAVIORAL HEALTH

Facility Type (BEHAVIORAL HEALTH CARE)	Acceptable Accrediting Agencies*
Acute Care Hospital—Psychiatric Disorders	CTEAM, DNV/NIAHO, HFAP, TJC
Acute Inpatient Hospital – Chemical Dependency/Detoxification and Rehabilitation	HFAP, NIAHO, TJC
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, HFAP, TJC
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Abuse	ACHC, CARF, COA, DNV/NIAHO, TJC
Outpatient Mental Health Clinic	CARF, CHAP, COA, HFAP, TJC
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Abuse	CARF, DNV/NIAHO, HFAP, TJC, for programs associated with an acute care facility or Residential Treatment Facilities.
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Abuse	CARF, COA, DNV/NIAHO, HFAP, TJC

REHABILITATION

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies*
Acute Inpatient Hospital – Detoxification Only Facilities	DNV/NIAHO, HFAP, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Abuse Clinics	CARF, COA, TJC

* Agency names are subject to change.

MEMBER RIGHTS & RESPONSIBILITIES

Successful relationships take a strong commitment from all sides, with each side recognizing the rights and responsibilities of the other. Member health care is no different. It takes strong teamwork between Members, health care professionals, and Piedmont for coverage Members can count on. Below is a statement of rights and responsibilities that guide our relationship with Members.

Piedmont is committed to:

- Recognizing and respecting the Member as a Covered Person.
- Encouraging Members to have open discussions with their health care professionals and Providers.
- Providing information to help Members become informed health care consumers.
- Providing access to health Benefits and our In-Network Providers.
- Sharing our expectations of Members as a Covered Person.

PIEDMONT MEMBER RIGHTS

Piedmont Members have the right to:

- Participate with their health care professionals and Providers in making decisions about their health care.
- Receive the Benefits for which they have Coverage.
- Be treated with respect and dignity.
- Preserve the privacy of their personal health information, consistent with state and federal laws, and Piedmont policies.
- Receive information about our organization and services, our Network of health care professionals and Providers, and their rights and responsibilities.
- Candidly discuss with their Physicians and Providers appropriate and Medically Necessary care for their condition, regardless of cost or Benefit Coverage.
- Make recommendations regarding the rights and responsibilities of any Covered Person as set forth in their Certificate of Coverage.
- Voice complaints, grievances or appeals about: our organization, any Benefit or Coverage decisions we (or our designated administrators) make, their Coverage, or care provided.
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by their Physician(s) of the medical consequences.
- Participate in matters of the organization’s policy and operations.
- For assistance at any time, contact their local insurance department: by phone in Richmond (804) 371-9032, toll-free from outside Richmond (877) 310-6560, or in writing: Virginia Bureau of Insurance, 1300 East Main Street, P.O. Box 1157, Richmond, VA 23218.

PIEDMONT MEMBER RESPONSIBILITIES

Piedmont Members have the responsibility to:

- Choose an In-Network Provider for services to receive the highest level of benefits.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with their Doctor and call the Doctor's office if they have a delay or cancellation.
- Read and understand to the best of their ability all materials concerning their health benefits or ask for help if they need it.
- To ask questions to help them understand their health problems and participate, along with their health care professionals and Providers, in developing mutually agreed upon treatment goals to the degree possible.
- Supply, to the extent possible, information that Piedmont and/or their health care professionals and Providers need to provide care.
- Follow the plans and instructions for care that they have agreed on with their health care professional and Provider.
- Tell their health care professional and Provider if they do not understand their treatment plan or what is expected of them.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let Piedmont know if they have any changes to their name, address, or family members covered under their Policy.
- Provide Piedmont with accurate and complete information needed to administer their health benefit plan, including other health benefit coverage and other insurance benefits they may have in addition to their coverage with Piedmont.

MEMBER COMPLAINTS AND GRIEVANCES

Overview

Members and their representatives (including providers) may file a Complaint or Grievance if they are not able to resolve issues through informal channels with Piedmont.

Members may agree to be represented by their health care provider in the filing of a Complaint or Grievance. Members may also request a provider's written certification when seeking an expedited review of a Complaint or Grievance. The provider's written certification for expedited review must state why the usual timeframe for deciding the appeal would jeopardize the Member's life, health or ability to attain, maintain or regain maximum function.

For a provider to represent the Member in the conduct of a Grievance, the provider must obtain written consent of the Member. A provider may not require a Member to sign a document authorizing the provider to file a Grievance as a condition of treatment. The consent form must maintain the following elements:

- The Member's name, address, date of birth, and identification number
- If the Member is a minor or is legally incompetent, the name address and relationship to the Member of the person who signed the consent
- The name, address, and Piedmont provider identification number of the provider who is receiving the Member's consent to file a Complaint or Grievance
- The name and address of Piedmont
- An explanation of the specific service/item for which coverage was provided or denied to the Member to which the consent will apply
- The following statement – "The Member or the Member's representative may not submit a Grievance concerning the services/items listed in this consent form unless the Member or the Member's representative rescinds consent in writing. The Member or the Member's representative has the right to rescind consent at any time during the Grievance process".
- The following statement – "The consent of the Member or the Member's representative shall be automatically rescinded if the provider fails to file a Grievance or fails to continue to prosecute the Grievance through the second level Grievance process"
- The following statement – "The Member or the Member's representative, if the Member is a minor or legally incompetent, has read, or has been read this consent form, and has had it explained to his/her satisfaction. The Member or the Member's representative understands the information in the Member's consent form."
- The dated signature of the Member, or the Member's representative, and the dated signature of a witness.

A Member who consents to the filing of a Complaint or Grievance by a health care provider may not file a separate Grievance. The Member retains the right to rescind consent throughout the Grievance.

The Quality Department has the overall responsibility for the management of the Member Complaint and Grievance process. This includes:

- Documenting individual Complaints and Grievances
- Coordinating resolutions
- Maintaining logs and records of the Complaints and Grievances
- Tracking, trending, and reporting data

The Piedmont Quality Department will serve as the primary contact department for the Complaint and Grievance process.

The Appeals Department, in collaboration with the Customer Service Department and

Provider Relations Department, is responsible for informing and educating Members and providers about a Member's right to file a Complaint or Grievance and for assisting Members in filing a Complaint or Grievance.

Members are advised of their rights pertaining to Complaints and Grievances at the time of enrollment and at least annually thereafter. Members are provided this information via the Member handbook, Member newsletters, and the Piedmont website. The information provided to Members includes, but is not limited to:

- the method for filing a Complaint or Grievance, the procedural steps and timeframes for filing each level of a Complaint or Grievance, and the method for requesting a Notification of Member rights related to Complaints and Grievances, including the right to voice Complaints or Grievances about Piedmont or care provided.
- the availability of assistance from Piedmont with filing a Complaint or Grievance along with Piedmont's toll-free number and address for filing Complaints and Grievances.
- how to access reasonable assistance with the Complaint and Grievance process. This information is provided upon request and includes but is not limited to providing oral interpreter services and a toll-free number.
- TTY/TDD numbers and sign language interpreter capability. Piedmont staff is trained to respond to Members with disabilities with patience, understanding and respect.

