Provider Manual

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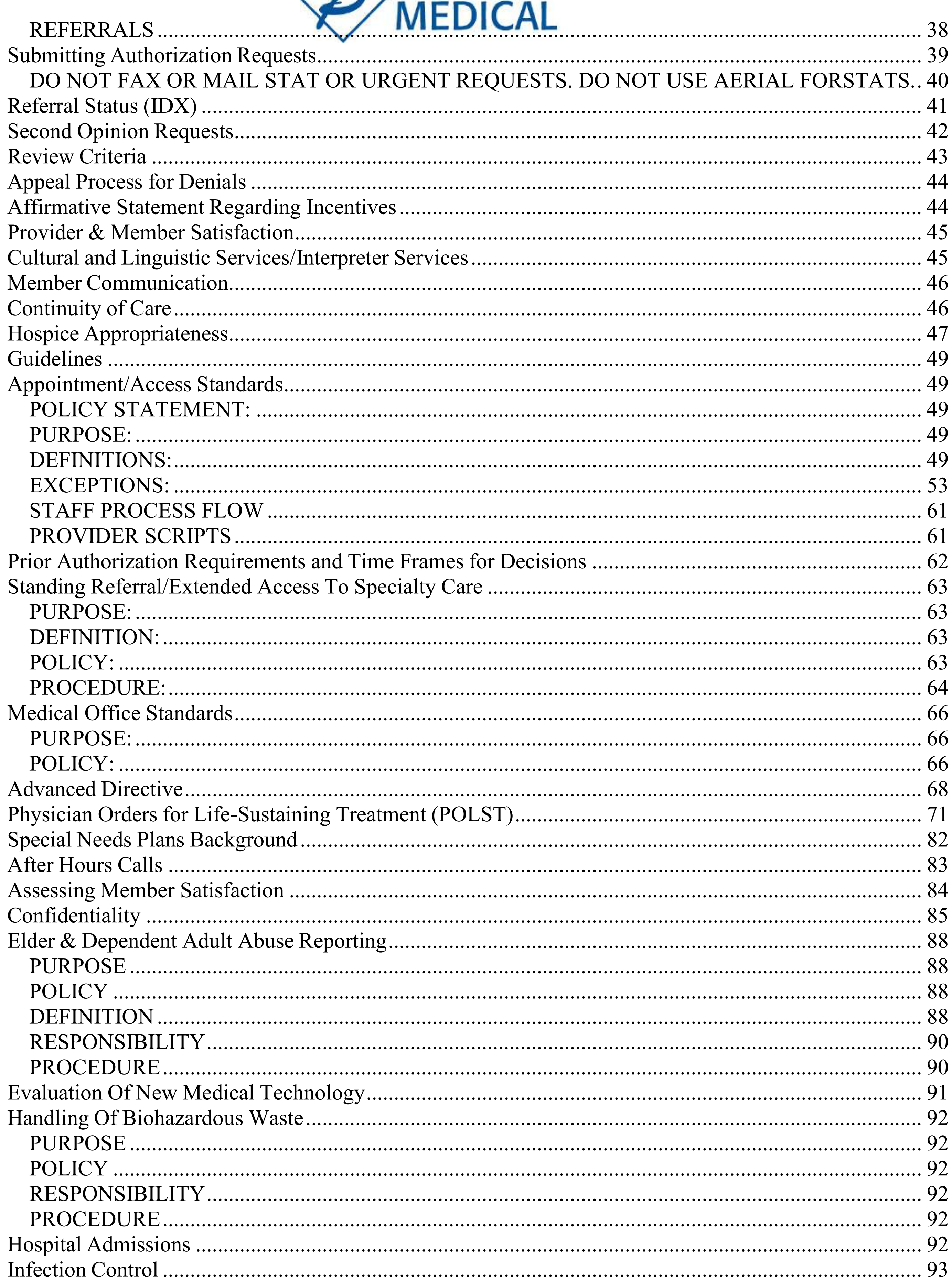

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Attached to the manual are the two reference guides – Adult and Pediatric provider reference guide. The reference guide can help the provider better understand the specifications for quality measures used to address care gap opportunities, as well as how to report data and what billing codes to use. 141
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How to Reach Us

Prospect Medical Main Toll Free Number: (855) 515-2408 **www.prospectmedical.com**

Press 1 for Providers – Providers Services	**Press 2 for Members – Members Services**
• STAT LINE press 1 • Hospital admissions press 2 • DME, Injectables, Chemo Therapy or Home Infusion Medications press 3 • HICM press 4 • All other inquires press 5	

Cozeva (Online web portal to track patient's quality measures for HCC, P4P, STAR & HEDIS Programs) To obtain a login and password, please call our Cozeva support team.

Via Cozeva: https://corp.cozeva.com

Via Phone: Cozeva Support: (877) 862-7047 or Performance Team: (714) 796-4205

Via Fax: (714) 560-5295 (to fax in P4P Correction Forms)

Via e-mail**: paid4performance@prospectmedical.com

Aerial Care

As a reminder, **Claim, Eligibility and Referral Status can be obtained on our physician portal**, ***Aerial Care***. Utilizing Aerial Care will help reduce wait times for your office. For Aerial Care setup contact Network Management.

Via Phone: Prospect Medical Group and Subsidiaries: (800) 708-3230, prompt 1, prompt 7

Via Website: HYPERLINK "http://www.prospectmedical.com/"www.prospectmedical.com, For Providers, Provider Login (Aerial Care)

Claims & Encounter Data Submissions

Via Clearing House: www.officeally.com
Office Ally Payor ID: **PROSP**
(866) 575-4120

Via Mail: Prospect Medical
P.O Box 11466
Santa Ana, CA 92711-1466
Attn: Claims Department

Via Aerial (for status only): www.prospectmedical.com, under For Providers, Provider Login

*****Please Note: Do not submit any information via email that would contain Protected Health Information (PHI) as outlined by the HIPAA Privacy Act.***

<u>Contracting</u> (Adding New Providers, Amending Contracts, Demographic Changes, Letters of Interest, Tax ID Change, Terminating Providers)

Via Mail: Prospect Medical
P.O Box 11466
Santa Ana, CA 92711-1466
Attn: Contracting Department

Via Fax: (714) 560-7399

<u>Customer Service Department</u> (Members, Providers, Health Plans, Claims Status, Eligibility Status, Referral Status)

Via Phone: Prospect: (800) 708-3230, prompt 1, select appropriate prompt

Via Fax: (714) 560-5252

Via e-mail**: provider.services@prospectmedical.com

<u>Eligibility Department</u> (Submit copy of health plan eligibility print screen, health plan id#, member's first name, last name and DOB)

Via Fax: (714) 560-5270

<u>HCC Risk Adjustment Department</u>

Via Phone: (714) 796-4277

Via Fax: (714) 560-5299

Via e-mail**: risk.adjustment@prospectmedical.com

<u>Network Management Department</u> (Aerial Care Set-Up & Troubleshooting, Contracting Issues, Compliance Attestations, Credentialing/Health Plan ID Questions, Membership Issues, Provider Office Orientations & Training)

The primary liaison between Prospect Medical and your office is the Network Management Department. We have representatives available to answer your questions between the hours of 9:00am and 6:00pm MST, Monday through Friday.

Via Phone: Prospect: (800) 708-3230, select appropriate prompt

Via Fax: (714) 560-7613

Via e-mail**: providerinfo@prospectmedical.com

<u>P4P Department</u>

Via Phone: (714) 796-4205

Via Fax: (714) 560-5295

Via e-mail **: p4p@prospectmedical.com

*****Please Note: Do not submit any information via email that would contain Protected Health Information (PHI) as outlined by the HIPAA Privacy Act.***

<u>Provider Disputes</u> (Claim, Enrollee, Reimbursement or Other Discrepancy)

Via Phone: (714) 347-5868

Via Mail: Prospect Medical
P.O Box 11466
Santa Ana, CA 92711-1466
Attn: Provider Disputes Department

Via e-mail **: providerdisputes@prospectmedical.com

Please Note: Do not submit any information via email that would contain Protected Health Information (PHI) as outlined by the HIPAA Privacy Act.

Welcome to the Prospect Medical Network!

As a physician participating with Prospect Medical you will benefit from the large expertise that comes from Prospect Medical services which handles 28 owned or managed Independent Physician Associations in California, Texas and other States. Prospect Medical has over 850,000 members and has been in business for over 30 years.

Prospect Medical is designed around providing quality service to our physicians, we hope this manual assists you with guidelines to expedite the managed care process. If you have any questions or suggestions, we want to hear from you! We are available from 9:00 am –6:00 pm MST, Monday through Friday.

Yours in health,

Network Management
Prospect Medical Systems

Prospect Compliance Program

PMG AZ has established a comprehensive Compliance Program that is consistent with the Federal Sentencing Guidelines as outlined by the OIG (Office of the Inspector General). Prospect's Compliance Program, established by its Board of Directors, consists of the Code of Conduct, the Compliance Program and various policies and procedures related to general compliance, fraud, waste and abuse, and privacy issues. The Compliance Program represents Prospect's commitment to high standards of conduct. In the event that Prospect becomes aware of non-compliance with the policies of the Compliance Program, Prospect will investigate, take disciplinary action when needed, and implement corrective actions to prevent future occurrences. The Compliance Program, which is under the leadership of the Chief Compliance Officer and the Prospect compliance committee consisting of senior management, demonstrates commitment to comply with federal, state, and local laws and to conduct our business in an ethical manner.

Privacy

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that requires all Covered Entities, including Prospect's providers, to protect the security and privacy of its members' Protected Health Information (PHI) and to provide its members with certain privacy rights, including the right to file a privacy complaint.

Prospect supports the efforts of its providers to comply with HIPAA requirements. Because patient information is critical to carrying out health care operations and payment, Prospect and its providers need to work together to comply with HIPAA requirements in terms of protecting patient privacy rights, safeguarding PHI and providing patients with access to their own PHI upon request.

In the event that PHI is improperly accessed, disclosed, transmitted, or handled, you must take immediate action to minimize the negative impact to the patient, and to notify Prospect's Compliance Department so that we can take prompt actions to address the incident in accordance with relevant Federal and State laws.

Fraud, Waste, and Abuse (FWA)

The government has increased investigations of fraudulent activities in health care, with respect to both providers and beneficiaries. State and federal authorities have prosecuted numerous healthcare providers for various fraudulent practices, and also mandated health care entities to establish anti-fraud programs.

Following this mandate and resultant industry trends, Prospect's Compliance Program contains policies and practices designed to detect and investigate incidents of fraud and abuse. Such policies include disclosure of such instances to health plans and government agencies or contractors, as appropriate. As a health care provider, your diligence and cooperation is critical to the effectiveness of our anti-fraud and abuse efforts.

Health care fraud includes, but is not limited to, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit. Thus, any intentional deception or misrepresentation that a provider, member, employee, supplier, or other entity makes knowing

that such action could result in an unauthorized payment, benefit, denial, or other illegal action would be classified as health care fraud. Other examples of health care fraud include overutilization of items and services, fraud in applications for health care benefits for beneficiaries, doctor shopping and identity theft.

If you have any questions or concerns related to compliance, privacy, or FWA, please contact Prospect's Compliance Officer at Compliance@prospectmedical.com.

Alternatively, you can report any issue (such as violations of the law or Prospect policies, conflict of interest, theft or fraud, unethical or improper dealings with members, vendors, or patients, etc.) by calling the **Compliance Hotline at 877-888-0002**. The Hotline is open 24 hours a day, 7 days a week and is operated by an independent company. Callers may remain anonymous and translators are available.

Please be assured that Prospect will not retaliate against or take any adverse action against any individual or entity that reports a good-faith compliance complaint through the Compliance Officer, hotline or otherwise.

Urgent Care Centers

Prospect Medical is happy to provide Urgent Care Centers for patients to access emergent care after normal business hours. We offer locations throughout our service areas. Maricopa County. **If members have a life or limb threatening emergency, please direct them to the nearest Emergency Room or call 9-1-1.**

For a current list of our Urgent Care Centers, please visit our website at https://www.prospectmedical.com/services-locations/urgent-care.

Please encourage members to call the urgent care center before arriving, to confirm hours of operation and availability.

For additional information on Urgent Care Centers, please see the Medical Management Department section of this manual.

Network Management Department

The Network Management Department is responsible for the oversight of all its contracted providers. Our responsibilities include education and service for you and your staff regarding Prospect Medical's programs, policies and procedures. We also serve as your liaison between our internal departments and the health plan to better serve and manage our member's healthcare needs. In addition, we also provide resolution of provider issues, complaints and grievances, monitor provider compliance regarding contractual obligations, and acting as a liaison between your office and Prospect Medical. Network Managers also assist with physician development and membership growth activities.

Prospect Medical strives to consistently provide excellent customer service to our valued providers. To help monitor our success in this area, the Network Management Department conducts regular Provider Satisfaction Surveys to all contracted providers. Details concerning the Provider Satisfaction Survey and a copy of the survey itself can be found under ***Provider Satisfaction Survey*** section in this manual.

Provider Education

It is the responsibility of the Network Management Department to ensure a complete understanding of Prospect Medical's policies and procedures. Topics include but are not limited to access standards, hospitalist coverage, eligibility, referral process, proper submission of claims and encounter data, laboratory and urgent care protocols, online tools and company initiatives.

Annual and ongoing provider education will be provided to our contracted providers to ensure provider compliance to its contractual obligations via one or all of the following formats.

- Office Manager Meetings: annual office manager meetings to update the provider staff of any new issues and review current policies and programs.

- Workshop/Training

- Provider Communication: Communicate to providers topics of managed health care issues, health plan and other regulatory agency requirements, Prospect Medical's policies and procedures as well as other pertinent administrative information. If you prefer to receive provider communication via electronic mail, please contact Network Management and provide us with your e-mail address or e-mail us directly at providerinfo@prospectmedical.com.

Provider and Staff Training

It is Prospect Medical's policy to provide training for the below mentioned programs to its contracted providers. **Training is a required part of participation with Prospect Medical.** It is the provider's responsibility for training his/her own staff members in the office on all applicable training requirements. **If training is not completed in a timely manner the provider contract may be terminated for breach of contract.**

Most training modules are available via our website at www.prospectmedical.com under For Providers, Provider Trainings. Resources include health plan sponsored trainings, website links, lectures, seminars, PowerPoint presentations and PDF files. Additionally, Network Managers or Network Management Staff will facilitate these sessions and obtain the appropriate attestations from providers.

The Network Management Department will forward the information regarding upcoming trainings, lectures and seminar to its contracted network via Provider Bulletins, education during provider visits and telephonic reminders. (Attachment: Training Programs Attestation)

- All Health Plan Required Trainings – may require review of training material and attestation directly on health plan's website. We also provide some training material on our website and provide the health plan specific training attestations required by some health plans. **Where applicable, please submit directly to the health plan, and send a copy of your attestation to Prospect Medical for audit and compliance purposes.**
- Chronic Care Improvement Program
- Special Needs Plan – Model of Care
- Serving Seniors and Persons with Disabilities
- HIPAA Privacy, Breach Notification and Compliance
- Cultural & Linguistic Sensitivity
- Fraud, Waste & Abuse
- Office of Inspector General

Training attestations may be submitted:
- Online at www.prospectmedical.com under For Providers/Provider Training section,
- E-mail to providerinfo@prospectmedical.com,
- Fax to (714) 560-7613,
- Mail to Prospect Medical P.O. Box 11466, Santa Ana, CA 92711-1466, Attention: Network Management Department.

Marketing Guidelines

Providers are reminded of contractual obligations to adhere to regulatory agency requirements for all activities, including marketing activities. For guidance and direction, refer to the CMS website at: www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing

Provider Information Request Changes

We strive to maintain the most current information on file for all contracted providers. It is the responsibility of the provider to notify Prospect Medical of any changes to their office that may impact members, payments or your participation with Prospect Medical.

If there is any change to one of the following, **you must notify the Network Management Department in writing within <u>120-days prior</u> to the effective date** unless otherwise indicated per your contract, so that we may notify our affiliated Health Plans as required by our contracts with the plans.

These changes may include but are not limited to:

- Change of Provider Name, Provider Group Name, Facility or Clinic Name Change
- Change of Address, Addition of New Location, Removal of Location
- Change of Phone or Fax Number, Addition or Removal of Phone or Fax Number
- Change of E-mail address or addition or removal of e-mail address.
- Change in Access/Availability
- Change of Office Hours, Addition or Removal of Office Hours/Days Office is open
- Change in Language(s) Spoken by the Physician and Office Staff
- Change of Hospital Affiliation or Admitting Privileges
- Change of Tax ID Number
- Change of National Provider Identifier Number
- Change in Panel Status, addition of panel restrictions or panel status
- Change in Age Restriction
- Change in IPA Affiliation
- Change in Provider(s) in the Practice
- Change in License number and type of license
- Change in Specialty and or Board Certification

Your written notice on letterhead (and a copy of your W-9 form if your Tax ID, Address or Name of Practice has changed) may be faxed to Provider Contracting at (714) 560-7399 or mailed to the Prospect Medical P.O. Box 11466, Santa Ana, CA 92711-1466, Attention: Contracting Department. ADD OOS EMAIL

Panel Status Changes

Providers requesting to close their panel to new and/or existing members must submit their request in writing to the Contracting Department 90-days prior to the effective date. Physicians may not close their panel to specific health plans or lines of business and must have closed-panel with all affiliated IPAs.

Please note that the health plans allow certain exceptions to panel closures:

- If an existing member changes their health plan and your panel is closed to new members only, the plan will allow the member to be assigned to your panel.

- If an existing member changes their health plan and your panel is closed to existing members, the plan will not allow the member to be assigned into your panel.

Requests will be reviewed by Prospect Medical's Committee and will be approved or denied at the discretion of Prospect Medical.

Age Restrictions

Providers requesting to age restrict their panel must submit their request in writing to the Contracting Department 90-days prior to the effective date. Physicians must state the reason for their change in panel.

Member Billing

Primary Care Physician

Primary Care Physicians shall accept their capitation as payment in full for services provided to members, plus any applicable co-payment. In accordance with your contract, Primary Care Physician shall not seek any other payment or surcharge from a member for covered services under any circumstances, including but not limited to the event of Prospect Medical's or any affiliated health plan's insolvency or Prospect Medical's nonpayment to Primary Care Physician, except as may be expressly provided in the agreement between the member and the plan.

Specialty Care Physician

Specialty Care Physicians shall accept their fees computed in accordance with their signed agreement with Prospect Medical as payment in full for services provided to members, plus any applicable co-payment. In accordance with your contract, Specialty Care Physicians shall not seek any other payment or surcharge from a member for covered services under any circumstances, including but not limited to the event of Prospect Medical's or any affiliated health plan's insolvency or Prospect Medical's nonpayment to Specialty Care Physician, except as may be expressly provided in the agreement between the member and the plan.

Specialty Care Physician may not bill a Prospect Medical member for services not authorized prior to services being rendered or for claims not billed properly and/or denied for untimely filing.

If Prospect Medical or the member's health plan receives notice of any such surcharge by a Primary Care Physician or Specialty Care Provider, Prospect Medical shall take whatever appropriate action necessary to assist the affected member(s) in obtaining restitution and to prevent a recurrence including but not limited to terminating the physician agreement for material breach. Any such termination shall not be deemed subject to cure unless otherwise determined by the sole discretion of Prospect Medical.

If a member wishes to obtain services that are not covered under their benefit plan, the member must sign the Out-of-Network Certification form (see Out of Network Certification Form in attachment section). In addition, you must specify which services the member will be receiving and by signature indicate that the member fully accepts to pay these services.

Failure to comply with these regulations would be a Material Breach of your agreement with Prospect Medical.

Provider Grievances

A provider may file a grievance by calling or writing to the Quality Management Department. Provider may also fax a grievance or appeal directly to the Quality Management Department to fax: (714) 560-7336. Providers may also contact the member's health plan. A Network Management staff member may be asked to work with the provider and any other party involved to resolve the issue in a timely manner.

Provider Satisfaction Survey

Prospect Medical strives to consistently provide excellent customer service to our valued providers. To help monitor our success in this area, the Network Management Department conducts regular Provider Satisfaction Surveys to all contracted providers. It is instrumental that physicians take a moment to complete the survey and provide feedback on ways to improve our service. It is also important to provide positive feedback as it assists in validating policies and procedures currently in place.

The Provider Satisfaction Survey assesses the level of satisfaction within Prospect Medical's key areas including our Specialty Network, Laboratory, Referrals & Authorizations, Case Management, Coding Programs, Rewards Programs, Claims & Capitation and Service.

Providers may submit a survey at any time.

1. **Respond by phone:**
    - You may call our Network Management Department at (800) 708-3230, prompt 1 then prompt 7. We will gladly assist you during our hours of operation, Monday-Friday 9 A.M. to 6 P.M. MST.

2. **Respond by fax:**
    - You may fax in your survey to (714) 560-7613

3. **Respond by mail:**
    - You may complete and mail your survey to:

Prospect Medical
Attn: Network Management Department
600 City Parkway West Suite 800
Orange, CA 92868

600 City Parkway West Suite 800
Orange, CA 92868
800-708-3230
www.prospectmedicalsystems.com

Survey Code(State License #): ________

Please rate the service you have received in the elements listed below

SPECIALTY NETWORK	1 Extremely Unsatisfied	2 Unsatisfied	3 Neither Satisfied nor Unsatisfied	4 Satisfied	5 Extremely Satisfied
Overall satisfaction with specialist panel.	☐	☐	☐	☐	☐
Coordination of care between specialist & PCP	☐	☐	☐	☐	☐
Necessary records being received timely	☐	☐	☐	☐	☐
Thorough requests and referral follow-up	☐	☐	☐	☐	☐
Patients being seen in a timely manner	☐	☐	☐	☐	☐

LABORATORY	1 Extremely Unsatisfied	2 Unsatisfied	3 Neither Satisfied nor Unsatisfied	4 Satisfied	5 Extremely Satisfied
Overall satisfaction with lab provider	☐	☐	☐	☐	☐
Ease of obtaining lab results	☐	☐	☐	☐	☐
Specimen handling/results turn-around-time	☐	☐	☐	☐	☐

REFERRALS & AUTHORIZATIONS	1 Extremely Unsatisfied	2 Unsatisfied	3 Neither Satisfied nor Unsatisfied	4 Satisfied	5 Extremely Satisfied
STAT Line answered promptly	☐	☐	☐	☐	☐
Referral turn-around-time within 5 business days	☐	☐	☐	☐	☐
Ease and clarity of authorization process from IPA Staff	☐	☐	☐	☐	☐
Calls handled courteously and responsively	☐	☐	☐	☐	☐

CASE MANAGEMENT PROGRAM Prospect360 (P360)	1 Extremely Unsatisfied	2 Unsatisfied	3 Neither Satisfied nor Unsatisfied	4 Satisfied	5 Extremely Satisfied
Overall satisfaction with P360 Programs (if applicable)	☐	☐	☐	☐	☐
Ease and responsiveness referring patients to P360 Program	☐	☐	☐	☐	☐
Response and turn-around-time from Case Managers	☐	☐	☐	☐	☐
PCP discharge notification: Were you notified within 24 hours of your patient's discharge?	☐	☐	☐	☐	☐
PCP admission notification: Were you notified within 48 hours of your patient's admission?	☐	☐	☐	☐	☐
Did you schedule a face to face post discharge meeting in five (5) days and follow up within thirty (30) days with your member?	☐	☐	☐	☐	☐

CODING PROGRAM (IF APPLICABLE)	1 Extremely Unsatisfied	2 Unsatisfied	3 Neither Satisfied nor Unsatisfied	4 Satisfied	5 Extremely Satisfied
Overall satisfaction with program/processes	☐	☐	☐	☐	☐
Annual Wellness Assessment summary accurately reflects patient status/condition	☐	☐	☐	☐	☐

600 City Parkway West Suite 800
Orange, CA 92868
800-708-3230
www.prospectmedicalsystems.com

Survey Code(State License #): ________

Continued from Page 1

REWARDS PROGRAMS (P4P, HEDIS, STARS)	1 Extremely Unsatisfied	2 Unsatisfied	3 Neither Satisfied nor Unsatisfied	4 Satisfied	5 Extremely Satisfied
Access to reports	☐	☐	☐	☐	☐
Satisfaction with user-friendliness of reports	☐	☐	☐	☐	☐
Preventative services scheduling assistance	☐	☐	☐	☐	☐

CLAIMS AND CAPITATION	1 Extremely Unsatisfied	2 Unsatisfied	3 Neither Satisfied nor Unsatisfied	4 Satisfied	5 Extremely Satisfied
Promptness of claims payment	☐	☐	☐	☐	☐
Clarity of Remittance Advice Summary (RA)	☐	☐	☐	☐	☐
Accuracy of Payments	☐	☐	☐	☐	☐

SERVICE	1 Extremely Unsatisfied	2 Unsatisfied	3 Neither Satisfied nor Unsatisfied	4 Satisfied	5 Extremely Satisfied
Customer Service Department Responsiveness	☐	☐	☐	☐	☐
Resolution Provided during initial call	☐	☐	☐	☐	☐
Satisfaction with assigned Network Manager (if applicable)	☐	☐	☐	☐	☐
Overall satisfaction with Prospect Medical	☐	☐	☐	☐	☐

Comments/Questions/Suggestions:

If you would like to leave additional details, have questions, or would like to discuss your comments or suggestions, please leave your name and phone number and a Network Management representative will contact you.

Name (optional):________________________ Phone:________________

Role within the office/title:________________________ Date:________________

Please Respond By:

Phone: (800) 708-3230, prompt 1 then prompt 7
Fax: (714) 560-7613
Mail to: Prospect Medical – Network Management
600 City Parkway West, Suite 800
Orange, CA 92868

Medical Records

Providers are required to establish and maintain a historical record of diagnostic and therapeutic services recommended, provided or under the direction of the provider for all members. The record shall be structured in a form so that the nature and extent of the member's medical problem and the services provided are readily understood

Medical Records Retention

The member record must be available upon request for up to 10 years from the date that the member becomes ineligible from their healthcare insurance.

If the provider is involved in an audit or in verification, the records must be made available until the investigation or audit has been resolved.

Pediatric records shall be maintained until the member is 21 years of age.

Request for Medical Records

Provider must provide a copy of a member's medical record to another treating or consulting provider regardless of the provider's affiliation with Prospect Medical or if requested by Prospect Medical or any of its contracted health plans, at no charge to the member or requesting party.

For your convenience a request for medical records form may be found in the attachment section of this manual. (Attachment: Authorization for Use of Protected Health Information)

Provider Contracting

Prospect Medical requires all credentialed physicians obtain a current contract for services prior to receiving referrals. Prospect may, from time to time, require various amendments to your present agreement to remain compliant with CMS, State, Federal and Health Plan requirements. Any amendments sent to your office for review and signature must be returned in a timely manner.

It is a contract requirement that physicians covering for your office be credentialed and contracted with Prospect. If you have extenuating circumstances and are unable to gain coverage, please notify the Provider Contracting Department immediately to make alternate arrangements.

To help streamline the process of collecting updated information, Prospect will be contacting your office on a quarterly basis via fax or email. We request that you review the information Prospect has on record and verify its accuracy within 15 days of receipt.

Adding New Providers to Existing Group Contract

Provider offices requesting to add new physicians to their existing contract must notify the Provider Contracting Department. Please contact us if you wish to add a physician to your practice that will render services to Prospect Medical members.

Our affiliated health plans require that physicians must be contracted and credentialed before treating members. Therefore, non-contracted/non-credentialed providers are expressly prohibited from treating Prospect Medical members until they have been approved by the Credentialing Committee and have a fully executed contract or signed Memorandum of Understanding (MOU).

Requests to add providers to your contract may be done in writing by forwarding your request via fax to the Provider Contracting Department at714) 560-7399.provideroos@prospectmedical.com

Amending Existing Contract

Providers may request to amend their existing contract by contacting the Provider Contracting Department. Requests to amend your contract may be done in writing by forwarding your request via fax to the Contracting Department at (714) 560-7399.

Soliciting to Members

All providers are prohibited from directly or indirectly, either individually or on behalf of any person or entity other than Prospect Medical to:

- Advise any member to disenroll from Prospect Medical or any of its subsidiaries
- Solicit any member or member's employer to become enrolled with any other health maintenance organization, provider organization, or any other similar hospitalization or medical payment plan or insurance program

In addition, Primary Care Physician shall use best efforts to ensure that no employee, agent or independent contractor of Primary Care Physician makes any derogatory remarks regarding Prospect Medical to any member, member's employer, health plan or health maintenance organization.

This section is not intended to limit, in any way, the provider’s communication to member of appropriate options for medical care.

Provider Terminations

Any provider requesting to terminate their agreement with Prospect Medical or any of its subsidiaries must submit their request 120 days in advance, or per contract provision. Any provider failing to provide the required notification may be held liable for services rendered to patients by other providers during the termination period.

The notice must be faxed or mailed directly to the Provider Contracting Department.

- Faxed requested may be submitted by faxing to (714) 560-7399
- Mailed request should be mailed to:

  Prospect Medical
  ATTN: Provider Contracting Department
  P.O. Box 11466
  Santa Ana, CA 92711-1466

Health plans will not process termination requests from providers that are forwarded to them directly.

Network Management will visit the Primary Care office to issue an attestation form requiring your signature and confirmation of your termination with 7 calendar days.

Upon confirmation, Provider Contracting will process accordingly and the health plans will be notified.

Online Tools

Aerial Care

Go to www.prospectmedical.com, select Provider Login under For Providers section. If you do not have a user name and password, contact Network Management.

System Requirements:
To access Aerial Care, you must have the following applications on your computer:

- Internet Explorer or Google Chrome
- Adobe Reader (most current version): Available at no cost to you by downloading from http://www.adobe.com/products/reader/.

PROSPECT MEDICAL SYSTEMS

ABOUT US CAREERS CONTACT US

FOR PROVIDERS

HOME | FOR MEMBERS & GUESTS | FOR PROVIDERS | MANAGED SERVICES ORGANIZATION

FOR PROVIDERS
General
How to Join
Contact Provider Relations
Provider Training
Provider Satisfaction Survey
Provider Login (Aerial Care)

FOR PROVIDERS

Click Log-in, and then enter user name & password

Please log in.
User ID *
Password *
Password Help
LOG IN
Provider Cozeva Log In

Aerial Care Login

You may reset your own Aerial Care password by selecting Password Help

Cozeva Login hyperlink

aerial | medecision

Terms of Use Privacy Policy Contact Support

DASHBOARD OVERVIEW

Aerial - Physician's Neighborhood
Status Tabs
WELCOME
aerial
reporting eligibility referrals claims

Quick Links
Submit Online Referrals
View Referral Alerts
My Favorite Reports

ELIGIBILITY HIGHLIGHTS
Month September October
Member Count 107 107
150 100 50 0
Jun Aug Oct

ELIGIBILITY LOOKUP
Search for members by Last Name, First Name, Member Code, or SSN:
Go
Eligibility Look-Up
Or enter up to 5 Member Codes to check for eligibility:
Go
Eligible Ineligible Non-Existent

CASE HIGHLIGHTS
You do not have sufficient permissions to view this information.
Clinical Alerts

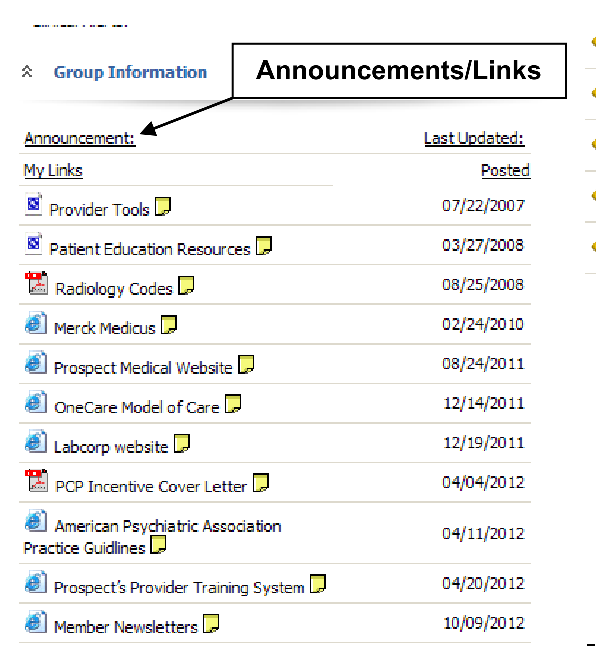
CLINICAL ALERTS
2013 Missing Senior Encounter - 2 / 14

GROUP INFORMATION
Announcement: Last Updated:
Software Updates are an important function that helps keep Aerial Care Coordination optimized and up-to-date to provide users with an enriched experience. We will be performing a Software Update to your production site on the following day and time: When: Friday, October 10, 2014. Time: 7:00PM-9:30PM What: Aerial Care Coordination will be installing a Software 10/03/2014

MY LINKS

The following resources located on the Dashboard under the My Links area:

- Annual Wellness Visit Reports
- Capitation Summary Reports
- Initial Health Assessment Reports
- Provider Tools
- Patient Education Resources
- Radiology Codes
- Merck Medicus
- Prospect Medical Website
- OneCare Model of Care
- American Psychiatric Association Practice Guide
- Prospect's Provider Training System
- Member Newsletters



VERIFY ELIGIBILITY

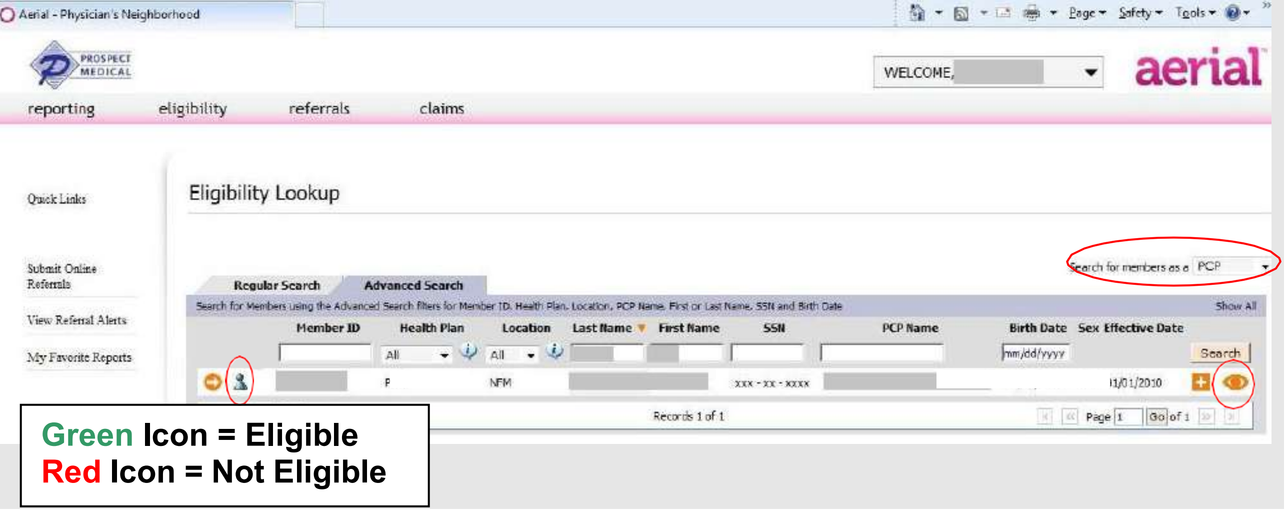
Eligibility status may be obtained by entering the ***Eligibility*** tab and select ***Eligibility Look Up***.

