PROVIDER MANUAL

In-Service training for: _____
Print Clearly Name of Primary Care Physician

In-Service Date: _____

Given by: _____

It is important to take proper care of your PCP Office Manual. You will need to refer to it from time to time. It will be necessary and your responsibility to post any updates and additional information that we provide in the future.

A copy of the **"STATE OF CALIFORNIA PATIENT RIGHTS AND RESPONSIBILITES"** and the **"BE INFORMED"** notice are also attached and must be posted where patients can read them (please see back pocket of binder) in your office.

Received by: _____
Print Name Clearly

_____
Sign Name

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Our administrative staff is available to assist you in any way to serve our patients efficiently. If you have any questions, please feel free to contact our Management Service Organization (MSO) at:

Network Medical Management
LaSalle Medical Associates
1680 S. Garfield Avenue # 204
Alhambra, Ca 91801
Telephone: (877) 282-8272

SECTION 1
Directory

LaSalle Medical Associates Corporate Office:
685 Carnegie Drive, Suite #230, San Bernardino, CA 92408
Phone: (909) 890-0407

Administration	EMAIL
Albert Arteaga, M.D. President and CEO	a.arteaga@lasallemedicalassociates.com
Cheryl Emoto, M.D. Medical Director	c.emoto@lasallemedicalassociates.com
Roberto Contreras, M.D. Medical Director	r.contreras@lasallemedicalassociates.com
Carl Maier, Executive VP of Operations	c.maier@lasallemedicalassociates.com
Victor Madero, Director of Business and Network Development	v.madero@lasallemedicalassociates.com
Alexandra Acosta, Director of Finance	a.acosta@lasallemedicalassociates.com
Barbara Garber, Manager, Compliance and Special Projects	b.graber@lasallemedicalassociates.com

NETWORK MEDICAL MANAGEMENT
(877) 282-8272

Administration	EXT.	EMAIL
Thomas Lam, M.D., M.P.H Chief Executive Officer	6298	
Kenneth Sim, M.D., Chief Financial Officer	6298	
Albert W. Young, M.D., M.P.H, Chief Medical Officer	6288	Albert.young@nmm.cc
Hing Ang, Chief Operating Officer	6238	Hing.ang@nmm.cc
Operations Management	**Ext.**	**EMAIL**
Kathleen Leano, Director of Operations and Claims		Kathleen.leano@nmm.cc
Rafael Zepeda, Director of Network Development	6090	rafael.zepeda@nmm.cc
Karrie Chan, Data Management (HCC & Encounters)	6268	Karrie.chan@nmm.cc
Isela Ochoa, Credentialing Supervisor	6267	Isela.ochoa@nmm.cc
Winsome Brown, IPA Manager & Provider Contracting Specialist	6218	winsome.brown@nmm.cc
Winsome Brown, Eligibility and Capitation Manager	6218	winsome.brown@nmm.cc
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Rayna Hurdle, Quality Management	6207	Rayna.hurdle@nmm.cc
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Priscilla Padilla, LaSalle Medical Associates Case Manager	6092	Priscilla.padilla@nmm.cc
Ana Bailey, Case Management Coordinator	6131	Ana.bailey@nmm.cc
Information Systems	**Ext.**	**EMAIL**
Nervin Averruz, IT Manager	6224	Nervin.averruz@nmm.cc
Neil Abesamis, IT	6260	Neil.abesamis@nmm.cc

SECTION 2
Network Administration

OUR MANAGED CARE NETWORK

Under LaSalle Medical Associates contracts with health plans, the organization is responsible for providing and for arranging for the provision for covered services which the IPA delegated for. LaSalle Medical Associates currently contracts with Knox Keene-licensed health plans. Under these contracts, LaSalle Medical Associates serves members enrolled for various lines of business offered by the health plans including:

Commercial HMO, Medi-Cal, Medi-Medi, and Medicare HMO Plans.

The Health Plans currently contracted with LaSalle Medical Associates include:

- Anthem Blue Cross of California
- Brand New Day
- Care 1st Health Plan
- Easy Choice Health Plan
- Humana
- Health Net
- Inland Empire Health Plan
- Molina Healthcare

SECTION 3
Business Code of Conduct

The Business Code of Conduct (BCC) establishes ethical and legal guidelines for providing care and services on behalf of LaSalle Medical Associates. It demonstrates LaSalle Medical Associates's commitment to compliance and applies to all Board of Directors, employees, volunteers, physicians, third-party payors, subcontractors, independent contractors, vendors, consultants, and other employees.

Elements of the Business Code of Conduct

Compliance with all Laws and Regulations
LaSalle Medical Associates will comply with all applicable laws and regulations. It is the responsibility of
employees, volunteers, and business associates to be knowledgeable of and comply with such regulations in the following areas:

- Accurate Claims for Reimbursement
- Medical Necessity
- Accurate Business Records
- Cost Reports
- Refunds
- Kickback Prohibitions
- Co-Payments & Discounts
- Honest Dealings with Payor, State, or Government Officials
- Cooperation of Audit and Investigations

SECTION 4
Provider Requirements

For Contracted Providers

All Contracted Providers must render services in accordance with the highest standards of competence, care and concern for the welfare and needs of Patient/ Participant/Clients and in accordance with the laws, rules and regulations of all governmental authorities having jurisdiction.

Authority and Responsibility Retained by LaSalle Medical Associates
The LaSalle Medical Associates Health Services Management has the ultimate responsibility for the performance of the organization. The Management has delegated the ongoing and continuous oversight of all operations to the Executive Committee through the President and Chief Executive Officer. LaSalle Medical Associates does not through its contracts, or other arrangements, delegate authority of its decision-making process and authority. LaSalle Medical Associates retains the right and authority over all key decisions affecting the corporation and its contracted provider operations and management.

LaSalle Medical Associates has the authority and responsibility to implement, maintain, and enforce LaSalle Medical Associates policies governing Contractors' duties under their agreement(s) with LaSalle Medical Associates and/or governing LaSalle Medical Associates's oversight role. LaSalle Medical Associates has the right and responsibility to conduct audits, inspections and/or investigations in order to oversee contractors' performance of duties described in their LaSalle Medical Associates agreement(s) and to require Contractors to take corrective action if LaSalle Medical Associates or the applicable federal or state regulator determines that corrective action is needed with regard to Contractors' duties under their LaSalle Medical Associates agreement, and/or if Contractors fail to meet LaSalle Medical Associates standards in the performance of those duties.

Contractors must cooperate with LaSalle Medical Associates in its oversight efforts and must take corrective action
as LaSalle Medical Associates determines necessary to comply with the laws, accreditation standards, Payor Contract requirements and/or LaSalle Medical Associates policies governing the duties of the Contractor or the oversight of those duties.

Medical Decision and Financial Statement
There is an established LaSalle Medical Associates policy requiring practitioners and licensed utilization management staff responsible for utilization decisions to affirm that utilization decisions are based solely on apropriateness of care and services. LaSalle Medical Associates Health Services Department does not reward practitioners or other individuals conducting utilization review decisions that result in under-utilization.

Open Communication with Patients
Providers are required to participate in candid discussions with their patients regarding all decisions about their care, including but not limited to, diagnosis, treatment plan, right to refuse or accept care, care decision dilemmas, advance directive options, and estimates of the benefits associated with available treatment options, regardless of the cost or coverage. Furthermore, patients must be provided

clear explanations about the risks from recommended treatments, the length of expected disability, and the qualifications of the physicians and other health care providers who participate in their care. Moreover, providers must inform Medi-Cal members that they have the freedom of choice in

obtaining Family Planning, Abortion Services, Sexually Transmitted Disease (STD) treatment, and Sensitive Services for Minors without prior authorization.

Contract Provisions
Additionally, Contracted Providers must comply with the following provisions, which are part of the provider's official contract:

Provision of Services
1) Contracted Providers must agree to render professional medical services to Patients/Participants/Clients referred to the Contracted Provider by LaSalle Medical Associates (provided that the Contracted Provider's application for participation has been approved by the LaSalle Medical Associates Credentialing Committee).

2) Contracted Specialist Providers may not provide services to LaSalle Medical Associates Patients/Participants/Clients, except in an emergency, without first securing authorization from LaSalle Medical Associates's Utilization Management Department.

3) Contracted Providers must consult with LaSalle Medical Associates physicians and other health professionals when so requested and must participate in LaSalle Medical Associates's peer review activities.

1.2 STANDARDS OF PRACTICE AND COMPLIANCE WITH LAWS:
1) Contracted Providers must comply with all applicable laws, rules and regulations of all governmental authorities relating to the licensure and regulation of health care providers and the provision of health care services.

2) Contracted Providers must at all times conduct a professional medical practice that is consistent with the applicable State and Federal laws and with the prevailing standards of medical practice in the community.

3) Contracted Providers are expected to adhere strictly to the canons of professional ethics.

1.3 AVAILABILITY:
1) Contracted Providers must provide available and accessible services to LaSalle Medical Associates Patient/ Participant/ Clients at all times, as defined in Section 12 "Access Standards".

2) Contracted Providers must agree to permit LaSalle Medical Associates to monitor and evaluate accessibility of care and to address problems that develop, which shall include but not be limited to, waiting time and appointments.

1.4 COVERING PROVIDERS:
1) Contracted Providers must give LaSalle Medical Associates reasonable, advance, written notice of any periods of unavailability (e.g., vacation).

2) In such cases, Contracted Providers must agree to arrange for the services of another qualified professional in the same specialty, satisfactory to LaSalle Medical Associates, to render services to any LaSalle Medical Associates Patient/Participant/Clients referred during the term of the absence.

3) Compensation for services rendered during such absence will be paid only to Contracted Providers and he/she must accordingly compensate the Covering Provider.

1.5 Provider Leave of Absence

In pursuant to all primary care physician contracts Article 2.18, providers must adhere to the following:
1) If PCP is, for any reason, from time to time unable to provide Covered Services when and as needed, PCP may secure the services of a qualified covering physician who shall render such covered services otherwise required of PCP; provided, however, that the covering physician so furnished must be a physician approved by IPA (to include credentialed by the IPA) to provide covered services to Enrollees.
2) PCP shall be solely responsible for securing the services of such covering physician and paying said covering physician for those covered services provided to Enrollees. PCP shall ensure that the covering physician:

(a) Looks solely to PCP for compensation
(b) Will accept IPA's peer review procedures,
(c) Will not directly bill Enrollees for Covered Services under any circumstances
(d) Will, prior to all elective hospitalizations, obtain authorization in accordance with IPA utilization review program.

3) Contracted PCP must notify the IPA in writing 14 calendar days in advance for any leave of absence.

4) Notifications shall be sent to Provider Relations Department via email at ProviderRelations.Dept@nmm.ccor via fax at (626) 943-6309.

1.6 SURGERY AND HOSPITAL ADMISSIONS:

1) If a Contracted Provider is a physician or other health care professional who possesses hospital privileges, the Contracted Provider must maintain throughout the term of his/her agreement with LaSalle Medical Associates, his/her medical staff membership at said hospital(s), and other privileges, which are deemed reasonably necessary by LaSalle Medical Associates for the performance of the duties under the contract(s) with LaSalle Medical Associates.

2) Whenever a Contracted Provider recommends surgery for an LaSalle Medical Associates Patient/Participant/ Client, the Contracted Provider must contact LaSalle Medical Associates to obtain prior authorization for the proposed treatment. The Provider must work to perform said surgery at an LaSalle Medical Associates or the financially responsible Health Plan contracted Hospital.

1.7 MEDICAL DOCUMENTATION:

1) After the initial office consultation with an LaSalle Medical Associates Patient/ Participant/ Client, Contracted Providers must submit to LaSalle Medical Associates an Initial Consultation and Follow-Up report.

2) Contracted Providers must submit to LaSalle Medical Associates, in a timely manner summary reports of findings as deemed necessary by the Contracted Provider and the referring LaSalle Medical Associates provider.

3) Health records must contain all information necessary to comply with documentation standards as outlined in Section 33 "Medical Record Standards".

1.8 CONFIDENTIALITY OF RECORDS:

1) Contracted providers (physicians and non-physicians) must comply with all applicable confidentiality requirements imposed by Federal and State law. This includes the development of specific policies and procedures to demonstrate compliance.

2) All information, records, data collected and maintained for the operation of the health care service plans or other payors with which LaSalle Medical Associates is associated, and information pertaining to Contracted Providers, LaSalle Medical Associates Patient/ Participant/Clients, facilities and associations, will be protected from unauthorized disclosure in accordance with applicable State and Federal laws and regulations.

3) LaSalle Medical Associates agreements may not be construed to require confidential treatment for any information that is subject to disclosure under the California Public Records Act.

1.9 QUALITY MANAGEMENT:

1) LaSalle Medical Associates maintains a Quality Management/Improvement Program in order to assure a standard of care consistent with State and Federal laws, with the applicable contractual obligations of health care service plans and payors, and with the prevailing standards of medical practice and health care in the community.

