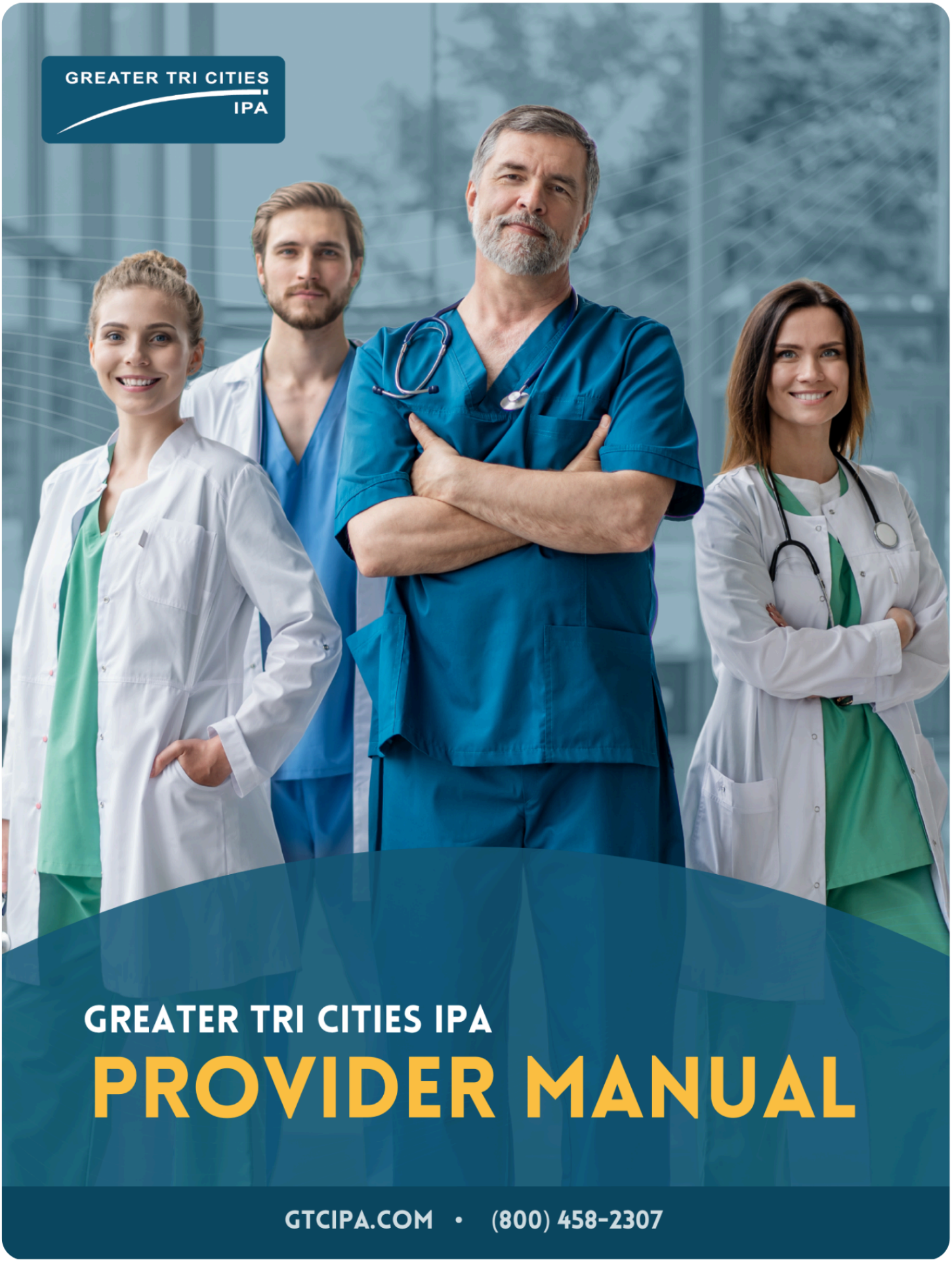

GREATER TRI CITIES IPA

PROVIDER MANUAL

GTCIPA.COM • (800) 458-2307

Table of Contents

(Numbers 20-24 are listed on our website at www.gtcipa.com; located on the bottom of the main page under Site Resources: Compliance Training & Resources)

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Welcome Letter

Dear Greater Tri Cities IPA Provider,

Welcome to GTCIPA! We would like to briefly review with you the many functions that the IPA is responsible for and your role in this important process. The IPA holds contracts with multiple HMOs or "Health Plans." The Health Plans give the IPA a portion of the monthly premium they collect for each member assigned to the IPA. The IPA is then responsible for providing healthcare services to these members. To do that, the IPA must contract with a network of PCPs, specialists, and other ancillary providers, such as outpatient surgery, home health, PT, radiology, pathology, and many others. The IPA is also delegated by the Health Plans for credentialing, utilization, management, quality improvement, claims, and capitation payment.

The responsible use of healthcare resources is maintained by authorizing services according to current medical necessity guidelines, and since we only have access to the information you provide us with your authorization request, your active participation in this process is crucial. You must provide complete information when submitting a request so it can be reviewed and either approved or denied appropriately.

Both authorizations and claims payments are subject to the patient's eligibility at the time of service. A patient has the right to change their IPA at any time, so you must check the patient's eligibility before each visit. You may obtain current eligibility by contacting the patient's health plan directly. We use an online portal, https://aerial.carecoordination.medecision.com/, for authorization requests and tracking in addition to claims submission and tracking. A username and password can be requested by emailing PR for access at dmillett@pdtrust.com and providing the full names of the employees and email addresses. We also accept electronic claims through Office Ally (866-575-4120). When calling one of those providers, give them our Payor ID of PDT01 to get set up.

Our objective is to manage the use of healthcare resources responsibly without impeding our provider's ability to deliver appropriate, quality healthcare. If you have any questions, please feel free to contact me at 760-941-7309 x 130

Sincerely,

Darcie Millett
Provider Relations

Staff Directory

Customer Service (760) 732-0272 | Website: GTCIPA.com	
Utilization Management	
Kaliah Burton, IPA Manager	Phone: (760) 941-7309 x 134 Fax: (760) 477-2924 Email: kburton@pdtrust.com
Darcie Millett, Provider Relations	Phone: (760) 941-7309 x 130 Fax: 760-407-6611 Email: dmillett@pdtrust.com
Dr. Victor Dalforno - IPA President	
Mark O'Brien, DO - Medical Director	(760) 889-1763
Cheryl Souza RN - VP Clinical Services	(760-941-7309 x118
Karen Palmer – Compliance Officer	(760) 941-7309 ext. 114
Caroline Begins - Risk & Quality Manager	(760) 941-7309, x227
Nicolina Alves - Marketing Manager	nalves@pdtrust.com
Iselda Gentry, DNP, MSN, FNP-BC - Nurse Practitioner	(760) 941-7309, x106 Email: igentry@pdtrust.com
Claims	
All mailed claims must be on CMS1500 and sent to the address at the right. Please submit claims electronically via Office Ally. ***The payor ID is PDT01***.	Greater Tri Cities IPA PO Box 5059 Oceanside, CA 92083
Claims Department	(760) 941-7309, x2000 Open 9:00 am – 3:00 pm
Clinical Services	(760) 941-7309, x2001 Open 9:00 am – 5:00 pm

Phone Menu Options

This number is dedicated to GTC members and providers.

Main Line: 800-458-2307

The following shortcuts will allow you to easily navigate our phone system options:

Main Option	Sub Options
1 - Member	1 - Claims Department 2 - Clinical Services Department 3 - General information (hours, mailing address, etc.)
2 - Provider	1 - General information (hours, mailing address, etc.) 2 - Claims department 3 - Clinical services department 4 - Credentialing department 5 - Risk adjustment department 6 - Provider relations department 7 - Health Net Community Care
4 - Assistance in Spanish	

** At any point, you can return to the previous menu by pressing * (star)

We highly encourage our providers to utilize Aerial Care to submit any authorization requests, and check eligibility, authorization, and claims status.

Turnaround Time Standards

Greater Tri Cities IPA follows or exceeds these national standards for referral turnaround time.

Routine referrals have a 5-business day decision time frame from the time a completed and signed referral has been received in the IPA office. The IPA must notify the PCP office within 24 hours of that decision via FAX, email, or telephone.

Urgent referrals have 72 hours.

Emergent referrals must have a 24-hour turnaround time during business hours (8:00 am – 4:00 pm).

Referrals received at the end of a business day (after 4:00 pm) will be processed as received on the next business day.

Pended routine referrals – can pend 45 business days for commercial members or 14 calendar days for senior members. Once we receive the requested information, we have five (5) business days to make a decision.

Pended urgent referrals – can pend 48 hours, then a decision must be made within 24 hours.

Procedures **should not** be scheduled until authorization is approved.

Aerial Care Portal Instructions

Greater Tri Cites IPA provides a Web Portal for Online Referrals & Claims Submission through Aerial Care, a managed care software system.

Simply follow the steps below to easily set up your online referral process for your GTCIPA patients.

1. Contact your GTCIPA Physician's Representative, to obtain your login and password.
2. Go to: https://aerial.carecoordination.medecision.com/gpm/physician/LoginDefault.aspx
3. Enter your login name and password. The first time you log on, you will be asked to change your password. (You will be asked to change your password every 60 days. Be aware that when that happens, you may reuse the same password.) After entering your new password, you will be taken to the site.
4. The screen you will first see is called the "dashboard". At the top and middle of the screen, under "Group Information", you will see any Provider notices we have posted, as well as documents for common use.