PROCESS AND TIMEFRAMES FOR COMPLAINTS AND GRIEVANCES

Piedmont will accept Complaints and Grievances telephonically via a toll-free telephone number, in writing or by facsimile. If the Member has a sensory impairment or needs translation services, Piedmont will assign a representative to assist that Member throughout the Grievance system process. Piedmont will accept Complaints and Grievances through a TTY/TDD line, Braille; tape or CD and other commonly accepted alternative forms of communication. If a Member should need a sign language interpreter or language translator services Piedmont will provide one at no cost to the Member. Additionally, Piedmont will train its staff to be aware of speech limitations of some Members with disabilities and treat these Members with patience, understanding and respect.

If a Complaint or Grievance is received in a written format (surface mail, facsimile, Braille), it will be forwarded to the Coordinator.

The Coordinator will assign the appropriate category (Complaint or Grievance request), level (first, second, expedited or external) and ensure the required timeframe.

Filing Grievances – Timelines

Once the Complaint or Grievance has been verified, acknowledged and documented in the Complaint and Grievance database, the Grievance staff will start the research process. Piedmont will issue an acknowledgement letter upon receipt of the Complaint or Grievance.

If a provider believes that the usual timeframes for deciding a Member's Complaint or Grievance will endanger their health, the provider can call Piedmont at 434-947-4463 and request an expedited review of the Complaint or Grievance. This request must be accompanied by a Provider Certification letter stating that the usual timeframe for deciding the Complaint or Grievance will endanger the Member's health. This letter should be faxed to the attention of the Complaints and Grievance Department at 434-947-4463. Piedmont will make a reasonable effort to obtain the certification from the provider.

If Piedmont is unable to obtain a Provider Certification from the provider within three (3) Business Days of a request for an expedited Complaint or Grievance, the Complaint or Grievance will be decided within the standard timeframes.

Complaint and Grievance Reviews

Piedmont Complaints and Grievances will be reviewed by the grievance coordinator and/or Medical Director. Additional department level support will be accessed as needed based on Member's complaint or grievance.

Timeframes for Resolution of Complaints, Grievances and Expedited and External Reviews

Piedmont resolves each Complaint or Grievance as expeditiously as the Member's health requires but no later than the timeframe identified by nationally accrediting bodies and regulatory guidelines.

PROVIDER APPEALS AND DISPUTES

Piedmont offers providers an appeal and dispute process for expressing dissatisfaction with a Piedmont decision that directly impacts the provider and a formal appeal process to request reversal of a denial by Piedmont. The definitions and processes for Provider Appeals and a Provider Disputes are as follows:

Provider Appeal – A request from a Provider for reversal of a denial by Piedmont related to the three (3) major types of issues that are to be addressed in a Provider Appeal system as outlined in the Provider Dispute Resolution System. The three (3) types of Provider Appeals issues are:

1. Provider credentialing denial by Piedmont.

- If a provider communicates dissatisfaction with a credentialing determination, Credentials Committee, at its next scheduled meeting, will review information provided by the provider and make a determination. If the provider's credentialing or recredentialing is denied, the provider has thirty (30) Business Days from receipt of notice to file an appeal.

2. Claims denied by Piedmont for Participating Providers participating in Piedmont's network. This includes payment denied for services already rendered by the Participating Provider to the Member or for pre-service medical necessity denials.

   - Piedmont will hear Provider Appeals and disputes and make a determination within thirty (30) days for post-service appeals. Preservice appeal decisions will be made within timeframes established by national accrediting bodies and regulatory guidelines according to the level of appeal.

3. Termination of Participating Provider Agreement by Piedmont based on quality of care or service.

   - Suspension, non-renewal, or termination of Participating Provider's participation initiated by Piedmont entitles the Participating Provider to an appeal hearing upon timely and proper request by the Participating Provider for said appeal for any of the following reasons:
     - Business need;
     - Breach of Agreement;
     - Suspected fraud and abuse;
     - Non-compliant behavior that jeopardizes Member satisfaction;
     - Temporary sanction, suspension or restriction by Medicare, any licensing board or professional review organization (Organizational Providers only*); and/or
     - Failure to immediately notify Health Plan of substantive changes in credentialing information including, but not limited to, adverse licensure actions, termination/cancellation of professional liability insurance or sanctions from billing private, federal, or state health insurance programs (Organizational Providers only*).

   - Participating Providers will have ten (10) Business Days from receipt of notice to file a written request for a hearing to appeal suspension, non-renewal, or termination of Piedmont participation. Requests for a hearing shall:
     - Specify in detail the reason(s) the Participating Provider wishes to contest the suspension, non-renewal or termination decision;
     - Be delivered certified or registered mail to the Piedmont contact who executed the notice to Participating Provider of non-renewal/termination;
     - Specify if Participating Provider intends to be represented by an attorney at the hearing;
     - Include the name, address, phone, fax and email (if available) of Participating Provider's attorney, if applicable;

- Include a list of the name(s), title(s), address(es) and phone number(s) of any witnesses expected to testify on behalf of Participating Provider at the hearing; and
- Include copies of all additional information Participating Provider wishes to present at the hearing.

Provider Dispute – A written communication to Piedmont made by a contracted provider, expressing dissatisfaction with a Health Plan decision that directly impacts the provider payment. This does not include decisions concerning Medical Necessity.

Provider Dispute Process – When a written Provider Dispute is received, it will be forwarded to the appropriate department within Piedmont for resolution. The dispute will be researched and a response provided within thirty (30) days of receipt.

COMPLIANCE

Piedmont strives to demonstrate high ethical standards in its business practices. Because contracted providers are an integral part of Piedmont's business, it is important that we communicate and obtain your support for these standards. Your Agreement with Piedmont details specific laws and contractual provisions with which you are expected to comply. This section highlights some provisions in the Agreement and provides some additional information about compliance.

COMPLIANCE WITH LAW

Piedmont is a recipient of federal funds. As such, all contracted providers, hospitals, and other facilities must agree to comply with all rules and regulations that are applicable to federal contracts. These include, but are not limited to, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, Americans with Disability Act, and all other laws applicable to recipients of federal funds. This may also include other program requirements issued by CMS.

In addition, Piedmont health plans fall under the statutory and regulatory requirements of the state in which they operate. Accreditation requirements of National Committee on Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) may also apply.

CULTURAL COMPETENCY & INTERPRETIVE SERVICES (for the Disabled and those with Limited English Proficiency)

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, gender identification, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English.

Piedmont expects contracted providers to treat all Members with dignity and respect as

required by federal law. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance, such as Medicare or Medicaid.

Piedmont policies conform with federal government Limited English Proficiency (LEP) guidelines stating that programs and activities normally provided in English must be accessible to LEP persons. Services must be provided in a culturally effective manner to all Members, including those with Limited English Proficiency (LEP) or reading skills, those with diverse cultural and ethnic backgrounds, those who are deaf or hard of hearing, the homeless and individuals with physical and mental disabilities. To ensure Members' privacy, they must not be interviewed about medical or financial issues within hearing range of other patients.

In compliance with federal and state requirements, Piedmont takes reasonable steps to provide meaningful access to health care and benefits for Members with Limited English Proficiency (LEP) and Members with disabilities. Piedmont provides the following auxiliary aids and services free of charge:

- Written information in other formats (large print, audio, accessible electronic formats) for the visually impaired
- TTY Service to communicate with the hearing impaired
- Qualified sign language interpreters for the hearing impaired
- Language line with qualified interpreters to communicate with non-English speaking individuals

Contact our Customer Service Department to learn more about these services.