1. Enter the first 3 letters of the first name
2. Enter the first 3 letters of the last name
3. Enter Birth Date
4. **Submit**

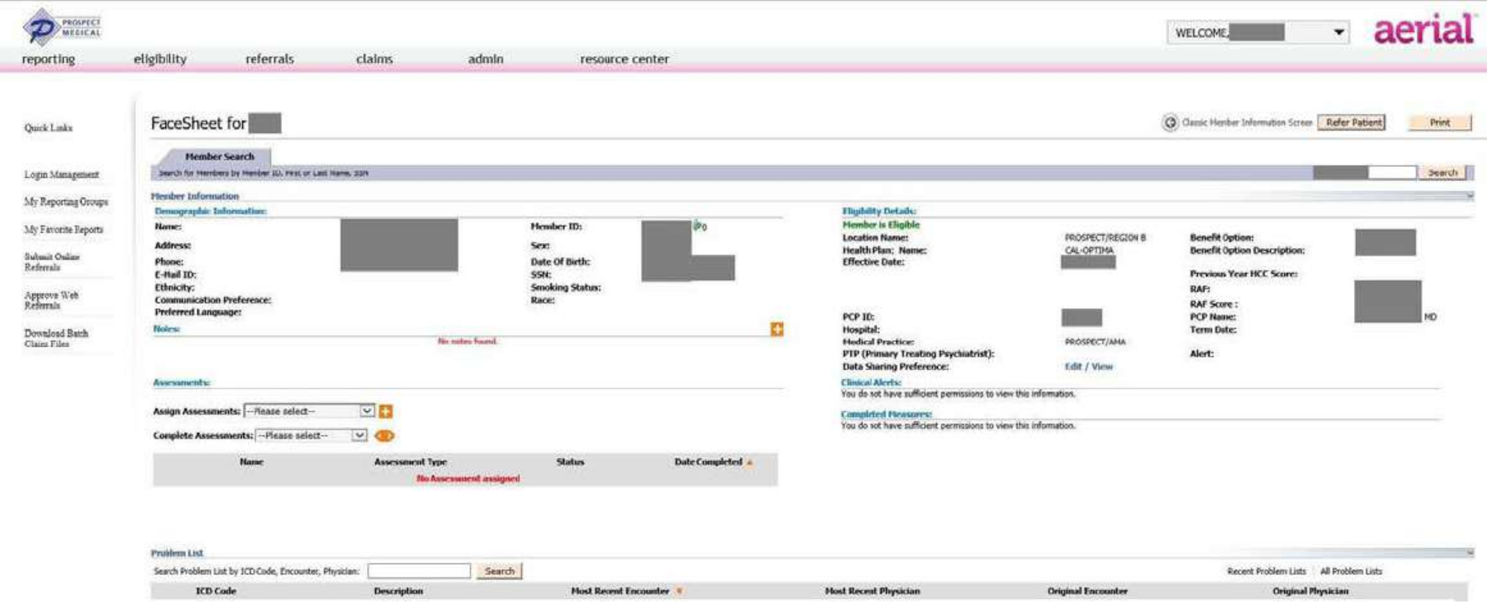
Select the member that matches your search criteria (date of birth, member id number, etc.).

Refrain from selecting or entering: Health Plan Code, Location, Member ID, SSN, or Provider ID. These fields are not required.

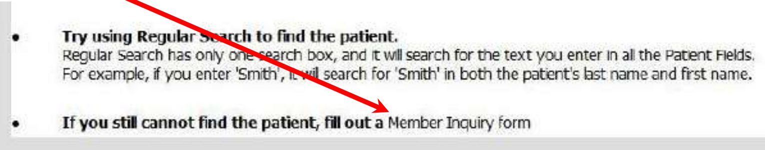
Member's information will appear.



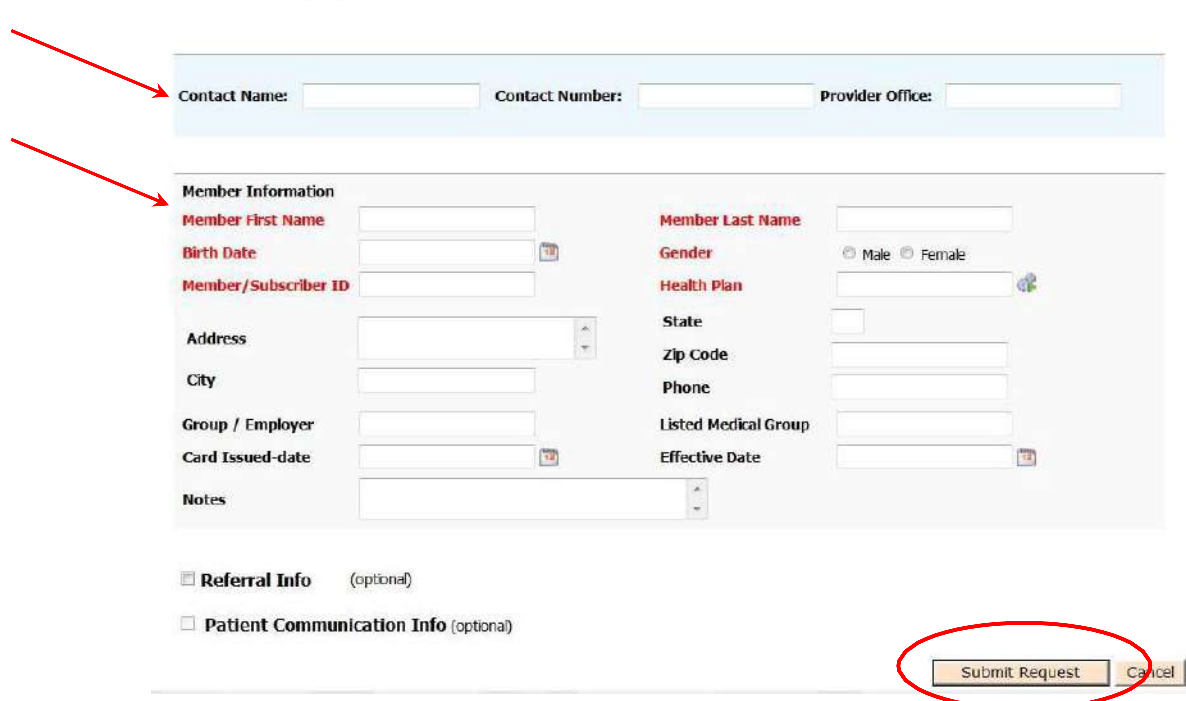
Clicking on the icon will open the member's file and provide you with eligibility details including member demographics, phone number, health plan ID number, date of birth, sex, IPA Name, effective date and PCP Name.



If “**Sorry, we could not find a match**” comes up, we do not have a member in our system that matches your search criteria. If you have confirmed eligibility at the health plan level and you have a current/valid health plan id card, but the member is not in our system, please fill out a **Member Inquiry form** found in the link embedded on the bottom of the page.



Fill out the required fields marked in **RED**. **Eligibility will be verified within 72 hours. All URGENT requests must be called in.**


Member Inquiry Form

Contact Name: Contact Number: Provider Office:

Member Information
Member First Name
Member Last Name
Birth Date
Gender Male Female
Member/Subscriber ID
Health Plan
Address
State
Zip Code
City
Phone
Group / Employer
Listed Medical Group
Card Issued-date
Effective Date
Notes

Referral Info (optional)

Patient Communication Info (optional)

Submit Request Cancel

Please check the Member Inquiry Task list under the Eligibility tab for status on Member Inquiry forms submitted.

- Requested – pending review by Eligibility Department
- Pending Action – pending information from provider or health plan
- Cancelled – member ineligible/request cancelled
- Completed – eligibility confirmed and entered into our system

Once member is entered into our system, please **allow 24-hours for Aerial Care to refresh** to view member information.

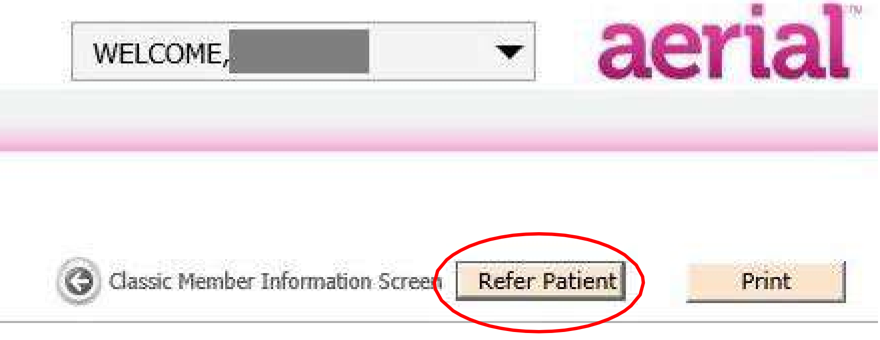
If you are having trouble with Aerial Care, please contact us! **Aerial Care Technical Support: (800) 708-3230, prompt 1, prompt 7 or e-mail ProviderInfo@prospectmedical.com**.

REFERRALS

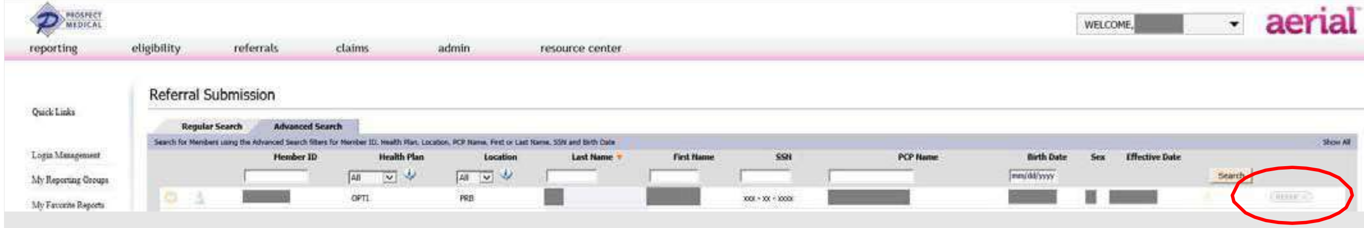
Referral Protocols

URGENT/STAT REFERRALS must be called in. Do not submit via Aerial Care.

- To submit a referral: Select the Refer Patient link after confirming member eligibility, directly from eligibility FaceSheet page or,



- Submit a referral from the Referral Online Submission tab after searching for member name – and selecting the Refer link.



Enter information, or select from the drop-down list, all the red fields which include Referring Provider Information, Referred Provider Information, Services, Service Units, ICD Code, and Clinical Symptoms/Findings. After completing all required fields, select the Submit Referral link.

Referral Submission

Member Information

Name:		**Birth Date:**		**Member ID:**	
Address:		**Age:**	29 yr(s)	**Health Plan:**	AETNA
		Gender:	Female	**PCP:**	
Phone:				**PCP Phone:**	

Referring Provider Information

Search by first or last name, or by ID: [ ] Find It

Referred Provider Information

Select the Referred Specialty: --- Specialty ---

Diagnosis Code Type: ○ ICD9 ◉ ICD10

Referral Details

Please note that the procedure, diagnosis codes and modifiers are date sensitive.
So any changes to the date will require that all the codes are entered again.

☐ **Retro Referral**

Click here to change Service Date: [ ] 12AM : 00

Priority: Routine

Place of Service: 11 - Office

Services **Modifier** **Service Units**

No modifier Add Next

ICD Code

Add Next

Clinical Symptoms/Findings:
Please make references to patient height, weight, history, labs and pertinent work up to date.

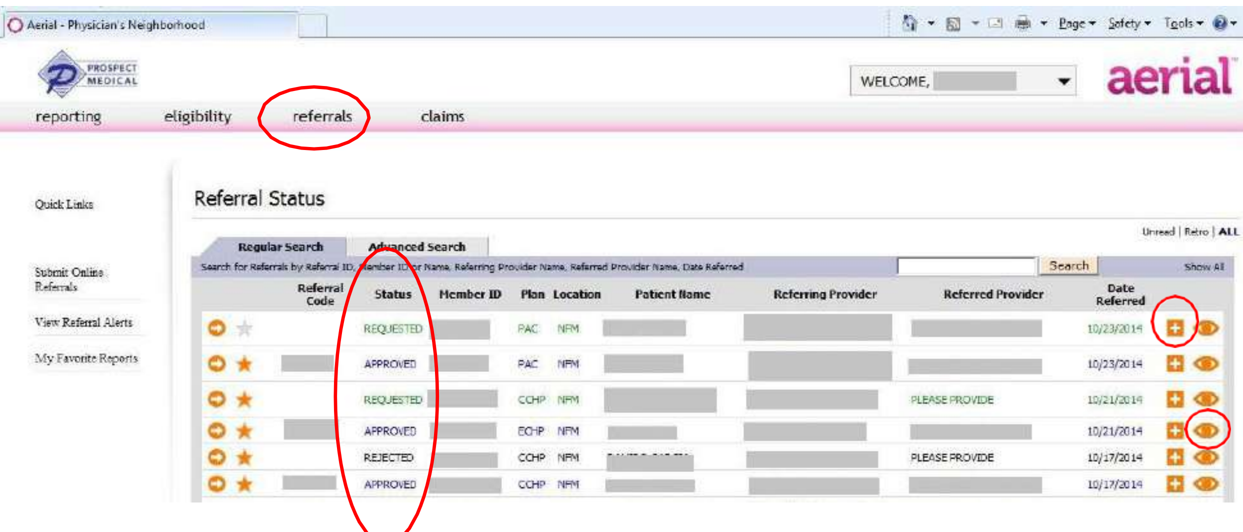
Treatment Plan:
Preferred Provider Comments.

Office Comments:

Submit Referral Cancel

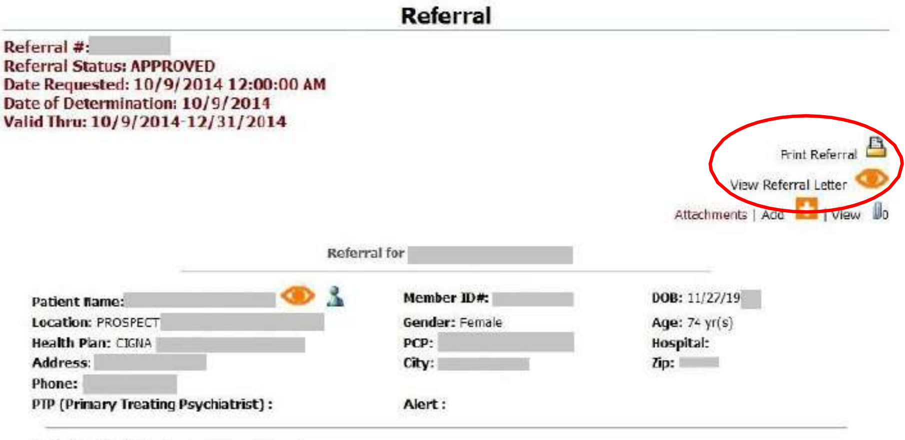
After submitting the referral request, verify the referral was submitted by checking the referral status page.

Attach supporting documentation such as medical records, clinical notes and lab results to the referral by selecting the sign to the requested referral.



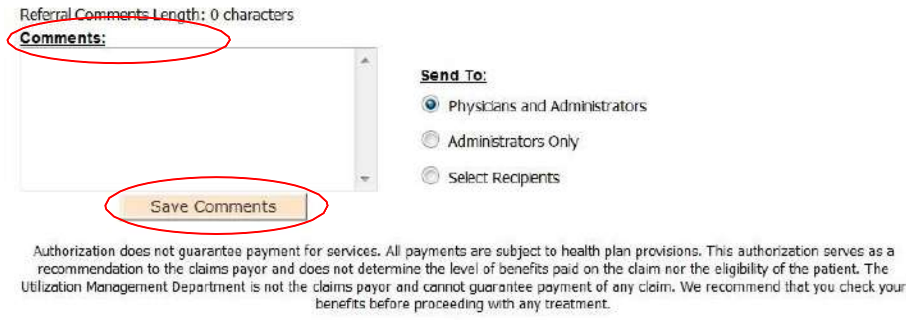
- Checking Referral Status: The status of the authorization request may be obtained by entering the Referrals tab. Referral status is in the Status column and referral will be either in the Requested, Approved or Rejected status. Click on the icon to the far right to obtain detail of referral. Contact Customer Service to obtain explanation of Rejected referrals.

- Printing a Referral: The physician office is able to print the referral by clicking on the icon to view referral detail. Click on the icon to print referral.



- Printing an Authorization Letter for a Patient: Click on the icon to view referral detail, click on icon to view the authorization letter. Click on icon to print authorization letter for patient.

- Modifying a Request: Click on the icon to view referral detail. Modification request can be made by entering the request in the Comments: box under Administrator Notes.



Type your request and click Save Comments tab.

The following can be requested:

- ➢ Extending the valid thru date (must verify patient is eligible on the date services are to be rendered)
- ➢ Adding or removing CPT or ICD-10 codes
- ➢ When entering the modification request, please ensure to add as much detail to assist Medical Management.
- ➢ Remember to Save Comments.

Request will be date and time stamped. The response from Medical Management may be viewed under Referral Alerts on dashboard within 5 business days.

- Legends: Legend of the health plan codes and location codes can be viewed by clicking on the icon in the Advance Search tab.

Auto-Approval Rules

Initial Consult Only: Only initial consultations are allowed on Direct Referral.

For non-capitated providers the range approved for initial consults are 99201-99203 and 99211-99213.

For capitated providers the range approved for initial consults are 99201-99215.

PLEASE NOTE: A question will pop up at the end of the request asking, 'Is this request for the initial consultation?' If answered with yes, request will auto approve, if answered with no, request will be forwarded to Medical management for review.

Initial Consult & 1 Follow Up Only: On selected specialties an initial consultation and 1 follow-up visit are allowed on Direct Referral. The business rules listed below provide guidance as to when/if a referral will be auto-approved for an initial consult and follow up.

Obstetrics/Gynecology

- Female only
- Female patients age 13+
- Services within range 99384-99387 and 99394-99397

Physical Therapy/Occupation Therapy:

- Procedure codes for auto approval are 97001 (1 unit), 97003 (1 unit) and 97110 (6 units). Provider is responsible for verifying benefits prior to rendering service.

Radiology:

- Plain films, ultrasounds (not guidance) and Mammograms (not guidance) will auto-approve. Refer to published auto approval codes located on Aerial Care under Provider Tools.
- Place of Service must be 11 unless service is being performed as an outpatient service at a hospital in which the Place of Service must be 22.

*PLEASE NOTE: A question will pop up at the end of the request stating "Follow-up and repeat studies require review by Medical Management. Has the patient had any radiology procedures performed on the same body part within the last 12 months?" If answered with **NO,** request will auto approve. If answered with **YES,** request will not auto approve and will go to Medial Management for review.*

If you receive the message below, enter 11 in each box (may be duplicated more than once) and then click Save for the referral to continue to process.

PLEASE REVIEW THE FOLLOWING

1. The provider selected does not perform or is not used for the requested service. Please edit the referral and choose another provider.
2. The provider selected does not perform or is not used for the requested service. Please edit the referral and choose another provider.

Save | Edit Referral | Cancel

Radiology (Hospitals)

- Only Mammograms and Breast Ultrasounds will auto approve at network approved hospital facilities. Place of service for hospitals should be 22.

Radiology (Premier Providers)

- Some Premier providers may also receive additional auto approvals for MRI and CT scans as per your contractual arrangement with Prospect Medical.

CLAIM STATUS AND DETAILS

Aerial offers the ability to verify claim status for claims received within the past 18 months.

Verifying Claim Status

1. Click on the Claims tab located on the dashboard
2. In the Advanced Search tab enter one of the following Claim Number, Patient ID and/or Patient Name.
3. Confirm Advanced Search results by verifying Patient Name, DOS and Billed Amount
4. Click on to view the Claim Details

Claim Detail

Claim Number:
Status: APPROVED
Check Number:
Date of Service: 10/27/2014
Date Received: 10/28/2014
Date Paid: N/A

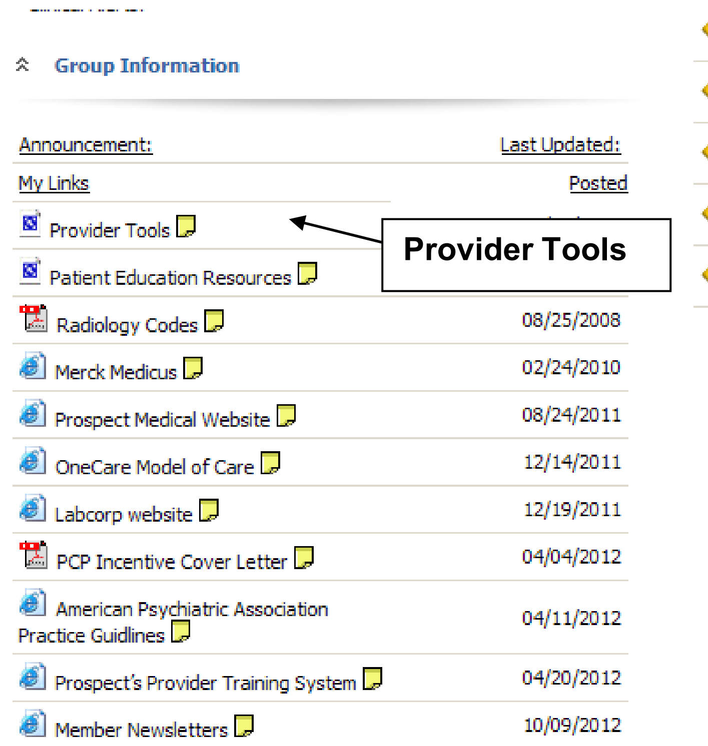
Patient Name:
SSN: XXX - XX - XXXX
Address:
City:
Member Code:
Telephone:
State: CA
Zip Code:

Billing Provider:
Address:
City: ORANGE
Billing Provider ID:
State: CA
Zip Code:

CPT®/ HCPCS Code	Description	Modifiers 1	2	3	Qty 4	Start Date	End Date	Amount Billed	Amount Net
1157F	ADVNC CARE PLAN OR EQV LGL DOC IN MED RCRD	NU	NU	NU	1	10/27/2014	10/27/2014	$0.00	$0.00
1159F	MEDICATION LIST DOCD IN MEDICAL RECORD	NU	NU	NU	1	10/27/2014	10/27/2014	$0.00	$0.00
1160F	RVW ALL MEDS BY RXNG PRCTIONR OR CLIN RPH DOC	NU	NU	NU	1	10/27/2014	10/27/2014	$0.00	$0.00
1170F	FUNCTIONAL STATUS ASSESSED	NU	NU	NU	1	10/27/2014	10/27/2014	$0.00	$0.00

PROVIDER TOOLS

Provider Tools is accessed via the Aerial Dashboard.



After clicking on Provider Tools, user will be forwarded to our Provider On-Line Resources

Network Updates includes links to:

- Prospect Medical's Provider Newsletter
- Provider Bulletins and Operational Updates
- Current Provider Manual
- Health Plan Updates

Frequently Asked Questions

Our office uses Firefox, Opera, Safari or Google Chrome and we have been experiencing glitches on Aerial.

Aerial is optimized for Internet Explorer or Google Chrome due to specific limitations found on other internet browsers known to impede the performance of Aerial.

Our office accesses Aerial through a shortcut saved on our desktop and noticed that we are not receiving updates to our referral status, claim status, and links are outdated.

Accessing Aerial through a shortcut does not allow you to receive updates. It is important that you access Aerial by keying in the website in the address line on Internet Explorer or Google Chrome at www.prospectmedical.com; selecting Provider Login link.

We have multiple physicians in our office and there are instances when we are unable to view eligibility for an eligible member.

You will not be able to verify eligibility for a member assigned to another physician. When your office is responsible for verifying eligibility for multiple providers, you may request a "Super User" account to be set up with one user and one password to view member information for all physicians. Please contact Network Management at (800) 708-3230, prompt 1 for Providers, prompt 7 for Aerial Care assistance.

Our office uses the Eligibility Lookup feature to verify member eligibility. We insert the member information into the fields provided and our member eligibility search does not find a match.

The Eligibility Lookup feature conducts a search based on the member information inserted into the fields provided. If any of the inserted information mismatches, your member eligibility search result will be match not found. Less is more in this case. Try entering only three letters from the member's first name and last name then proceed to conduct your member eligibility search. You may submit a Member Inquiry form using the hyperlink when you receive the "Sorry, we could not find a match" notice. Please allow 1 to 2 days for eligible member to show on Aerial Care.

We are a group of physicians who submits referral request using the provider login of the physician that has requested treatment. We have noticed that we are sometimes unable to verify referral status using a partner physician's provider login.

When you follow up on a submitted referral request, you must use the same provider login that was used to submit the referral request. You will not be able to verify referral status using another provider's login.

Our office has many approved referral requests that we want to print for the member's medical record but when we click on the icon, the referral request does not open for viewing.

This may be a result of the settings on your Internet Explorer Pop-up Blockers or capacity of Cookies (storage of previously viewed internet pages). The setting on your Pop-up Blockers must be turned off and your Cookies must be deleted regularly.

Referrals submission page freeze when the office is using multiple Aerial tabs under Internet Explorer 9 or Newer.

Aerial does not recognize that multiple tabs are being used and will freeze because of this. Please use only one browser tab for a single login session to avoid this error.

I am not able to submit a referral for follow-up care via Aerial?

Provider must be contracted with the same network that the member is enrolled in, to be given rights to view eligibility and submit referrals. If unable to find the member, please fax in your referral request using Prospect's Treatment authorization Form or request a new referral from the member's PCP.

My specialist provider not showing on the drop-down list when it used to show before?

The drop-down list is dependent on the member. The specialist must be contracted with the same network that the member is enrolled with, in order to see provider when trying to submit a referral for that member.

Member Eligibility

The Eligibility Department is responsible for updating and processing the eligibility files received from the health plans. Data is received at various times throughout the month and applicable changes are made daily. For the purposes of capitation compile, all files received for the month are processed and frozen by the 17th of each month. Any additional eligibility changes received after the 18th of the month will be reflected immediately via the Prospect Medical website, but capitation payment will not be made until the following month.

Member Coverage

A member's eligibility is determined solely by our contracted health plans and not by Prospect Medical. ***Any patient showing eligible per the health plan website with Prospect Medical and presenting for primary care services with the assigned Primary Care Physician should not be turned away if not listed on the PCP's current eligibility list on Aerial Care.***

Member Benefits

A member's benefits are determined solely by our contracted heal plans and not by Prospect Medical. Member benefits should be verified directly through the health plan website for the most up to date coverage information.

Member Verification

We recommend that member eligibility be verified as close to the visit as possible at a minimum of 30 days from scheduled visit. In addition, we encourage the use of the Eligibility Certification Form (see Eligibility Certification Form in attachment section) to secure payment from a member that may become retro-terminated by their health plan.

Listed below are several options available to you to verify member eligibility.

- Health Plan**:** Verify the member's eligibility by contacting the member's health plan directly. They have the most current and up-to-date eligibility information.

- Aerial Care**:** Member eligibility may be verified via our web based portal Aerial Care. Please note that member eligibility is only as current as the health plan files we receive. Please contact the Network Management Department to obtain your login name and password.

  If you need a member's eligibility updated in Aerial Care to process a referral, please submit a Member Inquiry Form on Aerial Care or FAX the member's information to 714-560-5270. The Eligibility staff will update this member in Prospect's system, and you will be able to retrieve the updated member information by the following business day in Aerial Care. Please note that Aerial Care takes 24 hours to refresh once member information is entered into Prospect's system.

*Please be advised that there may be a 60-90-day period before a new member is added to the electronic eligibility file the Health Plan sends to Prospect Medical. On your fax, please include the following information:

- Health plan fax print out of member's eligibility from the health plan and/or
- Member's health plan ID#
- Member's last name
- Member's first name
- Member's date of birth
- Member's demographics (if possible)

Newborn Visits

In most instances newborns of the subscriber are automatically covered for the first 30 days of life under the subscriber's insurance. Pediatricians seeing newborns in the hospital are provided reimbursement to cover the initial newborn exam andfollow-up visit. To ensure proper payment at the end of the 1st month of birth, PCP's should advise the subscriber that the child should be formally enrolled through their employer group or health plan representative. The subscriber needs to contact their employer or insurance company to add the child. If the child is added to the subscriber's insurance, the IPA will receive capitation from the health plan and in turn will pay capitation to the Primary Care Provider (PCP).

Preventive Care Guidelines

Below are links which may be referenced to search for the most current Preventive Care Guidelines. The list is not all-inclusive. However, you may also reference specialty specific board associations.

U.S. Preventive Services Task Force – Published Recommendations

https://www.uspreventiveservicestaskforce.org/BrowseRec/Index

American Academy of Pediatrics

https://www.aap.org/en-us/Pages/Default.aspx

American College of Obstetrics and Gynecology

https://www.acog.org/

National Institutes of Health – Health Topics

https://www.nih.gov/health-information

Medical Management Department

Urgent Care

For urgent, non-emergent illnesses Prospect Medical encourages its members to utilize its contracted urgent care centers. Patients may access any of the urgent care centers affiliated with Prospect Medical directly without prior approval from their PCP or Prospect Medical Group both during and after your normal business hours.

Remind your patients to utilize the urgent care facilities instead of visiting a hospital emergency room for non-life-threatening illnesses. Usually emergency room co-payments are higher than office visit/urgent care co-payments, and for non-emergent illnesses, patients may find their wait time at an emergency room excessive.

If a patient's condition is life or limb threatening, they should seek care from the nearest emergency room.

Please refer to the updated listing of contracted urgent care centers for hours and locations found on the www.prospectmedical.com website. You may post a copy of the contracted urgent care centers in your office as a reminder to your patients that they always have access to care for urgent illnesses. Please contact Network Management to request Urgent Care booklets for your office.

Direct Access Referrals

All Direct Access Referrals are now auto approved on Aerial. Direct Access Referrals are designed for the convenience of the patient, Primary Care Provider (PCP) and Specialty Care Provider (SCP). You will be able to identify as an auto approval when you get a drop down of specialist you can select from. Once auto approved, you can give a copy to the patient and instruct them to contact the SCP to schedule an appointment.

A Direct Access Referral is valid for 60 days, or date of submission through Aerial.

