



**Alliance Physicians Medical Group**

**PROVIDER RESOURCE MANUAL**

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**SECTION I.**

**ADMINISTRATION**

## **Mission Statement**

It is Coast Healthcare Management's mission to establish a collaborative partnership with our clients and to identify each medical group's practice objectives in order to customize a flexible business solution to suit their needs. We are committed to offering the highest level of service to clients, their physicians and patients. Utilizing the latest technology we strive to move ahead of increasing administrative costs, industry trends and marketplace challenges to provide consistent and stable management services. Coast takes a long-term approach to business development, with sustained and controlled growth being the cornerstone of our philosophy. As health care complexities continue, it remains the goal of Coast to assist physicians in focusing their energies and attention on patient care. We will do so through our continued development and investment in people and systems.

## **Values Statement**

Physicians, providers and the management staff of Alliance Physicians Medical Group (APMG) are dedicated to the provision of health care excellence. APMG has designed their delivery system to accommodate accelerated access to providers. Through innovations in medical service delivery, integrity and compassion in member treatment and communication, we strive to positively influence each of our member's personal health status and the overall well being of the surrounding communities.

## **Vision Statement**

The Vision Statement of APMG is structured on the values of the organization, which have been adopted by the Board of Directors, physician members and professional staff of our organization.

**SERVICE:** Excellence in the delivery of health care and support to our members, physician providers, health plan partners, ancillary providers, vendors and employees.

**INTEGRITY:** Ethical and professional treatment is always given to our members, providers, health plan partners and employees.

**INNOVATION:** We continue to develop and seek out innovation in health care while remaining fiscally stable and responsible to our providers, members and health plan partners.

**COLLABORTION:** As a provider group and a professional team of managers, we share findings, audit results and systems improvements with our providers and health plan partners in order to achieve a higher level of member satisfaction in all aspects.

**COMPASSION:** Our members and their individual medical status are dealt with on a compassionate level, by our medical providers, management and clerical staff, while keeping the privacy of our members in mind at all times.

*Utilization management decisions are based solely on appropriateness of care and benefit coverage*

# Coast Healthcare Management, LLC

## Contact Information

**Administrative Office Location:** 4909 Lakewood Blvd. Ste. #200  
Lakewood, CA 90712

**Hours of Operation:** Monday – Friday  
8:30a.m. – 5:00p.m.

**Toll Free #:** (877) 602-1563

**Website:** [www.coasthealthcare.net](http://www.coasthealthcare.net)

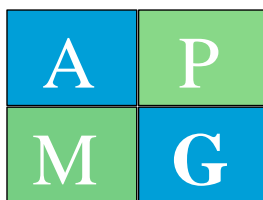
**We are closed in observance of the following holidays:**

New Years Day                                      Presidents Day                                      Memorial Day  
Independence Day                                      Labor Day                                      Thanksgiving Day  
Day after Thanksgiving                                      Christmas Day

### BOARD OF DIRECTORS:

Title	Name	Fax or Mobile	E-mail Address
<b>APMG Chairman &amp; Chief Executive Officer</b>	Gil Bender, MD	(mobile) 562-508-9667 & (fax) 562-862-1768	gilbender@aol.com
<b>APMG Chief Financial Officer</b>	Devadatt Mishal, MD	(mobile) 562-508-9634 (fax) 562-862-1768	DRDMM837@aol.com
<b>APMG President</b>	David Aguilar, MD	(mobile) 508-9730 (fax) 323-582-6950	dr.a@tcpeds.com
<b>APMG Vice President</b>	Alan Frischer, MD	(mobile) 310-740-7507 (fax) 927-4801	fmedgrp@aol.com
<b>APMG Medical Director</b>	Al Lopez, MD	(mobile) 909-708-7016 & (fax) 562-220-1026	ea.lopez@verizon.net

**For any provider related issues, please call Bonnie Eng-Suess (APMG IPA Manger) at (562) 602-1563 ext. 263 or Elizabeth Noriega (APMG Director of Physician and Network Development) at (562) 500-1701**



## What Sets Us Apart

- **Internet Website Access** – Look-up eligibility, authorizations and claims status 24 hours a day, seven days a week.
- **Interactive Authorizations** – Submit authorization requests online, through our secure website, utilizing “point and click” technology with some requests being “auto-approved.”
- **Direct Referrals** – Many specialist consults do not require prior authorization.
- **Automatic Fax-Back System** – Your authorizations are sent to your office automatically whether submitted online or manually.
- **Electronic Claims In-load** – Save money on overhead expenses (paper, printing and staff time) by utilizing our electronic system. Just print your claims to a file and upload through our secure FTP site and we will confirm receipt by email.
- **Scanning** – If you prefer paper claims, you can send the most current CMS form or print on plain white paper and mail. Once your claims are received, they are scanned and uploaded utilizing current technology, which reduces the processing time.
- **Dedicated IPA Manager** – A knowledgeable and dedicated manager is available to assist your office with any questions that may arise.
- **Provider Relations Staff** – Education and training, as well as trouble-shooting of our systems and services, are available both telephonically and in-person.
- **Advocacy and Support Programs**
  - Chronic Disease Management and outreach for homebound or at risk patients through the Outreach Program
  - 24/7 SNF placement assistance
  - Diabetic and Anticoagulation Clinic
  - After-hours care clinic
  - Office staff training
    - Pay for Performance
    - Risk Adjustment
  - Quarterly Newsletters
  - Educational Materials
  - Live customer service assistance

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## About Our Staff

Our staff consists of experienced professionals each of whom are knowledgeable in the functions of a managed care system and are organized in a team-focused environment. Through commitment to and development of our staff and systems we continue to enhance our operations in order to maintain the highest level of service and professional standards.

**SECTION II.**  
**RESOURCES**



ALLIANCE  
PHYSICIANS  
MEDICAL  
GROUP

## Alliance Physicians Medical Group Contracted Providers Quick Reference List

### LABORATORY CENTERS

<p>Unilab is now a part of Quest Diagnostics. For the nearest Lab facility, please call (800) 377-8448 or log on to <a href="http://www.questdiagnostics.com">www.questdiagnostics.com</a></p>			
<p><b>Quest Diagnostics</b> 10800 S. Paramount Blvd.#103 Downey, CA 90241 T: (562) 869-6181 F: (562) 869-0261</p>	<p><b>Quest Diagnostics</b> 11525 Brookshire Ave. #103 Downey, CA 90241 T: (562) 904-9171 F: (562) 869-8655</p>	<p><b>Quest Diagnostics</b> 14906 Paramount Blvd. Paramount, CA 90723 T: (562) 633-9704 F: (562) 630-6586</p>	<p><b>Quest Diagnostics</b> 10230 Artesia Blvd. # 307 Bellflower, CA 90706 T: (562) 461-9337 F: (562) 461-9347</p>

### DIAGNOSTIC RADIOLOGY CENTERS

<p>All radiological services require prior authorization with the exception of x-rays, ultrasounds and mammograms</p>			
<p><b>Preferred Diagnostic Imaging</b> 10230 Artesia Blvd. Suite 100 Bellflower, CA 90706 T: (562) 461-2585 F: (562) 461-2591</p>			

### PHYSICAL THERAPY CENTERS

<p><b>Active Sports Rehabilitation</b> 13330 Bloomfield Ave Norwalk, CA 90650 T: (562) 484-3860 F: 9562) 684-4070</p>	<p><b>California Ancillary Network</b> 7860 Imperial Hwy. # C Downey, CA 90242 T: (562) 869-8525 F: (562) 869-7786</p>	<p><b>Nifty After Fifty Medical Group</b> 5510 Clark Ave. Lakewood, CA 90712 T: (562) 677-3700 F: (562) 677-3705</p>	<p><b>Nifty After Fifty Medical Group</b> 16405 Whittier Blvd. Whittier, CA 90603 T: (562) 501-2200 F: (562) 501-2206</p>	<p><b>Western Physical Therapy</b> 9901 Paramount Blvd. #116 Downey, CA 90240 T: (562) 928-0121 F: (562) 806-3021</p>
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### AFTER HOURS CARE CENTERS

<p><b>Downey Facility</b> 11480 Brookshire Ave. # 101 Downey, CA 90241 T: (562) 862-2775 <b>M-F:</b> 6 pm – 9 pm <b>SAT:</b> 9 am – 5 pm <b>SUN:</b> 9 am – 1pm</p>	<p><b>La Mirada Facility</b> 15034 Imperial Hwy. La Mirada, CA 90638 T: (562) 902-3000 <b>M-F:</b> 5 pm – 9 pm <b>SAT/SUN/HOLIDAYS:</b> 8 am – 4 pm</p>	<p><b>Long Beach Facility</b> 2220 Clark Ave. Long Beach, CA 90815 T: (562) 597-4181 <b>M-F:</b> 6 pm – 9 pm <b>SAT:</b> 9 am – 5 pm <b>SUN:</b> 9 am – 1pm</p>	<p><b>Santa Fe Springs Facility</b> 11460 Telegraph Rd. Santa Fe Springs, CA 90670 T: (562) 864-1000 <b>M-F:</b> 5 pm – 10 pm <b>SAT:</b> 9 am – 3 pm <b>Closed Sundays</b></p>	<p><b>Whittier Facility</b> 9200 Colima Rd. #101 Whittier, CA 90605 T: (562) 945-2128 <b>M-F:</b> 5:30 pm – 9 pm <b>SAT:</b> 10am – 2pm <b>Closed Sundays</b></p>
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### CLAIMS ADDRESS

<p>4909 Lakewood Blvd., Suite 200 Lakewood, CA 90712</p>
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### PRIOR AUTHORIZATION/REFERRAL FAX NUMBERS

<p>(562) 924-1790 – Outpatient (562) 602-2772 – Inpatient</p>
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### GENERAL QUESTIONS

<p>(562) 220-1011</p>
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**PREFERRED CONTRACTED  
SKILLED NURSING FACILITY LISTINGS**

**Alliance Physicians Medical Group**

<b>Name</b>	<b>Address</b>	<b>Phone # (562)</b>	<b>Fax # (562)</b>
Country Villa Belmont Heights	1730 Grand Ave. Long Beach, 90804 <i>Contact: Stephanie/Julie (For Sub Acute &amp; SNF)</i>	597-8817	597-2843
Downey Care Center	13007 S. Paramount Downey, CA 90242 <i>Contact: Rosa</i>	923-9301	904-8005
Villa Elena Convalescent Hospital	13226 Studebaker Road Norwalk, CA 90650 <i>Contact: Angie</i>	868-0591	864-4271
Windsor Gardens	3232 E. Artesia Long Beach, CA 90805 <i>Contact: Priscilla/Yesenia</i>	422-9219 or 428-4681	428-0208
*Woodruff Convalescent	17836 Woodruff Ave, Bellflower, CA 90706 <i>Contact: JoAnne</i>	925-8457	867-5918

**Updated: 03/20/2009**

**Referral to a facility other than listed above must be coordinated through the APMG  
SNF Management Team.**

**Gerinet Phone: (714) 619-8777      FAX: (714) 327-0149**

**Please fax face sheet and contact to Gerinet at above number.**

**SECTION III.**

**INTERNET AVAILABILITY**

**WEBSITE ACCESS:** (562) 602-1563 x225  
Ava Ervin, Customer Service and Credentialing Manager

## **SECTION. III INTERNET BASED MODULE**

Alliance Physicians Medical Group has established a website to better streamline the delivery of health care services as well as give our contracted physicians and members access to applicable information.

### **Website:**

The website is designed specifically to provide information and market our physicians and is available 24 hours a day at [www.coasthealthcare.net](http://www.coasthealthcare.net). Some of the features include the following:

- Information about APMG
- How to enroll with our physicians
- Hospital affiliations
- Directions to hospitals
- Health plan affiliations
- Provider list and contact information
- Health education
- Preventive health guidelines

### **Provider Module:**

Through our secure and password protected site, providers and their staff can access the following:

- Check eligibility
- Check authorization status
- Request authorization (Interactive Authorization)
- Check claims status
- Print forms (Direct referral, Prior authorization request, Eligibility guarantee, Outreach Case Management referral)
- Print provider manual
- Search network providers
- Point of Care (Pay for Performance)

## **SECTION. III INTERNET BASED MODULE**

(Continued)

### **Accessing the Website:**

To access the Provider Module, please follow the instructions shown below:

1. Go to our website located at **www.coasthealthcare.net**
2. Double-click on the box in the upper right hand corner denoted as “For Providers Only.”
3. Enter your username and password in the appropriate boxes on the next screen.

Take advantage of the referenced resources to reduce your overall administrative costs. The website and Provider Module were designed with the provider’s office in mind and are therefore efficient and user friendly.

