PACIFIC PARTNERS
MANAGEMENT SERVICES, INC.

# PPMSI
# Operations Manual

**SIGN UP FOR *ACCESS EXPRESS* TODAY!**
**Online Eligibility, Authorizations, Lab Results, Payment & Capitation Tracking, Secure Messaging & Pay for Performance Tracking**

**Call the Access Express Help Desk at (650) 358-5832**
**OR toll-free (877) 258-4357 (877-258-HELP)**
**OR Get your User Name & Password online at www.ppmsi.com/login**

With our roots in Silicon Valley, PPMSI is a management services organization and software developer that brings the power of managed care technology to physician network management. We use advanced Internet and on-site systems to manage HMO membership, referrals and administrative data. We provide a wide range of financial, contracting, marketing and administrative services to two California independent practice associations with over 1500 physicians and 150,000 members—SCCIPA (Santa Clara County Individual Practice Association) and Affinity Medical Group.

Our unique web software, *Access Express*, can dramatically reduce managed care hassles for your office. Designed with the IPA physician office in mind, it requires no previous Internet experience or training. Many offices already have the simple tools required to use the system---a PC and Internet access. In most cases, no additional hardware or software purchase is required.

*Access Express* helps physician staff make the right network provider choices for each patient and health plan. It improves response time and accuracy because it automates referral and benefit details that vary by health plan. And, it reduces staff time and overhead---physician offices have reported saving up to $10-$20,000 per year in employee costs!

Please take some time to read this information. Along with your IPA Authorization Matrix, it will answer a number of important questions about our management services organization and facilitate future interactions with your patients. Please give us a call if we can assist you in any way. We look forward to working with you to optimize the quality of health care for our members.

PACIFIC PARTNERS
MANAGEMENT SERVICES, INC.

# Table of Contents

# 1. PPMSI Days & Hours of Operation

**PPMSI is open for business from 8:00 AM to 5:00 PM, Monday through Friday with the exception of the following holidays:**

| | |
|---|---|
| **Presidents Day** | **Monday, February 20, 2006** |
| **Memorial Day** | **Monday, May 29, 2006** |
| **Independence Day** | **Tuesday July 4, 2006** |
| **Labor Day** | **Monday, September 4, 2006** |
| **Thanksgiving Holiday** | **Thursday, November 23, 2006**<br>**Friday, November 24, 2006** |
| **Christmas Holiday** | **Monday, December 25, 2006**<br>**Tuesday, December 26, 2006** |
| **New Year's Day** | **Monday, January 1, 2006** |

# 2. About Access Express

- **Access Express is available 7 days a week, 24 hours a day.**
- **For technical assistance with Access Express installation and support, call the Help Desk at 1-877-258-4357 (258-HELP), Monday through Friday, 8 am through 5 pm.**
- **The *Access Express Provider Office Guide* is available at your *Access Express* website to help your office staff learn how to use the system.**

*Access Express* is a proprietary web-based system designed to dramatically reduce managed care hassles for your office. Designed with the IPA physician office in mind, it requires no previous Internet experience or training. *Access Express* helps physician staff make the right network provider choices for each patient and health plan. It improves response time and accuracy because it automates referral and benefit details that vary by health plan. And, it reduces staff time and overhead---physician offices have reported saving up to $10-$20,000 per year in employee costs!

*Access Express* is the fastest way to confirm HMO membership, get a medical service approved, or have PPMSI personnel investigate eligibility for an individual who is not yet in the electronic system. Since replies are automated, your staff receives faster responses. In addition, they can send secure electronic messages to

network providers and PPMSI personnel. Your billing staff can view online claims and capitation history for your office. CMS 1500 claims can be submitted electronically through the PPMSI web site.

**Secure Online Communications**

To provide secure access to confidential patient data, the *Access Express* system has been developed with CMS and HIPAA security protocols using 128-bit encryption. Microsoft Internet Explorer 5.x with 128-bit encryption is the only Web browser supported by PPMSI, although other browsers with 128-bit encryption may be used. Use the MSO web link at the online website to download the most recent release of Microsoft Internet Explorer 5.x software.

**Minimum Required Hardware**

Many offices already have the simple tools required to use the system---a PC and Internet access. In most cases, no additional hardware or software purchase is required. Your office will need a personal computer capable of running Microsoft Internet Explorer 5.x (or more recent) software. The recommended minimum configuration for the computer is listed below:

- → Pentium 100 with 48 mb RAM
- → Adequate hard drive capacity, and
- → Windows 95, 98, NT or 2000 operating system or equivalent Mac system

# 3. Provider Services

The PPMSI Provider Inquiry Department provides a dedicated telephone service to assist providers and their staff with questions or concerns. Issues related to claims payments, appeals, capitation and PPMSI programs should be directed to this department.

**Multi-lingual representatives are available Monday through Friday, 8:00 AM to 5:00 PM.**

Below is an overview of the functions performed by our Provider Inquiry Representatives:

- Problem Resolution — Investigates and resolves problems or concerns brought to the attention of PPMSI
- Provider Education — Explains PPMSI policies and procedures
- Benefit Interpretation — Helps interpret and explain member health plan benefits and coverage
- Grievance Process — Informs providers about the grievance process for service or authorization denials
- Appeals — Explains procedures for Commercial and Medicare Risk appeals

# 4. Member Services

The PPMSI Member Services Department assists health plan members with their questions and concerns. Issues related to claims payment and referral authorization should be directed to this department.

**Representatives are available Monday through Friday, 8:00 AM to 5:00 PM.**
**The department is staffed with multi-lingual representatives.**

Below is an overview of the functions performed by our Member Services Representatives:

| | |
|---|---|
| • Problem Resolution | Investigates and resolves problems or concerns brought to the attention of PPMSI |
| • Member Education | Explains PPMSI policies and procedures |
| • Benefit Interpretation | Interprets and helps explain member health plan benefits and coverage |
| • PCP Selection | Assists members to select their PCP and to contact the health plan to actually make the change |
| • Member Complaints | Records verbal complaints from members regarding potential quality of care or service issues |
| • Grievance Process | Informs members about the grievance process for service or authorization denials |

# 5. Identifying Members

An identification card is issued directly to the member by his or her contracted health plan. Each time a health plan member presents himself or herself for services, eligibility must be verified in the following manner:

- Ask the member to present his or her health plan identification card or a copy of their *Health Plan Enrollment Form* if the member has new coverage and does not yet have an ID card.
- Maintain a photocopy in the file of the front and back of the members' ID card/enrollment form.
- To verify eligibility in the event the health plan member cannot produce an ID card or a Health Plan Enrollment Form, use *Access Express* or call the *PPMSI Provider Inquiry Department.*
- Copayments should be collected prior to rendering services.

You may have your members complete an Eligibility Guarantee Form, like the one below, to ensure that members who are not eligible to receive services assume liability for the charges.

PACIFIC PARTNERS
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**PACIFIC PARTNERS MANAGEMENT SERVICES, INC.**

**ELIGIBILITY GUARANTEE FORM**

I, _____ hereby certify that

I am eligible for _____ _____ through

Name of Health Plan/IPA Month / Date / Year

_____ _____

Employer Group Name of Subscriber

I have chosen _____ to be my Medical Provider.

I understand that if the above is not true or if I am not eligible under the terms of my employer health plan that 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 from the above noted Medical Group/ Physician.

_____

Signature of Member (Or Guardian)

Eligibility Verified By:

_____

IPA Date

_____

Office Personnel Verifying Eligibility Date

# 6. Discharging Members

The following guidelines should be followed if a provider concludes that he or she cannot continue to be responsible for the continuing care of a health plan member:

- Send a letter to the member giving **SPECIFIC** reasons for the discharge.
- State a specific deadline of **at least 30 days** for the patient to find another physician. During this notice period, needed medical care must continue to be provided.
- Advise member to contact their Health Plan to change the PCP or to contact the PCP for a new specialist.
- Send a copy of the discharge letter to the member's Health Plan and your PPMSI Provider Services Representative. This will allow the Health Plan and/or PPMSI time to send letters to the member regarding his/her impending discharge from a provider's practice.

***DOCUMENTATION***

It is important that you document the problems you encounter with a particular patient so that PPMSI can track and monitor the patient's behavior. Occasionally, attempts to counsel members fail and it is necessary to make arrangements to transfer members to another medical group or to initiate proceedings to discharge the member from the health plan. In order to do this, PPMSI must have sufficient documentation.