To access the Aerial Care Training information:

1. Click on the word Training at the top of the screen.
2. If you would like to download written documentation, on the left side of the screen under Documentation click on Provider. Then click Physicians Training. The training materials will open up in Adobe Reader. You can then print the information or save the document to your computer.

To enter a referral:

1. Click on "Submit Online Referrals", which you will find in the far-left column on your screen.
2. You may search for the patient using the ID#, Name, SSN, or DOB. We have found that the name or DOB is the easiest search option. Please note that the patient will show up with the name and DOB that the health plan believes they have. For this reason, if you have trouble finding the patient, you should look at their ID card to see if the health plan knows them by a different name or DOB. (Note: if the plan has any of the patient's information noted incorrectly, the patient must contact the plan to have that corrected.) If you do not find the patient at all, please verify their eligibility with the health plan.
3. If the patient is newly effective with GTCIPA, please use the "Member Inquiry Form" (which can be found on the dashboard under Group Information) to report the new patient to us. We will add patients to our system, and they will soon be available to you on Aerial Care.
4. Once the correct member has been located, take note of the icon to the left of their record on the screen. If it is red, they are ineligible according to the last information provided to us by the health plan. If this is incorrect and they are still eligible under this health plan, use the "Member Inquiry Form" to have the patient updated by us. If the icon is green, they are eligible, and a purple "refer" button will appear to the right of their record on the screen. Click on the "refer" button to proceed with submitting a referral.
5. A referral form will come up on the screen. You will fill in the fields using a combination of typing and drop-down menus. All fields in red must be completed, including CPT and ICD-10 codes. If you

do not know a code, you can type in a description, and the system will provide a drop-down menu of choices to select from.

6. You will see 2 boxes; Clinical Symptoms and Proposed Treatment. Please provide complete information on the patient's condition including pertinent test results. This will allow us to make a decision and respond to your request quickly.
7. Once you have completed the form, click on the "submit" button at the bottom of the screen.
8. Any applicable questions will come up on the next screen. Complete them and click on the "submit" button. (If you want to change anything on your referral, this is your last chance – click the "edit referral" button.)
9. The next screen will tell you whether your referral has been received and is being processed or approved. You can attach any notes or test results here by clicking on the statement below that says, "Click here to add attachments."

To look up the status of a referral that you previously submitted:

1. Click on the "eligibility" tab near the top of your dashboard.
2. Enter the patient's first and last name or DOB. Click "submit".
3. If more than one patient comes up, identify the correct one. To the far right of their record, you will see two icons. Click the "paper with the blue arrow" icon to open the patient's record.
4. This will bring up the patient's demographic information. At the top of the page, you will see two buttons. To view their referrals, click the "member referrals" button. (The small number to the right of the button represents the number of referrals on record for this patient.) Any referrals on file for this patient will appear on the next screen. You may click on the "paper with the blue arrow" button on the far right to open the referral details.

REFERRAL FORM A – PCP

TRACKING NUMBER
IPA USE ONLY

Greater Tri Cities IPA
Fax: (760) 631-7602 Phone: (760) 941-7309

Date of Referral Request: _____/_____/_____ ☐ **Routine** ☐ **Urgent** ☐ **Emergent**

☐ **Member Request**

Patient Name: (First, Last) _____

Address: _____ City: _____ Zip: _____

Date of Birth: ____/____/_____ Phone: _____

Health Plan: _____ Patient ID#: _____

Referred To: **ICD-10:**

Specialty Type: _____

Referred By: (PCP) **Diagnoses:**

PCP OFFICE CONTACT : _____

PCP Phone: _____

PCP Fax: _____

SIGNATURE OF PCP:
(MANDATORY – WILL NOT BE PROCESSED WITHOUT MD SIGNATURE) _____

Procedures/services requested:	CPT CODE:
	CPT CODE:
	CPT CODE:
	CPT CODE:

Reason for REFERRAL: _____

Attachment(s)	
Notes:	
Lab:	
EKG/EEG:	
X-Ray	
Other:	

Place of Service: ☐ **Office** ☐ **Out-Patient** _____ ☐ **In-Patient** _____

FOR USE BY GREATER TRI CITIES IPA UM STAFF ONLY

☐ Authorize Date: _____ ☐ Pending Date: _____ ☐ Modified Date: _____

☐ Denied Date: _____ ☐ Not a covered benefit. ☐ T P L

Comments/Remarks: _____

UM Signature: _____ **Date:** _____

Date PCP Notified: _____ **Please notify member today of referral status.**

Certification does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions. This certification is good for sixty (60) days from approval date

PCP Scope of Service

PRIMARY CARE PROVIDER AGREEMENT - EXHIBIT B
A Primary Care Physician (PCP) in managed care is responsible for all eligible services required by the patient, except when precipitous emergency circumstances preclude the primary physician's role.

The primary care physician's services are personal, and his/her responsibility is comprehensive, i.e. all required services including preventive services.

The PCP should provide those services that can be provided appropriately within his or her skills and obtain consultation when additional knowledge or skills are required. Consultation may consist of telephonic advice from a specialist or may involve referrals for services.

When care by one or more specialists is required, the responsibility of the PCP is to coordinate all services, not only his/her own but also all services by all specialists.

Primary Care Services should include, but are not limited to:

A. Routine office visits (including after-hours office visits) and related services of a physician and other health care providers received by Enrollees in the Physician's office. This includes evaluation, diagnosis, and treatment of illness and injury, including but not limited to: specimen collection; simple minor surgery and laceration repair; punch, excisional, and shave biopsies; uncomplicated ingrown toenail removal; control of nasal hemorrhage; aspiration and injection or trigger points/joint; and all related written documentation.
B. Visits and Examinations This includes consultation time and time for personal attendance with the patient at an emergency room (except for Emergency Room between 5:00 p.m. and 8:00 a.m.) or during confinement in a hospital (including critical care visits), skilled nursing facility, or extended care facility.
C. Immunizations and injections (including injectables) shall be provided by the Physician but shall be subject to payment in accordance with IPA's Fee Schedules.
D. Urinalysis and finger stick glucose and stool for occult blood. All other laboratory services shall be performed by IPA-contracted laboratory(s). If any other laboratory services are provided in the Physician's office, no additional payment shall be made.
E. Periodic health appraisal examinations, including all routine tests performed in the Physician's office, as determined pursuant to accepted practice guidelines as adopted by IPA.
F. Miscellaneous supplies related to treatment in the Physician's office. This includes but is not limited to: gauze, tape, minor surgery trays, injection trays, bandages, and other routine medical supplies.
    a. Non-routine billed supplies shall be paid by IPA in accordance with a fee schedule adopted by IPA. Payment is subject to the usual utilization management procedures.
G. Physician home visits are when the nature of illness dictates, as determined by the physician.
    a. Supervision of complex home care regimens involving ancillary health personnel (e.g., home TPN, tube feeding, antibiotics) may warrant additional payment to the Physician as determined by IPA. Payment is subject to the usual utilization management procedures.
H. Referral of Enrollee to appropriate consulting physician or ancillary services as medically necessary and according to guidelines established by IPA.

I. Telephone consultations with Enrollees and referral physicians.
J. Twenty-four (24) hour on-call coverage. Physicians are responsible for making financial arrangements with the covering physician.
K. All medical care (exclusive of procedures) is provided to Enrollees by medical sub-specialists who execute this Agreement.
L. Health Education.
M. Family Planning – The physician agrees to ensure that an Enrollee's Family Planning information and records are confidential as required by State law.
N. Cultural/Linguistic Sensitivity – The physician shall address the special health needs of Enrollees who are members of specific ethnic and cultural populations and those with disabilities.

This list shall not be all-inclusive, and additional Primary Care Services may be included as determined by IPA in its sole and absolute discretion.

Laboratory
All laboratory services should be provided by IPA's designated contracted laboratory(s) LABCORP. Laboratory services provided in the physician's office are included under capitation. Expenses for PCP referral to non-capitated/non-contracted labs without prior authorization from IPA will be deducted from PCP's capitation for the total amount paid.

Radiology and Other Imaging
All radiology and other imaging services should be provided by IPA's designated contract facility. Radiology services provided in the physician's office are included under capitation.

Any additional lab and radiology expenses incurred by IPA or a Plan due to a referral to non-capitated or non-contracted labs or to an imaging center without prior authorization from IPA may be deducted from the Provider's compensation.

Retro Authorization Request

As a contracted provider with Greater Tri Cities IPA,
You are required to obtain prior authorization for all services unless it is specifically addressed in your contract.

Claims that are received for services where prior authorization has not been obtained will be denied for no authorization.

We realize that there may be times when obtaining prior authorization would only delay a patient's treatment (i.e. urgent or emergent appointments). In those instances, please complete an authorization request as you normally would; indicate what date the patient was seen and why authorization was not obtained prior to the patient being seen. Fax or submit it via Aerial Care to the IPA UM department as normal. As long as we receive your request within 30 days of the services, we will process the request as a normal referral.

Eligibility Research Request

Date: _____ IPA: **Greater Tri Cities IPA**

PCP: _____ Contact: _____ Phone: _____ Fax: _____

The following members are effective per the health plan but are not showing on my capitation list. Please research and verify that patients are eligible. We request that you fully complete all fields. Any incomplete information may be delayed. Please be reminded that although enrollment data is current, you may find some members who are new to the HMO plan and/or Provider. **MEMBERS LOADED AFTER CAPITATION WILL APPEAR ON THE NEXT CAPITATION REPORT WITH ANY RETRO DUE. RETROACTIVE/DELETE WILL ONLY GO BACK UP TO SIX (6) MONTHS.**

This form will be faxed back to the provider within 10 business days.