2) Contracted Providers must cooperate and comply with LaSalle Medical Associates quality assurance requirements, credentialing and peer review processes.

1.10 CONTINUING CARE OBLIGATION:

1) In instances where a provider contract is terminated "without cause" and any LaSalle Medical Associates Patients/Participants/Clients are receiving care for acute or serious chronic conditions, California state law (SB1129) requires that such Patients/Participants/ Clients have the right to continue to be treated by their terminated provider for up to 90 days, if they so request.

2) In accordance with CA Health and Safety Code 1373.65(f), LaSalle Medical Associates notifies members of the termination of specialists in the preferred network. The notification to members states "If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated period. Please contact your HMO's customer service department, and if you have any
questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll- free number, 1-888-HMO- 2219, or at TDD number for the hearing impaired at 1- 877- 688- 9891, or online at www.hmohelp.ca.gov."

3) "Without cause" includes terminations NOT attributable to quality of care issues, fraud, or other criminal activity.

4) LaSalle Medical Associates Patients/Participants/Clients may continue to be treated by the physician for up to 90 days, as long as the physician agrees to reasonable contract terms proposed by LaSalle Medical Associates. This time period may be extended if the transfer of services is not considered safe. Some examples of acute medical conditions or serious conditions include, but are not limited to:

a. Second or third trimester of pregnancy (as applicable);

b. High-risk pregnancy (as applicable);

c. Recent surgery with subsequent complications requiring the patient to receive ongoing home health services;

d. Outpatient critical cases in the process of stabilization (such as intensive radiation therapy or treatment of uncontrolled diabetes); and/or

e. Terminal cases.

5) To assist LaSalle Medical Associates in maintaining continuity of care for its Patients/ Participants/Clients, Contracted Providers are required to share the medical records of services rendered to LaSalle Medical Associates Patients/Participants/Clients, provided that the appropriate release of information has been obtained.

6) Upon a member reassignment or transfer, Contracted Providers must provide one copy of these records, at no charge, to the member's new physician. Upon request, additional copies must be provided at reasonable and customary copying costs, as defined by California Health and Safety Code 1792.12.

1.11 REPORTING OF GRIEVANCES/UNUSUAL INCIDENTS:

1) Contracted Providers must agree to immediately report to LaSalle Medical Associates, by telephone and in writing, any complaints received from LaSalle Medical Associates Patient/Participant/Clients and any incidents or unusual occurrences at or in a Contracted Provider's office.

1.12 COMPENSATION:

1) Contracted Providers must bill only LaSalle Medical Associates for all approved services he/she provides to LaSalle Medical Associates Patients/Participants/Clients, with the exception of applicable copayments or deductibles.

2) Contracted Providers may not seek any reimbursement for authorized services provided to LaSalle Medical Associates Patient/Participant/Clients from the Payors with which LaSalle Medical Associates contracts.

3) Surcharges to LaSalle Medical Associates Patient/Participant/Clients are strictly prohibited.

4) In the event that LaSalle Medical Associates fails to pay Contracted Providers for authorized health care services rendered to an LaSalle Medical Associates Patient/Participant/Client, including but not limited to LaSalle Medical Associates's insolvency, the Patient/Participant/Client will not be liable for any sums owed to Contracted Providers by LaSalle Medical Associates.

5) Under no circumstances may Contracted Providers or their agents, trustees or assignees maintain any action at law against any LaSalle Medical Associates Patient/Participant/Client to collect sums owed to Contracted Providers by LaSalle Medical Associates.

1.13 RECOVERY FROM THIRD PARTIES; LIEN RIGHTS:

1) Where duplicate coverage exists, Contracted Providers must assist LaSalle Medical Associates in pursuing coordination of benefits or other permitted method of third party recovery.

2) Contracted Providers must identify and notify LaSalle Medical Associates of all instances or cases in which Contracted Providers believe that an action by a Patient/ Participant/ Client involving the tort or workers' compensation liability of a third party or estate recovery could result in recovery.

3) Contracted Providers may not claim recovery of the value of covered services rendered to a Patient/Participant/Client in such cases or instances and must refer all cases or instances to LaSalle Medical Associates Provider Relations Department within thirty (30) days of discovery.

1.14 BOOKS AND RECORDS:

1) Contracted Providers must agree to maintain its books and records pertaining to the goods and services furnished under his/her agreement(s) with LaSalle Medical Associates, to the cost thereof, in a form consistent with the general standards applicable to such book or record keeping.

2) Contracted Providers must cooperate with LaSalle Medical Associates in order to enable LaSalle Medical Associates to fulfill its contractual and statutory obligations, by allowing LaSalle Medical Associates access to Contracted Providers' books, records, and other papers, including the following:

a. Retain such books and records for a term of at least ten (10) years from the close of the fiscal year in which the provider contract is in effect;

b. Comply with all requirements of LaSalle Medical Associates's contracts with Payors, as applicable.

3) These obligations are not terminated upon termination of the respective agreement(s) with LaSalle Medical Associates whether by rescission or otherwise.

1.15 INDEPENDENT CONTRACTORS:

1) Contracted Providers are at all times acting and performing as independent contractors.

2) The sole interest and responsibility of LaSalle Medical Associates with respect to such performance is to ensure that the services are rendered in a competent, efficient, and satisfactory manner.

3) The legal relationship between LaSalle Medical Associates and Contracted Providers or any of Contracted Providers' employees, associates or subcontractors, may not be construed to cause any such employee, associate or subcontractor to become or to be treated as an employee of LaSalle Medical Associates.

1.16 ASSIGNMENT AND DELEGATION:

1) Contracted Providers may not assign or delegate any of the duties covered in his/her contract(s) with LaSalle Medical Associates without the prior written consent from LaSalle Medical Associates and its Payors, as applicable.

1.17 NON-DISCRIMINATION:

1) Contracted Providers may not discriminate against LaSalle Medical Associates Patient/ Participant/Clients in the rendition of services on the basis of race, color, national origin, ancestry, sex, marital status, sexual orientation or age.

2) Contracted Providers may not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (including cancer), age (over 40), marital status, and/or family care leave.

3) Contracted Providers must insure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment.

4) Contracted Providers must comply with the provisions of the Fair Employment and Housing Act and the applicable regulations promulgated thereunder.

1.18 Grievance and Dispute Procedures:

1) Contracted Providers must comply with the Patient/Participant/Client grievance procedures, as described in Section 11 “Grievances”.

2) Contracted Providers must abide by LaSalle Medical Associates's adjudication process for provider grievances, as described in [ ], consistent with the applicable LaSalle Medical Associates/Payor contracts.

3) All disputes regarding the denial or modification of payments for authorized services provided by Contracted Provider, or a denial or modification of a Contracted Provider’s request to obtain authorization for services, shall be resolved according to LaSalle Medical Associates’s Provider appeals procedures as outlined under Section 8 “Medical Service Denials and Appeals”.

1.19 DUE PROCESS:

1) LaSalle Medical Associates offers its contracted providers “due process” by notifying providers in writing of the reason(s) for participation denial, suspension or termination from LaSalle Medical Associates’s contracted network.

2) Contracted Providers have the right to request and to be offered due process in appealing initial determinations.

3) LaSalle Medical Associates processes reports to the Medical Board of California (MBC-805 report) and/or the National Practitioner Data Bank (NPDB) when required to do so by State and Federal law.

1.20 INSURANCE COVERAGE:

1) Contracted Providers must provide, at their own expense (unless otherwise defined in their contract), a policy of general liability, professional liability insurance and other insurance, as applicable.

2) Contracted Providers' Professional Liability Insurance (unless the parties otherwise designate in writing) shall provide for limits of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate.

3) Such insurance must cover Contracted Provider and its employees against any

claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of any services provided by Contracted Providers.

4) Insurance coverage must be maintained by Contracted Providers throughout the entire term of his/her agreement(s) with LaSalle Medical Associates.

5) Contracted Providers must provide LaSalle Medical Associates with certificates of insurance or evidence of self-insurance demonstrating the insurance coverage, and must provide for no less than thirty (30) days written notice to LaSalle Medical Associates of any cancellation, reduction, or other material change in the amount or scope of any coverage(s).

SECTION 5

Confidentiality

Information about our patients/participants/clients/practitioners must be maintained in the strictest confidence with Sections 1374.8 and 1399.900 et seq. of the California Health and Safety Code and Section 56.10 of the California Civil Code.

Definition: Senate Bill (SB) 1903, Chapter 1066, Sections 56.10, 56.11 and 56.07 of the Civil Code and Section 12311 of the Health and Safety Code - "Confidentiality of Medical Information Act" - that except for specified circumstances, would require a valid authorization for release of medical information to a person or entity not otherwise authorized by law to obtain such information.

This law also provides that an adult patient/participant/client shall be entitled to inspect his/her health records upon written request to the health care practitioner. The bill also authorized an adult patient/participant/client to prepare a specified addendum to his/her health record if the patient/participant/client believes that the records are incomplete or inaccurate and requires the health care practitioner to attach that addendum to the patients/participants/clients health records.

1. Confidential patient/participant/client specific medical information is data related to a patient/participant/client physical or mental condition, medical history or medical treatment, that provides sufficient detail to allow identification of the individual member and, includes any one of the following:

a. Social Security Number;

b. Family Identification number;

c. Patient/Participant/Client number;

d. Address; or

e. Any other patient/participant/client identification number.

2. Except to the extent expressly authorized by the patient/participant/client, LaSalle Medical Associates may not intentionally share, sell or otherwise use any medical information for any purpose not necessary to provide the health cares services to the patient/client.

3. All personal and clinical information related to patients/participants/clients is considered confidential. This may include, but is not limited to:

-Medical information relating to his or her physical or medical condition.
-Medical history or medical treatment that provides sufficient detail to allow identification of the patient/participant/client and/or any one of the following:

a) Social Security Number

b) Family Identification number

c) Patient/participation/client name

d) Medical information collected during the utilization management

process for the purposes of managing the quality of health care resources;

e) Claims records or files containing data pertaining to claims or certification of requested services. This includes patient/participant/client grievance materials;

f) Patient/Participant/Client data collected during the enrollment and underwriting process; and

g) All information of a personal nature acquired by LaSalle Medical Associates.

4. The fact that a patient/participant/client is established with LaSalle Medical Associates Health Services is not considered confidential.

5. LaSalle Medical Associates Health Services staff is responsible for maintaining confidential information.

6. Clinical information received verbally may be documented in a database. The database may include a secured system restricting access to only those with authorized entry. Computers must be protected by a password known only to the computer user assigned to that computer. Computers will not be left on

unattended if any computer screen displays member or practitioner information.

7. Electronic, facsimile, or written clinical information received is secured, with limited access to employees to facilitate appropriate participant/patient/client care. No confidential information or documents will be left unattended, i.e. open carts, bins or trays at any time. Hard copies of all documents will not be visible during breaks, lunches, or time spent away from desks.

8. Written clinical information will be stamped “confidential” with a warning that the information release is subject to State and Federal law.

9. Confidential information will be stored in a secure area and medical information will be disposed of in a manner that maintains confidentiality, i.e., paper shredding and destroying of recycle bin materials.

10. Any confidential information used in reporting to other departments or to conduct training activities, which may include unauthorized staff, will be “sanitized” (i.e., all identifying information blacked out), to prevent the disclosure of confidential medical information.

11. All records related to quality of care, unexpected incidence investigations, or other peer review matters are privileged communications under California Health & Safety Code section 1370 and California Evidence Code section 1157.

12. These records are maintained as confidential. All such written information will be stamped “confidential”, with a warning that release is subject to state and federal law. Information is maintained in locked files.

CONFIDENTIAL INFORMATION – RELEASE TO THE PATIENT/PARTICIPANT/CLIENT

1. No written request is required for information/documents that the patient/participant/client would normally have access, such as copies of claims, etc.

2. LaSalle Medical Associates will substantiate the identity of the individual patient/ participant/ client, e.g., ID number, date of service, etc., before releasing any information.

3. A written request signed by the patient/participant/client or representative will be required to release medical records.

4. All requests for confidential information not directly related to scope of patient/participant/client management program will be in writing, stating the requester's name, the specific information being requested and how the information will be used.

5. Information will be limited to person(s) who have a need to know and/or as required by law.

6. No additional information will be released other than that which is requested.

SECTION 6
Utilization Management

The Decision Making Process

The Chief Medical Officer and/or designee(s) will regularly monitor and assess the decision-making performance of its Utilization Management Team participants, (Chief Medical Officer, Utilization/Quality Committee Members, Case Managers), involved in determining medical necessity, managing care and evaluating the effectiveness of the process and outcomes involved. The assessment is based on the consistent application of specified utilization management criteria (e.g., Health Plan guidelines, Milliman & Robertson, Health Care Management Guidelines).

CONSISTENT APPLICATION OF CRITERIA:
The consistent application of utilization management process is enhanced, monitored and evaluated in a number of ways.