Medical Management and Customer Service can extend past 60 days based on eligibility. Any follow-up visits for non-capitated providers will require prior authorization by Prospect's Medical Management Department and should be generated by the treating SCP with notification of the treatment plan to the PCP. A copy of the medical record for the last visit with the PCP should be provided to the SCP via fax or hand carried by the patient, as appropriate.

It is important to note that the Direct Access Referral is for the benefit of the member to be directed by the PCP for necessary services without waiting for prior authorization. This process should not eliminate the PCPs role as the primary provider of care to the member or give cause for excessive or inappropriate referrals to specialists.

Inappropriate Referrals

The use of Referrals for the following is not appropriate:

- Referring members for non-covered services
- **DO NOT USE THE DIRECT REFERRAL PROCESS THROUGH AERIAL, FOR STAT REFERRALS**

- These services **must be called in** to Prospect's Medical Management Department by calling **Prospect Medical (800) 708-3230.**

Submitting Authorization Requests

Please review the following guidelines for submitting authorization requests for referrals:

All routine requests shall be submitted via Aerial Care:

- When submitting a referral via Aerial Care and you search for a member, this step will verify eligibility for you. If a member is not eligible then it will not allow you to submit a referral.

- Include as much information as possible regarding the diagnosis and reason for the request.

- Attach a consult letter, test results, office notes, etc. You are now able to attach medical records via Aerial Care, please refer to the online tools of the provider manual for step by step instructions. All medical records and test results must have patient identification and must be legible for Prospect's Medical Management department to make accurate and timely decisions regarding your request. **(Include Physician prescription for any DME, Drug, SNF or Custodial patient order.)**
- Please be clear and specific as to what you are requesting. (i.e., consult, procedure, Outpatient Surgery and, In-Patient Surgery, etc.) CPT codes must be listed.

- **Do not schedule a procedure or surgery before your request is authorized.**

Once your authorization request is received, it will be verified for eligibility and benefits. Prospect encourages providers to verify co-payments directly with the health plan, especially if it is not indicated on the authorization. Prospect's Medical Management department will then evaluate the request and assign a disposition. If the necessary information needed to process your request is not received, a Medical Management representative will call the referring provider to request medical records. If the information is not received within 5 days, a delayed decision letter will be issued to the member and provider.

If approved, an authorization will be generated and faxed to the PCP and Specialist. If not auto approved on Aerial Care, an approval letter will be mailed to the patient if the authorization is generated from the IDX system.

All medical necessity denial decisions will be determined by a Physician Reviewer in accordance with review criteria. The Physician Reviewer is available to discuss determination by calling (800) 708-3230. A written notification will be sent to both the member and provider within 1 business day of denial determination.

Out-Of-Network Referrals

Referrals to out-of-network providers are permitted only if the required specialty is not represented in the medical group or a required specialist is not otherwise available. All out-of-network referrals must receive advance authorization from Prospect's Medical Management Department.

Prospect Medical will manage all patients in non-participating facilities. The Case Manager will transfer the patient to a participating facility when the patient is stable.

STAT/Urgent Referral Requests

DO NOT FAX OR MAIL STAT OR URGENT REQUESTS. DO NOT USE AERIAL FOR STATS.

Sometimes a "STAT" or "Urgent" referral is indicated. If you feel a "STAT" or "Urgent" referral is medically indicated, **contact Prospect's Medical Management Department at Prospect Medical (800) 708-3230.**

If you feel the diagnosis represents a potentially life-threatening emergency, send the patient directly to the nearest emergency room.

Unable To Process

The following is a list of the most common reasons why referrals are delayed.

- Printed information is not legible
- Inability to locate member due to:
  - The patient's name is not spelled correctly
  - The patient's DOB or ID# is not valid, incomplete or not given
- The EDC date or LMP is not given if applicable
- Additional information is needed, i.e., test results
- Service or procedure is not clear
- CPT code missing
- Diagnosis code missing
- Lesion size and/or location are not given if applicable
- Date of service is missing
- Copies of progress notes supporting your request are not submitted
- The specific nature of the request is not clear

A call will be placed to your office by a medical management representative to obtain additional information. If the information is not received in a timely manner, a delayed decision letter must be sent to the member 5 days from the original submission of the referral per Health Plan requirements. Please be advised that upon receipt of this letter, the member may call you to obtain status of their referral. Senior decision must be made to approve or deny within 14 days of receipt of request.

Expiration of Referrals

The length of time in which a referral expires is 60 days. If for any reason the patient is unable to get an appointment with a specialist, please call our Customer Service Department at (800) 708-3230 to request an extension. Authorization extensions are subject to the member's eligibility

with Prospect Medical.

Categories of Referrals

All referrals shall be classified into one of the following categories:

STAT: A referral for a condition that threatens loss of life, loss of limb, loss of bodily function or substantial impairment.

Urgent or Emergent: A serious condition requiring immediate intervention.

Routine Referral: Limited physical exam, follow-up to acute or chronic medical or surgical condition, not life or limb threatening.

Referral Status (IDX)

Processing of each referral will vary depending on one of four dispositions:

- Approved
- Carve Out
- Delayed Decision
- Denied
- Pended
- Rejected Duplicate

Approved: All routine requests shall be submitted by referral form, and faxed to the Medical Management Department. Once approved by Prospect's Medical Management Department they will notify the Specialist and the PCP by faxing an authorization within 48 hours of decision. Members will receive a copy of their authorization via U.S. Mail.

Denied: If the procedure is denied, the appeals process shall be explained to the patient and the requesting physician in the denial letter specific to the assigned health plan.

Pended: Reasons for pended request may include:

- Inadequate information to determine medical necessity
- Illegible notes
- Specific nature of request unclear

Prospect's Medical Management Department will follow-up on the pended requests within five business days after notification.

Pended for alternative treatment: The provider may choose to implement the alternative treatment plan offered by Prospect's Medical Management Department. If the provider disagrees with the alternative options they are encouraged to phone Prospect Medical management and speak with the reviewing physician.

Delayed Decision: If the requested information on a pended authorization is not received by the 5th working day, a delayed decision letter is sent to the patient and the requesting physician. Senior member referrals may not be pended.

For Aerial Users:

All routine requests shall be submitted via Aerial, you can view status on Aerial with the following dispositions:

- Approved
- Carve Out
- Delayed
- Rejected Duplicate
- Rejected
- Requested

An appeal is not accepted on a pended or delayed request. The requesting party must supply the requested information for an approval or denial. They may also choose to withdraw the original request. If the requesting party chooses to withdraw the request, it is essential that Prospect's Medical Management Department be notified.

Referral status may be obtained by logging onto Aerial via Prospect Medical's website at www.prospectmedical.com or by calling our Customer Service Department.

Second Opinion Requests

Decisions and notification should be made and a second opinion provided within the time frames appropriate to the type of request. Second opinion authorizations or denials will be rendered within a period of time appropriate for the member's circumstances, but within no more than 72-hours from receipt of the request when the member's condition poses an imminent and serious health threat, including potential loss of life, limb or other major bodily function, or if lack of timeliness would be detrimental to the member's ability to regain maximum function. The second opinion will be rendered by a Primary Care or Specialty Care Provider within the scope of practice and who possess clinical background including training and expertise, related to the particular illness or condition. The authorization process will take into account the member's ability to travel to the practitioner rendering the second opinion.

- If the original opinion is from the member's Primary Care Provider, the second opinion will be obtained within Prospect Medical Group Network.
- If the original is from a Specialty Care Provider, the second opinion may be obtained within the Health Plan network (with the Health Plan incurring cost beyond the member's co-payment). If the member requests a second opinion outside of Prospect Medical Group Network, the member will be directed to call the Health Plan for direction and review of request.
- Member is responsible only for applicable co-pay in accordance with the health plan.

Approvals for second opinions will be provided for the following reasons:

- If the member questions the reasonableness of necessity of recommended surgical procedure
- If the member questions a diagnosis or plan or care for a condition that threatens loss of life, loss of limb, loss of bodily function or substantial impairment
- If clinical indications are not clear or are complex, a diagnosis is in doubt due to conflicting tests or treating practitioner is unable to diagnose the condition and the

member requests and additional diagnosis

- If the treatment plan progress is not improving the medical condition 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 practitioner concerning serious concerns about the diagnosis or plan of care
- If a member is requesting a second opinion from a non-contracted provider, they will be referred to the health plan and not denied.

Prospect Medical will notify the member in writing if a request for a second opinion is denied, with the reasons for the denial and information on the member's right to appeal the denial.

Review Criteria

Standards utilized for prior authorization admissions and concurrent review includes National Medicare Coverage Determination, Local Articles, CMS Manuals, DHCS (Medi-Cal Criteria) Health Plan Specific Criteria, Apollo Managed Care. These are nationally recognized as a definitive resource for evidence-based knowledge at the point of care, specialist panel review, developed practice guidelines, and health plan policies and guidelines. A criterion is applied on a case-by-case basis to all members considering age, co-morbidity, complications, home environment, treatment progress and psychological situation. Criteria will be objective, measurable, and based on sound clinical evidence. All provider offices receive a provider manual at the time of their orientation, which indicates developed practice guidelines. Audits of prior authorization decision as well as all denials are monitored for appropriateness and application of review criteria. The review criterion is updated on an annual basis or as needed and also available to providers and members upon request. Eligibility and benefits are determined prior to any referral decision. A board-certified practitioner of same or similar specialty, reviews all denials. A psychiatrist or certified addiction medicine specialist will review any denials of behavioral health and all outpatient, inpatient and concurrent reviews and will be involved in implementation of UM plan and criteria. Reasons for denial are clearly documented with guideline or criteria relied upon for decision disclosed in the denial letter and communicated to member and provider. This notification of denial includes appeal information.

If the information received from the provider does not meet the established criteria for the medical necessity, the Utilization Review staff will:

- Request for additional information
- Refer to provider reviewer or specialty panel
- Coordinate a second opinion if appropriately requested
- Refer the case to the Medical Director or his/her designee
- Refer to specific criteria

Discussions will take place regarding the case, so that a final determination is able to be made either to approve or deny the request within 5 business days of receipt of information.

Retrospective Review

Retrospective review refers to a process that occurs after a treatment has been completed or when a discharge from services has been accomplished.

- Any procedure or test that was not properly pre-authorized will be reviewed by a Medical Director for approval or denial. A decision will be made within 15 - 30 days of receiving all necessary information.
- Medical claims for professional and institutional services will be reviewed according to established screening criteria and medical policies.
- Determination for the denial or requests; based on medical appropriateness will be made only by a board-certified physician.

Appeal Process for Denials

Prospect's Medical Management Department makes decisions based on efficacious and state-of-the-art management of medical problems in a cost-effective environment. Prospect Medical also enforces coverage of policies of the health plans. In the event that a request is denied and the decision is not acceptable to the patient, PCP, specialty care physician, or ancillary provider, an appeals process is available. Please note, appeals for denied referrals should not be confused for retro-authorization requests as they are not the same.

An appeal may be initiated through any source, including the patient, physician, health plan, or ancillary provider and then forwarded to the member's health plan directly. Appropriate medical records should be forwarded to the member's health plan in a timely manner (please refer to the Health Plan Contact Information section of this manual). After review of the medical records and appeal letter, a decision will be forwarded to the respective parties within the time frame mandated by each health plan.

The appeal shall be addressed in letter form with the following points included in the letter and website:

- Patients name and ID#
- Health Plan name
- Specific nature of the appeal
- Medical documentation to support the appeal

Affirmative Statement Regarding Incentives

A Utilization Management affirmative statement regarding incentives will be signed by all UM decision-makers yearly. Prospect Medical does not give financial incentives for UM decision makers and does not encourage denials of coverage or service. Decision makers include Medical Directors, UM and CM Managers, Case Management, Quality Improvement Committee members, licensed staff and management personnel. Providers may freely communicate with patients about their treatment, regardless of benefit coverage limitations. Practitioners are ensured independence and impartiality in making referral decisions that will not influence hiring,

compensation, termination, promotion or any other similar matters. This is also posted on the company website.

Provider & Member Satisfaction

Prospect Medical understands the importance of achieving customer satisfaction, for both our patients and our providers. To help monitor our success in this regard, we turn to several sources of information.

- The first source is the Provider Satisfaction Survey. The Provider Satisfaction Survey assesses the level of satisfaction our providers have with key areas of the management company, such as Utilization Management, Referrals and Network Management. The survey is conducted by the Network Management Department on an annual basis. All contracted providers are asked to complete a survey. The results are tabulated and each department is expected to implement changes bases on the results to improve the quality of service given to our providers.

- The second source is the Patient Assessment Survey (PAS). The PAS is the member satisfaction survey for the Pay for Performance (P4P) Program and assesses the level of satisfaction our members have with their doctors and their doctor's office. The PAS is conducted annually by the Pacific Business Group on Health and targets commercial members only.

- The third source of data is complaints and grievances submitted through either our Customer Service Department or through the health plans. We are required to investigate every grievance and come up with a resolution as appropriate to each situation. We are also required to level the severity of the grievance and the results are monitored for tracking and trending purposes. The Medical Director is responsible for overseeing the appeals and grievance process.

Cultural and Linguistic Services/Interpreter Services

It is the policy of Prospect Medical to provide members with Interpreter Services in threshold languages, and oral translation for other languages upon request, **at no cost** to the member. Prospect will also provide culturally and linguistically appropriate services for vision and hearing-impaired members.

Prospect will provide Interpreter Service coordination for provider offices upon request. Requests for interpreter services should be submitted through our referral request process within five (5) business days of member's appointment or called in to our Customer Service line for coordination. Urgent requests will be processed within two (2) business days. Every effort will be made to obtain an in-person interpreter if there is an immediate need and will at minimum, offer telephonic interpreter services on a 3-way call with the provider office, member, and the interpreter service provider.

Prospect, nor the provider office, shall require or suggest to a member to use friends or family members, particularly minors, as interpreters. A member's family or friend may be used if the

member is advised that an interpreter is available at no cost to the member; it is requested by the member; it will not compromise the effectiveness of service, and it will not violate a member's confidentiality. The provider must document choice in the member's medical record.

Provider offices will use certified office personnel who are bilingual to provide interpretive services. If there is no one able to interpret a language, the office should call Prospect Medical **Customer Service Department at (800) 708-3230** to receive tracking number and phone number to call for a contracted interpreter service or **711 TDD/TTY services** for deaf, hard of

hearing or speech-impaired members.

When a member is a patient in the hospital, a certified interpreter will be drawn from the hospital certified interpreter list. If the hospital has or utilizes a person who can sign, that individual will be used. If there is no one who can sign, the contracted provider with Prospect Medical will be called upon to provide the service.

Member Communication

Written member information shall ensure member's understanding of the health plan covered services, processes and ensure the member's ability to make informed decisions.

Written member-informing materials including the member handbook and all grievances acknowledgment and resolution letters shall be translated into the identified threshold and concentration languages.

Written member-informing materials shall be provided in alternative formats including braille, large size print and audio format upon request and in a timely fashion appropriate for the format being requested.

Physician shall establish policies and procedures to enable members to make a standing request to receive all information materials in a specified alternative format.

Providers must have a policy and procedure in place to ensure members are aware of this option and an opportunity to request

Continuity of Care

Prospect Medical is required to give 60-day advance notice when a Primary Care or Specialty Care Provider is terminated. This must be done in writing to each member that is affected by this change. The member will receive a letter concerning continuity of care rights. The condition under which a member may continue with terminated or non-contracted providers are as follows:

- Continuing care for pregnancy
- Acute condition
- Terminal illness
- Mental Health

- Care of a newborn between birth and 36 months covered for 12 months from the contract termination date

The length of the transition period will consider the severity of the member's condition and the amount of time necessary to affect a safe transfer on a case by case basis.

Hospice Appropriateness

Hospice is defined as palliative care for a person with a life-limiting illness of 6 months or less. Members must meet the following criteria to be eligible for hospice care:

- Illness is incurable and has a declining functional status
- If the patient/family has been informed that the patient's condition is terminal
- If the patient/family has elected treatment directed toward palliative care
- If the quality of life is currently unacceptable to the patient/family
- If the prognosis is for a life expectancy of one year or less (if the disease runs its normal course)

Observable Clinical Deterioration

- Unintentional weight loss (more than 10% over the past 3-6 months)
- Decreased appetite/nutritional intake related to the terminal process
- Decreased activity tolerance with restriction in activities of daily living
- Decreased cognitive abilities
- Multiple emergency room visits (3 or more in the past 3-6 months)

Organ-Specific Diseases

- End-Stage Neurologic Disease
  - Severe Alzheimer's, Stroke, Parkinson's, ALS, traumatic brain injury
- End-Stage Renal Disease
  - Chronic dialysis patient/candidate who has chosen to refuse dialysis
- End-Stage Liver Disease
  - Severe weight loss, recurrent infections, increased debilitation requiring supportive care, has been on therapy and refusing therapy or has displayed resistance to available medication
- End-Stage AIDS
  - Severe weight loss, recurrent infections, increased debilitation requiring supportive care, has been on therapy and refusing therapy or has displayed resistance to available medication
- Malignant Disease
  - Documented tissue diagnosis of malignant/metastasis disease.
  - Incurable diagnosis and treatment that is regarded most likely to be futile
  - Evidence of progressive cancer and treatment (even if available) is felt to be futile
  - Patient with incurable disease but treatment is refused or cannot be tolerated or where treatment is for palliative reasons

- End-Stage Cardiopulmonary Disease
  - Disabling dyspnea at rest or with minimal exertion, poorly responsive to

bronchodilators

- Recurrent congestive heart failure (NYHA Class IV) on optimal diuretic therapy
- Presence of corpulmonale
- Recurrent pulmonary infections and/or respiratory failure
- Chronic hypoxemia (less than 90%) at rest on supplemental oxygen
- Chronic hypercapnea (pCO2 more than 50mmHg)
- Intractable angina
- Resting tachycardia (more than 100/min) or symptomatic arrhythmias resistant to therapy

Guidelines

Appointment/Access Standards

POLICY STATEMENT:

This policy establishes minimum compliance standards for member accessibility to primary, specialist, behavioral health, and ancillary care providers. It also defines the process to monitor network compliance to the Centers of Medicare and Medicaid Servicesaccess standards; and where applicable, access standards and National Committee for Quality Assurance (NCQA) accreditation requirements. PROSPECT will ensure that monitoring and oversight is performed on Prospect Medical Systemsto evaluate all service of care that timely access to such service is available.

All Providers are required to operate reasonable hours of operation to ensure there are no delays in member care that may be detrimental to member's health.

PURPOSE:

To establish a process of timely access to care standards andmonitoring activities;, and NCQA accreditation requirements, to assist in improved availability and accessibility to practitioners, providers, and health care services, meeting regulatory, accreditation, and licensingrequirements

DEFINITIONS:

a. "Advanced access" means the provision, by an individual provider, or by PROSPECT or independent practice association to which a member is assigned, of appointments with a primary care physician, or other qualified primary care provider such as a nurse practitioner or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the member prefers not to accept the appointment offered within the same or next business day.

b. "Ancillary service" includes, but is not limited to, providers of pharmaceutical, laboratory, optometry, prosthetic, or orthopedic supplies or services, suppliers of durable medical equipment, and home-health service providers

c. "Appointment waiting time" means the time from the initial request for health care services by a member or the member's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or medical group (if delegated) and completing any other condition or requirement of the plan or its contracting providers.

d. "Health care service plan" or "specialized health care service plan" means either of the following:
   - Any person who undertakes to arrange for the provision of health care services to subscribers or members, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or members.
   - Any person, whether located within or outside of this state, who solicits or contracts with a subscriber or member in this state to pay for or reimburse any part of the cost of, or who undertakes to arrange or arranges for, the provision of

health care services that are to be provided wholly or in part in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or member.

e. “Mental Health Care Provider (MHCP)” includes Medical Doctors and Doctors of Osteopathy with specialties in addictionology or psychiatry, clinicians licensed by the state for the independent practice of psychology (including Master’s Degree Psychologist, if permitted in the state where the psychologist practices and Master’s Level Clinicians: counselors, therapists, social workers, licensed professional examiners and nurses who are licensed or certified to practice independently according to state laws in their practice location. Marriage and Family Therapists and Licensed Clinical Social Workers are licensed or certified to practice independently in Arizona. .

f. “Provider” means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services

g. “Provider Group” means a medical group, independent practice association, or any other similar organization

h. “Preventive care” means health care provided for prevention and early detection of disease, illness, injury or other health condition and, in the case of a full service plan includes but is not limited to all of the basic health care services.

i. “Specialist” is defined as a residency-trained, board-certified or board-eligible licensed practitioner who completed advanced training in a field recognized by the American Board of Medical Specialists (ABMS) or the American Osteopathic Association (AOA).

j. “Telemedicine” means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications (real-time or near real-time two-way transfer of medical data and information). Neither a telephone conversation nor an electronic mail message between a health care practitioner and member constitutes telemedicine for the purposes of this policy and procedure.

k. “Triage” or “screening” means the assessment of a member’s health concerns and symptoms via communication, with a physician, registered nurse or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care, for the purpose of determining the urgency of the member’s need for care.

l. “Triage or screening waiting time” means the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care.

m. “Urgent care” means health care for a condition which requires prompt attention when the member’s condition is such that the member faces an imminent and serious threat to his or her health, including but not limited to, potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the member’s life or health or could jeopardize the member’s ability to regain maximum function of the Act).

PROCEDURES:

This section summarizes the access to care standards and monitoring requirements. The following information delineates the non-emergency access standards for appointment and telephonic access to health care services and the monitoring activities to ensure compliance. PROSPECT will take into consideration member's condition in arranging timely provision of covered healthcare services.

Commercial & Medicare Non-Emergent Medical Appointment Access Standards

Appointment Type	Time-Elapsed Standard
Routine and Preventative Care appointments	Within 30 calendar days
Non-urgent/Non-Emergent appointments for Primary Care (PCP)	Must offer the appointment within 1 week
Non-urgent Care appointments with Specialist physicians (SCP)	Must offer the appointment within 15 Business Days of the request
Urgent Care appointments that do not require prior authorization (PCP)	Must offer the appointment within 48 hours of request
Urgent Care appointments that require prior authorization	Must offer the appointment within 96 hours of request
Non-urgent Care appointments for ancillary services (for diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment within 15 Business Days of the request
In-office wait time for scheduled appointments (PCP and SCP)	Not to exceed 15 minutes

Behavioral Health Emergent & Non-Emergent Appointment Access Standards

Appointment Type	Time-Elapsed Standard
Non-urgent appointments with a physician mental health care provider	Must offer the appointment within 10 business days of request
Non-Urgent Care appointments with a non-physician mental health care provider	Must offer the appointment within 10 business days of request
Urgent Care appointments	Must offer the appointment within 48 hours of request
Access to Care for Non-Life Threatening Emergency	Within 6 hours
Access to Life-Threatening Emergency Care	Immediately
Access to Follow Up Care After Hospitalization for mental illness	Must Provide Both: One follow-up encounter with a mental health provider within 7 calendar days after discharge Plus One follow-up encounter with a mental health provider within 30 calendar days after discharge

Medicare Dental Appointment Access Standards

Appointment Type	Time-Elapsed Standard
Routine and Preventative Care	Within 40 business days
Non-Urgent Dental	Within 36 business days of request (except for preventative dental care)
Urgent Care appointments that do not require prior authorization (PCP)	Must offer the appointment within 48 hours of request
In-office wait time for scheduled appointments (PCP and SCP)[1]	Not to exceed 15 minutes

EXCEPTIONS:

Preventive Care Services and Periodic Follow Up Care:
Preventive care services and periodic follow up care including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice

Advance Access:
A primary care provider may demonstrate compliance with the primary care time-elapsed access standards established herein through implementation of standards, processes and systems providing advance access to primary care appointments as defined herein.

Appointment Rescheduling:
When it is necessary for a provider or enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice and consistent with the objectives of this policy.

Extending Appointment Waiting Time:
The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.

Telemedicine
To the extent that telemedicine services are appropriately provided as defined per Section 2290.5(a) of the Business & Professions Code, these services shall be considered in determining compliance with the access standards hereby established.

Prior to the delivery of health care via telemedicine, the provider must obtain verbal and written informed consent from the enrollee or the enrollee's legal representative. The informed consent procedure shall ensure that at least all of the following information is given to the enrollee or the enrollee's legal representative verbally and in writing:

1. The enrollee or the enrollee's legal representative retains the option to withhold or withdraw consent at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which the enrollee or the enrollee's legal representative would otherwise be entitled.
2. A description of the potential risks, consequences, and benefits of telemedicine.
3. All existing confidentiality protections apply.

4. All existing laws regarding enrollee access to medical information and copies of medical records apply.
5. Dissemination of any enrollee identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without the consent of the enrollee.

An enrollee or the enrollee's legal representative shall sign a written statement prior to the delivery of health care via telemedicine, indicating that the enrollee or the enrollee's legal representative understands the written information provided and that this information has been discussed with the health care practitioner, or his or her designee. The written consent statement signed by the enrollee or the enrollee's legal representative shall become part of the enrollee's medical record

Other Applicable Requirements:

Interpreter Services
Interpreter services shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment.

Prior Authorization Processes
Prior authorization processes, are to be completed in a manner that assures the provision of covered health care services to enrollees in a timely manner appropriate for the enrollee's condition and in compliance with the requirements of the time-elapsed access standards.

Shortage of Providers
To ensure timely access to covered health care services as required in this policy, where there is a shortage of one or more types of providers, providers are required to refer enrollees to available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. Furthermore, providers shall arrange for the provision of specialty services from specialists outside the provider's contracted network if unavailable within the network, when medically necessary for the enrollee's condition.

Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider

If Delegated for Behavioral Health

Triage &/or Screening
The delegate shall provide or arrange for the provision of 24/7 triage or screening services by telephone. The delegate shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the enrollee's condition, and the triage or screening wait time does not exceed 30 minutes.

The delegate must at a minimum maintain a procedure for triaging or screening enrollee telephone calls, which shall include the 24/7 employment of a telephone answering machine/service/or office staff that will inform the caller:

a. Regarding the length of wait for a return call from the provider (not to exceed 30 minutes); and

b. How the caller may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

The delegate is responsible for the answering service it uses. If an enrollee calls after hours or on a weekend for a possible medical emergency, the delegate is held liable for authorization of or referral to, emergency care given by the answering service. There must be a message immediately stating, "If this is an emergency, hang up and call 911 or go to the nearest emergency room."

- Answering service/office staff handling enrollee calls cannot provide telephone medical advice if they are not a licensed, certified or registered health care professional. Staff members may ask questions on behalf of a licensed professional in order to help ascertain the condition of the enrollee so that the enrollee can be referred to licensed staff; however, they are not permitted, under any circumstance, to use the answers to questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of the enrollee, or to determine when an enrollee needs to be seen by a licensed medical professional. Unlicensed telephone staff should have clear instructions on the parameters relating to the use of answers in assisting a licensed provider.
- Additionally, non-licensed, non-certified or non-registered health care staff cannot use a title or designation when speaking to an enrollee that may cause a reasonable person to believe that the staff member is a licensed, certified or registered health care professional.
- The answering service should document all calls.

Triage &/or Screening

Prospect provides or arrange for the provision of 24/7 triage or screening services by telephone. Prospect ensures that telephone triage or screening services are provided in a timely manner appropriate for the enrollee’s condition, and the triage or screening wait time does not exceed 30 minutes. Prospect provides triage or screening services through medical advice lines

At this time, Prospect does not have a Telemedicine Line

Communication of Guidelines

Guidelines regarding access standards must be fully distributed by the plan or delegate throughout the contracted provider network via operation manuals, online practitioner portals, written update notices, policy and procedure documents, or other recognized methods. Standards should be reviewed/revised annually or as necessary.

COMPLIANCE MONITORING:

Please refer to the Plan’s Compliance Monitoring Policy(ies) and Procedure(s) and/or Provider’s Operations Manuals for specific compliance monitoring and reporting processes.

EXCEPTIONS:

Preventive Care Services and Periodic Follow Up Care:

Preventive care services and periodic follow up care including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice

Advance Access:

A primary care provider may demonstrate compliance with the primary care time- elapsed access standards established herein through implementation of standards, processes and systems providing advance access to primary care appointments as defined herein.

Appointment Rescheduling:

When it is necessary for a provider or member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the member's health care needs, and ensures continuity of care consistent with good professional practice and consistent with the objectives of this policy.

Extending Appointment Waiting Time:

The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the member.

PROVIDER AVAILABILITY:

A. Prospect total physician availability standard: Ratio of total physicians to Members shall not be less than 1:1,200.

B. Prospect and Health Network Mid-Level Practitioner availability standard: Ratio of total Mid-Level Practitioner to Members shall not exceed 1:1,000.

   i. Mid-Level Practitioners shall have a maximum Member case load of 1,000 members.
   ii. A Primary Care Provider can employ a maximum of four (4) Mid-Level Practitioners to comply with the PCP availability standards.

C. Prospect and Health Network Health Care Delivery Organization (HDO) standard:

   i. HDO availability by geographic distribution:

      a) Hospitals: At least one (1) hospital shall be within fifteen (15) miles or thirty (30) minutes from the Member's residence
      b) Skilled Nursing Facilities: At least one (1) skilled nursing facility shall be within fifteen (15) miles or thirty (30) minutes from the Member's residence.
      c) Outpatient Dialysis to be in a reasonable distance from member's place of residence.

   ii. HDO availability by number of each type of Provider:

      a) Hospitals: Ratio of hospitals to Members shall not be less than 1:25,000.
      b) Skilled Nursing Facilities: Ratio of skilled nursing facilities to Members shall not be less than 1:2,500.

D. PCP:

   I. Primary Care Practitioner (PCP) availability standards by geographic distribution:

GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS	
Practitioner Type	**Measure**
General Practice/Family Practice	Members within ten (10) miles or thirty (30) minutes
Internal Medicine	Members within ten (10) miles or thirty (30) minutes
Pediatrics	Members within ten (10) miles or thirty (30) minutes
Obstetrics/Gynecology (OB/GYN):	Members within ten (10) miles or thirty (30) minutes

   iii. PCP availability standards by the ratio of practitioner to Members:

NUMBER OF PRACTITIONERS		
Practitioner Type	**Measure**	**Performance Goal**
General Practice/Family Practice	Ratio of practitioner to members	1:2,000
Internal Medicine	Ratio of practitioner to members	1:2,000
Pediatrics	Ratio of practitioner to members	1:2,000
Obstetrics/Gynecology (OB/GYN):	Ratio of practitioner to members	1:2,000

iv. High-volume specialists availability standards by geographic distribution:

GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS	
Practitioner Type	**Measure**
Obstetrics/Gynecology (OB/GYN):	Members within thirty (30) miles or forty-five (45) minutes
Orthopedic Surgery	Members within thirty (30) miles or forty-five (45) minutes
Neurology	Members within thirty (30) miles or forty-five (45) minutes
Cardiovascular Disease	Members within thirty (30) miles or forty-five (45) minutes
Ophthalmology	Members within thirty (30) miles or forty-five (45) minutes
Dermatology	Members within thirty (30) miles or forty-five (45) minutes

v. High-volume specialists availability standards by the ratio of practitioner to Members:

NUMBER OF PRACTITIONERS		
Practitioner Type	**Measure**	**Performance Goal**
Obstetrics/Gynecology (OB/GYN):	Ratio of practitioner to members	1:2,000
Orthopedic Surgery	Ratio of practitioner to members	1:5,000
Neurology	Ratio of practitioner to members	1:10,000
Cardiovascular Disease	Ratio of practitioner to members	1:5,000
Ophthalmology	Ratio of practitioner to members	1:5,000
Dermatology	Ratio of practitioner to members	1:5,000

f. Behavioral Health Specialists: Health Plan shall identity behavioral healthcare practitioners based on the types of practitioners most likely to provide office-based behavioral health services to the largest segment of the membership.

i. Behavioral health specialist's availability standards by geographic distribution:

GEOGRAPHIC DISTRIBUTION OF BEHAVIORAL HEALTH PRACTITIONERS	
Practitioner Type	**Measure**
Psychiatrist	Members within thirty (30) miles or forty-five (45) minutes
Psychologist	Members within thirty (30) miles or forty-
	five (45) minutes
Licensed Clinical Social Worker	Members within thirty (30) miles or forty-five (45) minutes
Marriage and Family Therapist	Members within thirty (30) miles or forty-five (45) minutes

ii. **Behavioral health specialist's standards by ratio of Practitioners to Members:**

NUMBER OF BEHAVIORAL HEALTH PRACTITIONERS		
Practitioner Type	**Measure**	**Performance Goal**
Psychiatrist	Ratio of practitioner to members	1:10,000
Psychologist	Ratio of practitioner to members	1:15,000
Licensed Clinical Social Worker	Ratio of practitioner to members	1:10,000
Marriage and Family Therapist	Ratio of practitioner to members	1:3,000

Other Applicable Requirements:

Interpreter Services

Interpreter services shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment.