Membership Information (Please Print Clearly):

Member Name	Date of Birth	Health Plan	Member ID#	Effective Date	*****CAP Month missing*****

ALL INFORMATION MUST BE COMPLETED **FAX REQUEST TO: (760) 407-6611** **ATTN: ProviderRelations**

Preferred Contracted Ancillary Provider

Please refer your patients only to the below-contracted facilities.

RADIOLOGY	
Cypress Imaging P 760-931-1200 F 760-931-1105 cypressdiagnosticimaging.com	
SimonMed P 866-282-7905 F 760-585-7527 simonmed.com	**Tricity Outpatient Imaging** P 760-940-7470 F 760-940-4063 tricitymed.org
IHS (multiple locations) P 858-658-6500 F 866-558-4329 imaginghealthcare.com	**Tricity Pet CT** P 760-599-9940 F 599-0885 tricitypetct.com
North County Radiology (multiple locations) P 760-630-0014 F 760-630-0015 northcountyrad.com	**Valley Radiology** P 760-739-5400 F 877-392-4462 valleyrad.com
LABORATORY	
Labcorp is to be utilized for all laboratory services. To find a location: labcorp.com/labs-and-appointments labcorp.com/providers	

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Urgent Care Facilities

Please inform patients to utilize our Urgent Care Services as an alternative to Emergency Care Services for Non-Emergent Needs such as a cough, sore throat or upset stomach. Please see below a listing of the contracted urgent care clinics for GTCIPA:

Centers	
828 Urgent Care 4171 Oceanside Blvd, Oceanside, CA 92056 Phone: 760-216-6253 828urgentcare.com Hours: 8 am to 8 pm DAILY Yes, even Holidays	
Rady Children's Urgent Care Oceanside 3605 Vista Way, Suite 172, Oceanside, CA 92056 Phone: 760-547-1000 rchsd.org Hours: M-F & holidays: 4 p.m.-10 p.m. Saturday-Sunday: 1 p.m.-10 p.m.	**Rady Children's Urgent Care Escondido** 2125 Citracado Parkway, Suite 100 Escondido, CA Phone: (760) 739-1543 Fax: 760-294-9274 Hours: M-F: 4:00 pm-10:00 pm Sat/Sun: 1:00 pm to 10:00 pm
Concentra Carlsbad Site 5810 El Camino Real, Carlsbad CA 92008 Phone: (760) 929-8269 concentra.com Hours: M-F: 8:00 am to 5:00 pm	**Concentra Oceanside Site** 3910 Vista Way, Oceanside, CA 92056 Phone: (760) 941-2000 concentra.com Hours: M-F: 8:00 am to 5:00 pm
Concentra San Marcos 740 Nordahl Road Ste. 131 San Marcos, CA 92069 Phone: 866-944-6046 concentra.com Hours: M-F: 8:00 am to 8:00 pm Sat 8:00 am -5:00 pm	**Concentra Escondido Site** 860 West Valley Parkway, Escondido, CA 92025 Phone: (760) 740-0707 concentra.com Hours: M-F: 8:00 am to 5:00 pm

Hospital Facilities

Greater Tri Cities IPA is proud to be affiliated with 3 excellent, local hospitals:

Locations
Tri City Medical Center 4002 Vista Way, Oceanside, CA 92056 Phone: 760-724-8411 Website: tricitymed.org
Palomar Medical Center Escondido 2185 Citracado Parkway, Escondido, CA 92029 Phone: 442-281-5000 Website: palomarhealth.org
Rady Children's Hospital 3020 Children's Way, San Diego, CA 92123 Phone: 858-576-1700 Website: rchsd.org

Office Update Request Form

Greater Tri Cities IPA must maintain accurate information in the provider database. This updated information will be forwarded to health plans affiliated with Greater Tri Cities IPA. Please complete, provide any changes, and fax this form to Provider Relations *(760) 407-6611 or email dmillett@pdtrust.com*

Physician's Name: _____

Additional Providers: _____
(including *Mid-level PA or NP)*
_____

Effective Date: _____

Address _____

City, State, Zip _____
Phone ( ) _____ Fax ( ) _____

Website: _____ Provider CAQH# _____

Tax ID Number : _____ Group
NPI: _____

Hospital Affiliations _____

Office Hours: M _____ T _____ W _____ Th _____ F _____ Sat _____ Su _____

Languages Spoken _____

Patient Ages ____ All Ages ____ Newborn - 18 ____ 18 & up ____ Other: _____

Office Manager/Contact: _____

****

PCPs ONLY:

Does your office provide Well Woman Exams to members? ____

Does your office provide EKGs to members? ____

****

Authorized Signature _____ *Office Manager/Supervisor or Physician* Title _____

Date _____ Phone Number: _____

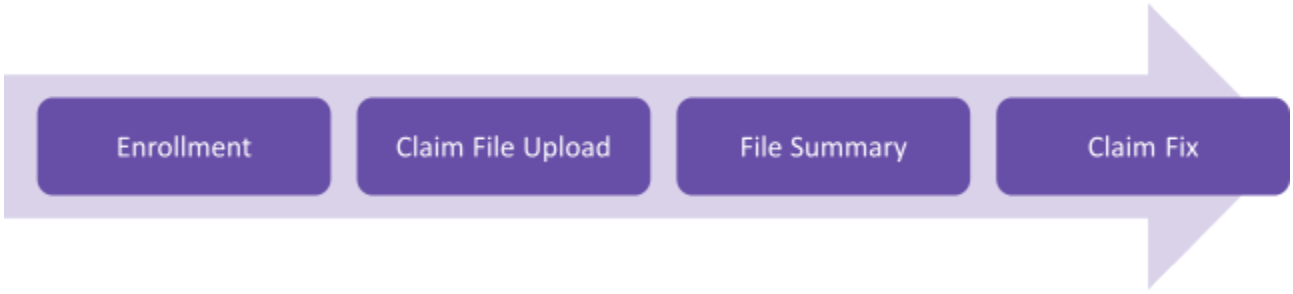
Claim Submission Options

There are 2 options for claims submission via Office Ally:

1. File upload, which allows for the upload of an ANSI837 Professional or Institutional Claim file, either via web portal or SFTP.
2. Online Claim Entry, which is claim submission via manual entry into an Online CMS1500 or UB04 Claim form.

Payer ID: **PDT01**

Claim Submission Process:



Enrollment: Contact Office Ally for enrollment and access at (360) 975-7000. Select option 1. Or visit https://cms.officeally.com/Register/Register.aspx to complete the Enrollment Form online.

Claim File Upload: Log onto officeally.com. Hover over the Upload Claims option on the left side of the screen. Select Upload HCFA, upload a Professional Claim file, or select Upload UB04 to upload an Institutional Claim file. Click Select File. Browse for your file and click Open. Click Upload. You will receive an uploaded confirmation page with your File ID number. Alternately, Office Ally does offer an option for SFTP file submission. Contact Office Ally at (360) 975-7000, option 1 to request SFTP. You will need to be prepared to provide the following information: Office Ally Username, Contact Name, Email, Software Name, Format being submitted, and whether you would like to receive 999/277s.

File Summary: Within 24 hours, your file summary will be available. This report is the receipt of the claims submitted.
To view the available reports, select Download File Summary under Download listed on the left side of the screen. Dates
listed with a pink background are dates that have reports that have not yet been viewed. Click on the date to view the available reports for that date. Click on the View link to review the report. Then click Open.

Claim Fix: If a claim receives an error and cannot be processed it will be made available in Claim Fix. You can view any claims in Claim Fix by selecting the Claim Fix option on the left side of your screen and then clicking “Repairable Claims”. Click on any date that has a pink background. Click the Correct link to view and fix the data on the claim. Click Update to save the changes and resubmit the claim. Once all of your claims for a specific date have been corrected the background for that date will change to white.

Online Claim Entry:

Enrollment: Contact Office Ally for enrollment and access at (360) 975-7000. Select option 1. Or visit https://cms.officeally.com/Register/Register.aspx to complete the Enrollment Form online.
Claim Entry: To view a detailed video that will walk you through the process, log onto the Office Ally Website at www.officeally.com. Click on Training Videos on the Menu Bar and then select the "Online Claim Entry" video under
Service Center. To submit your claim(s) via Online Claim Entry, click the Online Claim Entry option under Claims, on the left side of your Office Ally screen, after you have logged onto the site.

Claim Batching: After online claims are submitted, they will be "Awaiting Batch". Claims can take 1-3 hours to be reviewed and batched. While a claim is in this status you can view, edit or delete the claim by selecting Claims Awaiting Batch under the Online Claim Entry option on the left side of the screen.
File Summary: Within 24 hours, your file summary will be available. This report is the receipt of the claims submitted.
To view the available reports, select Download File Summary under Download listed on the left side of the screen. Dates listed with a pink background are dates that have reports that have not yet been viewed. Click on the date to view the available reports for that date. Click on the View link to review the report. Then click Open.
Claim Fix: If a claim receives an error and cannot be processed it will be made available in Claim Fix. You can view any claims in Claim Fix by selecting the Claim Fix option on the left side of your screen then clicking "Repairable Claims". Click on any date which has a pink background. Click the Correct link to view and fix the data on the claim. Click Update to save the changes and resubmit the claim. Once all your claims for a specific date have been corrected the background for that date will change to white.