# 7. Billing Requirements for Health Plan Members

- By entering into an agreement with your medical group, you have agreed to look exclusively to the medical group for payment for covered HMO services provided to our health plan members.
- An **Authorization Matrix** is included in this package detailing service exceptions that must be billed to the health plan directly. *Please note that the Authorization Matrix can change on a monthly basis.* The most up-to-date matrix can be found in the Information section on the *Access Express Main Menu.*
- **You may not bill health plan members for the difference between your actual charge and your contractual reimbursement rate**. Payment from the medical group constitutes payment in full for covered health plan services that you provide. With the exception of applicable copayments, the provider must bill their IPA directly and not bill the health plan member for covered services. Copayments vary by health plan. However, copays for office visits are generally listed on the Member ID card.
- Should a health plan member be billed by the provider for services covered by the health plan, the full payment will be deducted from further payments to the provider.
- **The provider may bill for non-covered services,** provided the physician first obtains written acknowledgement of financial responsibility from the member in the format specified for such procedures and required by the applicable health plan, medical group and CMS.
- **Billing of patients is a violation not only of the Medical Group Physician Agreement, but also of the Knox-Keene Act in the State of California.** Persistent billing of patients is a cause for termination from the Medical Group and will likely cause additional penalties from the State of California.

# 8. Submitting a Clean Claim

- **Electronic Claims Submission is the best way to submit your claims**. PPMSI receives claims electronically through *Access Express.* If you bill using the CMS 1500 format and do not yet submit claims electronically contact PPMSI technical support at (877) 258-4357 to initiate the process.
- **For claims not submitted electronically,** the following requirements must be met to minimize the potential for rejection of a claim, delay in processing, and/or identification problems.
  - → Claims must be submitted on a CMS 1500 form & mailed directly to the PPMSI claims department at:

    **PPMSI (*Name of IPA)* Claims**
    **PO Box 5860**
    **San Mateo, CA 94402-5860.**

  - → **Superbills and handwritten forms will not be accepted.**
    CMS 1500 forms should be typed or computer-generated with clear and legible print.
  - → The patient's name, address, date of birth and insurance information must be completed fully on each CMS 1500 form submitted.
  - → **Please print patient's name EXACTLY as it appears on the ID card.** Nicknames and initials will cause delays in paying your claims because they cannot be matched to health plan eligibility records.
  - → Claims must be billed using current CPT codes & Level II HCPCS codes for supplies and injectables.
  - → **Boxes #25** (Federal Tax ID #), **#31** (Signature of Physician) and **#33** (Physician Name and Address) **must be completed on each CMS submitted.**
- The **Name of your IPA/Medical Group** must be clearly marked on each CMS submitted
- **Timely Submissions Required.** Claims should be submitted within the timeframe specified in your IPA contract. Most contracts require that claims be submitted within ninety (90) days from the date of service. Your medical group accepts no obligation to pay claims received after the timeframe in your contract.
- **Coordination of Benefits.** Approved exceptions include Coordination of Benefits (COB) claims where collection from a primary source is required prior to billing your medical group. In these cases, submission is required 90 days from the date payment is received from the other carrier.
- **Health Plan Payments.** Claims requiring health plan payment should be forwarded directly to the appropriate health plan. Claims that are sent to PPMSI inadvertently will be redirected to the health plan or to the party responsible for payment.
- **Please see full details concerning the IPA's Claims Settlement Practices and Dispute Resolution Mechanism in compliance with AB1455.**

# 9. Tracing Claims

- ***It is unnecessary to send a tracer for Claims in Process. Please allow 30 days for PPMSI to work these claims before following up with a tracer***. Before tracing a claim, please refer to your latest Remittance Advice (RA) report for a list of claims in process. You can also utilize *Access Express* to check the status of your fee-for-service claims and your capitated encounters. Contact PPMSI technical support at (877) 258-4357 to activate your *Access Express* account.
- ***Read your Remittance Advice (RA) carefully***. The PPMSI Remittance Advice has been revised over time to meet the needs of physician billing staff to reconcile payments with patient accounts. An updated RA will be mailed after every check run. *It will include both capitated encounters and non-capitated claims.* Please refer to the Sample RA in your Welcome Package for more information.
  - → The first section lists by provider the claims that have been entered and adjudicated by the claims system—including for each claim and line item— amounts billed, allowed, excluded, withheld & paid.
  - → Reasons for denials are clearly stated after each provider's paid claim listing.
  - → Provider subtotals for processed claims are also shown as well as *code descriptions* (abbreviations that explain the system logic used to adjudicate each claim and line item—e.g. allowable, duplicate claim or missing authorization number).
  - → ***Claims in process are listed separately.*** These are claims received by PPMSI that are being researched with the health plans prior to processing. Read your Claims in Process: PPMSI may be—(a) Waiting for the health plan to check eligibility for HMO members, (b) Matching authorizations for fee-for-service claims, or (c) Already scheduling payment on the next checkrun.
- ***Working the RA.*** Use the RA to identify claims that may require further action from your office, including—
  - → Duplicate claims that should be written off by your office
  - → Claims that require submission with copies of medical records and/or revised procedure codes
  - → Claims that you feel may not have been processed/paid correctly.
- **DO NOT RESUBMIT these claims by mail or ECS. They will be denied as duplicates unless adjustments are requested. Adjustments should be requested as follows:**
  - → Through *Access Express* using the claim inquiry request form
  - → Through the PPMSI Provider Services number listed in your IPA Phone Directory, OR
  - → By mailing in a copy of your RA with line items in question highlighted and documentation attached.
- **Tracers for claims not listed on the RA must be submitted within 120 days from the date of service with proper documentation.** Tracer claims must be labeled TRACER to be considered for payment.
- **Requests for adjustment or reconsideration of a claim must be submitted within 365 days of the medical group's initial claim payment.** Claims and requests for adjustment or reconsideration not submitted in accordance with guidelines outlined in your contract or in accordance with AB1455 may be denied. All claim inquiries will be reviewed & outcomes communicated to the provider office. Responses will be in the form of *Access Express* inquiry response, return call, Remittance Advice or letter depending on case.

# 10. Electronic Claims Submissions (ECS)

**How it works—**

- *Access Express* helps your billing staff submit and track claims efficiently, and expedite claims payments that would be rejected by the payer's claims system.
- Batches of claims files are uploaded to *Access Express*, where they are screened to make sure each claim includes the information required for processing.
- Incomplete claims are rejected, with rejections documented in *Access Express*. PPMSI claims remain with PPMSI, and NON-PPMSI claims are forwarded for payment to Medicare and other payers.

Your office can expedite payment for incomplete claims by weekly auditing the information reported through *Access Express,* and by completing and resubmitting the rejected claims.

**Your Office Saves on Staff Time/Overhead & Minimizes Accounts Receivable**

- PPMSI ECS dramatically reduces office supplies and postage used to print and mail paper claims.
- You save staff time printing claims, billing and recording unnecessary tracers, and reconciling claims mailed with payments. It virtually eliminates claims lost in the mail.
- PPMSI ECS reduces Accounts Receivable by identifying incomplete claims so they can be resubmitted in a timely manner by your office.
- **PPMSI ECS is Priced WELL BELOW Competing ECS Services. CALL 650-358-5832 OR 1-877-258-4357 for more information.**

**PPMSI interfaces with most practice management systems that can create a file of batched claims—either CMS 1500 print image or NSF format. It requires a PC that can run Microsoft Internet Explorer 5.x (or newer) software with 128-bit encryption. Recommended minimum configuration: Pentium 100 with 48 mb RAM, Adequate hard drive capacity, and Windows 95, 98, NT or 2000 operating system or equivalent Mac system.**

# 11. Referrals & Authorizations

**The Authorization Matrix enclosed with your *Welcome Package,*** summarizes HMO services that require preauthorization by your IPA, by the health plans and by third party organizations appointed by the health plans. Most care delivered by the primary care doctor in the office does not require prior approval, with the exception of the Special Procedures listed in the table in this section. Most other care requires an entry into the web-based *Access Express* system for automated eligibility checking and/or authorizations.

***Access Express* is the fastest way to confirm membership, get a medical service approved, or have PPMSI personnel investigate eligibility for an individual who cannot yet be identified in the system.** In a business with ever-changing contracts, *Access Express* helps your office staff make the right provider choices for each patient and health plan, and it provides *direct* access to IPA data, using drop-down lists to simplify data entry and minimize offline research. Your staff can quickly check IPA member eligibility and enter authorization requests using search tools to select appropriate diagnosis (ICD-9) and procedure (CPT) codes. They can confirm the status of prior authorization requests, update patient Pay for Performance data now required by most California health plans, and submit claims electronically. ***PPMSI does not use or accept faxed requests.***

- **Access Express is available 7 days a week, 24 hours a day.**
- **For technical assistance with installation and support, call the *Access Express Help Desk* at 1-877-258-4351 (258-HELP), Monday through Friday, 8 am through 5 pm.**
- **The *Access Express Provider Office Guide* is available at your *Access Express* website to help your office staff learn how to use the system.**

*Access Express* helps your office automatically select the right provider for each patient and health plan. It provides *direct* access to medical group data, using drop-down lists to simplify data entry and minimize offline research. Your staff can quickly check member eligibility and enter authorization requests using search tools to select appropriate CPT and diagnostic codes. They can add attachments to authorizations and confirm the status of prior authorization requests.