ACCESS TO SERVICE – DISCRIMINATION PROHIBITED

Pursuant to their Agreement, Piedmont Participating Providers must not intentionally segregate Members in any way from other persons receiving services.

Piedmont investigates Complaints and takes affirmative action so that Members are provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, language, Medicare status, health status, disease or pre-existing condition, anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

- denying or not providing a Member any covered service or access to a participating facility within the Piedmont Network. Piedmont policy provides access to complex interventions such as cardiopulmonary resuscitations, intensive care, transplantation, and rehabilitation when Medically Necessary. Health care and treatment necessary to preserve life must be provided to all persons who are not terminally ill or permanently unconscious, except where a competent Member objects to such care on his/her own behalf.
- subjecting a Member to segregated, separate, or different treatment, including a different place or time from that provided to other Members, public or private patients, in any manner related to the receipt of any Piedmont covered service,

except where Medically Necessary.

- the assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, income status, program membership, language, Medicare status, health status, disease or pre-existing condition, anticipated need for health care or physical or mental disability of the participants to be served.

PIEDMONT COMPLIANCE PROGRAM AND CODE OF CONDUCT

Piedmont maintains a robust Compliance Program. Piedmont's Compliance Program is designed to oversee the development, implementation and maintenance of a compliance and privacy program that meets or exceeds federal and state laws and regulations, as well as contractual and accreditation obligations.

Piedmont's Code of Conduct (The Code) further sets forth our commitment to ethical and legal conduct that is compliant with all relevant laws and regulations, and to correcting wrongdoing whenever it may occur in the administration of any of our plans.

Piedmont requires its contracted healthcare providers and third parties to uphold a similar commitment to ethical and legal conduct and assure that they, their employees, and downstream entities who support Piedmont comply with the guiding principles outlined in The Code. We have attached a copy of The Code as an addendum to this document and invite contracted healthcare providers and third parties to review this information.

HIPAA AND CONFIDENTIALITY

HIPAA Notice of Privacy Practices

Piedmont maintains strict privacy and confidentiality standards for all medical records and Member health information, according to federal and state standards. Providers can access up-to-date Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices on our website at www.PCHP.net. This includes explanations of Members' rights to access, amend, and request confidential communication of, request privacy protection of, restrict use and disclosure of, and receive an accounting of disclosures of Protected Health Information (PHI).

Confidentiality Requirements

Providers are required to comply with all federal, state and local laws and regulations governing the confidentiality of health information including all laws and regulations pertaining to, but not limited to the Health Insurance Portability and Accountability Act (HIPAA) and applicable contractual requirements.

Providers are contractually required to safeguard and maintain the confidentiality of data that addresses medical records and confidential provider and Member information, whether oral or written in any form or medium. All "individually identifiable

health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral is considered confidential PHI.

"Individually identifiable health information" is information, including demographic data, that relates to:

- The individual's past, present or future physical or mental health or condition
- The provision of health care to the individual
- The past, present, or future payment for the provision of health care to the individual
- Information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual
- Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number)

Excluded from PHI are employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g.

Providers must have mechanisms and safeguards in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of Piedmont.

Providers must comply with HIPAA and other applicable privacy law requirements when releasing Members' health information to third parties. In general, providers must obtain Members' written authorization prior to disclosing PHI, unless the disclosure is for treatment, payment or healthcare operations purposes, is required by law, or is otherwise permitted by HIPAA or other applicable law.

Member Privacy Rights

Piedmont's privacy policy assures that all Members are afforded the privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations, and applicable contractual requirements. Our privacy policy conforms with relevant sections of HIPAA that provide Members with privacy rights and place restrictions on uses and disclosures of protected health information, including but not necessarily limited to 45 C.F.R. §§ 164.520, 522, 524, 526 and 528.

Our policy also assists Piedmont personnel and providers in meeting the privacy requirements of HIPAA when Members or authorized representatives exercise privacy rights through privacy requests, including:

- Making information available to Members or their representatives about Piedmont's practices regarding their PHI
- Maintaining a process for Members to request access to, changes to, or restrictions on disclosure of their PHI
- Providing consistent review, disposition, and response to privacy requests within required time standards
- Documenting privacy-related requests and actions taken

Member Privacy Requests

Members may make the following requests related to their PHI (privacy requests) in accordance with federal, state, and local law:

- Make a privacy Complaint
- Receive a copy of all or part of their designated record set
- Amend records containing PHI
- Receive an accounting of health plan disclosures of PHI
- Restrict the use and disclosure of PHI
- Receive confidential communications
- Receive a Notice of Privacy Practices

A privacy request must be submitted by the Member or Member's authorized representative. A Member's representative must provide documentation or written confirmation that he or she is authorized to make the request on behalf of the Member or the deceased Member's estate. Except for requests for a health plan Notice of Privacy Practices, requests from Members or a Member's representative must be submitted to Piedmont in writing.

Privacy Process Requirements

Piedmont's processes for responding to Member privacy requests shall include components for the following:

- **Verification**
  If the requester is the Member, Piedmont personnel shall verify the Member's identity; verification examples include asking for the last four digits of Member's Social Security Number, Member's address, and Member's date of birth. If the requester is not the Member, Piedmont personnel shall require an Authorization for Use or Disclosure completed by the Member to verify the requester's authority to obtain the Member's information. If the requester identifies him/herself as a Member's authorized representative, Piedmont personnel shall require a healthcare Power of Attorney (POA) or comparable document for a representative to act on behalf of the Member.

- **Review, Disposition, and Response**
  Piedmont personnel review all privacy requests and shall comply with applicable federal, state, and local laws and regulations, and applicable contractual requirements, including those that govern use and disclosure of PHI. Responses to privacy requests shall conform to guidelines prescribed by HIPAA, including response time standards, and shall include a notice of administrative charges, if any, for granting the request.

- **Use and Disclosure Guidelines**
  Piedmont personnel are required to use and disclose only the minimum amount of information necessary to accommodate the request or carry out the intended purpose.

- **Limitations**
  A privacy request may be subject to specific limitations or restrictions as required by law. Piedmont personnel may deny a privacy request under any of the following conditions:

  - Piedmont does not maintain the records containing the PHI
  - The requester is not the Member and Piedmont personnel are unable to verify his/her identity or authority to act as the Member's authorized representative
  - The documents requested are not part of the designated record set (e.g., credentialing information)
  - Access to the information may endanger the life or physical safety of, or otherwise cause harm to, the Member or another person
  - Piedmont is not required by law to honor the particular request (e.g., accounting for certain disclosures)
  - Accommodating the request would place excessive demands on Piedmont's time or resources and complying with the request is not required by HIPAA or other applicable law

FRAUD, WASTE, AND ABUSE

Piedmont is committed to a policy of zero tolerance for fraudulent insurance acts that victimize Piedmont and its' stakeholders. Accordingly, Piedmont will investigate allegations of Provider fraud, waste or abuse, related to services provided to Members, and where appropriate, will take corrective action, including but not limited to civil or criminal action.