Other Important Information:

1. Member and Provider information on Office Ally is updated weekly.
2. Claims submitted via Office Ally are received by the IPA the business day after successful submission and processing by Office Ally.
3. Office Ally offers to Print and mail any claims that cannot be submitted electronically. If you are interested in this service contact Office Ally or access the "Update Printing Option Form" available on the Office Ally website under Resource Center, Office Ally Forms & Manuals then Account Management.
4. Technical Support is available at (375) 975-7000, option 2.
5. Office Ally offers Free Training. To utilize this service contact Office Ally at (360) 975-7000 Option5.

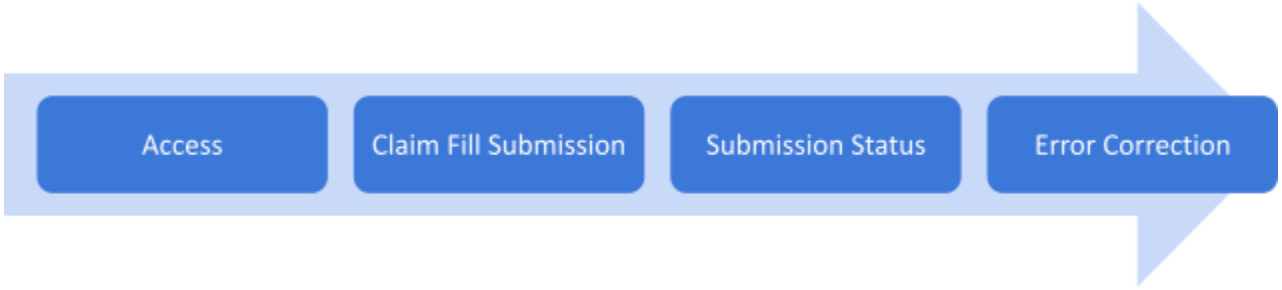
Smart Data Solutions

There are 2 options for claims submission via Office Ally:

3. File upload, which allows for the upload of an ANSI837 Professional or Institutional Claim file, either via web portal or SFTP.
4. Online Claim Entry, which is claim submission via manual entry into an Online CMS1500 or UB04 Claim form.

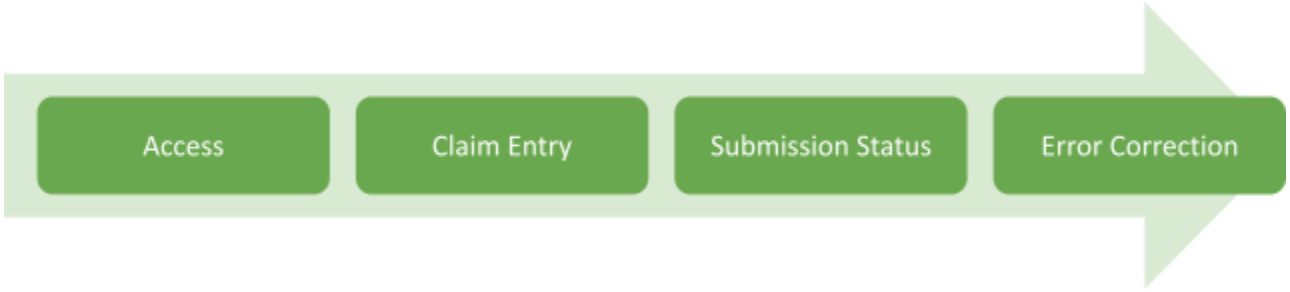
Payer ID: **PDT01**

Claim Submission Process:



Access: Contact Smart Data Solutions (855)297-4436 to obtain access.
Claim File Submission: Once you have access to the SDS Quick Claim Portal, you can submit a Claim file by clicking the Upload New File option.
Submission Status: You can check the status of any submitted batch by clicking on Batch History on the Main screen. Error Correction: From the main screen, you can click on View Rejected documents to review and correct any claims that were rejected.

Online Claim Entry:



Access: Contact Smart Data Solutions (855)297-4436 to obtain access.
Claim Entry: Once you have access to the SDS Quick Claim Portal, you can submit a Claim online by clicking the Key New Claim option. Enter your claim information and click Save.
Submission Status: You can check the status of any submitted batch by clicking Batch History on the Main screen. Error Correction: From the main screen you can click on View Rejected documents, to review and correct any claims that were rejected.

Other Important Information:
Member and Provider information with Smart Data Solutions Aerial Care is updated every Friday.
Claims successfully submitted via Smart Data Solutions are received by the IPA the following business day.
Both Professional and Institutional Claims can be submitted via SDS.

CPT Code Levels by Specialty

SPECIALITY	NEW PT	ESTAB PT
ALLERGY	99203	99213
CARDIAC SURGERY	99203	99213
CARDIOLOGY	99203	99213
CARDIOVASCULAR SURGERY	99203	99213
COLORECTAL SURGEON	99203	99213
DERMATOLOGY	99203	99213
ENDOCRINOLOGY	99203	99213
ENT	99203	99213
GASTROENTEROLOGY	99203	99213
GENERAL SURGERY	99203	99213
INFECTIOUS DISEASE	99203	99213
NEPHROLOGY	99203	99213
NEUROLOGY	99203	99213
NEUROSURGERY	99203	99213
ONCOLOGY	99204	99214
ORAL SURGERY	99203	99213
ORTHOPEDICS	99203	99213
OPHTHALMOLOGY	92002	92012
PLASTIC SURGERY	99203	99213
PODIATRY	99203	99213
PULMONARY	99203	99213
PSYCHOLOGY	99203	99213
RADIATION THERAPY	99203	99213
RHEUMATOLOGY	99204	99213
THORACIC	99203	99213
UROLOGY	99203	99213
VASCULAR SURGERY	99203	99213

This list specifies what level code will be approved by Specialty. If a higher code is requested, a referral will be downgraded to level on this list. If, at the time of service, it is determined the patient meets a higher level of care, the provider will bill the applicable CPT code with supporting medical records for review.

For further information, please contact Provider Relations.

Access to Care Standards

Primary Care Physician (PCP)	Standard
Emergency (Serious condition requiring immediate intervention)	Immediately (office, UCC, ER)
Urgent (Condition that could lead to a potentially harmful outcome if not treated)	Within 48 hours (office, UCC)
Non-Urgent (routine) (visit for symptomatic but not requiring immediate diagnosis and/or treatment)	Within 10 business days
Adult or Pediatric Health Assessment / Physical (Physical: periodic health evaluation with no acute medical problem) (Preventive: for prevention and early detection of disease, illness, or condition)	Within 30 calendar days, unless a more prompt exam is warranted
IHA (18 months and older)	Within 120 days of enrollment
IHA (under 18 months)	Within 60 days of enrollment
Waiting Time in a physician's office	Less than 30 minutes
After-hours Access	Answering Service or service w/ option t page Provider
Enrollees with life-threatening medical problems must have access to health care twenty-four (24) hours per da and 7 days per week. After-hours answering system or voice mail should instruct members that if they feel they have a serious acute medical condition, to seek immediate care by calling 911 or going to the nearest Emergency Room. Members must be assured that a Health Care Professional (Dr., Advice Nurse, PA, NP) will communicate with them within 30 minutes.	
Telephone Triage and Screening (urgent and routine)	Within 30 minutes

Specialty Care Provider (SCP)	Standard
Urgent referral (includes Behavioral Health)	Within 96 hours
Non-urgent / routine (includes Behavioral Health)	Within 15 business days from the time of PCP request

Behavioral Health Provider (based on Plan contracts)	Standard
Urgent	Within 96 hours
Routine	Within 15 business days
Non-physician BH	10 business days
Urgent (for diagnosis and treatment)	Within 96 hours
Routine (for diagnosis and treatment)	Within 15 business days

PHYSICIANS DataTrust

INTEROFFICE MEMORANDUM

TO: PCP, SCP, Clinical Services and Administrative Staff

FROM: Lisa Serratore, Chief Executive Officer

CC: Evelyn Jimenez, IPA Manager, CVPG
Clarissa Lomeli, IPA Manager, GPMG
Kailah Burton, IPA Manager, GTC IPA
Mary Beltran, IPA Administrator, Noble AMA IPA; Exec. Dir. IPA Administration
Michael Gella, IPA Manager, St. Vincent IPA

DATE: January 8, 2025

RE: Affirmative and Impartiality Statements

AFFIRMATIVE STATEMENT

As a utilization management organization, Physicians DataTrust on behalf of Citrus Valley Physicians Group, Golden Physicians Medical Group, Greater Tri Cities IPA, Noble AMA IPA, and St. Vincent IPA, ensures that all decisions are made based on the available medical information at the time of the request. Should a member ask to see the criteria utilized to make a medical decision; the statement below is attached to that guideline, as required by the National Committee for Quality Assurance (NCQA):

Decisions regarding requests for medical care are based on the medical necessity of the request, the appropriateness of care and service and existence of coverage. There is no monetary reward for non-approval of services. Compensation for individuals who provide utilization review services does not contain incentives, direct or indirect, for these individuals to make inappropriate review decisions.

Utilization review criteria, based on reasonable medical evidence and acceptable medical standards of practice (i.e. MCG and/or applicable health plan guidelines) are used to make decisions pertaining to the utilization of services. Review Criteria are used in conjunction with the application of professional medical judgment, which considers the needs of the individual patient and characteristics of the local delivery system.

IMPARTIALITY STATEMENT

All participating practitioners are ensured independence and impartiality in making referral decisions which will not influence hiring, compensation, termination, promotion or any other similar matters.

These statements are also on our websites: www.cvpg.org, www.gpmedicalgroup.com, www.gtcipa.com, , www.nobleamaipa.com, and www.stvincentipa.com, along with other valuable information for our contracted providers and our members, and can be printed, if needed. Our business hours are Monday through Friday, 9:00a.m. to 5:00p.m. and Administrative staff can be reached at (760) 941-7309 or (800) 458-2307 during business hours. Should you have a question for the Utilization Management Department after hours, you may call (760) 941-7309 or (800) 458-2307 and leave a message for someone to call you back the next business day.