Prior Authorization Processes

Prior authorization processes, are to be completed in a manner that assures the provision of covered health care services to members in a timely manner appropriate for the member's condition and in compliance with the requirements of the time-elapsed access standards.

Shortage of Providers

To ensure timely access to covered health care services as required in this policy, where there is a shortage of one or more types of providers, providers are required to refer members to available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the member's health needs. Furthermore, providers shall arrange for the provision of specialty services from specialists outside the provider's contracted network if unavailable within the network, when medically necessary for the member's condition.

Member costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating a member's preference to wait for a later appointment from a specific contracted provider

Triage &/or Screening

Prospect providers shall provide or arrange for the provision of 24/7 triage or screening services by telephone. The provider shall ensure that telephone triage or screening services are

provided in a timely manner appropriate for the member's condition, and the triage or screening wait time does not exceed 30 minutes.

The provider must at a minimum maintain a procedure for triaging or screening member telephone calls, which shall include the 24/7 employment of a telephone answering machine/service/or office staff that will inform the caller:

a. Regarding the length of wait for a return call from the provider (not to exceed 30 minutes); and

b. How the caller may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

The delegate is responsible for the answering service it uses. If a member calls after hours or on a weekend for a possible medical emergency, the provider is held liable for authorization of or referral to, emergency care given by the answering service. There must be a message immediately stating, "If this is an emergency, hang up and call 911 or go to the nearest emergency room."

- Answering service/office staff handling member calls cannot provide telephone medical advice if they are not a licensed, certified or registered health care professional. Staff members may ask questions on behalf of a licensed professional in order to help ascertain the condition of the member so that the member can be referred to licensed staff; however, they are not permitted, under any circumstance, to use the answers to questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of the member, or to determine when an member needs to be seen by a licensed medical professional. Unlicensed telephone staff should have clear instructions on the parameters relating to the use of answers in assisting a licensed provider.
- Additionally, non-licensed, non-certified or non-registered health care staff cannot use a title or designation when speaking to a member that may cause a reasonable person to believe that the staff member is a licensed, certified or registered health care professional.
- The answering service should document all calls.

Communication of Guidelines

Guidelines regarding access standards must be fully distributed throughout the contracted provider network via operation manuals, online practitioner portals, written update notices, policy and procedure documents, or other recognized methods. Standards should be reviewed/revised annually or as necessary.

Extending Appointment Waiting Time:

The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.

Access Audit / Secret Shopper

QM Department will perform access audits on a quarterly basis by randomly selecting 25 high volume PCP and Specialists from each contracted network and MSO. QM will monitor Providers based on access audit results and will implement interventions as needed to ensure compliance to Access and Availability standards. QM will forward findings to Network Management on a quarterly basis and post log to a common internal folder.

Access issues identified on a daily basis from Customer Service, UM or QM are handled immediately with communication and Corrective Action (CAP) requested from provider.

Provider survey by Health Plan will be addressed by QM Team to include corrective action within ten (10) business days to comply. If resolution of non-compliance is not addressed by provider may result in freezing or termination of current contract. All findings, CAPs, provider responses and access audit results are reviewed at QM & UMCommittees.

Provider Disciplinary Action for Continued Non-Compliance

Providers who are identified, by either a Health Plan survey or by internal QM access audit, and found to be non-compliant with meeting Access and Availability standards will be subject to disciplinary action.

Step 1: Written Warning Notification will be issued to Provider when a deficiency is identified. QM will conduct re-audit 10-15 days after Provider has received written warning notification to correct the deficiency. QM will forward findings/recommendations to Network Management on a continual basis and post QM survey log to a common internal folder to be accessed by Network Management.

Step 2: If Provider is non-compliant after Step 1, QM Department will issue a Corrective Action Plan (CAP) to Provider and inform Network Management within 1 business day after due date is noncompliant. Provider Network will respond to QM within 3 business days with outreach or action plan for noncompliant provider. The Provider will be required to address the deficiency, document a respond to CAP, sign CAP and send back to QM within 7 days of receiving the CAP. Upon receipt of completed CAP, QM will re-audit Provider to ensure deficiency was corrected and Provider is compliant. QM will forward findings/recommendations to Network Management on a continual basis and post QM survey log to a common internal folder to be accessed by Network Management.

Step 3: If Provider remains non-compliant after Step 2, QM may escalate actions to Network Management and Contracting Department to issue letter of communication to Provider for potential breach of contract for not meeting Access and Availability standards. The following repercussions will be incorporated:

- Providers that are non-compliant for three (3) consecutive occurrences will not be eligible for Prospect Quality Incentive Rewards & Bonus Programs, until compliance is met and sustained for three (3) months.
- Prospect may impose capitation withholds (adhering to contract stipulations) for Providers who remain non-compliant.
- In addition, for continued non-compliance, Prospect may include panel closure for the respective line of business.
- Final disciplinary action, Prospect may terminate Provider contract.

Access Studies

PHP will identify enrollees each year who have utilized emergency room (ER) services. PHP advocate contacts enrollees who access ER for causes for visits. A study of the barriers to the usage of ER visits and the impact of LTSS to such usage will be done with a random sample of enrollees who visit the ER.

QM will analyze the results of the calls and causes of ER utilization and will be reviewed by

the Quality Management Committee for any improvements needed. If indicated, a referral to Case Management will be made and involve PCP/SCP. If an IPA system issue exists, process improvements will be addressed.

STAFF PROCESS FLOW

A. QM receives quarterly PCP/SCP/Ancillary lists for filtering of providers to begin access calls. QM Team receives access and availability complaints by fax, telephone, in writing, or by Health Plan request.

B. QM Team will outreach to provider with use of Access Audit Tool. Results of audit will be documented on workflow sheet with findings.

C. Daily QM team outreach calls to provider offices to verify compliance with:
   - After hours phone script
   - Appointment availability
   - After hours physician call back

D. Compliant Providers are documented in tool. They will remain on list and re-audited annually or as needed if access issue is identified.

E. Non-Compliant Providers:
   - QM Team will send out a warning letter regarding the audit results with request for correction of findings.
   - Re-audit completed with-in fifteen (15) days after the warning letter is sent out.
   - If non-compliance continues a corrective action letter is sent to provider for response within seven (7) to ten (10) days.
   - Re-audit will take place after response letter is received to ensure compliance is confirmed and accurate.
   - If still non-compliant:
     - The provider is escalated to Provider Network, Contracting and Credentialing for further action which may include termination of contract.
   - QM Team will continue to audit provider that received a CAP letter and are compliant for two (2) additional quarters.

PROVIDER SCRIPTS

AFTER HOURS CALL SCRIPT

- You have reached the office of (name of Physician or Practice name).
- If you are having a life threatening emergency, please hang up and call 9-1-1 or go to the nearest emergency room.
- Our office is now closed. Our normal office hours are (fill in the office hours)
- If your call is urgent, please press (##) to be connected to our answering service. **-- OR --** If your call is urgent, please hang up and call our on call physician at (cell phone number), your call will be returned within 30 minutes.
- Our practice is committed to provide you access to our doctor, nurse and office staff; and values you as a patient.
- Please feel free to leave a non-urgent message and your call will be returned to you with in one business day.

DAY TIME CALL SCRIPT

- Thank you for calling the office of (name of Physician or Practice name).
- If you are having a life threatening emergency, please hang up and call 9-1-1 or go to the nearest emergency room.
- Our normal office hours are (fill in the office hours)
- If your call is urgent, and you have reached this message during normal office hours, please press (##) or leave a message and your call will be returned within 30 minutes.
- Our practice is committed to provide you access to our doctor, nurse and office staff; and values you as a patient.
- Please feel free to leave a non-urgent message and your call will be returned to you with in one business day.
- Please reference the Provider Manual saved on your Aerial Care Dashboard under the My Links section for more detail regarding the *Exceptions for Preventative Care Services and Periodic Follow-Up Care - Advance Access; Appointment Rescheduling; Extending Appointment Waiting Time; and Other Applicable Requirements.* Thank you for your cooperation and dedication to our members.

Prior Authorization Requirements and Time Frames for Decisions

Prospect Medical offers direct access/auto-approval for initial consultations to many specialties. For requests requiring evaluation, Prospect Medical will adhere to the following standards for timeliness of utilization determinations based on regulatory requirements for product lines including Medicare Advantage, D-SNP, Dual Option:

Medicare/Dual Option Timeliness Standards

UM decision needed	Decision time frame
Standard (non-expedited) Pre-service Determinations	Within 14 calendar days of receipt of request
Urgent Concurrent Review	Within 24 hours of receipt of the request
Expedited Initial Determinations	Within 72 hours of receipt of request
Reopening of Adverse Determination (additional information received)	If meets CMS criteria (MCM Chapter 13 130.1) for reopening.

Standing Referral/Extended Access To Specialty Care

PURPOSE:

To outline a process for Prospect members with a condition or disease that requires specialized medical care over a prolonged period of time to obtain a standing referral for ongoing extended access to a specialist or specialty care center for the treatment of a disabling, life threatening or degenerative condition

DEFINITION:

A. Standing Referral – A referral by the PCP for more than 1 visit to a participating specialist or specialty care center as indicated in an approved treatment plan. A member may request a standing referral to a specialist through his/her PCP or through a participation specialist.

B. Specialty Care Center – A center that is accredited or designated by an agency of the State or Federal government or by a voluntary national health organization as having a special expertise in treating a life threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

C. Life-threatening, degenerative or disabling conditions include, yet are not limited to: Oncology, HIV/Aids, and chronic care patients being managed by a specialist (e.g. Cardiology, rheumatology)

D. HIV/AIDS Specialist – means a physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the State of Arizona

POLICY:

A. Standing Referral requires that a health plan, or Prospect, who is responsible for a patient with a condition or disease that requires specialized medical care over a prolonged period and is life threatening, degenerative, including Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or a disabling conditions must be allowed a standing referral to a specialist or a specialty care center who has expertise in treating the condition or disease.

B. A member with HIV or AIDS will have access to an HIV specialist defined by the HIV Medicine Association of the Infectious Disease Society of America (HIVM or the IDSA) and American Academy of HIV Medicine (AAHIVM) as:

   1. Having clinically managed at least 25 HIV infected patients within the last year (number of patients may vary depending upon the concentration of HIV infected patients in a given community).

   2. Demonstrating continuous professional development by a minimum of 30 hours of HIV specific CME category 1 credits per year (including a minimum of 5 hours related to antiretroviral therapy) or completing annually at least 15 hours of related CME category 1 credits, plus passing the HCME (HIV Medicine Competency Exam).

3. Successfully completing the Infectious Diseased Board certification or maintenance of certification for the current year provided the patient experience and educational recommendations above are continued.
4. At least having a consultative relationship with a physician meeting the above criteria (in communities where no physician meeting these criteria are available).

C. The patient's PCP in consultation with the specialist and Medical Director of the health plan or Prospect Medical (Prospect) determine if the member needs continuing care from a specialist or a specialty care center. If it is determined that access to be medically necessary, then the specialist must be allowed to see the patient in his/her area of expertise in the same manner as the patient's PCP. Prospect can approve the current standing referral order to a specialist or a specialty care center with or without a treatment plan.

D. The PCP shall retain responsibility for basic case management/coordination of care unless a specific arrangement is made to transfer care to the specialist for a specified period of time, in accordance with the PCP contract with Prospect.

E. A decision on all referral requests must be made within four (4) business days from the date the necessary information is received and the determination notification shall be within 2 working days of treatment plan agreement. **One (1) consult and four (4) follow-up will be approved.**

F. Decisions must be made within the time frames appropriate to the condition of the member (e.g., urgent, non-urgent, concurrent.)

G. Treatment plans may limit the number of specialist visits or the length of time the visits are authorized and may require the specialist to make regular reports to the PCP.

H. If the needed specialist is unavailable within Prospect's network, the PCP will refer to an out of network specialist who can provide the appropriate care.

I. Standing referrals do not require Prospect to refer a specialist who, or to a specialty care center that, is not employed by or under contract with Prospect to provide health care services to members unless there is no specialist within the plan network that is appropriate to provide treatment to members as determined by the PCP in consultation with the Medical Director has documented in the treatment plan

J. Annually Prospect will provide to the department responsible for standing referrals a list of appropriately qualified HIV/AIDS specialists

K. HIV/AIDS referrals on direct, in instances where this does not apply follow standing referral process of one (1) consult and four (4) follow-up approved.

PROCEDURE:

1. Standing Referrals
   A. Requests for standing referrals will be made either by the member's PCP, Specialist, or the member.
   B. The request will be reviewed and agreed to by the PCP and specialist and submitted to Prospect.
   C. Standing referral requests include

i. Member diagnosis
ii. Required treatment, specific services
iii. Requested frequency and time period
iv. Relevant medical records

2. Review and Determination (Refer to ICE Standards)

A. Prospect will review the request and determination will be made in a timely fashion appropriate for the member's condition not to exceed 3 business days of receipt of the request.
B. Once the determination is made, the referral must be made within 4 business days of the date the proposed treatment plan, if any, is submitted to Prospect Medical Director.

C. Communication of determination to the member and involved practitioners will be provided within 2 working days of receiving necessary records and information.

D. The approval may include:
   i. Number of visits approved.
   ii. Time period for which the approval will be made.
   iii. Specific services.
E. If denial appropriate after Medical Director Review clear and concise reason for the denial will be documented. Clinical reasons for deny, delay or modified services will be documented in core system and on member/provider letter. Medical Director name and direct phone number will be available on denial cover sheet. Member denial letter will include appeal rights and IMR.

3. Out of network providers

A. Prospect is not required to refer members to out-of-network providers unless appropriate specialty care is not available within the plan or group's network.

B. Prospect's physician reviewer and PCP will consult and shall determine whether an appropriate in-network specialty provider is available.

4. Terminated Specialists and Primary Care Physicians Process

A. Prospect Medical will notify members with a 60 day prior notice when a specialist or PCP terminates his/her contract with PROSPECT. PROSPECT will notify the health plan 90 days prior to a specialist or PCP terminating.

B. Credentialing Department will notify assigned Medical Management by email the terminating provider with term date.

C. The Medical Management will run a current authorization report for terminated providers. The specialist will be asked for a current list of members receiving treatment/care.

D. Medical Management will generate a letter and mail to the member with notification of termination and re-direction with approval to continue care with specialist until further arrangements are made with newly contracted provider. The Patient Advocate will assist member with transition to a new specialist within the contracted network providers when indicated.

Medical Office Standards

PURPOSE:

To ensure that contracted medical offices are clean, safe, consistent with state and federally regulatory, and accrediting agency standards, and to assure appropriate access to quality of patient care.

POLICY:

PROCEDURE:

Access

- Entrance for handicapped equipment with a ramp and handrails on both sides
- Access to an elevator if facility is a multi-story building
- Bathroom is handicapped accessible
- Adequate regular and designated handicapped parking available
- Facility is easily recognizable with clearly marked address and name
- Waiting and exam rooms (2 exam rooms/physician on duty) are of adequate size and seating
- Exits and evacuation plan are clearly identified
- Office hours and after hours are posted

Cleanliness and Safety

- Corridors, hallways, and doorways are free of obstruction
- Exits are visible and clear of obstruction
- Waiting rooms, exam rooms, equipment, and supplies are clean
- There are no noxious odors
- Fire extinguisher(s) are visible and conveniently located
- Fire inspections are current
- Emergency/Disaster Plan for earthquake, fire, etc.

Appropriate Storage of Supplies, Instruments, Trash and Infection Control

- Containers for disposal of syringes and needles are located in every room
- Hazardous and toxic materials are centrally stored away from treatment areas
- There is compliance with a written OSHA Exposure Control Plan and Policy and Procedure
- There is compliance with a written Sterilization Policy and Procedure
- Medical instruments are sterilized after each use, or disposed of if disposable
- No needles or syringes are stored in the exam rooms or within patient access
- No prescription pads are stored in the exam rooms or within patient access
- Trash is contained and properly stored
- All clean patient supplies are stored above floor level.

Appropriate Storage of Drugs and Medical Records

- Medical records are stored in a secure area with no patient access
- Drugs are current and routinely checked for outdates
- There is a procedure for dispensing samples
- Refrigerated drugs are locked with restricted access and log

- Drug administration is done by a licensed staff member or practitioner
- There is compliance with a written policy & procedure for storage of drugs and medical records

Imaging (if applicable)

- Equipment is appropriately state inspected and licensed
- Equipment and staff licenses are current and posted
- There is compliance with a written imaging policy and procedure

Lab (if applicable)

- On-site lab is CLIA certified, or if meets requirements has a certificate of waiver

Emergencies

- Staff are trained in emergency procedures (CPR or 911)
- Emergency equipment/supplies/drugs are available and routinely checked
- There is compliance with a written emergency policy and procedure
- There is compliance with a written Fire/Safety/Disaster policy and Procedure

Written Risk Management Policies and Procedures (staff is familiar and in compliance with):

- Advance Directive
- Confidentiality
- Medical Office Standards
- Medical Office and Record Keeping On-Site Audit Tool and Reviewer Guidelines
- Member's Rights and Responsibilities
- Member and Practitioner Complaint process
- Missed appointments
- Notification of Test Results
- Referral/Authorization/Eligibility/Benefits/Co-Pay process
- Reporting Abuse/Neglect for Children, Elder/dependent, Domestic Violence
- Risk Management
- Treatment Consent

Intake System

- Office staff are professional and courteous
- Office staff speak language of member population
- There is provision for 24 hour care coverage
- Office waiting room wait time is within 30 minutes
- Office telephone wait time is within 30 seconds
- Appointment schedule wait time is 1) immediate for emergent, 2) within 24 hours for urgent, 3) within 7 calendar days for PCP routing (symptomatic), 4) within 14 calendar days for SCP non-urgent referral, 5) within 30 calendar days for preventive care (includes physical exams).
- No more than 2,000 total members/practitioner
- There is an access policy and procedure
- There is an after-hours calls policy and procedure

Health Education/Promotion

- Practice and Preventive Care Guidelines are followed
- Written practice guidelines
- Written preventive guidelines
- Information and services are made available to members

Advanced Directive

Purpose

To ensure patient's rights to make decisions concerning medical care, inclusive of the right to accept or refuse treatment and the right to prepare advance directives (defined by the Patient Self-Determination Act) effective 11/5/90 as part of the Omnibus Budget Reconciliation Act of 1990, as written instructions, such as living wills or durable powers of attorney of health care, recognized by State law or court decisions.

Policy

It is the policy of Prospect Medical Group (PMG) that information describing the patient's rights to formulate advance directives and PMG's policies respecting implementation of these rights, as well as advance directive forms
will be provided to all adult members who may complete a Durable Power of Attorney for Health Care, a declaration under the Natural Death Act, or any other recognized advance directive. PMG will not refuse to treat, or otherwise discriminate against a member who has completed an advance directive or self-determination forms. PMG will honor advance directivesand assist and guide patients with regard to these sensitive issues concerning advance directives. An adult is defined as being 18 years of age or older.

Procedure

- The patient's physician will become well informed about advanced directives and take an active role in assisting patients to understand the benefits of these documents. Such discussions ideally should take place before a patient is faced with a serious illness, for example; during a patient's annual exam or other routine visits.
- If the patient's physician has a moral objection to a patient's or surrogate's decision to forgo life sustaining treatment, PMG will have established protocols for how to transfer a patient to another physician/facility.
- If a patient's physician is requested to provide treatment that the physician believes is unambiguously futile, the physician will be advised to consult his/her hospital ethics committee and/or his/her professional liability carrier and/or personal legal counsel.
- PMG will have concurrently established policies on determination of a patient's decision making capacity, identification of a surrogate and Do Not Resuscitate (DNR) orders.
- A signed advance directive should be noted in the patient's medical records.

Decision Making Capacity: case law, adult persons with decision making capacity have the right to accept or refuse any proposed medical treatment or procedure, including a life- sustaining procedure. A medical treatment or procedure should not be performed without a patient's informed consent. If a patient becomes mentally incapacitated, the right to control medical decisions survives to the extent that a surrogate decision-maker is recognized ashaving authority to make decisions on behalf of the patient.

Identification of a Surrogate: A surrogate decision-maker has the same rights to accept or refuse medical treatment that the patient had before becoming incapacitated and can be an agent (attorney-in-fact) appointed in a Durable Power of Attorney for Health Care, a court-appointed conservator of the person, a family member, or a significant other. An agent appointed pursuant

to a Durable Power of Attorney for Health Care (DPAHC) has priority over all other potential surrogates, including a conservator of the person. A conservator of the person takes precedence over family members or significant others. If there is neither a DPAHC agent nor a

conservator of the person, the attending physician must identify an appropriate surrogate decision-maker with whom to consult. Health care providers can safely follow the practice of turning to an incapacitated patient's spouse, parents, adult children or other close relatives to make the following medical decisions on behalf of an incapacitated patient: 1) placement in a mental health treatment facility, 2) involuntary mental health treatment, 3) experimental therapy, 4) convulsive treatment, 5) sterilization, or 6) abortion. Health care providers should consult their legal counsel regarding these treatments. If no surrogate decision-maker can be obtained, then the physician/facility will obtain a court order authorizing the recommended medical decision.

DNR Orders: Do Not Resuscitate or No-Code Orders have been used by physicians to indicate that the application of standard cardiopulmonary resuscitative procedures in the event of cardiac arrest would be inappropriate for a patient under particular circumstances. The issue of the appropriateness of withholding CPR is treated the same with respect to withholding any other kind of life-saving or life-sustaining treatment. policy states that in the rare event a physician has determined that a resuscitation attempt would be unambiguously futile and harmful to the patient; it is ethically acceptable to write a DNR order even if the patient or family disagrees.

Durable Power of Attorney: Individual names an agent to make health care decisions for him/her when incapacitated and unable to do so (inclusive of right to patient information, treatment decisions, donation of organs, autopsy authorization, and disposal of remains.) The following cannot be agents: the patient's treating health care provider, or an operator or employee of a community care facility or of a residential care facility for the elderly, unless they are the patient's relative by blood, marriage or adoption. In addition, the conservator of a patient who is a conservator under the Lanterman-Petris-Short Act may not serve as an agent, unless the conservator's attorney has signed a certificate indicating the attorney has advised the patient about this or her/his rights in connection with the consequences of signing or not signing a DPAHC. Specific instructions can be given to this agent as to what treatment is to be provided under a given circumstance and under what circumstance(s) treatment should be withdrawn.. It provides legal protection to the agent and physician when directives are followed and it eliminates the need for a Living Will when both agent and specific guidelines are defined. A terminal illness is not required to enact. A DPAHC is enforceable onlyif and while, the principal is mentally incapacitated. A valid document is effective indefinitely unless the document specifies that it is only valid for a certain period of time. The document must be appropriately witnessed or notarized. The notary may be a notary public employed by PMG. If the witness option is chosen, there must be two (2) witnesses who sign the document. The following persons may not be witnesses: the agent named in the DPAHC, the patient's treating health care provider (inclusive of individuals or facilities), an employee of the patient's treating health care provider, or the operator or an employee of an operator of a community carefacility, or a residential care facility for the elderly. In addition, at least one of the witnesses can not be related to the principal by blood, marriage, or adoption, or entitled to any part of the patient's estate under the patient's current will or by operation of law. If the patient is in a skilled nursing facility, one of the witnesses must be a patient advocate or ombudsman. A patient (withsufficient decision-making capacity) may revoke a DPAHC by notifying the agent or treating provider orally or in writing, legislation effective 8/9/92, a DPAHC or similar document executed in another state in compliance with the laws of that state or of California, is valid and enforceable

in California.

Natural Death Act (Living Will): To withhold or withdraw specific procedures that would artificially

prolong life. A patient may sign a document stating that he or she does not wish to receive life sustaining treatment, including artificially administered nutrition and hydration, if in the future he or she becomes terminally ill or permanently unconscious (incurable or irreversible injury/disease, illness) as diagnosed by two physicians. The document should contain at least the specific language. A declaration must be appropriately signed by the declarant and witnessed by two persons. The following persons cannot be witnesses: a health care provider, an employee of the health care provider, the operator or the employee of a community care facility, or the operator or employee of an operator of a residential care facility for the elderly. In addition, one of the two witnesses cannot be a person who is related to the declarant by blood or marriage or who would be entitled to any portion of the declarant's estate under the existing will or codicil or by operation of current law. Finally, if the declarant is in a skilled nursing facility, one of the witnesses must be a patient advocate or an ombudsman. A qualified patient's Declaration is not enforceable if the attending physician knows that the patient is pregnant. A Declaration becomes effective when 1) the Declaration is communicated to the attending physician and 2) the declarant is diagnosed and certified in writing by the attending physician and a second physician to be terminally ill or permanently unconscious and no longer able to make decisions regarding the provision of life-sustaining treatment. A valid declaration is effective indefinitely. Upon determining that the patient is terminally ill or permanently unconscious, the attending physician who knows that a Declaration exists must document the determination of terminal condition or permanent unconsciousness and the Declaration's terms in the patient's medical record and place a copy of the Declaration in the record, if he has not already done so. A physician who willfully fails to record a determination of terminal condition or permanent unconscious condition or the terms of a Declaration in the patient's medical record is subject to criminal sanctions. A Declaration does not provide a means for a declarant's desires to receive life-sustaining or other types of treatment. A patient may revoke his or her Declaration at any time and in any manner regardless of his or her mental or physical condition. A revocation is effective when it is communicated to the attending physician or health care provider by the declarant or a witness to the revocation. The attending physician or health care provider must note the revocation in the patient's medical record. Preexisting Living Wills that meet these requirements now have the same status as a Declaration prevails unless the person expressly provided otherwise in the DPAHC itself.

Directive to Physician Form: Unexpired (effective only 5 years from date it was signed) and properly completed directive to physician forms remain valid and may be given effect, however since a Directive's terms are more restrictive than a Declaration, and it expires. Patients who present with this form should be encouraged to replace it with a Declaration.

IT SHOULD BE NOTED THAT ALL PERSONS 18 YEARS AND OLDER ARE URGED TO SIGN AN ADVANCE DIRECTIVE UPON INITIAL REGISTRATION AND FOR THOSE WHO HAVE ALREADY REGISTERED AT THEIR NEXT SCHEDULED APPOINTMENT.

Physician Orders for Life-Sustaining Treatment (POLST)

POLST is a physician order that helps give seriously ill patients more control over their end-of-life care. Produced in a distinctive bright pink form and signed by both the doctor and patient, POLST specifies the types of medical treatment that a patient wishes to receive towards the end of life. As a result, POLST can prevent unwanted or medically ineffective treatment, reduce patient and family suffering, and help ensure that patients' wishes are honored.

The decisions documented on the POLST form include whether to:

- Attempt cardiopulmonary resuscitation,
- Administer antibiotics and IV fluids,
- Use intubation and mechanical ventilation, and
- Provide artificial nutrition.

POLST was developed in response to seriously ill patients, or those who are medically frail, regardless of their age, receiving medical treatments that were not consistent with their wishes. The goal of POLST is to provide a framework for healthcare professionals so they can provide the treatments patients DO want, and avoid those treatments they DO NOT want.

Filling out a POLST form is entirely voluntary..

The POLST form compliments an Advance Directive and is not intended to replace that document. An Advance Directive is still necessary to appoint a legal health care decision maker, and is recommended for all adults, regardless of their health status. If there is a conflict between a POLST form and an Advance Directive, the more recent document would be followed.

A healthcare professional can complete the POLST form based on a family members' understanding of their loved one's wishes. The appointed decision maker can then sign the POLST form on behalf of their loved one.

The original POLST form, on bright pink paper, stays with the patient at all times. If the patient is transferred to another setting, the POLST form goes with them.

- In the acute care or long-term care setting, the form should be kept in the patient's medical record or file.
- At home, patients should be instructed to place the form in a visible location so it can be found easily by emergency medical personnel – usually on a table near the patient's bed, or on the refrigerator.

The POLST can be modified or revoked by a patient, verbally or in writing, at any time. Changes may also be made by a physician, or requested by a patient's decision maker, based on new information or changes in the patient's condition.

It is good clinical practice to review a patient's POLST form when any of the following occur:

- The patient is transferred from one medical or residential setting to another;
- There is a significant change in the person's health status, or there is a new diagnosis;
- The patient's treatment preferences change.

Facing Serious Illness: Making Your Wishes Known

Your Guide to POLST
(Physician Orders for Life-Sustaining Treatment)

POLST: WHY IT'S IMPORTANT

Making sure your loved ones and doctors know what kinds of medical treatment you want toward the end of your life is very important. But until recently, there was no reliable way to do that. That's where POLST comes in.

POLST (Physician Orders for Life-Sustaining Treatment) is a form that clearly says what kinds of medical treatment patients want toward the end of their lives. Printed on bright pink paper, POLST helps give seriously-ill patients more control over their treatment. The form is signed by the patient and their doctor, nurse practitioner or physician assistant. The form works even if the patient later loses the ability to say what he or she wants.

POLST also helps you talk with your health care team and your loved ones about your choices. In this way, POLST can help reduce patient and family suffering, and make sure that your wishes are known and honored.

This brochure will help you learn more about POLST.

"Because my mom made her own decisions by filling out a POLST form, I didn't have to guess about what she wanted. This was comforting for both her and our family."

— Paul Waterstraat, Davis, CA

ABOUT POLST

Here are answers to questions often asked about POLST.

What does POLST do?

- **POLST makes your treatment wishes known to doctors and other members of your health care team.** Too often, patients near the end of their lives may get treatment they do not want. These treatments may not help them live longer or better. Sometimes this treatment can cause pain. POLST gives you a way to tell doctors, nurses, and other health care team members what types of treatment you want.

- **POLST makes your wishes clear to your family members and caregivers.** Sometimes, family members have their own ideas about what types of treatment their loved ones would want. POLST makes sure your family members and caregivers know exactly what treatments you do and do not want. No one has to guess or argue.

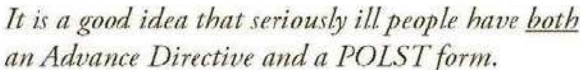
Who should have a POLST?

Doctors say that any seriously-ill patient should have a POLST form. Filling out a POLST is completely up to you. It's your choice.

Is POLST different from an Advance Health Care Directive?

Yes. An Advance Directive allows you to choose the person you want to speak for you, and provides a general guide to what you want. POLST is different because:

- POLST is for the seriously ill;
- POLST tells your exact wishes about certain medical treatments;
- POLST is a signed medical order that your health care team can act upon; and
- POLST goes with you to your home, your hospital, or your long-term care facility. It goes where you go.



It is a good idea that seriously ill people have <u>both</u> an Advance Directive and a POLST form.

Who can help me fill out a POLST form?

Your doctor, nurse, social worker, or chaplain can help fill out the POLST form. Make sure you talk with your health care provider about the treatments you want or don't want. The form must be signed by your doctor, nurse practitioner or physician assistant, and you or the person you pick to make decisions for you.

What do I do with my POLST form?

Once signed, the POLST form will become part of your medical record. The form stays with you all the time.

- If you are at home, put it near your bed or on your refrigerator.
- If you are in a hospital, nursing home, or assisted living facility, it will be in your chart or file.
- If you are moved between locations, your POLST form will go with you.

What if I want to change my POLST form?

You and your doctor can change your POLST form whenever you want.

POLST: WHAT THE TREATMENT OPTIONS MEAN

The POLST form lists some of the medical treatments you can choose to have or not have. Your doctor, nurse practitioner or physician assistant can help you decide which treatment options will best help you reach the goals you have for your care.

- **Resuscitation:** Cardiopulmonary resuscitation, or CPR, is when someone tries to start your breathing and heartbeat after they stop; CPR may or may not work. The person doing CPR must push hard on your chest to try to restart your heart. They may also use an electrical shock (defibrillation). Or, they may put a tube down your throat to help you breathe (intubation). A machine may also pump air in and out of your lungs through the breathing tube (mechanical ventilation/ respiration).

  Resuscitation can benefit healthy people, but it is not usually helpful for people who are seriously ill. It can cause broken ribs or punctured lungs. Even if the heart is started again, the brain can be damaged by lack of air. Older patients and those with serious illness often lose physical and mental ability even if the heart is started again.

- **DNR:** Do Not Resuscitate (or DNR) is a medical order not to try resuscitation because the patient does not want it or because it won't help. DNR is also called *Allow Natural Death*.

- **Comfort-Focused Treatment:** These medical treatments are always provided. They are meant to make you feel comfortable and reduce your pain. They are not meant to make you live longer.

- **Antibiotics:** Antibiotics fight infections like pneumonia, and reduce the symptoms and pain caused by those infections. They do not relieve the suffering that is caused by other health conditions.

- **Intravenous (IV) Fluids:** These are fluids that are put into your body through a tube placed in a vein. Usually, IV fluids are given for a short time to help you get through a specific illness.