The five most important Federal fraud and abuse laws that apply to physicians are the False Claims Act (FCA), the Anti-Kickback Statute (AKS), the Physician Self-Referral Law (Stark law), the Exclusion Authorities, and the Civil Monetary Penalties Law (CMPL). This section provides an overview of Fraud, Waste and Abuse and provides guidance on how to comply with those Federal laws. The Office of Inspector General (OIG) for the U.S. Department of Health & Human Services has created a free educational guide that providers and practices may use to ensure their workforce understand these laws - "A Roadmap for New Physicians – Avoiding Medicare and Medicaid Fraud and Abuse."

Defining Fraud, Waste, and Abuse

- Fraud – An intentional deception or misrepresentation made by a person or entity that knows or should know the deception or misrepresentation could result in some unauthorized benefit to himself/herself or some other person(s) or entity(ies). The Fraud can be committed by many entities, including Piedmont, a subcontractor, a Provider, a State employee, or a Member, among others.

- Waste – Waste includes practices that, directly or indirectly, result in unnecessary costs or unnecessary repetition of services. Waste can be caused by misuse of resources, acts of carelessness, lack of training or similar issues.
- Abuse – Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to a federal or state program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards or contractual obligations for health care in a managed care setting. The Abuse can be committed by Piedmont, a subcontractor, Provider, State employee, or a Member, among others. Abuse also includes Member practices that result in unnecessary cost to a federal or state program, Piedmont, a subcontractor, or Provider.

Reporting Fraud and Abuse

Suspected Fraud and Abuse can be reported to Piedmont's Compliance Department:

Email: Garland.Morton@PCHP.net

Phone: Piedmont/Centra Compliance Hot Line: 1-800-713-4703
Customer Service Team: 1-800-400-7247

Mail: Fraud Investigation Department
Piedmont Community Health Plan
2316 Atherholt Road
Lynchburg, VA 24501

Providers and Members can also report suspected Fraud and Abuse involving healthcare practitioners directly to the Virginia Department of Health Professions (DHP) Enforcement Division:

Phone: 1-800-533-1560 or (804) 367-4691

Fax: (804) 212-2174

Email: enfcomplaints@dhp.virginia.gov

Mail: Virginia Department of Health Professions Enforcement Division
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Website: Virginia Department of Health Professions Enforcement Division

The Department of Health Professions receives complaints about Virginia healthcare practitioners who may have violated a regulation or law. Complaints for all the licensing and regulatory Boards are received and processed by the agency's Enforcement Division.

ATTENTION: The Department of Health Professions cannot guarantee anonymity. A copy of your complaint and any supporting documentation provided by you may be shared with the subject of the complaint (practitioner or licensee) pursuant to the Code of Virginia § 54.1-2400.2 (G). Using the online complaint form may help preserve your anonymity. If you wish to submit an anonymous complaint, please ensure you check the "Anonymous" box on the online complaint form, and do not include any information on the complaint form or supplemental documents that reveals your identity. If you wish to use an alternative method for filing a complaint and wish to remain anonymous, do not include any information on the complaint form, envelope, email address, body of email, or supplemental documents that reveals your identity.

False Claims Act (FCA)

The civil provisions of the FCA make a person liable to pay damages to the Government if he or she knowingly:

- Conspires to violate the FCA;
- Carries out other acts to obtain property from the Government by misrepresentation,
- Knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay the government,
- Makes or uses a false record or statement supporting a false claim, or
- Presents a false claim for payment or approval.

Example - A Medicare Part C Plan in Florida:

- Hired an outside company to review medical records to find additional diagnosis codes that could be submitted to increase risk capitation payments from the Centers for Medicare & Medicaid Services (CMS),
- Was informed by the outside company that certain diagnosis codes previously submitted to Medicare were undocumented or unsupported,
- Failed to report the unsupported diagnosis codes to Medicare, and
- Agreed to pay $22.6 million to settle FCA allegations.

A **Whistleblower** is a person who exposes information or activity that is deemed illegal, dishonest, or violates professional or clinical standards. Those who report false claims or bring legal actions to recover money paid on false claims are protected from retaliation. Persons who bring a successful whistleblower lawsuit receive at least 15% but not more than 30% of the money collected.

Anti-Kickback Statute (AKS)

The Anti-Kickback Statute prohibits knowingly and willfully soliciting, receiving, offering, or paying remuneration (including any kickback, bribe or rebate) for referrals for services that are paid, in whole or in part, under a federal health care program (including the Medicare Program).

Example - A radiologist who owned and served as medical director of a diagnostic testing center in New Jersey:

- Obtained nearly $2 million in payments from Medicare and Medicaid for MRIs, CAT scans, ultrasounds, and other resulting tests,
- Paid doctors for referring patients,
- Pleaded guilty to violating the Anti-Kickback Statute, and
- Was sentenced to 46 months in prison.

The radiologist was among 17 people, including 15 physicians, who have been convicted in connection with this scheme.

Physician Self-Referral Law (Stark Statute)

The Stark Statute prohibits a physician from making referrals for certain designated health services to an entity when the physician (or a member of his or her family) has:

- An ownership/investment interest, or
- A compensation arrangement (exceptions apply).

Example – A physician paid the Government $203,000 to settle allegations that he violated the physician self-referral prohibition for routinely referring Medicare patients to an oxygen supply company he owned.

Exclusion

No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the OIG. The OIG has authority to exclude individuals and entities from federally funded health care programs and maintains the List of Excluded Individuals and Entities (LEIE). You can access the LEIE on the internet.

The United States General Services Administration (GSA) administers the Excluded Parties List System (EPLS), which contains debarment actions taken by various Federal agencies, including the OIG. You may access the EPLS on the System for Award Management (SAM) website.

If looking for excluded individual or entities, make sure to check both the LEIE and the EPLS since the lists are not the same.

Example –Two physicians were excluded from participation in all Federal health care programs for three years for submitting false claims to the Federal government for medically unnecessary services and services that were not actual performed or were not rendered as represented.

Civil Monetary Penalties Law (CMPL)

The Office of Inspector General (OIG) may impose civil penalties for a number of reasons including:

- Arranging for services or items from an excluded individual or entity,
- Providing services or items while excluded,
- Failing to grant OIG timely access to records,

- Knowing of an overpayment and failing to report and return it,
- Making false claims, or
- Paying to influence referrals.

Example – A California pharmacy and its owner agreed to pay over $1.3 million to settle allegations they submitted claims to Medicare Part D for brand name prescription drugs that the pharmacy could not have dispensed based on inventory records.