1. Member and Provider Appeals: The evaluation of the appeals process provides an opportunity to monitor for consistency. The medical necessity determination is made by the Chief Medical Officer according to established policies and procedures in case review:

a) Outpatient denied referrals;

b) Concurrent review denials;

c) Tracking overturns of original denials by the appeals process;

d) Authorizations.

e) Utilization Management Clinical Criteria.

f) The effectiveness of the review process will be evaluated utilizing participant's follow-up surveys. The results of the evaluation will be reported at least annually to the Quality Management Committee.

g) Recommendations for improvement and a written action plan will be developed as appropriate. This may include coaching, training or other measures to assist with achieving compliance goals.

THE AUTHORIZATION / REFERRALS PROCESS:
The Authorization Referral Request Form is an instrument to communicate to a provider the approval, modification or denial of requested medical treatment, services and/or procedure. The Authorization Referral Request must be submitted with all pertinent information to LaSalle Medical Associates for authorization prior to the practitioner performing any treatment and/or services.

All specialty care services require prior authorization unless otherwise described in communications distributed by the IPA (i.e., direct referral program, authorization matrix, etc.). Primary care physicians are responsible for performing services covered under capitation as described in the Primary Care Physician Agreement under 'Primary Care Physician Responsibilities' (Exhibit 1.1A, Exhibit 1.15, or

Exhibit D; exhibit numbers will vary). PCPs shall submit an authorization request when appropriate and/or in circumstances where patient medical care is outside the PCP scope of services.

Utilization Management referral policies.

RESPONSE TIMEFRAMES:
The request will be reviewed, completed accurately and timely within ICE compliance standards:

- Urgent within (3)
- Routine All others within five (5) business days

AUTHORIZATION PROCESS:
1. Physicians have on-line access 24 hours a day/7 days a week to request authorization for medical services.

2. The authorization, modification or denial determinations will be based on medical necessity and will reflect appropriate application of approved practice guidelines.

3. A computer generated authorization letter will be sent via FAX to the requesting practitioner and requested specialist. A computerized approval letter is sent to the patient/participant/client via the U.S. Postal services.

4. If the requested medical treatment, services and/or procedure are covered by the Health Plan and meets the established criteria, the request will be approved for sixty (60) days.

5. Should the case be questionable, or if additional information is required, the Authorization Coordinator will contract the Primary Care Physician and/or specialist by fax or telephone, requesting specific information as appropriate.

6. When the authorization is pended, the authorization form is faxed to the Physician requesting additional information within 24 hours of the decision.

7. If the case is pended for additional medical information, requests will be upheld no longer than four (4) working days. There will be notification to practitioners within 24 hours of the decision.

8. Should the decision be to deny, the rationale for the denial, an alternative treatment, and the Utilization Management Criteria, including information that the Chief Medical Officer and/or designee shall be available by telephone to discuss the case will be included in the letter.

9. The letters denying or modifying requested services are sent to the patient/participant/ client, via registered mail, provider and Health Plan, within two (2) working days of the determination. Only a physician may make an adverse determination.

OVER AND UNDER UTILIZATION:
The Quality Management Committee on a quarterly basis will review practitioner's report with significant deviations from the standard. The Quality Management Committee will develop any corrective action plans as appropriate. Thresholds/benchmarks to be developed based on the number of members assigned to each practitioner and practitioner's performances.

SPECIALTY REFERRAL DATA:

1. Quarterly, the Primary Care Physician (PCP) monthly rate of referrals by specialty is tabulated. This data is collected by LaSalle Medical Associates to review the data by specific product lines and clinics.

2. The PCPs with a significant number of members whose referral patterns differ significantly from the mean will be identified.

3. The Utilization Management Committee will review approved and denied referrals of the practitioners identified with significant deviations from the standard.

4. Potential over-utilizers will be reviewed for difference in case mix, appropriateness of referrals and evidence of knowledge or skill deficiencies.

5. Potential under-utilizers will be reviewed for case mix differences and evidence of strength in a specialty field (i.e. a Primary Care Physician who does all biopsies prior to dermatology referral).

6. A statistical report will be generated for each practitioner indicating referral performance relative to the mean and standard deviation of the group, validating any change from the previous quarter's data.

HOSPITAL ADMISSION/RE-ADMISSION:

7. High outliers may be due to intensive treatment for members. Low outliers may be due to underutilization, i.e. barriers to care, case mix or effective preventive health care. Outliers will be identified using M&R guidelines.

EMERGENCY ROOM VISITS

8. High outliers may reflect poor PCP access, management, or case mix. A combination of high emergency room use or low institutional use may raise concern about barriers to primary care and to secondary care.

9. Practitioners with statistics higher than the M&R guidelines or industry benchmark will be flagged for possible under-utilization.

FEEDBACK AND CORRECTIVE ACTION:

10. Practitioners reviewed by the Utilization Management and/or Quality Management

Committees will receive specific feedback and/or on-going education.

11. Practitioner Corrective Action Plans (CAP) will be developed as appropriate at the recommendations of the Committee.

Referral to Non-contracted practitioner/provider:

The member must be referred to a contracted/credentialed practitioner/provider through LaSalle Medical Associates. In the event that a contracted/credentialed practitioner/provider cannot be located for a particular health service, the referring physician must contact the UM Department for further guidance.

Providers who inappropriately refer a patient to a non-contracted provider will be held responsible for the medical charges incurred.

SECTION 7
Service Coordination

Network Medical Management is responsible for coordinating services for the following services:

- Acupuncture
- Adult day Health
- AIDS and AIDS related conditions waiver program
- California Children Services (CCS)
- Chiropractic Services
- Dental
- Direct Observation Therapy for Treatment of Tuberculosis
- Drug and Alcohol Treatment
- Kidney Transplants
- Lead Poisoning Case Management
- Local Education Agency Assessment Services
- Mental Health
- Prayer or Spiritual Healing
- Regional Centers
- Vision
- Help line support groups transportation services
- Transportation services
- Women Infant and Children (WIC)

Member receiving services from the following carve out programs may be required to disenroll from Health plan:

- In home Medical Care Waiver Program
- Long term care
- Major organ transplants other than kidney (members under 21 will be referred to CCS)
- Multi-purpose senior services
- SNF waiver program
- Acupuncture
- Chiropractic services
- Lead poisoning case
- Prayer or spiritual healing
- MMSP
- AIDs and AIDs related conditions waiver programs and services.

SECTION 8

Medical Service Denials & Appeals

Members and providers will receive written notification of any denial of medical treatment, service and/or procedure with the appropriate accurate information to allow for a timely appeal.

1. Utilization Management Department will send denial letters to the member, provider, and health plan, after the Medical Director or designee has determined the request does not meet medical necessity criteria.

2. All denials for service will be handled in a timely manner (see Referral/Authorization process time frames), and will be entered into the system for tracking purposes.

3. Utilization review criteria are applied consistently and the assessment information is clearly documented by the Medical Director or designee. The approval, denial, or deferral/ modification determinations will be based on medical necessity, benefit coverage, approved Utilization Management Crtieria and practice guidelines.

5. Medical Director or designee will be available to the requesting practitioner to discuss by telephone any determinations based on medical appropriateness.

6. All expedited appeals will be processed in compliance with timeframe required by Centers for Medicare and Medicaid Services (CMS) and in accordance to health plans process.

7. The Utilization Management Department will send denial letters to the member, providers and health plan, in the event that the requests for services are denied by the Utilization Management designated physicians.

8. Only physicians may make an adverse determination by using clinical reasons for the decisions regarding medical necessity referencing description of approved criteria or clinical guidelines.

9. These denial letters are used to communicate to the member, provider and health plan that the requests are inappropriate. The rationale for the denial and alternative treatment plan will be documented clearly with a concise explanation of the reasons for the decision.

10. The requesting practitioner may at any time contact the LaSalle Medical Associates Medical Director or designee during normal working hours to discuss determination of medical appropriateness.

11. The letters are computer-generated, and are sent to the member within two (2) working days of the determination. It includes an explanation regarding the appeals process for both LaSalle Medical Associates and the member's health plan.

12. Denials: Common reason for denial:

a) The provider is not contracted with LaSalle Medical Associates Health Services;

b) The service does not meet utilization review criteria or benefits;

c) The member is not eligible;

d) The service is not a covered benefit. (This includes "Carve-Out" plans);

e) The member's benefits for that service have been exhausted;

f) The primary care physician may provide the services;

g) The referring physician is not contracted with LaSalle Medical Associates; and/or

h) Emergency Department services for a non-emergent situation were not authorized prior to treatment.

APPEALS PROCESS

Member Appeal

1. It is the policy of Network Medical Management to refer all member appeals to the appropriate Health Plan, to ensure members are provided appropriate medical care of the highest possible quality.

2. The health plan will contact Network Medical Management for appropriate information needed to resolve the member's issue. Network Medical Management will contact the provider to obtain the information requested, which must be submitted within the time guidelines mandated by each health plan.

Provider Appeal

1. If the provider chooses to appeal the determination for a denial of a requested service by LaSalle Medical Associates, the appropriate medical information is gathered by the Utilization Management Coordinator for evaluation by the Chief Medical Officer, Physician Leader and/or the Utilization Management Committee.

2. If appropriate, the appeal will be reviewed at the next regularly scheduled Utilization Management Committee meeting. The Chief Medical Officer or designee reviews expedited appeals immediately.

3. Previous decisions are reconsidered.

4. A determination is made regarding a reversal or to uphold the original denial will be completed within thirty (30) days of appeal. The Provider shall receive written notification of the outcome.

5. All expedited appeal responses are made within seventy-two (72) hours.

6. Should the determination be made to modify or reverse the original decision:

a) Reversals of denials for requests for service will be processed within thirty (30) days; and

b) Reversals of denials for requests for expedited appeals are processed immediately.

7. The Utilization Management Committee reviews all denials and appeal determinations on a regular basis.

SECTION 9
Case Management

- **Availability**

  LaSalle Medical Associates has 24 hour, seven days a week, on-call coverage for its participating physicians. If you need to reach the LaSalle Medical Associates after hours or on weekends, please call (877) 282-8272. A case manager and/or physicians are on call routinely. The answering service will contact the appropriate on-call physician for any problem that may arise after hours, including emergency room authorizations or after hour patient calls. Also if a patient feels they have a serious medical condition, they are instructed to hang up and dial 911 or to go to the nearest emergency room.

- **Hospital Admissions – After Hours**

  All non-emergency hospital admissions **must be authorized**. Hospitals calling after hours to report a hospitalization will be put in contact with the designated case manager. The answering service has access to contact our case managers after hours and on weekends. The case manager will coordinate the members care as needed.

  The primary care physician should notify LaSalle Medical Associates of any admissions by calling (877) 282-8272, in the event they are contacted by the hospital regarding a hospitalization. The case manager will coordinate the members care accordingly.

- **Hospital Admissions – Business Hours**

  Providers requesting to admit a member into the hospital, needs to contact Network Medical Management (NMM) and speak with a case manager. The provider will need to may need to submit an authorization request for the hospital admission.

Hospitalists

In an effort to coordinate hospital admissions LaSalle Medical Associates has hospitalist providers' on-call. Our Case Management Department will be contacted by the admitting hospital for notification purposes. The Case Manager will contact the hospitalist assigned to coordinate the member's care. We encourage the primary care physicians to contact our Case Management in the event you receive notification of an admission, or if you require assistance on directing the patient to the appropriate hospital. Case Management is available 24 hours a day, 7 days week at (877) 282-8272

SECTION 10
Quality Management

Program Overview

The mission of LaSalle Medical Associates Quality Management Department (QM) is to ensure continuous improvement, providing for the highest quality health care and human services. This is accomplished through the establishment of a fully integrated multi-disciplinary healthcare network and coordination of all practitioners' participation in performance improvement activities, both clinical and administrative services, under the provision of LaSalle Medical Associates Corporate Quality Committee.

Overview

- Quality Management Department (QM) is designed to insure that optimal patient care within this health care delivery continuum fulfills the programs' responsibility to patients/participants/clients.
- Quality Management is an ongoing integrated program committed to the delivery of optimal care consistent with current medical standards.
- Quality Management guidelines are prepared by the QM Manager and Medical Officer to serve as a resource document, and will be updated as new information is obtained, and as performance improvement activities or external review bodies indicate.
- Quality Management will be evaluated annually.

Procedures:

QM promotes the highest quality of medical care and service to members by performing ongoing evaluation and modifications. QM identifies and resolves issues that directly or indirectly affect member care.

Quality Management Committee Meetings:

- Special studies & trending
- Preventative Health Services
- Development/Implement Clinical
- Practice Guidelines
- Policy and Procedures
- Grievance Resolution
- Culturally and Linguistically Appropriate Services (CLAS)

All Primary Care Physician offices will be audited on a routine basis by Network Medical Management and on a periodic basis by all HMO companies.

If you need assistance preparing for audits, please contact our Quality Management Department at (626) 282-0288. Network Medical Management will assist you in any way that we can to make sure that you are audit-ready at all times.