Compliance Information: FDR Compliance Program Requirement

What is an FDR?
FDR is a Centers for Medicare & Medicaid Services (CMS) acronym for first-tier, downstream, or related entity.

A first-tier entity is a party with a written arrangement with a Medicare Advantage (MA) plan to provide administrative or healthcare services to Medicare-eligible individuals. Independent Physicians Associations (IPAs) are considered first-tier entities.

A downstream entity is a party with a written arrangement, below the level of the arrangement between the MA plan and a first-tier entity, to provide administrative or healthcare services to Medicare-eligible individuals. Your organization is considered a downstream entity.

Your subcontractors might also be considered downstream entities. Not all subcontractors are downstream entities.

A related entity is a party that holds common ownership or control of a Medicare Advantage plan.

FDR employee refers to employees, temporary employees, volunteers, consultants, and members of an organization's governing body (such as a Board of Directors).

FDR Responsibilities
As a first-tier entity, the IPA is responsible for fulfilling the terms and conditions in our contracts with MA plans, including compliance program requirements. As a downstream entity, you are responsible for adhering to these requirements as well. This includes ensuring that your downstream entities also comply with all applicable requirements.

You must keep evidence of your compliance with these requirements for at least 10 years. This may include employee training records, exclusion screening results, or proof of the way you oversee your downstream entities. You may be asked to complete an attestation or audit to verify your adherence to these requirements.

If you or your downstream entities fail to meet compliance program requirements, it may lead to retraining, corrective actions, or other sanctions. If you discover a compliance issue, you must take quick action to fix and report the issue. And, you need to prevent it from happening again.

FDR Compliance Requirements
Standards of Conduct and/or Compliance Policies

As a downstream entity, you must provide standards of conduct and/or compliance policies to your employees and downstream entities. The material(s) must include:

- Your commitment to comply with all applicable federal and state laws, ethical behavior, and compliance program requirements.

Fdr Compliance Program Requirements

- The requirement for employees and downstream entities to report compliance and FWA concerns, and all available reporting methods.
- The requirement to report compliance and FWA concerns (that impact the IPA) to Physicians Data Trust; and
- Your zero-tolerance policy for retaliation or intimidation in response to good faith reporting of noncompliance, FWA, or other misconduct.

You must provide this material within 30 days of hire or contracting, annually thereafter, and when the materials are updated. You must also save proof that you provided the material, such as a sign-in sheet, electronic acknowledgment, or signed attestation.

The PDT Code of Conduct and PDT's "Reporting Compliance & FWA Concerns" poster are available at https://pdtrust.com/compliance. You are not required to use these materials.

General Compliance Training & Fraud, Waste, and Abuse Training

As a downstream entity, you must conduct General Compliance training and Fraud, Waste, and Abuse (FWA) Training with your employees and downstream entities. You may use the two training modules developed by CMS, or another version of these training materials, as long as they include all of the concepts from the CMS versions.

You must conduct this training within 30 days of hire or contracting, annually thereafter, and when the materials are updated. You must also save proof that you conducted the training. If you use training logs, reports, or sign-in sheets as evidence of completion, they must include names, dates, and training topics.

The CMS training modules are available at https://pdtrust.com/compliance. You are not required to use these materials.

OIG/GSA Exclusion Screenings

Federal law prohibits Medicare, Medicaid, and other federal healthcare programs from paying for items or services provided by a person or entity excluded from these federal programs. So, before hiring or contracting and monthly thereafter, you must check two exclusion lists. This will help confirm that your employees and downstream entities aren't excluded. The two exclusion lists are:

1. Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) List of Excluded individuals and Entities (LEIE) https://oig.hhs.gov/exclusions/
2. General Service Administration (GSA) System for Award Management (SAM) https://sam.gov

Your organization must maintain evidence that you've screened your employees and downstream entities against both lists. This may include screenshots, input lists, or reports from a third-party vendor. The evidence must show the person or entity's name, the date, the list that was checked, and the screening outcome.

Suppose your employee or downstream entity matches with a person or entity found on one of these lists. In that case, you must investigate a potential match, and document the outcome of your investigation.

False match	Confirmed match
● Document that the match is false. This can be as simple as a note on the screening results that says "false match." ● Save the source documentation, such as a screenshot, that shows the person or entity name, the date, the source, and the information that proves that the match is false.	● Immediately remove the person or entity from direct or indirect work supporting IPA business ● Notify Physicians DataTrust at compliance@pdtrust.com, or by phone at (562) 860-8771, ext. 114

Detailed instructions on how to conduct OIG/GSA exclusion screenings, and how to document having done so, are available at https://pdtrust.com/compliance.

Downstream Entity Oversight

As a downstream entity, you must monitor the compliance of your downstream entities. If you choose to subcontract with other parties for services for the IPA business, you must make sure they abide by all requirements that apply to you as a downstream entity. This includes ensuring that:

- Written agreements between you and a downstream entity include all CMS-required provisions
- The downstream entity complies with the requirements described in this guide
- The downstream entity complies with applicable operational requirements

You must conduct enough oversight (auditing and monitoring) to ensure your employees and downstream entities are compliant. You must:

- Retain evidence of this oversight
- Ensure that a root cause analysis is conducted for any deficiencies
- Implement corrective actions to prevent recurrence of noncompliance

Not every subcontractor is a downstream entity. Only subcontractors that provide administrative or healthcare services for Medicare beneficiaries, such as a third-party biller, are considered downstream entities. The following types of subcontractors are NOT downstream entities:

- Housekeeping/custodial
- Grounds and maintenance
- Machine repair or servicing

For help identifying which of your subcontractors are downstream entities, please contact Physicians DataTrust at compliance@pdtrust.com, or by phone at (562) 860-8771, ext. 114.

Compliance Information: Subcontractor Privacy/Security Requirements

Who must comply?

Organizations providing healthcare services or certain administrative services must uphold an individual's right to privacy. This means adhering to requirements set forth by the Centers for Medicare & Medicaid Services (CMS), HIPAA and the HITECH Act, the Gramm-Leach-Bliley Act, the IPA, and the IPA's affiliated health plans.

Under HIPAA, health plans, healthcare clearinghouses, and healthcare providers are considered covered entities.

Subcontractors that perform activities involving the use or disclosure of protected health information (PHI) are considered business associates. These activities include creating, receiving, maintaining, transmitting, processing, accessing, or storing PHI.

A covered entity may be a business associate of another covered entity.

Workforce members are employees, volunteers, trainees, and any other persons under the direct control of a covered entity or business associate, regardless of payment.

Your Responsibilities

As a business associate, the IPA is responsible for fulfilling the terms and conditions in our contracts with covered entities, and to meet regulatory requirements for patient privacy and information security. As a subcontractor to the IPA, you are responsible for adhering to these requirements as well. This includes:

> ***Upholding the Business Associate Agreement (BAA) provisions set forth by the IPA,***
> ***Ensuring your subcontractors also uphold these privacy and security standards.***

You must keep evidence of your compliance with these requirements for at least 6 years. This may include employee training records, policies, risk assessments, documentation of privacy/security incidents, or proof of the way you oversee your subcontractors. You may be asked to complete an attestation or audit to verify your adherence to these requirements.

If you or your subcontractors fail to meet privacy and security requirements, it may lead to retraining, corrective actions, or other sanctions. If you discover a privacy or security issue, you must take quick action to fix and report the issue. And, you need to prevent it from happening again.

Privacy/Security Requirements

Offshore Operations

Offshore operations refer to operations conducted outside of the United States or United States Territories. An offshore subcontractor provides services performed by workers located offshore. This includes:

- American-owned companies with operations performed outside of the United States
- Foreign-owned companies with operations performed outside of the United States

If any of your employees or subcontractors perform work offshore, and that offshore work includes receiving, processing, transferring, handling, storing, or accessing PHI on the IPA's behalf, you must notify Physicians Data Trust at compliance@pdtrust.com, or by phone at (562) 860-8771, ext. 114.

Physicians Data Trust may be required to report these operations to the IPA's affiliated health plans. And, Physicians Data Trust may require your organization to develop additional controls to ensure PHI is protected in the course of offshore business.

More information about offshore operations is available at https://pdtrust.com/compliance.

Privacy & Security Training

As a subcontractor to the IPA, your organization must maintain policies and procedures to uphold privacy and security requirements. And, you must train your workforce and business associate subcontractors on these policies and procedures, as necessary and appropriate for them to carry out their assigned duties in compliance with privacy and security requirements.

The policies, procedures, and training materials must include the requirement and the method(s) for workforce members and business associates to report privacy and security concerns. And, your policies and procedures must include a provision to report privacy and security concerns (that impact the IPA) to Physicians Data Trust without delay.

You must conduct this training prior to granting access to PHI, annually thereafter, and when there are changes to privacy and security policies. You must also save proof that you conducted the training. If you use training logs, reports, or sign-in sheets as evidence of completion, they must include names, dates, and training topics.

PDT Privacy/Security Training is available at https://pdtrust.com/compliance. You are not required to use these materials.

Subcontractor Oversight

As a subcontractor to the IPA, you must monitor the compliance of your business associate subcontractors. If you choose to subcontract with other parties for IPA business, you must make sure they abide by all requirements that apply to you as a subcontractor of the IPA. This includes ensuring:

- A written service agreement and BAA are in place prior to involvement with IPA business
- The business associate subcontractor complies with the requirements described in this guide
- The business associate subcontractor complies with all applicable privacy and security standards

PDT's BAA template is available at https://pdtrust.com/compliance. You are not required to use this BAA template.