### **Obtaining Access:**

If you do not already have access but would like to start utilizing the Provider Module, please fill out the Primary **Care/Specialist Provider Internet Password Release Form** located on page 15. This form will designate whom in your office should be allowed access and to what degree. Upon completion of this form, please mail or fax to the attention of Ava Ervin (fax number (562) 602-1516.) Within two weeks, you will receive the usernames and passwords, which will allow access to your patient information.

*In compliance with HIPAA requirements and to prevent unauthorized use and disclosure of member personal health information, staffing information and personnel privileges should be updated quarterly, or sooner, as required.*

### **Education and Training:**

Our staff is available to provide telephonic and one-on-one support of our website capabilities and the Provider Module, as necessary. Demonstrations can be planned at a time that is most convenient for your office and can be scheduled by contacting Provider Services at (562) 602-1563 ext. 478.

# INTERNET PASSWORD RELEASE FORM



Coast Healthcare Management, LLC

Management Company for

Alamitos IPA ♦ Alliance Physicians Medical Group ♦ Brookshire IPA

Lakewood IPA ♦ Pioneer Provider Network ♦ Primary Care Associates of California ♦ St. Mary IPA

4909 LAKEWOOD BLVD., SUITE 200, LAKEWOOD, CA 90712

P: (562) 602-1563 ♦ F: (562) 529-8490 ♦ www.coasthealthcare.net

## PRIMARY CARE/SPECIALIST PROVIDER INTERNET PASSWORD RELEASE FORM

**Physician Instructions: #1 - select all applicable boxes. #2 - select only one box. #3 - complete applicable information, sign and date. Please do not write in shaded area.**

**#1. PLEASE CHECK ONE**

- Yes, I wish to have access to the Internet Based Provider Module
- No, I do not wish to have access to the Internet Based Provider Module at this time
- I already have access but am requesting to add staff member(s)

**#2. PLEASE CHECK ONE**

Privileges to access the Internet Based Provider Module are being requested for:

Physician only (complete physician info below)

Physician and staff (complete physician & staff info below)

**#3. PLEASE COMPLETE APPLICABLE FIELDS (please print legible or type)**

**Group Name:** \_\_\_\_\_  
**Tax ID #:** \_\_\_\_\_  
**CAN'T PROCESS WITHOUT YOU PROVIDING YOUR GROUP/ORGANIZATION NAME & Tax ID #.**

	First & Last Name	Type of physician/staff PCP or SCP/ Job Title/Dept:	First & Last Name	Type of physician/staff PCP or SCP/ Job Title/Dept:
Physician				
Authorized Staff				

**Address:** \_\_\_\_\_ **City & Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Provider, Ofc. Manager or Administrator who has the authority to sign off on administrative functions, Signature is required:**

Sign here: \_\_\_\_\_

(Stamped signature not acceptable)

**Title:** \_\_\_\_\_

**Print name here:** \_\_\_\_\_

**Provider, Ofc. Manager or Administrator's E-Mail address:** \_\_\_\_\_

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

**If you are able to scan and e-mail documents, please complete, sign and date and return via e-mail to [svae@LHPIPA.COM](mailto:svae@LHPIPA.COM) otherwise fax to 562-602-1516.**  
 Detailed instructions, plus passwords & user names will be sent to you within 5 business days.

**SECTION IV.**  
**ELIGIBILITY MANAGEMENT**

**ELIGIBILITY ASSISTANCE: (562) 602-1563 x234**  
**Victoria Castillo, Eligibility and Capitation Manager**

## SECTION IV. ELIGIBILITY MANAGEMENT

### **Eligibility Verification:**

Eligibility verification is an essential step in the care process and should be done prior to rendering services. All health plans issue an insurance card with the currently assigned PCP IPA affiliation, which should be available and presented at each visit.

### **Eligibility Guarantee:**

Your office can access patient eligibility information online or by phone with each **health plan** at the phone numbers and websites listed below. It is important to maintain documentation with either a screen shot of the website information or, if you verify eligibility by phone, get the name of the health plan representative you spoke with and include the time and date of your conversation. **If you check eligibility with the health plan on the date of service, the IPA will guarantee your payment for services.** If under any circumstance the patient's eligibility changes, the IPA will request your eligibility documentation and address any discrepancy directly with the health plan. There will be no retroactive capitation or claims deduction.

<b>Healthplan</b>	<b>Eligibility Phone Numbers</b>	<b>Website Address</b>
Aetna	(800) 624-0756	<a href="https://navinet.navimedix.com">https://navinet.navimedix.com</a>
Blue Cross/California Care	(800) 933-6633	<a href="https://provideraccess.bluecrossca.com">https://provideraccess.bluecrossca.com</a>
Blue Cross Senior/California Care 65	(800) 230-7338	<a href="https://provideraccess.bluecrossca.com">https://provideraccess.bluecrossca.com</a>
Blue Shield	(800) 424-6521	<a href="https://www.blueshieldca.com">https://www.blueshieldca.com</a>
Blue Shield 65	(800) 776-4466	None
Cigna	(800) 343-9197	<a href="https://cignaforhcp.com">https://cignaforhcp.com</a> (new)
HealthNet	(800) 641-7761	<a href="https://www.healthnet.com">https://www.healthnet.com</a>
PacifiCare/Secure Horizons	(800) 542-8789	<a href="https://www.pacificare.com">https://www.pacificare.com</a>
Caremore	(888) 250-5800	None

**SECTION IV.  
ELIGIBILITY MANAGEMENT**

(Continued)

**Newborn Eligibility:**

The policy for processing newborn claims is as follows:

1. All newborn claims are paid under the mother's ID for the first 30 days of life.
2. If the baby is eligible with APMG but the mother is not, all newborn charges must be billed to the mother's IPA for the first 30 days of life.
3. After the first 30 days claims will only be processed under the baby's own identification record.

**Authorizations and Eligibility:**

As a reminder, authorizations are valid for a sixty (60) day time frame only and are **CONTINGENT UPON CURRENT ELIGIBILITY**. It is the responsibility of the rendering Provider's office to verify the eligibility at the time of service and ensure that the authorization is still valid. As a way to ensure coverage for the authorized services, please implement steps to verify and confirm eligibility on the day of the scheduled appointment.

**Unconfirmed Eligibility:**

If you are unable to verify a member's eligibility for any reason, please use the **Eligibility Guarantee Form** or "waiver" (page 19) in the interim. This waiver will explain to the individual that he/she will be financially responsible for the resulting bill should the patient not be eligible.

**APMG**  
**Alliance Physicians Medical Group**

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***ELIGIBILITY GUARANTEE FORM***

I, \_\_\_\_\_ hereby certify that I am eligible for  
(Name of patient/member/guardian)

\_\_\_\_\_ as of \_\_\_\_\_  
(Insurance) (Month/ Day/ Year)

through \_\_\_\_\_. I have chosen \_\_\_\_\_  
(Medical group / physician)

*to be my Medical Provider. I understand that if the above given information is not true, or if I am not eligible under the terms of my employer's Medical and Hospital subscriber agreement, I am liable for all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services received within 30 days of receiving a bill for the above noted Medical Group / Physician or*

\_\_\_\_\_.  
(Insurance)

\_\_\_\_\_  
*Signature of Member (or Guardian) Date*

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Eligibility Verified By: \_\_\_\_\_  
Insurance Member Service Representative Date

Member Verified: Yes  No

Name of IPA: \_\_\_\_\_

Effective Date: \_\_\_\_\_ PCP: \_\_\_\_\_

\_\_\_\_\_  
Office Personnel Verifying Eligibility Date

## **SECTION V.**

# **PRIMARY CARE PHYSICIAN POLICIES AND PROCEDURES**

**CONTRACTING ISSUES: (562) 602-1563 x263**

**Bonnie Eng-Suess, IPA Manager**

**PAYMENT ISSUES: (562) 602-1563 x272**

**Michelle Hernandez. Claims Lead**

**SECTION V.  
PRIMARY CARE PHYSICIAN  
POLICIES AND PROCEDURES**

**I. Services to be Made Available by Physician:**

Physician agrees to serve as a Primary Care Physician (PCP) in APMG's network. Primary Care Services, as defined below, shall be available and accessible to Beneficiaries 24 hours a day, seven days a week, throughout the year through Physician personally or through APMG approved "covering" physicians. Physician shall be solely responsible for securing the services of such covering physician and shall ensure that the covering physician looks solely to physician for payment for services rendered and will not directly bill Beneficiaries for Covered Services.

Delays encountered by patients in obtaining physician's services in accordance with the standards shall be grounds for sanctions under APMG Rules or for termination of this Agreement.

**Capitated Services**

1. Routine office visits (including after - hours office visits).  
An office visit is inclusive of the following:
  - a. Evaluation
  - b. Diagnosis and treatment of the illness or injury
  - c. Venipuncture
  - d. Suturing of minor lacerations
  - e. Wound care
  - f. Specimen collection
  - g. Splinting of simple fractures
2. Application of dressings
3. Anoscopy
4. Cauterization of nasal passages - simple
5. Ear irrigation and removal of cerumen
6. Administration of therapeutic injections including the serum given
7. Collection of Specimens (analysis to be performed by contracted laboratory)
8. Simple abscess drainage
9. Periodic health examination
10. Supplies needed for minor treatments
11. Suture removal, including sterile tray if used
12. Taping of minor skin lacerations
13. Telephone consultations with beneficiaries and other providers
14. EKGs
15. Pap Smears
16. Stools for occult blood
17. Breathing treatments
18. Trigger point injections
19. Bursa injections
20. Treadmill testing
21. Nasal cautery-simple
22. Removal of warts/skin tags
23. Splinting simple fractures
24. Removal of foreign body from ear/eye (simple)
25. Routine nutritional counseling
26. Family Planning
27. Burn care, first and second degree, and other minor injuries
28. Biopsy or removal of cysts, moles, and growths (except facials)
29. TB skin test
30. In office inhalation treatments

**SECTION V.  
PRIMARY CARE PHYSICIAN  
POLICIES AND PROCEDURES**

(Continued)

**NON-CAPITATED SERVICES**

**A. Authorized Non-Capitated Case Rate**

Flexible Sigmoidoscopy	\$100.00
Newborns Circumcision	\$100.00
Newborn Examination	\$100.00

**B. Non-Capitated Immunization and Injections, effective 02/01/2010 (Do not require prior authorization)**

<u>IMMUNIZATION</u>	<u>CODE</u>	<u>ALLOWABLE PER DOSE</u>
TB Intradermal	86580	\$7.00
Hepatitis A (Adult)	90632	\$66.00
Hepatitis A (2-17 yrs) 2 dose	90633	\$33.00
HIB	90645	\$26.00
Gardasil	90649	\$134.00
Cervarix	90650	\$134.00
Influenza	90657 & 90658	\$15.00
Prennar (Pneumococcal)	90669	\$88.00
RotaTeq	90680	\$73.00
RotaRix	90681	\$108.00
Kinrix	90696	\$50.00
Pentacel	90698	\$76.00
DtaP	90700	\$25.00
DT (Pediatric)	90701	\$6.00
Tetanus Toxoid	90703	\$4.00
Mumps	90704	\$19.00
Measles	90705	\$18.00
Rubella	90706	\$18.00
MMR	90707	\$50.00
ProQuad	90710	\$122.00
Polio (injection)	90713	\$24.00
TdaP	90715	\$37.00
Varicella	90716	\$85.00
Td (Adult)	90718	\$23.00
Pediarix	90723	\$74.00
Pneumovax (Adult)	90732	\$40.00
Menactra	90734	\$102.00
Zostavax	90736	\$165.00
Hep B (0-19 yrs)	90744	\$23.00
Hepatitis B - (20 yr & older)	90746	\$61.00
Comvax	90748	\$45.00
Rocephin (under 250 mg)	J0696	\$3.00
Rocephin (over 250 mg)	J0696	\$5.00

\* Influenza vaccine for high-risk enrollees and seniors, as defined by the CDC, only during flu season.

**SECTION V.  
PRIMARY CARE PHYSICIAN  
POLICIES AND PROCEDURES**

(Continued)

**C. Non-Capitated Immunization and Injections, effective 5/1/05 (Require prior authorization)**

<b><u>IMMUNIZATION</u></b>	<b><u>CODE</u></b>	<b><u>ALLOWABLE/DOSE \$\$</u></b>
Depo Lupron 3.75 mg	J1950	465.00
Depo Lupron 7.5 mg	J9217	\$150.00
Depo Provera	J1055	60.00
Rhogam	90786	95.00
Mirena IUD	J7302	400.00
Paraguard IUD	J7300	400.00

**D. All other FDA approved, pre-authorized and medically covered injectables such as inoculations, immunizations, chemotherapeutic agents and infertility require prior authorization and must be billed according to the established HCPCS Codes. The reimbursements shall be Medicare Allowable.**

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**• The primary hospital for inpatient care is:**

Downey Regional Medical Center

From time to time APMG may authorize services to be rendered at alternative facilities.