**Telephone requests to PPMSI Utilization Management** may also be used by those who lack an Internet connection. Please keep in mind that phone requests take considerably more of your staff time. There is a PPMSI maximum of three requests per phone call to assure availability of phone lines to other callers.

**Authorization request calls are received from 8:30 to 5 pm, Monday thru Friday, excluding holidays.** On weekends, after hours and on holidays, requests may be called into UM voice mail, which is checked daily during normal business hours. When calling in requests, the caller must have the following information available to assist the authorization representatives:

- Member name & Identification number
- Health plan name
- Referring provider
- Provider selected to perform or provide the service
- Type & Number of services or procedures requested to be authorized
- Diagnosis code (ICD-9)
- Procedure code (CPT)
- Clinical information relating to the requested service or procedure

## Four Categories of PPMSI Service Requests

**A. Referrals** are typically completed by PCP offices to request visits to Specialists and by Specialist offices to request additional visits/followups through PCPs with the exception of 'Special' procedures.

**B. Precertifications** cover all services performed in a facility (hospital, surgicenter or hospital outpatient surgical suite) with the exception of 'Special' procedures. The Pre-certification category approves *both* the

facility *and* the doctors who provide care during the stay at the facility. The Pre-certification approval authorizes only a single stay in that facility, although the stay may be brief or lengthy. It covers all needed care from date of admission to date of discharge. No further authorizations are required for needed inpatient consultants if the admission is authorized.

C. **Special Procedure Authorizations** involve Special Procedures & medical equipment listed in the IPA Authorization Matrix that your IPA wants to review before care is rendered. Only limited services are listed in this category. All other services are entered as Referrals, Precertifications or Emergencies.

   Special Outpatient Procedures are listed in the *Access Express* drop-down list in the Procedure Authorization input form. No additional approval is necessary when these services are performed as part of an approved inpatient authorization,.

   **The following do not require prior authorization when performed in the doctor's office:**
   routine immunizations, ophthalmic ultrasounds, fetal stress tests, obstetrical and urologic ultrasounds, gynecologic endoscopies, anoscopy, sigmoidoscopy, proctosigmoidoscopy, and laryngoscopy.

D. **Emergency Authorizations** are required for urgent care already taken place that has not been authorized in advance due to specific clinical circumstances. Services performed without prior authorization because of the urgent or emergent nature of the medical problem should be entered into the system as Emergencies. Emergencies are the only services that can be entered retroactively.

   - Users should note why the Authorization was not requested until after the care was rendered. Include name, phone number and address of all non-Plan providers used. This is the only place where past unauthorized care can be described for possible retroactive approval.

   - Retroactive care is only authorized for urgent or emergent problems or when certain administrative difficulties prevented necessary approval before care was rendered. For example, when the member was not in the medical group data bank or the wrong patient was entered into the system in error. Retroactive authorizations are not given for elective services in other circumstances

## Urgent & Emergent Referrals, Procedures & Precertifications

- ***If care has not yet taken place:*** Fill out a Referral, Precertification or Procedure Authorization Request explaining why the care is Urgent in the Note Section.

- ***If care has already been provided on an Emergency basis:*** Fill out an Emergency Request explaining why the care was required as Urgent or Emergency care without advance authorization.

## Authorization Table

This table provides examples of the services and procedures that require authorization regardless to which specific health plan the member belongs. The services and procedures are characterized by the type of authorization data-entry screen to be used by *Access Express* users. Updated information from this table is programmed into *Access Express.*

| Referral Authorization | Special Procedure Authorization | | Precertification Authorization | Emergency Authorization |
|---|---|---|---|---|
| • Referals/visits/ procedures by specialists in specialist's office<br>• Brain stem auditory evoked response (BSAER/BAER)<br>• Pulmonary function test (in office)<br>• Radiation therapy<br>• Radiology procedures not done by contracted radiologists<br>• Routine vision care services (call health plan to verify benefits)<br>• Request for consultation with non-contracted providers (explain why contracted provider could not be used) | • Ambulance<br>• Amniocentesis<br>• Bone Density Study<br>• Bunionectomy<br>• Chelation therapy<br>• Chorion biopsy<br>• CT scans<br>• Dialysis<br>• Durable Medical Equipment (DME)<br>• Echocardiogram<br>• Electroconvulsive Therapy (ECT)<br>• Endoscopy<br>• Epidural injection<br>• Holter monitoring<br>• Home Health Care<br>• Hospice Care<br>• Hyperbaric oxygen treatment<br>• Infusion services<br>• Laboratory services | • MRI scans<br>• Nerve conduction study<br>• PET scans<br>• Physical, Occupational, Speech therapy<br>• Psychological Testing<br>• Repair of Hammertoe<br>• Stress test/treadmill<br>• Supplies, medical<br>• Ultrasound<br>• Specified injections-- <u>the only medications</u> that require prior authorization in an outpatient office setting: *anticancer chemotherapy, Botox, intravenous clotting factors & gamma globulin, travel immunizations, erythropoetin, Filgrastrim, G-CSF, Foscarnet, Growth hormone, Ganciclovir, DHPG, intravenous immunosuppressants, Interferon & Sumatriptan*<br><br>***Routine immunizations <u>do not</u> require prior approval.*** | • All in-area facilities including acute hospital care, SNU/SNF admission<br>• Outpatient procedures and diagnostic testing when done in a hospital surgi-center, outpatient center or urgent care center<br>• Surgical center care<br>• Facility-based surgical procedures (D&C, liver biopsy, etc.)<br>• Arteriogram when done at a facility<br>• Hospital-based diagnostic tests | • Emergent/ urgent sevices/ visits/ procedures<br>• Request for services that have already occurred (describe both the medical problem & reason prior notification was not done)<br>• Services/visits/ procedures that could not be previously entered because the member was not in the PPMSI eligibility system<br>Retro authorization for in-area facility admission |

## Important Information About Referral Authorizations

- **All Non-Emergent referrals from a Primary Care Physician to a Specialist require Referral Authorization.**
- **Primary Care Physicians (PCPs) and Specialists may perform office procedures as necessary with the exception of the Special Procedures** in the Authorization Matrix which require Procedure Authorization.
- **A PCP acting as a Sub-Specialist** does not require a Referral Authorization to see one of his/her primary care patients.
- **Specialist care is limited to the number of visits authorized,** which is determined based on input by the PCP, Utilization Management policy and other industry-specific criteria. A visit includes all care provided by all providers who share a common tax ID in a given day.
- **Referral Authorizations to an out-of-network provider will not be approved if services can be provided by a network provider.** Any request for referral to a non-preferred provider requires the reason why a member was not directed to a preferred provider. Costs incurred by the medical group for non-authorized out-of-network referrals will be charged back to the referring physicians.
- **A Specialist cannot refer directly to another Specialist.** A Referral Authorization must be requested by the PCP.
- **Referral Extensions.** After an initial referral, a Specialist can request additional visits through *Access Express.* These requests are electronically routed to PCPs for input and transferred to the Medical Director for a decision if PCP input is not provided within 24 hours. A Specialist should not expect to receive an extension if s/he has not submitted a progress or consultative report.
- **Referral Authorizations are not issued retroactively**. They are effective on the date of entry into the PPMSI system and expire four months after the authorization has been approved, with the exception of maternity referrals, dialysis, and chemotherapy that expire in ten months.
- **Authorization Guideline Questions**. *Access Express* users who request referrals and authorizations will often be required to answer additional questions about their requests. These questions were developed to expedite authorization requests by making sure requesters included the minimal information required for an appropriate decision. For example, the medical group may have decided that all allergist referrals should be made only after trying two antihistamines and an intranasal steroid. For these referrals, requesters will be asked to answer two questions with the answers factored into referral decisions.

  **Has primary care doctor treated patient with at least 2 different antihistamines?**
  **Has primary care doctor given patient a prescription for an intranasal steroid?**

## Authorization Details & Exceptions

- **Carefully review Approved Authorizations** to make sure you understand exactly the approved provider and the number of visits.
- **Reason Field** explains WHY the patient requires a service. When services are denied, it is printed in the Authorization letters sent to patients, causing great confusion. Please restrict your entry in the *Reason* field to the specific reason procedure or service requested.

- → ***Reason*** field should NOT include # of requested visits, abbreviations, codes or terms a member would not understand.
- → ***Notes*** to the Medical Director, like number of visits, reasons for requesting a non-network provider, and clinical and provider information to support your request should be included in the *Notes* field, which is NOT printed in the Authorization letter.
- → ***Check the box*** in the Request form to indicate when the Member (NOT the doctor) requests the service.