Examples of Risks for Fraud, Waste and Abuse

Provider/Prescriber Fraud, Waste and Abuse

- *Unbundling:* Using multiple CPT codes for the individual parts of that procedure to increase payment.
- *Split Billing:* Services rendered by the same provider on the same date of service and submitted on more than a single claim. Failure to file all services rendered on a single claim can prevent the application of all necessary claim edits and adjudication logic during claim processing, causing claims to be overpaid or underpaid (and Member liability over applied or under applied).
- *Upcoding:* Provider submits codes for more severe and expensive diagnoses or procedures than the provider diagnosed or performed.
- *Routinely waiving copays and deductibles:* Can lead to overutilization of medical services, thereby increasing costs to Federal health care programs. Waiving copays and deductibles can result in violations of the Anti-Kickback Statute, False Claims Act and other laws.
- *Illegal remuneration schemes*: Prescriber is offered, or paid, or solicits, or receives unlawful remuneration to induce or reward the prescriber to write prescriptions for drugs or products.
- *Prescription drug switching*: Drug switching involves offers of cash payments or other benefits to a prescriber to induce the prescriber to prescribe certain medications rather than others.
- *Script mills*: Provider writes prescriptions for drugs that are not medically necessary, often in mass quantities, and often for patients that are not theirs. These scripts are usually written, but not always, for controlled drugs for sale on the black market, and might include improper payments to the provider.
- *Provision of false information*: Prescriber falsifies information (not consistent with medical record) submitted through a prior authorization or other formulary oversight mechanism to justify coverage. Prescriber misrepresents the dates, descriptions of prescriptions or other services furnished, or the identity of the individual who furnished the services.
- *Theft of prescriber's DEA number or prescription pad*: Prescription pads and/or DEA numbers can be stolen from prescribers. This information

could illegally be used to write prescriptions for controlled substances or other medications often sold on the black market. In the context of e-prescribing, includes the theft of the provider's authentication (log in) information.

Member Fraud, Waste and Abuse Risks

- *Misrepresentation of status*: A Member misrepresents personal information, such as identity, eligibility, or medical condition to illegally receive the drug benefit. Members who are no longer covered under a drug benefit plan may still attempt to use their identity card to obtain prescriptions.
- *Identity theft*: Perpetrator uses another person's Piedmont identification card to obtain prescriptions.
- *Prescription forging or altering*: Where prescriptions are altered, by someone other than the prescriber or pharmacist with prescriber approval, to increase quantity or number of refills.
- *Prescription diversion and inappropriate use*: Member obtains prescription drugs from a provider, possibly for a condition from which they do not suffer, then gives or sells this medication to someone else. May also include the inappropriate consumption or distribution of a Member's medications by a caregiver or anyone else.
- *Resale of drugs on black market*: Member falsely reports loss or theft of drugs or feigns illness to obtain drugs for resale on the black market.
- *Prescription stockpiling*: Member attempts to "game" their drug coverage by obtaining and storing large quantities of drugs to avoid out-of-pocket costs, to protect against periods of non-coverage (i.e., by purchasing a large amount of prescription drugs and then disenrolling), or for purposes of resale on the black market.
- *Doctor shopping*: Member or other individual consults a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market.
- *Improper Coordination of Benefits*: Improper coordination of benefits where Member fails to disclose multiple coverage policies or leverages various coverage policies to "game" the system.
- *Marketing Schemes*: A Member may be victimized by a marketing scheme where a sponsor, or its agents or brokers, violates the marketing guidelines, or other applicable Federal or state laws, rules, and regulations to improperly enroll a beneficiary.

Pharmacy Fraud, Waste and Abuse

- *Inappropriate billing practices:* Inappropriate billing practices at the pharmacy level occur when pharmacies engage in the following types of billing practices:
    - Incorrectly billing for secondary payers to receive increased reimbursement.
    - Billing for non-existent prescriptions.
    - Billing multiple payers for the same prescriptions, except as required for coordination of benefit transactions.
    - Billing for brand when generics are dispensed.
    - Billing for non-covered prescriptions as covered items.
    - Billing for prescriptions that are never picked up (i.e., not reversing claims that are processed when prescriptions are filled but never picked up).
    - Billing based on "gang visits," (e.g., a pharmacist visits a nursing home and bills for numerous pharmaceutical prescriptions without furnishing any specific service to individual patients).
    - Inappropriate use of dispense as written (DAW) codes.
    - Drug diversion.
    - Prescription splitting to receive additional dispensing fees.
- *Prescription drug shorting:* Pharmacist provides less than the prescribed quantity and intentionally does not inform the Member or arrange to provide the balance but bills for the entire prescribed amount.
- *Bait and switch pricing*: Bait and switch pricing occurs when a Member is led to believe that drug will cost one price, but at the point of sale the Member is charged a higher amount.
- *Prescription forging or altering:* Where existing prescriptions are altered, by an individual without the prescriber's permission to increase quantity or number of refills.
- *Dispensing expired or adulterated prescription drugs:* Pharmacies dispense drugs that are expired or have not been stored or handled in accordance with manufacturer and FDA requirements.
- *Prescription refill errors:* A pharmacist provides the incorrect number of refills prescribed by the provider.
- *Illegal remuneration schemes:* Pharmacy is offered, or paid, or solicits, or receives unlawful remuneration to induce or reward the pharmacy to switch Members to different drugs, influence prescribers to prescribe different drugs, or steer Members to plans.

GLOSSARY

Agreement — the written binding document between Participating Provider and Health Plan together with any attachments, exhibits, applicable Provider Manual and the Member benefit plan, as amended from time to time and made part of the Agreement by reference.

Appeal (Provider) — A request from a Health Care Provider for reversal of a denial by Piedmont, regarding the three (3) major types of issues:

- Health Care Provider credentialing denial by Piedmont;
- Claims denied by Piedmont for Health Care Providers participating in Piedmont's Network. This includes payment denied for services already rendered by the Health Care Provider to the Member;
- Agreement termination by Piedmont.

Behavioral Health Services – Mental health and/or substance abuse services.

Case Management — Services which will assist individuals in gaining access to necessary medical, social, educational, and other services.

Centers for Medicare and Medicaid Services (CMS) — The federal agency within the Department of Health and Human Services responsible for oversight of federal health care programs.

Nurse Practitioner (NP) — An advanced practice registered nurse who is jointly licensed by the Board of Medicine and Nursing pursuant to Virginia Code § 54.1-2957

Claim — A bill from a Health Care Provider of a medical service or product that is assigned a unique identifier (i.e., Claim reference number). A Claim does not include an Encounter form for which no payment is made or only a nominal payment is made.

Clean Claim — A Claim that can be processed without obtaining additional information from the Health Care Provider of the service or from a third party. A Clean Claim includes a Claim with errors originating in Piedmont's Claims system. Claims under investigation for Fraud or Abuse or under review to determine if they are Medically Necessary are not Clean Claims.

Company -- Piedmont Community Health Plan, Inc., which provides health plan administration services to governmental sponsored and private health plans issued by Company's health insurance issuer subsidiaries, third party health plans and other third party administrators.

Complaint - A verbal objection to something expressing that it is unfair, unacceptable or otherwise not up to normal standards. A complaint escalates to a grievance when the dissatisfaction is submitted in writing, or if a formal grievance is requested by the member and/or their representative.

Cultural Competency — The ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Disease Management — An integrated treatment approach that includes the collaboration and coordination of patient care delivery systems and that focuses on measurably improving clinical outcomes for a particular medical condition through the use of appropriate clinical resources such as preventive care, treatment guidelines, patient counseling, education and outpatient care; and that includes evaluation of the appropriateness of the scope, setting and level of care in relation to clinical outcomes and cost of a particular condition.

Dispute (Provider) – A written communication to Piedmont, made by a Provider, expressing dissatisfaction with a Piedmont decision that directly impacts the Provider. This does not include decisions concerning Medical Necessity.

