PROVIDER MANUAL

In-Service 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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Contact Sheet

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NETWORK MEDICAL MANAGEMENT
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List of Contracted Health Plans

LaSalle Medical Associates currently contracts with Knox Keene licensed health plans in the greater Los Angeles, Central Valley and Inland Empire areas and is contract with the following health plans

- Commercial HMO
- Commercial/Covered California
- Medi-Cal
- Medi-Medi
- Senior HMO Plans

The table below reflects the health plans and lines of business that are currently offered by region:

LaSalle - Inland Empire

Riverside & San Bernardino Counties

PLAN	LINES OF BUSINESS
Inland Empire Health Plan	• Medi-Cal
Health Net	• Commercial (Salud) • Medi-Cal • Community Care/Covered CA
Molina	• Medi-Cal • Medicare • Medi-Medi / Dual Eligible • Covered CA
Anthem	• Commercial • Covered CA
Central Health (San Bernardino County only)	• Medicare

ANCILLARY CONTRACTS

TYPE	VENDOR/PROVIDER
Laboratory	LabCorp
Radiology/Imaging	RadNet
DME	Express Rx

LaSalle - Central Valley

PLAN	LINES OF BUSINESS
Anthem Blue Cross	• Medi-Cal
Care1st	• Medicare
Health Net	• Medicare • Medi-Cal

ANCILLARY CONTRACTS

TYPE	VENDOR/PROVIDER
Laboratory	**LabCorp**
DME	**Express Rx**

LaSalle – Los Angeles

PLAN	LINES OF BUSINESS
Anthem Blue Cross	• Medi-Cal
Care1st	• Medi-Cal
Health Net	• Medi-Cal
Molina	• Medi-Cal

ANCILLARY CONTRACTS

TYPE	VENDOR/PROVIDER
Laboratory	**LabCorp**

Section 2: Member Enrollment and Eligibility

Eligibility Verification Process

If it is a member's first time visiting a practice, the front office staff should ask the member for their health plan identification card or for a copy of the enrollment form and make a copy for their records. Each member identification card may look different, but most cards typically include the following elements:

- Name of Insurance Company – HMO/PPO/IPA
- Member's Name
- Membership Number
- Group Number
- Type of Plan
- Effective Date
- Co-Payment Amount (varies; must be checked with member's current health plan)
- Name of Provider (PCP)

Member eligibility must be verified at the time of the appointment, and a membership identification card is not necessarily valid proof of eligibility. If a practice is in doubt about a member's eligibility, front office staff may verify eligibility by calling Network Medical Management's Eligibility Department at (626) 282-0288,sending an email to Eligibility.Department@nmm.cc, logging on to Network Medical Management's Web Portal at https://www.nmm.cc/Portal, or by contacting the health plan directly online or by phone (see table below). Given the frequency of eligibility changes, it is always best to check eligibility directly with the health plans.

Note: If a practice is unable to locate a member on the web portal but had previously confirmed eligibility, the office staff should submit the Eligibility Request Form (page 46), copy the member identification card onto the form and fax the form to Network Medical Management's 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
Health Net	(800) 554-1444	www.healthnet.com
Molina	(888) 665-4621	www.molinahealthcare.com
Central Health	(866) 314-2427	www.centralhealthplan.com

Eligibility and Capitation Report

On a monthly basis, all capitated providers will receive an eligibility and capitation report. Capitation is calculated over a six month period (indicated on the report) to capture enrollment retro-activity and current membership.

Information contained in the report includes the following:

- Member's first and last name
- Member's gender
- Member's age
- Member's health plan identification number
- HMO: Capitated health plan with capitated membership
- Effective date: Member's effective date with the provider
- Term date: Member's termination date with the provider
- CAP: Capitation paid amount for the capitation period
- CAP/member: Capitation rate by member
- CAP month/year: Capitation period by month
- Adjustment column: Shows any manual adjustments applied to a provider's current capitation payment
- Member months to date: Cumulative total of member months for the capitation period
- Capitation dollars earned to date: Total capitation earned for the capitation period
- Adjustment column: Shows any manual adjustments applied to a provider's current capitation payment
- Gross capitation due: Current capitation payable for the capitation period
- Capitation previously earned: Capitation previously paid for the capitation period minus the current month payment
- Net capitation due: Current month capitation payment

Any questions regarding the eligibility and capitation report should be directed to Winsome Brown at (877) 282-8272 ext. 6218.

Section 3: Provider Relations

LaSalle Medical Associates provides support to providers seeking information about items such as network operations, credentialing, contracts and payment schedules as part of their commitment to providing effective and timely communication with all providers.