## Special Procedures

- **Services NOT FOUND on the *Special Procedure* list** are to be requested as Referral Authorizations, Precertifications or Emergencies.
- **Procedures that DO NOT Require Prior Authorization when performed in the doctor's office:**
  - → routine immunizations
  - → ophthalmic ultrasounds
  - → fetal stress tests
  - → obstetrical & urologic ultrasounds
  - → gynecologic endoscopies
  - → anoscopy
  - → laryngoscopy
  - → proctosigmoidoscopy
  - → sigmoidoscopy

## Authorizations for Health Plans & 3rd Party Services

The provider may need to contact the Health Plan or a Third-party vendor to obtain benefit information or prior authorization (e.g., services authorized and provided by a mental health or vision care vendor, etc.). Claims for these services must be submitted to the Health Plan or to the third party for payment, not to PPMSI.

## Authorization Denials & Notifications

- Most online referral requests are instantly approved based on automated protocols embedded in *Access Express.* **MOST COMMON CAUSE FOR DENIALS OF NEEDED CARE: The requesting provider leaves out relevant information to explain why the service is needed.**
- **Most *Access Express* authorization requests are reviewed instantly using automated PPMSI protocols** developed by UM management over the past fifteen years. Utilization criteria used to make the decision are included in the notification letter sent to the Requesting Provider, and a copy of these criteria are also available to the provider upon request by calling 650-358-5831 during normal business hours.
- **APPROVED authorizations.** Requesting and Referred to providers are notified of APPROVED authorizations in one of three ways, depending on office capability:
  - Instantly receives notification through secure *Access Express* email, OR
  - Next business day receives Faxed notification, OR
  - Notification mailed next business day after request is made.

  Approval letters are also sent via *Access Express* or fax to involved Facilities and mailed to Members.
- **DENIAL letters** (including Utilization Criteria) are sent to
  - Requesting providers, via *Access Express* or Fax within 24 hours of the denial decision
  - Referred to providers and Members, within 2 business days.

When additional information is needed, UM staff contact the requesting provider's office.

- Request is pended for 5 days and, if the additional information is not received, a letter is sent to the requesting provider specifying the needed information.
- Request is pended for an additional 5 days and, if the additional information is not received, a review decision is made based on available information.

## Open Access

**ObGyns.** All female members have open access to participating OB/GYN providers for routine obstetrical and gynecological services. If the OB/GYN is a participating IPA provider, members do not need a referral from their PCP to see an IPA OB/GYN for most gynecological services. However, authorization is required for:

- Elective inpatient hospital admission and inpatient admissions for obstetric care
- Outpatient hospital procedures
- Infertility treatment
- Out of network provider

OB/GYN providers continue to coordinate and communicate all treatment with the member's PCP as needed.

**Blue Cross of California.** The Open Access program allows Blue Cross members to self-refer to three types of specialty providers within the IPA (besides ObGyn physicians) without obtaining a referral from the PCP or PPMSI UM. Members may self-refer to these providers for medically necessary and appropriate services that can be performed in the specialist's office without limiting the number of visits. The specialist office is responsible for obtaining the necessary authorizations for services they will provide to the member.

| Specialty | Medical Guidelines | Authorization Required |
|---|---|---|
| **Allergy** | Initial and subsequent office-based visits.<br>Office-Based, on-site diagnostic testing | Elective and non-emergent surgical procedures |
| **Dermatology** | Initial and subsequent office-based visits.<br>Office-Based, on-site diagnostic testing, including simple biopsies | Elective and non-emergent surgical procedures |
| **Ear, Nose & Throat (ENT)** | Initial & subsequent office-based visits.<br>Office-Based, on-site diagnostic testing, including basic audiometry, & simple biopsies | Endoscopic exams, Radiologic or ultrasonic testing, Complex auditory and vestibular function testing, Elective and non-emergent surgical procedures |
| **OB/GYN** | Initial & subsequent office-based visits. Office-Based, on-site diagnostic testing | Elective & non-emergent surgical procedures |

## Standing Specialist Referrals

Standing specialist referrals are arranged for members with life threatening, degenerative, disabling or complex conditions that require prolonged care and/or care coordination by a specialist or recognized Specialty Center.

- Prior to approving a standing referral, PPMSI may require submission of a treatment plan (after initial consultation) to be approved by the PPMSI Medical Director or Associate Medical Director in consultation with the PCP, the specialist and the member.
- PPMSI may limit the number of visits to the specialist, the period of time visits are authorized, or require that the specialist provide the PCP with regular reports on the care provided to the member.
- PPMSI will authorize use of non-contracting providers only when there is no specialist within the PPMSI network capable of providing appropriate specialty care to the member, given the member's condition. Determination of need for a referral to a non-contracting provider is made by the PPMSI Medical Director or Associate Medical Director in conjunction with the PCP.
- Once approved, if a particular member does not receive standing referrals and open access, please contact the PPMSI Medical Director to confirm that the automatic PPMSI system logic is in place to achieve this goal.

## Turnaround Guidelines for Authorization Requests

Turnaround time guidelines for processing authorization requests have been established to provide for timely review of requests for health care services and timely communication of determinations regarding services to the provider, facility, and/or member. **Determinations for authorizing requests are made in a timely manner and the urgency of the individual situation of the member is always taken into consideration.**

**Turnaround time** is defined as the time between receipt of the request and all information needed to make a determination--whether by electronic transmission or by telephone--and the time the determination is made and communicated to the requesting party.

| Category | Decision Timeliness Requirement | Initial Notification to Practitioner | Notification of Modification or Denial to Member & Provider |
|---|---|---|---|
| **Elective/ Routine Inpatient pre-cert**<br><br>**Referral Authorizations**<br><br>**Special Procedure Pre-authorizations** | Within 2 working days of obtaining all reasonably necessary clinical information. | Immediate telephonic or electronic confirmation of services programmed to auto approve.<br><br>Within 1 working day of the decision for other services that are not automatically approved. | Initial provider denial notification within one working day of decision via Access Express, fax or telephone.<br><br>Written follow up to provider and enrollee within two working days of the decision (includes information on filing an expedited appeal). |
| **Ongoing Ambulatory Care**, including behavioral health | Within 2 working days of obtaining all reasonably necessary clinical information | Within 1 working day of the decision to the treating provider | Written notification within 1 working day of making the decision (includes expedited appeal language) |

| | | | |
|---|---|---|---|
| **Concurrent Review** (Inpatient, intensive outpatient and residential behavioral care) | Within 1 working day of obtaining all reasonably necessary clinical information.<br>Care is not discontinued until the enrollee's treating physician has been notified of the decision, and a care plan appropriate to the medical needs of the enrollee has been agreed on by the treating provider | Within 1 working day of the decision to the Treating Provider. | Within 1 working day of making the decision (includes expedited appeal language). |
| **Urgent/Emergent Authorizations** | Within 1 calendar day. | Same day decision & notification is made with telephonic, electronic or fax notification | Written notification within 1 working day of a denial decision.<br>Provider/enrollee are informed how to file an expedited appeal. |
| **Expedited Initial Determination** (see definition*) applies to seniors | Within 72 hours of receipt | Within 24 hours of receipt | Written notification next business day after decision |
| **Retrospective Review** | Within 30 working days of obtaining the information neces-sary to make the determination | Within 30 working days (simultaneous with the decision) | Written notification within 5 working days of the decision. |

**Note: All approved/denial letters are sent to members the day after they are generated.**

***Expedited Initial Determination: a decision to authorize or deny a service involving a situation in which when 14-day time frame for regular authorization process could seriously jeopardize the life or health of the enrollee or could jeopardize the enrollee's ability to regain maximum function.***

# 12. Second Opinions

Second opinions must be provided by an appropriately qualified healthcare provider, i.e., a primary care physician or a specialist who is acting within his/her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

**Second opinions are covered under the following circumstances:**

- If the member questions the reasonableness or necessity of recommended surgical procedures.
- If the member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.
- If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the member requests an additional diagnosis.

- If the treatment plan in progress is not improving the medical condition of the enrollee within an appropriate period of time given the diagnosis and plan of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment.
- If the member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

It is not required to refer outside of the network of providers for PCP services unless additional PCP services are not available within the network.

Second opinions within the contracted network requested by the member or the member's treating participating provider are authorized.

If an enrollee obtains a first opinion out of network without prior authorization, the enrollee may have a second opinion within the network of providers. If the first and second opinions differ, a third opinion may be given within the network provided there is a qualified health care provider available as defined above.

When the member's condition is such that s/he faces an imminent and serious threat to life, limb or other major bodily function, or lack of timeliness that would be detrimental to the enrollee's ability to regain maximum function, the second opinion is reviewed and a determination made within 72 hours after receipt of the request.