**SECTION V.  
PRIMARY CARE PHYSICIAN  
POLICIES AND PROCEDURES**  
(Continued)

**Access Standards:**

Physician’s services shall be available and accessible to Beneficiaries 24 hours a day, seven days a week, throughout the year through physician personally or, in physician’s scheduled absence or necessary unavailability, through the PCPs approved “covering” physician(s).

Description	Standard Timeline (Scheduling of Appointment)
<b>PCP Appointments:</b>	
Preventive Health Assessment	30 calendar days (include routing physical examination, test and immunization)
Routine Primary Care	7 calendar days (Primary care for non-urgent asymptomatic care conditions)
Urgent Care	Within 24 Hours
After-hours Coverage	24-hour availability
Emergent Care	Immediate-Emergency medical condition based on Prudent Layperson
Waiting Time in Office	Not to Exceed 30 Minutes
<b>SCP Appointment:</b>	
Urgent Care	24-hours
Routine Care	14 Calendar days
<b>Behavioral Health Care Appointments:</b>	
Routine Services	Within 10 business Days
Urgent Care	48-hours
<b>Emergent Services:</b>	
Non-life Threatening	Within 6-hours
Life Threatening Emergencies	Immediately
Phone Triage (24/7)	Live person within 30 seconds

**SECTION V.  
PRIMARY CARE PHYSICIAN  
POLICIES AND PROCEDURES**

(Continued)

**Compensation and Encounter Data Submissions**

- A. **Payment of Capitation:** APMG shall pay Physician's capitation by the thirtieth (30<sup>th</sup>) day of the month or the end of the month following the month that APMG received its capitation payment from the Plan, (e.g., in April for capitation received in March).
- B. **Billing and Payment for Non-Capitated Services:** Physician shall submit bills within ninety (90) days of rendition of the service. APMG may deny payment if bills are submitted thereafter, and in that event physician shall have no recourse against the patient, Plan or APMG. **The address to send Claims is: 4909 Lakewood Blvd., Suite 200, Lakewood CA 90712.** Payment is due sixty (60) business days after APMG receives a clean and completed claim for Covered Services to a Plan Beneficiary submitted in accordance with APMG rules. For non-capitated services appropriately authorized, physician shall be paid as per Attachment B of the Agreement.
- C. **Encounter Data:** Encounter data consists of the charges for patient services submitted to the medical group for capitated procedures. This information is entered into APMG's database and monthly reports are sent to each health plan. The submission of encounter data is important because the reporting of these charges is a contractual obligation for APMG. Submit encounter claims on/or before the fifteenth (15<sup>th</sup>) of the month following the date of service to:
- Alliance Physicians Medical Group**  
Claims Department  
4909 Lakewood Blvd., Suite 200  
Lakewood, CA 90712
- D. **Withholds for non-Compliance:** APMG may withhold all or a portion of physician's compensation so long as physician continues to fail, despite written notice of non-compliance, to submit encounter data, pre-authorization forms and other reports and documentation that APMG has reasonably requested.
- E. **Implementation of New or Modified Rates:** APMG may adjust the capitation and other compensation rates upward or downward or to a different formula, with respect to a particular Plan contract, type of contract, or across-the-board, as APMG administrative and financial needs require, upon at least forty-five (45) day's prior written notice to physician.
- F. **Compensation for Coverage Services:** If physician covers for another Participating physician, physician shall, with respect to Plan Beneficiaries, look only to that provider for payment, and not to APMG or the Plan.
- G. **Coordination of Benefits:** In the event of third party liability, where APMG has reimbursed physician for Covered Services rendered, physician agrees that APMG be entitled to recover and retain the costs of such Covered Services. Physician assigns to APMG any rights physician may have to bill and collect any sums with respect to services paid or payable by APMG or a Plan. Physician shall promptly execute any documents reasonably required by APMG or Plans in order to facilitate APMG's collection in such situation.
- H. **Closure of Panel:** Provider must give (90) days written notice of intent to close panel to new enrollees. APMG has the right to terminate closed panel physicians whose membership falls below 50.

**SECTION VI.  
SPECIALTY CARE PHYSICIAN  
POLICIES AND PROCEDURES**

**CONTRACTING ISSUES: (562) 602-1563 x263**

**Bonnie Eng-Seuss, IPA Manager**

**PAYMENT ISSUES: (562) 602-1563 x232**

**Caesar Abutin, Controller**

## SECTION VI. SPECIALTY CARE PHYSICIAN POLICIES AND PROCEDURES

### Access to Services:

Physician's services shall be available and accessible to Beneficiaries 24 hours a day, seven days a week, throughout the year through the physician personally or, in physician's scheduled absence or necessary unavailability, through the IPA's approved "covering" physician(s).

### **Access Standard:**

Description	Standard Timeline (Scheduling of Appointment)
<b>Primary Care Physician Appointments:</b>	
Preventive Health Assessment	30 calendar days (include routing physical examination, test and immunization)
Routine Primary Care	7 calendar days (Primary care for non-urgent asymptomatic care conditions)
Urgent Care	Within 24 Hours
After-hours Coverage	24-hour availability
Emergent Care	Immediate-Emergency medical condition based on Prudent Layperson
Waiting Time in Office	Not to Exceed 30 Minutes
<i>*Post Hospitalization follow-up visits</i>	<i>Within 48 hours of discharge</i>
<b>Specialist Appointment:</b>	
Urgent Care	24-hours
Routine Care	14 Calendar days
<b>Behavioral Health Care Appointments:</b>	
Routine Services	Within 10 business Days
Urgent Care	48-hours
<b>Emergent Services:</b>	
Non-life Threatening	Within 6-hours
Life Threatening Emergencies	Immediately
Phone Triage (24/7)	Live person within 30 seconds

**SECTION VI.**  
**SPECIALTY CARE PHYSICIAN**  
**POLICIES AND PROCEDURES**  
(continued)

**Covering Physician:**

Physician shall be solely responsible for securing the services of such covering physician(s) and shall ensure that the covering physician(s) looks solely to physician for payment for services rendered and will not directly bill Beneficiaries for Covered Services. Physician must notify the IPAs of the timeframe for which a physician will be covering as well as demographic information of covering physician.

In the event the physician wishes to refer a patient to another physician or physician group for any services included in the capitation, the physician must notify the IPAs of the timeframe for which a physician will be covering as well as demographic information of covering physician. The physician is responsible for ensuring payment to the covering physician. Should the covering physician bill the IPA's member(s) for services rendered, the IPAs shall pay the covering physician and deduct the amount paid from the physician's future capitation payment(s).

**Pre-authorization:**

Unless capitated, certain referral specialist services require pre-authorization by the IPAs.

**Billing Procedure for Non-Capitated and Fee for Service:**

**a. Billing** - Physician shall send bills for all Plan Beneficiaries to the IPAs, unless advised otherwise by the IPAs. Physician shall submit bills within ninety (90) days of rendition of the service. All claims are subject to National Correct Coding Initiative Coding Policy Manual edits. The IPAs may deny payment if bills are submitted thereafter, and in that event Physician shall have no recourse against the patient, Plan or the IPAs. Payment is due sixty (60) calendar days after the IPAs receive a clean and completed billing for Covered Services to a Plan Beneficiary submitted in accordance with the IPAs rules.

Claims should be submitted to the following address:

**IPA Name**  
**4909 Lakewood Blvd., Suite 200**  
**Lakewood, CA 90712**  
**Attn: Claims Department**

**b. Coordination of Benefits** - In the event of third party liability, where the IPAs have reimbursed physician for covered services rendered, physician agrees that the IPAs are entitled to recover and retain the costs of such covered services. Physician assigns to the IPAs any rights physician may have to bill and collect any sums with respect to services paid or payable by the IPAs or a Plan. Physician shall promptly execute any documents reasonably required by the IPAs or Plans in order to facilitate the IPAs collection in such situation.

# **SECTION VII. CLAIMS MANAGEMENT**

**PAYMENT ISSUES: (562) 602-1563 x272**  
**Michelle Hernandez, Claims Lead**

## **SECTION VII. CLAIMS MANAGEMENT**

### **I. Claims Submission:**

Submit Claims to:                   **Alliance Physicians Medical Group**  
4909 Lakewood Blvd., Suite 200  
Lakewood, CA 90712

Claims must be submitted within ninety (90) days from the date of service. Claims received after ninety (90) days can be denied for late submission and will not be a liability of the member, APMG or the health plan. If APMG is being billed as a secondary payor, the date of the Explanation of Benefits (EOB) from the primary payor will be the date from which the ninety (90) days will be allowed.

### **Acceptable Claims Format:**

All claims should be submitted using a CMS 1500 claim form or printed on plain paper using CMS format and should include the required information shown on the next page. Claims will not be accepted until fully complete, including any supporting documentation requested by the claims office. Incomplete claims, including claims submitted with an invalid CPT code or ICD9 code, will be returned with a request for additional information.

### **Claims Inload Technology:**

We have attempted to make the process of submitting claims as easy as possible and are able to accept claims electronically. "837" format will be available according to HIPAA compliance. All you need to do is print your claims to a file. If you are unsure of whether or not your office' practice management system has the option, please call your vendor and ask them "how to print claims to a file". Once the claims are in a file we can assist you with your submission to us.

The claims in-load process is an efficient method for submitting both encounter data and your FFS claims. By using this technology, you will save time as well as the costs associated with postage and acquiring the CMS forms. If you are interested in Claims In-Load, please contact our Claims Systems Compliance Supervisor at (562) 602-1563 ext. 230.

### **Claim Return Form**

Periodically, APMG will receive claims for services in which the patient may be unidentifiable or may not be assigned to APMG. These claims will be returned to you with a cover sheet (p. 35) designating the specific reason why the referenced claim was unable to be processed as billed.

**SECTION VII.  
CLAIMS MANAGEMENT**

(Continued)

**Required Information (Whether Submitting Manually or Electronically):**

- Patients Name (as it appears on I.D. Card)
- Patient Member I.D. Number (not insured's)
- Patient's date of birth
- Insured's name
- Insured's Group name and/or policy number
- Name of Insurance Company/Plan
- Name of referring physician
- Date(s) of service
- Place of service
- Code and diagnosis description (to the most specific disease)
- CPT/RBRVS Procedure Code, description, and billed amount
- Physician's name, address and Tax, I.D. number
- Physician's signature
- Authorization number for a claim requiring an authorization
- NPI Number

**II. Encounter Data:**

Encounter data consists of the charges for patient services submitted to the medical group for capitated procedures. This information is entered into APMG's database and monthly reports are sent to each health plan. The submission of encounter data is important because the reporting of these charges is a contractual obligation for APMG.

Submit encounter claims on/or before the fifteenth (15<sup>th</sup>) of the month following the date of service to:

**Alliance Physicians Medical Group**  
Claims Department  
4909 Lakewood Blvd., Suite 200  
Lakewood, CA 90712

## **SECTION VII. CLAIMS MANAGEMENT**

(Continued)

### **III. Explanation of Benefits (EOBs):**

An explanation of benefits (EOB) is attached to each check that is mailed to our providers for payment of services rendered to the managed care members and billing services that have the responsibility for adjudicating your accounts receivable. EOBs for prior months should be kept on file and referenced before tracers are sent on outstanding accounts.

The information is being supplied to you about your billed charges includes:

- Check number
- Vendor number
- Provider number
- Member name
- Claim number (the first eight (8) digits indicate when the claim was entered into the APMG database)
- Procedure code
- Service date
- Billed amount
- Contract amount
- Co-pay amount
- Adjustment amount (if applicable)
- Withhold amount (if applicable)
- Net amount
- Adjustment code (if applicable)

All charges (fee for service and capitated services) that have been received and processed by APMG will be detailed on the EOBs. Please read your EOBs. They contain valuable information. Should you have any questions the claims staff is available to answer your questions.

### **IV. Coding:**

**Direct Referrals:** The procedure code for services provided using the Direct Referral form will be paid under 99203 for office consultation. If provider perceives that the services provided is at a higher level, then please submit a copy of the medical chart along with the claims. The Medical Director will review each case carefully using industry medical guidelines and a decision will be communicated to you.

If a provider bills for codes that are not authorized, APMG shall, at its sole discretion, have the right to deny payment.