Scope

- The scope of the program is comprehensive and includes all activities that have a direct or indirect influence on the quality and outcome of clinical care and service delivered to all LaSalle Medical Associates patients/participants/clients and the services provided to health plans and the LaSalle Medical Associates provider network.
- The framework for improving performances includes the assessment of clinical performance, patient satisfaction, efficiency and effectiveness of processes, patient/family communication, education, access to, and outcome of care.
- Issues, which affect a high volume of patients/participants/clients, occurring frequently, affect specific age groups or identified risk populations, or impact the health and safety of patients/participants/clients will be considered priorities for immediate improvement.

Quality Improvement Priorities

Each annual review of the quality improvement initiatives will be prioritized, and will include, but not be limited to the following:

1. High volume/low volume – those services frequently or infrequently performed,

variation has a greater impact.

2. Problem prone – those services known to have an increased rate of complications

or problematic conditions.

3. Documented patient satisfaction outcomes - positive or negative feedback from patients, families or referral sources.

4. Risk management potential - patient, medical staff, employee, financial, or facility risk.

5. Financial impact - a process or outcome that has the potential for significant negative financial standing if not performed well.

6. Health education - improve patient/ client/ participant outcomes by promoting healthy behaviors and involving the patient and family where appropriate. Education should be directed at both prevention of illness and treatment of acute and chronic conditions.

7. Other issues - relating to the organization's mission, vision, values, and strategic plan.

GOALS

The primary goal of QM is to establish, support, maintain, and document quality improvement in LaSalle Medical Associates. This is accomplished through:

1. Providing quality health care services for all patients/clients/participants through monitoring clinical outcomes and satisfaction.

2. Coordinating Quality Improvement Activities to ensure the development and implementation of effective health management systems to increase overall heathcare standards of care and services.

3. Monitoring the Quality Management Program that involves all providers of health care, thereby, ensuring that all levels of care are consistent with professionally recognized Standards of Practice.

4. Conducting studies of outcome patterns and trends, and communicating, documenting, and trending Quality issues to appropriate person(s).

5. Providing effective utilization of staff time, resources, and minimizing duplication of efforts.

OBJECTIVES

1. Ensure an ongoing Quality Management Program conducted in a cost effective manner that includes mechanisms for the monitoring and evaluation of the quality and appropriateness of patient/client/member care and services.

2. Focus of quality management data at a central point for examination, analysis and documentation of ongoing implementation.

3. Identify and correct problems that have the greatest impact on patient/client/member care and services; identify trends or patterns that warrant evaluation, and identify important single clinical events.

4. Improve operational systems to provide optimal care and services in a cost effective manner.

5. Review adverse outcomes in order to ensure system and procedure corrections.

6. Ensure effective communication systems for reporting quality management activities to Medical Staff and Administration.

7. To identify and evaluate urgent situations requiring immediate action.

8. Coordinate Quality Management activities with other performance monitoring activities including, but not limited Utilization Management, Risk Management, Credentialing, and Safety.

SECTION 11
Grievances

Purpose
To establish an equitable, timely and efficient mechanism to resolve patient/ participant/ client, or provider grievances regarding care and/or services delivered by the LaSalle Medical Associates network providers.

Policy
It is the policy of Network Medical Management to refer all member grievances and appeals to the appropriate Health Plan, to ensure members are provided appropriate medical care of the highest possible quality.

The health plan will contact Network Medical Management for appropriate information needed to resolve the member's issue. Network Medical Management will contact the provider to obtain the information requested, which must be submitted within the time guidelines mandated by each health plan.

PROCEDURE

1. Complaint or grievance process

1.1 If not delegated by respective health plans for complaints and grievances, Member Services will forward the grievance to the respective health plan for assistance. If the complaint or grievance is received directly from a Member that is assigned to LaSalle Medical Associates through a managed care plan that does not delegate the responsibility for handling grievances to LaSalle Medical Associates, such grievance shall be forwarded to the appropriate health plan within 24 business hours of receipt. The review process will be followed as appropriate or guided by the health plan.

2. Assistance to Members

2.1. Members are not required to use any particular form or document to file a complaint in writing; LaSalle Medical Associates's Member Services Department may assist members with processing complaint or grievance statements in writing or the member may submit a complaint statement directly to their health plan.

2.2. LaSalle Medical Associates's Member Service Department shall assist Members with questions regarding the procedures for filing Complaint or Grievances.

3. Responsible staff

3.1. LaSalle Medical Associates's Chief Medical Officer (CMO) shall have primary responsibility for maintenance of the complaint or grievance process and utilization of any emerging patterns of Complaint or Grievances in the formulation of policy changes and procedural improvements to LaSalle Medical Associates's administration of the program.

3.2. LaSalle Medical Associates's Health Care Services, or designee shall have primary responsibility for the oversight of the complaint or grievance process.

SECTION 12
Access Standards

Health care access standards established by LaSalle Medical Associates ensure all members have access to health care services. We monitor performance annually for each of these standards as part of our quality improvement program. This enables us to identify areas for improvement. LaSalle Medical Associates access standards are listed below in accordance with California Managed Health Care Coalition, health plan and NCQA standards.

Access Criterion	LaSalle Medical Associates Standard
Preventive Care Appointment	Within 30 calendar days – 20 days for Medicare members
Specialty Appointment	Within 14 calendar days
Routine Primary Care Appointment	Within 7 calendar days
Urgent Appointment (PCP & SPC)	Within 24 hours or Same day appointments
Sensitive Services	Sensitive Services must be made available to members preferably within 24 hours but not exceed 48 hours of appointment request. Sensitive Services are services related to: • Sexual Assault • Drug or alcohol abuse • Pregnancy • Family Planning • Sexually Transmitted Disease • Outpatient mental health treatment and counseling. • Minors under 21 years of age may receive these services without parental consult. Confidentiality will be maintained in a manner that respects the privacy and dignity of the individual.
Emergency Care (In & Out of Area)	Immediate – Patient must go to the nearest emergency room for life threatening emergencies.
After Hours Phone Emergency	Respond immediately and refer to 911/ER & addresses the needs of non-English speaking members
After Hours Phone Urgent	Respond within 30 minutes
After Hours Phone Non-Urgent	Respond within 24 hours
Telephone Access	Live person answers within 30 seconds
Waiting Time	Within 30 minutes
Self Referral for Preventive Care, Mammography exams+*, Flu Vaccine+*, Women's Health Care	+Annually, *Direct Access: within the contracted network – no authorization required (Medicare)
ER approval for post-stabilization services	Automatically
Out of Area Temporary Urgently Needed Services	No authorization required (Medicare only)
Full-time PCP to Member Ratio	1:2000 (Title 10)

Access Standards

Behavioral Health Access Criterion	LaSalle Medical Associates Standard
Life-threatening Needs	A member with life-threatening emergency needs is seen immediately as same day appointments
Non-life-threatening Needs	A member with non-life-threatening emergency needs has access to care within 6 hours.
Urgent Needs	A member with urgent needs has access to care within 24 hours.
Routine Needs	A member with routine needs has access within 10 working days.
Telephone Access	A member has telephone access to screening and triage; abandonment rates do not exceed 5% at any given time.

LaSalle Medical Associates defines the above criteria as follows:

1) **Preventive care:** e.g., physical exam, GYN exam or immunizations.
2) **Specialty appointments:** e.g. referral by PCP to specialty provider i.e., cardiology, urology or orthopedics.
3) **Routine Primary Care Appointments:** e.g., non-urgent or symptomatic, non-acute, none-life or limb threatening, not interfering with function. Symptoms of milder nature or longer duration. Non-urgent symptoms, intermittent headache, fatigue colds, minor injuries or joint/muscle pain.
4) **Urgent Care Appointments:** e.g. acute but not life threatening, symptoms Present sufficiently bothersome of recent onset, acute abdominal pain, fever, dyspnea, serious orthopedic injuries, vomiting, and persistent diarrhea.
5) **After-hours non-urgent phone call:** e.g. Rx refill, questions regarding current treatment plan or problem identified.
6) **After-hours emergency/urgent phone call:** e.g. life threatening illness or accident requiring immediate medical attention for which delay could threaten life or limb.
7) **Waiting time:** e.g. period from scheduled appointment time until seen by provider in exam room. (Assumption of patient arriving on time)

*** Providers are encouraged to accept walk-in members in case of unforeseen circumstances. Please let your patients know of your office policy for same day appointments.**

SECTION 13
Health Education

Providers are encouraged to inform members about Health Education programs offered by LaSalle Medical Associates and contracted Health Plan organizations which is available in the threshold languages and different formats. The following is a list of health education programs which are available:

Other topics to talk to your doctor about:

- Asthma
- Diabetes
- Drug and Alcohol Problems
- Exercise
- Family Planning/Birth Control
- How to Quit Smoking
- Nutrition
- Parenting
- Prenatal Health (for pregnant women)
- Safety Tips
- STDs and HIV
- Weight Problems

Childhood Obesity

To help members improve and manage their health, we developed several Health Management Programs to address the member's health status and condition.
Given the public health nature of childhood obesity, we have developed a multipronged initiative to assist and equip physicians and health care providers to screen members who are overweight or at risk for overweight, focus on preventive efforts, institute appropriate management, and empower members to lead healthier lifestyles. We offer reference tools and materials to assist providers who care for children to initiate dialog with families about their child's weight, nutrition, physical activity and to enhance patient knowledge of such issues.

Tobacco Cessation Program

Our tobacco cessation program, The Last Cigarette (TLC), offers numerous resources and tools to assist members who want to quit smoking. This program will help members in any stage of cessation readiness and includes several resources. A TLC Quit Kit is available by calling the TLC hotline at **1-866-634-3435**.

Health Education Referral Process

I. Complete Treatment Authorization Request (TAR).
II. Retain copy of TAR in Medical Record and document Health Education referral in progress notes.
III. Fax to Utilization Review Department at number specified on the TAR corresponding to Medical Group.
IV. Utilization Review Coordinators will enter into system and give an authorization number.
V. Utilization Review Coordinators will forward a copy of the TAR to QM/Health Education Department for tracking purposes only.
VI. QM Coordinator will log data on respective Health Education Log per Medical Group. QM Coordinator will find a Health Education facility for the member and contact the member by phone. A letter is mailed to the member and a copy of the letter is faxed to the PCP. QM Coordinator will follow up with member for confirmation of attendance.
VII. Loop closure will be via communication between health educator at the facility and QM coordinator with documentation of member attendance.

SECTION 14
Material Needs Form

If your office is in need of Health Education Materials, please fill out this assessment form and fax response to 626/943-6383.

Provider Name: _____
Provider Address: _____
Provider Telephone: _____
Provider Fax Number: _____
Provider Health Plan Contracts: _____

1. Would you like more information about health education classes?

   _____Yes _____No

2. Do you have health education materials in your office?
   _____Yes _____No

3. What sources have you used to obtain health materials?
   _____

4. Please Circle Health Education Materials needed in your office and specify languages

Advance Directive	Hypertension	Medi-cal Materials
Asthma	Men's Health	Healthy Family
Breastfeeding	Nutrition	Staying Healthy
Cholesterol	Pregnancy	WIC Services
Congestive Heart Failure	STD's	Parenting
Depression	Stress Management	Other:_____
Diabetes Mellitus	Smoking Cessation	_____
Family Planning	Weight Management	
Gyn. Disorders	Women's Health	

English Spanish Chinese Other: _____

Completed by: _____Sent:_____

NETWORK MEDICAL MANAGEMENT USE ONLY

Date Health Education Materials sent to Provider: _____ By: _____

SECTION 15
Cultural and Linguistic Services

Culturally and Linguistically Appropriate Services areas the provider will be responsible for include:

a. Identification of limited English proficient (LEP) and hearing impaired members and recording language preferences/American Sign Language in medical charts. (For example in the registration form)

b. Posting signs at all patient key points of contact to inform LEP and hearing impaired members on the availability of free interpreter services. (see attached)

c. Ability to access interpreter services through Network Medical Management and or Health Plans for medical and non medical points of contact.

d. Ensuring access to free interpreter services to LEP and hearing impaired members on a 24-hour basis which includes an after hours protocol on how to access interpreter services. This also includes face- to- face and over-the-telephone interpreter services.

e. Offering interpreter services and recording request/refusal of interpreter services in LEP or hearing impaired member's medical chart. Minors are prohibited to be used as interpreters except in emergency/life threatening situations.

f. Attend and/or promote cultural competency training/resources for you and your staff. Ensure qualifications of bilingual staff are kept on file. Language Skills Self-Assessment attached.

g. Making member-informing and health education materials available to LEP members in the threshold languages and also in alternative formats such as Braille, large print etc.

h. Having the right of the members/providers to file a grievance when a C&L is not met and having the availability of the form in the threshold languages and how to obtain it. If you need materials please contact Quality Management department at (626) 282-0288.