Emergency Services — (I) Health care services provided to a Member after the sudden onset of a medical condition that manifests 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 one or more of the following:

- Serious jeopardy to the mental and physical health of the Member
- Danger of serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- In the case of a pregnant woman, serious jeopardy to the health of the fetus

Transportation and related emergency services provided by a licensed ambulance service shall constitute an emergency service if the condition is as described in the above subparagraph.

Covered inpatient and outpatient services that are medically necessary to evaluate or stabilize an emergency medical condition described in (I).

Family Planning Services — Services which enable individuals voluntarily to determine family size, to space children and to prevent or reduce the incidence of unplanned pregnancies. Such services are made available without regard to marital status, age, sex, or parenthood.

Federally Qualified Health Center (FQHC) — An entity which is receiving a grant as defined under the Social Security Act, 42 U.S.C. 1396d(l) or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under the above-mentioned sections of the Act.

Formulary — An exclusive list of drug products for which the Contractor must provide coverage to its Members.

Health Care Provider — A licensed hospital or health care facility, medical equipment supplier or person who is certified or otherwise regulated to provide health care services under the laws of the Commonwealth or state(s) in which the entity or person provides services, including but not necessarily limited to a physician, podiatrist, optometrist, psychologist, physical therapist, nurse practitioner, registered nurse, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, chiropractor, dentist, or an individual accredited or certified to provide behavioral health services.

Medical Management (MM) — An objective and systematic process for planning, organizing, directing and coordinating health care resources to provide Medically Necessary, timely and quality health care services in the most cost-effective manner.

Medically Necessary or Medical Necessity — A service or benefit is Medically Necessary if it meets any one of the following standards:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or exception basis, must be documented in writing. The determination is based on medical information provided by the Member, the Member's family/caretaker and the PCP, as well as any other Providers, programs, agencies that have evaluated the Member. All such determinations must be made by qualified and trained Health Care Providers. A Health Care Provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement.

Member — An individual enrolled in a Piedmont health plan who is eligible to receive health care services.

Network — All contracted or employed health care providers in the Piedmont service area who offer covered services to Members.

Participating Provider – A licensed hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide health care services under the laws of the Commonwealth or state(s) in which the entity or person provides services, including but not necessarily limited to a physician, podiatrist, optometrist, physical therapist, certified registered nurse practitioner, registered nurse, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, , chiropractor, or dentist who has a written Provider Agreement with and is credentialed by Piedmont to provide health services to Piedmont Members.

Prior Authorization — A determination made by Piedmont to approve or deny payment for a provider's request to provide a service or course of treatment of a specific duration and scope to a Member prior to the provider's initiation or continuation of the requested service.

Quality Management (QM) — An ongoing, objective, and systematic process of monitoring, evaluating, and improving the quality, appropriateness, and effectiveness of care.

ADDENDUM

PIEDMONT COMMUNITY HEALTH PLAN

Code of Conduct

January 1, 2023

PIEDMONT COMMUNITY HEALTH PLAN

HealthWorks

Piedmont may amend this Code as needed. The most recent version may be obtained upon request.

Message from the Board of Directors and CEO

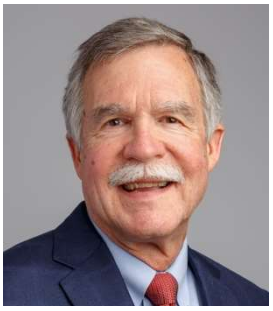
This Code of Conduct (Code) provides guidance to help in ensuring that our work is performed in an ethical manner. The Code emphasizes a dedication to fostering the values of a work environment of respect, honesty, and responsibility. This Code articulates those values, as well as the policies and practices that translate them into action.

If you have questions or comments regarding this Code, please let us know. The Code should be viewed as a living document, with changes to it being expected, reflecting the dynamic nature of our organization, industry, and society. Likewise, if you come across any situation that you believe violates provision of this Code, please alert your supervisor, any member of the management team, or the Compliance Department. There will never be retaliation for reporting, in good faith, possible misconduct.

We trust you as a valuable member of our team! Thank you for embracing the values and principles that are foundational to Piedmont's continued success and adhering to the spirit, as well as the specifics, of the Code.

Sincerely,

Richard Tugman
President and CEO



Lewis Addison
Board Chair

Our Mission

To provide exceptional and affordable healthcare coverage and services that promote well-being to the communities we serve.

Our Vision

To be a leader in transforming the delivery of healthcare coverage and services that are innovative, affordable, and inclusive.

Our Values

Respect and Kindness

- Treat others with kindness and compassion
- Bring respect, openness, and honesty to our encounters
- Identify needs, and go above and beyond our duty
- Listen with empathy and respond with clarity

Excellence

- Work as a team, combining our expertise with innovative healthcare and best practices
- Devote ourselves to the highest quality of service
- Strive for continuous improvement, excellence, and professionalism

Integrity

- Behave ethically and responsibly in everything we do
- Report wrongdoing, including illegal or unethical conduct, fraud, waste, and abuse
- Hold ourselves accountable for our actions
- Do not retaliate against those who raise concerns with the intention of adhering to the law or Code of Conduct

Diversity, Equity & Inclusion

- Commit to the fair treatment, access, opportunity, and advancement in our professional relationships
- Foster intellectual, social, and cultural diversity

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Introduction and Purpose

This Code of Conduct reflects the commitment of Piedmont Community Health Plan (Piedmont) to quality, honesty, and integrity in our business practices. It is an integral part of the operations of Piedmont as it sets forth legal and ethical principles to be upheld by all employees and business partners ("associates").

The Code of Conduct tells us what we must do (compliance) and what we should do (ethics).

Our Code has the full endorsement of the Board of Directors, as well as the management team. While this document does not cover the specifics of every situation, it does provide a resource to direct us when questions arise. The management team is always available to assist you and answer any questions.

Our Responsibilities

All associates must:

- Read the Code and conduct business accordingly
- Use good judgement and seek help when questions arise
- Behave ethically and honestly
- Speak up, ask questions, and report issues
- Complete required trainings
- Cooperate with inquiries and investigations related to reported issues

Duty to Report

Reporting a Violation or Concern

Piedmont associates have an important role in ensuring compliance with laws, regulations, and Piedmont policies. When you discover a problem or suspect something is wrong, it is your individual responsibility to report the activity.

You may ask questions about filing a report or raise concerns with:

- Your supervisor
- Any member of management
- Human Resources (HR)
- Compliance/Privacy Officer
- CEO/President
- Anonymous Hotline

Anonymous Hotline

Piedmont's hotline is staffed by an independent third party, and calls are not traced or recorded. You may provide your name or remain anonymous. We do our best to protect your identity within the limits of the law. You may contact the hotline by:

- Calling: 1-800-713-4703
- Visiting the hotline website at: **Centrahealth.ethicspoint.com**
- Scanning this QR code with your mobile device:

Non-Retaliation

When you report a concern in good faith, you are safe from retaliation. "Good faith" does not mean that you must be correct; but it does mean that you must be telling the truth as you know it.