### **V. Claims Status Notification:**

APMG will enter claims into the system within fifteen days (15) from the date of receipt. Physicians may access our website (See Section III for instructions) using an assigned confidential and secured access code to view and print claims status 24/7.

**SECTION VII.**  
**CLAIMS MANAGEMENT**

(Continued)

**VI. Appeal Mechanism for Claims Denial:**

As required by Assembly Bill 1455, the California Department of Managed Health Care has set forth regulations establishing certain claim settlement practices and the process for resolving claims disputes for managed care products regulated by the Department of Managed Health Care. This information notice is intended to inform you of your rights, responsibilities, and related procedures as they relate to claim settlement practices and claim disputes for commercial HMO, POS, and, where applicable, PPO products where APMG is delegated to perform claims payment and Physician dispute resolution processes. Unless otherwise provided herein, capitalized terms have the same meaning as set forth in Sections 1300.71 and 1300.71.38 of Title 28 of the California Code of Regulations.

**I. Claims Submission Instructions.**

A. Sending Claims to APMG. Claims for services provided to beneficiaries assigned to APMG must be sent to the following:

Via Mail, or Physical Delivery:	APMG 4909 Lakewood Blvd., Suite 200 Lakewood, CA 90712
Via e-mail:	michelleh@lhpiipa.com
Via Fax:	(562) 529-2807

B. Calling APMG Regarding Claims. For claim filing requirements or status inquiries, you may contact APMG by calling: (562) 602-1563 ext. 275.

C. Claim Submission Requirements. The following is a list of claim timeliness requirements, claims supplemental information and claims documentation required by APMG:

Claims must be submitted within ninety (90) days from date of services or payment may be denied. APMG shall pay or deny Physician's claims within sixty (60) calendar days or according to regulatory guidelines.

APMG has the right to request "reasonably relevant information" to determine the nature, cost and extent of the liability for the adjudication of claims.

D. Claim Receipt Verification. For verification of claim receipt by APMG, please do the following:

Physician can request claims receipt verification via facsimile at (562) 529-8490 or telephone at (562) 602-1563 or by checking through the secure web portal.

## SECTION VII. CLAIMS MANAGEMENT

(Continued)

### II. Dispute Resolution Process for Contracted Physicians

- A. Definition of Contracted Physician Dispute. A contracted Physician dispute is a Physician's written notice to APMG and/or the beneficiary's applicable health plan challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim. Each contracted Physician dispute must contain, at a minimum the following information: Physician's name; Physician's identification number, Physician's contact information, and:
- i. If the contracted Physician dispute concerns a claim or a request for reimbursement of a underpayment of a claim from APMG to a contracted Physician the following must be provided: claim number, a clear identification of the disputed item, the date of service and a clear explanation of the basis upon which the Physician believes the payment amount, request for additional information, request for reimbursement for the underpayment of a claim, contest, denial, adjustment or other action is incorrect;
  - ii. If the contracted Physician dispute is not about a claim, a clear explanation of the issue and the Physician's position on such issue; and
  - iii. If the contracted Physician dispute involves a beneficiary or group of beneficiaries, the name and identification number (s) of the beneficiary or beneficiaries, a clear explanation of the disputed item, including the date of service and Physician's position on the dispute, and the beneficiary's written authorization for Physician to represent said beneficiaries.
- B. Sending a Contracted Physician Dispute to APMG. Contracted Physician disputes submitted to APMG must include the information listed in Section II.A., above, for each contracted Physician dispute. All contracted Physician disputes must be sent to the attention of the Director of Claims as follows:

Via Mail or Physical Delivery:	Director of Claims Alliance Physicians Medical Group 4909 Lakewood Blvd., Suite 200 Lakewood, CA 90712
Via e-mail:	<a href="mailto:donna@lhpipa.com">donna@lhpipa.com</a>
Via tele:	(562) 602-1563, ext. 249
Via Fax:	(562) 529-8490

## SECTION VII. CLAIMS MANAGEMENT

(Continued)

- C. Time Period for Submission of Physician Disputes.
- (i) Contracted Physician disputes must be received by APMG within 365 days from Physician's action that led to the dispute (or the most recent action if there are multiple actions) that led to the dispute, or
  - (ii) In the case of inaction, contracted Physician disputes must be received within 365 days after the Physician's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.
  - (iii) Contracted Physician disputes that do not include all required information as set forth above in Section II.A. may be returned to the submitter for completion. An amended contracted Physician dispute which includes the missing information may be submitted to APMG within thirty (30) working days of your receipt of a returned contracted Physician dispute.
- D. Acknowledgment of Contracted Physician Disputes. APMG will acknowledge receipt of all contracted Physician disputes as follows:
- i. Electronic contracted Physician disputes will be acknowledged by APMG within two (2) working days from date of receipt.
  - ii. Paper contracted Physician disputes will be acknowledged by APMG within fifteen (15) working days from date of receipt.
- E. Contact APMG Regarding Contracted Physician Disputes. All inquiries regarding the status of a contracted Physician dispute or about filing a contracted Physician dispute must be directed to Director of Claims at (562) 602-1563 ext. 249.
- F. Instructions for Filing Substantially Similar Contracted Physician Disputes. Substantially similar multiple claims, billing or contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted in the following format:
- 1. Sort Physician disputes by similar issue
  - 2. Provide cover sheet for each batch
  - 3. Number each cover sheet
  - 4. Provide a cover letter for the entire submission describing each Physician dispute with references to the numbered coversheets
- G. Time Period for Resolution and Written Determination of Contracted Physician Dispute. APMG will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) working days after the date of receipt of the contracted Physician dispute or the amended contracted Physician dispute.
- H. Past Due Payments. If the contracted Physician dispute or amended contracted Physician dispute involves a claim and is determined in whole or in part in favor of the Physician, APMG will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) working days of the issuance of the written determination.

## PROVIDER DISPUTE RESOLUTION REQUEST

**NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT**

### INSTRUCTIONS

- Please complete the below form. Fields with an asterisk ( \* ) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.

Mail the completed form to: Director of Claims/APMG

<b>*PROVIDER NAME:</b>	<b>*PROVIDER TAX ID # / Medicare ID #:</b>
<b>PROVIDER ADDRESS:</b>	

**PROVIDER TYPE**    MD    Mental Health    Hospital    ASC    SNF     
DME    Rehab    Home Health    Ambulance    Other

(please specify type of "other")

**\* CLAIM INFORMATION**    Single    Multiple **"LIKE"** Claims (complete attached spreadsheet)  
*Number of claims:* \_\_\_\_\_

<b>* Patient Name:</b>		<b>Date of Birth:</b>
<b>* Health Plan ID Number:</b>	<b>Patient Account Number:</b>	<b>Original Claim ID Number:</b> (If multiple claims, use attached spreadsheet)
<b>Service "From/To" Date:</b> ( * Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	<b>Original Claim Amount Billed:</b>	<b>Original Claim Amount Paid:</b>

<b>DISPUTE TYPE</b>	
<input type="checkbox"/> Claim	<input type="checkbox"/> Seeking Resolution Of A Billing Determination
<input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision	<input type="checkbox"/> Contract Dispute
<input type="checkbox"/> Request For Reimbursement Of Overpayment	<input type="checkbox"/> Other:

<b>* DESCRIPTION OF DISPUTE:</b>
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<b>EXPECTED OUTCOME:</b>
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		(   )
<b>Contact Name (please print)</b>	<b>Title</b>	<b>Phone Number</b>
		(   )
<b>Signature</b>	<b>Date</b>	<b>Fax Number</b>

For Health Plan Use Only <b>TRACKING  NUMBER</b>
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## SECTION VII. CLAIMS MANAGEMENT

(Continued)

### Immunizations and Injectables Claims Process:

APMG is not financially responsible for immunizations and injectables for **Blue Cross of California/California Care**.

Blue Cross of California/California Care - For most immunizations and low cost injectables, prior authorizations are not required. Please submit your claims to:

**Blue Cross of California**  
**P.O. Box 60007**  
**Los Angeles, CA 90060-0007**

This new address will begin to appear on most ID cards upon renewal. However, for some Blue Cross members, this address may not be appropriate, please continue to check the member's ID card for the correct billing address.

Additionally, **PacifiCare/United Healthcare** is financially responsible for the following injections:

90649	Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use
90680	Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use
90716	Varicella virus vaccine, live, for subcutaneous use ( <b>second dose only</b> )
90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetraivalent), for intramuscular use

APMG is not financially responsible for the above referenced injections. Please submit these claims directly to PacifiCare. The address for submitting claims is as follows:

**PacifiCare Administrative Services**  
**P.O. Box 6006**  
**Cypress, CA 90630**

### Newborn Claims:

APMG policy for processing newborn claims is as follows:

1. Newborn carve-out claims (i.e., care of newborn, immunizations) will be paid to our contracted pediatricians for the first 30 days of life under the mother's coverage if the birth mother is an eligible member of APMG.
2. Claims received for dates of service beginning on the 31<sup>st</sup> day of life will be returned to the PCP if the baby is not enrolled directly with APMG.
3. APMG will not pay any claims for newborns during the first 30 days of life if the mother is not enrolled through APMG. In this case, the pediatrician should bill under the birth mother's insurance

**CLAIMS MANAGEMENT**  
(Continued)

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*SAMPLE CLAIM RETURN FORM*

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

**Provider:** \_\_\_\_\_

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

**The claim (s) attached are being returned due to the following:**

1.     \_\_\_\_\_ **Member not assigned to APMG**
2.     \_\_\_\_\_ **Need to bill on HCFA 1500 form.**
3.     \_\_\_\_\_ **Need copy of current insurance card.**
4.     \_\_\_\_\_ **Need copy of E.R. notes**
5.     \_\_\_\_\_ **Need copy of O.R. notes.**
6.     \_\_\_\_\_ **Member using Point of Service benefit. Bill Health Plan.**
7.     \_\_\_\_\_ **Other** \_\_\_\_\_
8.     \_\_\_\_\_ **This is not a denial but a request for additional information.**

**This claim cannot be paid until the missing information is received, and the member cannot be billed, as a valid claim has not been submitted.**

**Please provide us with the information requested so that we may process your claim.**

**Thank you,**

**Claims Department**

**SECTION VIII.**

**UTILIZATION MANAGEMENT**

**Utilization Management Assistance: (562) 602-1563 x516**  
**Candis Kliewer, RN-Director of Compliance and Utilization**

**SECTION VIII.  
UTILIZATION MANAGEMENT**

**UM Coordinator Assignments  
Contact List**

**Medical Director: Al Lopez, MD                      (909) 708-7016**

Case Manager:	Molly Anderson, LVN	297
UM Coordinator:	Vivien Semira	227
SNF Case Manager:	Judith Groves, LVN	485
Director of Outreach Programs:	Robin Tufono, RN	288
Pediatric Case Manager:	Cindy Adams, RN	236

## **SECTION VIII.**

### **UTILIZATION MANAGEMENT**

(Continued)

**Purpose:**

APMG has developed a comprehensive UM program to manage the health care services utilized by its patients in a quality and cost effective manner. The UM activities are coordinated and conducted by the UM Department under the direction of the Utilization Management Committee.

**Goals:**

The goals of the UM Department include, but are not limited to the following:

1. To ensure that authorized services are covered under the member's health plan benefits.
2. To develop systems to evaluate and determine which services are consistent with accepted standards of medical practice.
3. To ensure that services, which are delivered, are medically necessary and are consistent with the patient's diagnosis and level of care required.
4. To facilitate communication and develop positive relationships between members, physicians, and health plans by providing education related to appropriate utilization.
5. To maintain compliance with state and federal regulatory requirements and with contractual requirements of contracted Health Plans.
6. To promote member satisfaction.
7. To promote timely and appropriate referral to care.
8. To identify "high risk" members and ensure that appropriate care is delivered by accessing the most efficient resources.

**SECTION VIII.**  
**UTILIZATION MANAGEMENT**  
(Continued)

**Referral Process and Decision Making Timeframes:**

**Criteria:**

During the review/authorization process, the UM Department staff uses approved criteria to assist in the clinical appropriateness determination. APMG has developed Clinical Guidelines for disease processes identified as needing specific, local community driven criteria other than the standard published criteria. The appropriate, local specialists will be involved in the development of these Clinical Guidelines. The criteria used to determine the appropriateness of the medical care delivered is based upon one or more of the following guidelines:

1. Apollo Managed Care Criteria (4<sup>th</sup> edition, 2005)
2. St. Anthony's Complete Guide to Medicare Coverage Issues
3. Centers for Medicare and Medicaid Services (*formerly HealthCare Finance Administration HCFA*) Medicare Guidelines
4. Health Plan Benefits and Coverage Guidelines
5. Preventative Health Guidelines

*\*The UM Criteria utilized in making decisions are available upon request.*

**Ensuring Appropriate UM Decision:**

- UM decision-making is based only on appropriateness of care and service.
- APMG does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service.
- Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization.