## 13. Work/Travel Immunizations

Most recent individual health plan coverage of work and travel immunizations is listed in the Authorization Matrix. This listing does not include routine immunizations benefits which are covered. The following matrix represents coverage as of January, 2004.

| PLAN | RESPONSIBILITY | COMMENTS |
|---|---|---|
| **Aetna Select Choice** | Member | Excluded from coverage in all HMO plans. |
| **Blue Cross Commercial HMO & POS** | Member | Excluded from coverage in all HMO plans. |
| **Blue Cross Medi-Cal** | Member | Excluded from coverage in all HMO plans. |
| **Blue Shield Access + & POS** | IPA | PPMSI Authorization required. If meets special requirements by the US Public Health Services - copayment may apply, depending on Member's plan benefits. |
| **CIGNA HealthCare** | Member | Unless included in Benefit Plan. |
| **Health Net Commercial** | IPA | PPMSI authorization required. If meets special requirements by the US Public Health Services – 20% copayment may apply. |
| **PacifiCare Commercial** | Member | Excluded from coverage in all HMO plans. |
| **PacifiCare Secure Horizons** | Member | Excluded from coverage in all HMO plans. |

# 14. Durable Medical Equipment

Durable Medical Equipment (DME) is medical equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the home. Equipment which basically serves comfort or convenience functions does not constitute medical equipment.

- All DME, regardless of cost, must be prior authorized. Not all health plans provide coverage for DME.
- If DME is covered, co-payment varies from plan to plan. Also, each health plan contracts with specific vendors and may be responsible for authorizing the equipment. By obtaining prior authorization, you will be informed of coverage and directed to the appropriate provider.
- Use the Authorization Matrix for a list of the vendors in your area with the products they provide.

# 15. Seniors At Home

PacifiCare Secure Horizons health plan has contracted with Seniors At Home to provide a social work based case management to patients with chronic care needs. The goal of the program is to improve primary care for patients whose condition place them at risk for disability or hospitalization.

**Selection Criteria Guidelines**

- Two or more hospital admissions within the previous 6 month period of time
- Discharge diagnosis of dehydration
- Discharge diagnosis of failure to thrive or new diagnosis of inability to ambulate
- Discharged with, or readmitted within 30 days for the same condition
- ER Frequent Flyer
- Two or more ER visits within the previous three month period of time, or
- Ambulance utilization of 2 or more calls within a 2 month period
- Frequent falls reported by member or caregiver
- Living alone or institutionalized and also has any of #1-5
- Previous history of difficulty to place, and also has any of #1-5
- Pre-hospital planning for major surgery, such as elective orthopedic procedures that may impact the fragility of enrollee or elderly enrollee aged spouse in the home.
- Frail senior cared for or giving care to another compromised person.
- Five (5) or more major classes of medications
- CHF, COPD, ESRD, Diabetes, Dementia/Alzheimers as primary diagnosis with any of #1-5
- Medical service utilization as a result of issues in their living environment

PPMSI staff will work with you to identify patients who may benefit from this program. The staff will also assist you in completing the Seniors-at-Home Case Management Request Form and helping facilitate the referral.

## 16. After Hours Policy

- Except in life-threatening emergencies when IPA members are instructed to contact 911, they are required to coordinate all their medical care through their PCP, including after-hour urgent and emergency care.
- Providers must be available, or have arrangements in place for a covering physician, 24 hours a day, 7 days a week, including after-hours, weekends and holidays.
- Most health plans define an Emergency as an unexpected acute illness or injury that could permanently endanger the health of a patient (or her fetus) if not treated immediately.

  In an effort to provide quality care to IPA members and limit use of the Emergency Room to conditions that require that level of care, the following guidelines were developed:

  **Non-Urgent Problems:** Direct the patient to your office for care the following day.

  **Urgent Problems:** When an illness or injury is acute, but does not require immediate care to prevent death or disability, refer the patient to the nearest contracted urgent care center or see the patient in your office.

  **Emergency Problems:** Direct the patient to the nearest participating hospital. Notify the Emergency Room, authorize the initial evaluation & instruct the Emergency physician to contact you for authorization before providing care other than routine diagnostic tests.
- IPA physicians must use their best efforts to inform the IPA of member emergency room visits and inpatient admissions.
- Covering physicians must agree to accept IPA reimbursement rates and member copayments as payment in full. On-call bills sent to IPA members by non-contracting providers will be paid by the IPA and deducted from future payments to the IPA provider.

## 17. Emergency Policy

- Your IPA allows for medically necessary emergency care leading to stabilization to be provided without prior authorization for all medical and behavioral health emergency services. The IPA covers emergency services authorized by an IPA provider or other authorized IPA representative, regardless of diagnosis.
- As defined in AB682, an Emergency is an unexpected acute illness or injury that, in the opinion of a prudent layperson, could permanently endanger the health of a patient (or her fetus) if not treated immediately.
- Emergency services and care include medical screening, examination, and evaluation to determine if an emergency medical condition exists or to eliminate the emergency medical condition.

Stabilization occurs when, in the opinion of the treating provider, no material deterioration of the patient's condition is likely to result and, if necessary, the patient can be transferred.

## 18. Medical Necessity Criteria

PPMSI uses clinical review criteria based on professionally recognized standards of practice reviewed by the IPA UM Committee. These criteria are subject to revision by the Committee to ensure they are consistent with current standards of practice, literature and national guidelines. The following criteria are used by the Utilization Management staff to review authorization requests for all types of services: inpatient and outpatient.

- IPA Developed Authorization Guidelines
- Health Plan Guidelines
- Medicare Coverage Issues
- InterQual
- Mandated Benefits-California and Federal Legislation
- Recommendations made by the American Board of (Specialty).

## 19. Disclosure of Utilization Management Criteria

IPA and PPMSI Utilization Management (UM) staff make review decisions based on appropriateness of care using their clinical experience, PPMSI-developed review criteria, industry-standard review criteria (such as: InterQual), Medicare Guidelines, etc. Providers may request a copy of any IPA Policy and Procedure and/or UM criteria utilized in the decision-making process by contacting the PPMSI Medical Director at 650-358-5811.

## 20. Authorization Appeals

All appeals for service denials by members and providers are handled by the Health Plans. Members should refer to their service denial letter for their appeal rights and submission requirements. Second level appeals are also directed to the health plan for resolution. The denial letter includes the address of the Appeals Department at the health plan or SCCIPA. The health plans have two types of appeals: expedited and routine.

- An appeal is expedited when a delay in making a decision might pose an imminent and serious threat to a member's health. These appeals are resolved in 72 hours after receipt of all necessary information.
- Routine appeals are resolved within 30 days after receipt of all necessary information.

PPMSI Appeal staff assist the health plans in the appeal process by contacting the providers to request medical records or information needed to support the appeal.

## 21. Independent Review of Denied Request for Experimental or Investigational Treatments

All authorization requests for experimental or investigational treatment for members with a life threatening or seriously debilitating condition are referred to the Health Plan and reviewed by the Medical Director of the appropriate Health Plan for coverage determination. AB 55 requires that the Department of Managed Health Care (DHMC) provide an impartial, independent, accredited review process where members may submit their grievance to the DMHC for resolution when authorization requests are denied.

In both situations, the member's PCP (or Specialist) must certify in writing that standard therapies to treat the condition either have not been effective, are not medically appropriate, or do not exist. The PCP/Specialist must certify that the recommended experimental or investigational drug, device, procedure, or therapy (based on 2 documents from medical and scientific evidence) would be more beneficial than conventional therapies.

The Medical Director obtains the following via telephone, fax, or written request of forms supplied by the Health Plan in addition to written certification from the physician requesting the therapies:

- A statement from the treating physician (PCP or Specialist) that the member has a life-threatening or a seriously debilitating condition
- Any consent document that the member is required to sign prior to receiving the investigational/experimental therapies
- Clinical or scientific literature regarding the proposed therapies
- Relevant medical records and documentation
- Current treatment plan
- Alternative treatment therapies
- Identification of attending physician and any leading medical consultants with addresses and phone numbers

## 22. Medical Decisions Not Influenced by Financial Considerations

IPA providers must provide services to members based on the individual's medical needs. Decision to provide medical care is based only on the appropriateness of care and service. Neither PPMSI nor the IPA offers incentives or rewards providers or any individuals conducting utilization review to deny coverage or to encourage inappropriate underutilization.

## 23. Confidentiality & Disclosure of Member Data

IPA providers and their staff must ensure the confidentiality of member medical records and the appropriate release of medical information in accordance with Civil Code 56.10(a)-(c). The member's medical record may

only be released if a written signed consent is obtained from the member, parent or legal guardian, or the person legally responsible for making medical decisions for the member.

Providers and their office staff may not release medical information without a signed consent to Health Plans, legal entities, arbitrators, licensing agency staff government or administrative agency staff, etc. when needed in the performance of their job activities.

Provider offices are required to have policies and procedures in place describing confidentiality and disclosure of member medical records. Provider office staff should sign a "Confidentiality Statement" and this statement should be placed in the employee's personnel file.

## 24. Patient Advocacy

Providers are not restricted when advocating on behalf of a member or advising a member on medical care, treatment options (regardless of plan coverage), risks, benefits and consequences of treatment or non-treatment, or a member's right to refuse medical treatment and to participate in determination of treatment plans.

## 25. Member Rights

IPA members should be treated with respect, dignity and courtesy. Members are responsible for taking an active role with their practitioner in making decisions regarding their healthcare. A complete listing of Member Rights & Responsibilities are provided in Your IPA Welcome Kit.