- **Artificial Nutrition/Tube Feeding:** This is a way of feeding a person through a tube either in his/her nose or directly through the skin into his/her stomach. Tube feeding can help people who cannot swallow now, but who are expected to get better. However, people near the end of life may feel more comfortable without a feeding tube and want to eat what they can by mouth. Tube feeding can cause pneumonia, and may result in swelling and infection.

  As a person nears the end of life, their need for food and fluids will lessen. During this time, their bodies are not able to use food and fluids like a healthy person. Near the end of life, tube feeding can actually cause increased bloating and discomfort.

It's important for you to understand what each of these options mean, so make sure you talk to your doctor, nurse practitioner or physician assistant before you make any decisions. You can then choose what treatment options you want and don't want.

"When patients have a POLST form, we know exactly what treatments they want and don't want. It clears up any confusion, and gives patients peace of mind."

— Steve Lai, MD, Santa Clara County, CA

To learn more about California POLST, log on to:

www.caPOLST.org

PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

The Coalition for Compassionate Care of California (CCCC) provides leadership and oversight for POLST outreach activities in California, with support from the California HealthCare Foundation.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 1/1/2016)*

First follow these orders, then contact **Physician/NP/PA**. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — Check One

CARDIOPULMONARY RESUSCITATION (CPR): *If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A requires selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — Check One

MEDICAL INTERVENTIONS: *If patient is found with a pulse and/or is breathing.*

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
☐ ***Request transfer to hospital only** if comfort needs cannot be met in current location.*

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: ____

____

C — Check One

ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

☐ Long-term artificial nutrition, including feeding tubes.
☐ Trial period of artificial nutrition, including feeding tubes.
☐ No artificial means of nutrition, including feeding tubes.

Additional Orders: ____

D

INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _______, available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: ____________________
Phone: ____________________

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	FOR REGISTRY USE ONLY
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information		
Name (last, first, middle):	Date of Birth:	Gender: M F

NP/PA's Supervising Physician	**Preparer Name** (if other than signing Physician/NP/PA)	
Name:	Name/Title:	Phone #:

Additional Contact ☐ None		
Name:	Relationship to Patient:	Phone #:

Directions for Health Care Provider

Completing POLST

- **Completing a POLST form is voluntary**. California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive**. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force. For more information or a copy of the form, visit **www.caPOLST.org**.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Special Needs Plans Background

2003: Special Needs Plans (SNP) were created as part of the Medicare Modernization Act. Medicare Advantage plans must design special benefit packages for groups with distinct health care needs, providing extra benefits, improving care and decreasing costs for the frail and elderly through improved coordination. A SNP can be for one of 3 distinct types of members:

- D-SNP: Dual Eligible SNP for members eligible for Medicare and Medicaid
- C-SNP: Chronic SNP for Members with severe or disabling chronic conditions
- I-SNP: Institutional SNP for members requiring an institutional level of care or equivalent living in the community

Goals of Special Needs Plans

- Improving access to medical, mental health, and social services
- Improving access to affordable care
- Improving coordination of care through an identified point of contact
- Improving transitions of care across health care settings, providers and health services
- Improving access to preventative health services
- Assuring appropriate utilization of services
- Improving beneficiary health outcomes

SNP Model of Care Includes:

- Specialized Provider Network
- Integrated Communication Systems
- Additional Benefits
- Case Management for All Members
- Annual Health Risk Assessments
- Individualized Care Plan for Each Member
- Interdisciplinary Care Team to Coordinate Care
- Management of Care Transitions
- Coordination of Medicare and Medicaid Benefits
- Specialized Services for Chronic SNPs
- Quality Improvement Program

Member Centered Model of Care

- Member is informed of and consents to Case Management
- Member participates in development of the Care Plan
- Member agrees to the goals and interventions of the Care Plan
- Member informed of Interdisciplinary Care Team (IDCT) members and meetings
- Member either participates in the IDCT meeting or provides input through the Case Manager and is informed of the outcomes.

Case Management

All SNP members are eligible for case management and have an individualized care plan and ICT developed. Members may opt out of active case management but remain assigned to a Case Manager who contacts member if there is change in status.

Members are stratified according to their risk profiles to focus resources on the most vulnerable.

PMG Case Manager will coordinate the member's Interdisciplinary Care Team (ICT).

After Hours Calls

PURPOSE
To ensure 24 hour provider access to members and to ensure continuity of care.

POLICY
It is the policy of Prospect Medical to ascertain that member's needs are responded to after normal business hours.

RESPONSIBILITY
Providers:

PROCEDURE
1. After hours calls (defined as those hours which are not normal medical group business hours) will be managed by a telephone system or service which pages an on-call provider for patient triaging and authorization of care. The after-hours message must include: a.) instructions to call 911 or go to the nearest ER, in cases of life-threatening condition, and b.) the procedure for reaching a Doctor on call, if needed.
2. After hours telephone logs will be maintained.
3. After hours calls patient information will be sent to patient's PCP for follow-up and documentation in patient's chart.

Assessing Member Satisfaction

Purpose
To outline the process to analyze the mechanisms to determine member satisfaction with Prospect Medical Group Arizona (PMG AZ).

Policy

- It is the policy of PMG AZ to participate in Physician Specific PAS Survey.
- It is the policy of PMG AZ to review grievances/appeals to determine membersatisfaction.

Procedure

- On a monthly basis, grievances/appeals will be reported to the QI Committee regardless of who performs the data collection and resolution/analysis.
- Categories reviewed include: Miscellaneous cases; Health Plan (HP) appeals, grievances and expedited appeals; Member grievances; Provider grievances and appeals; Internal quality of care cases.
- Reasons reviewed include (all reasons are member allegations): Access problems; Member unhappy; Problems with office staff; Delay of referrals; Mismanagement of care; Co-payment/balance bill issues/claims issues.
- Opportunities for Improvement: Grievance/appeal tracking/trending will be reviewed to identify opportunities for improvement, to decide which opportunities to pursue, and the interventions for implementation. Results will be based on number per 1000 members and compared to a standard or a goal, if one was set.
- At the time the PAS results are received, they will be reported to the QI Committee for review to identify opportunities of improvement, development interventions and the process to implement.

Confidentiality

PURPOSE
To protect the patient's right to privacy and the records pertaining to medical care from loss, alteration, unauthorized use or damage in compliance with HIPAA regulations and all applicable law. To ensure the confidentiality of member information used for any purpose. To protect the patient's right to access their medical records. To define the guidelines for release of patient information.

POLICY
It is the policy of Prospect Medical to maintain the patient's right to privacy and right to access their medical records.

RESPONSIBILITY
Providers and office staff

PROCEDURE
- The contracted practitioner/provider's contracts will explicitly state expectations about the confidentiality of member information and records.
- Prospect Medical will inform members of its Confidentiality Policy and Procedure.
- All requests for patient information will be reviewed to determine whether or not the party requesting the information will be allowed access to the information. Court orders (subpoenas, search warrants, etc.) for patient medical records must be reviewed by the medical group's legal counsel prior to turning over the records.
- The identity of the member will be blinded when using data for reporting, training, research, publication and/or marketing unless a written release is obtained from the member.
- Release of information must be documented in the patient medical records. The documentation must include:
    - Date and circumstances under which disclosure was made
    - Names and relationships to the patient of persons or agencies to whom disclosure was made
    - Specific information disclosed
- Professional personnel involved with the patient's care and related activities (i.e., provider, nurse, and other appropriate staff) are permitted access to the patient's medical record.
- Individuals not involved with the patient's care and related activities are not permitted access to the patient's medical record without a completed and signed Patient Medical Record Release Form.
- A Specific Authorization Patient Medical Record Release Form is required to release some types of information (i.e., results of blood test for HIV, mental health information protected by the Lanterman-Petris-Short Act and ETOH and drug abuse records), which are not covered by the Confidentiality of Medical Information Act.
- Medical Record Information will never be released via telephone by medical record personnel.

- Patient medical records may be transmitted to a requesting provider or facility via facsimile machines making sure that the transmission is confidentially directed and received. Medical staff will verify the FAX telephone number with the recipient prior to sending the document, will attach a cover sheet explaining confidentiality of documents sent, and will verify receipt of document with recipient. The FAX machine will be located in a secure area.

- Computerized Medical Records. Appropriate steps will be taken to reduce the likelihood of record destruction and to backup information adequately, such as anti-virus software, stringent protocols on data sharing and introduction of software programs, and off site automatic tape back-up systems. Providers will implement a system for documenting corrections to computerized records, and make sure that no improper alterations are made, such as compact-disc read-only memory (CD-ROM) systems that allow for automatic and tamper-proof computer dating of subsequent entries. An imaging mechanism will be implemented capable of copying signature documents. Only authorized users are able to input data implementing security measures such as password protected and secure terminal location. Computerized medical record storage should be only in systems that are protected against unwarranted third-party access.
- Patients may request a copy of their medical records by completing and signing a Patient Medical Record Release Form and showing appropriate ID. Patient or patient designated representative access medical record must be permitted within 5 working days following receipt of the patient's written request. However, the provider may, upon notification of the patient, have up to 30 days if the record is voluminous or if the patient has been discharged from a licensed health facility within the preceding 10 days. A minor (under 18 years of age) needs the consent of his/her parent or legal guardian unless the minor has a right to their treatment consent. A minor with such rights will not be allowed to designate a representative if the practitioner/provider determines that access to a minor's medical record by that representative would have a detrimental effect on the practitioner/provider professional relationship with the minor patient or would be detrimental to the minor's physical or mental well being. Proof of executor of estate is required if a relative of a deceased patient is requesting a medical record copy.
- Patient access to medical records may be limited as follows:
  Mental Health Record (including drug and ETOH abuse) when a practitioner/provider determines that there is a substantial risk of significant adverse or detrimental consequences to a patient in seeing or receiving a copy of his/her own mental health record information, the practitioner/provider can refuse the patient access. If the practitioner/provider denies access in this manner, the practitioner/provider must document the request and reason for refusal in the patient medical record and notify the patient of the denial and their right to designate another practitioner/provider for access to the patient.
- Outpatient Mental Health Records will not be disclosed unless there is written consent by the treating provider (psychotherapist) and written notification to the patient within 30 days of receipt of the medical records. The provider requesting the psychotherapist medical records shall make the request in writing 30 days prior and

shall include:

- Specific information requested and it's intended use or uses.
- The length of time the information will be kept before being destroyed or disposal of.
- A statement that the information will not be used for any purpose other than its intended uses.
- A statement that the provider requesting the information will destroy or return the information and all copies made by the provider after the length of time have elapsed.

- Original patient medical records will not be removed from the medical group except under court order or under special arrangements with the Director of Medical Records.
- Patient medical records will be kept in a secure, confidential area.
- Patient medical records will be retained indefinitely. Patient medical records may be converted to microfilm or computer disks for long-term storage.

Elder & Dependent Adult Abuse Reporting

PURPOSE
To ensure that elder and dependent adult rights are protected.

POLICY
It is the policy of Prospect Medical that any report of, or appearance of, a physical injury or condition appearing to be the result of physical abuse, abuse of financial affairs, neglect or abandonment of an Elder or Dependent Adult, will be reported, in accordance with state laws, to the local enforcement agency and Department of Health.

DEFINITION
Abuse means physical abuse, neglect, intimidation, cruel punishment, fiduciary abuse, abandonment, or other treatment with resulting physical harm or pain or suffering, or the deprivation by a care custodian of goods and services which are necessary to avoid physical harm or mental suffering.

Physical Abuse per the Welfare and Institutions Code Section 15610(c) means assault, battery, assault with deadly weapon or force likely to produce great bodily injury, unreasonable physical constraint or prolonged or continual deprivation of food or water, and sexual assault. Sexual assault means sexual battery, rape, rape in concert, incest, sodomy, oral copulation, penetration of the genital or anal opening by a foreign object. Physical abuse means a situation where any person who has the care or custody of or who stands in a position of trust with an elder or dependent adult, willfully inflicts upon that elder a cruel or inhumane corporal punishment or injury.

Physical Abuse Indicators may include but are not limited to the following:

- Multiple injury sites, bruises or welts that have a regular pattern resembling the shape of an article which might have been used to inflict the injury.
- Burns that appear to be from a cigar or cigarette.
- Injuries to the head, neck, chest, breasts or abdomen, contusions, abrasions such as rope burns or lacerations especially on the wrist, ankles, torso, or extremities.
- Fractures many times at different stages of healing, to the skull, ribs, or long bones.
- Injuries to the abdomen, kidney, bladder or pancreas, intestinal perforation, ruptured liver, spleen, or blood vessels, spontaneous abortions resulting from injury to the abdomen, intramural hematoma or the duodenum or proximal jejunum.
- Symptoms of suffocation or chemical abuse.
- Improbable explanation of injuries or major inconsistencies between elder or dependent adult and caregiver's injury etiology description.
- Changes in the elder or dependent adult's behavior when the caregiver enters or leaves the room.

- Appearance of fright, shame, or embarrassment, depression, agitation, stress, inability to cope, panic attacks, feelings of isolation, withdrawal, homicidal or suicidal tendencies.
- Frequent use of prescribed tranquilizers or pain medication.
- Risk factors such as caregiver substance abuse or historical family violence.

Sexual Abuse Indicators may include but are not limited to the following:

- Bruises or abrasions on the inner thighs or external genitalia.
- Alteration in anorectal tone.
- Evidence of a sexually transmitted disease.
- Multiple gynecological problems.

Fiduciary Abuse means a situation where any person who stands in a position of trust, with respect to an elder or dependent adult, willfully steals the money or property of that elder or secrets or appropriates the money or property of that elder to any use or purpose not in the due and lawful execution of his or her trust (inclusive of misappropriation of Social Security funds).

Neglect means negligent failure of any person having the care or custody of an elder or dependent adult to exercise that degree of care, which a reasonable person in a like position would exercise.

Neglect Indicators may include but are not limited to the following:

- Historical or current lack or delay of appropriate care.
- Malnutrition, untreated medical conditions, weight loss.
- Failure to provide physical aids (i.e. eyeglasses, hearing aids, dentures and/or ambulatory assistive devices).
- Signs that caregiver has been unwilling or unable to provide assistance with daily living skills, e.g., poor hygiene, lack of appropriate clothing, lack of a proper diet, urine stains on clothing, etc.

Abandonment means the desertion or willful forsaking of an elder or dependent adult by any person having the care of custody of that elder or dependent adult under circumstances in which a reasonable person would continue to provide care of custody.

Dependent adult means any person between the ages of 18 and 64 who has physical or mental limitations which restrict him or her to carry out normal activities or to protect his or her rights, including but not limited to persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age.

Elder means any person 65 years of age or older.

RESPONSIBILITY
Any medical office personnel (medical or non-medical practitioner or employee) who either has observed an incident that reasonably appears to be physical abuse, has observed physical injury where the nature of the injury, it's location on the body, or the repetition of the injury clearly indicated that physical abuse has occurred or is told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse. Other persons who are not in direct contact with the elderly or dependent adult, but who have knowledge of actual/suspected abuse.

PROCEDURE
A thorough health assessment must be conducted by the provider, which includes a history and physical examination of elder or dependent adult suspected of being a victim of abuse. X-rays, CT scans, bone scans or other laboratory studies are of use in determining and defining the current trauma, previous trauma and excluding other medical conditions. The following diagnostic process should be performed:

- An assessment of the elder or dependent adult's immediate medical needs.
- Compilation of the past medical and social history of the elder or dependent adult and family members (if applicable).
- Assessment of the plausibility of the history being provided in light of pre-existing medical conditions.
- Determination of how great a risk it would be if the elder or dependent adult were to return to their living situation or residence.

Medical Record documentation maintained by the health care practitioner should include but not be limited to the following:

- Name of abuse victim.
- Date/time abuse became known.
- Physical assessment/evaluation, location, extent and character of injuries.
- Map of the location of the injuries on the abuse victim's body, documented at the time of health care service.
- Name and identity of the alleged abuser.
- Description of the abusive event or abuse victim's complaints (in their own words).
- Medical and relevant social history of the abuse victim.
- Health practitioner follows up (i.e. reporting etc.).

The telephone report must be made immediately or ASAP when reporter has knowledge or reasonably suspects that abuse has occurred, to the County Adult Protective Services Agency, Department of Social Services, State Department of Aging, or to a local enforcement agency (i.e. police or sheriff's department), and should include the name of the person making the report, the name, address and age of the elder or dependent adult, the nature and extent of the dependent adult or elderly person's condition, present location of the elder or dependent adult, the names and addresses of family members or any other person responsible for the elder or dependent adult, if known, the alleged

incident of elder or dependent adult abuse and any other information including what led the person to suspect elder or dependent abuse. **The Elder and Dependent Adult Abuse Hot Line for Los Angeles County is (877) 477-3646; for Orange County is (800) 451-5155; for San Bernardino County is (877) 565-2020; and for Riverside County is (800) 491-7123. The Long-Term Care Ombudsman Program 24-hour toll-free number for the Department of Aging Crisis Hotline is (800) 231-4024.**

A written report must be completed within 2 days of telephone report, on a California Department of Social Services form SOC341 entitled “Report of Suspected Elder or Dependent Adult Physical Abuse”, and mailed to the address indicated by the agency that took the phone report as well as the county department of Adult Protective Services.

This form is obtainable from the County Adult Protective Services Agency or the local long-term care ombudsman program.

If the incident is alleged to have taken place in a long-term care facility, the report should be filed with either the long-term care ombudsman coordinator or a local law enforcement agency (i.e. police or sheriff’s department) within 48 hours. If the abuse is alleged to have taken place anywhere else, the report should be filed with the County Department of Adult Protective Services within 48 hours.

The law provides that care custodians, health practitioners, or employees of adult protective services agencies or local law enforcement agencies will not incur either civil or criminal liability for any report they are required or permitted to make under this law. However, any person who knowingly fails to report, when required, an instance of elder abuse is statutorily guilty of a misdemeanor punishable by a fine not to exceed $1,000 or imprisonment in the county jail not exceeding (6) months or both. A health care practitioner may also be liable in civil court for damages, which occur if the elder or dependent adult is further victimized because of failure to report the abuse.

Each medical office employee is subject to this policy and procedure and should be oriented to the policy.

Evaluation Of New Medical Technology

Prospect Medical recognizes the daily advances in the area of health care and the development of new, more advanced technology to improve patient outcomes. In an effort to maintain and improve upon the quality of patient care, authorized use of all new technology must be approved by the Health Plan prior to implementation. All experimental or investigational procedures will be reviewed by the health plan.

Prior to utilizing new technology, documentation of efficacy must be determined. This determination will be used to educate providers who are requesting new technology. This information may also be shared with the health plans to help them determine whether this new technology or treatment is now a “covered benefit”.

Handling Of Biohazardous Waste

PURPOSE
To provide a consistent approach to handling waste considered to be biohazardous and to label or color-code containers used for this waste. To educate all employees that the containers require compliance with universal precautions.

POLICY
It is the policy of Prospect Medical to consider all materials that are potentially contaminated with blood or other body fluids to be considered biohazardous waste and to handle and dispose of this waste in a way consistent with universal precautions and all applicable agency regulations, including CAL-OSHA.

RESPONSIBILITY
Providers, nursing, and office staff.

PROCEDURE
1. Protective gloves are to be worn when handling any potentially contaminated waste.
2. A cover gown should be worn to protect clothing when it is possible that clothing will be contaminated by waste.
3. Masks and/or eye protection should be worn when it is possible that mucous membranes and/or eyes may be splashed with contaminated waste.
4. Biohazardous waste must be disposed of in an appropriate container (i.e., Sharps in Sharps container).
5. Containers holding biohazardous waste must be red and/or labeled with standard fluorescent orange or orange-red “Biohazard” label.
6. All biohazardous waste containers will be disposed of according to federal, state, and local regulations.
7. An exposure control plan is contained in the Bloodborne Pathogens Resource Package.

Hospital Admissions

The emergency room provider or referring MD should contact the Prospect Hospitalist on duty with a medical update prior to admission or transfer decision.

Failure to contact Prospect or the Hospitalist may result in non-payment of the inpatient stay.

Infection Control

PURPOSE
To prevent transmission of potentially infectious agents by providing a consistent approach to managing body substances from all persons.

POLICY
It is the policy of Prospect Medical to consider any materials that could be potentially contaminated with blood or other human body fluids as infectious and to consider all materials, instruments, environmental surfaces, etc. that could possibly be contaminated with blood or body fluids as infectious and to prevent cross contamination of infection between the following categories of persons: patients and employees, patients and patients, patients and visitors, employees and employees, and employees and visitors by the use of proper infection control techniques, appropriate use of clean/sterile supplies and equipment and providing a safe environment utilizing infection control procedures and precautions.

RESPONSIBILITY
1) It is the responsibility of the employer to insure that all policies and procedures meet with all current and appropriate regulations and recommendations and to provide training and review of all policies and procedures as mandated by OSHA and all other applicable agencies.
2) It is the responsibility of the employee that policies and procedures be reviewed, understood and followed at all times.

PROCEDURE
1) All personnel who have occupational exposure to blood borne pathogens will be offered Hepatitis B vaccine and necessary boosters as per OSHA requirements. Documentation of vaccine status or declination will be kept.
2) All personnel must wear protective gloves during procedures where contact with potentially contaminated substances is likely.
3) All personnel must wear protective masks during procedures when it is likely that mouth or nose may be splashed with potentially contaminated substances.
4) All personnel must wear protective eyewear during procedures when it is likely that the eyes may be splashed with potentially contaminated substances.
5) All personnel must wear protective cover gowns during procedures when it is likely that clothes will be contaminated with blood or body fluids.
6) Hands must be washed when gloves are removed or after any direct or indirect contact with any blood or body substances.
7) Potentially contaminated instruments must be handled carefully and while wearing gloves designed to withstand cleaning procedures.
8) Instruments, equipment and environmental surfaces must be cleaned in solutions or sterilizers that are
   appropriate to the level of contamination and that meet appropriate guidelines.
   a) If a critical instrument has penetrated soft tissue or bone or come in contact with mucous membranes it must be sterilized in heat or heat pressure sterilizer.

b) A touch and splash surface that is exposed to the splatter of blood or body fluids or

contaminated by treatment personnel it must be carefully disinfected with an intermediate or higher level EPA registered, hospital grade disinfectant. This includes but is not limited to equipment and environmental surfaces.

9) Use of appropriate housekeeping techniques to prevent cross-contamination.
10) Appropriate management of infectious patients with communicable diseases.

Potentially contaminated waste must be disposed of per Handling of Biohazaradous Waste.

Office Examination Staffing

- When performing certain procedures on a patient of the opposite sex, a staff member should assist the provider and remain in the room until the exam is completed.
- Should the patient request not to have the staff member present, it is recommended that the exam not be done.
- The provider is encouraged to practice risk management and enforce this policy.
- Documentation of refusal to have chaperone present, and failure to complete the exam as a result, should be documented in the medical record.

Practitioner's Right to Discuss Treatment Options

Practitioners are not prohibited from advocating on behalf of the member and are advised of the following:

- The expectation to educate members regarding health needs
- To share findings of medical history and physical exams
- To discuss potential treatment options (including those that may be self-administered) and the risks, benefits and consequences of treatment or non-treatment
- The side effects and management of symptoms (without regard to plan coverage)

Recognize that the member has the right to receive sufficient information, to be able to provide input into the proposed treatment plan and has the final say in the course of action to take among clinically acceptable choices.

Member's Rights & Responsibilities

PURPOSE

To ensure members receive quality care delivered in a professional manner with respect for the member and his/her rights and to ensure members are informed of their rights and

to ensure the protection of member rights during healthcare delivery.

POLICY

It is the policy of Prospect Medical Group (PMG) to demonstrate a commitment to treating members with dignity and in a manner which respects their rights. This policy will be distributed to all contracted practitioners and annually reviewed and revised as necessary.

- Members have the right to receive information about Prospect Medical, its services, its practitioners, its providers, and member's rights and responsibilities.
- Members have the right to be treated with respect and recognition of their dignity and right to privacy.
- Members have the right to make recommendations regarding the organization's member's right and responsibilities policy.
- Members have the right to participate with practitioners in decision making regarding their health care.
- Members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit.
- Members have a right to voice complaints or file appeals regarding Prospect Medical or the care provided.
- Members have the right to be presented by parents, guardians, family members or other conservators for those who are unable to fully participate in their treatment decisions.
- Members have the responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Members have the responsibility to follow plans and instructions for care that they have agreed on with their practitioners.
- Members have the responsibility to supply information (to the extent possible) that PMG and its providers need in order to care for them.
- Members have the right to access services and information in alternative format (inclusive of oral and written) in the language that is prevalent to the PMG population.

Senior Member Complaints & Appeals

PURPOSE
To ensure that all CMS and health plan regulatory requirements are met in processing Senior Member Complaints and Appeals.

POLICY
It is the policy of Prospect Medical to refer senior member service complaints and appeals according to health plan guidelines. Questions/issues, which are not complaints, will be processed by Prospect Medical. Prospect Medical will notify all pertinent staff and Senior Members in writing of this policy. Prospect Medical will log all referred complaints and appeals, and when necessary, conduct an internal investigation for purposes of peer review and quality management.

RESPONSIBILITY
Prospect Medical Quality Management Department.

PROCEDURE

Complaints

- Senior Members who wish to pursue a grievance related to the provision of medical services will be immediately directed to call or submit a written complaint to their health plan.
- Prospect Medical will cooperate with the health plan in resolving all Senior Member complaints relating to the provision of medical services in a timely manner.
- Prospect Medical will provide the health plan with information and copies of pertinent medical records (if applicable), within the timeframes specified in the Health Plan's procedure.

Appeals:

- Senior Members who wish to pursue an appeal related to the provision of medical services will be immediately directed to submit their complaint to their health plan. Prospect Medical will resolve all Senior Member appeals in a timely manner.
- If the Senior Member wishes to utilize a representative to file an appeal request, Prospect Medical will direct member to complete a statement inclusive of their name, representative, appointment, reason, sign and date it, and include with appeal request. Prospect Medical will notify Senior Member of their right to assistance with Appeal request.

Laboratory & Pathology Services

Each provider may draw the patient in their office (refer to your PCP or SCP current agreement), or send his/her patients to the nearest contracted lab. If you are unaware of your contracted lab, please call Network Management. If a provider violates this policy

they will be educated after their first violation. Subsequent violations may result in the provider bearing part or all of the costs associated with this violation.

Medical Record Maintenance & Confidentiality

I. Purpose:

To define the minimum standards for maintaining medial records.

II. Policy:

A. Medical records shall be established and maintained to meet at least the minimum standard for documentation of care as described in this policy and procedure.

B. Medical records are to be kept in the strictest of confidence in accordance with HIPPA policies and procedures.

C. Medical records will be maintained, as required by CMS and DHCS and other regulatory agencies.

D. Medical Records will be made available to CMS and DHCS and its agents, designees or contractors or any other authorized representatives of the state of California or the United States Government, or their designees or contractors, at such times, places, and in such manner as such entities may reasonably request for the purposes of financial or medical audits, inspections, and examinations.

E. The Secretary of the U.S. Department of Health and Human Services or his or her designee, the Governor or his or her designee, Comptroller General, and the state Auditor or his or her designee have the right at reasonable times and upon reasonable notice to examine the books, records, and other compilations of data of the Contractor and its First Tier, Downstream and Related Entities that pertain to: the ability of the Contractor to bear the risk of potential financial losses; services performed; or determinations of amounts payable.

F. Prospect Medical will make available, for the purposes of record maintenance requirements, its premises, physical facilities and equipment, records relating to its Enrollees, and any additional relevant information that CMS or DHCS may require, in a manner that meets CMS and DHCS record maintenance requirements.

III. Procedure

A. Organization – providers are required to have an organized medical record keeping system.

1. All active records shall be labeled and filed in a defined system (alphabetically) or numerical using a terminal digit.
2. Active records are to be stored in a secured area, which protects records from loss, tampering, alteration or destruction.
3. Medical records, medical charts, prescription files and other documentation pertaining to medical and non-medical services rendered to members will be maintained for a period of not less than six (6) years after the filing date of the documents based on the information which they contain, or six (6) years after the date on which such documents would have been filed.

4. Inactive records for adults shall be retained for ten (10) years. For minors the record shall be retained ten (10) years beyond the minor's 21st birthday.
    a. Storage may be electronic or hard copy.
    b. Storage must be in a secured location with restricted access that meets the same security requirements for active records.
    c. Inactive records shall be retrievable within five (5) working days if necessary.
5. Medicare records shall be retained for ten (10) years.

B. Filing of Information
1. All documents shall be filed chronologically within the record with the members name and the name of the PCP on each document. Serial reports may be filed in segregated manner in chronological order. The documents must be secured in the folder to prevent loss.
2. All reports shall be filed in the medical record within 48 hours of receipt including, but not limited to, the following:
    a. Laboratory reports
    b. X-ray reports
    c. EEG's
    d. EKG's
    e. Consultation reports
    f. Hospital reports (admission/outpatient procedures)
    g. ER reports

C. Format and Content
1. An individual record shall be established for each member, available at each encounter and shall be updated during each visit or encounter.
2. The record shall be in a legible hand written or printed format.
3. The record shall reflect the findings of each visit or encounter including, but not limited to:
    a. Recording date of service
    b. Chief complaint/documented history of present illness
    c. Follow-up from previous visits
    d. Test/therapies ordered
    e. Diagnosis or medical impression
    f. Plan of treatment/care and/or education related to stated diagnosis.
    g. Any physical, psychosocial and/or educational needs identified during the encounter
    h. Follow up instructions and a definitive time for a return visit. Time period is required to be stated in number of days, weeks, months or PRN.
4. The following data sets shall be included in each chart:
    a. Demographic information including but not limited to:
        - Name (required to be on each page)
        - Address
        - Age and DOB
        - Sex

- Telephone number (home and work)
- Parents name is patient is a minor
- Emergency contact person and nearest relative (phone number(s) for each)
- Social Security Number
- Plan Identification
- Medi-Cal Number

b. Clinical related data

- Record of diagnosis and treatment
- Drug orders

c. PCP Identification

- The assigned PCP is required to be identified when there is more than one PCP on site and/or when the patient has selected health care form a non-physician medical practitioner.

5. If a patient refuses to provide information, “refused” shall be noted in the medical record.
6. Vital signs and signature/title of person performing these functions, including:
   a. Height
   b. Weight
   c. Temperature
   d. Pulse and respirations
   e. Blood pressure (> three (3) years of age)
7. Allergies and adverse reactions (recorded on front of chart or on standardized location within the record). If member has no allergies/adverse reactions, “No Known Allergies” (NKA), “No Known Drug Allergies” (NKDA), or “none” must be documented.
8. Problem list, maintained with current updates (if no end date is documented, the problem is considered open)
9. List of medications, maintained with current updates, including:
   a. Name
   b. Dosage
   c. Frequency
   d. Start/stop dates
10. Ancillary services
11. Medical and surgical histories including relevant family history for:
    a. Significant health problems
    b. Reactions to drugs
    c. Personal habits (alcohol/drug/diet)
12. Physical examination by body systems with findings and treatment plan when medically indicated.
13. Records related to all hospitalizations, such as:
    a. H&P

b. Discharge summary
c. Operative reports
d. Pathology reports

14. Office laboratory and/or surgical/invasive procedures including anesthetics used and specimens collected for pathological examination
15. Emergency room encounter visit record reflecting:
    a. Assessment
    b. Treatment
    c. Discharge instructions
    d. Recommended follow up
16. Signed consent form or statement for any invasive procedure
17. Significant telephone advice, documented with date, time and signature
18. Consultation and diagnostic reports. There is evidence of physician review evidenced by physicians initial or signature.
19. Preventive Care
    a. Patient education should be documented
    b. Immunizations should be recorded with lot number and expiration date. A copy of the appropriate VIS should be filed.
20. .

D. Authentication of Medical Record Entries
   1. Medical record entries shall be dated and signed by each staff person or health care provider at each encounter.
   2. A signature shall consist of first initial, last name and title.

E. Recall System for No-Show Members

   Physician shall have a system in place to identify, monitor and follow up on any member who does not keep his/her appointment. The following guidelines shall be used, at a minimum, in managing no show members.

   1. Physician office shall document in the record:
      a. All attempts to reach the member.
      b. Instructions given to the member when contact is made advising the member of the need to obtain medically necessary care and the risks of not keeping an appointment.
   2. In the event the physician office is not able to reach the member by telephone, a letter shall be sent from the physician advising him/her of the need to obtain care and the risks of not getting treatment.
   3. In the event a member exhibits a habitual pattern of not keeping appointments the physician may phone AMVI/Prospect Health Network's (AMVI/Prospect) Case Management (CM) Department for assistance in managing the member's non-compliance.
   4. In situations where non compliance presents a severe threat to the member's health, the case manager along with the Medical Director shall send a certified letter indicating termination of all responsibility for that condition for which the

member is being non-compliant.