Responsibilities

LaSalle Medical Associates and Network Medical Management's Provider Relations Department work with contracted providers to ensure that the provider has the necessary information, resources, and assistance to work with the IPA. Their list of duties/responsibilities includes the following:

- Orienting providers to processes and services around customer service, utilization management, claims, eligibility, quality management, etc.
- Provider Manual distribution
- Issue resolution involving authorizations, claims, eligibility, capitation and contracting
- Provider education/training
- Disseminating network updates, including health plan policy changes/updates
- Health education material distribution
- Member enrollment issues
- Provider complaints
- Assistance with grievances

LaSalle Medical Associates IPA encourages providers to contact its Managers of Contracting and Provider Relations or Network Medical Management's Provider Relations Department with any questions or concerns.

- Roberta Sanchez, Provider Network Specialist
  (Central Valley Region)
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  Roberta.Sanchez@nmm.cc

- Kristina Hlebo, Provider Network Specialist
  (Inland Empire Region)
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Section 4: Member and Provider Satisfaction Surveys

LaSalle Medical Associtates IPA and its network partners are constantly making strides to improve satisfaction for their members and providers. In an effort to evaluate its performance, Network Medical Management conducts an annual member and provider satisfaction survey. The survey covers all areas of operations, including utilization management, case management, claims, eligibility, customer service, marketing, provider relations, and quality management. The survey allows LaSalle Medical Associtates IPA and Network Medical Management to evaluate and improve the quality of their services.

Network Medical Management's Provider Relations staff will work with contracted providers on key member satisfaction survey questions (e.g., access, overall satisfaction, specialty access) and will distribute member satisfaction survey results to contracted providers upon completing their analysis.

Section 5: Web-based Systems

Network Medical Management Web Portal

Network Medical Management's Provider Web Portal is a web-based application that enables practices to verify member eligibility, submit/view authorization requests, and submit/view claims data from any location with internet access. Providers can also take advantage of the portal to download a copy of the provider rosters (PCP and/or specialist) and can search individually for a provider (PCP and/or specialist) and/or ancillary service provider.

In order to set up a portal account, a practice must fill out the Web Portal New Account Registration Form (page 47) and contact Network Medical Management's Web Portal team via email at portal.help@nmm.cc or by calling Wayne Dong at (626) 943-6146. Once account information is set up, providers can access the portal at the following address: https://www.nmm.cc/Portal. Portal features include:

- Authorization status inquiry
- Authorization submission
- Claims submission and status
- Provider rosters
- Member eligibility verification

After an account has been set up, questions about the portal can be directed to Network Medical Management's Web Portal team.

Office Ally

LaSalle Medical Associates IPA and Network Medical Management have partnered with Office Ally as one of the preferred methods for submitting encounters and claims. Providers are required to set up an account before they can start submitting all encounters and claims through Office Ally. Please see Section 9 of the Provider Manual (page 26) for more information on how to submit encounters and claims.

Providers should note that Network Medical Management's payer ID is*:* **NMM02**

Practices should contact Office Ally directly via phone at (866) 575-4120 or email at Info@OfficeAlly.com to set up an account.

Section 6: Utilization Management

Utilization Management Program

Utilization management involves evaluation of the necessity of services and the appropriateness of the selected level of care and procedures according to established criteria or guidelines. In the managed care system, the monthly revenue received by the IPA from the health plan for each member (also known as PMPM or per member per month) is fixed. Out of this revenue, all costs must be paid, which means that the resources must be effectively managed. If the costs exceed the revenue, the budget will be in deficit.

Utilization metrics are used to determine how much care is being utilized by a network's members. Typically, utilization is measured per thousand members so that it can be compared and analyzed across providers and practices. Some common utilization metrics are:

- ER/K: Emergency room visits per thousand members
- UC/K: Urgent care visits per thousand members
- Admits/K: Admissions per thousand members
- Bed days/K: Inpatient days per thousand members

These metrics represent some of the most costly points of care and are used to determine how well a provider/practice performs. The key to successful utilization is proactive identification and medical management of those members who are at risk for inappropriate utilization of the most costly points of care. It is important to determine if these members can be more appropriately treated in less acute settings and/or with targeted care management programs. In addition to the aforementioned list, utilization can also be measured through referral metrics on referral patterns to specialists and through encounter submission data which tracks the frequency with which providers see the network's members.

Along with Network Medical Management's Utilization Management Committee, LaSalle Medical Associates IPA's Utilization Management and Quality Management Committees will regularly monitor and assess the performance of its participants (e.g., Medical Director, Utilization Management and Quality Management 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 ability to consistently apply specified utilization management criteria (e.g., health plan guidelines, MCG [formerly Milliman], Health Care Management Guidelines).