Not every subcontractor is a business associate. Only subcontractors that create, receive, maintain, transmit, process, store, or access PHI are considered business associates. The following types of subcontractors are not business associates:

- Housekeeping/custodial
- Grounds and maintenance
- Machine repair or servicing

For help identifying which of your subcontractors are business associates, please contact Physicians Data Trust at compliance@pdtrust.com, or by phone at (562) 860-8771, ext. 114.

PHYSICIANS DATATRUST

PROVIDER CLAIMS DISPUTE RESOLUTION REQUEST

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

INSTRUCTIONS

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

Mail the completed form to: **The appropriate IPA address listed on the attached sheet.**

***PROVIDER NAME:**	***PROVIDER TAX ID # / Medicare ID #:**
PROVIDER ADDRESS:	

PROVIDER TYPE ☐ MD ☐ Mental Health ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other _____ (please specify type of "other")

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

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

DISPUTE TYPE

☐ Claim
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Request For Reimbursement Of Overpayment
☐ Seeking Resolution Of A Billing Determination
☐ Contract Dispute
☐ Other:

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

Contact Name (please print) | **Title** | **( ) Phone Number**

Signature | **Date** | **( ) Fax Number**

[ ] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED

For Health Plan Use Only
TRACKING NUMBER
PROVIDER ID#

PHYSICIANS DATATRUST

PROVIDER DISPUTE RESOLUTION REQUEST
(For use with multiple "LIKE" claims)

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

Number	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID Number	* Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

[ ] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED

PHYSICIANS DATATRUST

PROVIDER DISPUTE RESOLUTION REQUEST

Tracking Form

INSTRUCTIONS

- This optional form may be used to track the status, time-frames and disposition of the Provider Dispute Resolution.
- The entity processing the Provider Dispute Resolution should track the following information internally for ensuring compliance with regulations and for later reporting to the appropriate entity.

TRACKING NUMBER:	**PROVIDER ID#:**
a. PROVIDER NAME:	**b. CONTRACTED PROVIDER: _____ YES _____ NO**
c. DATE DISPUTE RECEIVED (Date Stamped):	**d. DATE OF INITIAL PAYMENT OR ACTION:**
e. WAS DISPUTE RECEIVED WITHIN TIMEFRAME? (c – d) _____YES _____ NO (If NO, should be returned to provider without action)	
f. DISPUTE TYPE: ☐ CLAIM ISSUE ☐ OVERPAYMENT REIMBURSEMENT REQUEST ☐ BILLING ISSUE ☐ CONTRACT ISSUE ☐ UM/MEDICAL NECESSITY ISSUE ☐ OTHER _____ (Please specify type of "other")	
g. DATE DISPUTE ACKNOWLEDGED:	**h. TURNAROUND TIME (g – c):**

TYPE OF LETTER SENT: **(List the various ICE letters as applicable)**

IF NO ADDITIONAL INFORMATION REQUESTED:

j. DATE OF ACTION:	**k. ACTION TURNAROUND TIME (j – c):**	**l. TYPE OF ACTION (Upheld, Denied, Partially Upheld):**

IF ADDITIONAL INFORMATION REQUESTED:

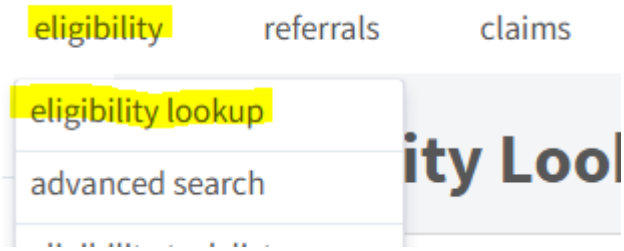
m. DATE ADDITIONAL INFO REQUESTED:	**n. TURNAROUND TIME (m – c):**	
o. DATE ADDITIONAL INFO RECEIVED:	**p. RECEIPT TURNAROUND TIME (o – m):**	
q. DATE OF ACTION:	**r. ACTION TURNAROUND TIME (q – o):**	**s. TYPE OF ACTION (Upheld, Denied, Partially Upheld):**

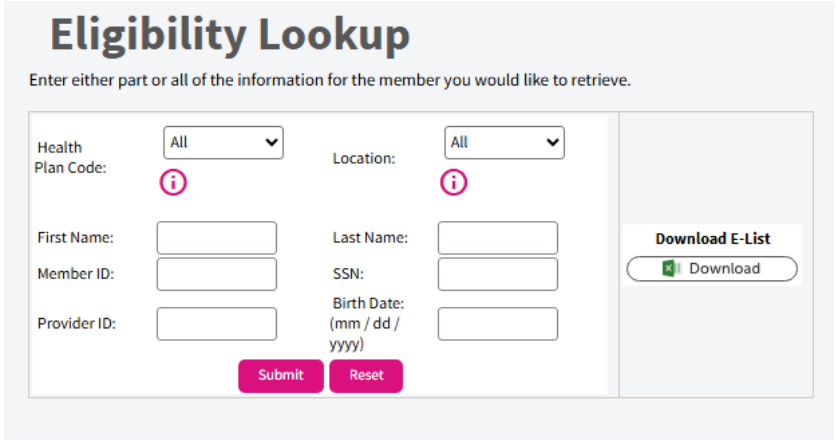
COMPLETE DESCRIPTION OF DETERMINATION RATIONALE:

Aerial Care
Member's Eligibility

Your member's eligibility

Enter a members DOB (preferably)





Once search criteria is entered, a member name will be generated. The following icon will appear:

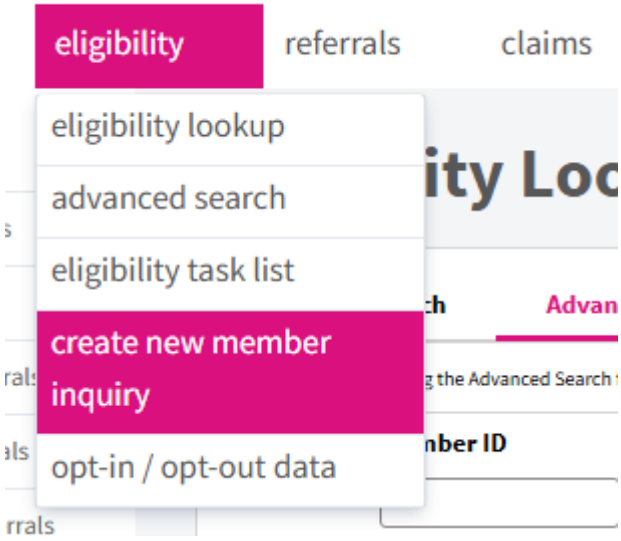
indicates the member is ineligible

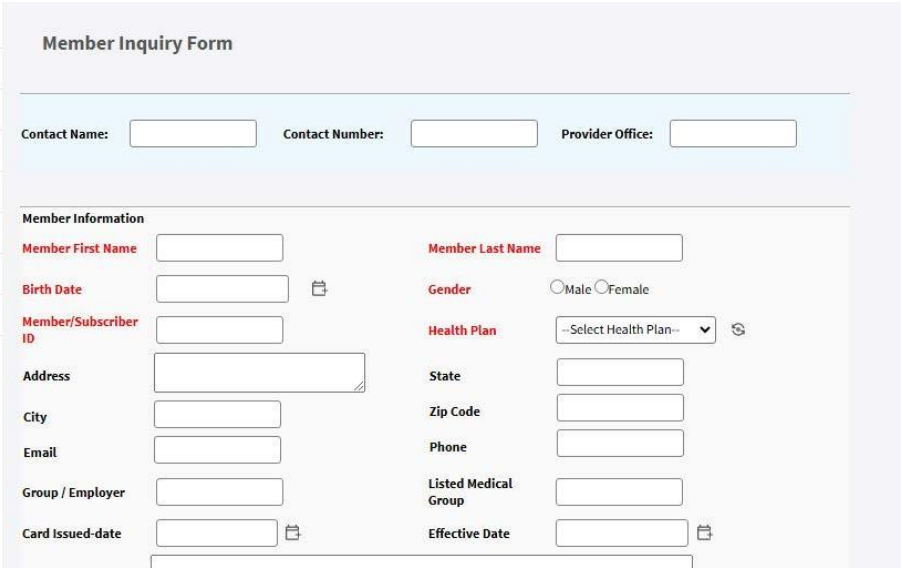
indicates member is eligible

If you have trouble finding the member, look at their ID card to check if the health plan knows them by a different name or DOB: (Note: If the health plan has the patient information incorrectly, member must contact the health plan directly and make corrections. If you do not find your member and all the information is correct, contact the health plan directly and verify the member's eligibility.)

Adding a New Member

There are a couple of ways to add a member if they aren't populating on Aerial. Best practice is to add member from Aerial portal.





Second option is to fill out the MBR Add/Update Request Form and fax it to the Elig Dept: 760-477-2951. It should be filled out COMPLETELY and it's always helpful to send a legible copy of the MBR's ID card.

GREATER TRI CITIES IPA
Independent Physicians – Providing Personal Care

Member Add Request Form

Complete all fields below and fax this form to (760) 477-2951.

Please Note that this form is for non urgent Member Adds only. If you have a patient who requires a medically urgent referral, please fax the referral directly to the UM Department for expedited processing. Requests will be processed within 3 business days.