SECTION 16
PCP Responsibility for Cultural & Linguistic Services

The California Department of Health Services (DHS) and Network Medical Management (NMM) and its affiliates expect providers/practitioners to adhere to the following:

24-Hour Access to Interpreters
When the Provider/Practitioner does not speak the members' language, he/she must ensure 24-hour access to interpreters for members whose primary language is not English. To access interpreters for NMM members at no cost to you or the patient call Language Line Services at 1-800-367-9559, access code for LaSalle Medical Associates is **2554** or ID **295164**, or utilizes free interpretation services provided by the contracted health plan. It is never permissible to ask a family member to interpret.

State and Federal laws state that it is never permissible to turn away or limit the services provided to them because of language barriers. It is also never permitted to subject a member to unreasonable delays due to language barriers or provide services that are lower in quality than those offered in English. Linguistic services must be provided at no cost to the member.

Documentation
If a patient insists on using a family member as an interpreter, or refuses the use of interpreter services, after being notified of his or her right to have a qualified interpreter at no cost document this in the member's medical record.

All counseling and treatment done via an interpreter should be noted in the medical record by stating that such counseling and treatment was done via interpreter services. Practitioners should document who provided the interpreter service. That information could be the name of their internal staff or someone from a commercial vendor such as Language Line. Information should include the interpreters' name, operator code number and vendor.

Facility Signage
DHS requires that Practitioner offices post important signs in the threshold languages such as the "free interpretation services" poster. Check the health plan's website for downloadable signs in a variety of languages. If you need particular signage and cannot locate it, contact Quality Management Department for assistance at (877) 282-8272ext.6207.

SECTION 17

Protocol to Request a Face to Face Interpreter

When is face-to face interpretation recommended?

- To explain complex medical consultation or education (i.e. medical diagnosis, treatment options, insulin instructions, etc.) to a limited- English proficient (LEP) or hearing impaired member.

- When an LEP or hearing impaired member requests it.

Please follow these instructions when requesting a face to face interpreter for a Health Plan member, including for the hearing impaired:

- Provider must call the member's designated health plan as listed below

NO LESS THAN 7 DAYS IN ADVANCE.

- The provider must verify the member's eligibility. Once eligibility is verified, the provider will arrange for an interpreter.
- Please have the following information ready:
  1. Provider's Name
  2. Provider's Telephone Number
  3. Contact Person
  4. Language requested (including American Sign Language)
  5. Patient's Name and ID Number
  6. Patient's Gender
  7. Date of Appointment
  8. Time of Appointment
  9. Type of Appointment (i.e. routine exam, specialist, OB/GYN, etc.)
  10. Duration of Appointment
  11. Location of Appointment
  12. Other special instructions (i.e. patient has other disabilities, driving directions, etc.,)
- Please make sure to provide your member with date and time of appointment.

Health Plan	Contact Number
Blue Cross Medi-Cal	1-800-407-4627
Care 1st Health Plan	1-800-605-2556
Health Net Medi-cal	1-800-977-3073
L.A Care Health Plan	1-888-450-2272
Molina Health Care	1-800-526-8196 ext. 4247

PLEASE CONTACT THE DESIGNATED HEALTH PLAN AT LEAST 24 HOURS IN ADVANCE IF THE APPOINTMENTHAS BEEN CANCELLED OR RESCHEDULED.

SECTION 18
Language Line Services Guidelines

Language Line Automated Access offers a fast and efficient way to connect to a professional Interpreter, anytime, anywhere. Language Line Automated is an over-the-phone interpretation service that ` more than 140 languages, 24 hours a day. The following is a ***Quick Reference Guide*** of how to use this free service provided for your office by Network Medical Management. Please ensure that all users in your office know how to use the conference feature on their phone for this service to be used efficiently.

Log In Information:
Toll Free Line: 1-800-367-9559
Client ID# 295164
Access Code: 2554

Help Information:
Customer Service Line: 1-800-752-6096 Option 1
E-mail: www.LanguageLine.com

1. Place the non-English speaker on Conference Hold.
   - ❖ If you are placing an outbound call, access the Interpreter first and then place the call to the non-English speaker.

2. Dial Language Line Services at 1-800-367-9559

3A. Press 1 for Spanish.
- ❖ Say "help" if you encounter a problem. Your call will be transferred to a representative.

3B. Press 2 for all other languages.
- ❖ Speak the name of the desired language clearly; (e.g. "Chinese", "Japanese"). *Say only the language name* – do not add any other words. The system will repeat your request and ask that you:
- ❖ Press 1 to confirm the language.
- ❖ Say "help" if you encounter a problem. Your call will be transferred to a representative.

4. Enter your 6-digit Client ID# (provided above) on the telephone keypad.

5. Enter your numeric Access Code (provided above) followed by the pound sign (#) on the telephone keypad.

6. Your Interpreter is connected to the call. Brief the Interpreter about the nature of the conversation and provide specific information to be relayed to the non-English speaker.

7. Add non-English speaker to the line after you have briefed the Interpreter.

Should your member refuse to utilize the Interpretative Services, please complete the Request/Refusal form for Interpretive Services and place in the member's medical records.

SECTION 19
Request/Refusal Form for Interpretive Services

Patient Name:
_____

Primary Language:
_____

- ❑ Yes, I am requesting interpretive services.
  Language: _____
- ❑ I prefer to use my family or friend as an interpreter. (Interpreters must be over 18 years of age)
- ❑ No, I do not require interpretive services.
- ❑ N/A

Please explain:
_____

_____

_____

_____ _____
Patient Signature Date

- Please place in patient's medical record.

Other languages are available upon request. (Spanish, Chinese, Vietnamese, Armenian, Russian, Khmer)

SECTION 20
Credentialing

POLICY

LaSalle Medical Associates Health Services is committed to providing quality care to its members. Consequently, LaSalle Medical Associates uses a rigorous process to evaluate providers. This process thoroughly evaluates a provider's experience, licensing and sanction activity, and quality of care.

PROCEDURES

1. The Credentialing Committee is responsible for making decisions regarding provider credentialing. The Credentialing Coordinator reviews each initial application with all supporting verifications and documentation prior to submission to the Credentialing Committee.

2. Initial Application:

LaSalle Medical Associates Health Services uses the approved California Participating Physician Application (CPPA) and the Council for Affordable Quality Healthcare (CAQH) application. These applications will require the provider to provide information on:

2.1. Reasons for inability to perform the essential functions as a provider, with or without accommodation;

2.2. Lack of present illegal drug use;

2.3. History of loss of license and felony convictions;

2.4. History of loss or limitations of privileges or disciplinary activities; and.

2.5. Attestation by the applicant of the correctness and completeness of

the application. Attestations will cover seven (7) years for initial providers and three (3) years for re-credentialed providers.

3. Completed application:

Each applicant will be required to complete an application. In addition, the applicant will provide:

3.1. A Curriculum Vitae (CV);

3.2. A copy of current State Medical or Dental License(s) (pocket license);

3.3. A copy of a valid DEA certificate (if applicable);

3.4. Face Sheet of Professional Liability Policy or Certification for past and present coverage, in the minimum amounts of $1 million per occurrence and $3 million aggregate;

3.5. Clear copies of permit to supervise/operate radiology/fluoroscopy (if applicable)

3.6. Board Certification Certificates (if applicable)

3.7. Certificates of Degree Completion (i.e. medical or dental school)

3.8. Internships and Residency certificates of completion

3.9. A copy of ECFMG (if applicable, Educational Commission for Foreign Medical Graduates)

3.10. CPR or PALS Card

3.11. Activity Report from another clinic/hospital for the previous two years

3.12. Proof of 50 hours of Category I continuing medical education activities for the previous two (2) years. Copies of actual certificates/hospital verification of course attended (CMA printout card containing hours only is not acceptable.

3.13. Addendum A;

3.14. Addendum B (as applicable);

3.14. Addendum C

3.15. Provider Rights;

3.16. HIV Designation Form

3.17. Completed Privileging form (as applicable);

3.18. Delegation of Service Agreements (mid-levels) (as applicable);

3.19. Forms of identification issued by state or federal agency;

3.20. Social Security Card: and

3.21. National Provider Identifier

3.22. Request for Taxpayer Identification Number (W-9)

4. Incomplete application:

The Credentialing Department will send three follow-up requests for missing information (e.g. any application which is incomplete, is not accompanied by all supporting documentation, does not include a signed Physician Provider Agreement or is dated more than three months prior to receipt). If the requested information is not received after the third request, the application will be considered inactive.

5. Primary source verification:

Upon receipt of a completed application, LaSalle Medical Associates will obtain and verify information from the sources listed in Appendix A. The Credentialing Department will obtain, through the most effective methods, additional information or clarification, as needed, to provide the Medical Director and Credentialing Committee adequate information to make an informed decision regarding the applicant's qualifications.

6. Provider' rights (Due Process).

Providers shall have the right to:

6.1. The right to review the information submitted in support of his/her

credentialing application. Exception: Applicants are not review references, recommendations, or other information that is peer review- protected;

6.2. The right to respond to information obtained during the credentialing process, which varies substantially from the information provided to LaSalle Medical Associates by the applicant;

6.3. The right to correct information provided to LaSalle Medical Associates which the applicant considers to be erroneous; and

6.4. The right to be informed upon request of the status of his/her credentialing/recredentialing application.

8. Re-applying:

Providers denied by the Board of Directors will not be eligible to reapply for membership for a period of at least two (2) years.

9. Length of appointment:

Practitioners will be credentialed for an initial period of not to exceed three years (36 months) accordance to credentialing policy Policy K – Re-Credentialing.

10. Errors and Omissions:

The Practitioner will be immediately notified in writing of any occurrence. A copy of the official report (if applicable) will be sent to the practitioner along with a letter of explanation.

11. All documents received will be date stamped and initialed.

SECTION 21
Provider Relations Department

Overview

Provider Relations (PR) is committed to being accessible to all contracted physicians on a daily basis. The representatives are responsible for answering inquiries and concerns from contracted providers and assist with resolution.

Provider Relations shall work with contracted providers to ensure that the provider has the necessary information, resources, and assistance to work with the IPA. The following are the responsibilities for Provider Relations:

- Provider Orientation to cover operations for Customer Service, Utilization Management, Claims, Eligibility, IPA rosters, and Quality Management.
- Provider Manual Distribution
- Issues Resolution involving authorizations, claims, eligibility, capitation, contracting
- Provider Education/Training
- Network Updates
- IPA or Health Plan Policy Changes/Updates
- Health Education Material Distribution
- Member Enrollment Issues
- Provider Complaints
- Assistance with Grievances

Provider Relations Department is available Monday-Friday from 9:00 a.m. – 5:00 p.m. Our contact information is follows:

- By phone: (877) 282-8272
- By email: ProviderRelations.Dept@nmm.cc

SECTION 22
Office Ally & On-Line Services

Web Portal, IPA Website

Please visit our websites to verify eligibility, submit claims, authorization submission, and inquiry status information. Providers can also take advantage of our on-line service to download a copy of the primary care physician and specialist provider rosters. You can also search individually for a PCP, specialist, and ancillary provider.

Our on-line features includes

- Authorization status inquiry
- Authorization submission
- Claims submission & status
- Provider rosters; provider search inquiries
- Member eligibility verification

To setup an account with our NMM web portal, contact us via email at www.portal.lsma@nmm.cc or, by phone at (877) 282-8272.

Office Ally

Providers are encouraged to setup an account to start submitting all claims through Office Ally. LaSalle Medical Associates of California/Network Medical Management have opted to partner with Office Ally for all claims submissions.

Please note our payer's ID is*:* **NMM02**

To setup an account with Office Ally please contact them directly at (866) 575-4120, or you can email them at Info@OfficeAlly.com

SECTION 23
Member & Provider Satisfaction Surveys

1.LaSalle Medical Associates is constantly making strides to improve satisfaction for our members and providers. Our Customer Service and Provider Relations Departments are on the phone and in person with members and providers on a routine basis. In effort to evaluate our performance we conduct an annual Member and Provider Satisfaction survey.

2. The survey will allow us to identify how we are doing a health care provider and will help us advance and/or improve our services. Our survey cover all areas of operations that includes, utilization management, case management, claims, eligibility, customer service, marketing, provider relations, and quality management.

3. Provider Relations staff will work with contracted providers to go over key member satisfaction survey questions (i.e., access, overall satisfaction, specialty access, etc.).

4. LaSalle Medical Associates will distribute member satisfaction survey results to contracted providers upon completing survey analysis.