5. A copy of all communications shall be forwarded to the physician to be filed in the member's medical record.

Archiving And Retrieving Medical Records

PURPOSE:

To provide the development of a systematic process to archive and retrieve medical records in a timely manner.

PROCEDURE:

A. Archiving
   1. Depending on the availability of space, the archiving activity may occur every 3 years.
   2. Each office will individually determine the meaning of an "inactive file". A medical record would be considered inactive if a patient has not had an encounter with the physician over an extended period of time. The time frame may be determined by the provider.
   3. Inactive files will be maintained in a separate storage area for no less than 10 years and a list of these records will be maintained by the office. The list will contain the patient's name, medical record number, DOB, and any other pertinent information.

B. Retrieval
   1. Retrieving medical records from storage should be the responsibility of a trained medical record associate to ensure proper handling and confidentiality.
   2. Archived medical records will be monitored and retrieved from storage as needed.
   3. A list of medical records retrieved from storage will be maintained and updated as necessary.
   4. Location of medical records will be maintained by the medical office staff and available at all times.
   5. Provisions for "STAT" record pulling will be available immediately. An acceptable timeframe for all other stored records is 24 hours.

Medical Record and Documentation/Availability of Medical Records

PURPOSE:

To define the minimum standards for maintaining medical records and availability standard.

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POLICY:

G. Medical records shall be established and maintained to meet at least the minimum standard for documentation of care as described in this policy and procedure.

H. Medical record standards will facilitate confidentiality in the strictest of confidence in accordance with HIPPA guidelines.

I. Medical record documentation standards will facilitate timely communication of clinical information and coordination and continuity of care.

J. Medical records policies and procedures may be available to providers via the Provider Manual and/or the Prospect Medical (PMS) website.

K. Performance goals and oversight will be done quarterly.

PROCEDURE:

F. Organization – providers are required to have an organized medical record keeping system.
   1. All active records shall be labeled and filed in a defined system (alphabetically) or numerical using a terminal digit.
   2. Active records are to be stored in a secured/central area, which protects records from loss, tampering, alteration or destruction and can be easily retrieved, available, and accessible.
   3. Inactive records for adults shall be retained for a minimum of ten (10) years from the end of the current fiscal year in which the date of service occurred, in which the record or data was created or applied, and for which the financial record was created or the contract is terminated.
      a. Records are stored in a confidential manner.
      b. Storage may be electronic or hard copy.
      c. Storage must be in a secured location with restricted access that meets the same security requirements for active records.
      d. Inactive records shall be retrievable within five (5) working days if

necessary.

G. Filing of Information
   1. All documents shall be filed chronologically within the record with the members name and the name of the PCP on each document. Serial reports may be filed in segregated manner in chronological order. The documents must be secured in the folder to prevent loss.
   2. All reports shall be filed in the medical record within 48 hours of receipt including, but not limited to, the following:
      a. Laboratory reports
      b. X-ray reports
      c. EEG's
      d. EKG's
      e. Consultation reports
      f. Hospital reports (admission/outpatient procedures)
      g. ER reports

H. Format and Content
   1. An individual record shall be established for each member, available at each

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encounter and shall be updated during each visit or encounter.

2. The record shall be in a legible hand written or printed format.
3. The record shall reflect the findings of each visit or encounter including, but not limited to:
    a. Recording date of service
    b. Chief complaint/documented history of present illness
    c. Follow-up from previous visits
    d. Test/therapies ordered
    e. Diagnosis or medical impression
    f. Plan of treatment/care and/or education related to stated diagnosis.
    g. Any physical, psychosocial and/or educational needs identified during the encounter
    h. Follow up instructions and a definitive time for a return visit. Time period is required to be stated in number of days, weeks, months or PRN.
4. The following data sets shall be included in each chart:
    a. Demographic information including but not limited to:
        - Name (required to be on each page)
        - Address
        - Age and DOB
        - Sex
        - Telephone number (home and work)
        - Parents name is patient is a minor
        - Member Language
        - Emergency contact person and nearest relative (phone number(s) for each)
        - Social Security Number/Member health plan number/CIN # (if applicable)
    b. Clinical related data
        - Record of diagnosis and treatment
        - Drug orders
        - History and Physical
        - Treatment Plan
    c. PCP Identification
        - The assigned PCP is required to be identified when there is more than one PCP on site and/or when the patient has selected health care form a non-physician medical practitioner.
    d. Identification of all providers participating in the members care and information of services furnished by these provides.
5. If a patient refuses to provide information, “refused” shall be noted in the medical record.
6. Request or refusal of interpreter services to include but not limited to hearing impaired services.
7. Vital signs and signature/title of person performing these functions, including:
    a. Height
    b. Weight
    c. Temperature

d. Pulse and respirations
e. Blood pressure (> three (3) years of age)

8. Allergies and adverse reactions (recorded on front of chart or on standardized location within the record). If member has no allergies/adverse reactions, “No Known Allergies” (NKA), “No Known Drug Allergies” (NKDA), or “none” must be documented.
9. A problem list will contain significant illness and medical conditions and maintained with current updates (if no end date is documented, the problem is considered open)
10. List of medications, maintained with current updates, including:
    a. Name
    b. Dosage
    c. Frequency
    d. Start/stop dates
11. Ancillary services
12. Past medical history (for patients seen 3 or more times. For children and adolescents (18 years and younger). Past medical history relates to pre-natal care, birth, surgeries, and childhood surgeries. Past medical and surgical histories should include relevant family history:
    a. Significant health problems
    b. Reactions to drugs
    c. Personal habits (alcohol/drug/diet)
13. Physical examination by body systems with findings and treatment plan when medically indicated.
14. Records related to all hospitalizations, such as:
    a. H&P
    b. Discharge summary
    c. Operative reports
    d. Pathology reports
15. Office laboratory and/or surgical/invasive procedures including anesthetics used and specimens collected for pathological examination
16. Emergency room encounter visit record reflecting:
    a. Assessment
    b. Treatment
    c. Discharge instructions
    d. Recommended follow up
17. Signed consent form or statement for any invasive procedure
18. Referral
19. Significant telephone advice, documented with date, time and signature/after hours calls.
20. Consultation and diagnostic reports.
    a. All tests will be given to the ordering physician for review within a clinically appropriate timeframe.
    b. All tests are to be reviewed by the ordering physician within 2 weeks after the completion of the test.

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c. Test results are required to be initialed and dated by the provider indicating he/she has reviewed the results.
d. Patients will be notified of test results or changes in their treatment plan by telephone, written notice or in person at their next office visit.
e. Panic level results (potentially life threatening) will be reported to the provider by the lab immediately and the provider will take immediate appropriate patient intervention.
f. Notification of abnormal results must never exceed 24 hours after the PCP has received them.
g. Notification/intervention will be documented in the patient chart.

21. Preventive Care/Risk Screening
    a. Patient education should be documented
    b. Immunizations should be recorded with lot number and expiration date. A copy of the appropriate VIS should be filed.
22. Documentation reflects anticipatory guidance and health education provided during an office visit.
23. Documentation of pertinent referrals to behavioral health services.
24. Completed PM160 form for all visits meeting CHDP standards (Medi-Cal only).

I. Authentication of Medical Record Entries
   1. Medical record entries shall be dated and signed by each staff person or health care provider at each encounter.
   2. A signature shall consist of first initial, last name and title.

J. Recall System for No-Show Members/Missed Appointments

   Physician shall have a system in place to identify, monitor and follow up on any member who does not keep his/her appointment. The following guidelines shall be used, at a minimum, in managing no show members.

   1. Physician office shall document in the record:
      a. "No Show" will be written in charts of patients who fail to keep an appointment.
      b. "Rescheduled" will be written in charts of patients who reschedule an appointment.
      c. "Canceled" will be written in charts of patients who cancel an appointment. Appointments should be re-scheduled at the time they are canceled whenever possible.
      d. The provider will be made aware at the close of each working day of all missed appointments and determine if the patient needs to seen and the urgency of contacting the patient.
      e. The provider will determine whether a phone call, letter, or no intervention is required.
         - Emergent – notification by phone, if follow up by mail is unsuccessful
         - Urgent – notification by phone if follow up by certified mail after 3 unsuccessful phone attempts
         - Non Urgent – notification by mail
      f. Interventions will be documented in the patient chart.

g. Instructions given to the member when contact is made advising the member of the need to obtain medically necessary care and the risks of not keeping an appointment.

2. In the event the physician office is not able to reach the member by telephone, a letter shall be sent from the physician advising him/her of the need to obtain care and the risks of not getting treatment.
3. In the event a member exhibits a habitual pattern of not keeping appointments the physician may phone the Case Management (CM) Department for assistance in managing the member's non-compliance.
4. In situations where non compliance presents a severe threat to the member's health, the case manager along with the Medical Director shall send a certified letter indicating termination of all responsibility for that condition for which the member is being non-compliant.
5. A copy of all communications shall be forwarded to the physician to be filed in the member's medical record.

K. Performance Goals
1. Medical Record Documentation/Availability of Medical Records.
    a. PMS shall require a CAP for scores of less than 80%.
2. Oversight of Medical Record review
    a. Fifteen random charts shall be reviewed quarterly and evaluated for quality and accurate documentation.
    b. Charts below the standard goal of 80% will have monthly reviews until score reaches 80%. If 80% is not reached within 90 days, provider will be reviewed at Peer Review Committee.

Non-Discrimination

Providers shall provide services to Plan enrollees or subscribers in the same manner as to non-Plan enrollees and shall not discriminate against any Plan enrollee or subscriber because of age, race, ethnicity, national origin, religion, marital status, gender, sexual orientation, mental or physical disability or medical condition, such as ESRD, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information or source of payment.

Prostate Cancer Screening

PURPOSE
To develop a policy to implement compliance with SB 2020 which mandates coverage for the screening and diagnosis of prostate cancer.

POLICY
The methods of screening and diagnosing this disease, which must be covered, are the prostate specific antigen (PSA) and the digital rectal exam. The member's policy is not required to cover any other procedures. With the office visit a co-payment can be collected. The member must utilize contracted providers.

Surgery Assists

Procedures that require assists and are approved by criteria may utilize a contracted PCP or Specialist to assist with surgical procedures.

Surgical Coding & Reimbursement

- The initial evaluation, procedure and/or consultation will be paid separately, identifying it as a distinct service. The evaluation will be pre-coded, taking into account the complexity of the problem as well as the potential need for consents and explanation of possible surgical management, except for case rates, e.g. OB, vasectomy, etc.
- The global surgery or procedure billing shall include pre-operative hospital and office visits during a 30-day pre-operative period, excluding the initial evaluation and consultation. If a surgeon is involved in stabilizing a seriously ill patient prior to surgery, these charges would be reimbursed. However, documentation justifying the need for additional services will be submitted.
- The global surgery/procedure fee shall include all intra-operative services that are a usual and necessary part of the surgical procedure. This shall be defined by the CPT coding. This should be completely delineated prior to the surgery on a Case Management review form.
- The global surgery/procedure fee shall include all additional medical and surgical services required of the surgeon because of complications, which do not require additional trips to the operating room. All medically necessary return trips to the operating room, for any reason without regard to "fault" will be separately billed and paid at a reduced rate. This will depend on the nature of the surgery/procedure and the CPT code.
- The global surgery/procedure fee will include all postoperative hospital and office visits for 90 days following the date of surgery, which will include all visits related to the diagnosis for which the surgery or procedure was performed.
- Exceptions to the 90-day post-operative period should be made via documentation to the CM board, the Primary Care Provider or surgeon depending on the details of the case.
- For services post 90 days: authorization is required and must be requested through the Case Management Department.

Transfer/Disenrollment/Removal Of Members

PURPOSE
To define the criteria and process by which a Primary Care Provider may request to disenroll, transfer, or remove a member from his or her practice.

POLICY
It is the policy of Prospect Medical to provide the Primary Care Provider with a process to follow for disenrollment, transferring, or removing a member in accordance to health plan specifications.

PROCEDURE
Primary Care Providers may remove members from their practice for cause, by following the procedure listed below. Examples of just cause must be fully documented, and may include, but are not limited to:

- Abusive behavior
- Failure to pay co-payments
- Repeated failure to keep appointments
- Non-compliance or unreasonable refusal to comply with the provider's recommended treatment plan, counsel, or procedure
- Serious personality conflicts, affecting the quality of care

A provider who has cause to disenroll, transfer, or remove a member from his/her practice, must follow one of the following procedures, depending on the health plan:

Anthem/BlueCross, UnitedHealthcare, Secure Horizons, Aetna

- The provider will notify Network Management and submit all supporting documentation, i.e., collection notices, medical records with notation of incident(s), any counseling done by provider, etc.
- Network Management will submit all pertinent information to the UM Board of Prospect Medical. The Board will review the documentation and make a determination to:
- Document the transfer and not disenroll the member from the medical group.
- Disenroll the member from Prospect Medical, depending on the severity and/or frequency of cause.
- If the decision is to disenroll the member, the documentation from the provider, as well as a letter from the board will be evaluated by the Health Plan, who will then notify Prospect Quality Management Department for tracking and trending data.
- If the request is granted by the Health Plan, the member will be asked to select another Primary Care Provider and/or Medical Group/IPA within thirty (30) days of that decision. However, care must be provided to the member for a period of thirty

(30) calendar days or until the member is re-assigned to another Medical Group/IPA.

Cigna Health

If a provider should have cause to disenroll a member from his/her Practice from one of the above health plans, the following will occur:

- The Primary Care Provider will notify Prospect Medical Network Management Department and submit all supporting documentation, i.e., collection notices, medical records with notation of incident(s), any counseling done by provider, etc.
- Network Management will contact the health plan and submit all pertinent information to them. The request letter will also be forwarded to the UM Board of Prospect Medical.
- The request will be evaluated by the health plan, which will notify the Network Management Department at Prospect Medical of their decision. Network Management will then notify the provider and the Quality Management Department for tracking and trending the data.

- If the request is granted by the health plan, the member will be asked to select another Primary Care Provider and/or Medical Group/IPA within 30 calendars of the decision. However, care must be provided to the member for a period of thirty (30) calendar days or until the member is re-assigned.

(Attachment: Request for Transfer/Disenrollment of Member Form)

Transporting Of Specimens

- Prospect Medical's policy is to assure the safe transportation of all laboratory and/or pathology specimens with regard to maintaining the integrity of the specimen, as well as preventing any contamination to the member by any preservative or chemical.
- It is our policy that members may transport certain appropriate specimens from their home to the provider's office. Examples of the specimens that may be transported include, but are not limited to; urine, feces, and semen samples. These specimens should be transported in an appropriate covered container.
- If blood is transported by the patient due to extenuating circumstances (i.e. drawn at home through a central line), it may be accepted by the provider or lab. This type of scenario would be evaluated on a case-by-case basis.
- **Pathology** specimens should **never** be transported by the member to any lab or provider office. Prospect has contracts in place with laboratory facilities that will provide courier service for pathology specimens. Please call the contracted lab directly to arrange this service. (Please see section on Laboratory Services).

Treatment Consent

PROSPECT MEDICAL

PURPOSE

To protect the patient's right to consent or refuse to consent to any recommended medical procedure and to ensure the patient has sufficient information to make that consent meaningful.

POLICY

It is the policy of Prospect Medical that patients have the right to information regarding therapy and/or treatment and that consent, either verbal or written, be obtained prior to the therapy and/or treatment.

PROCEDURE

1. Consent: The patient must give consent for the administration of any therapy or treatment. This consent may be verbal or in writing. When the procedure is not readily understood or considered to be complex, carrying significant risk, the patient's consent must be informed. All written and verbal consent information must be in the language the patient understands.
2. Informed consent: The patient must be given sufficient medical information in lay terms to make a knowledgeable decision. The provider will have a discussion with the patient and document its occurrence. Documentation will include:
   a) Nature of the recommended treatment.
   b) Risks, complications and expected benefits.
   c) Alternatives to the procedure and their risks and benefits.

   Where the patient's decision making must be informed, the provider is responsible to provide the information to ensure that the patient understands the consequences of their choice. This should not be delegated to the staff. However, where appropriate, the staff can serve to provide supplemental information and education to support the provider's efforts to educate the patient.
3. Written Consent: A "Consent to Treatment" form must be signed on those

   procedures deemed to be complex or with significant risk or serious disease. This serves as an adjunct to provider.
4. Specific Procedures: Compliance with CA statutes is required in the case of blood testing in pregnancy, and experimental therapies.
5. Implied Consent: Implied consent may be used in the following situations:
   a. Emergency situations (defined as requiring immediate services for the alleviation of pain, or immediate diagnosis and treatment of unforeseeable medical conditions, which, if not, immediately diagnosed and treated would lead to serious
      disability or death). Treatment should not exceed that necessary to address the emergency.
   b. If there is no legally authorized representative who can consent on behalf of the patient, the reason why the exception was invoked should be documented in the medical record.
   c. Therapeutic privilege/provider discretion – In rare situations where a provider can prove that under the circumstances it was reasonable to believe that "the disclosure would so seriously upset the patient that the patient would not have

PROSPECT MEDICAL

been able to dispassionately weigh the risks of refusing to undergo the recommended treatment," the provider may withhold the information.

6. Informed Refusal: Applies to any recommended test, procedure, or medical recommendation, which has been refused. The provider must inform the patient to undergo the recommended procedure of the potential consequences. This informed refusal will be documented in the patient's medical record.
7. Consent of Minors: A written parental consent is required in order to treat a minor (under age 12 yr) with the following exceptions:
   - Minors with divorced parents – either parent may consent to treatment if parents have joint custody or death.
   - Adopted minors – adoptive parents may consent to treatment
   - Children of minor parent – The minor parent may consent to treatment
   - Minor pupil – when child is ill or injured during school hours and parents cannot be reached, the child may be treated without parental consent
   - Minor in custody – May be treated when ordered by the court
   - Minor parents with legal capacity to consent to medical treatment
     1) Self-sufficient minor – defined as a minor 15 years of age or older living separate and apart from his/her parents or legal guardian and manages his/her own financial affairs, regardless of the source of income, is capable of giving valid consent. This minor will affirm the above conditions in writing.
     2) Emancipated minor per court order. If the court order is obtained, the DMV issues an ID card, which states the capable of giving valid consent. This minor will affirm the above conditions in writing.
     3) Minors on duty in the US Armed Forces
     4) Minors receiving pregnancy care (treatment or prevention)
     5) Minors 12 years and older suffering from a reportable disease relating to the diagnosis or treatment of that disease.
8. Married minor with marital proof (marriage certificate).

9. Specific Procedure Consents: Sterilization consents require specific consent procedures and time limitations.
10. Consent Distribution: A copy of the consent must be given to the patient and a copy must be retained in the patient's medical record. Copies of court orders, etc. will also become part of the patient's medical record.

Co-payments may be collected for professional services when services are provided by a physician, physician assistant, nurse practitioner or any qualified professional provider for basic medical care. If the member's visit is for the sole purpose of receiving an injection or a blood pressure check, a co-payment may not be collected. A co-payment must be collected according to the services provided and not according to the licensure of the professional providing the service.

Providers may not collect a co-payment for missed appointments. After a member has missed three appointments, the provider has the option of transferring the member (see Section 7.28).

Quality Management Department

Communication

It is the policy of Prospect Medical to utilize Quality Management activities to educate providers and improve the quality of care given to our patients. These include, but are not limited to:

- Facility and medical record audit results
- Adverse outcome or trend analysis
- Changes in policy and procedures
- Health Plan communications
- Educational Opportunities
- Evidence-based Clinical (Referral) Guidelines
- P4P, HEDIS and PAS results
- Individual provider quality report cards

PROCEDURE

1. Quality Management activities are reported to the Quality Committee of Prospect Medical monthly.

2. The Quality Management Committee determines what quality related issues are to be communicated to providers.

3. This information is communicated to each contracted provider using a newsletter format and is distributed at least quarterly.

It is the policy of Prospect Medical to facilitate the provision of quality medical care in an appropriate, timely manner to all of our patients. A process of prospective and retrospective peer review is essential to the realization of that commitment.

Peer Review Activities

PROSPECT MEDICAL

The Peer Review process will utilize the methods of continuous quality improvement, as described in the Quality Management Program. The process allows the committee to address opportunities for improvement in the delivery of health care by the providers of Prospect Medical. It is the responsibility of Prospect Medical to conduct peer review activities on a continuous basis through the Quality Management Committee. These activities are designed to:

- Identify areas of provider practice which can be improved upon
- Discover specific instances of inappropriate or substandard medical practice on the part of a Prospect provider
- Develop corrective action plans for each case or trend that is discovered
- Provide oversight of the credentialing process

Peer review activity will be considered at the time of reappointment. The Medical Director, Quality Management Committee and the Quality Management Manager will have exclusive access to all peer review files that are maintained.

No committee minutes will be distributed outside of the meeting and all minutes will be collected before the meeting ends. These minutes will be destroyed to protect confidentiality of all persons being evaluated.

Prospective review will be accomplished through the development and implementation of a standardized method of evaluating providers on a routine basis. This includes, but is not limited to:

- Peer evaluation
- Patient satisfaction surveys, access and wait times, and after hours instructions
- Medical record review
- Random Medical Record review conducted using pre-determined criteria:
  - Completeness and legibility of documentation
  - Updated problem lists
  - Diagnostic skill and efficiency
  - Documentation of and compliance with preventative health screenings
  - Documentation of patient education or referral for preventative health screenings
  - Appropriateness of referrals (under and over utilization)
  - HEDIS or P4P criteria

Retrospective Review:
Review of significant complaints/grievances brought by patients or providers.

- Review of other significant cases as requested by a Medical Director.
- Ongoing tracking of instances of inappropriate or substandard care for the purpose of identifying trends within practice specialties and by individual Providers.

Corrective Actions: Problems identified by the activities previously described are managed at the discretion of the Committee, as necessitated by the severity of the

problem. All corrective actions are reviewed by the Committee and documented in the minutes.

When an issue of concern over quality of care is referred to the committee, the provider involved is notified in writing and asked for a response. This response can be:

- A written response to the issues raised by the inquiry within 3 days of receiving request for response from the Q.M. Manager.

- Provider may be asked to attend a meeting of the Quality Committee for the purpose of open discussion of the issues identified and any necessary remedial measures.

Failure to respond to a second request within a specified time frame may result in sanctions placed upon the provider at the recommendation of the Medical Director.

After evaluation is completed, the Q.M. Manager or the Medical Director notifies the provider in writing of the outcome of the evaluation. These outcomes may include:

- Evaluation complete; no action taken/no further action required
- Further information/action required
- Provider may be monitored for clinical activity
- Mandated proctoring or specific continuing medical education
- Provider is terminated under the terms of the applicable contract provisions. A report is sent to the health plan on the outcome of an inquiry. If a serious problem of quality is determined, all of the provider's contracted HMO's will be notified of a termination or suspension of provider's privileges. A Provider has specific Fair Hearing rights, available from Prospect, in advance of Plan notification or MBC 805 reporting.

Reporting Provider Preventable Conditions (PCC)

Provide Preventable Conditions (PPC) - Title 42 of the Code of Federal Regulations Parts 434, 438 and 447 list thirteen (13) PPCs for Medicaid which the Department of Health Care Services (DHCS) adopted for California. There are two types of PPCs: health care acquired conditions (HCAC) which should be reported when they occur in inpatient acute care hospitals and other provider preventable conditions (OPPC) which should be reported when they occur in any health care setting.

<u>Provider Preventable Conditions</u>:

Health care-acquired conditions (HCAC) are defined as:

- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection (UTI)
- Falls and trauma that result in fractures, dislocations, intracranial injuries, crushing

injuries, burns and electric shock
- Foreign object retained after surgery
- Latrogenic pneumothorax with venous catheterization
- Manifestations of poor glycemic control – diabetic ketoacidosis, nonketotic hyperosmolar coma, Hypoglycemic coma, Hypoglycemic coma secondary diabetes with ketoacidosis, Secondary diabetes with hyperosmolarity
- Stage III and IV pressure ulcers
- Surgical site infection following: Mediastinitis following coronary artery bypass graft (CABG), Bariatric surgery, restrictive surgery Orthopedic procedures for spine, neck shoulder and elbow, Cardiac implantable electronic devise CIED procedures
- Vascular catheter associated infection
- For non-pediatric/obstetric population, deep vein thrombosis (DVT)/pulmonary embolism (PE) resulting from: Total knee replacement, hip replacement

Other provider-preventable conditions (OPPC) are defined as:
- Wrong surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient.

Network Providers shall report PPC events:
1. Complete DHCS 7107 form for any PPC event found at https://apps.dhcs.ca.gov/PPC/SecurityCode.aspx
2. DHCS 7107 form will be sent directly to DHCS in a manner specified by DHCS
3. Send a copy of DHCS 7107 form to the Health Plan
    a. For CalOptima Providers: send a copy of the DHCS 7107 Form to CalOptima's Quality Improvement (QI) department via secure e-mail to qualityofcare@caloptima.org or fax to 657-900-1615.
4. Send a copy of DHCS 7107 form to Prospect Medical
    a. A copy of the DHCS 7107 form will be submitted to Prospect Network Management via secure fax to (714) 560-7613

Please remember to submit encounter data in a timely manner as outlined in the Claim & Encounter Data Submission Instructions section of this provider manual.

Appeals & Grievances

PURPOSE:

The PMG staff provides for a timely and organized system for resolving member and provider's complaints.

The PMG staff forwards grievances and complaints directly to individual HMOs per HMO specific agreements with the Plan and/or IPA.

SCOPE:

All PMG member or provider complaints received by PMG staff are handled efficiently according to PMG approved policy and procedure and the health plan contractual agreement. *A complaint is defined as an expression of dissatisfaction*

by a member. Complaints may be either verbal or written. When PMG is **delegated** to handle a complaint or grievance, or in the circumstances indicated below, the PMG staff provides an avenue for members or providers to express their concerns and receive appropriate responses or resolutions on the part of the PMG staff. The health plan staff is involved as per the contractual agreement.

POLICY:

1. All appeals and grievances must be directed to the appropriate health plan.
2. PMG investigates the substance of the complaint and completes the grievance process within (30) days. This only applies if PMG is **delegated** by any HMO to handle their specific grievances. PMG approved standards for timely response to complaints accommodates the clinical urgency of the situation.
3. PMG has approved written policies and procedures for the resolution of all complaints that may be handled at the PMG level. All PMG staff utilize their training and skills to handle all member complaints according to PMG and health plan approved policy and procedure. PMG/IPA employees are aware of grievance process by health plan and will refer member to the plan for filing of grievance. Grievance materials are readily available via Member Portal, Provider Portal and Customer Service staff.
4. Documented complaints, aggregated data and analysis is coordinated with the quality improvement program and performance monitoring activities throughout the organization, including but not limited to utilization management, customer services, provider services, credentialing, assessment of member satisfaction and medical records review.
5. The impact of the situation is assessed, and the Quality Management Manager defines the resource criteria whether it be medical staff, nursing, quality of care, billing or other (e.g., hospital system). PMG will advise members of grievance process and assist with grievance submission information.
6. Provider(s) and/or the member's legal representative may act on behalf of the member as appropriate.
7. The information is handled according to PMG approved confidentiality policies and procedures.
8. The Quality staff assists with the periodic assessment and enhancement of member satisfaction with the PMG services. The assessment will include a review of member concerns/complaints.
9. PMG complies with specific health plan contractual requirements with regard to the handling and reporting of complaints. PMG will send information to providers and continue to ensure it is made available to practitioner sites via newsletter, website or provider manuals.
10. PMG staff monitors performance with standards for timeliness of the complaint process.

General Information:

1. Complaints include member and provider telephone calls expressing concern about PMG related issues and written member and provider complaints expressing concern about PMG related issues.
2. *Quality of Care Complaints may impact the quality of care given to a member*. These cases include but are not limited to: delayed and denied referrals, provider availability and access and medical quality of care.
3. *Administrative Complaints include cases that do not have a direct impact on the quality of patient care* but require investigation (such as delay/error in claims payment and issues related to employee behavior).

PROCEDURE:

1. The complaint may be expressed by telephone, by facsimile, in writing or in person by the member (patient), legal guardian or provider via telephone, in writing or in person. Health Plans can also receive complaints by email or on line through the HMO's Web site.
2. PMG has standard approved grievance forms available for grievances to be given to subscribers and enrollees who wish to register written grievances. PMG will supply the form to the enrollee if the enrollee requests it. The form also gives the specific HMO, including Health Net contact and address to forward the complaint/ grievance to. A record of the member call and the form being mailed will be available at PMG.
3. In cases of complaints or grievances that are NOT coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment and that are resolved by the next business day shall have a log maintained by PMG of all these grievances. The log will be periodically (quarterly) reviewed by PMG and also forwarded to each individual HMO. The log includes the following information:
    - Date of the call
    - Name of the complainant
    - Complainant's member identification number
    - Nature of the grievance
    - Nature of the resolution
    - Name of PMG staff who took the call and who resoled the grievance.
4. For other grievances in which PMG is **delegated** to handle the complaint by the specific HMO, PMG will provide for a written acknowledgment within five calendar days of the receipt of a grievance. The acknowledgment shall advise the complainant of the following:
    - That the grievance has been received.
    - The date of receipt.
    - The name of the plan representative and the telephone number and address of the plan representative who may be contacted about the grievance.
5. PMG will keep in its files all copies of grievances and the responses thereto, for

a period of five years.

6. The grievance system requires the plan to resolve grievances within 30 days if the Plan or IPA was responsible and **delegated** to handle the grievance. PMG does not handle grievances for Health Net or for any Medi-Cal HMO. These are forwarded to Health Net or for any Medi-Cal HMO for resolution.
7. Member/provider complaints are documented in the IDX CSR system.
8. The documentation will include the following information:
    a) The substance/issues and the actions taken;
    b) The date received and the date closed;
    c) The names of any staff members identified in the complaint;
    d) The investigation including any aspects of clinical care;
    e) The member notification of the disposition of the complaint and the right to appeal as appropriate and according to appropriate regulatory language;

Quality of Care or Service Complaints

1. If the case is a QM case, the information is delivered to the Quality Management Department at PMG and directly to the specific HMO.
2. QM Complaints are documented and logged in the QM Profile Database.
3. Urgent or serious problems are followed up immediately by telephone, and may require intervention by the Medical Director.
4. The Quality Management staff or designee notifies the member/practitioner in writing within (5) days that the complaint has been received and has been forwarded to the specific HMO. PMG will issue a written statement to the member of the disposition or pending status of the complaint within 30 days of the Plan's receipt of the complaint.
5. PMG will also perform an internal review of the complaint.
6. PMG investigates and resolves complaints within (30) days of receipt and recognizes and respects member rights throughout the process. The CMO/Medical Director and/ or The Quality Management Committee is responsible for this process.
7. If appropriate, the medical record of the member (patient) and other supportive information is obtained according to PMG approved policy and procedure with particular attention to confidentiality. The medical record of the member is sent to the Quality Management Chairperson or an appropriate Quality Management Committee physician member for review.
8. The Quality Management staff sends a letter to the practitioners and/or staff involved, requesting a documented response to the situation.
9. A log and statistics of the processed complaint is maintained by the (Quality

Manager) and will be reported to the Quality Management Committee and contracted health plans (frequency of reporting according to contractual agreement).

10. The documented events and provider/staff response is taken to the Quality Management Committee for analysis, problem resolution and recommended follow-up action.
11. Extensions may be made by the Quality Management Committee and/ or the CMO/ Medical Director as they are needed for thorough investigation and appropriate action and follow-up.
12. The Risk Management Committee is notified according to PMG approved policies and procedures. Legal counsel may be consulted prior to responding to the member in writing.
13. The Quality Management Manager and the appropriate department Manager (e.g.: Network Management, Customer Services) carry out the follow-up actions which include sending a letter to the member, the provider and/ or the health plan. The written information sent to members is readable, comprehensible and well designed. The information includes the disposition of the complaint and the right to appeal.
14. Opportunities for improvement are identified by gathering the appropriate information and by assessment and evaluation. Decisions are made regarding which opportunities for improvement to pursue.
15. Staff and providers are informed of the results of the quality improvement process.
16. Interventions to improve the system and provider performance are implemented.
17. Complaints regarding providers are filed and tracked in the provider's Quality Profile for use in re-credentialing and for other evaluation and tracking purposes.
18. The Quality Manager monitors the outcome of the actions.
19. Evaluations are conducted to determine whether interventions have been effective.
20. All documented complaints and follow-up process are kept in a confidential file.

Tracking of Complaints

1. Individual departments will track complaints and include them as part of their coordination with the Quality Management Program.
2. The Quality Management Manager receives summarized information from each department on a monthly and quarterly basis and provides a complete summary of complaint activity to the Quality Management Committee so that trends and problems can be identified and resolved through the Quality Management process. Departmental reporting may be done electronically or manually. A centralized log of all Complaints is be maintained by the Quality Management Department. <u>Complaints are analyzed in 4 major categories; quality of care issues, access to</u>

<u>care, attitude and services and billing/financial concerns.</u>

Reporting to Contracting Health Plans

All complaints are reported to health plans according to health plan contractual agreements.