You may submit Member Add requests electronically, by logging into Cerecons and selecting "Create a New Member Inquiry" under the Eligibility Tab

** All fields must be completed for your request to be processed.**

Provider Name:			
Contact Name		Contact Phone#	
Contact Fax#			
Purpose for this Request:	☐ New Member ☐ Health Plan Change ☐ Update Member information (Member information is received from the Health Plan. Member must notify their Plan of any necessary updates.) ☐ Date of Birth ☐ Address ☐ Sex ☐ Other :		
Health Plan		Health Plan Member ID	
Member First Name		Member Last Name	
Member Date of Birth		Member Gender	
Member Address			
Member Phone #			
Comments			

To Be Completed by IPA:
Response: ☐ Member has been added or updated; Changes will be reflected in next month's capitation report. ☐ Member is not eligible with IPA Name / PCP ☐ Form Incomplete / Information Submitted can not be verified with Health Plan ☐ Other:

Re: Outsourcing Credentialing to Gemini

Dear Valued Provider,

Thank you so much for your application and/or continued participation with **Greater Tri Cities IPA. Greater Tri Cities IPA** has partnered with Gemini Diversified Services, Inc. (GDS) to assist in the administration and execution of our credentialing verification process.

We are reaching out to inform you as you may be receiving correspondence from this entity and want to assure you of the credibility and reasoning behind the outreach to you. Any credentialing elements can be sent directly to Gemini at mc@servicesbygemini.com. If you have any questions, please contact Gemini at (866)437-6968 or Greater Tri Cities IPA Provider Relations at (760) 941-7309 x 130

We look forward to a long-term, mutually beneficial relationship with you and your staff. If you should have any questions regarding this letter or any contract-related matters, please do not hesitate to contact us.

Sincerely,

Darcie Millett
Practice Performance Specialist
Greater Tri Cites IPA
P: (760) 941-7309 x 130
E: DMillett@pdtrust.com

Request for Medical Record Form

Dates of Service < Range >

Type of Record	Description
☐ History and Physical	To include the following: • Present and past illness(es) • Hospitalizations, operations • Medications • Physical exam (including review of all systems) • Height, weight, BP • Identification of screening needs • Identification of preventative services (per the USPSTF A and B Guidelines for 65-year old) • Mental Health Exam Social history (i.e. Current living situation, Marital status, Work history, Education level • Assessment of Risk Factors (Staying Healthy Assessment) (i.e. Sexual history, Use of alcohol, tobacco and drugs) • Diagnosis and plan of care
☐ Member Information Form	Document that is filled out by the patient on the first visit to the physician's office and then updated as necessary, providing data that relates directly to the patient, including: last name, first name, gender, DOB, marital status, street address, city, state, zip code, telephone number, social security number, employment status, address and phone number of employer, name and contact information for the person who is responsible for the patient's bill, and vital information for the person who is responsible for the patient's bill, and vital information concerning who should be contacted in case of an emergency
☐ Admission Summary	Documentation of the patient's status (including history and physical examination findings), reasons why the patient is being admitted for inpatient care to a hospital or other facility, and the initial instructions for that patient's care.
☐ Admission Face Sheet	A one-page summary of important information about a patient. It may include patient identification, past medical history, medications, allergies, upcoming appointments, insurance status, or other pertinent information.
☐ Nursing Notes	Record of the patient's care that includes vital signs, particularly temperature (T), Pulse (P), Respiration (R), and blood pressure (BP). The procedures, and patient's responses to such care.
☐ Social Worker Notes	Documentation of Social Worker evaluation and coordination of services
☐ Ancillary Progress Notes	Documentation of procedures or therapies provided during a patient's care, such as physical therapy, respiratory therapy, or chemotherapy
☐ Discharge Summary	Outline summary of the patient's hospital care, including date of admission, diagnosis, course of treatment and patient's response(s), results of tests, final diagnosis, follow-up plans, and date of discharge
☐ Patient Discharge Instructions	Written discharge instructions or other documentation of educational material given to patient/caregiver including list and utilization of all discharge medications
☐ Emergency Room Notes	Documentation given by the emergency physician regarding the patient's condition, results of the physician's examination, summary of test results, plan of treatment, and updating of data as appropriate.

☐ Physician Orders	Record of the prescribed care, medications, tests, and treatments for a given patient
☐ Physician Progress Notes or Office Visit Notes	Documentation given by the physician regarding the patient's condition, results of the physician's examination, summary of test results, plan of treatment, and updating of data as appropriate.
☐ Consultation Summary	Documentation given by specialists whom the physician has asked to evaluate the patient; Designate physician or specialty
☐ Medication Administration Records	Documentation of medications administered in the hospital
☐ Treatment Records	Documentation of specific treatments (i.e. wound care, fall precautions)
☐ Medication List	List of patient medications
☐ Transfer Form(s)	Designate specific transfer information
☐ Consent Form(s)	Signed document by the patient or legal guardian giving permission for treatment -
☐ Informed Consent Form(s)	Signed document by the patient or legal guardian that explains the purpose, risks, and benefits of a procedure and serves as proof that the patient was properly informed before undergoing a procedure - designate procedure
☐ Diagnostic Tests/Laboratory Reports	Documents providing the results of all diagnostic and laboratory tests performed on the patient
☐ Operative Report	Documentation from the surgeon detailing the operation, including the preoperative and postoperative diagnosis, specific details of the surgical procedure, how well the patient tolerated the procedure, and any complications that occurred
☐ Pathology Report	Documentation from the pathologist regarding the findings or results of samples taken from the patient, such as bone marrow, blood, or tissue
☐ Anesthesia Record	Documentation from the attending anesthesiologist or anesthetist that includes a detailed account of anesthesia during surgery, which drugs were used, dose and time given, patient response, monitoring of vital signs, how well the patient tolerated the anesthesia, and any complications that occurred.
☐ Plan of Care/Care Plan	Documented Plan of Care/Care Plan
☐ MDS (Long Term Care ONLY)	Medical Data Set: a standardized, primary screening and assessment tool of health status which forms the foundation of the comprehensive assessment for all residents (regardless of payer) of long-term care facilities certified to participate in Medicare or Medicaid. The MDS contains items that measure: •physical •clinical •psychological •psycho-social functioning •life care wishes

Language Assistance Program Quick Reference Guide

Anthem Blue Cross (Anthem) is committed to providing culturally and linguistically appropriate healthcare services in a competent manner. This means all reasonable accommodations are provided to ensure equal access to communication resources for members. We achieve this through our Language Assistance Program.

We provide language assistance services to the following members with:

- Limited English proficiency (LEP).
- Hearing, speech, or visual impairments.
- Culturally and ethnically diverse backgrounds.

Language assistance services are not limited to the members identified above.

Language Assistance Program services and guidelines

Language assistance services are available to members at no cost for those enrolled in Medi-Cal Managed Care (Medi-Cal).

Service offered	Guidelines
Telephonic interpreter services provided at all points of contact	◦ Qualified interpreters are proficient in healthcare terminology. ◦ Qualified interpreters receive training regarding *HIPAA* and ethical standards. ◦ Points of contact include administrative, clinical, and related services.
Face-to-face and sign language interpreter services	◦ Interpreters are available to members, providers, and staff at key points of medical contact. ◦ Three days or more advance notice is needed for scheduling face-to-face and sign language interpreters. ◦ 24-hour advance notice is requested for cancellations.
TTY services for the hearing impaired	◦ Services are available for the hearing impaired during business hours via Medi-Cal TTY line: **800-735-2922**. ◦ After-hours services are available through the California Relay Line (**711**) or Anthem's 24/7 NurseLine (**800-224-0336, TTY: 800-368-4424**).
Vital documents provided in threshold languages	◦ Materials translated prospectively include enrollment, eligibility, and membership information; *Explanation of Coverage*; and notices of language assistance. ◦ Members must indicate their preferred written language to receive prospectively translated materials.
Additional materials translated upon request	◦ Materials that are member-specific (for example, denial, delay, or claims letters) are sent in English with the offer of translation upon request. ◦ We send translated materials to the member no later than 21 days from the request date. ◦ Oral translations will be provided for all languages. ◦ Translators are proficient in healthcare terminology. ◦ Translators receive training regarding *HIPAA* and ethical standards.

Threshold language translations available

We designed the Language Assistance Program to meet the growing needs of our state's population as well as our membership. Threshold language translations are available for Medi-Cal members and vary by county. Based on U.S. Census data released in December 2015, the top 18 non-English languages spoken by individuals with LEP in California are: Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, Japanese, Korean, Laotian, Mien, Punjabi, Russian, Spanish, Tagalog, Thai, Ukrainian, and Vietnamese. These languages will remain in effect until the next U.S. Census Survey.

Accessing the Language Assistance Program

To access the Language Assistance Program for members with LEP, call our Customer Care Center at the appropriate phone number provided at the end of this guide and ask to speak to an interpreter.

Cultural sensitivity resources

In addition to language services, the Language Assistance Program offers web-based information regarding: cultural differences including communication styles; healthcare traditions; commonly held beliefs; alternative medicine; and healing disparities including quality of care and preventive care, pain management and treatment, and aging.

You will find more cultural and linguistic information on our website under Provider Support > Resources > Provider Training Academy:

- Cultural Competency Training — offers information and key components to the provision of culturally competent care
- Caring for Diverse Populations toolkit — offers comprehensive information on working with diverse patients, tools and resources to help mitigate barriers, including materials that can be printed and made available for patients in your office
- My Diverse Patients — resource-rich care provider website that covers topics relevant to providing culturally competent care and services for diverse individuals

Anthem offers additional information in our online provider manuals, also located on this site at *Provider Manuals, Policies & Guidelines*. On this page, choose from the latest manual for Medi-Cal.