Specialty Referral Data

Specialty referral data on contracted providers is collected and tabulated on a quarterly basis by Network Medical Management on behalf of LaSalle Medical Associates IPA. Providers whose referral patterns differ significantly from the average will be identified and reviewed by the Utilization Management Committee. Potential outliers will be reviewed for differences in case mix, appropriateness of referrals and evidence of knowledge or skill gaps. A statistical report will be generated for each provider indicating referral performance relative to the mean and standard deviation of the group.

Hospital Admission/Re-admission

Outliers for hospital admission and/or re-admission may be due to intensive treatment for members or underutilization reflective of barriers to care, case mix differences or lack of access to effective preventive health care. Outliers will be identified using MCR guidelines.

Emergency Room Visits

High outliers for emergency room visits may be reflective of poor access to primary care, management issues, or be due to case mix differences. A combination of high emergency room use or low institutional use may raise concerns about barriers to primary care and to secondary care. Providers with statistics higher than MCR guidelines or industry benchmarks will be flagged for possible access issues.

Feedback and Corrective Action

Providers reviewed by the LaSalle Medical Associates IPA Utilization Management and Quality Management Committees will receive specific feedback and/or on-going education. Provider Corrective Action Plans (CAP) will be developed as appropriate at the recommendations of the Committees.

Referral to Non-contracted Provider

All members must be referred to a contracted and credentialed provider through LaSalle Medical Associates IPA. In the event that a provider cannot be located for a particular health service, the referring provider must contact Network Medical Management's Utilization Management Department for further guidance. Providers who inappropriately refer a member to a non-contracted provider without prior authorization may be held responsible for the medical charges incurred.

Service Coordination

Network Medical Management is responsible for coordinating the following services on behalf of LaSalle Medical Associates:

- Acupuncture
- 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
- Community Based Adult Services (CBAS)
- Regional centers
- Vision
- Developmentally Disabled-Continuous Nursing Care (DD-CNC)
- Family Planning, Access, Care and Treatment Program (Family PACT)
- Transportation services
- Women Infants and Children (WIC)
- Pediatric Palliative Care Waiver (PPC)
- Assisted Living Waiver (ALW)

Case Management

Availability

Network Medical Management's Case Management Department provides 24/7 on-call coverage for contracted providers. Providers needing to reach Case Management after hours or on weekends should call (877) 282-8272. The answering service will contact the appropriate on-call provider for any problem that may arise after hours, including emergency room authorizations or after-hour patient calls. If a member feels they have a serious medical condition, they will be instructed to hang up and dial 911 or to go to the nearest emergency room.

Hospital Admissions

Non-business 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 who will coordinate the member's care accordingly. The answering service has access to contact the Case Manager after hours and on weekends. The provider should notify Network Medical Management of any admissions by calling (877) 282-8272 in the event they are contacted by the hospital regarding a hospitalization.

Business Hours
Providers requesting to admit a member into the hospital should contact Network Medical Management's Case Manager Jade Ocalum at (877) 282-8272 ext. 6169. The provider may need to submit an authorization request for the hospital admission.

Hospitalists

In an effort to coordinate hospital admissions, Network Medical Management provides hospitalists on call. The 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. Network Medical Management encourages providers to contact its Case Management Department in the event that they receive notification of an admission or if they require assistance on directing the member to the appropriate hospital. Case Management is available 24 hours a day, 7 days week at (877) 282-8272. Admission face sheets and in-patient medical records can be faxed to Case Management at (626) 943-6392.

Process for Submitting a Referral Request

An authorization referral request must be submitted with all pertinent information to Network Medical Management for authorization prior to the provider performing any treatment and/or services. Providers are able to submit authorization referral requests 24 hours a day/7 days a week. Authorization approval, modification, deferred or denial determinations will be made based on medical necessity and will reflect the appropriate application of approved guidelines.

The request will be reviewed and completed accurately and timely within Industry Collaboration Effort (ICE), health plan and/or regulatory agency compliance standards as follows:

- Urgent within 72 hours/three (3) business days
- Routine within five (5) business days

For cases that need to be expedited (i.e., non-emergency services needed within 24 hours), providers should submit the request via the Network Medical Management Web Portal and contact Network Medical Management's Customer Service Department at (877) 282-8272.

Authorization Process

Providers wishing to submit an authorization referral request can log in to the Network Medical Management Web Portal at www.nmm.cc/Portal and follow the steps included in the *Web Portal User Guide* provided at the time of orientation.