Medicare Advantage +Choice Plan
MemberAppeal & Grievance Form

This form is for your use in making suggestions, filing a formal complaint, or appealing regarding any aspect of the care or service provided to you. Your health plan **is required by law** to respond to your complaints or appeals, and a detailed procedure exists for resolving these situations. If you have any questions, please feel free to call the Customer Services department of your provider group and/or your health plan's Customer Service department. Health plan customer service contact information is provided on the back of this sheet and may also be found on your health care card.

Please print or type the following information:

____

Member Name (Last, first, middle initial)

______________________________ ______________________

Address Home Phone number

______________________________ ______________________

City, State, Zip Work Phone number

______________________________ ______________________

Name of Employer or Group Enrollment ID #

______________________________ ____ ______ ______ ____ ____

Date of Birth Male/Female

Authorized Representative: If the complaint is filed by someone other than the member, please review the section called "Who may file an Appeal" and provide the following information:

Name:______________________________Telephone # ____________________

Relationship to Member:

____

Address:

____

City:______________________________State:__________Zip:

____

Please state the nature of the complaint, giving dates, times, persons, places, etc. involved. Please attach copies of any additional information that may be relevant to your complaint or appeal.

____

____

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Please sign and MAIL TO your health plan (see page # 2 for health plan addresses)

Date________________ **Signature**______________________________

Date________________ **Signature of Representative**____________________

Send your Medicare Advantage +Choice Patient Appeal and/or Grievance Letter to your health planat:

Health Plans:	Phone/Fax
Scan Desert Health Plan	

Information for all Medicare +Choice Members
(OMB Approval No. 0938-NEW Form No. HCFA-10003-NDMC (June 2001):

You may have the right to appeal.

To exercise your appeal rights, file your appeal in writing within 60 calendar days after the date of your original denial notice. Your plan can give you more time if you have a good reason for missing the deadline.

Who May File an Appeal?

You or someone you name to act for you (your **authorized representative**) may file an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you. Others not previously mentioned may already be authorized under State law to act for you.

You can call us at: (___)_________to learn how to name your authorized representative. If you have a hearing or speech impairment, please call us at TTY/ TDD (___) _________

If you want someone to act for you, you and your authorized representative should sign, date, and send us page 1 of this form, which will serve as a statement naming that person to act for you.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

For more information about your appeal rights, call your plan or see your Evidence of Coverage.

There Are Two Kinds of Appeals You Can File:

Standard (30 days) - You can ask for a standard appeal. Your plan must give you a decision no later than 30 days after it gets your appeal. (Your plan may extend this time by up to 14 days if you request an extension, or if it needs additional information and the extension benefits you.)

Fast (72-hour review) - You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting too long for a decision. Your plan must decide on a fast appeal no later than 72 hours after it gets your appeal. (Your plan may extend this time by up to 14 days if you request an extension, or if your plan needs additional information and the extension benefits you.)

- If any doctor asks for a fast appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 30 days could seriously harm your health, your plan will automatically give you a fast appeal.
- If you ask for a fast appeal without support from a doctor, your plan will decide if your health requires a fast appeal. If your plan does not give you a fast appeal, your plan will decide your appeal within 30 days.

What Do I Include With My Appeal?

You should include: your name, address, Member ID number, reasons for appealing, and any evidence you wish to attach. You may send in supporting medical records, doctors' letters, or other information that explains why your plan should provide the service.

Call your doctor if you need this information to help you with your appeal. You may send in this information or present this information in person if you wish.

How Do I File An Appeal?

For a Standard Appeal: You or your authorized representative should mail or deliver your written appeal to your health plan at the address indicated on the California Medicare + Choice Plan Member

Appeal & Grievance Form.

For a Fast Appeal: You or your authorized representative should contact us by telephone or fax using the plan contact information indicated on the California Medicare + Choice Plan Member Appeal & Grievance Form.

What Happens Next? If you appeal, your plan will review our decision. After your plan review our decision, if any of the services you requested are still denied, Medicare will provide you with a new and impartial review of your case by a reviewer outside of your Medicare +Choice Organization. If you disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens.

Other Contact Information:

If you need information or help, call us at:

Other Resources To Help You:

Medicare Rights Center:

Toll Free: 1-888-HMO-9050

TTY/TTD**:**

Elder Care Locator

Toll Free: 1-800-677-1116

1-800-MEDICARE (1-800-633-4227)

TTY/TTD: 1-877-486-2048

OMB Approval No. 0938-NEW Form No. HCFA-10003-NDMC (June 2001)

June 17, 2020

Member *Confidential*
Address

RE: Issue:
Member:
ID:

Dear

PMG's Quality Department is in receipt of your (date) (letter, telephone call, etc_______________) of concern. I would like to take this opportunity to thank you for bringing this matter to our attention, as the quality of care and service provided to our members is very important to us. We do take any member concerns quite seriously.

Your complaint has been forwarded on _ to (HMO) _____________________, attention Grievance and Appeals Department. The HMO will carefully review your concerns. Your HMO must resolve the grievance within 30 days. If you have any questions or additional comments regarding this complaint, please contact your HMO directly at _________________________.

Mr._______________, the fact that we did not meet your expectations is a customer service concern to us and we apologize for the frustration you encountered. We can only hope that your future care and service through PMG providers will be a more positive experience for you.

Thank you for taking the time to communicate to us about your feelings. Again, we do apologize for the dissatisfaction caused to you. If you have any further concerns, please feel free to direct these concerns to the Customer Services Department at Pro Med.

Sincerely,

______________________Department

Credentialing Department

Credentialing Process

It is the policy of Prospect Medical to keep all physicians' files up to date at all times. This is imperative to meet NCQA standards and all Health Plan standards.

It is the responsibility of each physician's office to send current copies of the physician's Malpractice Insurance whenever the old one expires, and new ones are obtained.

During the credentialing process, Prospect Medical verifies the license is renewed and current with the appropriate board. Malpractice coverage is also verified to be current at the time provider iseligible to see members. NCQA requires that completion of residency or highest level of education for those that did not participate in a residency program is verified. The National Practitioner Data Base is queried for all providers at each credentialing cycle.

It is the responsibility of all practitioners to provide written notification, within five (5) days of receiving any written or oral notice of any adverse action, including, without limitation:

- any filed and served malpractice suit or arbitration action
- any adverse action by the Medical Board of taken or pending, including but notlimited to, any accusation filed, temporary restraining order or interim suspension order sought or obtained, public letter of reprimand, public approval, and any formal restriction, probation, suspension or revocation of licensure
- any adverse action taken by any Healthcare Organization, which has resulted in the filing of a S a report with the National Practitioner Data Bank
- any revocation of DEA license
- a conviction of any felony or a misdemeanor of moral turpitude
- any action against any certification under the Medicare, Medicaid or Medi-Cal programs
- any cancellation, non-renewal or material reduction in medical liability insurance policy coverage

Failure to comply with requirements of the reappointment process can result in suspension or termination, as per Prospect Medical's Credentialing Policies & Procedures.

Recredentialing Process

Recredentialing takes place every three years after the Physician's appointment date. The appointment date is determined by the date the physician's credentials file is approved by the Credentialing Committee for Prospect Medical and its subsidiaries. Physicians are urged to respond quickly when the reappointment request comes, so that the work performed by the Credentialing Department can be completed in the limited time that NCQA allows.

Failure to comply with requirements of the reappointment process can result in suspension or termination, as per Prospect Medical's Credentialing Policies & Procedures.

Facility Site Audit

Please Note: If an office site review is required, you will be contacted by any of our contracted health plans, or Prospect Medical's Quality Management Department to schedule the review; your cooperation is greatly appreciated. The following are a few of the important elements that will be reviewed during the visit.

Critical Elements

There are 9 Critical Elements located in various areas in the Facility Site Review. If you miss one of these during the site audit, you will need to show proof of correction within ten days. For all other deficiencies, you will have 30 days to complete the corrections. The following items are Critical Elements:

1. Exit doors and aisles are unobstructed and escape is accessible. (This means make sure there is nothing blocking or partially blocking your exit doors.

2. Airway management: oxygen delivery system, oral airways, nasal cannula or mask, Ambu bag (these are part of the required items in your emergency kit. The portable oxygen tank must be at least ¾ full at the time of the site audit. Airway, masks, Ambu bag must be Adult size, Peds size or both depending on your patient population).

3. Only qualified/trained personnel retrieve, prepare or administer medications. (Please see guidelines, page 15. MA's must be trained in medication administration either through an MA program or documented training by licensed staff.

4. Physician review and follow up referral/consultation reports and diagnostic test results.

5. Only lawfully authorized persons dispense drugs to patients (MD, pharmacist or other persons (i.e., NP, CNM, RN, PA) may dispense drugs to patients).

6. Personal Protective Equipment is readily available for staff use (this includes water repelling gloves, clothing barrier, face/eye protection, i.e. goggles, face shield, and respiratory infection protection, i.e. mask).

7. Needlestick Safety Precautions are practiced on site. (This means your office is using safety needles which is a OSHA requirement. If your Sharps containersare in a patient exam room, they must be inaccessible to the patient, i.e., secured to the wall or placed in a lockable cabinet).

8. Blood, other potentially infectious materials and Regulated Wastes are placed in appropriate leak proof, labeled containers.

9. Spore testing of autoclave/steam sterilizer with documented results at least monthly. (A log should be kept documenting monthly spore testing).

Regular Confirmation of Provider Information

Quarterly Prospect Medical will send a practitioner a request for a practitioner to confirm the accuracy of information required for Prospect Medical and health plans provider directories. Practitioner shall complete such request by either conforming the information is correct or updating demographic information as appropriate. Practitioner shall complete such confirmation or updating within fifteen (15) business days of receipt of such request from Prospect Medical.

Such information should include the following:

The practitioner's name, practice location or locations, and contact information.

- Type of practitioner
- National Provider Identifier number
- California license number and type of license
- The area of specialty, including board certification, if any
- The provider's office email address, if available
- Informing Prospect Medical whether a practitioner has retired or otherwise ceased to practice or is otherwise no longer associated with practitioner practice
- Non-English language, if any, spoken by practitioner or other medical professional as well as non-English language spoken by a qualified medical interpreter, if any, on the practitioner staff
- Identification of practitioner who no longer accepts new patients
- All other information necessary for a Member to conduct a provider directory search, including name, practice address, city, zip code, license number, NationalProvider Identifier number, admitting privileges to an identified hospital, product, tier,provider languages, provider group, hospital name, facility name, or clinic name, as appropriate.

Health Plan Submission Process

Upon notification from the **Credentialing Committee for Prospect Medical Group and its subsidiaries** that a physician has been approved for participation, the credentialing profile is submitted to the Contracting Department for completion of the contracting process. The Contracting Department will route an Internal Change Form, which will result in submission directly to the health plans for affiliation under the applicable Medical Groups.

Those delegated Health Plans generally take 4 – 12 weeks from submission to be loaded into the Health Plan system. Once loaded, the Physician will appear on the Health Plan's website and in the next directory printing for that Health Plan. Appearance in current directories is based upon the loading of the physician. Those physicians that are loaded into the system after the cut-off date for directory printing will appear in the next printing.

Prospect makes every effort to ensure that the directory printings are accurate. However, any omissions or errors found in the directories are not the responsibility of Prospect. Please notify us immediately if you find any such error in the directory and we will notify the Health Plan of the error.

Provider identification numbers are assigned by the Health Plan and can be obtained by contacting Prospect Medical, through Prospect Medical's website, or the Health Plan directly. All contracted Health Plans have provider directories available on-line via each health plan website. See health plan contact information.

Performance Programs Department

The Performance Programs Department is responsible for HCC Risk Adjustment, and Quality metrics as they relate to CMS Star Rating, NCQA HEDIS measure performance, and the Pay for Performance (P4P) program. Performance Programs ensures providers have the resources and reporting required to achieve excellence in quality metrics. The department consists of a Vice President, 2 Directors, 2 managers, and 2 supervisors. It also includes a robust support team, including Quality Care Coordinators, who outreach to members to encourage preventive care, Specialists who work directly with providers and plan partners, and HCC Risk Adjustment Analysts and HCC Risk Adjustment Specialists, who are AAPC and/or AHIMA Certified Coders. The Quality team also provides COZEVA access, training, and support.

HCC Risk Adjustment Contact Numbers

Office Number: (844)683-3227
Fax Number: (714) 560-7693

HEDIS Quality Team Contact Numbers

Office Number: (855)696-6596
Fax Number: (714) 560-5295

What is HCC and Risk Adjustment?

HCC stands for **H**ierarchical **C**ondition **C**ategory. CMS has taken ICD-10 diagnoses codes and put them into risk adjusted categories.

Risk Adjustment is a payment method used by CMS to accurately pay Medicare Managed Care organizations for Medicare Advantage patient care. Payment is no longer based on demographics alone; payment is now based on patients' actual health status.

How HCC Risk Adjustment Works.

Inpatient, outpatient and physician encounter data is used to determine the risk adjustment payment for patient care. All pertinent and documented diagnosis codes must be submitted each calendar year (January 1 – December 31) for CMS reporting. Any diagnosis that is not documented and submitted via claims data is considered a resolved condition by CMS and payment for patient care will be adjusted accordingly. This is true whether the condition is a chronic systemic condition or not.

Why Is HCC Risk Adjustment important to providers?

To provide benefits and services to our members, it is important that we receive accurate reimbursement. Accurate reimbursement depends on our providers' documentation and their coding and/or billing staff reporting diagnoses codes in a complete, accurate and timely manner.

CMS Validation Process

Risk Adjustment Data Validation (RADV) is a process used by CMS to verify a diagnosis code submitted by a Medicare Managed Care organization is appropriately documented in the member's medical record. The validation process is done annually by CMS and there is a short time frame to obtain, review, and submit chart documentation to CMS. Due to the time frame given by CMS, it is imperative that medical record requests for Risk Adjustment Data Validation (RADV) are responded to within 5 business days.

During the Risk Adjustment Data Validation (RADV) process you may be asked to provide medical record documentation for a member or members for which you have submitted encounter data. When submitting medical records for validation, all documentation to support a reported diagnosis should be provided and must be legible.

Centers for Medicare & Medicaid Services (CMS) Chart & Documentation Requirements

Encounter Progress Notes must support ICD-10 Diagnosis and CPT Codes submitted on a CMS 1500 claim form and meet Centers for Medicare and Medicaid Services (CMS) chart and documentation requirements such as:

Chart Mechanics and Documentation Considerations

- Identify patient name and date on each page of the record.
- Reported diagnoses must be supported with medical record documentation.
- Acceptable documentation should be clear, concise, consistent, complete and legible.
- Document and report co-existing diagnoses – any that require or affect the care and treatment of the patient that day.
- Use only standard abbreviations (acronyms and symbols).
  - It is NOT appropriate to code a condition that is represented only by an up or down arrow in combination with a chemical symbol or lab abbreviation such as "↑chol" for "hypercholesterolemia"
- CMS requires that the documentation show evaluation, monitoring or treatment of the conditions documented.

Authentication by the Provider

All dates of service must be signed (with credentials) and dated by the physician (provider) or an appropriate physician extender (e.g., nurse practitioner).
The credentials for the provider of services must be somewhere on the medical record:

- Next to the provider's signature, or
- Pre-printed with the provider's name on the group practice's stationery.
    - If the provider utilizes the front and back pages of the note this information must be onboth pages

The (provider) physician must authenticate each note for which services were provided with:

- Handwritten signatures, or
- Electronic signature.

Stamps of the provider's signature are not acceptable per CMS

Types of Acceptable (Provider) Physician Signatures and Credentials'

- Hand-written signature or initials, including credentials (e.g., Mary C. Smith, MD; or MCS, MD).
- Electronic signature, including credentials.
    - Requires authentication by the responsible provider (for example, but not limited to, "Approved by," "Signed by," "Electronically signed by").
    - Must be password protected and used exclusively by the individual physician (provider).

Additional Documentation Information

It is additionally important to understand some general guidelines which may affect appropriate code selection.

Rule Out, Probable or Questionable Diagnoses – In the outpatient setting a coder is not allowed to code "Rule Out", "Ruled Out", "Probable" or "Questionable" diagnoses. In such a case you should document the most definitive diagnosis or patient symptom(s).

Diabetic Complications – When you are documenting a complication or manifestation of diabetes you must link each condition that is a direct effect of diabetes. This is performed by using linkage words such as "Diabetic…"' "… secondary to diabetes", "… due to diabetes", "… 2nd to DM", "… due to DM" or "… related to diabetes". A diagnosis statement such as "Diabetes with …", "Diabetes and …" does not offer proper linkage. You must also always document and code the diabetic condition and the diabetic manifestation.

Active CVA vs. History of CVA
It is incorrect to document CVA for a patient in the outpatient setting unless the CVA happens during the actual office visit. When doing a routine follow-up of a patient who has experienced a CVA, document the visit as one of the following:

History of CVA – This indicates that the patient has had a CVA but has no active residuals or late effects of the CVA.

CVA with Residuals – When a patient has residuals or late effects of a CVA you must document the residuals or late effects appropriately.

EXAMPLES: CVA with dysphagia
Hemiplegia due to CVA

Note: An outpatient setting is either a physician office visit or outpatient hospital visit.

Patient Status

CMS requires that you document a patient's condition each year (January 1 – December 31). Due to this requirement, it is important that you document patient status such as, but not limited to the following:

- Amputation Status
- Dialysis Status
- Ostomy Status

  i.e., Gastrostomy or tracheostomy
- Long Term Drug Use

  - Insulin
  - Anticoagulants
  - Tamoxifen
  - Femara
  - Lupron
  - Aspirin

Although you may not be treating the patient directly for the condition, the patients' existing condition does affect your medical decision making and treatment planning and therefore should be documented. Without appropriate documentation and claim submission, conditions such as the above will be considered resolved as of January 1st of each year.

Appropriate ICD-10 Diagnosis, CPT Procedure, Level II CPT and HCPC Code Usage

Centers for Medicare and Medicaid Services (CMS) no longer has a 90-day grace period for incorrect code submission: therefore, it is vital that each year you update your code books.

ICD-10 – Effective October 1st of each year ICD-10 diagnosis code changes take effect. These code changes are effective for dates of service October 1 through September 30 of each year.

CPT / HCPC – Effective January 1st of each year CPT and HCPC code changes take effect. These code changes are effective for dates of service January 1 through December 31 of each year.

Be sure to update your code books to help reduce the number of rejected and/or denied claims.

Chart Audits and Medical Record Requests

The Performance Programs Department is one of several departments which may request a chart audit or medical record for Prospect Medical.

Chart Audits

The Prospect Health Services' Performance Programs Department and/or your Medicare Advantage Health Plan will audit your Medicare Advantage member charts at least once annually. This audit involves all Medicare Advantage members enrolled with you as their Primary Care Physician and the audit will involve dates of service for two consecutive calendar years. These audits may be performed directly by Prospect Health Services, the Medicare Advantage Health Plan or by a company that has been contracted to perform the audit for us. In either case, we ask you and your staff to cooperate with Prospect Health Services, the Medicare Advantage Health Plan and/or the contracted vendor by working together to schedule the audit as soon as possible. If required, scheduling may be done in multiple sessions within a 2-week time frame.

Medical Record Requests

The Prospect Health Services' Performance Programs Department may request medical records for selected patients or dates of service for special audits. When requesting these charts, we are looking for documentation for specific patients and specific dates of service or date ranges. These types of audits usually are requested and responded to via fax, unless otherwise instructed.

HEDIS MY 2020 & MY 2021

The Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used sets of health care performance measures in the United States. The term "HEDIS" originated in the late 1980s as the product of a group of forward-thinking employers and quality experts and was entrusted to NCQA in the early 1990s. NCQA has expanded the size and scope of HEDIS to include measures for physicians, Accountable Care Organizations and other organizations. HEDIS is published across several volumes. HEDIS MY 2020 includes 92 measures and HEDIS MY 2021 includes 91 measures across 6 domains:

- Effectiveness of Care.
- Access/Availability of Care.
- Experience of Care.
- Utilization and Risk Adjusted Utilization.
- Health Plan Descriptive Information.
- Measures Reported Using Electronic Clinical Data Systems.

Measures per domain are listed below:

Effectiveness of Care

Prevention and Screening

WCC .... Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents
CIS................ Childhood Immunization Status
IMA .... Immunizations for Adolescents
LSC................ Lead Screening in Children
BCS .... Breast Cancer Screening
CCS .... Cervical Cancer Screening
COL .... Colorectal Cancer Screening
CHL .... Chlamydia Screening in Women
COA................ Care for Older Adults

Respiratory Conditions

CWP .... Appropriate Testing for Pharyngitis
SPR .... Use of Spirometry Testing in the Assessment and Diagnosis of COPD
PCE .... Pharmacotherapy Management of COPD Exacerbation
AMR................ Asthma Medication Ratio

Cardiovascular Conditions

CBP .... Controlling High Blood Pressure
PBH .... Persistence of Beta-Blocker Treatment After a Heart Attack
SPC .... Statin Therapy for Patients With Cardiovascular Disease
CRE................ Cardiac Rehabilitation

Diabetes

CDC................ Comprehensive Diabetes Care
KED .... Kidney Health Evaluation for Patients With Diabetes
SPD .... Statin Therapy for Patients With Diabetes

Musculoskeletal Conditions

ART .... Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
OMW................ Osteoporosis Management in Women Who Had a Fracture
OSW .... Osteoporosis Screening in Older Women

Behavioral Health

AMM .... Antidepressant Medication Management
ADD .... Follow-Up Care for Children Prescribed ADHD Medication
FUH .... Follow-Up After Hospitalization for Mental Illness
FUM................ Follow-Up After Emergency Department Visit for Mental Illness
FUI .... Follow-Up After High-Intensity Care for Substance Use Disorder
FUA .... Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

POD ....Pharmacotherapy for Opioid Use Disorder
SSD .... Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
SMD.. Diabetes Monitoring for People With Diabetes and Schizophrenia
SMC............ Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
SAA .... Adherence to Antipsychotic Medications for Individuals With Schizophrenia
APM..................................... Metabolic Monitoring for Children and Adolescents on Antipsychotics

Medication Management and Care Coordination

TRC .... Transitions of Care
FMC......... Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions

Overuse/Appropriateness

NCS.................................. Non-Recommended Cervical Cancer Screening in Adolescent Females
PSA ....Non-Recommended PSA-Based Screening in Older Men
URI ....Appropriate Treatment for Upper Respiratory Infection
*AAB ....Avoidance of Antibiotic Treatment for Acute Bronchitis/*Bronchiolitis
LBP..Use of Imaging Studies for Low Back Pain
DDE .... Potentially Harmful Drug-Disease Interactions in Older Adults
DAE .... Use of High-Risk Medications in Older Adults
HDO... Use of Opioids at High Dosage
UOP... Use of Opioids from Multiple Providers
COU... Risk of Continued Opioid Use

Measures Collected Through the Medicare Health Outcomes Survey

HOS.. Medicare Health Outcomes Survey
FRM.. Fall Risk Management
MUI.. Management of Urinary Incontinence in Older Adults
PAO .... Physical Activity in Older Adults

Measures Collected Through the CAHPS®[1] Health Plan Survey

FVA..Flu Vaccinations for Adults Ages 18–64
FVO ....Flu Vaccinations for Adults Ages 65 and Older
MSC...Medical Assistance With Smoking and Tobacco Use Cessation
PNU .... Pneumococcal Vaccination Status for Older Adults

Access/Availability of Care

AAP ....Adults' Access to Preventive/Ambulatory Health Services
ADV .... Annual Dental Visit
IET............ Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
PPC .... Prenatal and Postpartum Care
APP ....Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Experience of Care

CPA .... CAHPS Health Plan Survey 5.0H, Adult Version
CPC .... CAHPS Health Plan Survey 5.0H, Child Version
CCC... Children With Chronic Conditions

Utilization and Risk Adjusted Utilization

Utilization

W30 Well-Child Visits in the First 30 Months of Life
WCV Child and Adolescent Well-Care Visits
FSP Frequency of Selected Procedures
AMB Ambulatory Care
IPU ....Inpatient Utilization—General Hospital/Acute Care
IAD Identification of Alcohol and Other Drug Services
MPT Mental Health Utilization

ABX Antibiotic Utilization
Risk Adjusted Utilization
PCR .... Plan All-Cause Readmissions
HFS Hospitalization Following Discharge from a Skilled Nursing Facility
AHU Acute Hospital Utilization
EDU .... Emergency Department Utilization
HPC .... Hospitalization for Potentially Preventable Complications

Health Plan Descriptive Information
ENP .... Enrollment by Product Line
EBS .... Enrollment by State
LDM .... Language Diversity of Membership
RDM .... Race/Ethnicity Diversity of Membership
TLM .... Total Membership
Measures Reported Using Electronic Clinical Data Systems
Guidelines for Measures Reported Using Electronic Clinical Data Systems
BCS-E .... Breast Cancer Screening
COL-E .... Colorectal Cancer Screening
ADD-E .... Follow-Up Care for Children Prescribed ADHD Medication
DSF-E .... Depression Screening and Follow-Up for Adolescents and Adults
DMS-E .... Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults
DRR-E .... Depression Remission or Response for Adolescents and Adults
ASF-E .... Unhealthy Alcohol Use Screening and Follow-Up
AIS-E .... Adult Immunization Status
PRS-E .... Prenatal Immunization Status
PND-E .... Prenatal Depression Screening and Follow-Up
PDS-E .... Postpartum Depression Screening and Follow-Up

2021 PCP Performance Programs Rewards

HCC, P4P, Star & HEDIS

Prospect Medical is pleased to facilitate processes for you and your staff to generate accurate risk scores and improve preventive care & screening measures. Our valuable resources will help maximize your earning potential.

2021 Medicare Advantage Annual Wellness Visit Rewards Program (HCC):

We will continue to provide Medicare Advantage (M.A) members an Annual Wellness Visit (AWV) during an evaluation at the patient's home by a provider with whom we contract or at the PCPs office by a provider at PCPs's request, but who does not practice as a primarycare physician. A copy of the AWV progress note will be faxed to your office. Patients may also elect to visit

Prospect Medical Wellness Clinics located at various sites.

2021 Member Healthy Action Rewards

Member Healthy Actions	Reward Amount
Annual Wellness Visit	$25
Breast Cancer Screening	$20
Colorectal Cancer Screening	$20
Bone Density test	$20
Diabetes Care Eye Test	$20
Diabetes Care Blood Test (HbA1c)	$20

2021 Provider Quality Incentive Program - HEDIS

Prospect Medical Systems is proud to offer our **2021 Quality Incentive Program** to our valued physician network. This program allows us to recognize the provision of superior patient care. HEDIS measures eligible for this program and their respective incentive payments are listed in the table below. Please see **Page 2** for Detailed Program Description.

Category/Measure	Target Measure Rate[1]	Incentive Payment Per Compliant Member[2]			Applicable Line of Business		
		Target Rate Not Met	Target Rate Met	90% Rate Met	Medicare	Medicaid	Commercial
Prevention and Screening							
Breast Cancer Screening	76.0%	**$15**	**$25**	**$35**	✓	✓	✓
Colorectal Cancer Screening	73.0%	**$15**	**$25**	**$35**	✓		✓
Cervical Cancer Screening	61.3%	**$15**	**$25**	**$35**		✓	✓
Osteoporosis Management in Women	50.0%	**$15**	**$25**	**$35**	✓		
Chlamydia Screening in Women	58.3%	**$15**	**$25**	**$35**		✓	✓
Controlling Blood Pressure <140/90 mmHg***◊** Most *recent* test of the year must be in range	75.0%	**$15**	**$25**	**$35**	✓	✓	✓
Childhood Immunization Status **(Combo 10)**	37.5%	**$15**	**$25**	**$35**		✓	✓
Immunizations for Adolescents **(Combo 2)**	36.9%	**$15**	**$25**	**$35**		✓	✓
Well-Child Visits (W30)							
0 – 15 months – 6 or more visits	67.9%	**$15**	**$25**	**$35**		✓	✓
15 – 30 months – 2 or more visits	67.9%	**$15**	**$25**	**$35**		✓	✓
Child and Adolescent Well Care Visits							
3 – 21 Years – 1 visit/year	66.0%	**$15**	**$25**	**$35**		✓	✓
Diabetes Care							
HbA1c Control < 9.0% Most *recent* test of the year must be in range	72.0%	**$15**	**$25**	**$35**	✓		

HbA1c Control < 8.0% Most *recent* test of the year must be in range	51.8%	**$15**	**$25**	**$35**		✓	✓
Retinal Eye Exam	73.0%	**$15**	**$25**	**$35**	✓	✓	✓
Care for Older Adults							
Pain Assessment*	87%	**$25**	**$35**	**$45**	✓		
Medication Review*							
Medication Management							
Medication Reconciliation Post Discharge*	71%	**$25**	**$35**	**$45**	✓		

Program Notes:

* Measures for which only administrative data and provider attestations will be used to calculate Measure Rate. Prospect Abstractor attestations for measure compliance will not be included in Measure Rate calculation.

◊ In 2017, the American College of Cardiology and American Heart Association revised the definition of hypertension to 130/80 mmHg. The current guideline for normal blood pressure is less than 120/80 mmHg. For Measurement Year 2021, 140/90 mmHg is required to achieve compliance for the NCQA HEDIS Measure Controlling High Blood Pressure and will be used to calculate the measure rate for the incentive program.

Program Description

[1] **Measure Rate Calculation**

# of compliant patients (Numerator) / # of patients in the eligible population (Denominator)

[2] **Incentive Payment Per Compliant Member**

Based on Provider Measure Rate and whether it is below *Target Rate*, at or above *Target Rate*, or equal to or greater than *90% Rate*.

Total Incentive Payment

Calculated by adding *Incentive Payments Per Compliant Member* for all applicable measures. *Total Incentive Payment* will be calculated and paid twice per year:

- **Period 1:** Compliance Dates of Service January 1 – June 30, 2021; paid out in Q4 2021
- **Period 2:** Compliance Dates of Service July 1 – December 31, 2021; paid out in Q2 2022

Note: If Measure Rate in Period 2 increases the *Incentive Payment per Compliant Member*, Provider will be reimbursed the difference for all previous compliant member payments received.

All incentive programs payments are paid in accordance with the Incentive Payment Guidelines. For additionalinformation about our Incentive Programs please contact the Performance Programs Department.

Cozeva

Prospect is pleased to offer access to **Cozeva**, an operating system for value-based healthcare, designed to drive the transition toward a value-based ecosystem for quality, risk, and cost performance. As a cloud-based solution for ACOs, IPAs, payers, providers, and patients, Cozeva aggregates and transforms multiple data streams into **actionable analytics** and registry-driven dashboards in real-time. Cozeva assists users in fulfilling their goals for HEDIS, AMP, HCC, Stars, and Care Management.

To obtain access and/or schedule training for your office, please contact Prospect's HEDIS Quality Team at (714) 796-4205.

Why use Cozeva?

- Real time tracking of member NCQA HEDIS measure eligibility and compliance
- Specifies measures from the Medicare Part C & D Star Ratings measure set, helping providers track and improve Star ratings
- Prioritize patients according to care gaps
- Utilizes analytics to create priority patient outreach lists
- View, print or download detailed patient information
- Advanced Suspect Model incorporates, claims, labs, medications to build the suspect score for each patient
- Enter services rendered and supplemental data directly into Cozeva

How to Access Cozeva:
Once you receive your login information, go to: www.cozeva.com to log into your account.

- Enter your Login ID.
- Enter your temporary password.
- Click "Sign On." The first time you sign on you will be prompted to create a new password.

Technical Support:
When logged into Cozeva, use the **chat functionality** for questions, feedback or other concerns.

For **phone support**, call

- 1 (877) 862-7048, Monday-Friday*, 8a-5p PST
- 1 (877) 862-7047, Monday-Friday*, 9a-5p EST

For **additional information** please contact your Network Manager or HEDIS Quality Team at (714) 796-4205.

Provider Reference Guide

Attached to the manual are the two reference guides – Adult and Pediatric provider reference guide. The reference guide can help the provider better understand the specifications for quality measures used to address care gap opportunities, as well as how to report data and what billing codes to use.

Claim Definitions

Clean Claim: A clean claim submitted on paper or on its electronic equivalent must be on a CMS 1500 form or UB 04 form and must include all information and attachments listed.

Non-Clean Claim: A claim will not be a clean claim if it is missing any of the information or attached specified below.

Electronic Claim: An electronic claim is a HIPAA-compliant electronic submission equivalent to a CMS 1500 form or UB-04 form.

Contested Claim: A contested claim is one that cannot adjudicate or accurately determine payer liability because more information is needed from either the claimant or a third party.

Encounter Data: Services that are covered under a physician's capitation are referred to as encounters. One encounter is considered for each patient treated for each date of service. If multiple procedures are performed, it is considered one encounter.