**Decision Timeframes:**

Utilization decisions are made in a timely manner depending upon the urgency of the request. The Utilization Management department personnel will provide review of urgent, routine and retrospective authorization requests in the timeframes listed below:

- URGENT – must be processed **within 72 hours** (of receipt of referral with complete information).
- ROUTINE – must be processed **within 5 days for Commercial and 14 days for Senior members** (of receipt of complete referral). Commercial requests may be pended up to 45 days for medical records or additional information.
- RETROSPECTIVE – is a request for services already rendered and will be processed **within 30 days for Commercial and 14 days for Senior members** of receipt of all information.

**Completion of Referral Authorization Request Form:**

In order for the UM staff to process your patient's Referral Authorization Request it is important that the form be completely and legibly filled out. Please be sure to complete the demographic information for your patient. You are the best source for correct patient address and telephone number. The date of birth and subscriber number are important identifiers in assisting the UM staff in authorizing the correct patient as well as for the authorized provider to contact the patient.

## SECTION VIII. UTILIZATION MANAGEMENT

(Continued)

In order to avoid unnecessary delays in the processing of your referral request, it is essential that the request be submitted with the appropriate ICD9 and CPT codes. Additionally, please be as detailed as necessary including all pertinent clinical information. Should the UM department request additional information; please return as soon as possible. If the requested information is not received within 45 days for Commercial patients and 14 days for Senior patients, the UM physician will make the determination based only on the information we have received. The UM criteria for decision-making is available upon request.

In order to improve efficiency, we have installed an **Auto-Fax System** that automatically faxes out authorizations. Please ensure your fax machine is turned on and has an adequate supply of paper. In addition, the **Interactive Authorization** is available through our website and can be used to submit authorization requests, obtain authorization status, verify eligibility and check claims status.

Auto-approval criterias have been implemented for many requested services. This means that when the authorization request is entered into the **Interactive Authorization**, the computer program will automatically approve the request.

### **The authorization statuses that you will see are:**

- ❖ **Requested** – the request has been received in the UM Department
- ❖ **Pended** – referral received and more information has been requested from requesting provider
- ❖ **Approved** – authorization has been given for requested service
- ❖ **Modified** – authorization has **not** been given for requested service but an alternative service has been authorized – denial letter will follow
- ❖ **Denied** – authorization has **not** been given for requested service – no alternative authorized – denial letter will follow

**Member notification of referral decisions has been delegated to the PCP or requesting provider.**

### **Referral Forms**

APMG has two referral forms; the **PCP** request form and the **Specialist** request form.

The **PCP** can make a **Direct Referral** to certain specialist without a prior authorization for initial consultations only.

**Specialists** who receive **Direct Referrals** will need to request authorization for follow-up appointments and all procedures to be done in their office or at the hospital.

## SECTION VIII. UTILIZATION MANAGEMENT

(Continued)

### **Home Health, DME and Medical Supplies:**

Whenever a patient in the outpatient setting needs a referral to home health for a piece of medical equipment (such as a wheelchair, walker, etc.) or disposable medical supplies, an Authorization Request Form must be completed and faxed to APMG. A thorough review of the patient's benefits will be conducted through the applicable health plan and then will be processed in accordance with that review.

It is essential that the referral form have the patient's correct address and telephone number. The following list shows the most frequently ordered non-covered supplies:

Most Frequently Ordered Non-Covered Supplies	Most Frequently Ordered Non-Covered DME (Convenience bath items covered by Medi-Cal only)	Other Frequently Ordered Non-Covered DME	Frequently Ordered DME Without Qualifying Criteria (therefore not covered)
<ul style="list-style-type: none"> <li>• Gloves</li> <li>• Incontinent supplies-covered benefit only for Medi-Cal</li> <li>• Normal Saline</li> <li>• Peroxide</li> <li>• Ointments</li> <li>• Skin cleansers</li> <li>• Home blood pressure monitoring kits</li> <li>• Jobst stockings or Ted hose: covered by Secure Horizons only for burns,</li> <li>• venous stasis, intractable edema</li> </ul>	<ul style="list-style-type: none"> <li>• Raised toilet seat</li> <li>• Shower chairs/benches &amp; bath chairs</li> <li>• Tub transfer bench</li> <li>• Grab bars</li> <li>• Shower hose</li> <li>• Reachers</li> </ul>	<ul style="list-style-type: none"> <li>• Gait belts</li> <li>• FWW with seats, brakes, etc. - not covered (FYI, purchase cost \$450.00) v.q. month w/c rental (usually capped)</li> </ul>	<ul style="list-style-type: none"> <li>• Hospital beds</li> <li>• Oxygen</li> <li>• Low airloss mattress – not covered for heel decubs</li> <li>• W/C + canes or W/C + walkers – Not covered together unless pt receiving P.T. for gait training</li> </ul>

### **Acute Hospital Management:**

Elective admissions to the hospital for either outpatient procedures or inpatient services should have been pre-authorized through the UM Department. The actual length of stay (LOS) will be determined day-by-day based on medical necessity. We have a Hospitalist Program in place at all of our contracted facilities. The Hospitalist is a Physician assigned to follow in-patients, make daily rounds, and write orders for needed care; they are available on a 24/7 basis with prearranged coverage when not available. The Hospitalist determines ongoing medical necessity for continued stay and appropriate level of care. They work closely with the Case Management Department at the hospital to determine discharge needs. The Hospitalist must be called for any direct admission. Please see the next page for covering Hospitalist:

<b>Hospital</b>	<b>Covering Physicians</b>	<b>Phone #</b>
St. Mary's Medical Center	NICU : <b>Pediatric &amp; Neonatology Medical Group</b>  Peds: <b>Pediatric Hospitalists of America / South Counties Pediatric Critical Care</b>	(800) 500-9616  (562) 533-0441 <i>(Any problems call Carlos Maggi, MD Cell (562) 964-9644)</i>
Fountain Valley Hospital	Peds: <b>Pediatric Hospitalists of America / South Counties Pediatric Critical Care</b>	(562) 533-0441 <i>(Any problems call Carlos Maggi, MD Cell (562) 964-9644)</i>
St. Francis Medical Center	Peds: <b>Pediatric Hospitalists of America / South Counties Pediatric Critical Care</b>	(562) 533-0441 <i>(Any problems call Carlos Maggi, MD Cell (562) 964-9644)</i>
Miller Children Hospital @ Long Beach Memorial <i>(Peds UM Clinical Oversight @ Long Beach Memorial by Dr Tellez)</i>	<b>1<sup>st</sup> Choice</b>  Peds: Pediatric Hospitalists of America / South Counties Pediatric Critical Care/Pediatric & Neonatology Medical Group of Orange County  <b>2<sup>nd</sup> Choice:</b> Nasir Tejani, MD	(562) 533-0441 <i>(Any problems call Carlos Maggi, MD Cell (562) 964-9644)</i>  (562) 421-8283
Long Beach Memorial Medical Center Community Hospital of Long Beach St. Mary Medical Center	<b>Admitting doctor if unstable to transfer (Adult)</b> Juan Polanco, MD	(562) 408-7505
East LA Doctor's Hospital	<b>Adult:</b> Cesar Velez, MD  <b>Peds:</b> Jeyaranjan Thambimuttu, MD	(818)589-1505 pgr (323)264-4004 ofc  (323) 780-5884
St. Francis Medical Center	Ricardo McKenzie, MD	(310) 604-3456
Kindred Westminster	<b>Admitting doctor:</b> Juan Polanco, MD (Westminster only)	(562) 408-7505
Presbyterian Intercommunity Hospital of Whittier	<b>Adult:</b> Bright Health Physicians	(562) 698-0811 press "0" and ask for the "on-call" hospitalist
Anaheim General Anaheim Memorial Medical Center Chapman Hospital Kindred - Brea; La Mirada; Santa Ana; Westminster La Palma Intercommunity Hospital Placentia Linda St Joseph Medical Center St Jude Medical Center Tustin Hospital Tustin Rehabilitation West Anaheim Western Medical Center - Anaheim Western Medical Center - Santa Ana Whittier Hospital	<b>Chest and Critical Care Consultants</b>	(714) 772-8282

- ❖ Primary Hospital for Adult Acute and OB Care are as follows:
  - ◆ Downey Regional Medical Center
- ❖ Primary Hospital for pediatrics and tertiary care are as follows:
  - ◆ Long Beach Memorial Medical Center - Pediatrics
  - ◆ St. Vincent's Medical Center – Tertiary Care
  - ◆ USC University Hospital – Tertiary Care
  - ◆ College Hospital Cerritos – Psychiatric in-patient care.

## **SECTION VIII. UTILIZATION MANAGEMENT**

(Continued)

### **SNF Management Program:**

Gerinet has been contracted to exclusively follow our skilled patients. When the patients remain beyond their skilled care, their PCP will follow for custodial care. The SNF Team will round on patients at least once a week and are available 24/7 for any medical needs. They will determine when patients no longer require skilled care, will initiate orders for the non-coverage notice and discharge planning needs. Their Discharge Summary will be sent to the PCP. In order to manage the patients while they are at the skilled level, we have limited the facilities to the following:

- **Country Villa Belmont Heights**
- **Downey Care Center**
- **Villa Elena**
- **Windsor Gardens**
- **Woodruff Convalescent Center**

### **Emergency Services:**

The Primary Care Physician or designee is responsible for authorizing Emergency Services and must be available 24 hours a day, 7 days a week. PCPs are expected to respond to requests for post stabilization within 30 minutes for a commercial patient and 1-hour for seniors. If no response, the service will be considered authorized. However, emergency services will not be denied for lack of authorization.

Patients seen in Emergency Rooms and who are deemed not to require hospital admission are routed to Skilled Nursing Facilities, Home Health, PCP offices or observation areas as indicated.

All patients admitted to non-contracted hospitals will be transferred to contracted hospitals as soon as medically stable. Stability should be decided between the transferring physician and the receiving physician. Patients are reviewed daily over the phone, level of care, intensity of services, estimated transfer date, transfer arrangements, etc., are reviewed and documented thoroughly.

### **After Hours Care:**

PCPs are expected to provide care for their patients on an urgent/emergent basis during regular business hours. This means that they need to have a procedure in place that allows them to see patients that same day. However, recognizing that some patients will need care for unexpected acute illnesses or injuries, APMG has contracted for **After-Hours Care (See Section II)**

**SECTION VIII.**  
**UTILIZATION MANAGEMENT**  
(Continued)

**Mental Health Management:**

Mental health benefits for commercial members are a health plan carve-out. Patients should be referred in accordance with the following grid:

Health Plan	Behavioral Health Provider	Telephone Numbers
Aetna	Magellan	(800) 788-4005
Blue Cross	Wellpoint Behavioral Health	(800) 274-7767
California Care 65	Windstone Behavioral Health	(800) 577-4701
Blue Shield	United Behavioral Health (UBH)	(877) 263-8827
Blue Shield 65	Windstone Behavioral Health	(800) 577-4701
CIGNA	CIGNA Behavioral Health	(800) 866-6534
Health Net	Managed Health Network (MHN)	(888) 426-0030
PacifiCare	PacifiCare Behavioral Health (PBH)	(800) 999-9585

**Denials/Appeals:**

A physician reviewer will make denial decisions for all medical services. The decision making process is based upon appropriateness of care and does not provide incentives to encourage denial of patient care. Utilization management reviewers can make benefit denials when no medical interpretation is required. Efforts are made to obtain all necessary information, including pertinent clinical information from the treating physician to allow the physician to make appropriate decisions. This includes but is not limited to patient records, conversations with the PCP and/or attending physician. Denial notification is sent by fax within 24 hours to the requested provider and the PCP. Denial notification is sent to the patient in writing within 48 hours of the decision for referrals or within 24 hours of decision for hospitalized patients with the reason for denial stated. The appeal process is clearly defined and includes the health plans address and phone number. A copy of the letter is sent to the requesting physician, health plan and facility. The criteria used to determine the decision is made available to the referring physician if requested. The request should be directed to the physician in charge of the decision.

If the physician receives an adverse decision, the physician can appeal. There are well-published and readily available appeal mechanisms for both providers and patients. These appeal mechanisms can be found in the contract language for providers and in the denial notifications distributed to members. The Health Plan member handbook also delineates the appeals process.

## **SECTION VIII. UTILIZATION MANAGEMENT**

(Continued)

### **Denials/Appeals (cont.):**

An expedited appeal may be initiated by the member or practitioner acting on behalf of the member. The expedited appeal process applies to Medicare and Commercial patients when criteria are met or as the medical condition requires. All patients may appeal any decision through their health plan. When a service is denied, the patient will be informed of the criteria used to make the decision.