## 26. How to Apply for Membership in the Medical Group

Membership Committee meetings are held separately for each IPA. Committees meet on a bi-monthly basis at regularly designated times to consider applications. Applicants are considered based on IPA specialty and geographic needs. If you would like to submit an application on behalf of a new physician joining your practice, the following items are ALL required:

**A.** **Letter of Intent** - The following information *must* be included in your Letter of Intent.
***Incomplete Letters of Intent will not be forwarded to the Membership Committee***.

- ✓ **Group:** *Name of medical group to which you are applying: SCCIPA, Affinity, Premier Care, Golden State*
- ✓ **Specialty:** *Are you requesting to be considered as a PCP, Specialist or both?*
- ✓ **Board Certification:** *Are you boarded in the specialty in which you are applying? If not, what is the date you are scheduled to take the boards?*

- ✓ **Solo or Group Practice:** *If you are in group practice, who are the other p*
- ✓ *hysicians in your group? Does your group practice under the same Tax Id Number?)*
- ✓ **Practice Address:** *Please provide your primary and secondary practice address*
- ✓ **Other Group Affiliations***: Do you belong to other IPAs or Medical Groups?*
- ✓ **Hospital Admitting Privileges:** *If not in place, what hospitals are you applying to?*
- ✓ **On-Call Coverage:** *What physicians share your call- group?*

**B. Curriculum Vitae** - A *current* CV is required

**C. Two Letters of Recommendation** - It is preferable that the Letters of Recommendation be provided by already-contracted providers

**Only complete packets of information will be presented to the Membership Committee.** Incomplete packets will be held until all information has been submitted. Once we receive complete information, you will be notified of the Committee's decision within 45 days. Completed information should be mailed or faxed to:

**Pacific Partners Management Services, Inc.**
**Attn: Provider Services**
**P.O. Box 5860, San Mateo, CA 94402**
**(650) 577-1464**

## 27. Panel Closure

- Upon the acceptance of at least two hundred fifty (250) enrollees, PPMSI providers may close their practice to new enrollees by providing PPMSI with at least **ninety (90) days** written notice prior to such closing.
- During this ninety (90) day period, providers must monitor, coordinate, approve and manage all of the covered services received by new enrollees and must verify enrollee eligibility prior to providing services.
- If the provider determines it is medically necessary for an enrollee to receive covered services from another physician or health care provider, he/she should refer the enrollee to a PPMSI participating provider. All referrals should be approved by PPMSI.

NOTE: A closed panel applies to new members only. Providers with a closed panel must continue to provide services to active patients or patients already assigned to their panel regardless of their insurance coverage. A patient that converts from one insurance type to another (ex: Health Net to Blue Cross) is still considered an established patient and must be seen.

**Panel Closure Letter**

*<<This letter should appear on the physician's letterhead>>*

Date:

Pacific Partners Management Services, Inc.
ATTN: Provider Relations (Name of Group)

P.O. Box 5860, Foster City, CA 94402

Re: Request to Close Panel to New Patients

This letter serves as my 90-day notice to close my panel to new patients. I understand that this closure applies to my HMO patients.

I will continue to provide services to all members currently under my care regardless of their insurance coverage. This includes both active patients and patients assigned to my panel. I will continue to provide services to patients that have were previously assigned to me but have had changes in their healthcare insurance. Please call me with any questions.

Sincerely, John Doe, MD

# 28. PCP & Specialist Termination

**PCP Termination.** NCQA guidelines and Knox Keene regulations require that health plan members receive (90) ninety days notice of a physician termination. Members are assigned to PCP providers through their health plan. Once PPMSI receives a physician termination, this information is forwarded to the health plan so the members assigned to the terminating physician can be moved to an alternate provider. All health plans require ninety (90) days notice to contact members and to implement this physician change. However, each plan administers this request differently. Some keep the members with the physician (if they participate in multiple networks or move to an alternate group) while some keep the members with the group. See below for detail:

| Health Plan | Membership Management | |
|---|---|---|
| Aetna | | Stay with Aetna |
| Blue Cross | Stay with IPA | |
| Blue Shield | Stay with IPA | |
| CIGNA | | Stay with CIGNA |
| Health Net/ Seniority Plus | Stay with IPA | |
| PacifiCare/ Secure Horizons | Stay with IPA | |

Physicians must provide written notice of the intent to terminate the agreement with the medical group ***a minimum of ninety days (90) prior to the proposed date of termination.*** Upon the effective date of termination the physician shall continue to provide services under the terms of the agreement to members who require continuing care as determined by the PPMSI Medical Director.

**Specialist Termination.** NCQA guidelines and Knox Keene regulations require that members receive (90) ninety days notice of a physician termination. However, since members are not actually assigned to specialist physicians, this process is administered by PPMSI.

- PPMSI generates a letter to members that have received an authorization with a specialist in the last six months advising them of the specialist termination.
- Once the termination notice is received, the physician will be suppressed in the Access Express system and no additional authorizations will be generated.
- Any needs for continuing care are reported by the health plan member to his/her Primary Care Physician so that a new authorization can be generated or alternative arrangements can be made.

## 29. Sanction Policy

If a participating provider fails to comply with the referral and authorization procedures, one of the following actions may result:

- The referring provider may be financially responsible for services received by the member resulting from unauthorized referral to a non-participating provider.
- Coverage of the medical services provided may be denied if required prior authorization is not obtained. This may result in no payment for the services provided. If this occurs, the provider may not bill the member.
- Repeated failure to comply with referral and authorization procedures may result in termination of the Provider Agreement.

Prior to a sanction being imposed, a letter is sent to the provider explaining the basis for the action. The provider may respond with information justifying failure to follow procedure. The Provider is not accountable for member's failure to follow directions. In such cases, the member will be financially responsible, not the provider.

## 30. Continuity of Care

IPA members receiving care for an acute or serious condition from a PCP or Specialist who terminates from the IPA without cause may continue to be treated by the terminated provider or transitioned to a new provider. Senate Bill 1129 allows an IPA member to continue to be treated by his/her provider for up to 90 days in the case of treatment of an acute or chronic condition or until post-partum services are completed in the case of pregnancy. This period may be extended beyond 90 days if it is believed to be unsafe to transition the member to a new provider. Examples of acute or serious chronic conditions include, but are not limited to:

- Recent surgery with subsequent complications requiring ongoing home health services
- Outpatient critical cases in the process of stabilization
  (e.g., cancer patients receiving radiation, uncontrolled diabetics, etc.)
- Terminal illness cases
- High risk pregnancy
- Second/third trimester pregnancy

PPMSI Network Management staff will negotiate a written agreement with the terminated provider to provide continuity of care services for those members they have been treating. The agreement (e.g., reimbursement rates and payment terms) will be similar to what the provider was paid when he/she was part of the IPA.

**Continuity of care guidelines do not apply when the member's health plan offers free choice of providers (e.g., PPO or POS) or to providers who are terminated for cause.** Members seeing these providers will be transitioned to a new IPA/Medical Group or a new provider within the IPA.

## 31. Disease Management

IPA members are eligible for a number of chronic disease management programs through their health plans. The goal of these programs is to identify and treat patients early in the disease process to improve quality of life, reduce morbidity and mortality, and reduce costs. Diseases that respond to management include asthma, congestive heart failure, diabetes mellitus, and coronary artery disease. Usually members are contacted directly by the health plan if they are considered for one of these programs which include congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease and end stage renal disease. Health improvement programs include asthma, depression, diabetes, smoking cessation, coronary artery disease and heart failure. Case management referrals on a limited basis are available for seniors with mental or physical risk factors, and end of life and cancer care management.

The health plans and their pharmacy benefit managers closely follow prescriptions to reduce use of costly brand name drugs, promote generics, and monitor drug interactions – these reports go to PPMSI and its physicians to promote change in prescribing habits.

## 32. Case Management

Case Management is provided by PPMSI health professionals trained in the coordination, knowledge, and delivery of services to members with complex and expensive health care needs. Case Managers collaborate with physicians, patients, family members, employers, clergy, and community resources to streamline the patient's medical regime, minimize unnecessary medical and service complications, promote care in the least restrictive setting and facilitate efficient and appropriate care. As a patient advocate, the Case Manager:

- Coordinates patient care across an episode or continuum of care
- Ensures and facilitates the achievement of quality and clinical cost outcomes

- Negotiates, procures, and coordinates services and resources needed by the patient/family
- Intervenes at key points (and/or at significant variances) for individual patients
- In conjunction with the team of health care providers, address and resolve patterns in aggregate variances that have negative quality-cost impact (e.g., frequent use of emergency room)
- Creates opportunities and systems to enhance outcomes

Potential cases may be identified and referred to the Case Manager for screening through—

Diagnoses
Concurrent review
Direct referral by physician, family, hospital, home health agencies, community agencies
Repeat or multiple hospitalizations
Length of Stay
Clinical acuity status
Total health care charges
Frequent usage of emergency room or urgent care centers

Case management focuses on early identification of high-cost cases, reduced inpatient admissions and length of stay, and implementation of cost-effective traditional, or alternative treatment plans that cover the patient's health-care needs and facilitate the continuum of care. Alternative care options may include:

Outpatient services
Hospice, home health and non-acute facility care
Skilled nursing facility care
Sub-acute facility care
Inpatient and outpatient rehabilitation therapies
Inpatient and outpatient psychiatric and chemical dependency treatment
Transitional living center/community reentry programs
Board and Care, Assisted living and residential facility residences
Community resource agencies
Flexing of health care benefits to provide for non-medical alternatives

PPMSI Case Managers can be contacted by the member's physicians through the UM phone number.