SECTION 24
Contracted Health Plans & Capitated Ancillary Agreements

LaSalle - Inland Empire
Riverside & San Bernardino Counties

➢ CONTRACTED HEALTH PLANS

PLAN	LINES OF BUSINESS	TYPE	CAPPED HOSPITAL
Anthem Blue Cross	• Healthy Families • Commercial	Shared Risk	n/a
Inland Empire Health Plan	• Medi-Cal • Healthy Families	Shared Risk	n/a
Health Net	• Medi-Cal • Commercial • Healthy Families	Shared Risk	n/a
Molina	• Medi-Cal • Healthy Families • Medicare • Medi-Medi / Dual Eligible	Shared Risk	n/a

➢ CAPITATED ANCILLARY CONTRACTS

TYPE	VENDOR/PROVIDER	NOTES
Laboratory	**LabCorp**	Fully Capped
Radiology/Imaging	**RadNet**	Capped w/Carve Outs
DME	**Lifecare Solutions**	Capped w/Carve Outs

❖ LaSalle - Central Valley

➢ CONTRACTED HEALTH PLANS

PLAN	LINES OF BUSINESS	TYPE	COUNTIES
Anthem Blue Cross	• Medi-Cal • Healthy Families (termed)	Shared Risk	Fresno, Tulare. Madera, Visalia
Easy Choice	• Medicare	Shared Risk	San Joaquin

➢ CAPITATED ANCILLARY CONTRACTS

TYPE	VENDOR/PROVIDER	NOTES
Laboratory	**LabCorp**	Fully Capped
DME	**Lifecare Solutions**	Capped w/Carve Outs

❖ LaSalle – Los Angeles

➢ CONTRACTED HEALTH PLANS

PLAN	LINES OF BUSINESS	TYPE	CAPPED HOSPITAL
Anthem Blue Cross	• Medi-Cal	Shared Risk	n/a
Care1st	• Medi-Cal	Shared Risk	n/a
Health Net	• Medi-Cal	Shared Risk	n/a

➢ CAPITATED ANCILLARY CONTRACTS

TYPE	VENDOR/PROVIDER	NOTES
Laboratory	**LabCorp**	Fully Capped
DME	**Lifecare Solutions**	Capped w/carve outs

SECTION 25

Direct Deposit Authorization Form

I. PAYEE INFORMATION

*Payee Name*_____

Tax ID _____ *IPA/Medical Group* **LaSalle Medical Associates**

II. ACCOUNT INFORMATION

Bank Name	Type of Account
	Check box: ☐ Checkings ☐ Savings
Routing # _____ Account # _____	

*Please provide a copy of a voided check

I hereby authorize Network Medical Management on behalf of LaSalle Medical Associates to initiate credit and, if necessary, debit entries* to the account listed on this form. My signature below indicates that I am either the accountholder or have the authority of the accountholder to authorize Network Medical Management to make deposits into the named account.

Signature_____ Date_____

Contact Person_____ Phone_____

E-Mail Address_____

* "Debit entries" applies to previous agreements, if any, between NMM and the provider in the case of fund transmission errors. No debit entries will occur without prior notification.

PLEASE COMPLETE AND FAX THIS FORM TO:
Fax: 626-943-6379

Attention Accounting Department

SECTION 26
Initial Health Assessment

The first responsibility that you have to new patients is a first check-up as soon as possible after the member enrolls in the health plan. An "initial health assessment," visit is the key to early identification of health problems, treatment, and establishing a strong relationship between the doctor and the new patient. But for members who are new to managed care or are unfamiliar with the importance of preventive care, initial health assessments don't always occur.

Initial Health Assessment Forms

The Initial Health Assessment must be performed using the age appropriate DHS-approved assessment tools. DHS has standardized assessment tools to be administered during office visits, reviewed at least annually and re-administered by the doctor at the appropriate age intervals.

What qualifies as an initial health assessment visit?

- A scheduled office visit for a complete history and physical examination
- An office visit for a specific problem is an opportunity to start an initial health assessment with documentation. Subsequent scheduled appointments must be completed within the 60 or 120 day timeframe.

The initial health assessment must consist of a history and physical examination with an individual health education behavioral assessment that enables a PCP to comprehensively assess the member's current acute, chronic and preventive health needs.

What does not qualify as an initial health assessment visit?

- An office visit for a specific problem without documentation of starting an initial health assessment with subsequent scheduled appointments for completion within the 60 or 120 day timeframe.
- Urgent care or an emergency visit.

When a member is able to manage a specific medical problem, the doctor may want to take advantage of these episodic visits to perform all or parts of the initial health assessment.

What are a Doctor's responsibilities regarding initial health assessments?

1. Schedule every new member for the initial health assessment within the identified timeframe.
2. Provide adequate documentation of the assessments, including the health education behavioral assessment, follow-up care, any exemptions from the initial health assessment and coordination of care in the medical records.
3. Provide documentation of all attempts to schedule an initial health assessment, including the follow-up or missed and broken appointments, and periodic preventive screenings.

Initial Health Assessment

Follow-Up Care

For follow-up care identified at the time of the initial health assessment, appropriate diagnostic and treatment services are required to be initiated as soon as possible but no later than 60 calendar days following either a preventive screening or other visits that identify a need for follow-up care.
For members identified with complex or chronic conditions prior to enrollment or upon completion of the initial health assessment, the doctor is responsible for adequately documenting appropriate referrals made to linked and carved-out service programs, including CCS, Department of Mental Health, Regional Centers, EPSDT Supplemental Services as well as basic care management/care coordination efforts.

Mandated Timeframes

Initial health assessments are age dependent and are required to be provided within mandated timeframes as follows:

- For children under the age of 18 months: within 60 calendar days following enrollment, or within the timelines established by the American Academy of Pediatrics (www.aap.org) for ages two and younger, whichever is less.
- For children 18 months and older: within 120 calendar days of enrollment. The assessment must include the elements of the California Child Health and Disability Prevention (CHDP) Program (www.dhs.ca.gov/pcfh/cms/chdp); arrange for immunizations necessary to ensure that a child is up-to-date for their age; and include an age appropriate health education behavioral assessment.
- For adults over the age of 21: within 120 calendar days of enrollment, and should include an initial complete history and physical examination as well as a health education behavioral risk assessment. For asymptomatic adults the assessment must include, at a minimum, the core preventive services as established in the latest edition of the Guide to Clinical Preventive Services by the U.S. Preventive Services Task Force (www.ahrq.gov).

SECTION 27

Encounter Data Requirements

Providers must certify the completeness and truthfulness of their encounter data submissions, as required by the DMHC. Network Medical Management requires that providers submit all professional encounter data.

- To comply with regulatory reporting requirements of DMHC
- To comply with NCQA-HEDIS reporting requirements
- To provide the Medical Group/IPA or other submitting entity with comparative data
- To produce the Provider Profile and Quality Index
- Utilization management oversight

Providers submit encounter data on a monthly basis. LaSalle Medical Associates encourages providers with large volumes to submit encounter data more frequently. LaSalle Medical Associates will continuously monitor encounter data submissions for quality and quantity.

All data elements found in the CMS 1500 form must be populated for the submission to be complete. The data elements required on the paper based CMS 1500 form will serve as a minimum standard for electronic submissions. Following are some of the most critical data elements:

Member Information:	**Provider of Service Information:**	**Referring physician information:**
• Member name • Member identification number • Member gender • Member date of birth • Medical Group/IPA and facility number • Patient chart number	• Name • National Provider ID (NPI) • UPIN • Federal Tax Identification (TIN) • Physician State License Number • DEA number	• Name • NPI • UPIN • TIN • Physician State License number • DEA number

Encounter Data Requirements

All data records must include the most current industry standard diagnosis (ICD-9-CM), procedure (CPT-4, HCPCS), and place of service codes. **All diagnosis codes must be reported to the highest level of specificity.**

It is imperative that all capitated services be submitted on a regular basis. The health plans hold all contracted providers accountable for this statistical information regarding our patient population, especially when it comes to prevalent disease, treatment outcomes, preventive medicine, etc.

The following are the Encounter Data submission benchmarks:

Commercial/Healthy Families = 1.5 up to 2.0 office visits PMPY
Medicare = 2.5 up to 3.0 office visits PMPY

Encounter data can be submitted using one of the following three methods:

1. NMM Web Portal
2. Office Ally (clearing house)
3. CMS 1500 form. Complete all sections indicated in the preceding example for a clean encounter submission; CMS 1500 like-format.

Encounter data must be submitted within **45 days** from date of service. For diagnosis codes, you must use the **highest 5-digit code** if it is available.

SECTION 28
Health Effectiveness Data and Information Set (HEDIS)

Overview

HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 71 measures across 8 domains of care. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. Health plans also use HEDIS results themselves to see where they need to focus their improvement efforts. HEDIS measures address a broad range of important health issues.

Many health plans report HEDIS data to employers or use their results to make improvements in their quality of care and service. Employers, consultants, and consumers use HEDIS data, along with accreditation information, to help them select the best health plan for their needs. To ensure the validity of HEDIS results, all data are rigorously audited by certified auditors using a process designed by NCQA.

Consumers also benefit from HEDIS data through the State of Health Care Quality report, a comprehensive look at the performance of the nation's health care system. HEDIS data also are the centerpiece of most health plan "report cards".

To ensure that HEDIS stays current, NCQA has established a process to evolve the measurement set each year. NCQA’s Committee on Performance Measurement, a broad-based group representing employers, consumers, health plans and others, debates and decides collectively on the content of HEDIS. This group determines what HEDIS measures are included and field tests determine how it gets measured.

Hedis data is collected from the providers through encounter and chart audits. For a complete summary of the most current HEDIS measures, please visit the website,
http://www.ncqa.org/tabid/59/Default.aspx

SECTION 29
California Children's Services (CCS)

Program

The California Children's Services (CCS) program is a state and county-funded program that serves children under the age of 21who have acute and chronic conditions such as cancer, congenital anomalies and other serious medical conditions that benefit from specialty medical care and case management. State statutes and contracts require that CCS program services be carved out to the applicable health plan. As a result, upon identification of a CCS-eligible condition, providers must refer a child to the local CCS program or contact us to assist with the referral to CCS.

The CCS program requires prior authorization through CCS for all services to be funded through CCS, per the California Code of Regulations. Services are generally authorized starting from the date of referral, with specific criteria for urgent and emergency referrals. A full description of the CCS program is available at **http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx Sample Services and Benefit.**

CCS provides funding for diagnosis, treatment and medical benefits (including medication and supplies) for eligible children. Care is delivered by CCS-paneled providers, CCS-approved facilities, Special Care Centers and other outpatient clinics. Additional services may be authorized by CCS based on a child's unique needs. This may include such necessary items as transportation to physician appointments, travel and lodging arrangements, special equipment and shift care. The state CCS program assesses the qualifications of each provider on its panel and maintains a list of specialists and hospitals that have been reviewed and found to meet CCS program standards. CCS also provides comprehensive medical case management services to all children enrolled in the program.

In addition, Insurance Code Sections 12693.62, 12693.64 and 12693.66, relating to the California's Healthy Families Program, provides that the services authorized by the CCS program to treat a Healthy Families plan's subscriber's CCS-eligible medical condition are excluded from the plan's responsibilities. The participating health plan's responsibility for providing all covered medically necessary health care and case management services changes at the time that CCS eligibility is determined by the CCS program for the plan subscriber. The health plan is still responsible for providing primary care and prevention services not related to the CCS-eligible medical condition to the plan subscriber so long as they are within the Healthy Families program scope of benefits. The health plan also remains responsible for children referred to but not determined to be eligible for the CCS program. - **www.dhcs.ca.gov**

For more information on CCS, updates regarding CCS, or to obtain the list of contracted and/or non-contracted CCS paneled physician, visit their website at:
www.dhcs.ca.gov/services/ccs/Pages/default.aspx

SECTION 30
Member Eligibility Verification

Member eligibility must be verified at the time of visit or appointment with the health plan directly via on-line or by phone. The membership card is not necessarily valid proof of eligibility. If you are in doubt about a patient's eligibility, contact the patient's contracted Health Plan and/or our Eligibility Department at (877) 282-8272or email: Eligibility.Dept@nmm.cc.

Each member identification card is different, but the information is essentially the same. Most membership cards include:

- Name of Insurance Company – HMO/PPO/IPA
- Member's Name
- Membership No.
- Group No.
- Type of Plan
- Effective Date
- Co-Payment Amount (varies **must** be checked with member's current health plan)
- Name of Primary Care Physician

Please use the Eligibility Request Form (see insert) or contact our Eligibility Department to add a member who is not in our system. If possible, copy the member card onto the Eligibility Request Form and complete all information requested. Fax the form to Eligibility Department at (626) 943-6352.

Health Plan Contact Information:

HEALTH PLAN	PHONE NUMBER	WEBSITE
Anthem Blue Cross	(800) 227-3560	www.anthem.com/ca
Care 1st	(800) 605-2556	www.care1st.com
Easy Choice	(866) 999-3945	www.easychoicehealthplan.com
Health Net	(800) 554-1444	www.healthnet.com
Humana	(800) 448-6262	www.humana.com
Molina	(800) 526-8196	www.molinahealthcare.com

Monthly Eligibility & Capitation Report

The eligibility and capitation reports are mailed to all capitated PCP's monthly. The reports contain current membership information, retroactive additions and terminations. The capitation rate by member is also included on your reports.