Requests for service authorizations are denied for the following reasons:

- The provider is not contracted with APMG.
- The service is not medically necessary.
- The member is not eligible.
- The service is not a covered benefit.
- The member's benefits for that benefit are exhausted.
- The PCP can provide the service.

### **Case Management:**

APMG has nurses to identify, intervene, coordinate and monitor care plans that provide high quality and cost-effective care for individuals with complex healthcare needs. The purposes of Case Management includes, but is not limited to, the following:

1. Evaluation of appropriateness of level of care.
2. Initiation and coordination of member's efficient discharge from inpatient facility
3. Promotion and coordination of the use of alternative, non-inpatient services.
4. The decrease of re-admissions and preventable emergency room usage through continued comprehensive care management and use of appropriate Durable Medical Equipment (DME).
5. Arrangement of the provision of care and appropriate cost-effective setting (i.e., home care).
6. Provision of information to members, providers, and families regarding community resources.
7. Identification to the Health Plans of high cost, high-risk cases.
8. Communication with Quality Management regarding any concerns about the quality of care.

### **On-Call Case Management Program (Out of Network):**

APMG has an Emergency Room Case Management Program with a nurse on call after hours, weekends, and holidays. The on-call nurse is reachable via the exchange and can contact the appropriate Hospitalist on call. The main role of this Case Manager is to transfer stable patients from Out Of Network emergency rooms into the assigned network facility.

## **SECTION VIII.**

### **UTILIZATION MANAGEMENT**

(Continued)

The **Outreach Case Management Program** expands the Case Management services available to our patients. This program was developed to follow our neediest patients who are frequently readmitted to the hospital, may be non-compliant with medications, do not understand their disease process or do not reside in a supportive environment. The Outreach Case Manager's services can be requested on an Authorization referral form or the special Outreach Case Management Referral Form found on the next page. The Outreach Case Manager will follow up by phone, as the situation requires. Outreach patients can be identified and referred by a variety of sources: PCP, Hospital CM, IPA CM, Home Care Nurses, etc.

Additional resources that have been developed are:

- **Diabetes Clinic** for new or poorly controlled diabetics. Request on a special Diabetic referral form.
- **Anti-Coagulation Clinic** for AVT, Bridge Therapy and long term Anti Coagulation Therapy. Request on Anti-coagulation referral form.

To refer patients to the Outreach program, please fill out the referral form (located on page 47) completely and then fax to the attention of the Outreach Manager at (562) 531-7567 or call (562) 602-1563, x. 288.

The **Pediatric Case Management Program** was developed to help children and their parents find the care and resources necessary in maintaining a healthy and active life. The goal of this program is to assist families with managing the challenges arising from some of the situations listed below and includes development of a comprehensive educational plan, telephonic support and follow-up, as well as the added benefit of coordination and follow-up with you, the primary care physician.

- Chronic, high utilization, care needs
- Complex medical treatments
- Frequent admissions/ER visits to non-contracted facilities
- Catastrophic illness or injury
- Trauma with multiple disabilities

To refer any of your pediatric patients to this program please use the Pediatric Case Management Referral Form located on page 48



### Outreach Case Management Referral Form

<b>Date of Referral:</b> _____ <b>Referred by:</b> _____ <b>Phone #:</b> _____ <b>Primary Care Provider:</b> _____ <b>Phone #:</b> _____	<b>To: Robin Tufono, RN</b> <b>Phone #: (562) 602-1563 Ext. 288</b> <b>Fax #: (562) 531-7567 or (310) 535-9289</b>  <b>Medical Group (check One):</b> <input type="checkbox"/> Alliance Physicians <input type="checkbox"/> Alamos IPAs <input type="checkbox"/> Brookshire IPAs <input type="checkbox"/> Lakewood IPAs <input type="checkbox"/> Pioneer Provider Network <input type="checkbox"/> Primary Care Associates of California <input type="checkbox"/> St. Mary IPAs
--	--

<b>Patient Information</b>	
<b>Member ID:</b> _____	<b>Health Plan:</b> _____
<b>Name:</b> _____	
<b>Phone #:</b> _____	<b>DOB:</b> _____
<b>Address:</b> _____	
<small>Street Number and Name</small>	
_____	
<small>City, State and Zip</small>	

**\*Criteria for Outreach Case Management: (Please check one or more diagnoses)**

Asthma  
 Biochemical Evidence of Malnutrition      **Albumin Level:** \_\_\_\_\_  
 CHF  
 Chronic Renal Failure  
 COPD  
 Poorly controlled Diabetes Mellitus  
 Three or four co-morbidities (please list below if applicable):  
     1. \_\_\_\_\_  
     2. \_\_\_\_\_  
     3. \_\_\_\_\_  
     4. \_\_\_\_\_

**AND / OR**

Four or more medications prescribed on a chronic basis  
 Frail, elderly or otherwise at risk  
 Inappropriate over-utilization  
 Medical complications of ETOH or drug abuse  
 Non compliant behavior  
 Two or more hospitalizations or ER visits in the past 12 month  
 OTHER (please explain): \_\_\_\_\_

Outreach patients can be referred by a variety of sources: PCP, Hospital CM, IPA CM, Home Care nurses, etc.



Coast Healthcare Management, LLC

Management Company for

Alamitos IPA • Alliance Physicians Medical Group • Brookshire IPA

Lakewood IPA • Pioneer Provider Network • Primary Care Associates of California • St. Mary IPA

4909 LAKEWOOD BLVD., SUITE 200, LAKEWOOD, CA 90712

P: (562) 602-1563 • F: (562) 529-8490 • www.coasthealthcare.net

## Pediatric Case Management Referral Form

To: Cindy Adams, R.N.

Tele: (562) 602-1563 ext. 236

Fax: (562) 220-1026

.....  
**Medical Group (circle one)**

Alamitos IPA

Alliance Physicians Medical Group

Brookshire IPA

Lakewood IPA

St. Mary IPA

.....  
Health Plan: \_\_\_\_\_

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

Care Giver's Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

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

**DOB:** \_\_\_\_\_

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

**Primary Physician:** \_\_\_\_\_

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

**Referred By:** \_\_\_\_\_

**Referral Date:** \_\_\_\_\_

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

### Criteria for Pediatric Case Management: Circle one or more

- Trauma with multiple disabilities
- Catastrophic illness or injury
- Frequent admissions/ ER visits to non contracted facilities.
- Complex medical treatments
- Chronic high utilization care needs

PLEASE SUMMARIZE THE REASON FOR THE REFERRAL:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HIGH RISK PATIENTS CAN BE REFERRED BY A VARIETY OF SOURCES: PCP, HOSPITALIST, ACUTE CASE MANAGER, HEALTH PLANS, ETC.

**PLEASE FAX THIS REFERRAL TO: (562) 220-1026**

**SECTION IX.**

**QUALITY MANAGEMENT**

**QUALITY MANAGER: (562) 602-1563 x226**

**Gloria Davis, Manager**

**QUALITY COORDINATOR: (562) 602-1563 x222**

**Maria Tavarez, Coordinator**

## **SECTION IX. QUALITY MANAGEMENT**

### **Area of Quality Management Focus/Key Performance Indicators:**

The Quality Improvement Program focuses on the following:

- a) Access and availability of care and service.
- b) Member/Provider satisfaction.
- c) Member /Provider grievance, complaints or appeals.
- d) Provider credentialing/re-credentialing.
- e) Clinical Quality Improvement Activities.
- f) Disease Management
- g) Provider site audits (PCPs and high volume Specialists).
- h) Development of practice guidelines for health promotion and health management promotion.
- i) Compliance with applicable state laws and regulatory requirements.
- j) Provider orientation and ongoing update to the medical group regarding policy procedure, practice guidelines.
- k) Change of Primary Care Physician.
- l) Statement of Concern.
- m) Monitoring of ancillary services (e.g., nursing, radiology, laboratory, home health etc.).

**Upon written request, APMG makes information about its QM program available to its practitioners, including a description of the QM program and a report on the organization's progress in meeting its goals.**

### **After Hours Accessibility:**

Annually data is collected and utilized in a broad framework of access analysis including member complaints, member satisfaction reports, and telephonic access reviews.

APMG monitors member's access to care through a number of mechanisms that include:

- Annual telephone survey of physician offices to determine compliance with access and availability standards for emergent, urgent, routine, specialty referral, and after-hours care.
- Annual telephone survey to check after-hour instructions. Physician offices are called after business hours to determine whether the telephone call was answered or not answered by a person or a recording, had emergency instructions, and had a means by which the caller could speak to a physician.
  - ✓ Access telephone survey results are aggregated and shared with the individual physicians through direct mail.
  - ✓ Member Satisfaction is measured annually using CAHPS (Consumer Assessment of Health Plan Satisfaction) methodology.

APMG has adopted access standards for appointment access to PCPs, Specialist (SCP) and Behavioral Health Care. These standards are monitored, updated periodically and shared with you annually.

**SECTION IX.**  
**QUALITY MANAGEMENT**  
(continued)

**After Hours Accessibility (cont.)**

After-hour calls (defined as those hours which are not during normal business hours) must be managed by a telephone system, which pages an on-call provider for patient triaging and authorization of care.

APMG and contracted health plans will be conducting telephone accessibility surveys on your offices. The purpose of the survey is to ensure that medical services and advice for after hour calls is in accordance with NCQA standards.

To help ensure that your office will be in compliance going forward for all after hours calls please ensure that the following are implemented:

- a) After hours calls are to be answered by the 4th ring.
- b) There should be no busy signal.
- c) After hours calls will be managed by a telephone system or answering service. Telephone logs must be monitored and maintained.
- d) After hours answering services or telephone system must instruct members that if they feel they have a serious acute medical condition, they should seek immediate care by calling 911 or going to the nearest emergency room. For the non-emergent needs, the patient can be directed to leave a phone number for a call back and should receive a call back within 30-60 minutes. After hours access to care: All PCPs or covering physicians must be available 24 hours a day, 7 days a week, including holidays and weekends.
- e) There is access to care after normal working hours for an urgent medical event that requires attention after hours which includes 24-hour physician access for members.

**SECTION IX.**  
**QUALITY MANAGEMENT**  
(Continued)

**Access to Care Standards:**

APMG has adopted the following standards for appointment access to Primary Care physicians (PCPs), Specialist (SCPs) and Behavioral Health Care.

Description	Standard Timeline (Scheduling of Appointment)
<b>PCP Appointments:</b>	
Preventive Health Assessment	30 calendar days (include routing physical examination, test and immunization)
Routine Primary Care	7 calendar days (Primary care for non-urgent asymptomatic care conditions)
Urgent Care	Within 24 Hours
After-hours Coverage	24-hour availability
Emergent Care	Immediate-Emergency medical condition based on Prudent Layperson
Waiting Time in Office	Not to Exceed 30 Minutes
<b>SCP Appointment:</b>	
Urgent Care	24-hours
Routine Care	14 Calendar days
<b>Behavioral Health Care Appointments:</b>	
Routine Services	Within 10 business days
Urgent Care	48-hours
<b>Emergent Services:</b>	
Non-life Threatening	Within 6-hours
Life Threatening Emergencies	Immediately
Phone Triage (24/7)	Live person within 30 seconds

In addition to these access standards, be reminded that a patient should not have to wait more than thirty minutes to be seen when he/she has a schedule appointment. Should an emergency arise and the doctor will not be in, or will be late, a reasonable attempt should be made to notify the patient at least 24 hours in advance when possible. The member should be given the option of rescheduling his/her appointment or to be seen by the covering physician. **Remember that referral to the Emergency Room or After Hour Clinic is inappropriate simply because the doctor is not in.**

## **SECTION IX. QUALITY MANAGEMENT**

(Continued)

### **Scheduling Offices Site Reviews:**

The site visit review process will include standards and thresholds for each of these elements:

- Accommodations for persons with disabilities
- Physical appearance
- Adequacy of waiting and examining room space
- Availability of appointments
- Adequacy of medical/treatment record keeping

### **Examples:**

#### Physical Accessibility and Appearance

- Handicapped accessible
- Well-lit waiting room
- Adequate seating
- Posted office hours

#### Medical Records

- Secure/confidential filing system
- Patients identified on each sheet in record
- Provider signature on each visit/report in the record

#### Appointments for Internists, General and Family practitioners, Pediatricians, Obstetricians

- Routine office visit within 7 days
- Urgent care within 24 hours
- Physical Examination within 30 days

### **Performance Thresholds.**

The performance threshold for the Office Site Visit is a score of 90%.