Provider Dispute: A contracted provider dispute is a provider's written notice to Prospect Medical and/or the member'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.

Full Risk: In a unique full-sharing arrangement, the Medical Group and hospital agree to partner into a risk pool. This arrangement is designed to give hospitals and the medical group incentives to work together to manage care in a cost-effective manner.

Shared Risk: In capitation, the pool established for sharing the risk of costs for referral services among all participating providers. Commonly, this involves a group or specialty category of physicians and is based on utilization. Sometimes, risk pools are established in partnered or limited partner or foundation capitation systems, whereby both providers share risk in a limited way with health plans.

Claim & Encounter Data Submission Instructions

Claims for services provided to members assigned to Prospect Medical must be sent to the following:

Via Mail:	Prospect Medical Group P.O Box 11466 Santa Ana, CA 92711-1466
Via Office Ally:	**www. Officeally.com**

The following is a list of claim timeliness requirements, claims supplemental information and claims documentation required by Prospect Medical.

- Contracted Providers: Contracted providers are required to submit claims within **90 days from the date services were rendered**, or according to the time specified in the contract, whichever date is longer. **All encounter data must be sent to Prospect Medical within 30 days from the date services were rendered.**

- Non-Contracted Providers: Non-contracted providers are required to submit claims within **180 days from the date services were rendered**, except as required by state or federal law or regulation.

- Hospital-Based Physicians: Hospital-based physicians are required to submit claims within **365 days from the date services were rendered**.

- Corrected claims that are resubmitted because Prospect has contested the original claim for additional information (e.g., medical records, correct modifier,invalid ICD-10 code) must be submitted to Prospect within **45 business daysfrom date of determination to be eligible for reconsideration.** Corrected claims or claims submitted with additional information will be **denied for untimely filing if received more than 45 business days after original claim's denial has been generated**.

Acceptable Proof of Timely Filing:

Acceptable documentation for proof of timely filing must be a confirmation receipt from Office Ally or Aerial. If you submit paper claims, please refer to Aerial to confirm that your claim has been received by Prospect. You will not receive written documentation of proof of receipt for paper claims from Prospect, since all contracted providers have the ability to view claims status on-line through Prospect on-line portal, Aerial.

All claims and encounter data must be submitted on a properly completed CMS 1500 claim form. The information must include the following:

- Patient's name
- Patient's date of birth
- Patient's ID number
- Place of Service
- Patient's address
- Patient's insurance company
- Date of Service(s)
- CPT code(s) and/or HCPCS
- ICD-10 code(s)
- NDC Number for drugs where contract rates are a percentage of AWP
- Name of Rendering Physician
- State License number of Rendering Physician must be present in box 24k
- Itemized Charges
- Tax I.D. Number of Contracted Entity
- Authorization Number in box 23
- No more than six lines of service on one claim
- For referred and/or ordered services, the name of the referring or ordering physician and the NPI or UPIN numbers must be present in box 17 and 17A
- Emergency Services shall include any necessary medical records to make a proper determination of the emergency service rendered.
- If Provider is understood to be and identified as a 'Direct Access' provider, a copy of the direct referral form must be attached to the CMS 1500 form.
- If member was treated under the Blue Shield Direct Access + Program, a copy of the member's ID card must be provided.
- Urgent Care providers must bill with the term 'Urgent Care' in box 23 and place service code 20.

For Institutional Providers, the following is required:

- Claims must be submitted on UB 04 Claim Form with all entries stated as mandatory by NUBC and required by federal statute and regulations and any state-designated data requirements included in statutes or regulations.
- Appropriate Revenue, CPT, ICD-10, and HCPCS
- Copies of invoices when billing for miscellaneous drugs and/or supplies

Patient's name
Patient's date of birth
Patient's ID number
Place of Service
ICD-10 code(s)
Charges
Patient's address
Patient's insurance company name
Date of Service(s)
CPT code(s)
Name of Admitting Physician
Tax I.D. Number

- Emergency Services shall include any necessary medical records to make a proper determination of the emergency service rendered.

Approved Retro-Authorization Claim Submissions

When submitting a claim with an approved retro-authorization, the claim must be submitted within 45 calendar days from the date the retro-authorization was approved by Prospect Medical.

Acknowledgement of Claim Receipt

Prospect Medical will acknowledge receipt of all contracted provider claims via our web portal Aerial Care.

Claim Status

To determine if your claim has been received by Prospect and to check the status of a claim, please log into Aerial Care and search for the claim under the Claims Status feature.

You may also obtain claims status or determine if your claim has been received by Prospect by calling our Claims Department.

Payments

Claims Processing Guidelines

Fee for service claims are paid at your contract rate(s) with Prospect Medical but processed in accordance with Medicare and Medi-Cal guidelines.

Physician Assistant and Nurse Practitioner Charges

Services provided by a Physician Assistant (PA) and/or a Nurse Practitioner (NP) are valued by Medicare at a lower level than if the same service had been provided by a physician.

The Medicare rates for PAs and NPs are as follows:

	PA rate	NP rate
Assistant Surgeon:	85% of physician rate	85% of physician rate
Facility:	75% of physician rate	85% of physician rate
Non- Facility:	85% of physician rate	85% of physician rate

Percentage is of the contracted physician's fee schedule amount. Therefore, if the physician's contract rate is 80% of Medicare, then PAs would be paid at **60%** (80% x 75%) of Medicare for facility services (other than assistant surgeon services) and 68% (80% x 85%) of Medicare for non-facility services and for assistant surgeon services. NPs would be paid at **68%** (80% x 85%)

of Medicare for all services.

Notice of Overpayment

In the event that an overpayment of a claim exists, and/or claims are used to offset the provider's overpayment, Prospect Medical will provide a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

Offsets to Payments

For Senior members, Prospect Medical may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when; (i) the provider fails to reimburse Prospect Medical within the timeframe specified in the written explanation to the provider, and (ii) Prospect Medical's contract with the provider specifically authorizes Prospect Medical to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions.

Prospect must acquire the provider's written approval for all Commercial members.

Past Due Payments

If the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, Prospect Medical will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) Business Days of the issuance of the written determination.

Time Allowed for Claim Payments

Senior Claims: All senior contracted claims will be paid within 60 calendar days.

Capitation Check Cashing

Capitation checks must be cashed within 90 days from the date of the check issued.

Claim Check Cashing

Claim checks must be cashed within 14 days of the date on the check issued.

Capitation Deductions

Definitions

Cap Deduct: Deductions made to a capitated provider's capitation check for payments made to non-contracted/non-authorized providers when members are referred for unauthorized services.

Fee for Service Deduct: Deductions made to a contracted provider's FFS reimbursement for payments made to non-contracted/non-authorized providers when members are referred for unauthorized services.

Policy

Contracted providers that refer members to non-contracted or non-authorized specialists, laboratories or radiology centers may be cap deducted for payments made to these non-contracted/non-authorized providers.

Contracted providers are contractually obligated to refer members to in-network providers for all ancillary and/or specialty care services unless otherwise pre-authorized by our Medical Management team.

For Service/Access Services

Upon notification from a member/provider regarding access issues to a capitated provider, the Medical Management team will:

1. Call the capitated provider and speak with the office manager to confirm availability. If the provider is unable to see the member in a timely manner or if the service is unavailable as required by their contract, the member will be redirected, and a capitation deduction will be entered into our system.
2. Upon receipt of the claim from the authorized provider, the capitated provider will receive a cap deduction for the payments made to the covering provider.

The same applies to capitated specialists that do not respond timely (within 30 minutes) to our contracted hospitalists.

For Change of Care/Member Grievance

If a request is received by a member/provider to change a referral from a capitated provider to a non-capitated provider because of a member/provider grievance against the capitated provider, the Medical Management team will:

1. Call the capitated provider and provide an opportunity to respond to the grievance.
2. The response will be reviewed by the Medical Director and a determination will be made whether to redirect the member.
    a. If the decision is to redirect the member, a cap deduction will be entered, and all payments affiliated with the redirect will be deducted from the capitated provider's

capitation payment.

Please note that all complex or questionable deductions will be reviewed by the Vice President of Medical Management and/or Medical Director prior to the actual processing of the cap deduction.

Provider Notification Process

Providers will be notified via a 'Cap Deduct Letter' prior to an actual cap deduction. Providers have 30-day from the date of the letter to dispute or accept the deduction(s). If a response is not received within 30 days, the cap deduction will take place on the next capitation/fee for service payment.

Verifying Status of Cap Deduction Dispute

Providers may contact the Provider Dispute Department directly to obtain status of their dispute. They may be reached by calling (714) 347-2029.

Remittance Advice Summary (RA)

Below is an illustration of our Remittance Advice Summary (RA) for all networks. All bolded items are fields, which are filtered by the information supplied by our database.

PROSPECT MEDICAL SYSTEMS
1920 E 17th St Suite 200
SANTA ANA,CA 92705
Prospect Medical Systems
Remittance Advice Summary P

Vendor address for billing and reporting

*Name of Contracted Entity
Billing Address
City,State Zip

Check number and post date information

Vendor Number: License#
Check Date: (Post date)
Bank Check #: (Number)

Name	Member #	HP	Referral #	POS	From-to date	Claim #	Rcvd Dt	Post date	Acct num	Loc	MP
SMITH, JANE	12345678-01	PAC	12345678	11	03/15/08-03/15/08	12345678	03/20/2008	03/22/08	0001234567	OC	NC

Rendering Facility: NAME OF RENDERING HOSPITAL
Claim Vendor: NAME OF CONTRACTED PROVIDER

EOB Comments: "ADDITIONAL DETAILED INFORMATION HERE"

Proc Code	Proc Description	D/U	Service dates From - to	CAP	Amount Billed	Amount Rejected	Deduct Amount	Copay Amount	Amount Approved	Amount Withheld	Net Amount
99213	OFFICE OUTPT EST 15 MIN:	1	03/15/08 – 03/15/08	N	200.00	153.00	0.00	10.00	37.00	0.00	37.00
COPAYMENT		10.00									
ABOVE CONTRACT AMT		153.00									
APPROVED FOR PAYMENT		37.00	PROSPECT STANDARD FUND								
	** Claim Totals **				200.00	153.00	0.00	10.00	37.00	0.00	37.00
	*** Vendor Remittance Claims Subtotals ***				200.00	153.00	0.00	10.00	37.00	0.00	37.00

Additional comments from processor

Line Adjudication detail; Distribution of billed dollars

N – Fee For Service Line

Y – Capitated Service Line

PAYMENT SUMMARY

Billed: Amount billed by provider.
Amount Rejected: Dollar above approved
Copay Amount: Patient Copay
Approved Amount: Amount approved for payment.
Amount Withheld: Any funds withheld by group.
Net Amount: Total Dollar Approved for Payment

Disposition Codes

Listed below are the disposition codes that you may find on your Remittance Advice Summary:

STATUS	MNEMONIC
$ ABOVE % TO PAY	RATP
$ ABOVE ALLOWED AMT	RAAA
$ ABOVE NEGOTIATED RATE	RMAR
$ NOT PAID BY COB	RNP
$ PAID BY COB	REJEC
ABOVE CONTRACT AMT	RAVCA
ABOVE INGENGIX 50TH PERCTILE	AIFP
ABOVE REFERRAL LIMITS	RLIM
ABOVE U&C RATES	AUC
ADD'L DAYS NOT AUTHORIZED	ADA
ADDITIONAL INFO REQUESTED NOT R	CINFO
ADJ ADMINISTRATIVE ERROR	AE
ADMIT DX INCLUDED CHF	AIC
AMBULANCE NOT MED NEC	NCAM
AMBULANCE NOT TRANSPORT	NCAMO
AMOUNT ORIGINALLY PAID	AOP
AMT ABOVE YR MAX	RAA
APP LEVEL OF CARE PER DIAG	ALOC
APPLIED TO ADVANCE PAYMENT	AAP
APPROVED $ PAID BY COB	RACOB
APPROVED FOR PAYMENT	AFP
APPROVED INTEREST PAYMENT	AIP
APPROVED PAID AS A COURTESY	APC
APPROVED PAID AT DRG RATES	APDR
APPROVED-ALLOWED AMOUNT IS LESS	APLC
ASST SURG DENY MCARE GUIDELINES	NCAS
ATT MED REC IF ADMIT DX INVALID	AMR
AUTHORIZATION EXPIRED	AUEX
BENEFIT EXCLUSION	RBE
BENEFITS NOT DEFINED	RBND
BILL HEALTHPLAN	BHP
BILL HEALTHPLAN PATIENT USING P	DPOS
BILL PCP NOT MEMBER	RBP
BILL PRIMARY INS	RBPI
BILL SECONDARY INSURANCE	BSE
CAPITATED SERVICE	RCS
CARVE OUT	CO
CARVE OUT DAY	RCOD
CHIRO BENEFIT VISIT LIMIT	MACH
CHIRO NOT MCARE CRITERIA	NCCH
CLAIM DENIED INFO NOT RECEIVED	CDI
CLAIM PENALTY	CPEN
CLAIM RECEIVED AFTER FILING LIM	RRAFL

PROSPECT MEDICAL

CLAIM RECEIVED OVER 1 YEAR	CRO
CLAIM RECEIVED OVER 45 DAYS	RRA
CLAIM RECEIVED OVER 60 DAYS	RR
CLINICAL PATHOLOGY NOT PAYABLE	CPA
COB OVERRIDE	RCO
COIN NOT PAID BY COB	NPCOB
COIN PAID BY COB	CCOB
COINSURANCE	COI
COINSURANCE - MEDICARE ALLOWABL	CMA
CONSIDERED TECHNICAL	RCT
CONTESTED INFO RECEIVED UNTIMEL	CIFU
CONTR PROV OP NO AUTH OV,LAB,ET	CONT
CONTRACT ADJUSTMENT	RCA
CONTRACT FAC DELAY IN CARE	CONTX
CONTRACT HOSP NO AUTH NON ER	CONTO
CONVERSION HOSP RESP	CHSP
COPAY 1	COP
COPAY 2	COPA
COPAY 3	COPAY
COPAY EXCEEDS ALLOWABLE PAYMENT	COPE
COPAY EXCEEDS PAYOUT AMOUNT	RCEP
COPAY NOT PAID BY COB	CNCOB
COPAY PAID BY COB	CPCOB
COPAYMENT	CCOP
COSMETIC PROCEDURE	NCCO
CPT CODE DOES NOT MATCH PROF CL	DNM
DAYS ABOVE LIFETIME MAX	LITI
DAYS ABOVE YEARLY MAX	RDA
DEACTIVATED DIAGNOSIS CODE	RDDX
DEACTIVATED PROCEDURE CODE	RDPC
DEDUCTIBLE	DED
DEDUCTIBLE NOT PAID BY COB	DNCOB
DEDUCTIBLE PAID BY COB	DPCOB
DENIED OUT OF NETWORK	DUN
DENTAL NOT MCARE CRITERIA	NCDS
DENY INCLUDED IN SETTLEMENT	DIS
DIAGNOSIS DOES NOT MEET DRUG CR	RDDC
DIRECT REFERRAL MISSING	RDRM
DME NOT AUTHORIZED	NCDMO
DME NOT MCARE CRITERIA	NCDM
DME PURCHASE PRICE MET	PPM
DUPLICATE CLAIM	DUP
DUPLICATE REFERRAL	RDF
DX DOES NOT MATCH ADMIT DX	DNH
EFF DATE ERROR	REDE
ELIG STATUS NOT VERIFIED	RES
ELIGIBILITY CLEARED	ELIC
EMPL PLAN ERROR	REPE
EPOGEN ABOVE REF LIMITS	EAR
ER CRITERIA NOT MET/NON-EMERG	ERCNM

ER NOTES NEC FOR BEN REV	RERNN
EXCEEDS REFERRAL LIMITS	ERL
HEALTH PLAN PAID CHARGES	RJPP
HEALTH PLAN RESPONSIBLE	RHP
HEALTH PLAN RESPONSIBLE II	RHPII
HEARING AIDS NOT COVERED	NCHA
HH MEMBER NOT HOMEBOUND	NCHHO
HH NOT MCARE SKILLED GUIDELINES	NCHH
HOME HEALTH NOT AUTH	NCHHX
HOME HLTH NOT MCARE GUIDELINES	NNHH
HOSP STAY DENIED	RHSD
IN AREA ER CRITERIA NOT MET	ERIA
IN AREA ER NON-EMERGENT	RIA
IN AREA ER NOT AUTH	RI
IN AREA ER RECORDS NOT RECD	ERIAO
INAPPROPRIATELY BILLED	REIB
INC GLOBAL FOLLOWUP AFTER SURGE	IGF
INCL IN CASE RATE	ICR
INCL IN GLOBAL RATE	RIGR
INCL IN PRIMARY PROCEDURE	IPP
INCL IN TRIAGE FEE	RIFTF
INCLUDED IN BANKRUPTCY	IBK
INCLUDED IN DRG RATE	DRG
INCLUDED IN FACILITY CAPITATION	RIFC
INCLUDED IN FLAT RATE	RIFR
INCLUDED IN PCP'S CASE RATE	RIPCR
INCLUDED IN SETTLEMENT	IIS
INCLUDED PER DIEM	RPD
INCOMPLETE DIRECT REFERRAL	IDR
INCOMPLETE PERMIT	RIP
INCORRECT/MISSING MODIFIER	IMM
INVALID PLACE OF SERVICE	IPS
INVALID/MISSING DRG CODE	IDC
INVALID/MISSING MODIFIER	IMMOD
INVALID/MISSING REV CODE	RIRC
IP PSYCH BENEFITS EXHAUSTED	MAPY
IPA NOT NOTIFIED OF HOSP ADMIT	INN
IPA NOT RESPONSIBLE	INR
LATE CHARGES INCLUDED IN CONTRA	RLCI
LATE CHARGES NO ORIGINAL BILL R	RLCO
MED REC NEC FOR BEN REV	RMRN
MEMBER NOT ELIG FOR INCENTIVE	MNE
MEMBER RESPONSIBILITY / SELF RE	MEMS
MISC ANNUAL MAX REACHED	MAMI
MISC NON-COVERED ITEMS	NCMI
MNS RESPONSIBILITY	MNS
MOD REFERRAL	RMR
MODIFIER APPLIED	RMA
NO CHARGE FOR TRIAGE	NCT
NO CHARGE PER AGREEMENT	NCP

PROSPECT MEDICAL

NO DOCUMENTATION FOR SERVICE PE	DSP
NO IPA/PMG AUTH = POS OPTION	POS
NON-AUTH OFFICE IN AREA	NCNA
NON-ER PAID TRIAGE FEE	RNE
NON MCARE FDA APPROVED	NCRXO
NOT A COVERED BENEFIT	NCB
NOT AUTH'ED-DO NOT BILL MEMBER	DNBM
NOT AUTHORIZED	NA
NOT CONTRACT PROVIDER	RNC
NOT ELIGIBLE ON DATE OF SERVICE	NOEL
NOT ELIGIBLE WITH THIS IPA	NEI
NOT IN PCP REFERRAL GROUP	RNI
NOT IN PCP'S CALL GROUP	NIPG
NOT ON ACCESS PANEL	NOA
NOT W/THIS IPA SENT TO CORRECT	FTIPA
NOT W/THIS IPA SENT TO HMO	FTHMO
NOT WITHIN SCOPE OF SERVICES	NWSS
OOA ER NOT URGENT	EROA
OOA ER RECORDS NOT RECD	EROAO
OV INCL IN SURGERY	ROV
OVER ALLOWABLE AMOUNT	OAA
OVER CLAIM AGE LIMIT	ROCAL
OVER MEDICARE ALLOWABLE	OMA
OVER MEDICARE ALLOWABLE AMT	RACF
PAID BY OTHER INS	RPB
PAID ON APPROVED CPT CODE	POA
PATIENT NOT RESPONSIBLE	PNR
PD AT U&C RATES	UNC
PENDED APPLY MULTIPLE SURGERY	PAMS
PENDED CAP REVIEW	PCAP
PENDED CASE RATES	PCR
PENDED CONTRACTING DEPT	PCD
PENDED INTERNAL AUDIT	PIA
PENDED MISSING REF TYP	PMRT
PENDED PRE-SURGERY FU DAYS	PRE
PENDED SURGICAL CLAIM W/O MODIF	SNMOD
PENDING	PEN
PENDING COB - CHECK COB SCREEN	PCOB
PER CONTRACT RATE	RPC
PER CMS (HCFA) POLICY	HCFA
PER MCARE GUIDELINES	RPMG
PER NATIONAL STANDARDS	RPI
PER PROSPECT POLICY	RPP
PERMIT ADJUSTMENT	PA
PERMIT FEE DEDUCTED	PFD
PERSONAL COMFORT ITEMS	NCPC
PODIATRY ROUTINE FOOT CARE MAX	MAPO
PREVIOUSLY CONSIDERED	RCP
PRIMARY INS PD MORE THAN CONTRC	PIPMT
PRIMARY INSURANCE PAYMENT MEETS	RPPR

PROSPECT MEDICAL

PROCARE CONVERSION	PC
PROCEDURE NOT ALLOWED	EXC
PROCESSED AT CONT RATE	RPACR
PROCESSED IN ERROR	RPIE
PROVIDE COPY OF AUTH	PCA
PROVIDE DESC OF SERVICE	PDS
PT USED VA BENEFITS	VAB
RE-ADMIT WITHIN 72 HOURS AFTER	DDR
REFER TO UPDATED AHA REPORT	HHCNA
REFERRAL NOT VALID THIS DOS	RRDE
REFUND ADJUSTMENT	RA
REJ ASSIST AT SURG RESTRICTED	ASR
REJ BILL MEDICARE HOSPICE SERVI	RBMH
REJ CO-SURG NOT PERMITTED FOR P	COS
REJ DUPLICATE SUBMISSION	DUPS
REJ RESUBMIT AS ONE CPT + MOD -	MODB
REJ RESUBMIT WITH MODIFIER -51	MODA
REJ TEAM SURG NOT PERMITTED	TMS
REJ TRANSFERED TO HERITAGE	RHERI
REJECT CALOPTIMA RESPONSIBILITY	RCOR
REJECT NON-CONTRACTED PROVIDER	RNCP
REJECTED	REJ
REJECTED INVALID BILL TYPE	IBT
REPROCESSED	REP
RESUBMIT BILLED AMOUNT	RBA
RESUBMIT CLAIM W/REF PHYS INFO	REF
RESUBMIT COPY OF ORIGINAL CLAIM	RCOC
RESUBMIT CORRECT DATE OF SERVIC	DOS
RESUBMIT EOB FROM PRIMARY CARE	RREP
RESUBMIT NDC FOR DRUG PRICING	RNDC
RESUBMIT POA INDICATOR	RPOA
RESUBMIT QUALIFIER/UPN	UPN
RESUBMIT RENDERING PHYSICIAN	RRP
RESUBMIT SOURCE OF ADM CODE	ADM
RESUBMIT URGENT CARE TIME	RUCT
RESUBMIT VALID MEDICARE CODE	RVMCC
RESUBMIT VALID PROC CODE	IPC
RESUBMIT W/ RENDERING FACILITY	RRF
RESUBMIT W/PHYS'S ORDERS	RRWPO
RESUBMIT W/TREATMENT AUTH CODE	TAC
RESUBMIT WITH ANESTHESIA TIME	RWAT
RESUBMIT WITH CORRECT PLACE OF	RWVP
RESUBMIT WITH CORRECT TAX ID	RVTI
RESUBMIT WITH CORRECTED UNITS	UNI
RESUBMIT WITH EOB FROM PRIMARY	REPRI
RESUBMIT WITH HIPPS CODE	HIPPS
RESUBMIT WITH INVOICE	RWI
RESUBMIT WITH MOD 51	RMP
RESUBMIT WITH VALID AUTH	RVA
RESUBMIT WITH VALID DIAGNOSIS C	RWVD
RESUBMIT WITH VALID I.D. CARD	RVIDC

ROUTINE PODIATRY SERVICE	NCPO
RX ANNUAL MAX REACHED	MARX
RX NON-FORMULARY	NCRX
RX OVER THE COUNTER DRUGS	NCRXX
SEND DETAILED LABS/MD ORDERS	SDL
SEND MEDICAL RECORDS FOR RECONS	SMR
SEND RECORDS FOR RECONSIDERATIO	SRFR
SEND RECORDS WITH HEMATOCRIT RE	SRH
SENT TO CORRECT IPA	FTH
SERVICE POST DATES DEATH	ELIGX
SHOE ORTHO NOT COV BENEFIT	NCSO
SNF BENEFITS EXHAUSTED	RSB
SNF CUSTODIAL CARE NOT COV	NCSN
SNF MAX ALLOW REACHED	MASN
SNF NOT AUTH	NCSNO
SUBMIT COMPLETE BILL INTERIM RE	CBIR
SUBMIT CORRECT CPT FOR INCENTIV	SCC
SUBMIT PROG NOTES FOR INCENTIVE	SPN
SVC APP AT BIL DISC RATE	BID
SVC APP AT MULT SURG DISC RATE	MSD
SVC IN BETWEEN ELIGIBILITY	ELINB
SVC POSTDATES ELIGIBILITY	ELIG
SVC PREDATES ELIGIBILITY	ELIGO
TENET RESPONSIBILITY	TR
TERMINATED MEMBER	TERM
TO BE DONE AT CAPITATED FACILIT	RCF
TO BE HANDLED BY PCP	RTB
TRANSPORT LOCATIONS REQUIRED	TLR
U&C ADJUSTMENT	RCADJ
UNBUNDLED/MEDICARE GUIDELINES	UNBU
UNITS ABOVE MAX LIMIT	UAM
UNITS ABOVE YEARLY MAX	UAY
VACCINES FOR CHILDREN PROGRAM	VFC
VENDOR CONTRACT TERMINATED	RVCT
WELLNESS CONTR REQUIRES ALL HCC	RALL
WITHHOLD	WTH

Billing Requirements

From time to time, Prospect Medical implements mandatory billing requirements to process your claims in a timely and more accurate manner. Listed below are the current billing requirements.

Urgent Care Claims
Providers may bill with any appropriate E&M code 99201-99208, 99211-99215, place of service code 20 and enter Urgent Care in the authorization box.

Well Woman Exams and Cervical Cancer Screenings (Pap Smears)
To ensure proper adjudication and payment of claims one the following diagnosis codes must be used with CPT codes 99385-99387 for new patients or CPT codes 99395-99397 for established patients when reporting a Well Woman visit with a pap smear as indicated by the patient's condition:

Z12.4 - Encounter for screening Pap smear for malignant neoplasm of cervix

Z01.42 - Encounter for cervical smear to confirm findings of recent normal smear following initial abnormal smear

One of the following diagnosis codes should be used to indicate a history of hysterectomy as applicable:

N99.3 - Prolapse of vaginal vault after hysterectomy

Z08 - Encounter for follow-up examination after completed treatment for malignant neoplasm

Z12.72 - Encounter for screening for malignant neoplasm of vagina (Vaginal Pap smear status-post hysterectomy for non-malignant condition)

Please note, diagnosis codes ***Z01.411*** (Encounter for gynecological examination (general) (routine) with abnormal findings) and ***Z01.419*** (Encounter for gynecological examination (general) (routine) without abnormal finding), ***while still valid diagnosis codes, are not specific enough*** to indicate that a Pap smear was performed. ***These codes must be used in conjunction with one of the codes listed above to count for the Pay for Performance or HEDIS measure.***

Depo Provera & Depo SubQ Provera
Providers should bill J1051 and J1055 when the ICD-10 falls within the following ranges – V25.01 through V25.1 and V25.40 through V25.5.

Providers can bill J1051 and J1055 for medical conditions such as endometriosis and contraception.

Immunization Billing and Reimbursement

Responsible Payer

Prospect Medical may not be responsible for payment of all of your immunizations. In some instances, you may have to bill the patient's health plan directly for immunizations. The grid on the following page outlines which immunizations are payable by Prospect Medical and/or by the health plan.

For Medicare Advantage members, most immunizations such as Zostavax and Tetanus-Diphtheria Toxoids (i.e., when used for prevention), are covered under their Part D benefits.

The following immunizations are covered under Medicare Part B and therefore remain payable by Prospect Medical for most health plans (See the grid below for Part B vs. D vaccine coverage):

- Pneumococcal vaccine
- Influenza virus vaccine
- Hepatitis B vaccine for individuals at high or intermediate risk (e.g., renal disease, hemophilia)
- Other vaccines (e.g., tetanus toxoid) when directly related to the treatment of an injury or direct exposure to a disease or condition.

Immunization CPT Codes for Reimbursement from Prospect

Refer to the Prospect Immunization Schedule to ensure correct CPT billing codes are used. For a copy of the most current immunization schedule please contact the Network Management Department.

Immunization Co-payments

In certain circumstances a member may be responsible for an immunization co-payment. Please refer to your Remittance Advise Summary (RA) to determine if a co-payment was taken from your reimbursement. If a co-payment was taken, you may bill the member since this is their financial responsibility in accordance with their health plan benefits.

Health Plan	Network	Submit Claim To IPA:	Submit Claim To Health Plan:
	All other networks		Part B & D immunizations
SCAN Desert Health Plan	All networks	Part B immunizations	Part D immunizations
Part B Immunizations (apply to Medicare Advantage members only): • Influenza: 90654-90657, Q2034-Q2039, 90660 • Pneumococcal: 90732 • Hepatitis B (for individuals at high or intermediate risk); 90740, 90743, 90744, 90746, 90748 • Vaccines used for the treatment of an injury or after direct exposure to a disease or condition) such as tetanus toxoids (90703, 90389, 90715, J1670)			

Forwarding Claims to Other Payors

When in receipt of a claim that is the financial responsibility of the health plan, it is Prospect Medical's policy is to forward claims to the plan for payment. Listed below are the addresses that claims are mailed to:

SCAN Desert Health Plan
3800 Kilroy Airport Way #100
P.O. Box 22616
Long Beach, CA 90801

Provider Dispute Submission and Resolution

Each contracted provider dispute must contain, at a minimum, the following information:

(1) Provider's Name (2) Provider's Tax ID Number (3) Provider's Contact Information, and:

If the provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from Prospect Medical Group to a contracted provider, the following must be provided:

- A clear identification of the disputed item (including original claim number)
- Date of Service
- A clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect

If the contracted provider dispute is not about a claim

- A clear explanation of the issue
- The provider's position on such issue

If the contracted provider dispute involves an enrollee or group of enrollees

- The name and identification number(s) of the enrollee or enrollees
- A clear explanation of the disputed item, including the Date of Service and provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.

Sending A Contracted Provider Dispute To Prospect Medical

Provider disputes submitted to Prospect Medical must include the information listed above, for each provider dispute. All provider disputes must be sent to the attention of the Provider Dispute Department at Prospect Medical at the following:

Via Mail: Prospect Medical Group
P.O Box 11466
Santa Ana, CA 92711-1466
Attn: Provider Disputes Department

Via e-mail: providerdisputes@prospectmedical.com

Please Note: Do not submit any dispute via email that would contain Protected Health Information (PHI) as outlined by the HIPAA Privacy Act.

Via Fax: (714) 560-7354

Instructions For Filing Substantially Similar Contracted Provider 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:

- Sort provider disputes by similar issue and separate into batches.
- Provide a cover sheet for each batch.
- Number each cover sheet.

Provide a cover letter for the entire submission describing each provider dispute with references to the numbered coversheets.

Time Period For Submitting A Provider Dispute

Provider disputes must be received by Prospect Medical within 365 days from Prospect Medical's action that led to the dispute or the most recent action if there are multiple actions that led to the dispute (please refer to Section 6.10 for date of resolution).

In the case of Prospect Medical's inaction, provider disputes must be received by Prospect Medical within 365 days after the provider's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

Contracted provider disputes that do not include all required information as set forth above will be returned to the submitter for completion. Please note that an amended provider dispute which includes the missing information must be submitted to Prospect Medical within forty-five (45) business days of your receipt of a returned provider dispute.

Please allow the time allowed before calling to verify status.

Time Period For Resolving A Provider Dispute

Prospect Medical will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) Business Days after the Date of Receipt of the contracted provider dispute or the amended provider dispute of a Commercial/Medi-Cal Claim.

Prospect Medical will issue a written determination stating the pertinent facts and explaining the reasons for its determination within thirty (30) Calendar Days after the Date of Receipt of the contracted provider dispute or the amended provider dispute of a Senior Claim.

Acknowledgement Of Provider Disputes

Prospect Medical will acknowledge receipt of all contracted provider disputes as follows:

Paper contracted provider disputes will be acknowledged by Prospect Medical within fifteen (15) business days from date of receipt.

To avoid duplicate submissions, please allow the time allowed before calling to verify receipt.

Provider Dispute Status

Status of a Provider Dispute may be obtained by calling our Provider Dispute Department at (714) 347-5868.

- Please allow 15-business days before calling to verify receipt of Provider Dispute.
- Please allow 45-business days before calling to obtain status/resolution of Provider Dispute.