The CAPITATION REPORT shows the recalculated membership for the Capitation period indicated on the report. Capitation is run for six months to capture retro-activity and current membership.

This report contains the following information:

a) **MEMBER NAME:** Identified member first and last name.
b) **MEMBER ID NUMBER:** Identifies the health plan identification number.
c) **GENDER:** Male or Female
d) **HMO:** Identifies the capitated health plan with capitated membership.
e) **EFFECTIVE DATE:** Identifies the member effective date with the PCP.
f) **TERM DATE:** Identifies the member termination date with the PCP.
g) **AGE:** Member age
h) **CAP MONTH/YR:** The capitation period by month.
i) **CAP:** The capitation paid amount for the capitation period.
j) **ADJUSTMENT COLUMN:** Shows any manual adjustments applied to your current capitation payment.
k) **MEMBER MONTHS TO DATE:** are an accumulative total of member months for the capitation period.
l) **CAPITATION DOLLARS EARNED TO DATE:** is the total capitation earned for the capitation period.
m) **ADJUSTMENT COLUMN:** shows any manual adjustments applied to your current capitation payment.
n) **GROSS CAPITATION DUE:** is the current capitation payable for the capitation period.
o) **CAPITATION PREVIOUSLY EARNED:** is the capitation previously paid for the capitation period minus the current month payment.
p) **NET CAPITATION DUE:** is the current month capitation payment.

If you have any questions regarding the information on the capitation report, please contact Karen Hung at (877) 282-8272ext. 6123

SECTION 31
Laboratory Policies & Procedures

LabCorp
www.labcorp.com

Policy
All laboratory procedures for LaSalle Medical Associates Members **must be ordered through LabCorp Laboratory**. All contracted providers must have an account setup with LabCorp.

Procedures
When ordering routine laboratory procedures please use the LabCorp requisition request form.

Patient Service Centers (PSC)
For a complete list of the PSC's for Labcorp, please visit their website at **www.labcorp.com**

IMPORTANT DISCLAIMER:

Your office will be held responsible for all charges if you use or send an LaSalle Medical Associates patient to an outside/non-contracted Laboratory.

SECTION 32
Claims Submission

All claims for Network Medical Management Managed IPA'S including Fee for Service, Encounters, and Capitated Services must be submitted to the following address:

Network Medical Management
LaSalle Medical Associates
1680 S. Garfield Avenue #204
Alhambra, Ca 91801

Claims Submissions will be accepted in the following method:

- Web Portal
- Office Ally (clearing house)
- Paper claims; via U.S. mail

Reminders for claims submissions

- Providers need to submit encounter data. Including services provided for capitated member visits.
- Claims should always be billed using the highest level of specification; 4th or 5th digit diagnosis code, if applicable.
- All immunizations are paid by Vaccines for Children (VFC) for **Medi-Cal** line of business; Providers will only bill the IPA for the administration fee.

Claims Submission Instructions

The following billing procedure is intended to provide a comprehensive source of instruction for billing personnel. The Health Insurance Claim Form or (CMS 1500 Form) answers the needs of many health insurers. It is a basic form prescribed by CMS for the insurance claim from physicians and suppliers, except for ambulance services. Our goal is to provide quality service to all of our patients. You can help accomplish this goal by following our billing instructions. Payment is dependent on sufficient / insufficient documents submitted (i.e. Operative Report, Patient Progress Report, notes and / or any other information on medical services or supplies). If information is insufficient, your claim may result in non-payment.

To ensure proper payment, please refer to the following instructions when completing the CMS 1500 Form: Items 1 – 12

Patient's and Insured's Information:

Box #	Instruction
1a.	Type the patient's ID Number or Social Security Number.
2.	Type the patient's Last Name, First Name, and Middle Initial (as shown on the patient's ID card).
3.	Type the patient's Date of Birth and Sex.
4.	Type Primary Insured's Name.
5.	Type patient's mailing address and telephone number.
6.	Patient relationship to insured (i.e. self, spouse, child, other)
9a.	Type other insured's policy or group number.
9d.	Type complete insurance plan and product. (i.e. medicare, commercial, medi-cal).
11.	Type insured's policy or group number.
11c.	Type complete insurance plan and product (i.e. medicare, commercial, medi-cal)
12.	Patient or authorized representative must sign and date this item, unless the signature is on file.
17.	Type or print the name of the referring or ordering physician (if applicable).
21.	Type or print the patient's diagnosis / condition. Please use the appropriate ICD9 code number. ***Please use the highest 5-digit code applicable.***
23.	Type prior authorizations number for those procedures requiring professional review organization (PRO), prior approval, or attach Treatment Authorization Request (TAR).
24a.	Type the month, day, and year for each procedure service or supplies.
24b.	Type the appropriate place of service code number. Identify the location by either where the item is used or the service is performed.
24c	Type the procedure, service, or supply code number by using the CMS Common Procedure Coding System (HCPCS). If applicable, show HCPCS modifier with the HCPCS code. However, if you use an unlisted procedure code, include a narrative description.
24d.	Type the diagnostic code by referring to the code number shown on item 21 to relate the date of service and the procedure performed to the appropriate diagnosis. Please

	remember to use the highest specialty code applicable.
24g.	Type the charge for each service listed.

Claims Submission Instructions

24f.	Type the number of days or units. This item is most commonly used for multiple visits.
25.	Type the physician's / supplier's federal tax ID number.
26.	Type the patient's account number assigned by the physician / supplier.
27.	Check the appropriate block to indicate whether the physician / supplier accept assignment.
28.	Type the total amount of charges for the services.
29.	Type the total amount that the patient paid on the submitted charges.
30.	Type the balance due.
31.	Type the physician / supplier, or his/her representative, must sign and date this item.
32.	Type the name and address of the facility if the services were performed in a hospital, clinic, laboratory, etc. If the name and address of the facility are the same as the biller's name and address shown on item 33, enter the word: "SAME".
33.	Type the name and address of the facility if the services were performed in a hospital, clinic, laboratory, etc

SECTION 33
Medical Record Standard

Policy Title: **Medical Record Standards**			Page 1 of 6
Policy No: 102	Effective Date: 6/99	Revision No: 4/00; 11/00; 4/02; 1/03;1/04; 1/05;1/06; 1/07; 1/08; 1/09; 1/10	
Prepared By:	Approved By:		
Quality Management Department	Quality Management Committee		

PURPOSE: To assure timely, consistent and complete medical record documentation that is detailed, organized, allows effective patient care, quality review appropriate health management and is in compliance with NCQA Standards.

ATTACHMENTS: A. Medical Record Audit Tool

POLICY: It is the policy of NETWORK MEDICAL MANAGEMENT to ensure that the medical record is maintained in a manner that is consistent with the legal requirements, current, protected, relevant, standardized, detailed, organized, available to practitioners at each patient encounter, facilitates coordination and continuity of care, and permits effective, timely, confidential, quality review, care and service. It is the policy of NETWORK MEDICAL MANAGEMENT to distribute this policy to all practitioners and to ensure its practitioners comply with these standards.

A. The records serve as the basis for planning and maintaining the quality of patient care. Records that are devoid of pertinent medical information may impact other treating physicians or health professional's ability to provide appropriate care. Failure to maintain adequate and accurate records relating to the provision of services constitutes unprofessional conduct. (Business & Professions Code 2266)

B. Reimbursement for services may be limited or denied unless documentation supports the level of care that the physician is charging for.

C. Incomplete medical records documentation may interfere with a physician's peer's ability to perform peer review and therefore maintain quality health care delivery and may subject the physician to disciplinary action or severe sanction by outside review agencies.

D. The medical records are often a physician's best evidence in a professional liability lawsuit. Inadequate medical records may undermine a physician's ability to defend him or herself.

E. It is recommended that each physician office site employ a process for ensuring that pertinent medical information pertaining to medical and non medical services rendered to members is available at each patient visit and that periodic purging and archiving of medical records information be conducted in accordance with all applicable state and federal laws. Network Medical Management has adopted a seven- (7) year minimum period from the last medical visit in which to purge and archive medical records. (10 yrs. for Medi-care members) Records of minors must be maintained for at least one (1) year after a minor has reached age 18, but in no event for less than seven (7) years. Member medical information and records must be stored in an anonymous manner, and if disposed of must be destroyed in a way such that information is not identifiable, this may mean reformatting, shredding, or another form of destruction, depending on the media involved. It is of Network Medical Management's policy that medical records be retained for seven (7) year to provide for retention of patient care and to establish facts regarding the patient's condition and course of treatment, should those facts ever come into question. *(10 years for Medi-care members) (5 years for Medi-cal & Healthy Families from the end of the current *Fiscal Year in which the date of service occurred; in which the record or data was created or applied; and for which the financial record was created or the Contract is terminated) (For Molina medical records must be kept for 10 years-all product lines)*

F. Occasionally an entry may be made in a medical record that is incorrect due to a mistake or clerical error. If such an entry is discovered, it should be corrected. The erroneous entry itself should not be obliterated or erased. Rather, a line should be marked through it to indicate the error, with the current date and initials of the person making the correction along side the entry. Obliteration of the entry with correction fluid so that it may not be read, may raise a question later as to what the entry contained or why it was erroneous and may jeopardize the defense of a medical mal-practice case should one be filed. Modifying or altering of a medical record for fraudulent purposes is prohibited by law and may result in both disciplinary action by the California Medical Board and criminal action punishable as a misdemeanor. (B&P Code 2262 & Penal Code 471.5)

I. The chart should be maintained and organized in the following manner:

A. An individual record is maintained for each patient. Each patient medical record will be individualized, format standardized, organized and secure and permit effective confidential member care, and quality review.

B. Each patient medical record will be filed and stored in a central place (restricted from public access), utilizing a standardized and centralized medical group network tracking system assuring ease and accuracy of filing, retrieval, availability and accessibility as well as confidentiality. *The staff must be periodically trained on and have evidence of confidentiality and HIPPA guidelines.*

C. Member identification is on each page, which includes first and last name, and or unique patient number established for use on clinical site. Electronically maintained records and printed records from electronic systems contain patient identification.

D. Biographical/personal data will include name, date of birth, address, employer name/phone, sex, home phone, work phone, principle spoken/written language, marital status and insurance information which will be kept in the member's health care record.

E. Member's emergency contact information will be documented in the medical record. This will include the name and phone number of a relative or friend or a home, work, pager, cellular or message phone number. If patient is a minor, the emergency contact must be a parent or guardian. If patient refused to provide information, "refused" is noted in medical record.
F. Entries must contain author authentication including, title and date.
G. Entries must be legible to someone other than the writer.
H. Medical records are consistently organized, content and formats of printed and or/electronic records within the practice site are uniformly organized.
I. Charts contents are securely fastened.
J. There must be evidence that Advanced Health Directive or evidence information has been offered and discussed to adult patient 18 years of age and over.
K. Documentation to occur within 24 hours of patient visit.
L. A clearly identifiable chronic problems/significant conditions (inclusive of behavioral health) are listed will be maintained and dated in the medical chart such as on a problem list. A chronic problem is defined as one which is of long duration, shows little change or is slow progression. *Absence of chronic problems will be noted on the problem list.*
M. A clearly identifiable current continuous medication is listed with name, strength, route, dosage, duration, dates of initial or refill prescriptions and quantity of all prescribed medications will be noted and maintained in the medical chart. Discontinued medication will be noted in the progress notes and stop date will be noted in the medication list.
N. All services provided directly by the PCP, reasons for and results of ancillary services, diagnostic and therapeutic services. *This includes all diagnostic and therapeutic services for which a member was referred by a practitioner such as home health nursing reports, specialty physicians' reports, hospital discharge reports and physical therapy reports.*
O. Allergies and adverse reactions shall be prominently displayed on either the front of the chart or inside cover, in addition to other areas, such as the problem list and on each visits progress note. If member has no allergies or adverse reaction, "No Known Allergies" (NKA), "No known Drug Allergies" (NKDA), also needs to be noted in the medical record.
P. History of present illness is documented. Physical exam to be documented related to presenting complaint. (includes subjective and objective information)
Q. Diagnosis or medical impression, clinical findings and evaluation to be documented regarding each visit.
R. Plan of treatment to be documented and to be consistent with findings and care is medically appropriate.

S. Follow-up plan and date of return visit, if indicated is noted specifically in weeks, months, or as needed.
T. Unresolved and/or continuing problems are addressed in subsequent visit(s).
U. Evidence of continuity of care between PCP and specialists if applicable via progress note notation indicating review of consultant's reports and actions taken by PCP if necessary or that patient was contacted. Evidence of appropriate use of consultants, if applicable. All requested referral information to be placed in the member's medical records. *The medical*

record will include identification for all practitioners participating in member's care and information on services they render.