The performance threshold for the Medical Record-Keeping review is 90%.

### **Member Complaints of Practitioner Offices**

Member complaints related to the quality of all practitioner office sites will be monitored and investigated when received. Alliance Physicians Medical Group (APMG) has established a threshold of 3 complaints that must be received before conducting an office-site visit. When 3 complaints have been received related to physical accessibility, physical appearance and adequacy of waiting and examining room space, a site visit will be performed within 60 days of the complaint to assess these elements. Depending on the severity of the complaint, a site visit will occur prior to receiving the 3 complaints threshold and will be assessed by the Quality Management Specialist and Medical Director. Specific issues include but may not be limited to the following:

- Unsafe building/structure
- Pets and/or, rodent and insect infestation,
- When a site does not meet APMG's performance thresholds, the site must develop an action plan for improvement.
- APMG will revisit the site at least every six months until the performance standards are met. Documentation of the revisit will be included in the practitioner's file.

## **SECTION IX. QUALITY MANAGEMENT**

(Continued)

- APMG will conduct a follow-up site visit of a previously deficient office if the practice site meets the reasonable complaint threshold subsequent to correcting the deficiencies. Follow-up site visits must be conducted within 60 calendar days of the reasonable complaint. If the site does not meet APMG's performance thresholds, the office site must develop and implement an action plan for improvement.

### **Quality Management In Relation to Credentialing/Re-credentialing Process:**

The same procedures described above will be followed when a PCP or OB/GYN relocates or opens a new site. Audits of new sites must be conducted prior to your next scheduled re-credentialing date. For staff or group model facilities, one review of the facility will suffice for all practitioners at that location. Whenever a PCP or OB/GYN joins or relocates to an existing office that has already been audited and found compliant, audits do not need to be conducted.

### **Credentialing Review/Referral to Quality Management Process:**

The Credentialing Committee will review all providers' malpractice claims history over the most recent five (5) year period for those providers who have applied to APMG for credentialing or re-credentialing status.

The Credentialing Committee may make determinations in the following situations:

1. No more than three (3) of any combination of:  
(a) arbitration, (b) settlement, (c) malpractice suit.
2. No evidence of a single suit, arbitration or settlement for greater than \$100,000.
3. No Medical Board action.

Should a provider file show evidence of malpractice history in excess of the above criteria, the file is presented to the Quality Management Committee. The Board of Directors, in its sole discretion, may adopt, reject or modify the Credentialing and/or Quality Management Committee determinations.

**SECTION IX.**  
**QUALITY MANAGEMENT**  
(Continued)

**Member Complaints Process**

**There is a procedure for registering and responding to oral and written complaints including investigation of the substance of the complaint, including any aspects of clinical care involved.**

***Definition:***

**Complaint** – is an oral or written expression of dissatisfaction.

**Quality of Care Issues** – are those relevant to the actual medical care, treatment that a member experiences or perceives.

- Example of a quality of care issue might be an undesired outcome of care (or lack of care) experienced or perceived by the member.
- A medical condition may have become worse due to a delay in treatment.

**Grievance** – is a formal complaint regarding anything with which the member is not satisfied, this includes quality of care issue, denied services and denied claims.

APMG is absolutely committed to member satisfaction. As such, it is our determination to resolve member concerns, complaints, and grievance as quickly as possible.

**Grievance Procedures:**

1. Member grievances are generally sent directly to the Health Plans.
2. The Health Plans requests a response from APMG regarding grievance. We are required to submit a complete file to them, including provider response and documentation, within 7 days.
3. To comply with this request APMG requests a response from the provider, within 5 working days from receipt of request.
4. Failure to do so could jeopardize the provider contract with the Health Plans/ APMG.
5. In order to expedite this matter you may FAX response to:  
Quality Manager > **FAX #: 562-602-2772 OR 562-531-3759**
6. APMG incorporates member complaints and grievances in its credentialing decision making process for all PCPs and SCPs.

## **SECTION IX. QUALITY MANAGEMENT**

(Continued)

### **Member Rights and Responsibilities:**

Health Plans have developed a statement of member rights and responsibilities indicating the level of service members can reasonably expect from their health care practitioners and providers. Members are also responsible for cooperating with practitioners and providers when obtaining health care.

### **Privacy and Confidentiality:**

APMG's member's personal health information, whether it is written, oral or electronic, is protected at all times and in all settings. APMG's, practitioners and providers can only release protected health information (PHI) without authorization when:

- This is a payment issue.
- Necessary for treatment or coordination care
- Used for health care operations (including but limited to HEDIS reporting, appeals and grievances, utilization management, quality improvement, and disease or care management programs)
- Where permitted or required by law

Any other disclosure of the member's PHI must have a prior, written member authorization. The practitioners must ensure that only authorized people with a need-to-know have access to a member's PHI. Special authorization is required for uses and disclosures involving sensitive conditions, such as psychotherapy notes, AIDS or substance abuse. To release a member's PHI regarding sensitive conditions, you must obtain prior, written authorization from the member (or authorized representative) that states information specific to the sensitive condition may be disclosed.

### **Medical Record Documentation:**

The medical record serves as a detailed analysis of the member's history, a means of communication to assist the multidisciplinary health care team in providing quality medical care, a resource for statistical analysis, and a potential source of defense support information in a lawsuit. It is the practitioner's responsibility to ensure not only completeness and accuracy of content, but also the confidentiality of the health record. APMG requires that the practitioner adhere to the standards for maintaining member medical records and to safeguard the confidentiality of medical information. All practitioners must have policies and procedures that address confidentiality and the consequences of improper disclosure of member's PHI. You may obtain more extensive information on all the above by contacting our Quality Management Department.

## **SECTION IX. QUALITY MANAGEMENT**

(Continued)

### **Appropriate ER Use:**

#### **911/Emergency Care**

If a member considers a medical condition to be an emergency, they should be instructed to call 911 or go to the nearest hospital emergency room immediately. APMG cover emergency services that are necessary to screen and stabilize a condition. No authorization or pre-certification is needed if the member reasonably believes that an emergency medical condition exists. Once the condition is stabilized, the member or family member should contact their physician for authorization of any additional services.

A medical emergency is an unexpected acute illness, injury, or medical or psychiatric condition that could endanger health if not treated immediately. Examples of medical emergencies *include*:

- Severe pain
- Chest pain
- Heavy bleeding
- Sudden weakness or numbness of the face, arm, or leg on one side of the body
- Difficulty breathing or shortness of breath
- Sudden loss of consciousness
- Active labor

### **HEDIS Measures:**

APMG and contracted health plans measures quality of care and services provided to members in a number of ways, including the Health Effectiveness Data Information Set (HEDIS), Consumer Assessment of Health Plans Survey (CAHPS), Consumer Assessment Survey (CAS), APMG's Member Satisfaction Survey, and PCP transfer data. Below are the HEDIS requirements to measure quality of care:

- Cervical Cancer screening
- Chlamydia screening
- Prenatal and Postpartum Care
- Childhood Immunizations
- Adolescent Immunizations
- Well-Child Visits in The First 15 months of Life
- Well-Child Visits in the Third, Fourth, Fifth or Sixth Years of Life
- Adolescent Well-Care Visits
- Beta Blocker Treatment After a Heart Attack
- Cholesterol Management After Acute Cardiovascular Events
- Comprehensive Diabetes Care

## **SECTION IX. QUALITY MANAGEMENT**

(Continued)

APMG's goal is to obtain **at least 80% in the below clinical indicators**, but your help is needed to accomplish our goals. You can help us by doing the following:

### **Cervical Cancer Screening**

- Obtain a cervical cancer screening (pap smear) every 3 years on women age 21 through 64 years

### **Diabetic Care**

- Obtain a HbA1c test yearly on all diabetics
- Refer patient to the appropriate ophthalmologist for an annual retinal exam
- Obtain a microalbuminuria/urine protein test
- Obtain a LDL-C test yearly
- LDL controlled (less than 100 mg/dL)
- Medical attention for nephropathy
- Blood pressure control (less than 130/80 or less than 140/90)

### **Chlamydia Screening in Women**

- Obtain a Chlamydia screening on women 16-25 years of age (or women who are sexually active) yearly.

### **Childhood Immunization**

- Ensure children have completed the following antigen series by their second birthday.
  - Four diphtheria, tetanus and acellular pertussis (DtaP/DT)
  - Three polio (IPV)
  - One measles, mumps, rubella (MMR)
  - Three H influenza type B (HIB)
  - Three hepatitis B
  - One Chicken pox (VZV)
  - Four pneumococcal conjugate vaccines

### **QI Program Materials:**

#### **Available Upon Request**

APMG is primarily motivated by our commitment to members' health and satisfaction with the care and service they receive. Supporting the patient-physician relationship continues to be the most important goal of the program, and the driver of all quality improvement.

For more information regarding our Quality Improvement Program, please call (562) 602-1563 ext: 226 or 266.

**SECTION X.  
RISK BASED REIMBURSEMENT**

**Risk Adjustment Assistance: (562) 602-1563 x281  
Vivien Tran, Quality Incentive Program Manager**

## SECTION X. RISK ADJUSTMENT

### ACCURATE CHART DOCUMENTATION AND DIAGNOSIS REPORTING NOW DETERMINES THE REIMBURSEMENT

Prior to the implementation of risk adjustment, reimbursement for senior patients was based solely on demographic factors such as age, sex, Medicaid status and county of residence. The CPT procedural codes were the primary factor driving the reimbursement from the Centers for Medicare and Medicaid Services (CMS). Under Risk Adjustment (RA), CMS's reimbursement to the health plans and subsequently to the medical groups is based on the patient's health status, which is subsequently based on the reported diagnoses. There are 70 HCC groups (Hierarchical Condition Categories) which contain 3,100 ICD-9 codes under the model. Each condition has a weight associated with it, which determines the reimbursement amount. Risk Adjustment is a predictive model, which means that the diagnoses reported in the current calendar year will be the basis for payments for the following year.

*Beginning with 2008 dates of service, CMS will no longer accept family codes as a risk adjustable code, if it is not coded to the highest level of specificity.* Under this requirement, any diagnosis code that requires a 4<sup>th</sup> and 5<sup>th</sup> digit and is only coded with three digits will be invalid and rejected. (Note: This level of coding specificity has always been a requirement for standard fee-for-service Medicare)

#### **Acceptable Data Sources**

- ▶ Face-to-Face Physician/ PA/ NP visit data-includes SNF, Hospital, Hospice visits
- ▶ Inpatient data
- ▶ Hospital Outpatient data

#### **Excluded Data Sources**

- ▶ SNF, Hospice, and ICF (Facility components)
- ▶ Lab, Radiology, Ambulance, DME, Prosthetics, Orthotics, and ASCs
- ▶ Members flagged as Hospice

#### **What You Can Do:**

- ▶ Conduct a complete evaluation of chronic conditions for all senior patients at least once per year
- ▶ Submit all diagnoses that were evaluated- our system can accept up to 8
- ▶ Code all diagnoses to the highest level of specificity (include 4<sup>th</sup> and 5<sup>th</sup> digits as needed)
- ▶ Ensure that the documentation is complete, legible, and supports the diagnoses submitted
- ▶ Ensure fee tickets/superbills/encounter forms support complete diagnosis coding
- ▶ Review patient problem lists and report to IPA any additional diagnoses not reported
- ▶ Attend Risk Adjustment Training for the latest information on RA

**SECTION X.**  
**RISK BASED REIMBURSEMENT**  
(continued)

Financial Impact - Top Occurrence of HCC

<b>Top Ten CMS-HCCs - Frequency, By Occurrence</b>			<b>Annual \$ Impact*</b>
<b>HCC #</b>	<b>HCC Description</b>	<b>Frequency</b>	
108	COPD	12.2%	\$ 3,660
80	CHF	11.2%	\$ 4,584
19	Diabetes without Complications	10.8%	\$ 1,716
105	Vascular Disease	9.4%	
92	Specified Heart Arrhythmias	8.9%	\$ 2,589
10	Breast, Prostate, Colorectal & Other Cancer Tumors	7.0%	\$ 2,267
83	Angina, Old MI	5.0%	\$ 2,287
96	Ischemic or Unspecified Stroke	4.0%	\$ 2,978
38	Rheumatoid Arthritis & Inflammatory Connective Tissue Disease	3.9%	\$ 3,134
82	Ischemic Heart Disease	3.5%	\$ 3,387
* In 2007 at 100% Risk Adjustment			
Based on Medicare FFS Data - 1997			

**SECTION X.**  
**RISK BASED REIMBURSEMENT**  
 (continued)

<b>Don't Report This (Does Not Risk Adjust)</b>	<b><u>If the Patient Has This</u> (Does Risk Adjust)</b>
<b>311.0</b> Depression	<b>296.xx</b> Major Depression sing/recurrent episode
<b>333.1</b> Essential Tremor	<b>332.0</b> Parkinson's
<b>401.9</b> Hypertension	<b>402.91</b> Hypertensive Heart Disease w/ heart failure
<b>414.01</b> CAD	<b>413.9</b> Angina
<b>440.9</b> Atherosclerosis, unspecified	<b>440.3</b> Atherosclerosis of bypass graft of extremity
<b>427.89</b> Other Specified Cardiac Dysrhythmia	<b>427.31</b> Atrial Fibrillation
<b>486.0</b> Pneumonia	<b>481.42 or 483.xx</b> Pneumoccal or Specified Bacteria
<b>490.0</b> Bronchitis	<b>491.9</b> Chronic Bronchitis
<b>805.8</b> Fracture of Vertebrae	<b>733.00</b> Pathological Fracture of Vertebrae

**SECTION X.**  
**RISK BASED REIMBURSEMENT**  
(continued)

***MEDICAL RECORD ESSENTIALS***

***A medical record entry must:***

- Support all diagnoses coded.
- Be complete and accurate.
- Be made at the time of treatment and dated.
- Be part of the medical record, not simply be a notation on a bill or other documents not considered part of the official medical record.
- Have a provider signature and date, even if an electronic record (“electronically signed by”)
- Identify the patient and the date of service, on each page
- Use only standard abbreviations and keep them to a minimum.
- Each facility or office should have a standard abbreviation list.