Leadership Responsibilities

While all Piedmont associates are obligated to follow this Code, we expect our leaders, including all individuals in a position of supervisory responsibility, to set the example. Therefore, the following additional responsibilities are expected of our leaders:

- Serve as a role model for supporting our Mission, Vision, and Values
- Clearly communicate expectations for high standards of ethical behavior
- Promote a culture of trust, open communication, and respect
- Encourage questions and address/resolve issues and concerns
- Comply with Piedmont's non-retaliation policy

Personal Conduct and Business Ethics

Conflicts of Interest

We are expected to always act in the best interest of Piedmont and our members/patients.

A “conflict of interest” exists when:

- We use our role at Piedmont for personal gain
- We help others profit at Piedmont’s expense
- Our outside interests skew our objectivity
- Outside activities interfere with our Piedmont duties

We must disclose any real or perceived conflicts of interest so that they can be addressed. Completion of the Conflicts of Interest Training and the Conflicts of Interest Disclosure Form are mandatory for this purpose.

Nondiscrimination

We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex in health programs and activities.

- We provide free aids and services to people with disabilities, such as qualified sign language interpreters and written information in large print.
- We provide free language services to people whose primary language is not English, such as qualified interpreters.

Personal Behavior & Safety

We are a team. Our success depends on our ability to inspire trust and respect one another.

Piedmont supports an environment that excludes bullying, threatening, or harassing conduct, such as:

- Hurtful jokes or slurs
- Sexual harassment
- Workplace violence or threat of violence
- Having firearms or other weapons (except as allowed for security reasons or in the lawful control of policy) on Piedmont property

Anyone who observes or experiences any form of harassment or violence should report the incident to HR, a member of management, or the anonymous hotline.

Workplace Health & Safety

Piedmont protects the workplace and the health and safety of everyone through compliance with health and safety laws and rules. We must practice safety awareness and think in a way that protects against harm and anticipates unsafe conditions.

This means we:

- Complete required safety training
- Comply with all laws, rules, accreditation standards, and Occupational Safety and Health Act requirements
- Report accidents, injuries, unsafe equipment, and conditions immediately so that action can be taken quickly
- Know our job fully and follow safety policies that apply to our job duties

If you are unsure of the safe way to do things, do not guess — ask a supervisor.

Substance Use

Piedmont maintains a smoke/vape-free, drug-free, and alcohol-free workplace.

- We report for work free of the effect of alcohol or illegal drugs.
- We notify our supervisor if we believe an over-the-counter and/or a prescribed drug may impair our judgement or ability to do our job.
- We talk to our supervisor at once if we notice someone who appears to be impaired.
- Smoking/vaping on Piedmont grounds is not allowed.
- Sale or use of alcohol or other drugs in the workplace is not allowed.

Background Checks

We hire and do business with qualified people and businesses. Piedmont screens all workforce members and vendors, at the time of hire/contracting and monthly thereafter, to ensure that they are not barred from doing business with government-funded healthcare programs (i.e., Medicare). Additionally, Piedmont runs background checks at the time of hire to make sure that we follow state and federal laws.

This means we do not hire, keep employed, contract with, or bill for work done by a person or business that:

- Has been convicted of a crime related to healthcare
- Has been convicted of a crime that bars the person from working at Piedmont
- Is barred from doing business with government-funded healthcare programs

We must alert HR or Compliance of all criminal convictions and pending charges. Failure to report such information may result in employment/contract termination.

Accurate Books and Records

Piedmont's books, business and medical records, reports, and accounts must accurately reflect the business dealings and assets of Piedmont. No one may:

- Make a false or misleading report
- Be dishonest in recording business transactions or maintaining records

Records must be kept in compliance with healthcare practice standards and requirements of any authority that governs Piedmont.

All billing policies, medical records, protocols, and instructions must comply with payment requirements under Medicare, Medicaid, and other applicable payment programs. We store records safely and securely, and manage them so we can retrieve them quickly.

Piedmont Assets

We must preserve our organization's assets, and protect them against theft and misuse.

- We follow approved procedures in handling, recording, and disposing of all Piedmont assets.
- Assets may not be used, and information may not be disclosed for non-Piedmont purposes without the approval of leadership or unless required or ordered by law.
- Community or charitable use of resources should be approved in advance.
- Any use of organization resources for personal gain is prohibited.

Computer and Information Systems

We must properly use all computer and information systems.

- Equipment may be used only for business reasons, with minimal personal use allowed.
- We must not access websites that contain sexually explicit, illegal, or discriminatory content.
- We must not violate copyright laws or licensing agreements.

Gifts and Entertainment

We are not allowed to request or receive anything of value that is or could be perceived as a bribe, including money, loans, rewards, or favors.

Acceptable gifts and entertainment:

- Those of "nominal" value (less than $50)
- Items shared with staff (e.g., food or flowers)
- We may accept modest entertainment. It must be reasonable, infrequent, in good taste, and not extravagant.

Unacceptable gifts and entertainment:

- Cash or items that are the same as cash, such as gift cards
- Gifts that are greater than nominal value
- We may not ask for gifts of entertainment from any person, vendor, or member/patient.

Offering Gifts:

- Piedmont adheres to regulatory standards related to gift giving.
- Our Policy on Gift Giving provides more guidance, or you may ask a supervisor.

Corporate Opportunities

We must not use Piedmont information or roles for our own gain. We are not allowed to compete with Piedmont.

We may speak on a topic linked to our role at Piedmont or Piedmont's business.

- We may accept modest travel, lodging and meals, or repayment for such costs.
- We may not accept a speaking fee when doing Piedmont business.
- We seek approval from a supervisor if the speaking engagement is outside normal business duties.

Procurement Integrity

We conduct business fairly and free from conflicts of interest. This means we:

- Hold ourselves to the highest ethical standards in all purchasing activities, to include selection, negotiation, and awarding of contracts
- Comply with contracts
- Require vendors to comply with our Vendor Compliance Addendum and Business Associate Agreement

Quality of Member/Patient Care

Piedmont provides quality care to all members/ patients. We make sure that members/patients have access to the right services to meet their needs.

Dignity and Respect

- We treat our members/patients with dignity.
- We respect their right to privacy.
- We respond to their needs promptly and politely.

Member/Patient Safety

- We provide services that are safe and comply with all laws, regulations, and standards.
- We make sure that those who provide services to our members/patients meet our credentialing criteria and standards.

Access to Quality Care

- We commit to arrange for or provide, as applicable, cost-effective and medically necessary services to our members/patients.
- We respect a member's/patient's right to make his or her own healthcare decisions after being informed.
- We maintain member/patient records that are complete and true accounts of all services/care rendered.

Privacy and Confidentiality

Piedmont is committed to protecting the privacy of the health information of our members/patients.

PHI and Member Rights

- We must respect and keep private all member/patient protected health information (PHI).
- We are required to follow the rules and regulations of the Health Insurance Portability and Accountability Act (HIPAA) governing uses and disclosures of PHI, and any state laws about the privacy of member/patient information.
- We only disclose or discuss member/patient information if we have a legitimate business purpose.

What is PHI? Any individually identifiable information, including demographic information, that relates to a past, present, or future physical or mental health condition of a member/patient, treatment, or payment that may identify a member/patient. PHI can be found in many places, including medical records and financial information.