V. Evidence of appropriates utilization of labs and other diagnostic studies with reasons for and results of studies. All labs and diagnostic reports should reflect PCP review via initials and date. This includes pertinent inpatient records that must be maintained in the office medical record. These records may include but are not limited to the following: history and physical, surgical procedure reports, ER reports and/or discharge summaries.
W. Missed/failed appointment, cancellations and follow-up contacts/outreach efforts are noted in the medical the medical record to ensure appropriate medical care and monitor member non-compliance. "No-show", "Rescheduled" or "Canceled" is noted in the medical records as applicable. Practitioner documents intervention in the medical records.
X. Evidence of compliance with established practice guidelines and related policies and procedures. (e.g., Confidentiality, Missed Appointments, Notification of Test Results, After Hours Calls, Treatment Consent)
Y. Documentation shall substantiate medical care rendered.

AA. Initial Health Assessment (IHA) must be completed on all members within 120 days of effective date of enrollment into the plan or documented within 12 months of prior member's enrollment. This assessment must include a comprehensive history and physical, assessment to determine health practices, values, behaviors, beliefs, literacy levels and health educational needs. *(Please refer to section VII)*
BB. Individual Health Education Behavioral Assessment (IBEHA), for new members must be conducted within 120 days of effective enrollment date as part of the initial health assessment. Existing members, age-appropriate IBEHA is conducted at member's next non-acute care visit, but no later than next scheduled health-screening exam. The tool is re-administered at appropriate age intervals.
CC. The member's primary language will be noted in the medical record.
DD. Linguistics needs for non or limited English proficient members will be prominently noted in the medical record. Request for language and or interpretation services will be documented. The member's refusal of these services will also be documented. Evidence of documentation on request for and refusal of Language interpretive services (see policy #138).
EE. Tracking of record location when out of filing system will be accomplished by way of a tickler system indicating chart whereabouts.

FF. Medical record data obtained between visits will be forwarded to the PCP's office for review and incorporation into the patient's chart.

GG. Adult patients (18 years and older) who inspect their medical records are allowed to provide a written addendum to the records if the patient believes that the records are incomplete or inaccurate. This addendum is included when disclosed to other parties.

HH. Medical records will be transferred among practitioners when a member changes to a new PCP (prior to the member's first visit with the new PCP). The privacy of the medical record will be safeguarded in transit. Requested information will be delivered in a timely manner (prior to the member's first visit with the new PCP) to ensure continuity of care. A practitioner furnishing a referral service will report appropriate information to the referring practitioner/provider in a timely manner. Also the record contains referral notes from medical practitioners to behavioral health practitioners (as applicable) and documented evidence of clinical feedback (i.e. consultations report inclusive of diagnosis, treatment plan, and psychopharmacological medication, as applicable) Practitioners will request information from other treating practitioners as necessary to provide care in a timely manner. *For Senior Members there is no charge for medical record and information transfer. Release of medical records to the member should include reasons but not limited to member's request and quality improvement activities.*

II Disclosure of Medical Information/HIPPA- The expanded definition of "individually identifiable"(includes name, address, phone number, SS number, email address, etc)

- Prohibition of requiring a patient as a condition to receiving Healthcare services to sign an authorization, release, consent or waiver permitting disclosure of medical information subject to confidentiality protection under the law.
- Medical information is release after member authorization and in accordance with applicable Federal or State law.
- A member has the right to authorize/deny the release of PHI beyond uses for treatment, payment or Health Care operations
- Disclosures and security measures for PHI meet the requirements under HIPPA
- In the event of improper use or disclosure of PHI steps will be taken to notify the health plan by self-reporting.

II. Health Maintenance documentation should include the following:

A. Appropriate adult past medical history documentation to include:

1. Smoking habits
2. Alcohol use
3. Substance abuse history
4. Family planning, reproductive health history
5. Surgical procedures
6. Illnesses & serious accidents

7. Discharge summaries from hospitalized members
8. In-patient hospital admissions
9. For members seen >/= times) is easily identified and includes serious accidents, operations, and illnesses.

B. Appropriate Children/Adolescents past medical history documentation to include:
1. Smoking history
2. Alcohol usage/history of substance abuse for patients over 12 years of age
3. Surgical procedures
4. Childhood illnesses
5. Personal/psychosocial/family history
6. Completed and current record

7. Documentation of education and age appropriate preventive/risk screening services and risk factors in accordance with NETWORK MEDICAL MANAGEMENT practice guidelines (including behavioral health practice guidelines (if applicable).
8. For members seen </= 18 years), past medical history relates to prenatal care, birth, operations, and childhood illnesses.

III. Pediatric Preventive Services Documentation should include the following:

A. Referral to Health Assessment Procedure to notify beneficiary to receive a health assessment:

1. For members under the age of 18 months, the PCP is responsible to perform an initial health assessment (IHA) within 60 days of enrollment or within periodicity timelines established by American Academy of Pediatrics (AAP) for age two and younger whichever is less.
2. For members 18 months of age and older upon enrollment, including all adults, the PCP is responsible for ensuring an initial health assessment (IHA) is performed within 120 days of enrollment.

B. Initial Health Assessment documentation for Medi-cal (CHDP PM 160 INF) and Healthy Families (Staying Healthy Assessment form) members should include:

1. Health Developmental history
2. Unclothed physical examination
3. Assessment of nutritional Status
4. Inspection of ears nose, mouth, throat, teeth and gums (any referrals if applicable which include but not limited to: dental care, eye care)
5. Vision Screening
6. Hearing Screening

7. Tuberculosis Testing, Laboratory Testing for anemia, diabetes, and urinary tract infections.
8. Testing for sickle cell trait and Lead Poisoning

9. Immunizations appropriate to age following recommendations of : Advisory Committee on Immunization Practices of the American Academy of Pediatrics
10. Health education and anticipatory guidance.

C. Periodicity Assessments should include:

a) Person's Eligible for periodic assessments shall receive one assessment during each designated age period. Providers must follow the schedule recommended by the American Academy of Pediatrics.

IV. Appropriate Health Education Documentation to include:

A. Date of health education intervention Type and topic of health education Intervention (i.e. one-on-one class, sub group).
B. Patient feedback or comments regarding health Intervention.
C. Referrals to other classes if applicable.
D. Follow-up from previous health interventions with explicit notations in the medical record particularly for consultation, abnormal lab and imaging study results

V. Communication, review and approval of the Medical Record Standards policy and procedure shall be accomplished as follows:

A. Annual review/revision and approval in Quality Improvement Committee
B. Promulgation to practice sites via mailings/meetings, provider visits
C. Inclusion in orientation of new providers

SECTION 34
What to Do In Case Of an Emergency

If an LaSalle Medical Associates patient telephones you with an emergency, the first thing to do is determine whether the patient should call 9-1-1, go to the nearest emergency room, urgent care center, or to your office.

LICENSED PERSONNEL SHOULD HANDLE TRIAGE OF PATIENTS ONLY.

If you determine that it is a life-threatening emergency, please instruct the patient to hang up the phone and dial 9-1-1 immediately.

If you determine that the patient is stable enough to go to the nearest emergency room, urgent care center, or your office to be evaluated, please instruct the patient to be transported by another person. A patient should never be instructed to drive himself/herself in the event of a life-threatening situation.

To seek care coordination for non-life threatening situation after 5:00 pm or on weekends, the physician and/or the patient can call Network Medical Management at (877) 282-8272 and speak to an on-call physician or case management person.

SECTION 35
How to Greet Patients

WHEN THE PATIENT ARRIVES AT YOUR OFFICE:

1) Ask the patient to present his/her medical insurance identification card and check your eligibility list to verify eligibility. To verify eligibility, please contact the patient's contracted Health Plan. Refer to section 5.2, for the Health plan listings.

2) Check the membership card to see if the patient owes a co-payment. Collect the co-payment if applicable. If the patient does not have a card, again, check your eligibility list.

3) Ask the patient if the injury/illness is work-related. If the answer is yes, bill the patient's Workmen's Compensation Insurance Carrier.

4) Ask the patient if they have any other insurance (Coordination of Benefits). In some cases, the other insurance is the primary insurance that should be billed.

5) If laboratory work is required, please contact our contracted laboratory service company.

6) If a patient needs to see a specialist for services not provided by the primary care physician, submit a request for authorization thru our Web Portal, or, via fax using our treatment authorization request form (TAR) to be completed and faxed to Utilization Management.

7) For patient hospitalization and discharge planning, you must fax the face sheet to Case Management Department at (626) 943-6382 for authorization.

8) Submit all ***fee for Service and encounter*** claims on-line through our Web Portal, Office Ally, or on a CMS 1500 FORM: Our claims mailing address: 1668 S. Garfield Avenue 2nd Floor, Alhambra, CA 91801.

SECTION 36
Patient's Rights and Responsibilitiies

It is the Patient's Rights to:

1. Exercise these rights without regards to sex or cultural, economic, educational or religious background or the source of payment for the patient's care.
2. Considerate and respectful care.
3. Knowledge of the name of the physician who has primary responsibility for coordinating the patient's care and the professional relationships of other physicians who see the patient.
4. Receive information from the patient's physician about the patient, the course of treatment and the patient's prospects for recovery in terms that the patient can understand.
5. Receive as much information about any proposed treatment/procedure the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include the procedure/treatment, the significant medical risks involved, alternate course of treatment or non-treatment and the risks involved in each, and to know the name of the person who will carry out the procedure or treatment.
6. Participate actively in decisions regarding the patient's medical care to the extent permitted by law; this includes the right to refuse treatment.
7. Full consideration of privacy concerning his/her medical program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual.
8. Confidential treatment of all communications and records pertaining to his/her care. Patient's written permission shall be obtained before medical records can be made available to anyone not directly concerned with his/her care.
9. Receive timely response to requests for services, including evaluations and referrals.
10. Leave the facility even against the advice of the patient's physician.
11. Continuity of care, advance notice of time and location of appointment and physician providing medical care.
12. Be dvised if facility/personal physician proposes to engage in or perform human experimentation affecting his/her care or treatment and the right to refuse to participate in such research projects.
13. Be informed by his/her physician or a delegate of his/her physician of his continuing health care requirements following the patient's discharge from the facility.
14. Examine and receive an explanation of the patient's bill regardless of source of payment.
15. Have all patients' rights apply to the person legally responsibility to make decisions regarding medical care.
16. Acquire information you desire about your Health Plan, including a clear explanation of benefits and services and how to receive them.
17. Obtain medically necessary health services, including preventive care.
18. Voice a complaint about a health plan or the care you receive through your plan's grievance and appeal procedures, and to receive a timely response to any complaints or inquiries regarding your benefits or care.
19. Discuss (and complete) an advance directive, living will or other health care directive with your health care provider.
20. Receive a second opinion when deemed necessary by the contracting medical group.

21. Receive emergency service when you, as a prudent layperson, believe that a life-threatening emergency occurred. Payment will not be withheld in such cases.

Patient's Rights and Responsibilities cont…

22. Receive urgently needed services when traveling outside of the service area.
23. Not be discouraged to enroll in, or be directed to enroll in, any particular Medicare Choice plans.

It is the Patient's Responsibility to:

1. Follow the plans and instruction for care agreed upon with his/her practitioners.
2. Provide, to the extent possible, information that the medical group and its practitioners and providers need in order to care for the patient.
3. Contact his/her physician or health plan with any questions or concerns about health benefits or health care services.
4. Understand health benefits; follow proper procedures to obtain services, and to abide by health plan rules.

BE INFORMED

IF YOU ARE A PATIENT BEING TREATED FOR ANY FORM OF ***BREAST CANCER***, OR PRIOR TO PERFORMANCE OF A BIOPSY FOR BREAST CANCER, YOUR PHYSICIAN OR SURGEON IS REQUIRED TO PROVIDE YOU A WRITTEN SUMMARY OF ALTERNATIVE EFFICACIOUS METHODS OF TREATMENT, PURSUANT TO SECTION 1704.5 OF THE CALIFORNIA HEALTH & SAFETY CODE.

THE INFORMATION ABOUT METHODS OF TREATMENT WAS DEVELOPED BY THE STATE DEPARTMENT OF HEALTH SERVICES TO INFORM PATIENTS OF THE ADVANTAGES, DISADVANTAGES, RISKS AND DESCRIPTIONS OF PROCEDURES.

BE INFORMED

IF YOU ARE A PATIENT BEING TESTED FOR ANY FORM OF ***PROSTATE CANCER***, OR PRIOR TO PERFORMANCE OF A BIOPSY FOR PROSTATE CANCER, YOUR PHYSICIAN OR SURGEON IS URGED TO PROVIDE YOU A WRITTEN SUMMARY OF ALTERNATIVE EFFICACIOUS METHODS OF TREATMENT PURSUANT TO SECTION 1704.1 OF THE CALIFORNIA HEALTH & SAFETY CODE.

THE INFORMATION ABOUT METHODS OF TREATMENT WAS DEVELOPED BY THE STATE DEPARTMENT OF HEALTH SERVICES TO INFORM PATIENTS OF THE ADVANTAGES, DISADVANTAGES, RISKS AND DESCRIPTIONS OF PROCEDURES.