## 33. Quality Improvement

PPMSI's quality improvement activities represent an ongoing continuous process of measurement, evaluation and improvement based on patient satisfaction, compliance with preventive health screening programs, and timely service for patients and physicians.

- PPMSI surveys its physicians and patients regarding multiple measures of satisfaction for a number of services provided. Results of these surveys are compiled and studied to develop processes or programs to solve difficulties or to improve service.

- PPMSI monitors and investigates complaints from patients, health plans or physicians regarding any quality of care issues. Input from both sides of a dispute are solicited and clinical care issues are then forwarded to the PPMSI Quality Improvement committee for discussion and review. A physician can be asked to respond to questions raised about quality of care issues. If significant problems or patient safety complaint is found, the Quality Improvement committee can forward recommendation for sanctions including restricting new patient assignment to physician, closing patient panel or termination from PPMSI.
- Notification from the Medical Board of California regarding actions of the board against physician or health care provider are investigated as well. Recommendations regarding continued patient care or membership in PPMSI would be made by the Quality Improvement committee to the Board of Directors.
- Quality Improvement efforts also include disseminating to PPMSI physicians guidelines for such clinical care items as flu immunization programs; promoting screening health programs such as mammography, pap tests, and colon cancer; plus advocating programs aimed at chronic diseases such as diabetes mellitus, asthma, or heart disease.

Employer and business groups as well as regulators have developed scorecards ranking health plans, hospitals and medical groups. These are primarily focused on patient satisfaction and compliance with preventive health screening initiatives. PPMSI quality improvement programs are guided by input from employer groups such as Pacific Business Group on Health, the California Cooperative Healthcare Reporting Initiative which collects data on health plans and providers, national organizations such as National Committee on Quality Assurance, HEDIS measures of related clinical standards, plus state and federal mandates.

## 34. Pay for Performance

*Pay for Performance* is a physician group quality initiative sponsored by the Integrated Healthcare Association (IHA), which includes representatives from California physician, consumer and purchaser groups, as well as most major commercial health plans—Aetna, Blue Cross, Blue Shield, CIGNA, Health Net and PacifiCare.

Beginning in 2003, these health plans began to use the results on common performance measures to design their own physician group bonus program.

- A single scorecard incorporating clinical measures, patient satisfaction and information technology is publicized for each physician group.
- Future health plan contracts will be designed to reflect scorecard results, with additional bonus funds paid to medical groups that achieve specific Pay for Performance goals.

The IPA would like to demonstrate the excellent care IPA physicians provide to members, so it will also monitor performance on these measures. Potential bonus distributions will be tied to performance on these measures.

**ALL physicians & staff must use the CPT & ICD-9 codes listed on pages 34-36 in ordering tests to receive credit for clinical measures.** For the IPA to qualify for the P4P bonus, PCP offices are asked to update *Access Express* to add missing P4P information, and to note patients with the conditions that exclude them from P4P requirements.

## How to Update Access Express Records with Pay for Performance Measures

The primary care office selects **Quality Measures,** a new **Support** section on the ***Access Express* Main Menu,** where the user will find a list of all patients for your office who lack specific P4P measures according to PPMSI records. The office then can print and research the list, and enter the measures missing from the system. Access Express entries will be transferred electronically to confidential online records to correct missing information and remove the member from the P4P followup file.

### *Pay for Performance Bonus Program Measures for 2004*

(revised measures are expected annually)

**A. Patient Satisfaction (40%)** is based on responses to satisfaction surveys sent to your patients by a state-wide vendor with questions in four areas (see page 36):

- Communication with the MDs
- Access to specialty care

It is important ALL staff understand *we are in a service industry* where courtesy, kindness and prompt physician access are important.

**B. Clinical measures (40%).** Specific measurements for each of these conditions are listed on page 34.

- **Asthma care:** Use the inhaled steroid recommended in each member health plan formulary. Member samples do not qualify.
- **Diabetes care:** Send patients to the contracted lab for Hemoglobin A1C (HbA1c) screening. Followup management required for out of range results.
- **Upper respiratory infections:** Do not prescribe antibiotics for children with colds.
- **Cholesterol Management:** Send patients to contracting lab for a LDL-C blood test screening.
- **Childhood immunizations** for children turning 2 are listed in the chart on page 35.
- **Annual mammograms:** Send women to contracted radiology services.
- **Pap test on all women between age 21 and 64**: **Use V76.2** as the specific code whenever you do a Pap test. The codes from PATH and LAB, (88141-88145, 88147. 88148, 88150, 88152-88155, 88164-88167) also count.

**C. Information Technology (20%).** Remaining payments are based on IT programs. Your staff will see *Access Express* reminders to encourage them to update our database and schedule the above tests required. Depending on your IPA's preference, relevant appointment reminders will be mailed to PCPs or to patients.

PACIFIC PARTNERS
MANAGEMENT SERVICES, INC.

## *Pay for Performance — Calendar 2004*
## *Clinical Measures — 40% of Bonus*

| *Condition* | *Measure Description* | *Action* |
|---|---|---|
| **Childhood Immunizations** | Percent of children turning two years old during 2004 who receive each of these immunizations:<br>· 4 DTaP or DT<br>· 3 IPV or OPV<br>· 1 MMR<br>· 3 H influenza type B<br>· 3 hepatitis B<br>· 1 chicken pox vaccine | **See "Immunization CPT/ICD-9 Table"** |
| **Asthma** | Percent of patients with persistent asthma who receive at least one dispensed prescription for inhaled corticosteroids or long-term suppressor drugs in 2004. Data will be reported for 3 groups:<br>5–9 year-olds, 10–17 year-olds, 18 – 56 year-olds | Rx for inhaled steroid or long-term suppressor drugs.<br>**(Giving member samples does not qualify as a prescription)** |
| **Upper Respiratory Infections** | Percent prescriptions written for antibiotics, for children diagnosed with a cold. | Antibiotics are not to be prescribed for children with colds |
| **Breast Cancer Screening** | Percent of women age 50–69 who have a mammogram in calendar 2003. | Requisition MUST include one of these ICD-9 codes: **87.36, 87.37, V76.11, V76.12 (Send to contracted radiologists)** |
| **Cervical Cancer Screening** | Percent of women age 18–64 who have a Pap test in 2003. | Requisition MUST include one of these ICD-9 codes: **91.46, V76.2, V76.47** |
| **Cholesterol Management** | Percent of patients age 18–75 with coronary artery disease: Lab: Lipid profile discharged alive by 12/31 for diabetics<br>· acute myocardial infarction (AMI),<br>· coronary artery bypass graft (CABG)<br>· percutaneous transluminal coronary angioplasty/ PTCA who have had evidence of LDL-C screening. | Lab: LDL-C Lipid profile screening **(Send to contracted labs)**<br>Patients with elevated values need management to improve test results. |
| **Diabetes** | Percent of patients age 18–75 with diabetes (Types 1 & 2) with evidence of Hemoglobin A1c screening. | Lab: Hemoglobin A1C (HbA1c) screening. Patients with elevated values need management to improve test results.<br>**(Send to contracted labs)** |

## *Pay for Performance — Calendar 2004*
## *Immunization CPT/ICD-9 Table*

| Immunization | CPT Codes | ICD-9-CM Codes |
|---|---|---|
| DTaP | **90700, 90701,** 90720, 90721, 90723 | 99.39 |
| Diphtheria and Tetanus | 90702 | |
| Diphtheria | 90719 | V02.4*, 032*, 9936 |
| Tetanus | 90703 | 037*, 99.38 |
| Pertussis | | Q33*, 99.37 |
| IPV/OPV | 90712, 90713, 90723 | V12.02*, 045*, 99.41 |
| MIMR | 90707, 90710 | 99.48 |
| Measles | 90705, 90708 | 055*, 99.45 |
| Mumps | 90704, 90709 | 072*, 99.46 |
| Rubella | 90706, 90708, 90709 | 056*, 99.47 |
| HiB | 90645, 90646, 90647, 90648, 90720, 90721, 90748 | 041.5, 038.41, 320.0, 482.2* |
| Hepatitis** | 90723, 90740, 90744, 90745, 90747, 90748 | V02.61*, 070.2*, 070.3* |
| VZV | 90710, 90716 | 052* |

* Indicates evidence of the disease. **If** a member has evidence of the disease during the numerator event time, the member should be considered compliant for the antigen.