Notes that are on scraps of paper and “sticky” or post-it notes are not acceptable

- Do not add to a previous note or obliterate an incorrect entry. Instead draw one line through the entry, date and initial.

***The medical record must:***

- Contain sufficient information to identify the patient
- Justify the treatment (and the level of care)
- Support the diagnosis
- Document the patient’s progress and results of treatment
- Promote continuity of care among the healthcare providers.
- Code all documented conditions that co-exist at the time of the encounter that require or affect patient care, treatment or management (e.g. HTN, CHF, etc.)

- Do not code conditions that no longer exist, however use history codes (V10-V19, not in the HCC model).

## **SECTION XI.**

# **QUALITY INCENTIVE PROGRAM**

**Quality Incentive Assistance: (562) 602-1563 x281**  
**Vivien Tran, Quality Incentive Program Manager**

## **SECTION XI. PAY FOR PERFORMANCE**

<b>Disease Registries- Point of Care</b>
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Your personal Pay for Performance (P4P) Disease Registries are available online. You and/or your staff can access and view your personal reports by logging onto our website, [www.coasthealthcare.net](http://www.coasthealthcare.net), using your assigned username and password. On our website, you will find a link to the module called Point of Care which will allow you to perform the following functions:

- Make changes to your P4P patient data and see these changes reflected immediately
- Update patient demographic and contact information
- Print patient's progress report and file into patient's chart
- Generate patient reminder letters with your physician signature
- Record any activity you have taken in the patient's care

The feedback we have received from our physicians regarding the disease registries has been overwhelmingly positive. The registries assist in improving patient care by identifying patients that require preventative tests and screenings. By making the registries available as a clinical tool for our physicians, we have seen significant improvements in our P4P scores and your P4P dollar returns.

### **Instructions for Accessing Your P4P Disease Registries On-Line**

1. Go to [www.coasthealthcare.net](http://www.coasthealthcare.net) and click on "For Providers Only"
2. Enter your assigned username and password
3. Once you are logged in to our secure website, click on the link "Point of Care", located at the lower right hand of the page
4. Click on the IPA name for the disease registry you would like to access

**SECTION XI.**  
**PAY FOR PERFORMANCE**  
(Continued)

<b>Overview of Pay for Performance (P4P)</b>
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The fundamental principles of Pay for Performance are:

- (1) Common performance measures for physician groups (developed collaboratively by health plan and physician group medical directors, researchers, and other industry experts); and
- (2) Significant health plan financial payments based on that performance (with each plan independently deciding the source, amount and payment method for its incentive program)

**Pay for Performance** is a statewide collaboration designed to create the business case for quality at the physician group level. The goal is to reward physician groups for performance in clinical care and patient experience by providing a clear set of health plan expectations, use of common metrics, and public reporting. The **performance measures** represent a balance of four key areas:

<b>Clinical measures</b> (40%)	Measures performance in the management of chronic conditions: <ul style="list-style-type: none"> <li>▪ <i>Asthma</i></li> <li>▪ <i>Coronary artery disease (cholesterol management)</i></li> </ul> Include preventive health measures: <ul style="list-style-type: none"> <li>▪ <i>Childhood immunizations</i></li> <li>▪ <i>Breast cancer screening</i></li> <li>▪ <i>Evidenced based cervical cancer screening</i></li> <li>▪ <i>Colorectal cancer screening</i></li> <li>▪ <i>Chlamydia screening</i></li> </ul> And treatment and medication monitoring measures: <ul style="list-style-type: none"> <li>▪ <i>Imaging Studies for Low Back Pain</i></li> <li>▪ <i>Medication Monitoring: ACE/ARBs, Digoxin, Diuretics</i></li> <li>▪ <i>Antibiotic Treatment for Acute Bronchitis</i></li> <li>▪ <i>Testing for Children with Pharyngitis</i></li> </ul>
<b>Patient satisfaction</b> (20%)	<i>Overall performance is based on individual patient satisfaction in these areas, equally weighted:</i> <ul style="list-style-type: none"> <li>▪ <i>Communication with the doctor</i></li> <li>▪ <i>Specialty care received</i></li> <li>▪ <i>Timely care and service</i></li> <li>▪ <i>Overall rating of care</i></li> <li>▪ <i>Office staff interaction</i></li> <li>▪ <i>Health promotion</i></li> </ul>
<b>IT investment</b> (20%)	This measure evaluates a physician group’s investment in information technology (IT) to support clinical quality through the ability to integrate data at the group level or to provide physicians with data to support clinical decision-making at the point of care.
<b>Coordinated Diabetes Care</b> (20%)	<ul style="list-style-type: none"> <li>▪ HbA1c Screening</li> <li>▪ HbA1c Poor Control (&gt;9)</li> <li>▪ HbA1c Good Control (&lt;8)</li> <li>▪ LDL Screening</li> <li>▪ LDL Control &lt;100</li> <li>▪ Nephropathy Monitoring</li> <li>▪ Diabetes Registry and related activities</li> <li>▪ Diabetes Care Management Program</li> </ul>

## **SECTION XI. PAY FOR PERFORMANCE**

(Continued)

Six participating health plans (representing more than 8 million enrollees) have agreed to participate:

- Aetna
- Blue Cross of California
- Blue Shield of California
- CIGNA HealthCare of California
- Health Net
- PacifiCare

Each plan will use the results on the common performance measures while still designing its own physician group bonus program. The initiative applies only to commercial enrollees and does not apply to Medicare beneficiaries.

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### **The following criteria are used to identify eligible Pay for Performance patients:**

#### **BREAST CANCER SCREENING (MS)**

The percentage of women age 40 through 69 years who had a mammography screening within the prior two years (1/1/2008 – 12/31/2009)

#### **CERVICAL CANCER SCREENING (CC)**

The percentage of women age 21 through 64 years, who have had a cervical cancer screening (Pap smear) within the prior three years (01/01/2007-12/31/2009)

#### **CHLAMYDIA SCREENING**

The percentage of women 16-25 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year

#### **CHILDHOOD IMMUNIZATIONS (CI)**

##### **MMR**

At least one measles, mumps and rubella (MMR) with a date of service falling on or between the child's first and second birthdays.

##### **VZV**

At least one chicken pox vaccine (VZV) with date of service falling on or between the child's first and second birthdays.

#### **CHOLESTEROL MANAGEMENT AFTER ACUTE CARDIOVASCULAR EVENTS (CM): LDL-C SCREENING AND CONTROL**

The percentage of members age 18 through 75 who, from January 1 through November 1 of the year prior to measurement year, were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PTCA), or who had a diagnosis of ischemic vascular disease (IVD) and who received a screening for LDL-C and LDL-C is controlled (< 130 mg/dL).

#### **COMPREHENSIVE DIABETES CARE (CD): HbA1c TEST**

Patients age 18 through 75 identified as diabetic who had an HbA1c test in measurement year.

## **SECTION XI. PAY FOR PERFORMANCE**

(Continued)

### **USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA (AZ)**

This measure evaluates if members with persisted asthma are prescribed medication acceptable as primary therapy for long-term control of asthma. Such as: Albuterol, Salmeterol, Methylxanthines, Leukotriene Modifiers, Mast Cell Stabilizers.

### **APPROPRIATE TREATMENT OF CHILDREN WITH UPPER RESPIRATORY INFECTION**

The percentage of children 3 months-18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the Episode Date.

### **MONITORING FOR DIABETIC NEPHROPATHY**

This measure is intended to assess if diabetic patients are being monitored for nephropathy.

### **COLORECTAL CANCER SCREENING**

This measure evaluates the percentage of adults 50-80 years of age who had an appropriate screening for colorectal cancer (CRC).

### **AVOIDANCE OF ANTIOTIOTIC FOR ADULTS WITH ACUTE BRONCHITIS (AAB)**

The percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription on or within three days of the diagnosis.

### **USE OF IMAGING STUDIES FOR LOW BACK PAIN (LBP)**

The percentage of members with a primary diagnosis of low back pain that did not have an imaging study (plan X-ray, MRI, CT Scan) within 28 days of the diagnosis.

### **ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS**

The percentage of members 18 years of age and older who received at least a 180 day supply of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Medications monitored are:

- ACE/ARB
- Digoxin
- Diuretics

### **APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS**

The percentage of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A strep test for the episode.

**SECTION XII.  
HIPAA COMPLIANCE**

**Candis Kliewer, Director of Compliance and Utilization  
(562) 602-1563 x516**

## **SECTION XII. HIPAA COMPLIANCE**

### **Regulatory Requirements**

The Department of Health and Human Services (HHS) has issued privacy regulations pursuant to the Health Insurance Portability and Accountability Act of 1996 (the “Privacy Rules”) to protect the use and disclosures of member confidential health information. These rules apply to all covered entities, such as physicians, health plans, clearinghouse and their business associates, that are involved in the delivery of healthcare.

There are requirements under the Privacy Rules that may impact you as our business associates. Among them includes member’s right to access and request amendments to their protected health information, receive an accounting of certain types of disclosures, and request restrictions regarding how their protected health information is used or disclosed.

For further information, you can access the Website at <http://aspe.hhs.gov/admsimp/final/PvcTxt01.htm>.

If you need help complying with HIPAA, you may contact the following agencies. Note that they may charge a fee for their services.

Denise Willet  
Senior Consultant  
DecisionTrac  
353 Bel Marin Keys Blvd., Suite 8  
Novato, California 94949  
Ph. (877) 389-2396  
[denise.willet@decisiontrac.com](mailto:denise.willet@decisiontrac.com)

Ronald Brandt/Jason Westhafer  
General Manager/Dir. of Bus. Develop.  
Integrated Health Systems  
12954 S. Hawthorne Blvd., Suite 102  
Hawthorne, CA 90250  
Ph. (310) 676-7800  
[brandt@integratedhealthsystems.com](mailto:brandt@integratedhealthsystems.com)

We value your partnership, and will make best efforts to keep you informed of the changes in regulations and HIPAA.

Should you have any questions, feel free to contact the Compliance Officer directly at (562) 602-1563 ext. 487.

**SECTION XII.**  
**HIPAA COMPLIANCE**  
(Continued)

**HIPAA COMPLIANCE:**

**Policy Statement**

APMG shall use best efforts to control the use and disclosure of Individually Identifiable Health Information and Protected Health Information as defined in the Health Insurance Portability and Accountability Act of 1996. APMG agrees that protecting its members' confidential information from unauthorized access is an important social policy and adopts herein standards of conduct in compliance with HIPAA.

**I. General Privacy Policy Standards**

- A. APMG shall be HIPAA compliant.
- B. APMG shall adopt all reasonable rules and standards to protect individuals' rights and privileges to privacy.
- C. All standards, requirements, policies and procedures shall be in compliance with public policy.
- D. APMG's Privacy Standards shall incorporate all applicable HIPAA standards, regulations and implementation specifications.
- E. Privacy is an important component of the individual-covered entity relationship. It is the duty of every employee and business associate of APMG to ensure the safety, security and privacy of an individual's Individually Identifiable Health Information.
- G. APMG shall adopt policies and procedures designed to regulate and monitor APMG's business associates' compliance with HIPAA.