Tips to optimize communications with your patients

Here are a few tips to optimize communications when working with telephonic interpreters:

- If possible, speak to the interpreter privately prior to the contact, providing relevant information regarding the member and the important information to convey.
- Interpreters are not allowed to rephrase or clarify. Encourage the interpreter to request clarification or to redirect explanations as needed.
- Direct the conversation to the member, not the interpreter.
- Use short sentences limited to a single concept, if possible.
- Allow adequate time for the interpreter to convey the information in the member's language.
- Avoid excessive medical terminology or technical explanations unless the member requests them.
- Avoid interrupting the interpreter.
- If the member's nonverbal cues indicate confusion, ask the member to summarize or restate what you have communicated.

Working effectively with members with LEP

Offer the Language Assistance Program to members who appear to be LEP, even if a member brings a family member or friend to their healthcare visit to act as an interpreter. The use of a qualified interpreter is preferred because relatives and friends are not usually proficient in healthcare terminology.

More communication tips

Here are a few more communication tips for your use when working with patients:

- Speak slowly, not loudly, with your patient.
- Organize information into short, simple sentences. Place important topics at the beginning and end of the conversation.
- Use open-ended questions to assess for understanding.
- If the member initially refused interpreter services and is not demonstrating full understanding, offer interpreter services again.
- Monitor nonverbal cues, such as facial expressions, positioning, and body language. These may indicate understanding or confusion.

Anthem hopes you will find this information useful in your everyday encounters with members with LEP.

If you have any questions or require assistance with the Language Assistance Program, contact our Customer Care Center at the appropriate phone number below:

- Medi-Cal (outside of Los Angeles County): **800-407-4627**
- Medi-Cal (inside Los Angeles County): **888-285-7801**

Best practices for providers

Hospitals, physicians, and other healthcare professionals should:

- Complete a language skills self-assessment, which is kept on file. The assessment provided by the Industry Collaboration Effort is a prescreening/self-assessment tool to be done before seeking interpreter credentialing. It does not qualify as appropriate documentation for staff to be considered a qualified interpreter that adheres to generally accepted interpreter ethics and principles.
  - The Employee Language Skills Self-Assessment Tool is available on our website under Resources > Forms > For Providers. Choose the correct form depending on the region.
- Document the member's preferred spoken and written language in their office chart or medical record.
- Document the communication aid used for the visit (for example, the person who provided interpretation services); any use or refusal of a professional interpreter; or the use of family, friend, office staff or the provider as the interpreter.
  - *Request/Refusal for Interpreter Services* forms are available on our website under Resources > Forms > Patient Care. Choose the appropriate form, available in a variety of threshold languages.
- Enhance their own knowledge and appreciation of the cultural differences that are inherent in their region by taking advantage of the opportunities listed on the Anthem website.
  - Post the Free Interpretation Services sign at key points of contact. The Free Interpretation Services sign is available on our website under > Resources > Provider Training Academy > Interpreter Services. Under *Free Interpreter Resources*, choose **Free Interpreter Services Poster**.

https://providers.anthem.com/ca

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Physicians DataTrust, and all contracted IPAs, comply with CMS requirements. The training herein is an overview of CMS guidelines. For comprehensive CMS Marketing Guidelines visit: www.cms.gov. Last update 08/06/2019.

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Introduction

CMS Compliance Concerns and Limitations

- CMS has expressed concern with providers participating in marketing activities because
  - Providers may not be aware of all plan benefits and costs.
  - It may confuse beneficiaries if they perceive providers as acting as an agent or plan representative.
  - Providers may face conflicting incentives when acting on a Plan Sponsor's behalf.

Definitions

- **Communications:** Activities and materials to provide information to current and prospective enrollees, including their caregivers and other decision makers.
- **Marketing:** A subset of communications. Includes activities and materials with the intent to draw a beneficiary's attention to a plan or plans and to influence a beneficiary's decision-making process when selecting a plan for enrollment or deciding to stay enrolled in a plan (that is, retention-based marketing). Additionally, marketing contains information about the plan's benefit structure, cost sharing, measuring, or ranking standards.

Definitions

- To identify marketing activities and materials, CMS will evaluate both the **intent and content** of the activities and materials to determine if the definition of marketing is met.
  - A flyer reads “Swell Health is now offering Medicare Advantage coverage in Nowhere County. Call us at 1-800-SWELL-ME for more information.” Marketing or Communication? Communication. While the intent is to draw a beneficiary’s attention to Swell Health, the information provided does not contain any marketing content.

Definitions

- A billboard reads “Swell Health Offers $0 Premium Plans in Nowhere County” Marketing or Communication? Marketing. The advertisement includes both the intent to draw the viewer’s attention to the plan and has content that mentions zero-dollar premiums being available.
- A letter is sent to enrollees to remind them to get their flu shot. The body of the letter says, “Swell Health enrollees can get their flu shot for $0 copay at a network pharmacy…” Marketing or Communication? Communication. While the letter mentions cost sharing, the intent is not to steer the reader into making a plan selection or to stay with the plan, but rather to encourage existing enrollees to get a flu shot. The letter contains factual information about coverage and was provided only to current enrollees.

Providers Must

- Providers must remain neutral when assisting patients with information about their Medicare plan options.
- Any communications by providers to patients must come from the provider or medical group and not the agent or health plan in a misleading way.
- Be aware of agent or health plan engagement in marketing events and ensure they are within the scope of CMS guidelines.

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Providers May

- If providers allow plan marketing materials to be available in their common areas, then:
  - Provider must allow **ALL** contracting plans to participate.
- Display posters or other materials announcing plan affiliations.
- Direct patient to plan materials in common areas.
- Refer patients to other sources for more information, such as:
  - CMS/Medicare.gov website, HICAP/SHIP office, etc.
- If **patient initiates** request, provider may refer to plan or plan marketing representatives (brokers or agents.)

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Providers May

- Provide names and contact information of Health Plans they contract with and any factual, publicly available information about plan benefits and formularies.
  - Example: Information from *Medicare and You* or *Medicare Options Compare.*
- Provide information and assistance to patients applying for Low Income Subsidy (LIS/Extra Help.)
- Display plan marketing materials (but **not** enrollment forms) in waiting rooms.

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Providers May NOT

- Provide an endorsement or testimonial for a health plan
- Mislead or pressure patients into participating in presentations.
- Use health screenings as a marketing activity.
- Offer anything of value to induce beneficiaries to enroll in a particular plan or set of plans.
- Provide list of Medicare eligible patients to an agent or health plan representative.
- Conduct marketing, sales, or enrollment activities in areas where patients receive or wait to receive care:
  - Example: Exam rooms, waiting rooms, etc.

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Providers May NOT

- Distribute/display marketing materials in an exam room.
- Distribute sales agents' business cards to patients (unsolicited.)
- Make available/distribute, help complete, or accept completed enrollment applications.
- Offer or assist with Scope of Appointment Forms, lead cards and/or business reply cards.
- Make phone calls or distribute materials in an attempt to steer, direct, urge or persuade beneficiaries to enroll in a specific plan or set of plans.
- Mail marketing materials on behalf of a plan or agent.
- Accept compensation directly or indirectly from a plan for enrollment activities.

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Promotional Activities

Nominal Gifts, any items offered to attendees of promotional activities, must:

- Be of nominal value – no more than $15, with a maximum aggregate of $75/person, per year.
- Be offered to all people regardless of enrollment and without discrimination.
- Not be items considered to be a health benefit, covered item or service.
- If the nominal gift is one large gift (e.g., concert, raffle, drawing, etc.) the total value must not exceed the nominal per person value based on attendance.
    - Example) For 10 attendees, the gift may not be worth more than $150.

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Promotional Activities

Nominal Gifts, any items offered to attendees of promotional activities, may not:

- Be in the form of cash or other monetary rebates, including gift cards or certificates that can be readily converted to cash, even if it is worth $15 or less.
- Be in the form of a meal, unless the event meets the CMS definition of an educational event and complies with the nominal gift value.

Marketing Unsolicited Contacts

Unless an individual has agreed to receive communications, providers may not initiate direct contact with non-patients for marketing purposes in the following forms:

- Telephonic outreaching including voice and text messaging.
- Electronic solicitation/electronic messaging via direct messaging on social media platforms.
- Approaching beneficiaries in common areas (e.g., parking lots, hallways, lobbies, etc.)
- Door-to-door solicitation including leaving flyers at residences or cars.

Marketing purposes pertains to health plan listings and benefit information. This does not extend to current patients, conventional mail, or other print medias.

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Marketing Unsolicited Contacts

Providers may not make unsolicited telephone calls to prospective enrollees expect for the following specific telephonic activities:

- Call current enrollees, including those in non-Medicare products, to discuss plan business
  - Calls to enrollees aging into Medicare from commercial products offered by the same organization
  - Calls to existing Medicaid/MMP plan enrollees to talk about its Medicare products
- Call former enrollees to conduct disenrollment surveys for quality improvement purposes (may not include sales or marketing information)
  - Call to market plans or products to former enrollees who have disenrolled, or to current enrollees who are in the process of voluntarily disenrolling;

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Marketing Unsolicited Contacts

Providers may not initiate Electronic Communication, including voicemail or direct messages, for marketing purposes unless an individual has agreed to receive those communications.

- If an individual likes or follows on social media, this does not constitute agreement to receive communication outside a public forum.
  - Providers may respond to questions or statements initiated by the beneficiary but only in the scope of the question.
- Providers may contact via email but must provide an opt-out process for recipients.

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Thank You

For a comprehensive understanding of CMS Marketing Guidelines visit:
https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html

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