** The 2 dose Hepatitis B antigen Recombivax is only recommended for children between the ages of 11 and 14.

**REFERENCE:**

**National Committee for Quality Assurance; HEDIS *2003 Volume 2***

***Technical Specifications* © 2002 by the National Committee for Quality Assurance.**

## *Pay for Performance — Calendar 2004*

### *Patient Satisfaction—40% of Bonus*

| Measure | Questions Sent to Members |
|---|---|
| **Physician Communication (10%)** | • How often did your doctor listen carefully to you?<br>• How often did your doctor explain things in a way you could understand?<br>• How often did your doctor spend enough time with you?<br>• How often did your personal doctor give you clear instructions about what to do to take care of health problems that were bothering you?<br>• When your doctor sent you for a blood test, x-ray, or other test, did someone from your doctor's office follow-up to give you the test results? |
| **Rating (10%)** | • Using any number from 0 to 10, where 0 is the worst personal doctor and 10 is the best personal doctor, what number would you use to rate your personal doctor? |
| **Specialty Care Referral Quality (10%)** | • What number would you use to rate the specialist you saw most? |
| **Timely Access (10%)** | • How often did you get an appointment for health care as soon as you wanted?<br>• When you called during regular office hours, how often did you get advice or the help you needed?<br>• When you needed care right away for an illness, injury or condition, how often did you get care as soon as you wanted?<br>• How often did you see the person you came to see within 15 minutes of your appointment time? |

# 35. Medi-Cal Programs

- **Child Health and Disability Program (CHDP).** CHDP is a public health program funded by federal and state funds. It provides for health assessments for the early detection and prevention of disease and disabilities in Medicaid children from birth through 21 years of age and for low-income children up to the age of 18 years and between a poverty level between 186-200%. All PCPs who provide CHDP services must complete an Information Only PM 160 form, which can be obtained by calling the local CHDP office.
- **California Children's Service (CCS).** The California Children's Services (CCS) covers children under 21 years of age who meet CCS residence and financial eligibility standards and is suspected of having a catastrophic or severely handicapping condition that may be ameliorated, arrested, improved or corrected. A child may be referred to CCS by a physician, public health nurse, teacher, parent, community agency or interested individual.
- **Child Abuse and Neglect.** Child abuse is a physical injury that is inflicted, by other than accidental means, on a child by another person. It also includes emotional abuse, sexual abuse (both sexual assault and sexual exploitation), neglect or abuse in home or out-of-home care, willful cruelty or unjustifiable punishment, unlawful corporal punishment or injury.

  Child abuse must be reported when one who is a legally mandated reporter has knowledge of or observes a child in his or her professional capacity, or within the scope of his or her employment, whom he or she knows or reasonably suspects has been the victim of child abuse. Reasonable suspicion occurs when it is objectively reasonable for a person to entertain such a suspicion based upon facts that could cause a reasonable person in a like position, drawing when appropriate on his or her training and experience, to suspect child abuse.
- **Family Planning and Other Sensitive Services.** Adolescents and adult members have the right to timely access to confidential and sensitive services without prior authorization from the health plan. Minors and adolescents also have the right to access sensitive services without parental consent. The member may self refer without prior authorization, including to out of network providers.
- **Comprehensive Perinatal Services Program.** This is a voluntary program available to any pregnant Medi-Cal patient. The program provides pregnant patients with comprehensive perinatal services during pregnancy and 60 days following delivery by or under the personal supervision of a physician approved to provide CPSP services.

# 36. Advance Directives

Advance Directives, known as the Patient Self-Determination Act (PSDA), is a federal statute, enacted as part of the 1990 Omnibus Budget Reconciliation Act (OBRA) (PL 101-508). The act requires health care providers to provide information on member's rights to formulate advance directives that impact decisions about his or her own health care. An advance directive is a formal document written in advance of an incapacitating illness or injury, in which members can assign decision-making for future medical treatment. In California this is legally recognized as the *Durable Power of Attorney for Health Care (DPAHC)* and the *Natural Death Act "Declaration"* as an advance directive for adults.

Members are encouraged to be active participants in decision making regarding their care. Adult persons with decision-making capacity have the right to accept or refuse any proposed medical treatment or procedure, including a life-sustaining procedure.

It is essential that providers become well-informed about advance directives and take an active role in assisting members to understand the benefits of these documents.

- Providers should encourage members to complete these documents and to provide them with written information using DPAHC or "Declaration" forms.
- Health care professionals have an obligation to provide members with sufficient information about their condition and about proposed medical procedures to make their consent or refusal meaningful.
- Complete documentation is essential whenever life-sustaining procedures are withheld or withdrawn and should include the following when indicated:
- The member's diagnosis and prognosis, including test results or other evidence forming the basis for the conclusions of the attending physician and the second, confirming physician.
- Whether or not the member is likely to regain mental function and the factors upon which the determination of the member's mental incapacity was based, when applicable.
- A statement that the member or surrogate has been fully informed of the facts and the consequences of withholding or withdrawing life-sustaining procedures and that the surrogate decision-maker has consented to the withholding or withdrawing of such procedures.
- A copy of any Durable Power of Attorney Health Care, Declaration or non-statutory living must be signed by the member and kept with his or her medical records.
- Any desires expressed by the member, a description of any discussions with family members or other surrogate.
- A copy of a certified letter of guardianship or conservatorship, when applicable.
- Clear written orders to withhold or withdraw specific medical procedures.
- If the PSDA has expired, the enrollee must invoke the proper procedure for instituting a current PSDA.
- Out-of-state PSDA must comply with the same conditions as those of the State of California.
- No enrollee will be required to execute an Advance Directive or otherwise be discriminated against based on whether or not an Advance Directive has been executed

# 37. Cultural and Linguistic Services

In accordance with Title VI of the Civil Rights Act of 1964, health plans and delegated medical groups and IPA's must have a 24-hour telephonic interpreter services system available to ensure that members with impaired sensory, manual, or speaking skills have access to interpreter services. These services may be available through the health plan or through the medical group or IPA (e.g., member services staff, telephone company TDD services, etc.)

Member requests or refusal of interpreter services must be documented in the member's medical record. Friends or family members may only be used as an interpreter when requested by the member. For discussion of complex medical conditions and treatment options, the member may request telephonic or face-to-face interpreter services.

Educational material in English and other threshold languages are available to the provider offices. Order forms can be obtained from the IPA, medical group or health plan. Provider office staff should contact Provider or Member Services to obtain the order forms. Health plan specific information on interpreter services will be published in the physician newsletter.

# 38. Senior Services

**Toll-free Senior Help Desk, Monday – Friday 1-877-722-4726**

Patients who are newly eligible for Medicare or transferring from a Medicare supplement are encouraged to call this number with questions about IPA participation in Medicare+Choice health plans. In 2004, with some geographic limitations, IPA physicians participate in Health Net Seniority Plus and PacifiCare Secure Horizons.

# 39. Maternity Length of Stay

The member's Ob/Gyn should notify his/her maternity patient that she has the right to remain in the hospital for up to two days after a vaginal delivery and up to four days following a C-Section delivery. The following letter may be used to document your discussion with the patient.

**A Message From Your Doctor About**
**Length of Hospital Stay for Maternity Care**

Dear Maternity Patient,

Your health plan and I want you to be informed about your rights, under a new California State Law which became effective January 1, 1998, concerning the length of your stay in the hospital following delivery of your baby. Under Section 1376 of the California Health and Safety Code, your health plan cannot restrict coverage for inpatient hospital care to a time period less than 48 hours following a normal vaginal delivery or 96 hours following a delivery by caesarean section

However, coverage for inpatient hospital care may be for a time period less than 48 or 96 hours if both of the following conditions are met:

The decision to discharge you and your baby before the 48- or 96-hour time period is made by your physician, in consultation with you, and

Your plan covers and offers a follow up visit for you and your baby within 48 hours of discharge, when prescribed by your treating physician.

If offered, the follow-up visit must be provided by a licensed health care provider whose scope of practice includes postpartum care and newborn care. The visit must include physical assessments of both you and the baby as well as parent education, plus assistance and training in breast or bottle feeding. As your treating physician, I must tell you about the availability of a post discharge visit which may be an in-home visit by me, a physician or a qualified nurse or a visit in the physician's office visit or at a health plan facility. I will determine, in consultation with you, whether the post discharge visit should occur at your home, the plan's facility, or the physician's office. To determine this, I must assess certain factors to include the transportation needs of your family, and environmental and social risks.

We will be discussing these options during your prenatal care and at the time of delivery. Meanwhile, I will be happy to answer any questions you may have about your care. You may also call your health plan's Member Services Department with questions about your coverage.

Received by patient:_____

Patient's signature Date: