St. Vincent IPA
Provider Manual

Provider Relations Department: (562) 860-8771

ST. VINCENT IPA

The Patient's Choice for Health Care

www.stvincentipa.com

Last Updated February 2020

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INTRODUCTION

Welcome Letter

Dear St. Vincent IPA Provider,

With so many Medical Groups and Independent Practice Associations (IPAs) to choose from, we thank you for selecting St. Vincent IPA Medical Group and would like to welcome you to the network. St. Vincent IPA has provided quality and care to tens of thousands of patients for over 20 years and is excited to have you as a participating provider.

Our objective is to manage the use of healthcare resources responsibly without impending our provider's ability to deliver appropriate, quality healthcare and we are looking forward to a long and mutually beneficial relationship. Should you have any questions regarding the information enclosed or need further assistance, please do not hesitate to contact me at (562) 860-8771, ext. 108.

To ensure you are set up to start receiving/referring patients as soon as possible, please make sure you are set up with a login to our online referral/claim portal, Aerial Care: **https://aerial.carecoordination.medecision.com/login.html**

A Username and Password can be requested by contacting Aerial Care directly at 1-800-864-8160. This number can also be utilized for any technical assistance. You can also request a login by contacting our Provider Relations Department at (562) 860-8771, ext. 112. We accept electronic claim submission through Aerial Care or Office Ally (866) 575-4120.

Our St. Vincent IPA's Payor ID is PDT01.

For more information on St. Vincent IPA including information about contracted health plans, urgent care locations, hospitals, labs, and etc., please visit our website: **stvincentipa.com.** Should you have any questions regarding the information enclosed or need further assistance, please do not hesitate to contact me at (562) 860-8771, ext. 108.

Sincerely,

Leesa Johnson

Vice President of IPA Operations

Distribution of this Manual

This Manual is delivered by St. Vincent IPA, Marketing Department to the Physicians' office when a Physician joins the IPA. An electronic version is also available on our website, www.stvincentipa.com.

Updates to this Manual

Updates to this manual will be available to all contracted providers on St. Vincent IPA's website. Additional communications related to health plan information, customer service, operations, or community information will be faxed out.

PCP Provider Listings

Our PCP Directory is available on-line and is updated on a monthly and ad-hoc basis. The website is available to both physicians and members with Internet access.

To access the Physician listings:

- Connect to the Internet and go to http://www.stvincentipa.com
- Our home page will appear. Click "Find A Provider" at the bottom of the page.

If your office does not have Internet access, please contact Provider Relations department at **(562) 860-8771 Ext. 112** to receive a listing.

Provider Directory Changes

The Provider Directory data is what is current in our systems. If you have a change of address, phone number, fax number, etc. please notify our Provider Relations Department of any changes, so that our directories and listings reflect your current information. Prompt notification is required to ensure checks, important announcements, reports, and communications are delivered to you in a timely manner.

Communication of Provider Address and Data Changes

Providers shall notify the IPA in writing (preferably on office letterhead) along with any required supporting documentation (e.g. a TIN change requires copies of the W-9 forms.) Requests may be sent to the Provider Relations Specialists by mail or fax.

Important: Delay in notifying us with address and data changes may affect your claims payments.

The following table illustrates some common data changes and the corresponding document(s) we require before each change can be made. Please call the Provider Relations department at **(562) 860-8771 ext. 112** if you have any questions.

Change Documentation

Type of Change Document Needed	Document Needed
Adding a new practice location, change of address, phone, fax, etc.	Letter, effective date
Change practice location, change of address, phone, fax, etc.	Letter, effective date
Billing address change Letter, effective date	Letter, effective date, W-9
Closing of panel; eliminating services Letter, effective date	Letter, effective date
TIN Change Letter	Letter, W-9

OR submit changes by mail to: St. Vincent IPA
Provider Services
17215 Studebaker Road
Suite 320
Cerritos, CA 90703

OR by email to: prsvipa@pdtrust.com

OR by fax to: **(562) 207-6558**

Termination of Contract/Business Associate Agreement

Advanced notice must be given in writing when electing to discontinue as an IPA provider. Refer to your IPA contract for specifics. If you have any questions, please contact Provider Relations at **(562) 860-8771 ext. 112**.

St. Vincent IPA Website - PCP Log-in Page

In an effort to better serve our Providers, St. Vincent IPA is continually making updates and enhancements to our website. We encourage you to visit our website at www.stvincentipa.com periodically to check for updated information.

Our Quality Programs tab offers our providers information regarding HEDIS, CMS 5 Star Measures and Best Practice Guidelines and you can find training documents related to Compliance Training under the Resource Compliance Training tab.

We also provide additional forms and documents available in our Provider Portal that can be accessed using the PCP Log-in information below.

PCP Log-in information:
Username = stvpcp
Password = stv893

If you have any questions, feel free to contact St. Vincent IPA's Marketing Department at **(562) 860-8771, ext. 112**.

St. Vincent IPA Important Lines

ADMINISTRATION	Phone	Fax	Email
Dr. Imad El Asmar **Medical Director**	(213) 487-6667	(310) 232-2332 Pager	
Leesa Johnson **VP of IPA Operations**	(562) 860-8771 Ext. 108	(562) 207-6581	ljohnson@stvincentipa.com

CLAIMS	Phone	Fax	Mailing Address
	(562) 860-8771 Ext. 2001	(760) 631-7614	Primary Care Physicians – Encounter Data St. Vincent IPA PO Box 4999 Oceanside, CA 92052 Fee-for-Service (FFS) Claims PO Box 5089 Oceanside, CA 92052

For Appeals, please fax to (760) 631-7614

Please mail all Claims and Encounter Data on a CMS-1500 form

CLINICAL SERVICES	Phone	Fax
Authorizations	(562) 860-8771 Ext. 2001	
Referrals	(562) 860-8771 Ext. 2001	(562) 924-1453
Utilization Management	(562) 860-8771 Ext. 2001	(562) 924-1453

For issues not being resolved for the Authorization department, please call Ext. 169

CREDENTIALING	Phone	Fax	Email
Sacha Burciaga **Credentialing Manager**	(562) 860-8771 Ext. 186	(562) 402-7965	sburciaga@pdtrust.com

MARKETING			
Valerie Chaidez **Network Development Rep**	(562) 860-8771 Ext. 165	(562) 207-6577	vchaidez@pdtrust.com
Michael Gella **Network Development Rep**	(562) 860-8771 Ext. 117	(562) 207-6547	mgella@pdtrust.com

PROVIDER RELATIONS			
Joanna Marquez **Provider Relations Specialist**	(562) 860-8771 Ext. 112	(562) 207-6558	jmarquez@pdtrust.com

RISK ADJUSTMENT			
Gabriel Ruiz **Director -** Risk Adjustment and Quality	(562) 860-8771 Ext. 168	(562) 477-2921	gruiz@pdtrust.com

Services

Hospitalist/Case Management

It is critical that only the St. Vincent IPA contracted Hospitalist admit and follow your patients requiring hospitalization.

Dr. Imad El Asmar
Office: (213) 487-6867
Pager: (310) 232-2332

- St. Vincent Medical Center
- Hollywood Presbyterian Medical Center

If you have a St. Vincent IPA patient that is requiring Hospital Emergency or In-Patient Services, please make sure to contact St. Vincent IPA's Case Management Department at:

During business hours: **(562) 860 - 8771**
After hours: **(562) 257 -7893**

St. Vincent IPA

The Patient's Choice for Health Care
For Hospital Needs

To ensure the highest level of care for inpatient needs, St. Vincent IPA is contracted with several of the region's top hospitals. Please review the list below for our network of contracted hospitals.

Our hospital network handles inpatient services. **If you have an emergency, call 911 or go to the closest emergency room**. Once you are stable, you will be transferred to an in-network facility for the remainder of your care.

California Hospital Medical Center
1401 South Grand Avenue
Los Angeles, CA 90015
Phone: (213) 748-2411

Good Samaritan Hospital
1225 Wilshire Boulevard
Los Angeles, CA 90017
Phone: (213) 977-2121

Hollywood Presbyterian Medical Center
1300 North Vermont Avenue
Los Angeles, CA 90027, USA
Phone: (213) 413-3000

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For Radiology Facilities

There are times when your provider will want you to see a radiologist. In these instances, services will be performed at one of the facilities list on this page. Your primary care doctor will give you an order for the radiological exam and direct you to the appropriate facility. Many questions about your radiological procedure can be answered by contacting the imaging department at the facility you will be visiting.

For providers: If you need to refer your patients to another facility, please contact our Provider Relations Department at (562) 860-8771 Ext. 112.

St. Vincent is also partnered with UMI and Radnet chains. To find an imaging center near you, please visit http://www.umih.com/locations/ and https://www.radnet.com/imaging-centers/find-an-imaging-center

Renaissance Imaging Center, Downtown
500 South Virgil Ave
Suite 102
Los Angeles, CA 90020
Phone: (323) 375-3950

Renaissance Imaging Center, Wilshire
1245 Wilshire Blvd
2nd Floor
Los Angeles, CA 90017
Phone: (213) 867-3275

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For Urgent Medical Needs That Are Not Life-Threatening

URGENT CARE	ADDRESS	PHONE	HOURS
Dusk to Dawn Urgent Care	1045 W Redondo Beach Blvd., Ste. 138 Gardena, CA 90247	(310) 323-2273	Mon -Fri 9am-9pm Sat-Sun 9am-2pm
Dusk to Dawn Urgent Care	323 North Prairie Ave. Inglewood, CA 90301	(310) 673-2273	Mon-Fri 9am-9pm Sat-Sun 9am-2pm
Dusk to Dawn Urgent Care	3680 E Imperial Hwy., Ste. 410 Lynwood, CA 90262	(310) 639-2220	Mon-Fri 9am-9pm Sat-Sun 9am-2pm
Dusk to Dawn Urgent Care	15745 Paramount Blvd. Paramount, CA 90723	(562) 808-2273	M-F 9am-12am Sat-Sun 9am-6pm
Glen Oaks Urgent Care	1100 W Glenoaks Blvd. Glendale, CA 91202	(818) 242-3333	Mon-Fri 9am-8pm Sat-Sun 9am-5pm
The Urgent Care at Vermont	1234 North Vermont Ave. Los Angeles, CA 90029	(323) 660-0831	Mon-Fri 9am-7pm Sat 9am-3pm
Vernon Urgent Care	231 W Vernon Ave., Ste. 112 Los Angeles, CA 90037	(323) 234-1468	Mon-Fri 11am-9 pm Sat-Sun 9am-6pm
Holy Cross Urgent Care	4864 Santa Monica Blvd. Los Angeles, CA 90029	(323) 660-7770	Mon,Wed,Fri 3-9pm Tue,Thur,Sat,Sun 9am-9pm
CINA Urgent Care	3756 Santa Rosalia Dr. Los Angeles, CA 90008	(310) 742-5961	Mon-Th 8am-6pm Sat 8am-2pm
LA Downtown Medical Clinic LLC (formerly Silver Lake Urgent Care)	1711 West Temple St., Second Floor Los Angeles, CA 90026	(213) 989-6160	Always Open 24/7
Reliant UC- Santa Fe Springs	11460 Telegraph Rd. Santa Fe Springs, CA 90670	(310) 491-7060	Mon-Fri 8:30am-8pm Sat-Sun 10am-5pm
Reliant UC- Huntington Park	5900 Pacific Blvd. Huntington Park , CA 90255	(310) 740-9867	Mon-Fri 8am - 9pm Sat-Sun 10am-5pm
Reliant UC- Blvd Los Angeles	5901 W Century Blvd., Los Angeles, CA 90045	(310) 910-9752	Always Open 24/7
Reliant UC- Street Los Angeles	814 S Francisco St. Los Angeles, CA 90017	(310) 597-4408	Mon-Fri 7:00am - 1:30am Sat-Sun 7am-11pm
Reliant UC- Blvd Montebello	2300 W Beverly Blvd. Montebello, CA 90640	(626) 587-3424	Mon-Fri 8am-9pm Sat-Sun 10am-5pm

Commonly treated illnesses at an Urgent Care

- Sore throat, fever or ear aches
- Minor injuries, burns, and lacerations
- Skin infections and rashes
- Sinus problems/other upper respiratory infection
- Minor fractures or broken bones
- Backaches/Sports Injuries
- Frequent urination/Burning sensation
- Persistent vomiting
- Abdominal pain or cramping
- Allergic reactions
- Insect or animal bites

Benefits of accessing an Urgent Care vs. ER

- Avoid long waiting time in the emergency room
- Urgent cares provide quality care
- Faster care, the average visit lasts under an hour
- Avoid higher co-pays for an emergency room visit
- Urgent Cares offer extended hours

ST. VINCENT IPA

Labs

St. Vincent IPA has partnered with Quest Diagnostics to provide routine laboratory services to our members. Quest Diagnostics has many convenient locations throughout Los Angeles County to ensure that you do not have to go far for lab services.

To find a lab near you, you can also use the Quest Diagnostics Find-A-Lab tool by going to this link: https://secure.questdiagnostics.com/hcp/psc/jsp/SearchLocation.do

Customer Care Center/ Appointments: **(866) 697-8378**

Health Plan Listings

St. Vincent IPA accepts the following health plans:

- Aetna
- Alignment Health Plan
- Anthem Blue Cross/California Care
- Blue Shield of California
- Blue Shield of California 65+
- Brand New Day
- Central Health Plan
- CIGNA
- Easy Choice Health Plan
- Health Net
- Humana
- L.A. Care Health Plan
- SCAN Health Plan
- United Healthcare

This information is subject to change.

Each of these health plans has various lines of business, and they are detailed on the following page.

Aetna
Commercial HMO/POS, Medicare Advantage
Phone: (866) 208-5931

Alignment Health Plan
Medicare Advantage
Phone: (866) 634-2247

Anthem Blue Cross
Commercial HMO/POS, Medicare Advantage
Phone: (888) 230-7338

Blue Shield 65 Plus
Commercial HMO/POS, Medicare Advantage
Phone: (800) 541-6652

Brand New Day
Medicare Advantage
Phone: (866) 255-4795

Central Health Plan
Medicare Advantage
Phone: (866) 314-2427

CIGNA
Commercial HMO/POS
Phone: (800) 244-6224

Easy Choice
Medicare Advantage
Phone: (866) 999-3945

Health Net
Cal MediConnect, Commercial HMO/POS, Medicare Advantage
Phone: (800) 641-7761

Humana
Medicare Advantage
Phone: (800) 457-4708

LA Care Health Plan
Cal MediConnect
Phone: (888) 522-1298

SCAN Health Plan
Medicare Advantage
Phone: (877) 452-5898

United Healthcare
Commercial HMO/POS, Medicare Advantage
Phone: (877) 596-3258

PROVIDER RESPONSIBLILTIES

Provider Responsibilities

Primary Care Physician Responsibilities

1. **Basic PCP Responsibilities**
    - Provide outpatient clinic care during normal business hours (Monday-Friday from 9a.m to 5p.m.)
    - Twenty-four hour On-call coverage
    - Provide cross coverage with an IPA contracted physician
    - Recommend and coordinate the care of consulting specialists
    - Telephone consultation to members contracted to the primary care physician's service

2. **Routine Office visits**
    - Well baby care (Family Practice/Pediatrics), including developmental assessment and patient/parent education
    - Complete physicals as outlined in Health Plan guidelines
    - T.B. Skin Test/Mantou
    - Preventive medical care including health risk identification, education, reduction, and periodic screening

3. **State Mandated Referrals**
    - Well Woman Exam
    - Mammography
    - Family Planning*
    - Vision Care*

4. **Injections**
    - Antibiotics, vitamins, hormones, flu vaccine, etc
    - Allergy treatment(in conjunction with treatment plan from Allergist if appropriate); not including sensitivity testing or antigen preparation
    - Authorized injectables (Betaseron, neupogen, etc.)

5. **Opthalmology**
    - Basic vision test
    - Removal of foreign body, external eye
    - Removal of foreign body, corneal, w/o slit lamp

6. **ENT**
    - Routine audiometry
    - Drainage external ear, abscess or hematoma; simple
    - Removal foreign body from external auditory canal
    - Removal impacted cerumen, one or both ears
    - Control of nasal hemorrhage, anterior simple

7. **Digestive System**
    - Proctosigmoidoscopy; diagnostic; rigid or flexible up to 25 cm**
    - Anoscopy; diagnostic
    - Colon cancer screening; age >50 yearly hemoccult testing with patient off
    - ASA/NSAID; Refer for flexible sigmoidoscopy every 3-5 years

8. **Musculoskeletal System**
    - Arthrocentesis aspiration or injection; small joint bursa, or ganglion cyst
    - Injection of tendon, ligament, trigger points, or ganglion cysts**
    - Care of routine and uncomplicated rheumatic and orthopedic conditions

9. **Localized burns**
    - Initial treatment first degree burns

10. **Surgical Procedures**
    - Simple repair of scalp, trunk and /or extremities lacerations <2.5 cm
    - Simple repait of lacerations 2.6-7.5 cm**
    - Incision and drainage of abscesses
    - Incision and drainage of pilonidal cyst
    - Removal of foreign body
    - Drainage of hematoma
    - Puncture aspiration
    - Debridement
    - Excision of benign lesions
    - Incision of thromboses hemorrhoid, external**
    - Destruction of lesion(s) anus(condyloma, papilloma, molluscum contagiosum)
    - Suture removal

11. **Reproductive System**
    - Destruction of lesions penis, simple, with chemicals
    - Destruction of lesions of vulva
    - Diaphragm fitting**
    - Treatment of uncomplicated venereal diseases
    - Other gynecologic procedures

12.Dermatologic Procedures

- Acne care
- Excision of benign lesions
- Excision of malignant lesions
- Biopsy of skin, subcutaneous tissue and /or mucous membrane
- Destruction of pre-malignant lesions
- Wart removal
    i. Cryotherapy
    ii. Electrosurgical
- Avulsion of nail plate**
    i. Partial
    ii. Complete
- Matricectomy**
- Evacuation of subungual hematoma**

13.Other Office Procedures

- Venipuncture
- EKG
- Diagnosis of alcohol/chemical dependency
- Recognition of psychological problems, including routine outpatient management of anxiety and depression
- Treatment and follow-up of uncomplicated hypertension
- Management and follow-up of uncomplicated, controlled diabetes mellitus

14.Advanced procedures

- Flexible Sigmoidoscopy**

* Check benefits prior to referral

** If PCP feels that the procedure is complex, or has required excessive time to treat, a referral to self may be submitted to Utilization Management for authorization and reimbursement. An explanation or report may be necessary.

National Provider Identifier

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

To obtain, update or find more information, please visit npiregistry.cms.hhs.gov

As outlined in the Federal Regulation, The Health Insurance Portability and Accountability Act of 1996 (HIPAA), covered providers must also share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

More detailed information is available on https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

Access Standards

We have adopted access guidelines using both the California Managed Health Care Quality Coalition as well as the National Committee on Quality Assurance (NCQA). A copy of the access standards is located on the next page.

Compliance to these Guidelines will be monitored and coordinated with other activities throughout the organization. Ways this is monitored may include member surveys and complaints. The IPA will conduct Member and Provider Surveys on a yearly basis focusing on appointment scheduling, waiting times and after hours care.

A summary sheet illustrating the access standards is provided on the following page.

AFTER HOURS ACCESS REQUIREMENTS

After Hours Access includes the following measures:

1. **Access** - After Hours recording or answering service must state emergency instructions to address medical emergencies (e.g. "If this is an emergency, please dial 911 or go to your nearest emergency room.")

2. **Access** - After Hours recording or answering service must state a way of contacting the provider (e.g. connect directly to the provider, leave a message and the provider will call back, page provider, etc.)

3. **Timeliness** - Recording or live person must state that provider will call back within 30 minutes

   Note: Providers must be compliant in all three of the above measures to be considered compliant with L.A. Care's After Hours standards

4. **Combined Access & Timeliness** – Compliance for both Access and Timeliness standards.

SAMPLE HOURS SCRIPT

In order to comply with all DMHC the suggested script examples will help to ensure that you meet SVIPA standards. Please modify your answering service script immediately, if not already implemented.

Example 1
"You have reached the office of (give Dr. name) our office is closed. If this is a life threatening medical emergency, please hang up and dial 911 or go to your nearest emergency room otherwise, please leave your name, number including your area code **& (give Dr. name) will automatically be paged and will return your call within 30 minutes."**

Example 2
"You have reached the office of (give Dr. name) our office is closed. If this is a life threatening medical emergency, please hang up and dial 911 or go to your nearest emergency room otherwise, please leave your name, number including your area code **& (give Dr. name) will automatically be paged and will return your call within 30 minutes."**

Example 3:
"You have reached the office of (give Dr. name) our office is closed. If this is a life threatening medical emergency, please hang up and dial 911 or go to your nearest emergency room otherwise, **(give Dr. name) may be reached at (give alternate phone number)."**

As an active provider for St. Vincent IPA, please be advised that you must adhere to all health plan requirements and most importantly honor your provider contract.

Please be aware that our St. Vincent IPA provider relations department will randomly select providers every month to check their after hours message.

Access to Care Standards: Commercial and Medicare Advantage Members

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, condition)	Within 30 calendar days, unless 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 physician office	Less than 30 minutes
After-hours Access	Answering Service or service w/ option to page Provider
• Enrollee with life threatening medical problem must have access to health care twenty-four (24) hours per day 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. • **Member 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)** • Telephone triage is available 24 hours a day and 7 days a week	**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 time of PCP request

Behavioral Health Provider (based on Plan contracts)

Appointment	Standard
Urgent	Within 96 hours
Routine	*Within 15 business days
****Non-physician BH**	** 10 business days

**Ancillary Services	Standard
Urgent (for diagnosis and treatment)	Within 96 hours
Routine (for diagnosis and treatment)	*Within 15 business days from time of PCP request

***Revised Standard 2011 ** New Standard 2011 Compliance = 80%**

Access to Care Standards: Dual Eligible (Medi-Medi) and Special Needs Plan (SNP) Members

Service	Standard
Appointment making systems	A written or computerized appointment making system, which includes following up on missed appointments
Appointments for routine primary care services for a member who is symptomatic but does not require immediate diagnosis and/or treatment	30 calendar days maximum
Appointments for routine prenatal care	• Within two weeks from request during the 1st and 2nd trimester • Within three working days from request during 3rd trimester
Appointments for routine preventative care	Physical exam/preventative services – four (4) weeks maximum for appointment
Appointments for urgent care	Within 24 hours
Routine specialty referral appointment	Within 10 working days
Availability of interpreter Service	24 hours/7 days a week
Availability of primary care physician – time requirements	24 hours/7 days a week
Routine specialty referral appointment	Within 10 working days
Availability of interpreter Service	24 hours/7 days a week
Availability of primary care physician – time requirements	24 hours/7 days a week
Preventative Exams A periodic health evaluation for a member with no acute medical problem, including: • Initial Health • Assessments and Behavioral Risk Assessments	Children under the age of 18 months – within 60 calendar days of enrollment or within the AAP periodicity timelines for ages two and younger, whichever is less 18 months of age and older – within 120 calendar days of enrollment EPSDT/CHDP or preventative health

	examination within four weeks from request.
Preventative Exams A periodic health evaluation for a member with no acute medical problem, including: • Initial Health • Assessments and Behavioral Risk Assessments	Children under the age of 18 months – within 60 calendar days of enrollment or within the AAP periodicity timelines for ages two and younger, whichever is less 18 months of age and older – within 120 calendar days of enrollment EPSDT/CHDP or preventative health examination within four weeks from request
AAP periodic screenings	As prescribed by AAP Periodicity guidelines
Emergency appointment: Services for a potentially life threatening condition requiring immediate medical intervention to avoid disability or serious detriment to health	Immediate, 24 hours a day/7 days a week
Non-emergent telephone appointment responsiveness	45 minutes
Office waiting time: The time a member with a scheduled medical appointment is waiting to see a doctor once in the office	5 – 45 minutes
Telephone waiting time: The maximum length of time for office staff to answer the phone	30 seconds
Call Return Time (After Hours): The maximum length for PCP or on-call provider to return a call	30 minutes
Services for members with disabilities	Compliance with all provisions of the Americans with Disabilities Act: • At least one designated handicapped parking space • A handicapped bathroom or alternative access which is equipped with handrails in the bathroom • A wheelchair access ramp • A handicapped water fountain or alternative provisions • An elevator

Availability of ancillary services	Available within a reasonable distance from the primary care physician
Availability of hospitals	Travel time and distance standards of 15 miles travel distance or 30 minutes travel time from their residence or workplace
Availability of primary care physician distance requirements (PCP Geo Access Reports)	Travel time and distance standards of 10 miles travel distance or 30 minutes travel time from their residence or workplace
Availability of specialty care	Travel time and distance standards of 15 miles travel distance
Member requested primary care physician changes	Members can request a PCP change monthly. Health Plans will process the member requested PCP change
Routine specialty referral authorization	Within 10 working days

Primary Care Physicians are compensated on a fee-for-service basis for the following immunizations that are approved by AAP/AAFP. Claims for immunizations will be paid at the rates indicated below.

Procedures to follow:

1) Bill Fee For Service to St. Vincent IPA, P.O. Box 5089 Oceanside, CA 92052
2) Use the listed CPT codes only. **Prior Authorization required for any other code not listed**.

CPT Code	IMMUNIZATION/INJECTION	REIMB SV	CPT CODE	IMMUNIZATION/INJECTION	REIMB SV
86580	Skin test; tuberculosis, intradermal	$10.00	Q2037	Influenza virus vaccine, split virus, when administered to individuals 3 years of age or older, for intramuscular use (Fluvirin)	$25.00
90632	Hepatitis A vaccine, adult dosage, for intramuscular use (Harvix, Vaqyta)	$75.00	G0008	Administration of influenza virus vaccine	$25.00
90633	Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use (Harvix, Vaqta)	$32.03	90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use (FLUZONE high-dose)	$45.00
90634	Hepatitis A vaccine, pediatric/adolescent dosage-3 dose schedule, for intramuscular use (Harvix)	$30.00	90670	Pneumococcal conjagate vaccine, 13 valent (PCV13). For intramuscular use (Prevnar13)	$195.00
90647	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use (Pedvax HIB)	$50.00	90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit preservative and antibiotic free, 0.5 mL dosage, for intramuscular use. (FLucelvax)	$24.05
90648	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use (ActHIB, Hiberix)	$45.00	90680	Rotavirus vaccine, pentavalent (RV5), 3 dose schedule, live, for oral use (RotaTeq)	$92.00
90649	Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (4vHPV quadrivalent), 3 dose schedule, for intramuscular use (GARDASIL)	$146.95	90681	Rotavirus vaccine, human, attenuated (RV1), 2 dose schedule, live, for oral use (Rotarix)	$92.00
90651	Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18, 31, 33, 45, 52, 58 (9vHPV quadrivalent), 2 or 3 dose schedule, for intramuscular use	$204.86	90685	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 05 mL dosage, for intramuscular use (Fluzone Quadrivalent)	$23.00
90653	Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use	$41.80	90688	Influenza virus vaccine, quadrivalent (IIV4), split virus, 05 mL dosage, for intramuscular use (FluLaval [multidose vial])	$25.00
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use (Afluria, Fluvarix, Fluvirin, Fluzone influenza virus vaccine, no preservative)	$25.00	90696	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and inactivated poliovirus vaccine (DTaP-IPV), when administered to children 4-6 years of age, for IM use	$51.66
90657	Influenza virus vaccine, trivalent (IIV3), split virus, 0.25mL dosage for intramuscular use (Afluria, Fluvarix, Fluvirin, Fluzone [5ml vial 0.25 ml dose])	$25.00	90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP - Hib - IPV), for intramuscular use (Pentacel)	$89.99

CPT Code	IMMUNIZATION/INJECTION	REIMB SV	CPT CODE	IMMUNIZATION/INJECTION	REIMB SV
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to individuals younger than 7 years, for intramuscular use (Daptacel, Infanrix)	$30.00	90736	Zoster (shingles) vaccine (HZV), live, for subcutaneous injection	$200.00
90702	Diphtheria and tetanus toxoids (DT) adsorbed when administered to individuals younger than 7 years, for intramuscular use (Diptheria and Tetanus Toxoids Adsorbed USP [For Pediatric Use])	$20.00	90740	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use (Recombivax dialysis)	$70.00
90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use (M-M-R II)	$75.00	90743	Hepatitis B vaccine (HepB), adolescent 2 dose schedule, for intramuscular use (Energix-B, Recombivax HB)	$35.00
90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use (ProQuad)	$202.40	90744	Hepatitis B vaccine (HepB), pediatric/adolescent dosage 3 dose schedule, for intramuscular use (Energix-B, Recombivax HB)	$35.00
90713	Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use (IPOL)	$30.00	90746	Hepatitis B vaccine (HepB), adult dosage, 3 dose schedule, for intramuscular use (Energix-B, Recombivax HB)-AUTH REQUIRED	$70.00
90714	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to individuals 7 years or older, for intramuscular use (DECAVAC/TENIVAC, Tetanus-diphtheria adult)	$25.00	90747	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage 4 dose schedule, for intramuscular use (Energix-B, RECOMBIVAX dialysis)-AUTH REQUIRED	$70.00
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use (Adacel, Boostrix)	$48.00	90748	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use (COMVAX)	$45.00
90716	Varicella virus vaccine (VAR), live, for subcutaneous use (Varivax)	$122.02	90750	Shingrix. Adult dose 0.5 mL	$169.99
90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV), for intramuscular use (PEDIARIX)	$50.00	90756	Influenza virus vaccine, quadrivalent (ccllV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use	$25.00
90732	Pneumococcal polysaccharide vaccine, 23-valent (PPV23), adult or immunosuppressed patient dosage, when administerd to individuals 2 years or older, for subcutaneous or intramuscular use (Pneumovax23)	$95.00	J0696	Injection, ceftriaxone sodium, per 250 mg-AUTH REQUIRED	$15.00
90733	Meningococcal polysaccharide vaccine serogroups A, C, Y, W-135, quadrivalent (MPSV4), for subcutaneous use (Menomune-A/C/Y/W-135)	$100.00	J0696	Injection, ceftriaxone sodium, per 500 mg-AUTH REQUIRED	$30.00
90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135, quadrivalent (MPSV4 or MenACWY) for intramuscular use (Menactra, Menveo)	$125.00	J0696	Injection, ceftriaxone sodium, per 750 mg-AUTH REQUIRED	$45.00

All vaccinations must follow the guidelines of the AAP and AFP. This Fee Schedule pertains only to those immunizations and injections that the IPA is responsible for reimbursing. For certain HMOs, some immunizations will be reimbursed directly by the Health Plan and will be paid at the Health Plan rate. All other medically necessary immunizations and injections not listed above are included under the PCP capitation. ***Please Note – the Zoster Shingles Vaccination requires prior authorization.**

CREDENTIALING

Credentialing

General Information

Credentialing is the process of obtaining, verifying and assessing the qualifications of a healthcare practitioner to provide patient care services in or for a healthcare entity.

To ensure consistency of credentialing and recredentialing, a routine process should be followed. This assures accuracy of approach and process as well as minimize the variation of references provided. Use of the same process for each new application or re-applicant also reduces the opportunity of charges of discrimination (from the applicant) if there is a negative outcome.

St. Vincent IPA will regularly obtain and review documentation on practitioner sanctions, complainants, adverse events and quality issues and implement appropriate interventions when poor quality, safety issues or limitations on licensure or exclusion from participation are identified. Among the types of media used, these sources have been identified as pertinent information used in the ongoing assessment of Practitioners.

- Reports publicized by licensing boards
- OIG Exclusions and Reinstatement Report/Database
- Medi-Cal Suspended and Ineligible Provider List maintained on the Medi-Cal website
- Medicare Opt Out Report
- SAM (System for Award Management) formerly known as Excluded Parties List System (EPLS)
- Member complaints, filed with the Health Plan or St. Vincent IPA
- Quality of Care issues, identified by the Health Plan or St. Vincent IPA
- Adverse Events, identified by Health Plan or St. Vincent IPA

Credentialing

Red Flags

The indicators below will not necessarily result in denial, only that an explanation is required. A practitioner should be afforded the opportunity to submit additional information in support of the application.

The Credentialing department will consider all factors when reviewing practitioner credentials.

- Missing dates or gaps in training or professional practice
- Discrepancies between information provided on application and verified information
- Suspension, reprimand, revocation, or challenge to licensure
- Excessive professional liability history, either in the number of claims filed or judgements awarded

Credentialing

Updating Expireables

Time sensitive documents such as primary state license, DEA certificate, malpractice insurance coverage will be kept current at all times.

- California state license must be updated no more than five days of expiration
- DEA will be verified with the next available update from the provider
- Insurance coverage will be verified with the next available update from the provider

Credentialing

Recredentialing Process

One hundred and twenty (120) days prior to the end of the three-year appointment period, you will receive the Practitioner's pre-populated recredentialing application. The practitioner is required to review the information; make any necessary updates or corrections; then sign and date where it is indicated.

Please return the completed recredentialing application and any supporting documents as requested. The reapplication will be processed, information verified, reviewed by the Credentialing department and updated in our database.

Questions?

Please reach out to Credentialing Manager, Sacha Burciaga if you have any questions.
Email: sburciaga@pdtrust.com
Phone: (562) 860-8771, ext 186
Fax: (562) 402-7965

Physician Re-Credentialing Sample Letter

Dear Provider:

As you may be aware, our contracted health plans require that providers be re-credentialed every three (3) years. Our records indicate that you are due for re-credentialing with **St. Vincent IPA**. It is imperative we receive your re-credentialing application without delay in order to meet health plan deadlines. Please note that failure to comply with the re-credentialing process may result in the closure of your office to new members or termination from **St. Vincent IPA**.

Enclosed is your reappointment application for **«Specialty name»,** which needs to be completed and returned in the enclosed self-addressed envelope **IMMEDIATELY**.

Directions for completing application:

- Complete Re-Application with all current information
- Complete and sign Addendums A, B, C, & W-9 taxpayer for**m (Please be sure to sign all addendum's whether they pertain to you or not).**
- Please include copies of your current DEA, & Professional Liability Insurance.

In accordance with St. Vincent IPA standards, Providers have the right to review information submitted in support of their credentialing and/or recredentialing application. This includes information received from any outside primary source verification entities.

We kindly request your prompt attention to this very important request. If you should have any questions regarding your application, please contact me directly at **(562) 860-8771, ext 186**.

Sincerely,

Sacha Burciaga
Credentialing Manager
P (562) 860-8771 ext. 186
F (562) 402-7965
Email: sburciaga@pdtrust.com

Enclosures

cc: Leesa Johnson, Vice President of IPA Operations St. Vincent IPA
Imad El Asmar, M.D., Medical Director St. Vincent IPA

REFERRALS

Referrals

Frequently Asked Questions

1. **What is the best way to submit a referral?**
   The best way to submit a referral is through Aerial Care.

2. **What is needed to submit a clean referral?**
   There are four things that are needed to submit a clean referral:

   1. Request of the contracted provider
   2. Recent office notes and pertinent diagnostic results
   3. Use the correct CPT code
   4. Use of the correct priority

3. **How do I determine if the request needs to be expedited?**
   Routine requests are for just that, routine, non-emergent evaluations, follow ups or testing. Urgent priority is for symptoms that warrant the service to be done sooner rather than later. STAT is typically used for blood transfusions or head CTs after a fall

4. **What is the TAT regulation?**
   Routine for seniors is 14 calendar days, 5 business days for commercial/Medi-Cal, urgent is 72 hours and STAT is 24 hours.

5. **How long is the reasonable expectation to have routine referrals determined**
   Within 3-4 business days if submitted cleanly.

6. **How do I know when a determination has been made?**
   You can check in Aerial care. Decisions are available in real time.

7. **Why do I need to attach notes?**
   This is strictly monitored and audited by the health plans on a regular basis.

8. **What is the best way to communicate with someone in clinical services?**
   You can message them in Aerial Care, be advised if you are requesting a J code or a service that requires review, you may need to submit another referral request. Please note that anything changed in our system takes 24 hours for the provider office to see in Aerial Care.

9. **What if I need to call and speak to someone?**
   If you need to contact someone, please call the office at (562) 860-8771 and press the prompt for Clinical Services (ext 2001).

10. **What is the preferred tertiary for higher level of care?**
    Cedars-Sinai Medical Center.

11. **Why is my referral request cancelled?**
    We have to make three attempts to obtain the clinical information needed and if not received, we cancel the request as incomplete and a new request must be submitted.

12. **Are there case managers available to assist with high risk patients**?
    Yes. There are 2 case managers that can do telephonic assistance and 2 nurse practitioners that can do assessments in the home setting. You may obtain more information by calling the Clinical Services department.

Aerial Care
New User Reference Guide

The Aerial Care system allows our providers to submit Referral Requests and Claims as well as the ability to check on their status and verify a patient's eligibility. Below are steps to help you log-in and get started using Aerial Care.

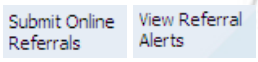
If you do not have an Aerial Care Log-in for St. Vincent IPA, please call us at (888) 255-5053.

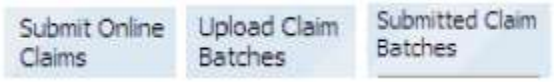
Aerial Care Log-in Steps

1. Go to the St. Vincent IPA website at www.stvincentipa.com

2. Click on **Aerial Care & Referrals** under the **Provider Information tab** on the Provider's side of the website. You will the click the Aerial Care icon that will direct you to the Aerial Care web portal.

3. Type in your **Username** and **Password**.
   New Users: Enter your Temporary Password. You will then be asked to change the password to one of your choice. Then enter your New Password to log-in.\

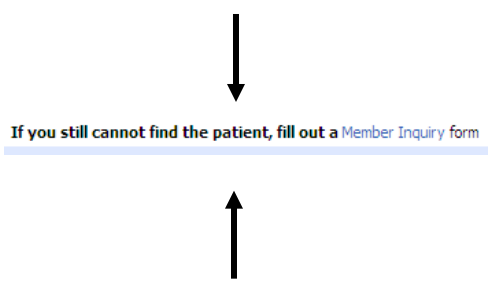
4. To submit a Referral Request or check status click on one of the following:
   

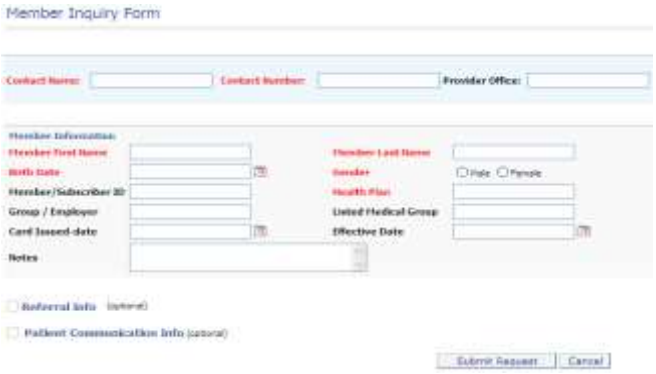
5. To submit/Upload a Claim or Claim Batches click one the following:
   

6. To download your e-list click on the **Eligibility** Tab at the top of the page
   

7. Then Click the **Download to Excel** button
   

- If you cannot find a member listed in Aerial Care, Click on the Member Inquiry Form and complete all the required information. It will be submitted directly to our Eligibility Department. The member will be loaded in Aerial Care once eligibility is confirmed.

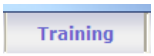




- If you are not able to scan and attach notes and/or additional information to your online Referral Request, please fax those to (562) 924-1453. Please note in the online Referral Notes that additional information will be submitted via fax.

- If you have any technical issues with Aerial Care, or forget your username and/or password, you may contact Aerial Care at (800) 864-8160.

- Online training is available 24/7. You can watch live videos, print out "quick reference" documents and instructions anytime just login and click on the Training Tab at the top of the page



If you have any questions or would like additional training on Aerial Care, please contact the Provider Relations Department at (562) 860-8771 Ext. 107 or Ex 112.

Aerial Care
On-line Referral Submission

Referral Submission

St. Vincent IPA (SVIPA) provides a Web Portal for on-line referral submissions. Internet access must be available in order to view and submit referrals. Simply follow the steps below to easily set up your own on-line referral process for your SVIPA members.

Contact Aerial Care at **1-800-864-8160, Option#1** to obtain a user name and password.

Web Portal Address

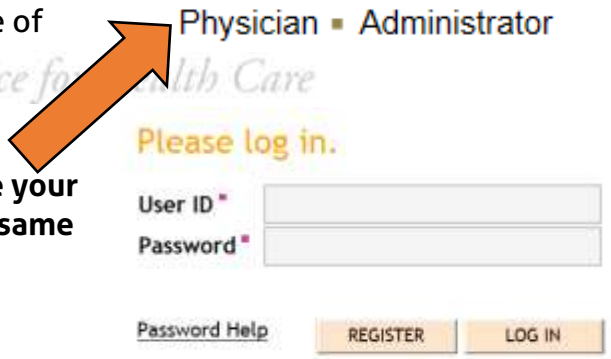
Once a username and password have been set up; go to www.aerial.carecoordination.medecision.com

Click on the Log- in button on the right upper hand.

Login instructions

Look for the St. Vincent IPA logo and click on the Physician option

- Enter your login user ID and password.
- First time log-in will promote a change of password.



Please note; you will be promoted to change your password every 30 days. You may reuse the same password every time.

Aerial Care Dashboard

Once in the portal, a main screen will appear named the "dash board." You will see recent referral comments and or clinical alerts.

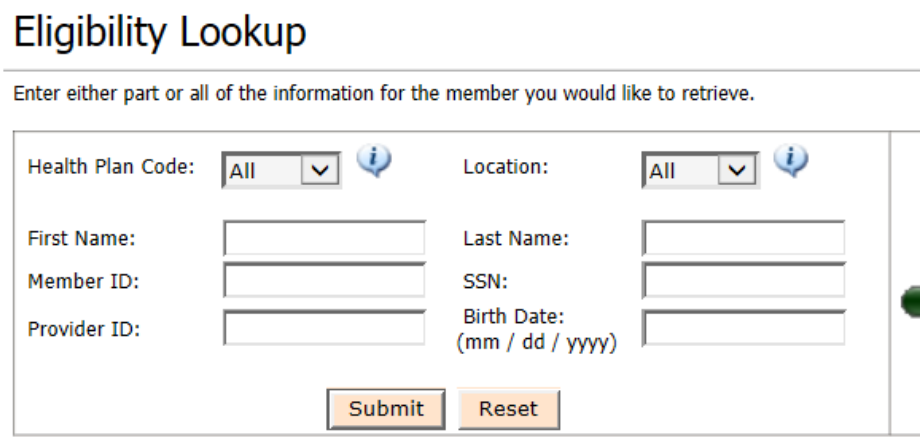
Entering a referral

Click on the eligibility tab on the dash board

Retrieve your member

Enter a members DOB (preferably)

Providing more than one search criteria can overload the search engine and not provide and result.



Your member's eligibility

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

Red indicates the member is ineligible

Blue indicates member is eligible

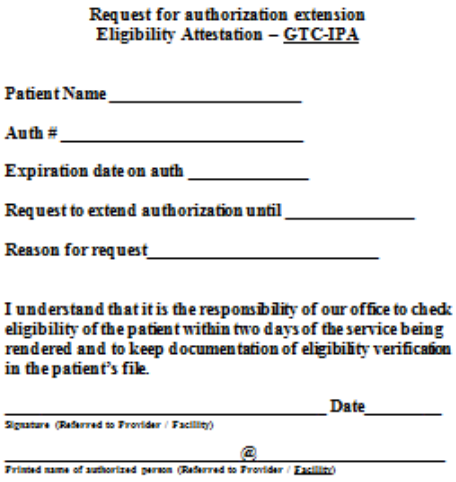
If you have trouble finding the member look at their ID card to check if the health plan knows them by a different name or DOB: (Note: If the health plan has the patient information incorrectly, member must contact the health plan directly and make corrections. If you do not find your member and all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

Adding a New Member

Once the member's eligibility has been verified with the health plan, please fax an eligibility attestation form to **(562) 207-6511** in order to have the new member added to our database. Please allow 24 hours for the member to appear on the on- line portal.

If you are unable to find your member after confirmation with the health plan, please fill out the Member Add Request Form.

You can submit to prsvipa@pdtrust.com or fax to (562) 924-1603.



Request for authorization extension
Eligibility Attestation – GTC-IPA

Patient Name _____

Auth # _____

Expiration date on auth _____

Request to extend authorization until _____

Reason for request _____

I understand that it is the responsibility of our office to check eligibility of the patient within two days of the service being rendered and to keep documentation of eligibility verification in the patient's file.

_____ **Date** _____
Signature (Referred to Provider / Facility)

_____ @ _____
Printed name of authorized person (Referred to Provider / Facility)

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 Aerial Care and selecting "Create a New Member Inquiry" under the Eligibility Tab.

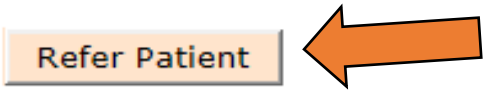
** **All fields must be completed for your request to be processed.**

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		Effective Date	
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:			

Refer your member

1. Click the blue icon on the left or the eye icon on the right to begin.

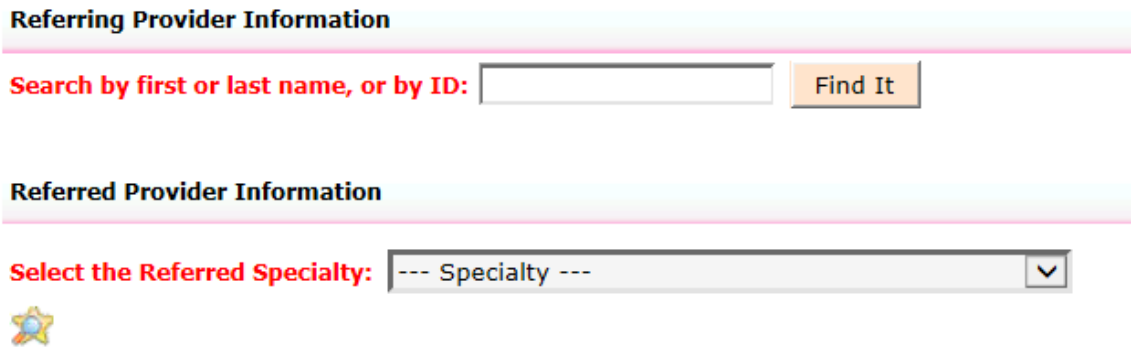
2. Member information will appear, on the bottom of the page a "**Refer Patient**" button will appear, click to enter the actual referral.



3. A referral form will come up on the screen. **All** fields must be completed in a dropdown option or typing format

Referring Physician

Referring physician (PCP, NP, PA , Specialist)



Referring to (Self, imaging facility, another specialist, physical therapy, surgery center etc...)

Referring Priority

Indicate the Priority of the referral:

- **Routine**
  Referrals processed within 5-7 business day (commercial health plans)
  Referrals processed within 14 days (Senior health plans)

- **Urgent**
  48 hour turn around time
  (medical necessity must be indicated)

- **STAT**
  24 hour turn around
  (medical necessity must be indicated)

- **Retro**
  Not to exceed more than 30 days from DOS

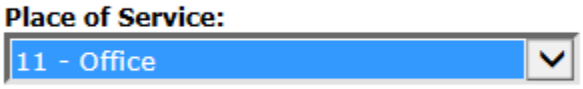
***Please note; urgent or STAT referrals entered due to administrative purposes will be downgraded from urgent/ STAT to routine. Please enter referrals in a timely manner.

*** Do not schedule appointments or procedures prior to obtaining authorization to ensure the member does not need to be rescheduled.

Indicate Services

- **Indicate Place of Service:**

  Office, outpatient includes (surgery center,
  outpatient hospital procedures less than 24hrs.) Inpatient, or Home (are a few of the most common)



Indicate Services & Quantity: CPT CODES

Please use appropriate modifiers as indicated.

CPT Codes

St. Vincent IPA uses a *claims editing software* which contains commercially available coding rules and guidelines to monitor internal claims processing and identify unclean claims which may require reduced payment for improper or erroneous coding.

When referrals with multiple CPT codes are received, it is processed through *claims editing software*, for appropriate claims processing. *Claims editing software* unbundles compounded codes and identifies compounded procedures. During the UM process, bundled CPT codes are removed from the referral. Please note; if CPT codes are taken off the request, look under the comment section and rational will be provided. If further clarification is needed please present provided information to your billing department.

Global Periods

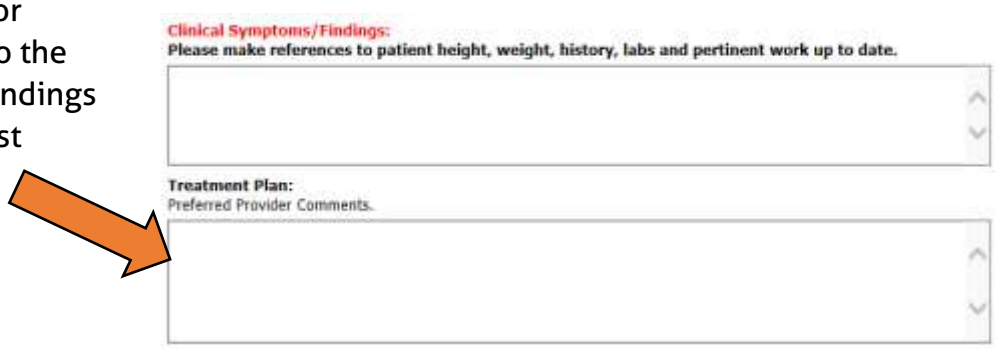
Post-op global periods

- **10**- Day Post- Operative Period, (minor procedures)
- **90**- Day Post- Operative Period, (major procedures)
- Follow up referrals may often be canceled due to members being under a post op period. During this post op period all office physician based visits are covered under a global procedural authorization and no authorization is warranted.
- Modifier **-25-** may be used to bill a separately identifiable evaluation and management (E/M) service by the same physician. If, the member presents with separate issue/ condition non related to the surgical procedure, the physician may evaluate, treat and bill the new condition with a 25 modifier.

Your member's diagnosis

- Enter the most accurate **ICD-10Code (s)** provided by the physician

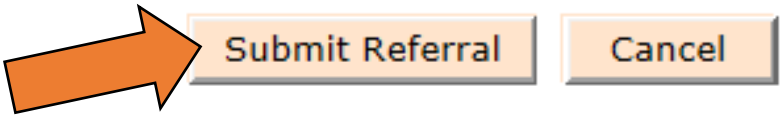
Every referral requires supporting documentation. It may either be faxed to (562) 207-6511, attached and or copied or pasted into the clinical symptoms/findings section of the request below (preferred).



Documentation is needed for review and to establish medical necessity.

Submit your members referral

- Lastly, once the referral is all set, click submit referral button.



- If, information is missing, please review the referral and make sure all required fields are entered.

- Once submitted, it will ask for the name of person entering the referral, please type in a point of contact.

- The last screen allows you to enter another referral for the same member, attach a document or edit the referral.

REFERRAL FORM

St. Vincent IPA Medical Corporation
Fax: (562) 924-1453 Phone: (562) 860-8771 Ext.2001

APPLICABLE COPAY	AUTHORIZATION NUMBER

Date of Referral Request: _____/_____/_____

☐ **Routine** ☐ **Urgent** ☐ **Emergent**

☐ **Specialist Request** ☐ **PCP Request**

Verbal notification to member of approval is required within 2 business days.
Member notified - Date:_____ Time:_____ Notified by:_____

Patient Name: (First, MI, Last) _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/_____ Phone: _____ Patient ID#: _____

Health Plan: _____

PCP Name: _____ Tel #: _____ Fax #: _____

Date of Last PCP Visit: _____ Date of Last Specialist Visit: _____

MD Office Staff Contact Name: _____ **Specialty Requested:**

MD Asking for Request: _____ _____

Tel #: _____ Fax #: _____

SIGNATURE OF REQUESTING PROVIDER:
(MANDATORY – WILL NOT BE PROCESSED WITHOUT SIGNATURE) _____

∴ Diagnosis: _____ ICD-10: _____

ICD-10: _____

Procedure/Service Requested: _____ CPT CODE: _____

CPT CODE: _____

CPT CODE:

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

Reason for REFERRAL: _____

Attachment

Notes: _____
Lab: _____
EKG/EEG: _____
X-Ray _____
Other: _____

FOR USE BY ST. VINCENT IPA MEDICAL CORPORATION UM STAFF ONLY

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

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

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 ninety (90) days from approval date. Referring providers may request a copy of the UM criteria or discuss their request with the IPA physician reviewer at any time. Your UM Case Management or Referral Coordinator will facilitate your request.

∴ This section must be reviewed by physician prior to submission.

Downtown LA Area Direct Referral Requisition Form

St. Vincent IPA c/o Physicians DataTrust, Inc.
P. O. Box 5089 Oceanside, CA 92052

Phone: (562) 860-8771/Fax: (562) 924-1453

Date of Referral Request: _____/_____/_____

Patient Name (First, MI, Last): _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____/__/ Phone: (_____ Patient ID #: _____

Health Plan: _____

Referring Physician: _____ Referring Physician Signature: _____

Referring Physician Phone: ( ) _____ Referring Physician Fax: ( ) _____

Diagnosis ***(must be listed)***: _____

NOTICE TO PATIENT: Your primary care physician has approved your visit to the provider/specialist listed below. Please call the phone number listed below to make an appointment for mammography screening, CT Sinus Survey, and routine OB/GYN services on this form. Walk-in appointments are accepted for all other X-Ray services on this form.

PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT.

NOTICE TO SPECIALIST: The above-listed patient has been referred to you for the procedure indicated.

X-RAY (PLEASE √ LOCATION AND SERVICE TYPE)

☐ **Renaissance Imaging**
245 Wilshire Blvd
Suite 205
Los Angeles, CA 90017
Tel: 213-867-3270

☐ **Renaissance Imaging**
500 S. Virgil Ave.
Suite 102
Los Angeles, CA 90020
Tel: 323-375-3940

☐ **Beverly Tower Wilshire Advanced Imaging**
8750 Wilshire Blvd.
Suite 100
Beverly Hills, CA 90211
Tel: 310-689-3100

☐ **Radnet**
Beverly Tower Women's Center
465 Roxbury Dr.
Beverly Hills, CA 90210
Tel. 310-385-9144

X-RAY TYPE: *****CPT CODES NOT LISTED REQUIRE SUBMISSION OF ROUTINE REFERRAL FORM*****

HEAD & NECK
☐70250 - Skull <4V
☐70486-CT Sinus Survey

CHEST
☐71045 –1V
☐71046 –2V
☐71100 - Ribs Uni 2V
☐71120 - Sternum Min 2V

SPINE & PELVIS
☐ 72040-Spine Cervical 2 or 3V
☐ 72070-Spine Thoracic 2V
☐ 72100-Spine Lumbosacral 2-3V
☐ 72170 -Pelvis 1V
☐ 72220-Sacrum & coccyx min 2V

MAMMOGRAPHY
☐ 77067 Mammography Screening, Digital (age 40+)

UPPER EXTREMITIES
☐ 73030 - Shoulder min 2V
☐ 73070 - Elbow 2V
☐ 73090 - Forearm 2V
☐ 73100 - Wrist 2V
☐ 73120 - Hand 2V
☐ 73140 - Fingers min 2V

ABDOMEN
☐ 74018-anteroposterior 1V

LOWER EXTREMITIES
☐ 73502 - Hip unilateral min 2V
☐ 73521 - Hip bilateral min 2V
☐ 73552 – Femur 2V
☐ 73560 - Knee 1 or 2V
☐ 73590 - Tibia & Fibula 2V
☐ 73600 - Ankle 2V
☐ 73620 - Foot 2V
☐ 73650 - Calcaneus min 2V
☐ 73660 - Toes min 2V

ROUTINE OB/GYN WOMEN'S HEALTH (PLEASE COMPLETE PROVIDER INFORMATION &√ SERVICE TYPE

OB/GYN Provider Name: _____

Address: _____

City, Zip Code: _____

Phone

☜ **REVIEW CURRENT ROSTER** ***(MUST BE A CONTRACTED ST. VINCENT IPA PROVIDER)***

Service Type:
☐ 99203 –OB/GYN Consult
☐ 99213 - OB/GYN Follow-up
☐ 99395 - Well Women Exam (Annual) – Age 18-39
☐ 99396 - Well Women Exam (Annual) – Age 40-64
☐ 99397 - Well Women Exam (Annual) – Age >65

This requisition does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual

GLENDALE AREA DIRECT REFERRAL REQUISITION FORM

St. Vincent IPA c/o Physicians DataTrust, Inc.
P. O. Box 5089 Oceanside, CA 92052
Phone: (562) 860-8771/Fax: (562) 924-1453

Date of Referral Request: ____/_____/_____

Patient Name (First, MI, Last): _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Phone: ( ) _____ Patient ID #: _____

Health Plan: _____

Referring Physician: _____ Referring Physician Signature: _____

Referring Physician Phone: ( ) _____ Referring Physician Fax: ( ) _____

Diagnosis ***(must be listed)***: _____

NOTICE TO PATIENT: Your primary care physician has approved your visit to the provider/specialist listed below. Please call the phone number listed below to make an appointment for mammography screening, CT Sinus Survey, and routine OB/GYN services on this form. Walk-in appointments are accepted for all other X-Ray services on this form.

PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT.

NOTICE TO SPECIALIST: The above-listed patient has been referred to you for the procedure indicated.

X-RAY (PLEASE √ LOCATION AND SERVICE TYPE)

☐ **Imaging Specialists of Glendale**
700 N. Central Ave, #100
Glendale, CA 91203
Tel: 818-480-7234

☐ **Renaissance Imaging Wilshire**
1245 Wilshire Blvd Suite 205 2ND Floor
Los Angeles, CA 90017
Tel: 213-867-3270

☐ **Renaissance Imaging Los Angeles**
500 South Virgil Ave. Los Angeles, CA 90017
Tel: 323-375-3945

☐ **Radnet – Los Angeles Wilshire Downtown Advanced Imaging Center**
3055 Wilshire Blvd. Ste. 150
Los Angeles, CA 90010
Tel. 213-487-4077

X-RAY TYPE: *****CPT CODES NOT LISTED REQUIRE SUBMISSION OF ROUTINE REFERRAL FORM*****

HEAD & NECK
☐70250 - Skull <4V
☐70486-CT Sinus Survey

CHEST
☐71045 –1V
☐71046 –2V
☐71100 - Ribs Uni 2V
☐71120 - Sternum Min 2V

SPINE & PELVIS
☐ 72040-Spine Cervical 2 or 3V
☐ 72070-Spine Thoracic 2V
☐ 72100-Spine Lumbosacral 2-3V
☐ 72170 -Pelvis 1V
☐ 72220-Sacrum & coccyx min 2V

MAMMOGRAPHY
☐ 77067 Mammography Screening, Digital (age 40+)

UPPER EXTREMITIES
☐ 73030 - Shoulder min 2V
☐ 73070 - Elbow 2V
☐ 73090 - Forearm 2V
☐ 73100 - Wrist 2V
☐ 73120 - Hand 2V
☐ 73140 - Fingers min 2V

ABDOMEN
☐ 74018-anteroposterior 1V

LOWER EXTREMITIES
☐ 73502 - Hip unilateral min 2V
☐ 73521 - Hip bilateral min 2V
☐ 73552 – Femur 2V
☐ 73560 - Knee 1 or 2V
☐ 73590 - Tibia & Fibula 2V
☐ 73600 - Ankle 2V
☐ 73620 - Foot 2V
☐ 73650 - Calcaneus min 2V
☐ 73660 - Toes min 2V

This requisition does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions. REV.3/7/18

St. Vincent IPA
The Patient's Choice for Health Care

St. Vincent IPA c/o Physicians DataTrust, Inc.

ROUTINE OB/GYN WOMEN'S HEALTH (PLEASE COMPLETE PROVIDER INFORMATION &√ SERVICE TYPE

OB/GYN Provider Name: _____

Address: _____

City, Zip Code: _____

Phone _____

☜ **REVIEW CURRENT ROSTER** ***(MUST BE A CONTRACTED ST. VINCENT IPA PROVIDER)***

Service Type:

☐ 99203 –OB/GYN Consult

☐ 99213 - OB/GYN Follow-up

☐ 99395 - Well Women Exam (Annual) – Age 18-39

☐ 99396 - Well Women Exam (Annual) – Age 40-64

☐ 99397 - Well Women Exam (Annual) – Age >65

This requisition does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions. REV. 3/7/18

HP AREA DIRECT REFERRAL REQUISITION FORM

St. Vincent IPA
The Patient's Choice for Health Care

St. Vincent IPA c/o Physicians DataTrust, Inc.
P. O. Box 5089 Oceanside, CA 92052
Phone: (562) 860-8771/Fax: (562) 924-1453

Date of Referral Request: _____/_____/_____

Patient Name (First, MI, Last): _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Phone: (_____) _____ Patient ID #: _____

Health Plan: _____

Referring Physician: _____ Referring Physician Signature: _____

Referring Physician Phone: (_____) _____ Referring Physician Fax: (_____) _____

Diagnosis ***(must be listed)***: _____

NOTICE TO PATIENT: Your primary care physician has approved your visit to the provider/specialist listed below. Please call the phone number listed below to make an appointment for mammography screening, CT Sinus Survey, and routine OB/GYN services on this form. Walk-in appointments are accepted for all other X-Ray services on this form.

PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT.

NOTICE TO SPECIALIST: The above-listed patient has been referred to you for the procedure indicated.

X-RAY (PLEASE √ LOCATION AND SERVICE TYPE)

☐ **Renaissance Imaging Los Angeles**
500 South Virgil Ave.
Los Angeles, CA 0017
Tel: 323-375-3945

☐ **Radnet - Zoe Huntington Park Advanced Imaging**
2679 Zoe Ave.
Huntington Park CA 90255
Tel: 323-584-3333

☐ **UMI of Maywood**
4316 E. Slauson Ave. Maywood, CA 90270
Tel: 323-374-6200

☐ **Radnet Huntington Park Advanced Imaging**
2680 Saturn Ave. Ste. 100
Huntington Park CA 90255
Tel. 323-584-3333

X-RAY TYPE: ***CPT CODES NOT LISTED REQUIRE SUBMISSION OF ROUTINE REFERRAL FORM****

HEAD & NECK
☐70250 - Skull <4V
☐70486-CT Sinus Survey

CHEST
☐71045 –1V
☐71046 –2V
☐71100 - Ribs Uni 2V
☐71120 - Sternum Min 2V

SPINE & PELVIS
☐ 72040-Spine Cervical 2 or 3V
☐ 72070-Spine Thoracic 2V
☐ 72100-Spine Lumbosacral 2-3V
☐ 72170 -Pelvis 1V
☐ 72220-Sacrum & coccyx min 2V

MAMMOGRAPHY
☐ 77067 Mammography Screening, Digital (age 40+)

UPPER EXTREMITIES
☐ 73030 - Shoulder min 2V
☐ 73070 - Elbow 2V
☐ 73090 - Forearm 2V
☐ 73100 - Wrist 2V
☐ 73120 - Hand 2V
☐ 73140 - Fingers min 2V

ABDOMEN
☐ 74018-anteroposterior 1V

LOWER EXTREMITIES
☐ 73502 - Hip unilateral min 2V
☐ 73521 - Hip bilateral min 2V
☐ 73552 – Femur 2V
☐ 73560 - Knee 1 or 2V
☐ 73590 - Tibia & Fibula 2V
☐ 73600 - Ankle 2V
☐ 73620 - Foot 2V
☐ 73650 - Calcaneus min 2V
☐ 73660 - Toes min 2V

ROUTINE OB/GYN WOMEN'S HEALTH (PLEASE COMPLETE PROVIDER INFORMATION & √ SERVICE TYPE

OB/GYN Provider Name: _____

Address: _____

City, Zip Code: _____

Phone _____

☜ **REVIEW CURRENT ROSTER** ***(MUST BE A CONTRACTED ST. VINCENT IPA PROVIDER)***

Service Type:
☐ 99203 –OB/GYN Consult
☐ 99213 - OB/GYN Follow-up
☐ 99395 - Well Women Exam (Annual) – Age 18-39
☐ 99396 - Well Women Exam (Annual) – Age 40-64
☐ 99397 - Well Women Exam (Annual) – Age >65

This requisition does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions. REV. 3/7/18

INGLEWOOD AREA DIRECT REFERRAL REQUISITION FORM

St. Vincent IPA c/o Physicians DataTrust, Inc.
P. O. Box 5089 Oceanside, CA 92052
Phone: (562) 860-8771/Fax: (562) 924-1453

Date of Referral Request: _____/_____/_____

Patient Name (First, MI, Last): _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Phone: (_____) _____ Patient ID #: _____

Health Plan: _____

Referring Physician: _____ Referring Physician Signature: _____

Referring Physician Phone: (_____) _____ Referring Physician Fax: (_____) _____

Diagnosis ***(must be listed)***: _____

NOTICE TO PATIENT: Your primary care physician has approved your visit to the provider/specialist listed below. Please call the phone number listed below to make an appointment for mammography screening, CT Sinus Survey, and routine OB/GYN services on this form. Walk-in appointments are accepted for all other X-Ray services on this form.

PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT.

NOTICE TO SPECIALIST: The above-listed patient has been referred to you for the procedure indicated.

X-RAY (PLEASE √ LOCATION AND SERVICE TYPE)

☐ **Radnet-Inglewood**
Westchester Advanced Imaging
8540 s Sepulveda Blvd.
Los Angeles CA 90045
Tel. 310-645-9050

☐ **UMI of Gardena**
1141 W. Redondo Beach Blvd. Suite #105
Gardena, CA 90247
Tel: 310-436-1730

☐ **UMI of Inglewood**
110 S. La Brea Ave.
Suite #150
Inglewood, CA 90301
Tel: 310-671-6000

☐ **UMI of Torrance**
3640 Lomita Blvd.
Suite 105
Torrance, CA 90505
Tel: 310-802-7000

☐ **Renaissance Imaging**
Los Angeles
500 South Virgil Ave.
Los Angeles, CA 90017
Tel: 323-375-3945

X-RAY TYPE: ***CPT CODES NOT LISTED REQUIRE SUBMISSION OF ROUTINE REFERRAL FORM****

HEAD & NECK
- ☐70250 - Skull <4V
- ☐70486-CT Sinus Survey

CHEST
- ☐71045 –1V
- ☐71046 –2V
- ☐71100 - Ribs Uni 2V
- ☐71120 - Sternum Min 2V

SPINE & PELVIS
- ☐ 72040-Spine Cervical 2 or 3V
- ☐ 72070-Spine Thoracic 2V
- ☐ 72100-Spine Lumbosacral 2-3V
- ☐ 72170 -Pelvis 1V
- ☐ 72220-Sacrum & coccyx min 2V

MAMMOGRAPHY
- ☐ 77067 Mammography Screening, Digital (age 40+)

UPPER EXTREMITIES
- ☐ 73030 - Shoulder min 2V
- ☐ 73070 - Elbow 2V
- ☐ 73090 - Forearm 2V
- ☐ 73100 - Wrist 2V
- ☐ 73120 - Hand 2V
- ☐ 73140 - Fingers min 2V

ABDOMEN
- ☐ 74018-anteroposterior 1V

LOWER EXTREMITIES
- ☐ 73502 - Hip unilateral min 2V
- ☐ 73521 - Hip bilateral min 2V
- ☐ 73552 – Femur 2V
- ☐ 73560 - Knee 1 or 2V
- ☐ 73590 - Tibia & Fibula 2V
- ☐ 73600 - Ankle 2V
- ☐ 73620 - Foot 2V
- ☐ 73650 - Calcaneus min 2V
- ☐ 73660 - Toes min 2V

ROUTINE OB/GYN WOMEN'S HEALTH (PLEASE COMPLETE PROVIDER INFORMATION & √ SERVICE TYPE

OB/GYN Provider Name: _____

Address: _____

City, Zip Code: _____

Phone _____

☜ **REVIEW CURRENT ROSTER** ***(MUST BE A CONTRACTED ST. VINCENT IPA PROVIDER)***

Service Type:

- ☐ 99203 –OB/GYN Consult
- ☐ 99213 - OB/GYN Follow-up
- ☐ 99395 - Well Women Exam (Annual) – Age 18-39
- ☐ 99396 - Well Women Exam (Annual) – Age 40-64
- ☐ 99397 - Well Women Exam (Annual) – Age >65

This requisition does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions. REV. 4/3/18

WEST LA DIRECT REFERRAL REQUISITION FORM

St. Vincent IPA
The Patient's Choice for Health Care

Date of Referral Request: _____/_____/_____

St. Vincent IPA c/o Physicians DataTrust, Inc.
P. O. Box 5089 Oceanside, CA 92052
Phone: (562) 860-8771/Fax: (562) 924-1453

Patient Name (First, MI, Last): _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____/__/ Phone: (_____ Patient ID #: _____

Health Plan: _____

Referring Physician: _____ Referring Physician Signature: _____

Referring Physician Phone: (_____) _____ Referring Physician Fax: (_____) _____

Diagnosis ***(must be listed)***: _____

NOTICE TO PATIENT: Your primary care physician has approved your visit to the provider/specialist listed below. Please call the phone number listed below to make an appointment for mammography screening, CT Sinus Survey, and routine OB/GYN services on this form. Walk-in appointments are accepted for all other X-Ray services on this form.

PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT.

NOTICE TO SPECIALIST: The above-listed patient has been referred to you for the procedure indicated.

X-RAY (PLEASE √ LOCATION AND SERVICE TYPE)

☐ **Renaissance Imaging**
245 Wilshire Blvd
Suite 205
Los Angeles, CA 90017
Tel: 213-867-3270

☐ **Renaissance Imaging**
500 S. Virgil Ave.
Suite 102
Los Angeles, CA 90020
Tel: 323-375-3940

☐ **Beverly Tower Wilshire Advanced Imaging**
8750 Wilshire Blvd.
Suite 100
Beverly Hills, CA 90211
Tel: 310-689-3100

☐ **Radnet**
Beverly Tower Women's Center
465 Roxbury Dr.
Beverly Hills, CA 90210
Tel. 310-385-9144

X-RAY TYPE: *****CPT CODES NOT LISTED REQUIRE SUBMISSION OF ROUTINE REFERRAL FORM*****

HEAD & NECK
☐70250 - Skull <4V
☐70486-CT Sinus Survey

CHEST
☐71045 –1V
☐71046 –2V
☐71100 - Ribs Uni 2V
☐71120 - Sternum Min 2V

SPINE & PELVIS
☐ 72040-Spine Cervical 2 or 3V
☐ 72070-Spine Thoracic 2V
☐ 72100-Spine Lumbosacral 2-3V
☐ 72170 -Pelvis 1V
☐ 72220-Sacrum & coccyx min 2V

MAMMOGRAPHY
☐ 77067 Mammography Screening, Digital (age 40+)

UPPER EXTREMITIES
☐ 73030 - Shoulder min 2V
☐ 73070 - Elbow 2V
☐ 73090 - Forearm 2V
☐ 73100 - Wrist 2V
☐ 73120 - Hand 2V
☐ 73140 - Fingers min 2V

ABDOMEN
☐ 74018-anteroposterior 1V

LOWER EXTREMITIES
☐ 73502 - Hip unilateral min 2V
☐ 73521 - Hip bilateral min 2V
☐ 73552 – Femur 2V
☐ 73560 - Knee 1 or 2V
☐ 73590 - Tibia & Fibula 2V
☐ 73600 - Ankle 2V
☐ 73620 - Foot 2V
☐ 73650 - Calcaneus min 2V
☐ 73660 - Toes min 2V

ROUTINE OB/GYN WOMEN'S HEALTH (PLEASE COMPLETE PROVIDER INFORMATION &√ SERVICE TYPE

OB/GYN Provider Name: _____

Address: _____

City, Zip Code: _____

Phone _____

☜ **REVIEW CURRENT ROSTER** ***(MUST BE A CONTRACTED ST. VINCENT IPA PROVIDER)***

Service Type:
☐ 99203 –OB/GYN Consult
☐ 99213 - OB/GYN Follow-up
☐ 99395 - Well Women Exam (Annual) – Age 18-39
☐ 99396 - Well Women Exam (Annual) – Age 40-64
☐ 99397 - Well Women Exam (Annual) – Age >65

This requisition does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions. REV. 4/3/18

INJECTABLE REFERRAL FORM

St. Vincent IPA Medical Corporation
Fax: (562) 924-1453
Phone: (562) 860-8771

APPLICABLE COPAY	AUTHORIZATION NUMBER

DateofReferralRequest:1 /1 /1 ☐ **Emergent** ☐ **Routine** ☐ **Urgent**

Patient Name (First, MI, Last): _____
Address: _____ City: _____ ST: _____ Zip: _____

Date of Birth: ___/___/___ Phone: _____ Patient ID#: _____
Health Plan: _____

Referred From:
MD Office Contact Name: _____
Provider Name: _____
PCP/Specialty: _____
Phone: _____
Fax: _____
SIGNATURE OF REFERRING PROVIDER:

_____
(Mandatory - Will not be processed without signature)

*Diagnosis: _____

*ICD 10: _____

Reason for Referral: _____

Additional notes attached: ☐ Yes ☐ No

If drug to be administered in office, office visit/administrative CPT code must accompany J code, if applicable.
Office Visit/Admin Code: _____

Drug Name:
J Code:
Dosage: _____
Duration of treatment: _____
Frequency: _____ Route: SQ IM

Drug Name: _____
J Code: _____
Dosage: _____
Duration of treatment: _____
Frequency: _____ Route : SQ IM

Drug Name: _____
J Code:
Dosage :
Duration of treatment :
Frequency : _____ Route : SQ IM

Drug Administered By:
☐ **Home Health** ☐ **Patient** ☐ **Physician**

Verbal notification to member of approval is required within 2 business days.
Member notified - Date:_____Time:_____Notified by:_____

- UM STAFF ONLY -

Benefits Verified By: _____

☐ Authorize Date _____ ☐ Pending Date _____
☐ Denied Date _____ ☐ Not a covered benefit.
☐ Modified Date _____

Comments: _____

UM Signature: _____ Date: _____
Date PCP Notified: _____

Referred To:
Vendor: _____
Phone: _____ Fax: _____

Deliver To : _____
Address : _____
City: _____ ST: _____ Zip: _____
Phone: _____

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 ninety (90) days from approval date.

Updated: 11/01/17

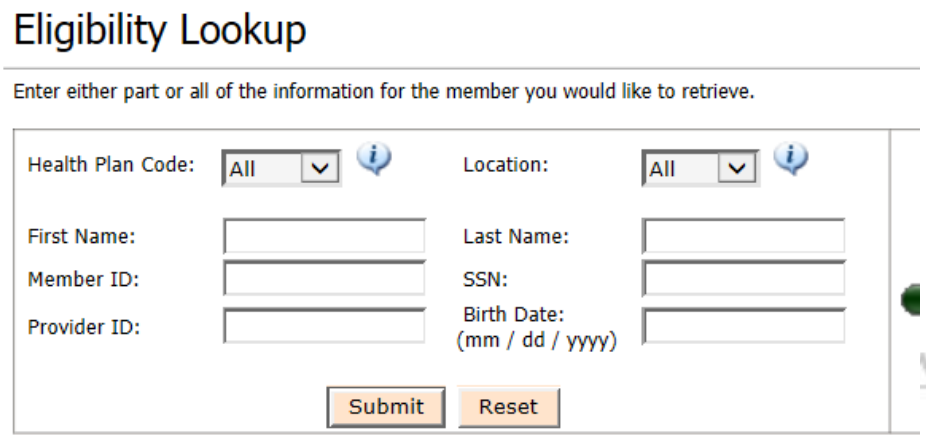
ELIGIBILITY

Aerial Care
Member's Eligibility

Retrieve your member

Enter a members DOB (preferably)

Providing more than one search criteria can overload the search engine and not provide and result.



Your member's eligibility

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

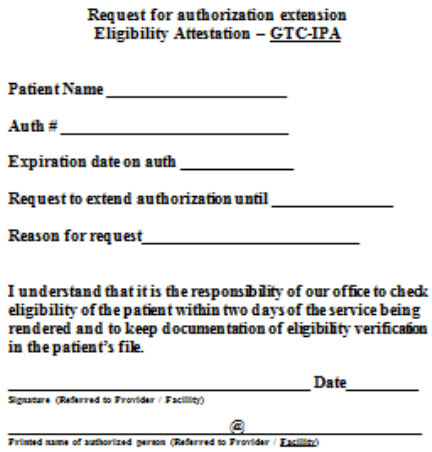
Red indicates the member is ineligible

Blue 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

Once the member's eligibility has been verified with the health plan, please fax an eligibility attestation form to **(562) 207-6511** in order to have the new member added to our database. Please allow 24 hours for the member to appear on the on-line portal.



Request for authorization extension
Eligibility Attestation – GTC-IPA

Patient Name _____

Auth # _____

Expiration date on auth _____

Request to extend authorization until _____

Reason for request _____

I understand that it is the responsibility of our office to check eligibility of the patient within two days of the service being rendered and to keep documentation of eligibility verification in the patient's file.

_____ Date _____
Signature (Referred to Provider / Facility)

_____
Printed name of authorized person (Referred to Provider / Facility)

Sample Eligibility List

MEMBER ID	LAST NAME	FIRST NAME	BIRTH DATE	SEX	EFFECTIVE DATE	Health Plan	ADDRESS	CITY	ZIP	TELEPHONE
123456-01	Doe	John	1/1/1960	M	1/1/2012	Blue Shield	123 Main St.	Los Angeles	90057	213-555-5555
654321-01	Smith	Jane	1/1/1940	F	1/1/2011	SCAN	111 Clark St.	Los Angeles	90026	213-444-4444

CLAIMS

Appeals

Appeals for St. Vincent IPA can be mailed to:

St. Vincent IPA
Attn: Appeals
PO BOX 5089
Oceanside, CA 92052

Fax to (760) 631-7614

Claims

Claim Electronic Submission Options: Aerial Care

There are two options for claims submission via Aerial Care:

- File upload, which allows for the upload of an ANSI837 Professional Claim file.
- Online Claim Entry, which is claim submission via manual entry into an Online CMS1500 Claim form.

File Upload

Access: Contact Medecision / Aerial Care for access at (800) 864-8160. Select the option for "Aerial Care Coordination".

Test File Submission: You must first submit a Test file before actual claims can be submitted. To upload a Test file, contact Support at (800) 864-8160 and select the option for "Aerial Care Coordination". A representative will assist you to ensure a successful Test File upload.

Claim File Submission: Once you have successfully submitted a Test file, you can submit a Claim file by clicking the Upload Claim Batches option, which is listed under Quick Links on the left side of your Aerial Care dashboard screen.

Submission Status: You can check the status of any submitted batch by clicking the Submitted Claim Batches option under Quick Links on the left side of your Aerial Care dashboard screen.

Error Correction: From the Submitted Claim Batches screen you can open any batch that has 1 or more listed in the Err field, meaning there are Errors. You can open the claim record and make the corrections on the online claim form.

Online Claim Entry

Access: Contact Medecision / Aerial Care for access at (800) 864-8160. Select the option for "Aerial Care Coordination".

Claim Entry: Click the Submit Online Claims option, which is listed under Quick Links on the left side of your Aerial Care dashboard screen. Enter the information on the search screen to locate the correct member. Click the Claim icon to create an online claim. Enter all applicable values. If you have only 1 claim to submit, click Submit Single Claim. If you have multiple claims to submit click Save in New Batch. Once all claims have been created and saved, click Submit Batch.

Submission Status: You can check the status of any submitted batch by clicking the Submitted Claim Batches option under Quick Links on the left side of your Aerial Care dashboard screen.

Error Correction: From the Submitted Claim Batches screen you can open any batch that has 1 or more listed in the Err field, meaning there are Errors. You can open the claim record and make the corrections on the online claim form.

Other Important Information:

- Member and Provider information in Aerial Care is updated nightly.
- Claims successfully submitted via Aerial Care are received by the IPA the following business day.
- Only Professional Claims or Encounters may be submitted via Aerial Care.

Claims

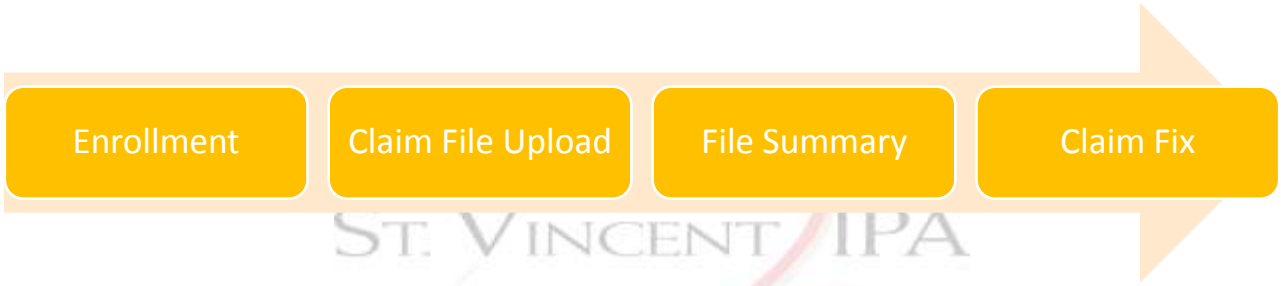
Claim Electronic Submission Options: Office Ally

There are two options for claims submission via Office Ally:

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

Payer ID: PDT01

File Upload



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.

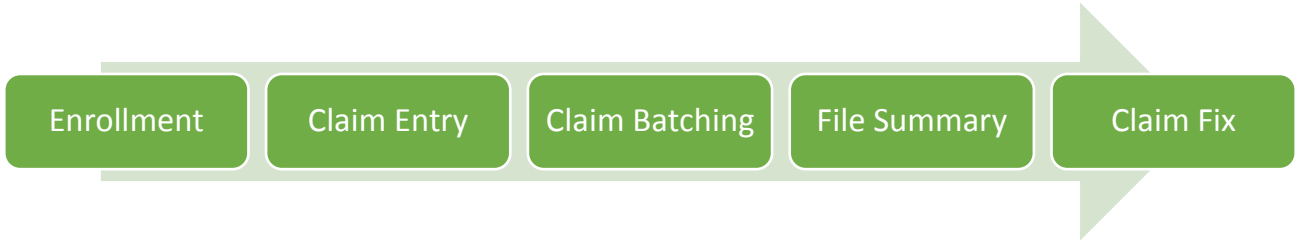
Claim File Upload: Log onto officeally.com. Hover over the Upload Claims option on the left side of the screen. Select Upload HCFA, to upload a Professional Claim file, or select Upload UB04 to upload an Institutional Claim file. Click Select File. Browse for your file and click Open. Click Upload. You will receive an upload 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 User Name, 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 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 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 which 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 can not 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 of your claims for a specific date have been corrected the background for that date will change to white.

Other Important Information:

- Member and Provider information on Office Ally is updated weekly.

- Claims submitted via Office Ally are received by the IPA the business day after successful submission and processing by Office Ally.
- 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.
- Technical Support is available at (375) 975-7000, option 2.
- Office Ally offers Free Training. To utilize this service contact Office Ally at (360) 975-7000 Option 5.

Claims

Claim Electronic Submission Options: Smart Data Solutions

There are two options for claims submission via Smart Data Solutions

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

Payer ID: PDT01

File Upload

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 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 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.

Claims

Claim Submission: Paper Claims

Paper claims are scanned for optimal processing and recording of data provided; therefore, even paper claims must be legible and provided in the appropriate format to ensure scanning capabilities. The following paper claim submission requirements can speed claim processing and prevent delays:

- Use the appropriate form type for submission
- Use black or blue ink; do not use red ink, as the scanner may not be able to read it
- Use the Remarks field for messages
- Do not stamp or write over boxes on the claim form
- Send the original claim form to us and retain the copy for your records
- Separate each individual claim form. Do not staple original claims together, as we would consider the second claim an attachment and not an original claim to be processed separately
- Information is typed within the designated area of the field. Be sure the type falls completely within the text space and is properly aligned with corresponding information. If using a dot matrix printer, do not use draft mode since the characters generally do not have enough distinction and clarity for the optical character reader to accurately determine the contents

All paper claims should be mailed to the following address:

St. Vincent IPA
Attn: Claims Department
PO Box 5089
Oceanside, CA 92052

Claims

EFT/ How to Submit Payment

St. Vincent IPA has partnered with InstaMed, the leading healthcare payments network, to offer a free solution to deliver your payments as Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT). You can register to receive St. Vincent IPA ERA/EFT payments today at www.instamed.com/eraeft.

ERA/EFT is a convenient, paperless and secure way to receive claim payments. Funds are deposited directly into your designated bank account. The benefits of ERA/EFT include:

- Accelerated access to funds with direct deposit into your existing bank account
- Reduced administrative costs by eliminating paper checks and remittances
- No disruption to your current workflow – there is an option to have ERAs routed to your existing clearinghouse

You have two simple options to register to receive St. Vincent IPA payments as free ERA/EFT transactions:

1. **Online**: visit www.instamed.com/eraeft
2. **Paper**: complete the enclosed Network Funding Agreement and fax it to (877) 755-3392

All electronic payments and EOB's will be provided by InstaMed. This includes providers that sign up for electronic payment as well as those providers that did not sign up. For those providers that do not sign up, hard copy checks and EOB's will be mailed from InstaMed instead of PDT.

This notice was mailed to all PCP's however it is important to note that "Capitation Payment" will not be paid electronically. InstaMed will provide hard copy checks and remittance advise (RA's) to all PCP's .

PCP's can sign up to receive FFS payment electronically.

Please do not hesitate to contact us directly at (866) 945-7990 or connect@instamed.comwith any questions.

Claims

Frequently Asked Questions

1. **Is Online Registration secure?**
   Yes. InstaMed places the highest importance on data integrity, security and compliance. InstaMed meets the highest industry standards for compliance and security, including Payment Card Industry (PCI) Level One and verification processes to prevent fraud. For details about InstaMed compliance standards, visit www.instamed.com/about/compliance-and-security.

2. **What information is needed during Online Registration?**
   - Tax ID
   - Email Address
   - Legal Business Name
   - Business Address/Phone
   - Principal Name (primary decision maker)
   - Billing NPI Number
   - Bank Name
   - Bank Routing Number

3. **How will I receive my ERAs?**
   You have multiple options to receive your ERAs. Upon registering for InstaMed, you will receive access to InstaMed Online, a free, secure provider portal that will allow you to access payment details 24/7 and view and print remittances. You also have the option to have ERAs routed to your existing clearinghouse. Finally, you have the option to have an SFTP folder set up. Please contact InstaMed at connect@instamed.com or (866) 945-7990 with any questions on ERA delivery.

4. **Will I still receive paper EOBs in the mail?**
   No. Once your register for ERA/EFT, you will stop receiving paper checks and mailed EOPs.

5. **How will I know when I get paid?**
   You will receive email alerts to notify you when a payment is made, so you can easily track all payments. Additionally, you will have 24/7 access to reporting with InstaMed.

6. **Which NPIs do I provide?**
   Please enter your Type 2 NPI(s) during Online Registration since they are used for billing claims.

7. **What if I have multiple Tax IDs?**
   Once you register, you may add additional Tax IDs to your account.

8. **Who is the contact vs. the principal?**
   The principal is the primary decision maker, i.e. director or owner. The contact is the person who will be the administrator on the account. The contact may be the principal or an authorized representative of the organization.

9. **Which email address should I enter during Online Registration?**
   InstaMed will send an email to this address to confirm registration, so this should be an email address you want to use for your InstaMed account.

10. **Why do I need to enter details about my business during Online Registration, including date established?**
    In order to prevent fraud, we use this information to verify your organization.

11. **What is the turnaround time between registering online and receiving payments?**
    After you register online, it takes about 8 to 10 business days to receive your first payment, because InstaMed completes a thorough verification process to ensure your bank account information is secure.

12. **I'm a billing service. Why should I register?**
    We work directly with you, the billing service, enabling you to manage payments for your providers as you do today, but with tools to make your processes more efficient. Plus, you manage all of the payments and reports for providers all in one place, and enhance your offering to providers by enabling them to receive the payments faster.

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

☐ Seeking Resolution Of A Billing Determination

☐ Appeal of Medical Necessity / Utilization Management Decision

☐ Contract Dispute

☐ Request For Reimbursement Of Overpayment

☐ Other:

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

Contact Name (please print)	Title	( ) Phone Number
Signature	Date	( ) Fax Number

For Health Plan Use Only

TRACKING NUMBER

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

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

Page _____ of _____

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									

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):

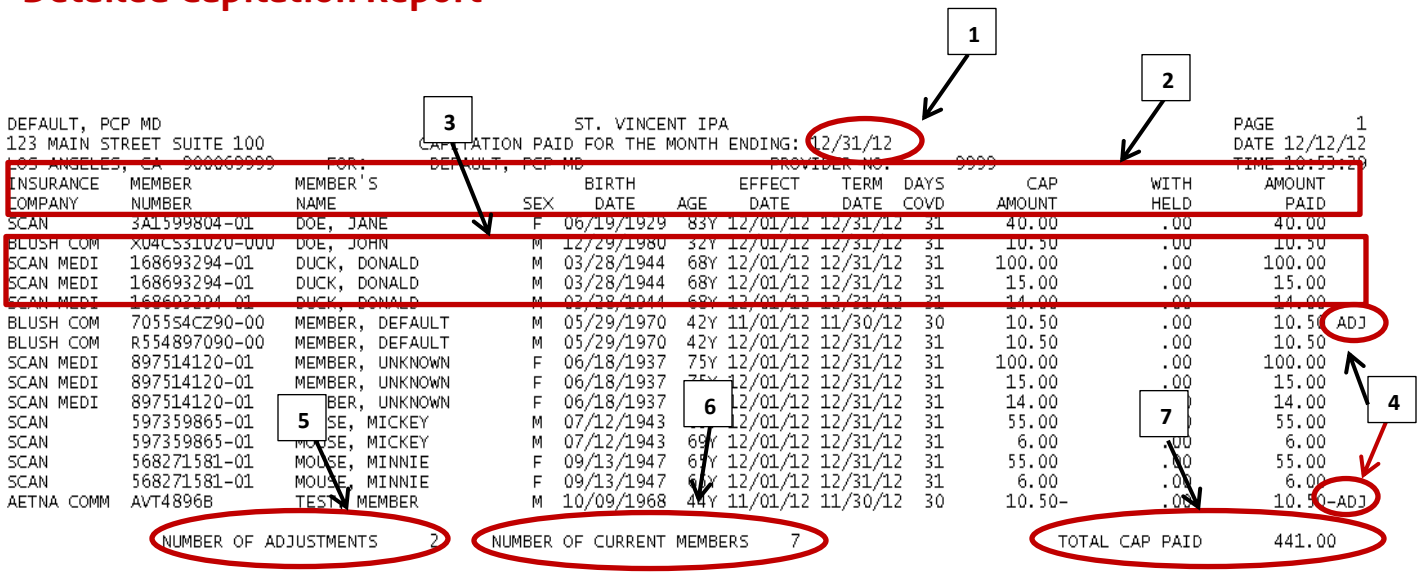
q. DATE OF ACTION:	r. ACTION TURNAROUND TIME (q – o):	s. TYPE OF ACTION (Upheld, Denied, Partially Upheld):

COMPLETE DESCRIPTION OF DETERMINATION RATIONALE:

CAPITATION REPORTS

How to Read Your Capitation Report

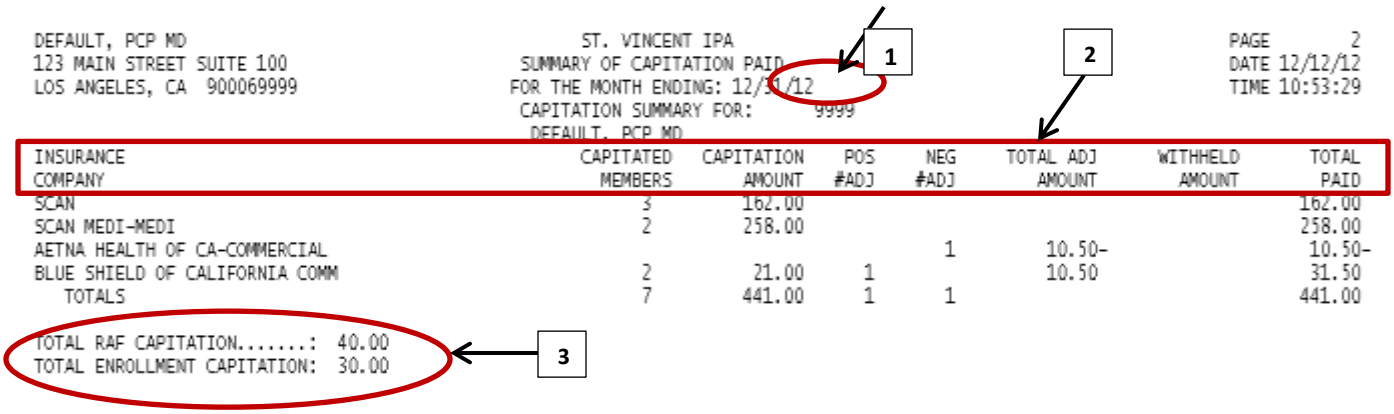
Detailed Capitation Report



1. **Capitation Paid for the Month Ending:** This date represents the last day of the month that capitation is being paid for.
2.
    a. **Insurance Company:** An abbreviation of the Health Plan Name that the member is assigned to.
    b. **Member Number:** The Health Plan assigned Member Number for the member.
    c. **Member's Name:** The name of the member.
    d. **Sex**: The sex of the member as noted by the Health Plan.
    e. **Birth Date**: The member's date of birth.
    f. **Age**: The current age of the member for the capitation month. If the value ends with a Y the number of years is being displayed. If the value ends in M the number of months is being displayed.
    g. **Effect Date & Term Date:** The first and last date of eligibility for which capitation is being paid.
    h. **Days Covd**: The number of days that the member was eligible for the applicable capitation month.
    i. **Cap Amount**: The amount of capitation that is being paid or deducted. Deductions will end with a "-".
    j. **With Held**: The amount of capitation being withheld.
    k. **Amount Paid:** The amount of capitation being paid.
3. If your contract includes multiple capitation programs, (RAF adjusted Capitation and/or Membership adjusted Capitation) there will be one record for each capitation program for each eligible member.
4. **Adj:** Any capitation adjustments (Retro Capitation) records include "ADJ". Adjustments are changes in the eligibility status of a member as notified by the Health Plan requiring an adjustment to capitation.
5. **Number of Adjustments:** The Total number of capitation adjustments for this month.
6. **Number of Current Members:** The total number of currently active members for this month.
7. **Total Cap Paid:** The total capitation being paid for the month.

How to Read Your Capitation Report

Summary Capitation Report



DEFAULT, PCP MD
123 MAIN STREET SUITE 100
LOS ANGELES, CA 900069999

ST. VINCENT IPA
SUMMARY OF CAPITATION PAID
FOR THE MONTH ENDING: 12/31/12
CAPITATION SUMMARY FOR: 9999
DEFAULT, PCP MD

PAGE 2
DATE 12/12/12
TIME 10:53:29

INSURANCE COMPANY	CAPITATED MEMBERS	CAPITATION AMOUNT	POS #ADJ	NEG #ADJ	TOTAL ADJ AMOUNT	WITHHELD AMOUNT	TOTAL PAID
SCAN	3	162.00					162.00
SCAN MEDI-MEDI	2	258.00					258.00
AETNA HEALTH OF CA-COMMERCIAL				1	10.50-		10.50-
BLUE SHIELD OF CALIFORNIA COMM	2	21.00	1		10.50		31.50
TOTALS	7	441.00	1	1			441.00

TOTAL RAF CAPITATION.....: 40.00
TOTAL ENROLLMENT CAPITATION: 30.00

1. **Capitation Paid for the Month Ending:** This date represents the last day of the month that capitation is being paid for.
2.
    a. **Insurance Company**: An abbreviation of the Health Plan Name.
    b. **Capitated Members:** The number of capitated members that are included in this month's capitation for the listed Insurance Company.
    c. **Capitation Amount:** The total capitation being paid for the listed Insurance Company, excluding any adjustments.
    d. **Pos #Adj:** The positive number of adjustments included in this month's capitation. For the listed Insurance Company.
    e. **Neg #Adj:** The negative number of adjustments included in this month's capitation, for the listed Insurance Company.
    f. **Total Adj Amount:** The total amount of capitation adjustments included in this month's capitation, for the listed Insurance Company.
    g. **Withheld Amount:** The total amount of capitation withheld from this month's capitation, for the listed Insurance Company.
    h. **Total Paid:** The total amount of capitation paid for the listed Insurance Company.
3.
    a. **Total RAF Capitation**: The total amount of capitation being paid as part of the RAF Adjusted Capitation Program.
    b. **Total Enrollment Capitation:** The total amount of capitation being paid as part of the Enrollment Adjusted Capitation program.

Capitation Research Request Form

Date: _____ **PCP**: _____
Contact: _____ **Phone**: _____ **Fax**: _____

The following members are effective with St. Vincent IPA per the health plan, but are not showing up on my capitation list. Please research and verify that the members are eligible for capitation payment.

Member Information: (Please print CLEARLY. All Information MUST be completed)

Member Name	Date of Birth	Health Plan	Member ID #	Months Cap Not Received
1.				
IPA USE ONLY:	**Effective Date:**		**Comments:**	
2.				
IPA USE ONLY:	**Effective Date:**		**Comments:**	
3.				
IPA USE ONLY:	**Effective Date:**		**Comments:**	
4.				
IPA USE ONLY:	**Effective Date:**		**Comments:**	
5.				
IPA USE ONLY:	**Effective Date:**		**Comments:**	
6.				
IPA USE ONLY:	**Effective Date:**		**Comments:**	
7.				
IPA USE ONLY:	**Effective Date:**		**Comments:**	
8.				
IPA USE ONLY:	**Effective Date:**		**Comments:**	
9.				
IPA USE ONLY:	**Effective Date:**		**Comments:**	
10.				
IPA USE ONLY:	**Effective Date:**		**Comments:**	

FAX REQUEST TO: (562) 924-1603 **ATTN:** PROVIDER RELATIONS
***Note:** Once eligibility has been verified, capitation will be paid retroactive from date of notification.

RISK ADJUSTMENT & QUALITY

Annual Visit (AV) Incentive Program

St. Vincent IPA has improved its Annual Visit (AV) Incentive Program to include a $200.00 incentive payment **for newly assigned Senior patients**. In order to qualify for the $200.00 incentive, the Annual Visit form must be completed and submitted within 90 days of the member joining your practice. For example, new member is assigned to PCP with an effective date of July 1, 2020. In order to qualify for the incentive, the completed assessment form must be returned by September 30, 2020.

The program has been improved to best reward your efforts to ensure your senior (Medicare Advantage and Medi-Medi) members receive their annual comprehensive health evaluation while enrolled with St Vincent IPA. Please be advised, as in previous years, incentive applies to AVs completed for your **Senior Membership** only.

Earn the below incentive amounts for completing acceptable Annual Visit Submissions:

Incentive Amount and Deadline	
If Annual Visit form is returned by July 31, 2020 and passes St Vincent IPA's quality review	**$200.00 per completed AV form submitted and eligible for incentive**
If Annual Visit form is returned by August 1-December 31, 2020 and passes St Vincent IPA's quality review	**$100.00 per completed AV form submitted and eligible for incentive.**
If the Annual Visit for, is returned within 90 days of new member(s) being assigned to PCP and passes St Vincent's IPA quality review	**$200.00 per completed AV form submitted and eligible for incentive.**
If Annual Visit form is returned after March 31, 2021 for **CY2020 dates of service.**	$0.00
For Newly Assigned Seniors	$200.00
*****All Risk Adjustable Codes in the body of the Annual Visit MUST have an assessment for the Risk Adjustable Code to considered acceptable by St Vincent's IPA.*****	

We are encouraging and recommend all providers complete as many AV Forms within the above timelines to earn maximum incentive in 2020.

St. Vincent IPA Network Representatives will be outreaching to you and your office staff within the next several weeks to review this program with you. Should you have any questions regarding this program or communication, please contact your Network Representative or the below departments:

Risk Adjustment Department	**Phone**: (562) 860-8771 x168 **Fax**: (562) 207-6508
Provider Relations Department	**Phone:** (562) 860-8771 x107 or x112 **Fax:** (562) 924-1603

Tips for Completing Your Annual Visit (AV) Form

Please follow these guidelines to help ensure that your AV forms are submitted as completely and accurately as possible:

- Send AV's to- Fax (562) 207-6508 or email riskadjustment@pdtrust.com

- Please complete the top section of the AV form, which includes the patient's height, weight, BMI, heart rate, blood pressure, date of last flu vaccine, date of last bone density test if known, patient's chief complaint, patient's history and present illness (HPI).

- Please check Yes/No for each medical condition listed on the AV Form.
  - If Yes is checked, please document the condition. All acute and chronic diagnoses must be fully documented with current status. If you prefer, you can also attach your progress notes.

- A treatment plan for each medical condition must be provided.

- Please assess the patient for the HCCs that appear on the HCC history and HCC suspect section of the form. The Yes/No box for each of these conditions must be checked, documentation, details and treatment plan must be included. Please note that if a Senior patient is new to St. Vincent IPA, the HCC history and/or HCC suspect information may not be available.

- Physician signature, physician credentials, and date of service must be included on each page.

- The AV Form must be complete and legible and only standard medical abbreviations may be used.

- Failure to provide any of the information noted above may result in your AV form being pended, which will affect the compensation received for the form.

When completing the depression section of the form, please include dates and results of PHQ-9 screening. If this section is not completed for a major depression diagnosis, the AV form will be pended for this information. The PHQ-9 does not have to be submitted with your AV form this year but must be maintained in the patient's medical chart.

PHYSICIANS DATA TRUST

Please Check IPA
⚐ GTC ⚐ St. Vincent ⚐ Noble

AV Incentive Payment is only payable upon accurate completion of Annual Visit form. Every field must be completed for incentive payment.

Height:	Weight:	★BMI:	HR:
★ BP Result ___/___/____mm hg			
Date of last Flu Vaccine ★ ___/___/___			Date of Last BDT (Bone Density Test) ___/___/___ Results:
Past Medical & Family History:			
Chief Compliant			

HEDIS STAR MEASURES

This will be Pre-Populated for our providers.

SNP Member: ☐ YES ☐ NO

Physical Examination

System	WNL	Abnormal	System	WNL	Abnormal
HEENT/Oral			Extremities/Pulses		
Neck			Respiratory		
Integumentary			Neurological		
Abdomen			Psychiatric		
Genitalia/Groin/Buttocks			Hematologic/Lymph		
Back			Musculoskeletal		

ReviewofSystems

The following section is to be used to provide a current assessment of the patient's active condition(s). Each diagnosis must show that it is being **M**onitored, **E**valuated and **A**ssessed. **T**reatment plan must be provided on the last page. If the form is not complete it will be returned.

×Yes × No	Cataracts	×RT ×LT or ×Both Eyes ×**Due to Diabetes** Surgery? ×Yes ×No (× RT × LT or × Both eyes)	×Active/Stable ×Progressive
×Yes ×No	Retinopathy	**Due to Diabetes**? × Yes × No Due to HTN? × Yes × No Date of last Dilated or Retinal Eye Exam ___/___/____ × Normal × Positive for Retinopathy Eye Provider Name: _____	×Active/Stable ×Uncontrolled
×Yes ×No	★ Glaucoma Document name of physician who performed glaucoma screen: _____ _____	× **Due to Diabetes**? × Yes × No All patients 65 years and older without a previous history of glaucoma should be screened. (Glaucoma Screen Reporting Requires Tonometry Results.) High-risk patients include: • Diabetes • Family history of glaucoma • African-American >50 years of age • Hispanic-American >65 years of age Screening Date: _____/_____/____ Screening performed by: Optometrist × Ophthalmologist ×	×Active/Stable ×Progressive
Cardiovascular		× Chest Pain × Dyspnea × Palpitation × Syncope × Previous MI × Diaphoresis ×Reynaud's × Claudication ×Cool Extremities × Cyanosis × Edema × Erythema × Pain in Extremities	
× Yes × No	Heart Failure	× CHF right or left ventricle failure × Left HF × Systolic HF × Diastolic HF ×Unspecified HF ×Combined Sysolic/Diastolic HF Last BNP Result: _____ Last Echo: _____Ejection Fraction %:_____ Exam Details	×Active/Stable ×Progressive ×Resolved
×Yes ×No	CAD/ASHD Old MI	×Effecting Native Vessel ×Affecting BP-Graft (type of graft) Exam Details: _____Date of Event: _____	×Active/Stable ×Resolved
×Yes ×No	Arrhythmia	Type: Date and Result of Last EKG: Pacemaker Y/N Reason:	×Active/Stable ×Uncontrolled ×Resolved
×Yes ×No	Sick Sinus Heart Block Angina	×Tachycardia-Bradycardia Type: Type: Exam Details:	×Active/Stable ×Acute ×Uncontrolled ×Resolved

Pre-Populated Member Information

Patient Name:		Member ID:		DOB:	
Provider Signature/ Credentials:		MD ⚐ DO ⚐ NP ⚐ PA ⚐		DOS:	___/___/___

PHYSICIANS DATA TRUST

Please Check IPA
⚐ GTC ⚐ St. Vincent ⚐ Noble

AV Incentive Payment is only payable upon accurate completion of Annual Visit form. Every field must be completed for incentive payment.

×Yes ×No	HTN	× Benign ×Malignant × Hypertensive Heart Disease ×with CHF/HF ×Hypertensive CKD × Hypertensive Heart & CKD _____ Date of LDL-C ___/___/_____ Results_____ Name of provider managing HTN: _____	×Active/Stable ×Uncontrolled
×Yes ×No	PAD/PVD	×**Due To Diabetes** or ×Due to Atherosclerosis or ×Both Diabetes & Atherosclerosis ×With Claudication ____ ×Pain at Rest ___ ×Ulcers & Location × Gangrene-Location ____ Other:_____ **Date and result of last ABI**:_____ Exam Details:	×Active/Stable ×Progressive
×Yes ×No	Amputation	Type and Location: _____ Exam Details:	×Healed ×Not Healed
×Yes ×No	DVT or PE	× Acute ×Chronic ×History of DVT/PE_____ ×Greenfield Filter Exam Details:	×Active/Stable ×Progressive
×Yes ×No	Aneurysm	Location:_____Size:_____ Last U/S:_____ Exam Details:	×Active ×Resolved
Respiratory		×Cough ×Dyspnea ×TB Exposure ×Hemoptysis × +PPD (Date:_____) ×Pleuritic Pain ×Snoring ×Frequent URIs ×Wheezing × Sputum Production (Color:_____Frequency:_____)	
×Yes ×No	Lung Disease	×COPD ×Emphysema ×Chronic Bronchitis ×Asthma ×Pulmonary HTN ×Fibrosis of Lung ×Smoker Cough Date of Last Spirometry : _____ FEV1% (FEV1/FVC): _____ Exam Details:	×Active/Stable ×Acute Exacerb ×End Stage
×Yes ×No	Chronic Resp. Failure/Hypoxia	×Oxygen Dependence ×Current Tracheotomy Status ×Reduce Size ×Hypoxic_____% Oxygen Oxygen Use: ×Yes ×No Exam Details:	×Active/Stable ×Progressive ×End Stage
Gastrointestinal		×Abdominal Mass ×Abdominal Pain ×Anorexia ×Hematemesis ×Hematochezia ×Constipation ×Diarrhea ×Dysphagia ×Jaundice ×Nausea×Enteral Feeding Tube ★ **Colonoscopy** × Yes × No Date:_____ Details: ★ **Sigmoidoscopy** × Yes × No Date:_____ Details: ★ **FOBT** × Yes × No Date:_____ Details:	
×Yes ×No	Cirrhosis	Etiology (if known): Exam Details:	×Active ×Resolved
×Yes ×No	End Stage Liver Disease	Etiology (if known): Exam Details:	×Active ×Resolved
×Yes ×No	Hepatitis	Type: ×A ×B ×C ×Alcoholic ×Drug Induced ×Autoimmune ×Acute ×Chronic	×Active/Stable ×Progressive
×Yes ×No	Pancreatic Disease	×HX of Pancreas Transplant ×Chronic Pancreatitis Exam Details:	×Active ×Resolved
×Yes ×No	IBS	Type: ×Ulcerative Colitis ×Crohn's Exam Details:	×Active/Stable ×Resolved
×Yes ×No	CKD	Type: × 1 × 2 × 3 × 4 × 5 × End Stage × Unknown **Due to Diabetes**? ×Yes ×No On Chronic Dialysis? ×Yes ×No Kidney Transplant? ×Yes ×No (If yes, which Kidney: × RT × LT) **ate and result of last eGFR**: _____	×Active/Stable ×Progressive ×Resolved
Musculoskeletal		×Ambulation/Gait Changes ×Back Pain ×Myalgias ×Join/bone Symptom ×Rheumatologic Manifestations	

HEDIS STAR MEASURES

Pre-Populated Member Information

Patient Name:		Member ID:		DOB:	
Provider Signature/ Credentials:		MD ⚐ DO ⚐ NP ⚐ PA ⚐		DOS:	___/___/___

PHYSICIANS DATA TRUST

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×Yes ×No	Arthritis	Has patient been prescribed drugs to prevent Osteoporosis? Y_N___ Name(s) of Bisphosphonate or Hormone Meds Prescribed: _____ _____ ×Osteoarthritis ×Rheumatoid Arthritis Other:_____ Has patient been prescribed Anti Rheumatic Drug? Y_N___ Name(s) of DMARD prescribed: _____	×Active/Stable ×Uncontrolled ×Resolved
Skin/Breast		Skin: ×Rash ×Skin Lesion ×Nail Changes ×Hair Loss Breast: ×Nipple Discharge ×Breast Lumps ×Breast Pain	
×Yes ×No	Skin Ulcer	Type and Location:_____ If Pressure Ulcer: Stage:_____ ×Gangrene Y× N× Exam Details:	×Active/Stable ×Progressive ×Resolved
Women Only	Breast Cancer Screening	Date of last Mamogram: ___/____/_____ Exam Details:	×Active/Stable ×Progressive ×Resolved
Neurology		×Aphasia ×Dysarthia ×Focal Weakness ×Gait Disturbance ×Headache ×Incoordination ×Progressed Cognitive Impairment ×Incontinence ×Involuntary Movement ×Lightheadedness/Dizziness ×Loss of Consciousness ×Paresthesias ×Seizures ×Tingling to Extremities ×Tremors ×Vertigo ×Numbness, weakness	
×Yes ×No	Seizures Multiple Sclerosis	Exam Details: Exam Details:	×Active/Stable ×Progressive ×Resolved
×Yes ×No	Parkinsons's Disease	Exam Details :	×Active/Stable ×Acute Exacerb
×Yes ×No	Neuropathy	**Due to Diabetes**? ×Yes ×No ×Date of last monofilament with result: Location & Etiology: Exam Details:	×Active/Stable ×Resolved
×Yes ×No	Dementia	Type: ×Alzheimer's ×Vascular ×Senile ×Last MMSE results if known: ×Agitation _Delirium × Depressed Mood Exam Details:	×Early Stage ×Middle Stage ×End Stage
Psychology		×Anger ×Anxiety ×Delusions ×Depression ×Euphoria ×Fearfulness ×Irritability ×Obsession ×Paranoia ×Psychotic Behavior ×Sleep Disturbance ×Suicidal Ideations ×Memory Loss ×Social Withdraw ×History of Antipsychotic Drug Use ×Mood Change ×Impulsive Behavior ×Impaired Abstract ×Personality Change	
×Yes ×No	Major Depression	Type: ×Mild ×Moderate ×Severe ×Partial ×Full Remission ×Single or ×Recurrent **Date & Results of PHQ9 Screening (must support diagnosis)** Exam Details:	×Active/Stable ×Progressive ×Resolved
×Yes ×No ×Yes ×No	Bipolar Disorder Schizophrenia	Type: ×Mild ×Moderate ×Severe ×Partial ×Full Remission ×Single or ×Recurrent Exam Details:	×Active/Stable ×Resolved

Pre-Populated Member Information

Patient Name:		Member ID:		DOB:	
Provider Signature/ Credentials:		MD ⚐ DO ⚐ NP ⚐ PA ⚐		DOS:	___/___/___

Date / Time Printed

PHYSICIANS DATA TRUST

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×Yes ×No	Drug/Alcohol	Addiction: _____Type:_____Frequency_____Date Quit: ×History Exam Details:	×Active ×Resolved
Endocrinology		×ABNL Habitus ×Goiter ×ABNL GTT ×Gynecomastia ×Underweight ×Generalized Weakness ×Hypoglycemia ×Polydypsia ×Polyphagia ×Polyuria ×Tremors ×Morbid Obesity × Other_____	
×Yes ×No	Protein Calorie Mal-Nutrition	× Weight Loss × Wasting × Malnourished × Supplements Exam Details:	×Active/Stable ×Progressive ×Resolved
×Yes ×No	★ Diabetes	Type: ×1 ×2 ×Currently taking insulin **Complications:** ×Gangrene in DM ×Retinopathy in DM ×ED in DM ×Chronic Skin Ulcer in DM Fingerstick blood sugar range (low to high) for past month: Date and Result of last HgbA1c: Date and result of last Microalbuminura: Exam Details:	×Active/Stable ×Controlled ×Uncontrolled
Hem/Onc			
×Yes ×No	Anemia	Type: _____In Neoplastic Disease: ×Yes ×No Date of Last CBC: _____Hgb_____HCT_____PLTS_____ Exam Details:	×Active/Stable ×Progressive ×Resolved
×Yes ×No	Neoplasm's	Site:_____ × Chemotherapy × Radiation Type:_____ Exam Details:	×Active/Stable ×Progressive ×Resolved
×Yes ×No	Metastatic	×Yes ×No Site:_____ × Chemotherapy × Radiation Exam Details:	×Active/Stable ×Progressive ×Resolved

Pre-Populated Member Information

Patient Name:		Member ID:		DOB:	
Provider Signature/ Credentials:		MD ⚐ DO ⚐ NP ⚐ PA ⚐		DOS:	___/___/___

PHYSICIANS DATA TRUST

Please Check IPA
☐ GTC ☐ St. Vincent ☐ Noble

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★ Care for Older Adults (COA) Assessment – *For SNP Members Only*

Please see page 1 (box highlighted in RED with Yellow STAR ★ next to it) If marked yes, please fill out this page.

☐ YES ☐ NO

(Patient was advised of their need to have an Advance Directive in place.) ☐

Medication Reconcilliation – CPT Codes: 90862, 99605, 99606 Category II Codes: 1159F, 1160F

NAME OF MEDICATION	PRESCRIPTION	O-T-C	DOSAGE
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Current Level of Function *(Compare to initial assessment.)* **Category II Codes: 1170F**

ADL	☐ INDEPENDENT ☐ MINIMAL ASSISTANCE ☐ NEEDS ASSISTANCE ☐ TOTAL ASSIST
MOBILITY	☐ CONTROLS/MOVES ALL LIMBS AT WILL AND SAFELY INDEPENDENT ☐CONTROLS/MOVES ALL LIMBS WITH MIN. ASSISTANCE ☐ REQUIRES 2 PERSONS FOR XFER ☐ UNABLE TO POSITION CHANGE/MECHANICAL LIFT XFER
BALANCE	☐ NORMAL ☐ MIN. ASSISTANCE WITH BALANCE ☐UNSAFE BALANCE AND NEEDS MODERATE ASSISTANCE ☐ MAXIMUM ASSISTANCE NEEDED WITH 1-2 PERSONS
MENTAL STATUS	☐ ORIENTED x3 ☐ ORIENTED x2 – FOLLOWS SIMPLE COMMANDS ☐ ORIENTED x1 – INCONSISTENLY RESTLESS, AGITATED OR NERVOUS ☐ UNRESPONSIVE TO VERBAL COMMANDS
COMMUNICATIONS	☐ IMPROVED ☐ DECLINED ☐ UNCHANGED

Pain Assessment – Category II Codes: 0521F, 1125F, 1125F

Location:	**Intensity:** On a scale of 0 to 10, with 0 being no at all and 10 being the worst pain you can imagine, how much does it hurt right now? 0-------1------2-------3-------4-------5-------6-------7-------8-------9-------10 *No Pain* *Moderate Pain* *Worst Pain Possible*
IS PAIN CONSTANT? ☐ YES ☐ NO	TYPE OF PAIN (Example: ache, deep, sharp, hot, cold, dull, like sensitive skin)
ONSET, DURATION, VARIATIONS	WHAT RELIEVES PAIN?
OTHER COMMENTS:	

Pre-Populated Member Information

Patient Name:		Member ID:		DOB:	
Provider Signature/ Credentials:		MD ☐ DO ☐ NP ☐ PA ☐		DOS:	/ /

Date / Time Printed

PHYSICIANS DATA TRUST

Please Check IPA
⚐ GTC ⚐ St. Vincent ⚐ Noble

AV Incentive Payment is only payable upon accurate completion of Annual Visit form. Every field must be completed for incentive payment.

The following information is required for each diagnosis on the Annual Visit Form

Add any additional diagnosis not mentioned in the "Assessment Plan" on the next page here.

	Diagnosis Description	Status of Diagnosis	Plan Of Care
Diagnosis #1		×Active/Stable ×Acute ×Declining × END Stage ×Resolved	Plan of Care:
ICD-9 #1			Current RX:
Diagnosis #2		×Active/Stable ×Acute ×Declining × END Stage ×Resolved	Plan of Care:
ICD-9 #2			Current RX:
Diagnosis #3		×Active/Stable ×Acute ×Declining × END Stage ×Resolved	Plan of Care:
ICD-9 #3			Current RX:
Diagnosis #4		×Active/Stable ×Acute ×Declining × END Stage ×Resolved	Plan of Care:
ICD-9 #4			Current RX:
Diagnosis #5		×Active/Stable ×Acute ×Declining × END Stage ×Resolved	Plan of Care:
ICD-9 #5			Current RX:
Diagnosis #6		×Active/Stable ×Acute ×Declining × END Stage ×Resolved	Plan of Care:
ICD-9 #6			Current RX:
Diagnosis #7		×Active/Stable ×Acute ×Declining × END Stage ×Resolved	Plan of Care:
ICD-9 #7			Current RX:
Diagnosis #8		×Active/Stable ×Acute ×Declining × END Stage ×Resolved	Plan of Care:
ICD-9 #8			Current RX:
Diagnosis #9		×Active/Stable ×Acute ×Declining × END Stage ×Resolved	Plan of Care:
ICD-9 #9			Current RX:
Diagnosis #10		×Active/Stable ×Acute ×Declining × END Stage ×Resolved	Plan of Care:
ICD-9 #10			Current RX:
Health Maintenance:			
Referrals:			
New RX in the last 180 days			

Pre-Populated Member Information

Patient Name:		Member ID:		DOB:	
Provider Signature/ Credentials:		MD ⚐ DO ⚐ NP ⚐ PA ⚐		DOS:	___/___/___

PHYSICIANS DATA TRUST

Please Check IPA
⚐ GTC ⚐ St. Vincent ⚐ Noble

AV Incentive Payment is only payable upon accurate completion of Annual Visit form. Every field must be completed for incentive payment.

AssessmentPlan

Home Address

Carrier Eligibility

Please ensure there is an **assessment check box marked** and **plan** for every diagnosis. This is a **requirement** for the AV to be considered complete for incentive payment.

Fax:

Check only one (1) box per diagnosis. More than 1 box checked will be considered not complete and will delay payment.

DX Code	Description	Assessment				
296.21	MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, MILD DEGREE	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
296.22	MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, MODERATE DEGREE	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
						by PCP
	Plan:					
412	OLD MYOCARDIAL INFARCTION	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
413.9	OTHER AND UNSPECIFIED ANGINA PECTORIS	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
427.31	ATRIAL FIBRILLATION	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
496	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHERE CLASSIFIED	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
585.4	CHRONIC KIDNEY DISEASE, STAGE IV (SEVERE)	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					

Each diagnosis not Resolved, MUST have a plan of care written out and must be legible for treatment of the above diagnosis. No plan of care written out will be considered not complete and will delay payment.

If you cannot validate this diagnosis please mark the box labeled "DX not followed by PCP"

Patient Name:		Member ID:		DOB:	
Provider Signature/ Credentials:		MD ⚐ DO ⚐ NP ⚐ PA ⚐		DOS:	/ /

PHYSICIANS DATA TRUST

Please Check IPA

☐ GTC ☐ St. Vincent ☐ Noble

AV Incentive Payment is only payable upon accurate completion of Annual Visit form. Every field must be completed for incentive payment.

Suspected Conditions

Please confirm or deny if condition is applicable and notate under the New Diagnosis and Treatment Plan below

Suspected conditions are based on historical data

Each valid, active diagnosis **MUST** have a Plan of Care written out and be legible

DX Code	Description	Assessment				
	Member with Rheumatoid Arthritis & Inflammatory Connective Disease Recaptured	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
	Member with Heart Arrhythmias and not Recaptured	Stable	Resolved	Worsening	Improving	DX not followed
	Plan:					
	496 - Member with COPD and not Reaptured	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
	Member with Inflammatory Bowel Disease and not Recaptured	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
	250.7x - Diabetic Member coded with CAD or Atherosclerosis and not coded with Peripheral Vascular Complications	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
	Member with history of MI or angina and not coded with Vascular Disease	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
	Member with Coronary Atherosclerosis and not coded with Angina	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
	250.4x - Diabetic Member not coded with Renal Complications	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
	250.4x - Diabetic Member presents renal complications	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
	250.8x - Diabetic Member not coded with other Specified Manifestations	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
	Member with COPD and prescribed home oxygen and not coded for Chronic Respiratory Failure	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
	Member coded with depression NOS, anxiety disorder, generalized anxiety disorder or panic attacks and not coded with Major Depressive Disorder	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					

Patient Name:		Member ID:		DOB:	
Provider Signature/ Credentials:		MD ☐ DO ☐ NP ☐ PA ☐		DOS:	/ /

★ Care for Older Adults (COA) Assessment – *For SNP Members Only*

Click here to enter text.
Member Name

Click here to enter text.
DOB

DOES PATIENT HAVE AN ADVANCE DIRECTIVE? ☐ YES ☐ NO
(*If No, check box to indicate that patient has been advised of their need to have an Advance Directive in place.)* ☐

Medication Reconciliation – CPT Codes: 90862, 99605, 99606 Category II Codes: 1159F, 1160F

NAME OF MEDICATION	PRESCRIPTION	O-T-C	DOSAGE
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Current Level of Function *(Compare to initial assessment.)* **Category II Codes: 1170F**

ADL	☐ INDEPENDENT ☐ MINIMAL ASSISTANCE ☐ NEEDS ASSISTANCE ☐ TOTAL ASSIST
MOBILITY	☐ CONTROLS/MOVES ALL LIMBS AT WILL AND SAFELY INDEPENDENT ☐CONTROLS/MOVES ALL LIMBS WITH MIN. ASSISTANCE ☐ REQUIRES 2 PERSONS FOR XFER ☐ UNABLE TO POSITION CHANGE/MECHANICAL LIFT XFER
BALANCE	☐ NORMAL ☐ MIN. ASSISTANCE WITH BALANCE ☐UNSAFE BALANCE AND NEEDS MODERATE ASSISTANCE ☐ MAXIMUM ASSISTANCE NEEDED WITH 1-2 PERSONS
MENTAL STATUS	☐ ORIENTED x3 ☐ ORIENTED x2 – FOLLOWS SIMPLE COMMANDS ☐ ORIENTED x1 – INCONSISTENLY RESTLESS, AGITATED OR NERVOUS ☐ UNRESPONSIVE TO VERBAL COMMANDS
COMMUNICATIONS	☐ IMPROVED ☐ DECLINED ☐ UNCHANGED

Pain Assessment – Category II Codes: 0521F, 1125F, 1125F

Location:	**Intensity:** On a scale of 0 to 10, with 0 being no at all and 10 being the worst pain you can imagine, how much does it hurt right now? Results : 1-10- with 0 = No Pain, 5 = Moderate Pain, 10 = Worst Pain Pain Result: Choose an item.
IS PAIN CONSTANT? ☐ YES ☐ NO	TYPE OF PAIN (Example: ache, deep, sharp, hot, cold, dull, like sensitive skin)
ONSET, DURATION, VARIATIONS	WHAT RELIEVES PAIN?
OTHER COMMENTS:	

Provider Signature/ Credentials:		☒ MD ☐ DO ☒ NP ☐ PA	Click here to enter a date.

Encounter Data

Encounter data is information submitted by health care providers, such as doctors and hospitals, that documents both the clinical conditions they diagnose as well as the services and items delivered to beneficiaries to treat these conditions.

Contracted PPGs, Specialty Plans, Vendors, Hospitals and LTSS Providers are responsible for gathering, processing, and submitting Encounter Data for the services provided to all health plans. Encounter Data is the primary source of information about the delivery of services provided by healthcare or atypical providers to L.A. Care Members.

Why is encounter data important?

Complete, accurate and timely Encounter Data is key for determining needed changes and improvements in health related programs. Health plans also uses Encounter Data for monitoring and oversight functions including HEDIS reporting, Capitation Rate development, and for meeting various regulatory requirements.

This data helps establish and the following as it relates to rates, access and important trends.

- Accountability: utilization, access, and quality analysis.
- Rate setting and risk adjustment.
- Studies of small, high-policy-interest populations.
- Community-wide studies.
- Other research and evaluation studies.

To use Office Ally, PPGs and Hospitals are required to:

- Submit Encounter Data to Office Ally within the parameters required by TransUnion Healthcare.
- Submit Encounter Data to Office Ally no more than sixty (60) calendar days after the end date of service in which the encounter occurred to ensure routine.

Please fax Encounters to (562) 207-6508 or email Quality@pdtrust.com

Medical Data Exchange (MDX)

MDX- Medical Data Exchange is the application we use to electronically transfer health related data among medical facilities, health information organizations -- companies that oversee and govern the exchange of this data -- and government agencies according to national standards.

In order to obtain your Annual Visit (AV) forms from **Medical Data Exchange (MDX),** to participate in St. Vincent IPA's AV Program, we require provider signature on the User Agreement.

Please fax your signed User Agreement to Fax # (562) 924-1603

Submitting your User Agreement is the first step toward participating in St. Vincent IPA's AV Program and we want to ensure you have all the tools you need to maximize incentive earnings.

Upon receipt of provider's signed User Agreement, you can expect to receive your login within 24-48 hours via fax with instructions on accessing and completing your AV forms. Over the next several weeks St. Vincent IPA's Network Development Representatives will be scheduling times to train with you and your staff in your offices.

Should you have any questions regarding this transition or communication, please contact your assigned Network Development Representative.

- You may also contact Provider Relations with any questions regarding this communication at **(562) 860-8771, ext 107 or 112** or by email: Prsvipa@pdtrust.com

- For any questions regarding MDX or completing your AVs, please contact St. Vincent IPA Risk Adjustment at **(562) 860-8771, ext 168** or by email: GRuiz@pdtrust.com.

Medical Data Exchange (MDX) User Agreement

I acknowledge that I will have access to certain of confidential or proprietary information and trade secrets of Cyber-Pro Systems, Inc., doing business as Medical Data Exchange ("MDX"). MDX has licensed the use of its HCC Manager product to Physician Data Trust ("Customer"). I will keep confidential and not directly or indirectly divulge, furnish, make accessible to anyone, or appropriate for my own use or the use of any other person or organization any Confidential Data (as hereinafter defined). I acknowledge and agree that MDX has a legitimate interest in protecting its Confidential Data from misappropriation or diversion by its competitors. For purposes of this Agreement, the term "Confidential Data" shall mean any data or information that is owned by, or that has at the time of determination of its status, been used by MDX or any of its affiliates relating to its business and is not generally known to competitors of MDX or its affiliates including, but not limited to (a) any scientific or technical information, design, process, procedure, formula or improvement, or any portion or phase thereof, whether or not patentable, (b) information concerning products, software, applications, services, marketing processes, market feasibility studies, and proposed or existing marketing techniques or plans relating to its or any of its affiliates' business that are not generally known to competitors and (c) the identity of a party's or any of its affiliates' suppliers, advertisers, sales methodology, and personnel information. Each party understands that the other party claims that its Confidential Data (a) contains confidential or proprietary information or trade secrets, (b) was developed at considerable expense and retains tangible value, (c) remains the property of the disclosing party and shall be returned upon request and (d) is disclosed solely to facilitate other agreements for the benefit of both parties. I will not, and will not permit anyone else, to (a) reproduce, modify, decompile, disassemble or reverse engineer in any manner any Confidential Data, (b) disclose any Confidential Data to anyone, except for authorized employees and contractors of Customer who reasonably need to know it and agree to maintain the confidentiality of the Confidential Data substantially in the form of this User Agreement and (c) use the Confidential Data for any purpose detrimental to MDX.

As used in this Agreement, the term "affiliate" shall mean any person or entity that directly, or indirectly, through one or more intermediaries, is controlled by the party.

User Signature: _____

Name and Title (Please Print): _____

Name of Medical Organization: _____

User ID: _____ (to be assigned by MDX)

Medical Data Exchange (MDX) Login Information

How to log into MDX

1. Type https://axis.mdxnet.com/Login.aspx into your Internet Browser

2. Enter account ID 119
3. Enter you User Name
4. Enter your Password
5. Click “Login” Button

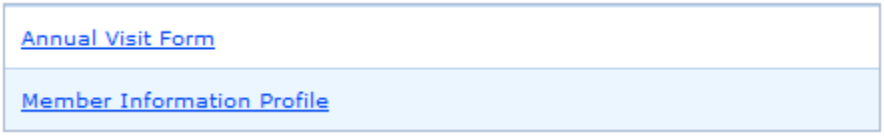
How to print your memberships MDX forms

AV Form or Member Information Form

1. Type in your members’ last name, member ID OR Date of Birth and click the “Search” button in the Search Criteria section.

For example:

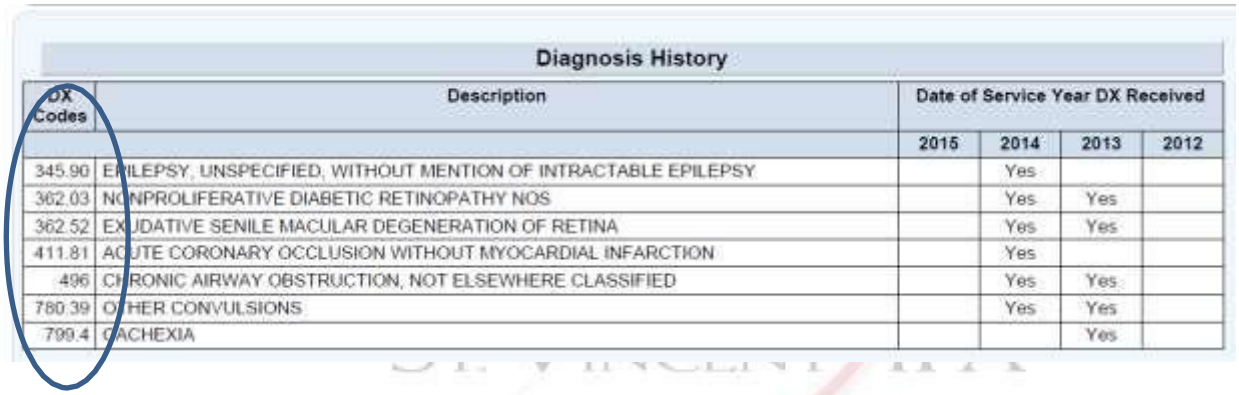
2. Make a selection from the above list by clicking on the member(s) you want to generate forms for.
3. You are given the default option to view 10 members per page. If you would like to view more membership, simply click on the drop down menu at the bottom right of your Portal labeled “Results per Page” to choose a different amount of membership to view per page.
4. You can select multiple members by holding down the “CTRL” button and clicking on the members you would like to select.
5. Once you have selected your member(s) click on the “Annual Visit Form” button on the bottom left of your Portal Page to view or print the members Annual Visit Form. If you would like to view the Member Information Profile, click on “Member Information Profile.”



6. A "File Download" box will pop up, click on the "Open" button to access your forms. If you would like to save your forms, click the "Save" button and choose the destination you would like to save your forms to.

EMR Instructions

If your office uses Electronic Medical Records (EMR) you do not need to print up an Annual Visit Form to submit. Simply print up the Member Information Profile and submit it with your Electronic Medical Record (EMR). In order for the EMR to be payable all chronic conditions on the Member Information Profile must be assessed in your EMR. See example below:



Diagnosis History

DX Codes	Description	Date of Service Year DX Received			
		2015	2014	2013	2012
345.90	EPILEPSY, UNSPECIFIED, WITHOUT MENTION OF INTRACTABLE EPILEPSY		Yes		
362.03	NONPROLIFERATIVE DIABETIC RETINOPATHY NOS		Yes	Yes	
362.52	EXUDATIVE SENILE MACULAR DEGENERATION OF RETINA		Yes	Yes	
411.81	ACUTE CORONARY OCCLUSION WITHOUT MYOCARDIAL INFARCTION		Yes		
496	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHERE CLASSIFIED		Yes	Yes	
780.39	OTHER CONVULSIONS		Yes	Yes	
799.4	CACHEXIA			Yes	

IE Compatibility

For versions 10 and 11 in Internet Explorer, you will need to add the MDX website in Compatibility View Settings. To do so, please follow these instructions:

1. Open Internet Explorer
2. At the toolbar, click the "Tools" tab and click "Compatibility View Settings"
3. The Compatibility View Settings screen displays.
4. In the section that says "Add this website:" type in mdxnet.com and click "Add."
5. Mdxnet.com should move down to the section that says "Websites you've added to Compatibility View:"
6. Make sure the "Display all websites in Compatibility View" is checked and click "Close"
7. Before clicking "Close" your screen should look like the following:

Please print AV forms as needed

Please print all AV forms within one week of intended use. MDX was designed to be used as an up-to-date system. If an AV form is printed and is not used we could be missing vital information pertinent to the members overall health. MDX is updated weekly with new claims and RX data. If new data becomes available and the form was printed too far in advance, we will be missing information we could have captured if the AV form was printed within a week.

AV Form Diagnoses that populate on the MDX form

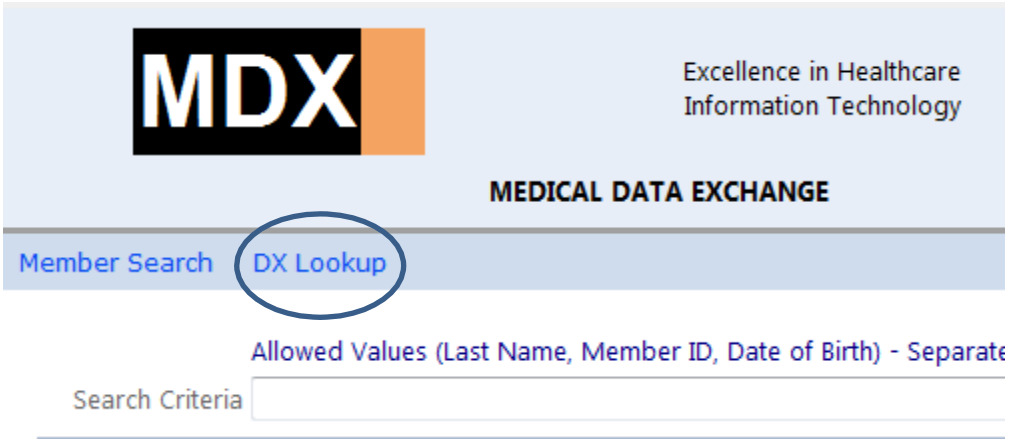
MDX is designed to pull information that populates on our current AV form from current and historical data from 2012 to current. For example, if a member was diagnosed with Congestive Heart Failure in 2012, it will pre-populate on the Diagnosis History portion of the AV form. This allows the provider to assess this condition. Suspected conditions are populated by algorithms using the historical diagnosis codes as well as medication history. For example if a member is on an ACE/ARB but does not have a diagnosis of diabetes, a suspect of diabetes will now be pre-populated under suspected conditions.

How to search for multiple members

You can search for multiple members in MDX. In the "Search Criteria" of the Provider Portal you can type in several members' last name, Member ID or Date-of Birth separated by a semicolon with **NO** space between the semicolon and next search item. Once you have all the members typed in and you are ready to search, simply click on the "Search" button to the right of the "Search Criteria." If you would like to sort these members using the header options just simply click on the header you would like the list to be sorted by:

MDX ICD-10 Look-Up:

MDX also has a great feature that allows you to crosswalk the current ICD-9 code into the ICD-10 code. On your MDX Provider Portal you will see a tab "DX Lookup"



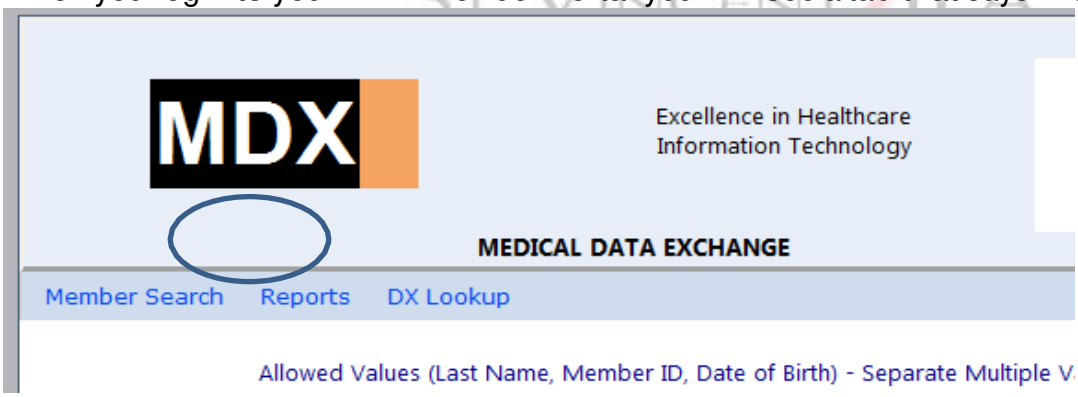
A “DX Code Lookup” box will appear. Type in the ICD-10 code in the DX Code section and click “Search”

The next box will give you the diagnosis description and the ICD-10 Equivalent code.

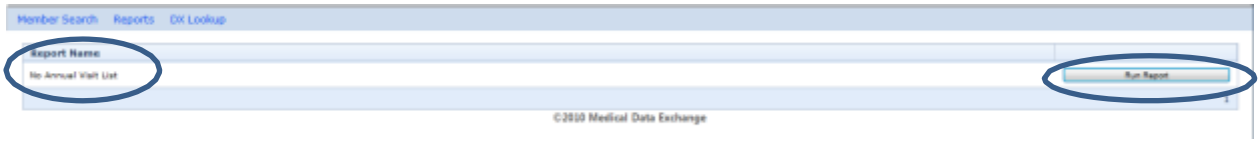
No AV Report

MDX allows providers to check outstanding Annual Visits that still need to be submitted to St Vincent’s IPA.

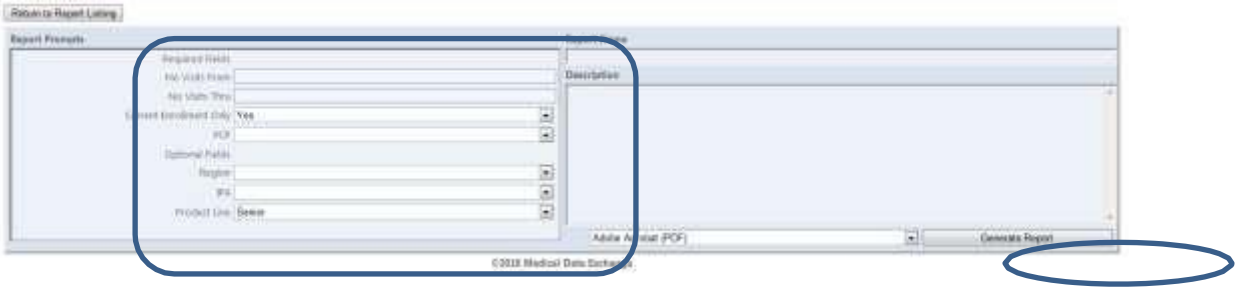
When you log into your MDX Provider Portal you will see a tab that says “Reports”:



Once you click on “Reports” you will see the following screen



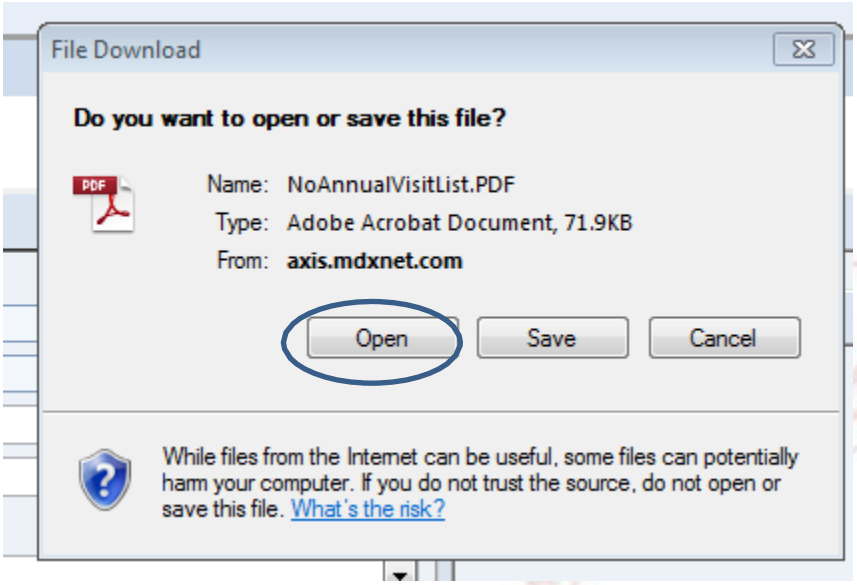
Click on the button that says “Run Report.” You will see the following screen.



Fill in all required fields.

1. Please use the current calendar year to run the report.
2. Make sure current year is entered. We suggest 01/01/20xx to 12/31/20xx
3. Please leave current enrollment set to "Yes." If you change it to "No" you will receive terminated members populating on your No AV report.
4. Region will be Physician's DataTrust

Once all required fields are entered click the "Generate Report" button to your right. You will see the following screen or something similar asking you if it is OK to open the report on your computer. Click "OPEN"



This will give you all AV's that still need to be submitted to the IPA. Please remember that if you have members on your "AV Pend Report," they will still populate on your No AV Form. Also, remember that there is about a 3-4 week delay from when you submit your AV to when the member will be removed from this report.

Please fax in all completed AV forms to:
(562) 207-6512

Or mail them to:
Physician DataTrust
Attn: Risk Adjustment Dept.
161 Thunder Dr., Suite 212
Vista, CA 92083

If you have any questions, please contact the Provider Relations department
(562) 860-8771, Ext 112.

Medicare Risk Adjustment Factor (RAF)

The purpose for the Centers for Medicare and Medicaid Services (CMS) to conduct Risk Adjustment Factors is to pay plans for the risk of the beneficiaries they enroll, instead of calculating an average amount of Medicare/Medicare Advantage beneficiaries. By doing so, CMS is able to make appropriate and accurate payments for enrollees with differences in expected costs. Lastly, the risk adjustment allows CMS to use standardized bids as base payments to plans.

CMS risk adjusts certain plan payments, such as Part C payments made to Medicare Advantage (MA) plans and Program for All Inclusive Care for The Elderly (PACE) organizations, and Part D payments made to Part D sponsors, including Medicare Advantage-Prescription Drug plans (MA-PDs) and standalone Prescription Drug Plans (PDPs).

Below is a high-level checklist of plan requirements with detailed information regarding risk adjustment data collection, submission, reporting, and validation:

- "Ensure the accuracy and integrity of risk adjustment data submitted to CMS. All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit.
- Implement procedures to ensure that diagnoses are from acceptable data source. The only acceptable data sources are hospital inpatient facilities, hospital outpatient facilities, and physicians.
- Submit the required data elements from acceptable data sources according to the coding guidelines.
- Submit all required diagnoses codes for each beneficiary and submit unique diagnoses once during the risk adjustment data-reporting period. Submitters must filter diagnosis data to eliminate the submission of duplicate diagnosis clutters.
- The plan sponsor determines that any diagnosis codes have been erroneously submitted, the plan sponsor is responsible for deleting the submitted diagnosis codes as soon as possible.
- Receive and reconcile CMS Risk Adjustment Reports in a timely manner. Plan sponsors must track their submission and deletion of diagnosis codes on an ongoing basis.
- Once CMS calculates the final risk scores for a payment year, plan sponsors can only request a recalculation of payment upon discovering the submission of erroneous diagnosis codes that CMS used to calculate a final risk score for a previous payment year and that had a material impact on the final payment. Plan sponsors must inform CMS immediately upon such a finding."

Reference:
http://www.hfni.com/assets/forms/Medicare%20Managed%20Care%20Manual%20%28Risk%20Adjustment%29.pdf

HEDIS

Healthcare Effectiveness Data and Information Set (HEDIS) is a standardized set of performance measurements developed by the National Committee for Quality Assurance (NCQA) to evaluate consumer health care.

Providing the correct code via encounter data keeps the Health Plans and Medical Groups out of your office.

P4P

P4P (Pay for Performance) is a means of attaching financial incentives to clinical care objectives. Using measurable metrics, a percentage of physician compensation can be tied to achieving specific clinical standards in the care they provide.

These measures are related to commercial/senior members.

CMS

CMS (Center for Medicare and Medicaid Services) rates Medicare Advantage plans on combination of measures that are captured through member surveys, HEDIS data and administrative data.

CMS uses a method in which they score each measure category by "weight". The higher the weight of the measure the more impact that measure will have on the overall star score. For example: Breast Cancer Screening is weighted a (1) and Diabetes Care is weighted a (3). So, Diabetes Care will have 3 times the impact of the overall star score.

These measures are related to senior members only.

5 Star Measures

The Centers for Medicare & Medicaid Services (CMS) uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the health care system. This rating system applies to all Medicare Advantage (MA) lines of business: Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO). It also applies to Medicare Advantage plans that cover both health services and prescription drugs (MA-PD).

The program **is a key component in financing health care benefits for MA and MA-PD plan enrollees**

Special Needs Plan (SNP)

Medicare SNPs are a type of Medicare Advantage Plan (like an HMO or PPO). Medicare SNPs limit membership to people with specific diseases or characteristics. Medicare SNPs tailor their benefits, provider choices, and drug formularies to best meet the specific needs of the groups they serve.

HEDIS Coding Tip Sheet

ST. VINCENT IPA
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CPT Category II codes are used for tracking data collection for the purposes of performance measurement. These codes are developed by the Performance Measures Advisory Group (PMAG). Using CPT II codes can ease the burden of chart review for HEDIS measures. These codes describe clinical components and are not associated with a billable amount, therefore, when used should be billed with a $0.01 charge amount.

CPT Category II Codes—By Measure

HEDIS Measure	CPT II Code	Description
Adult BMI	3008F	BMI Documented *See below for dx codes*
Care of Older Adults	1157F	Advance care plan (document) present in medical records
	1158F	Advance care planning discussion documented in records
	1170F	Function status assessed
	0521F	Plan of care to address pain documented
	1125F	Pain severity quantified, pain present
	1126F	Pain severity quantified, no pain present
	1159F	Medication list documented in medical record
	1160F	Review of all meds by prescriber documented in record
Cholesterol Mgmt.	3048F	Most recent LDL-C <100 mg/dL
	3049F	Most recent LDL-C 100-129 mg/dL
	3050F	Most recent LDL-C >=130 mg/dL
Controlling Blood Pressure	3074F	Most recent systolic blood pressure <130 mmHg
	3075F	Most recent systolic blood pressure 130-139 mm Hg
	3077F	Most recent systolic blood pressure >=140 mm Hg
	3078F	Most recent diastolic blood pressure <80 mm Hg
	3079F	Most recent diastolic blood pressure 80-89 mmHg
	3080F	Most recent diastolic blood pressure >=90 mm Hg
Comprehensive Diabetes	3044F	Most recent HbA1c level less than 7.0%
	3045F	Most recent HbA1c level between 7.0-9.0%
	3046F	Most recent HbA1c level greater than 9.0%
	2022F	Dilated retinal eye exam documented/reviewed
	2024F	7 standard filed stereoscopic photo documented/reviewed
	2026F	Eye imaging validated to match dx documented/reviewed
	3072F	Low risk for retinopathy

HEDIS Coding Tip Sheet

ST. VINCENT IPA
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CPT Category II Codes—By Measure (Cont.)

HEDIS Measure	CPT II Code	Description
Comprehensive Diabetes	3048F	Most recent LDL-C <100 mg/dL
	3049F	Most recent LDL-C 100-129 mg/dL
	3050F	Most recent LDL-C >=130 mg/dL
	3060F	Positive microalbuminuria test documented/reviewed
	3061F	Negative microalbuminuria test documented/reviewed
	3062F	Positive microalbuminuria test confirmed with lab result
	3066F	Documentation of tx for nephropathy
	4010F	ACEI or ARB therapy prescribed or currently taking
	3074F	Most recent systolic blood pressure <130 mmHg
	3075F	Most recent systolic blood pressure 130-139 mm Hg
	3077F	Most recent systolic blood pressure >=140 mm Hg
	3078F	Most recent diastolic blood pressure <80 mm Hg
	3079F	Most recent diastolic blood pressure 80-89 mmHg
	3080F	Most recent diastolic blood pressure >=90 mm Hg
Medication Management	1111F	Medication reconciliation post discharge

BMI Diagnosis Codes

BMI	Dx Code	BMI	Dx Code
Less 19	Z68.1	32.0-32.9	Z68.32
20.0-20.9	Z68.20	33.0-3.9	Z68.33
21.0-21.9	Z68.21	34.0-34.9	Z68.34
22.0-22.9	Z68.22	35.0-35.9	Z68.35
23.0-23.9	Z68.23	36.0-36.9	Z68.36
24.0-24.9	Z68.24	37.0-37.9	Z68.37
25.0-25.9	Z68.25	38.0-38.9	Z68.38
26.0-26.9	Z68.26	39.0-39.9	Z68.39
27.0-27.9	Z68.27	40.0-44.9	Z68.41
28.0-28.9	Z68.28	45.0-49.9	Z68.42
29.0-29.9	Z68.29	50.0-59.9	Z68.43
30.0-30.9	Z68.30	60.0-69.9	Z68.44
31.0-31.9	Z68.31	70-Over	Z68.45

2020 P4P Best Practice Guidelines

****ENSURE THAT EVERY PATIENT VISIT IS DOCUMENTED AND BILLED****

Measure	Who it applies to	Frequency	Qualified Event(s) and accepted codes	
BREAST CANCER SCREENING (BCS)	**Females 50-74 yrs**	Every 2 years	Mammogram	
CHLAMYDIA SCREENING IN WOMEN (CHL)	**Females 16-24 yrs** identified as **sexually active**	Annually	Chlamydia test (87110, 87270, 87320, 87490-87492, 87810)	
COLORECTAL CANCER SCREENING (COL)	**Males and Females 50-75 yrs**	Annually	FOBT (82270, 82274)	
		Every 5 years	Flexible Sigmoidoscopy	
		Every 10 years	Colonoscopy	
EVIDENCE-BASED CERVICAL CANCER SCREENING (ECS)	**Females 21-65 yrs and 67+** (66 yr olds are excluded due to the 3 yr look back period. Depending on where their bday falls, they fall into Appropriately Screened and Screened too Frequently)	Every 3 years	1 Pap test: females 21-65 yrs w/ no hysterectomy (88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174, 88175	
		Every 5 years	1 Pap test: females 21-65 yrs w/ no hysterectomy **AND** an HPV test tested at the same time	
		None	No Pap test: females 21-65 yrs with a hysterectomy and females 67+	
		Excluded	Females who have been DX with HPV or Cervical Cancer are excluded from this measure ICD-10 (Cervical Cancer) C53.0, C53.1, C53.8, C53.9 ICD-10 (HPV) R87.810, R87.811, R87.820, R87.821	
IMMUNIZATIONS FOR ADOLESCENTS (IMA)	Males and Females **who turn 13 in 2015**	1 between 11 and 13 yrs	Meningococcal (90733, 90734)	
		1 between 10 and 13 yrs	Tdap (90715) ***OR*** Td (90714, 90718)	
		3	HPV vaccinations between 9 and 13 (90649 or 90650)	
USE OF IMAGING STUDIES FOR LOW BACK PAIN (LBP)	Members **18-50 yrs** with primary **dx of low back pain**		**DID NOT** have an imaging study (MRI, x-ray or CT scan) within 28 days of dx	
ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS (MPM)	Members **18+ yrs** who rcvd **at least a 180 treatment days of one of the following: ACE Inhibitors or ARBs, Digoxin or Diuretics**	Annually	**1 of the following:** a lab panel test, a serum potassium and serum creatinine, or a serum potassium and blood urea nitrogen	
PROPORTION OF DAYS COVERED BY MEDICATIONS (PDC)	Males and Females **18+** who filled at least 2 prescriptions for one of the following:		Oral diabetes medication	Compliance is based on the proportion of days covered threshold of 80% for these medications
			Renin Angiotensin System Antagonists	
			Statin medications	
COORDINATED DIABETES CARE	Males and Females **18-75 yrs** with **diabetes (Type 1 and Type2)**	Annually	Eye Exam	By eye care professional
			Monitoring Diabetic Nephropathy	Nephropathy Screening test, Urine miscroalbumin test, received medical attention for Nephropathy, OR ACE inhibitor/ARB therapy
			HbA1c Control	<8.0%
			Blood Pressure reading (result of <140/80)	Systolic: 3074F, 3075F, 3077F; Diastolic: 3078F, 3079F, 3080F
CHILDHOOD IMMUNIZATION STATUS (CIS)	Males and Females **who turn 2 in 2015** and have received the following:	4	DTaP	90698, 90700, 90721, 90723
		3	IPV	90698, 90713, 90723
		1	MMR	90707 or 90710
		3	HiB	90645-90648-90698, 90721, 90748
		3	Hep B	90723, 90740, 90744, 90747, 90748
		1	VZV	90710 or 90716
		4	PCV	90669 or 90670
		1	Hep A	90633
		2 or 3	Rotavirus	90681 or 90680
Avoidance of Antibiotic Treatment for Adults w/ Acute Bronchitis (AAB)	Adults **18-64 yrs** w/ dx of **acute bronchitis**		No antibiotic prescription given	
Asthma Medication Ratio (AMR)	Members **5-64** who were identified as having **persistent asthma**		Ratio of controller medications to total asthma medication of .50 or greater	Ratio = Units of Controller Meds divided by Units of Controller Meds + Units of Reliever Meds
Appropriate Testing for Children with Pharyngitis (CWP)	Children **2-18** who were diagnosed w/ **pharyngitis**		Dispensed an antibiotic and received a group A strep test	
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Children **3 mths-18 yrs** given dx of **upper respiratory infection**		No antibiotic prescription given	

2020 CMS 5 Star Best Practice Guidelines

****ENSURE THAT EVERY PATIENT VISIT IS DOCUMENTED AND BILLED****

Measure	Who it applies to	Frequency	Qualified Event(s) and accepted codes	
Breast Cancer Screening (BCS)	**Females 50-74 yrs**	Every 2 years	Mammogram	
Colorectal Cancer Screening (COL)	Males and Females **50-75 yrs**	Annually	FOBT (82270, 82274)	
		Every 5 years	Flexible Sigmoidoscopy	
		Every 10 years	Colonoscopy	
Osteoporosis Management - Fracture (OMW)	**Females 65-85 yrs** who **suffered a fracture**	Within 6 months from time of fracture	Bone Density Test (DEXA) OR Prescription for a drug to treat or prevent osteoporosis	
Controlling Blood Pressure (CBP)	Males and females **18-85 yrs** with **hypertension**	Annually	**Blood Pressure** reading - 18-85 yrs (<140/90 mm/Hg)	Systolic: 3074F <130 mmHg 3075F <130-139mmHg 3077F <=140mmHg Diastolic: 3078F < 80 mmHg 3079F <80-89 mmHg 3080F <=90 mmHg Hypertension Dx: I10
DMARD Therapy for RA (ART)	Males and Females **diagnosed with RA**	Annually	Prescription for a disease modifying anti-rheumatic drug	
Comprehensive Diabetes Care (CDC)	Males and Females **18-75 with diabetes. Type 1 and Type 2**	Annually	Eye Exam	By eye care professional
			Monitoring Diabetic Nephropathy	Nephropathy Screening test, Urine miscroalbumin test, received medical attention for Nephropathy, OR ACE inhibitor/ARB therapy
			HbA1c Control (≤ 9.0)	3044F: 6.9 or less 3046F: >9 3051F: 7-7.9 3052F: 8-9
Adult BMI Assessment (ABA)	Males and Females **18-74** who had an outpatient visit	Every 2 years	Body Mass Index recorded	Z68.1 - Z68.45
Care for Older Adults (SNP only)	Males and Females **65+** on a Special Needs Plan	Annually	**Medication Review**	1160F
			Medication List present	1159F
			Functional Status Assessment to see how well they are able to do "activities of daily living" (dressing, eating, and bathing)	1170F
			Pain Screening or pain management plan	1125F - Pain severity quantified 0-10; pain present 1126F - No pain present
Flu Shots (FSO)	Males and Females	Annually	Flu Vaccine	90660-90662, 90654, 90656, Q2034-Q2039
Medication Reconciliation Post-Discharge (MRP)	Males and Females 66+		Medication reconciliation within 30 days of discharge from an inpatient admission	1111F
Proportion of Days Covered by Medications (PDC)	Males and Females **18+** who filled at least 2 prescriptions for one of the following:		Oral diabetes medication	Compliance is based on the proportion of days covered threshold of 80% for these medications
			Renin Angiotensin System Antagonists	
			Statin medications	
Hospitalization for Portentially Preventable Complications (HPC)	Males and Females 67+		The rate of patients with an inpatient stay related to complications of the following diseases… Diabetes, Lower-extremity amputations, COPD, Asthma, Hypertension, Heart Failure, Pneumonia, UTI, Cellulitis & Pressure Ulcers	Proper use of outpatient facilities and coordination of care with specilaist to avoid complications and subsequent admissions

Special Needs Plan (SNP)

CPT codes

CMS 5 Star measure "Care for Older Adults" states that any male or female 66+ on a ***Special Needs Plan*** must have (4) annual services performed every year.

These services also have very specific CPT II codes in which should be billed with your E&M code and require documentation in the patient medical record.

Please see below for CPT II details:

Service	CPT	Description
Medication List	1159F	Medication list documented in medical record
Medication Review	1160F	Review of all medications by a prescribing practitioner or clinical pharmacist documented in the medical record
Advanced Care Planning	1157F	Advance care plan or similar legal document present in the medical record
	1158F	Advance care planning discussion documented in the medical record
Functional Status Assessment	1170F	Functional status assessed. A minimum of (3) of the following to be assessed and documented in the • medical record: cognitive status, ambulation status, • sensory ability • function of independence
Pain Screening	1125F	Pain severity quantified 0-10; pain present
	1126F	No pain present

Homebound/High Risk Program and Diabetic/Wellness Clinic

St. Vincent IPA Homebound/ High Risk Program and **St. Vincent IPA Diabetic/Wellness Clinic** are designed to contribute and/or enhance the services you are rendering to your St. Vincent IPA patients. It is our hope that together we will better meet the health care needs and challenges of your patients, our members.

The purpose of these enhancements is three-fold:

(1) To improve the health and well-being of St. Vincent IPA patients

(2) To provide you with a complete H&P, problem list, medications list and other pertinent clinical information which will assist you in the ongoing management of your patients (this will be faxed to you after the evaluation is completed

(3) To assist our Nurse Practioner in identifying patients that may benefit from admission into the Homebound/ High Risk Program and or the Diabetic clinic

Candidates to the Programs will be identified by the IPA based on internal and health plan claims data and targets patients identified with one or more of the following:

- Potential or actual high risk health care problems/complex diagnoses
- Frequent emergency room visits
- Multiple hospitalizations and/or multiple re-admissions within a short period of time
- Frequent utilization of out-of- network facilities
- Require post-hospitalization follow-up until seen by their primary care provider
- Frail elderly at risk for requiring extensive outpatient and/or inpatient services
- Comprehensive education of your diabetic members
- Patients with gaps in their preventative care are identified in the 5star program

The process of Homebound/ High Risk Program is as follows:

1. Candidates for the Program will be identified by the IPA utilizing the above criteria.
2. If a patient is a candidate and admitted into the Program, the Primary Care Physician (PCP) will be contacted by mail. The PCP will continue to receive capitation for the patient. In order to maximize patient compliance and cooperation with the Program, the PCP must remain involved and serve as an advisor and facilitator to the Homebound/High Risk team while the patient is in the Program.
3. The patient will be contacted via phone by the nurse practitioner and an in-home appointment will be scheduled.

4. A home visit will be done which will consist of a complete history and physical. Laboratory and diagnostic studies will be ordered as indicated.
5. Follow-up visits to the patient's home will be based on patient's acuity and needs.
6. PCP will receive progress notes and periodic updates from IPA Case Manager/Nurse practitioner. This is a collaborative effort and we encourage PCP involvement and communication with our nurse practitioners; Cynthia Clegg or Adamma Epoh.
7. Once it is determined that continued participation in the Program is no longer required, the PCP will be contacted to discuss the termination of services (discharge from Homebound/ High Risk Program) and pertinent medical documentation will be provided.
8. PCP will resume patient care management and will schedule a follow-up visit.

The process for the Diabetic/Wellness Clinic is as follows:

1. Candidates will be referred by either the primary care physicians, St. Vincent IPA nurse case managers and/or the nurse practitioners.
2. Identifying factors shall consist of newly diagnosed Diabetic patients, Pre-Diabetic, non-compliant and uncontrolled diabetic members, long-standing diabetic, obese members and members starting insulin therapy or members resistant to starting insulin therapy. As well as, members motivated to learn more and take better care.
3. The patient will be contacted by phone and an appointment will be scheduled.
4. The visit will consist of one-on-one counseling on diet, exercise, medication education, discussion and review of lab results and their significance. Furthermore, preventative care, specialist referral needs and disease progression shall be discussed with the member. Referrals will be provided to member as needed.
5. Follow up appointments are scheduled as needed with members for more stringent and proper management of Diabetes.
6. The PCP will receive progress notes and periodic updates from the nurse practitioners.
7. We also deliver services that aim to serve members who require further education on nutrition and diet for better health management and weight control.

Also we offer case management with complex-disease management which involves: Comprehensive assessment of a member's condition to include but not limited to determination of any available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up. Which will lead to improved self-management, increased member satisfaction and reduced inpatient re-admissions.

Complex case management may include members with one or more off the following risks:

Acute health care needs, diagnoses or hospitalizations, complex medical issues and/or comorbidities, poorly controlled disease states, frequent admissions, multiple emergency department visits, and predictive modeling identified risk level. With one of the following needs: Adherence to treatment such as meds, md visits, behavior changes, diet, etc. Care coordination, patient education and activation, community resources.

We are available to assist you with your patients with ongoing case management for as long as the member has identified needs and expresses willingness to receive support and services from the program at no cost to them.

In an effort to maximize the success of these programs and continually improve the quality of service rendered, your assistance is requested in this team effort. Your assistance in providing us with any information that will enable us to achieve the best possible patient outcomes will be invaluable. Should you have any questions regarding this program, please do not hesitate to contact Leesa Johnson, Vice President of IPA Operations at (562) 860-8771 extension 108. You may also contact Cynthia Clegg, FNP at (213) 393-8402 or Adamma Epoh, FNP at (213) 628-6539 and for case management Cynthia Acker at 213-215-5217.

ST. VINCENT IPA

The Patient's Choice for Health Care

TAKE ADVANTAGE OF OUR DIABETES PROGRAM $0 COPAY

You and your health come first with St. Vincent IPA and it is important for you to have regular check-ups.

St. Vincent IPA understands that you have a busy schedule; in an effort to help you receive the best care, St. Vincent IPA has established a diabetic clinic to help you manage your diabetes. You also have the option to schedule a call to review and discuss management of your diabetic care.

In addition to providing routine diabetic services and education. Our Diabetic Nurse Educators will personally work with you to keep your diabetes under control.

Please contact (888) 387-8472 to schedule an appointment or a telephonic appointment. We encourage you to take advantage of these services.

OUR DIABETIC NURSES EDUCATORS WILL ASSIST YOU WITH THE FOLLOWING:

- Diabetic Exams/Check-ups
- Blood Sugar/ Cholesterol Monitoring
- Diabetic Foot Exams
- Nutritional Counseling
- Review of Medications
- Education on Exercise
- Pre-Diabetes

Diabetes Educators:
Cynthia Clegg, FNP
Adamma Epoh, FNP
ENGLISH & SPANISH

Diabetes Clinic
1931 W. Sunset Blvd
Los Angeles, CA 90026

COMPLIANCE

Mandatory Health Plan Trainings

The Centers for Medicaid Services (CMS) requires annual Fraud, Waste and Abuse (FWA), Special Needs Plan (SNP) and Language Assistance Program (LAP) training for all physicians and staff organizations providing health, prescription drug, or administrative services to Medicare Advantage (MA) or Prescription Drug Plan (PDP) beneficiaries on behalf of MA health plans (See 42 CFR 422.503 "Medicare Advantage Programs" and 42 CFR 423.504 "Voluntary Medicare Prescription Drug Benefit.").

These trainings are available to you on our website at www.stvincentipa.com. You can access these by:

- Clicking on **Provider Compliance Training** under the **Resource Compliance Training** tab on the Provider's side of the website for **FWA Training** to view the Power Point presentation.
- Clicking on **Provider Compliance Training** under the **Resource Compliance Training** tab on the Provider's side of the website to view one of the **Model of Care Training by Health Plan** Power Point presentations.
- Clicking on **Language Assistance Contact List** under the **Resource Compliance Training** tab on the Provider's side of the website to view the information for each health plan.
- Clicking **on Provider Compliance Training** under **the Resource Compliance Training** tab on the Provider's side of the website to view one of the **Health Plan Standards of Conduct.**

CMS requires all Health Plan Sponsors to have written standards of conduct that communicate the Sponsor's commitment to comply with all applicable Federal and State standards. To ensure Sponsors' delegated entities adhere to these standards, CMS expects Sponsors to share their standards with first tier, downstream, and related entities (FDR) and/or verify that these FDRs adopt and follow a similar code.

You should maintain an attestation in your office documenting all people who have completed these trainings in the event of a CMS or health plan audit.

If you have any questions, please do not hesitate to contact Provider Relations at (**562) 860-8771 ext. 112**.

Please note that these trainings should be completed now and annually **by December 31st** of each year.

Affirmative Statement

As a utilization management organization, Physicians Data Trust on behalf of 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. Milliman Care Guidelines 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.

Providers, members, and the public can obtain a copy upon request

St. Vincent IPA
17215 Studebaker Rd., Ste 320
Cerritos, CA 90703
(562) 860-8771
Compliance@pdtrust.com

2020 Medicare Compliance Program Guidelines Attestation for Downstream Entities

As required by the Centers for Medicare & Medicaid Services (CMS), First Tier, Downstream, and Related Entities (FDRs) that provide administrative and/or health care services for Medicare Parts C and D plans must meet specific CMS compliance program expectations. ***St. Vincent IPA Medical Corporation*** *is considered a First Tier as we provide administrative and or health care services for several contracted Medicare Advantage plans. Your organization is considered a Downstream Entity of the Medicare Advantage organizations, and this attestation is intended to be evidence that the requirements listed below were met by your organization for* ***2020.*** *These requirements are further described within CMS's updated guidance on the compliance program requirements and related provisions for Sponsors ("Guidelines"), published in both Pub. 100-18, Medicare Prescription Drug Benefit Manual, Chapter 9 and in Pub. 100-16, Medicare Managed Care Manual, Chapter 21 and are identical in each.*

1. **General Compliance and Fraud, Waste and Abuse ("FWA") Training**
   The CMS *Medicare Parts C and D FWA Training and General Compliance Training* or internal equivalents were provided in **2020** to all of our employees and downstream entities who are assigned to work on Medicare business. If deemed*, our organization is exempt from completion of FWA training but ensures general compliance training is provided to all employees and downstream entities who are assigned to work on Medicare business. This occurred initially within 90 days of hire or contracting and annually thereafter.
2. **Code of Conduct and/or Compliance Policies**
   Several Code of Conduct and Compliance Policies are in place and available in **2020** via the website (www.stvincentipa.com) to all our employees and downstream entities who are assigned to work on Medicare business. This occurred initially within 90 days of hire or contracting, upon revision, and annually thereafter.
3. **Reporting Mechanisms**
   Internal employees were informed of their obligation and how to report any suspected or detected non-compliance or potential FWA for internal investigation. The reporting mechanisms ensure confidentiality and allow for anonymity, as desired. In addition, we don't allow retaliation or intimidation against anyone who reports in good faith. In turn, our organization reports any applicable incidents to the appropriate Medicare Advantage carrier as they arise.
4. **Exclusion/Debarment**
   Our organization ensures that none of our employees that service Medicare business are on the HHS Office of Inspector General (OIG) or the General Services Administration (GSA) System for Award Management (SAM) exclusion lists through the screening of these lists prior to hire and monthly thereafter.
5. **Offshore Operations**
   Our organization does not engage in offshore operations for Medicare business without the express consent of an authorized representative since these activities, if involving the receipt, processing, transferring, handling, storing or accessing of PHI, must be reported to CMS. Our operations are consistent with direction from the CMS memo titled "Sponsor Activities Performed Outside of the United States" date July 23, 2007.

* Deemed: means that the organization has met the FWA certification requirements through enrollment into the Parts A or B of the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); deeming status only applies to the training and educational requirements for FWA.

HEALTH PLAN REQUIREMENTS

Provider Satisfaction Survey

In our effort to improve our services to our physicians, your feedback is needed. St. Vincent IPA requests you complete a provider satisfaction survey annually. We hope you will take a couple minutes to complete the attached survey and return by **fax (562) 924-1603** or **email Prsvipa@pdtrust.com** by the end of the year.

Should you require additional copies of the survey or have any questions, please feel free to contact Provider Relations at **(562) 860-8771 ext. 112**, or by **email Prsvipa@pdtrust.com**.

We thank you for your hard work and support for St. Vincent IPA.

ST. VINCENT IPA

The Patient's Choice for Health Care

PROVIDER SATISFACTION SURVEY

Date

Dear St. Vincent IPA Physician:

St. Vincent IPA is striving to improve the service we provide our physicians. Your input is very important to us. Please complete the following survey with your comments and return it by **Day, Month, Day, Year.** Please check the appropriate response below:

Provider Name: _____ PCP ☐ SPC ☐

5=Strongly Agree 4=Agree 3=Neutral 2=Disagree 1=Strongly Disagree

	5	4	3	2	1
1. St. Vincent IPA responds to your calls promptly.					
2. St. Vincent IPA staff answers your questions to your satisfaction.					
3. St. Vincent IPA staff is courteous and helpful when you call.					
4. Your St. Vincent IPA claims are processed in a timely fashion (within 60 days).					
5. Questions regarding claims are handled quickly.					
6. St. Vincent IPA referral forms are user friendly.					
7. Referrals are returned to you timely.					
8. Questions regarding referrals are handled appropriately.					
9. Contracted ancillary providers render acceptable services:					
a. Lab – Unilab/Quest Diagnostic					
b. Physical Therapy – St. Vincent Medical Center					
c.1. Radiology – St. Vincent Radiological Medical Group					
c.2. Radiology – Samaritan Imaging					
d.1. Mammography – St. Vincent Radiological Medical Group					
d.2. Mammography – Samaritan Imaging					

Comments:_____

_____

_____

_____

Please return survey via fax to 562-924-1603

Thank you for your response.

Member Satisfaction Survey

In our effort to continuously improve our delivery of services to our members, we need your help capturing feedback from our patient community. For every St. Vincent IPA member that comes in, please have member complete survey and return by fax: **(562) 924-1603** or email: **Prsvipa@pdtrust.com** by the end of the year.

Please be advised, submission of the member satisfaction survey impacts your Surplus Distribution to be distributed in Month Year. You must submit at least four (4) completed member satisfaction surveys to qualify for this portion (7.5%) of the final Surplus Distribution.

If you have less than 4 members, you will need to submit member satisfaction survey for each of your members in order to qualify for this portion of the PCP Surplus Distribution.

Should you require additional copies of the survey or have any questions, please feel free to contact Provider Relations at **(562) 860-8771 ext. 112** or you can email **Prsvipa@pdtrust.com**.

We greatly appreciate your help with this effort to assist St. Vincent IPA better serve our communities and we thank you for your hard work and support for St. Vincent IPA.

CUSTOMER SATISFACTION SURVEY

Doctor Seeing today:		**PCP on ID Card:**
Age:	**Gender: ☐M ☐F**	**Today's Date:**

We constantly strive to serve our member/customer population better. We are evaluating your satisfaction with the Primary Care Physician (PCP) you have chosen to manage your medical care, and your ability to receive the services you feel are appropriate for you. Please take a minute, while you are waiting in your doctor/PCP's office and answer a few questions. Thank you in advance for helping us improve our service to you.

1. In the last 12 months, how often did you get an appointment with your PCP as soon as you wanted? ___(always) ___(usually) ___(sometimes) ___(never)

2. In the last 12 months, when you called your PCP office during regular office hours, how often did you get the advice or help you needed?
   ___(always) ___(usually) ___(sometimes) ___(never)

3. In the last 12 months, how often did your PCP **listen** carefully to you?
   ___(always) ___(usually) ___(sometimes) ___(never)

4. In the last 12 months, how often did your PCP **explain** things in a way you could understand? ___(always) ___(usually) ___(sometimes) ___(never)

5. In the last 12 months, how often was the office staff at your PCP's office as helpful as you thought they should be? ___(always) ___(usually) ___(sometimes) ___(never)

6. In the last 12 months, when you needed care right away (during office hours) for an illness, injury or condition, how often did you get care as soon as you wanted?
   ___(always) ___(usually) ___(sometimes) ___(never)

7. In the last 12 months, when your PCP sent you for a blood test, x-ray, or other test, did someone from your PCP office follow-up to give you the test results?
   ___(Yes, always) ___(Yes, sometimes) ___(No, never)

8. In the last 12 months, if you were referred outside your PCP office, how often were you notified timely of the approval for the service?
   ___(always) ___(usually) ___(sometimes) ___(never)

9. When waiting in your PCP office, how long do you usually wait, from the time of your scheduled appointment to the time your doctor sees you?
   ___(5-10 min) ___(11-20min) ___(21-30min) ___(>30min) ___(>45min) ___(>60min)

10. Using any number from 0 to 10 (where10 is the best and 0 is the worst) what number would you use to rate your PCP?
    ___(10) ___(9) ___(8) ___(7) ___(6) ___(5) ___(4) ___(3) ___(2) ___(1) ___(0)

***Please write any helpful comments you may have on the back of this form.**

L.A. Care HEALTH PLAN®

For All of L.A.

Attestation for L.A. Care Health Plan Trainings

As a contracted entity with L.A. Care Health Plan, you and your staff must participate in the New Provider Training as part of the onboarding process, and when ad hoc trainings or updates are required.
You must have all required staff in attendance of training(s), legibly complete the sign-in sheet, and the facilitator or Office Manager must attest below that the staff listed on the corresponding sign-in sheet were in attendance for the entire presentation. Signing this attestation confirms that you and your staff have completed the required training. As part of L.A. Care Health Plan's oversight and monitoring activities, L.A. Care Health Plan will review sign-in sheets, attestations, and any other corresponding materials to ensure they are complete, accurate, true, and meet any required deadlines.

Please indicate which training has been completed by you and your staff.

L.A. Care Health Plan New Provider Training _____ Date Completed: _____

Other (please print title) _____ Date Completed: _____

Other (please print title) _____ Date Completed: _____

Other (please print title) _____ Date Completed: _____

By signing below, I attest that staff listed on the corresponding sign-in sheet representing my organization, _____,
a contracted entity with L.A. Care Health Plan, have completed the training(s) listed above.
I attest that my organization will furnish copies of sign-in sheets, attestations, and any other related material at the request of L.A. Care Health Plan.

Name of facilitator/office manager: _____

Title: _____

Signature: _____ Date:_____

Email: _____ Phone: _____

L.A. Care HEALTH PLAN®

For All of L.A.

L.A. Care Health Plan Sign-In Sheet

Name of PPG/PCP/Specialist/Hospital/Other: _____

Training Name: _____

Facilitator Name: _____

Facilitator Contact Number: _____

Training Location: _____

Date of Training: _____ Time of Training: _____

Print Name (First and Last)	Signature	Job Title	Email Address

By signing your name above, you attest that you have completed the training or attended the event indicated on this sign-in sheet.

Health Net
COMMUNITY SOLUTIONS

CONFIRMATION OF NEW PROVIDER TRAINING

Please complete the following and submit it within 48 hours via email to HN_Provider_Relations@healthnet.com, or send it via fax to 1-855-863-5987.

REQUIRED: Initial #1 OR #2

1. _____ (initial) I have received the new provider training materials from Health Net Community Solutions, Inc. (Health Net), reviewed them for training purposes, and understand essential components of Health Net's Medi-Cal plan, including basic information about public health programs available to Health Net Medi-Cal members, Health Net's quality improvement program, and interpreter services and provider tools to care for diverse populations.

OR

2. _____ (initial) I have completed Health Net's new provider training online on the provider website and understand essential components of Health Net's Medi-Cal plan, including basic information about public health programs available to Health Net Medi-Cal members, Health Net's quality improvement program, and interpreter services and provider tools to care for diverse populations.

REQUIRED: Initial #3

3. _____ (initial) In addition, I understand my responsibilities related to Health Net's Medi-Cal managed care program services, policies and procedures, and ways to communicate between providers, members and Health Net. I understand how to access and find information on Health Net's provider website about Medi-Cal benefits and services, claims and payment policies, California Children's Services (CCS)-eligible conditions and referral processes, case management services, tools to care for a diverse population, and operations manuals located under *Working with Health Net > Contractual > Provider Library.*

_____ _____ _____
Provider name (PRINT) Provider signature Date

_____
Provider address (street, city, ZIP)

_____ _____ _____
Phone number Email address Tax identification number (TIN)

INTERNAL USE ONLY

_____ _____ _____
Received date Data entry date Provider representative

Provider Training Sign-In Sheet

Trainer Name:_____

DATE: _____

TYPE OF TRAINING:

	New Provider Onboarding		**PM160 Online Submission**		**Tool Kit:**
	S.B.I.R.T.		**Newborn Referral Process**		**Other:**

PLEASE FILL OUT PROVIDER /CLINIC INFORMATION BELOW **- OR-** **STAMP CLINIC INFO HERE**

PROVIDER/CLINIC NAME: _____

PROVIDER NPI: _____

PROVIDER ADDRESS: _____

CITY: _____ **ZIP:**_____

PROVIDER TEL: _____ **FAX:** _____

ATTENDEES

	FULL NAME	POSITION	EMAIL ADDRESS (ONLY IF USED FOR WORK PURPOSES)	PHONE NUMBER	SIGNATURE
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

-ATTENDEES CONTINUED-

	FULL NAME	POSITION	EMAIL ADDRESS (ONLY IF USED FOR WORK PURPOSES)	PHONE NUMBER	SIGNATURE
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					

MEMBER RIGHTS AND RESPONSIBILITIES

- To exercise these rights without regard to age, gender, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status, source of payment or utilization of services.

- To be treated with respect and recognition of your dignity and need for privacy.

- To receive confidential treatment of all information and records associated with your care.

- To not be discriminated against in the delivery of health care regardless of race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, such as ESRD, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information or source of payment.

- To be provided with information about your IPA, its services, and the health care service delivery process.

- To be informed of the name, qualifications, and titles of the physician who has primary responsibility for coordinating your care, and be informed of the names, qualifications, and specialties of other professionals who may be involved in the your care.

- To have 24-hour access to your Primary Care Physician (or covering physician).

MEMBER RIGHTS AND RESPONSIBILITIES

- To receive complete information about the diagnosis, proposed course of treatment or procedure, alternate courses of treatment or non-treatment, the clinical risks involved in each, and prospects for recovery in terms that are understandable to you, in order for you to give informed consent or to refuse that course of treatment.

- To be informed of continuing health care requirements following office visits, treatments, procedures, and hospitalizations.

- To actively participate in decisions regarding your health care and treatment plan. To the extent permitted by law, this includes the right to refuse any procedure or treatment. [If the recommended procedure or treatment is refused by you,, an explanation will be given by your provider and will address the effect that this will have on your health.

- To have access to personal medical records based upon state and Federal requirements.

- To be informed of non-emergent costs of care and receive an explanation of your financial obligations prior to incurring the expense (including co-payment, deductibles, and co-insurance).

- To examine and receive an explanation of bills generated for services delivered to you.

- To be informed of applicable rules in the various health care settings regarding member conduct.

MEMBER RIGHTS AND RESPONSIBILITIES

- To express opinions or concerns regarding your IPA or the care provided. To offer recommendations for change in the health care delivery process by contacting your IPA Member Services Department. In turn, your IPA will have a timely and organized system for resolving member complaints and formal grievances.

- To be informed of the member grievance and appeal process.

- To change your Primary Care Physician by contacting your Health Plan's Customer Services Department.

- To receive reasonable continuity of care and be given timely and sensible responses to questions and requests made for service.

- To be able to formulate advanced directives for health care.

- These member rights shall apply to any person who has legal responsibility to make health care decisions for you.

- Note: Members have the right to be represented by parents, guardians, family members or other

- Conservators for those who are unable to fully participate in their treatment decisions.