It is proper to disclose the minimum necessary portions of a member's/patient's records for treatment, payment, or healthcare operations, consistent with the applicable Notice of Privacy Practices for the health plan being administered by Piedmont or for any provider affiliated with Piedmont, such as HealthWorks, that has its own Notice of Privacy Practices.

We are permitted to disclose for:

- Treatment – to help manage a member's/patient's healthcare treatment
- Payment – to pay for a member's/patient's health services
- Operations – to run our organization or to administer our member's health plan

Familiarize yourself with Piedmont's policies and procedures and Notices of Privacy Practices to protect the privacy and security of PHI. Any known violation of member/patient privacy must be reported to the Piedmont Compliance Department.

Piedmont's Compliance/Privacy Officer is available if you have questions or need further guidance related to HIPAA or any other privacy laws.

CAUTION!
If your friend or colleague is in the hospital, and you are not involved in their care, you must not access their PHI. You may only access a member's/ patient's PHI or other information if you need it to fulfill your job responsibilities.

Personal Information

Piedmont respects the personal information of our employees.

- We treat all salary, benefits, and personnel files as confidential.
- We only use or access this information for authorized business purposes.

Proprietary & Intellectual Information

Proprietary information includes all non-public information that might be of use to competitors or that may be harmful to Piedmont or its affiliates if disclosed.

- We must get consent of a supervisor before sharing such information with others.
- We must check with a supervisor to ensure appropriate contracts (such as non-disclosure agreements) are in place prior to sharing Piedmont's information with third parties.

We respect intellectual property and resources of Piedmont, its affiliates, and our vendors, business partners, and competitors. We keep confidential any such information.

Information Security

We must properly use all computer and information systems.

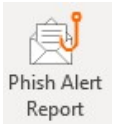
- We should not expect a right to privacy in our email or internet use.
- No one may access or try to access someone else's electronic communications (such as email) without proper approval.

We should follow Piedmont's security policies by:

- Using password guidelines and keeping passwords private
- Encrypting and securing mobile devices that contain confidential or member/patient information
- Logging off or locking computers when not in use
- Securely emailing confidential or member information
- Reporting concerns to Piedmont's Security or Compliance/Privacy Officer
- Follow all instructions from Piedmont's security team as new threats emerge

CAUTION!
Cyber criminals use social engineering schemes such as "phishing" to lure individuals into providing them with their network credentials to gain access to confidential member/patient, business, or financial information.

Use the ***Phish Alert Report*** on your Outlook menu bar to report suspicious email.



Social Media

We may use social media in various platforms such as Facebook, LinkedIn, Twitter, blogs, etc. during personal time. During such use, you are expected to follow all Piedmont policies, including privacy and confidentiality, and not let your use of social media interfere with your job responsibilities. You must not post any PHI, pictures, or comments regarding a member/patient of Piedmont.

CAUTION!
You must not post any information about a member/patient, even if you do not believe that it contains PHI. It is possible that someone might be able to identify the member/patient based on the clues that you provide in your post. Once a member/patient is identified, all related information becomes PHI.

Compliance with Laws and Regulations

Piedmont business is highly regulated, and its business and affairs must be conducted in accordance with all applicable laws and regulations.

Fraud, Waste, and Abuse Laws

Certain laws or regulations applicable to Piedmont and/or its affiliates describe activities that may constitute fraud, waste, and abuse, including but not limited to the False Claims Act, the federal Anti-Kickback Statute, and the Physician Self-Referral Law called the Stark Law.

False Claims Act

This federal law makes it a crime for any person or organization to "knowingly" make a false record or file a false claim for payment under any federal or state healthcare program. "Knowingly" means having actual knowledge that a claim is false or acting in deliberate ignorance or with "reckless disregard" as to whether a claim is false.

We comply with this law by making sure we do **NOT**:

- Bill or pay for work that was
  - never performed or items that were never given
  - not ordered by a provider
  - poor-quality work that the government would not pay for
- Fake records
- Double bill
- Pay at an inflated price
- Fail to report overpayments or credit balances within 60 days

Anti-Kickback Statute

This law prohibits knowingly and willfully soliciting, receiving, offering, or paying remuneration (including any kickback, bribe, or rebate) for referrals for services that are paid in whole or part under a federal healthcare program.

We comply with this law by making sure we do **NOT**:

- Offer, give, ask for, or receive money, gifts, loans, rewards, favors, business opportunities, or anything of value that creates or could be seen as creating a bribe or kickback
- Ask for or take anything of value in exchange for the referral of members/patients
- Provide "professional courtesy" discounts

Stark Law

The Stark Law prohibits a physician (or a member of their family) from making federal healthcare program (e.g., Medicare or Medicaid) referrals for "designated health services" (DHS) to the healthcare entities with which the physician has a financial relationship unless an exception applies. A subsidiary or affiliate of Piedmont may be a provider that makes referrals for certain DHS to entities such as hospitals and, therefore, is subject to the Stark Law.

We comply with this law by making sure we do **NOT**:

- Enter into financial arrangements governed by the Stark Law that do not satisfy an exception.

Antitrust Laws

We are committed to antitrust compliance and fair competition. We do not enter into any discussions or contracts with a competitor about:

- Our pricing
- Terms of business partner relationships
- Key factors such as labor costs and marketing plans

We comply with marketing policies and laws related to truth in advertising.

Government Investigations

We fully cooperate with government inquires.

- We assist and are polite to all inspectors.
- We provide all information they are entitled to during an investigation.

Upon learning of a government inquiry, we:

- Notify our manager at once. The report is then promptly disclosed to the proper leaders and the Compliance/Privacy Officer.
- Are always truthful in response to questions and do not conceal, destroy, or alter any records.

Records Retention Policy

Piedmont's records retention policy governs how long records should be kept. A record is any info that has been made or received as part of Piedmont's business.

- We must comply with all records retention policies and preservation notices.

- Records must be kept for the proper duration, according to applicable laws and regulations and, as applicable, consistent with our contractual obligations.
- Records that pertain to litigation or a governmental or internal investigation may not be destroyed until the matter has been resolved and the Compliance Office has approved.

CAUTION!
Destroying or changing documents with the intent to block a pending or expected official government proceeding is a criminal act. Doing so could result in large fines and jail time.

Violations of Our Code

The standards set forth in our Code are mandatory and must be followed. All Piedmont associates will be held accountable for behaviors and actions inconsistent with the Code.

The following are examples of behaviors and conduct that can result in disciplinary actions or sanctions:

- Participating in, or failing to report a violation of law, regulation, or Piedmont policy
- Arranging for or providing substandard, unsafe, or medically unnecessary patient care
- Falsifying records of any type
- Theft or misappropriation of Piedmont assets, funds, equipment, supplies, or other property
- Retaliating against individuals who report issues and concerns in good faith
- Deliberately filing false or frivolous reports of violations
- Actions that may be discriminatory, harassing, or bullying
- Committing or threatening to commit an act of violence, or possessing a gun or other weapon in the workplace
- Reckless or intentional actions or behaviors that jeopardize the privacy and security of personal health information and other confidential business information

Questions

If you have any questions, please contact the Compliance Department at Compliance@pchp.net or by calling 434-947-4463, Option 2.

Acknowledgement

All Piedmont associates are required to certify that we:

- Have read this Code
- Agree to follow its standards
- Agree to follow Piedmont policies and procedures