After an authorization is submitted, the following process will occur:

1. If the requested medical treatment, service and/or procedure is covered by the health plan and meets the established criteria, the request will be approved for sixty (60) days. An approval letter is sent to the member via the U.S. Postal Services (USPS) and a fax is sent to the requesting provider.
2. If additional information is required, Network Medical Management's Authorization Coordinator will contact the requesting provider and/or specialist by fax or telephone in order to obtain specific information as appropriate.
3. If an authorization is pended, a form is faxed to the requesting provider requesting additional information within 24 hours of the decision.
    a. If the case is pended for additional medical information, requests will be upheld no longer than five (5) business days for routine and 24 hours if marked as urgent. There will be notification to requesting providers within 24 hours of the decision.
4. If the authorization is denied, the reason for the denial, an alternative treatment, and the Utilization Management criteria will be included in the letter. The Medical Director and/or designee shall be available by telephone to discuss the case.
5. The letters denying or modifying requested services are sent to the member via USPS and via fax to the requesting provider and the member's primary care provider within two (2) working days of the determination. Only a Medical Director or designee may make an adverse determination.

In some cases, a provider will be able to re-submit an authorization with new supporting documentation. Providers should attach additional supporting documentation to the authorization via the Network Medical Management Web Portal. If the provider is unable to upload the information, supporting documentation should be submitted via fax.

Recommended Records and Clinical Guidelines

The following section lists recommended records and clinical guidelines for specialty referrals. For each specialty (listed alphabetically) there are documents/information which LaSalle Medical Associates IPA may require to evaluate medical necessity:

Allergy

- Clinical notes describing the member's signs and symptoms and conservative management attempted; e.g., nasal steroids
- Consult notes (if obtained) by ENT

Bariatric Surgery

- Completion of bariatric screening tool, to include member's height, weight, BMI, and attempts at weight reduction
- Psych consult

Cardiac

Cardiac consultation is appropriate for:

- Evaluation of member who is high-risk and who remains symptomatic or uncontrolled after provider (PCP) initiation of and titration of therapy
- Evaluation of member with unstable cardiac condition, including unstable angina
- Sustained or complex non-sustained ventricular arrhythmia
- Sustained or severely symptomatic supra ventricular arrhythmia
- Severe cardiomyopathy
- Angina despite maximal medication or markedly abnormal stress test
- Evaluation and surveillance of complex or cyanotic congenital disease
- Severe valvular disease
- Symptomatic
- Associated with LVD
- Atrial fibrillation (AF), if member is candidate for cardioversion or chronic AF with inability to control rate or patient is symptomatic with usual measures
- Chest pain with unstable pattern of angina, exercise stress test abnormal at low-level, ischemia with L V dysfunction, angina post M.I., suboptimal response to medications with limiting symptoms
- Palpitations, if member is having disabling symptoms or has had syncope or near syncope
- Members with new or frequent palpitations, particularly when associated with other symptoms in face of known CAD or significant LVD or other serious structural heart disease
- Request for cardiac rehabilitation must be initiated/recommended by cardiologist
  Information necessary with consultation request may include:
  - Clinical record documenting risk, condition and treatment regimen
  - EKG
  - Previous (outside) report of cardiac cath, PTCA, CABG, stress test, Echo, Chest x-ray, etc.

Endocrine

- Clinical record documenting medical need for service, member's signs and symptoms of concern, and treatment tried
- Current lab verifying deficiency/problems; e.g., thyroid panel
- Special diagnosis study reports; e.g., U.S., C.T., etc., which may have been obtained to validate/diagnose condition

ENT

- Clinical record indicating concern, physical exam findings, signs and symptoms and conservative treatment tried; e.g., series of antibiotics (date and type), antihistamine, and/or steroid use (oral and/or nasal)
- Any current lab and/or x-ray finding specific to concern
- Any specialty consult that may have been accomplished; e.g., allergy consultation or FNA report (of neck node)
- Any diagnostic study which indicates pathology; e.g., biopsy, MRI, CT, etc., requiring surgical intervention
- Any outside records/consultations which indicate need for follow-up

Gastroenterology

- Clinical record documenting signs and symptoms; e.g., anorexia, weight loss, upper abdominal distress persistent after treatment, melena, fecal occult blood and conservative treatment tried.
- Current lab demonstrating concern; e.g., iron deficiency, anemia.
- Current radiology report demonstrating concern; e.g., Barium Enema
- Current specialty study/exam demonstrating concern; e.g., Barium Enema or UGI series report(s)
- Past specialty study/exam/surgical report demonstrating concern; e.g., previous colorectal cancer operative report, colonoscopy or EGD with path report (specifically, previous polyp size and type)

General Surgery

- Clinical record documenting signs and symptoms of condition and treatment tried (if appropriate)
- Current lab demonstrating concern; e.g., CBC with diff
- Current radiology report demonstrating concern; e.g., KUB, U.S.
- Current specialty sh1dy/exam demonstrating concern; e.g., colonoscopic/sigmoid report with path findings

G.U.

- Clinical records indicating reason for consult, with treatment tried
- Urinalysis and, where appropriate, C&S (which should have been treated if positive growth)
- P.S.A. report, where appropriate. If elevated, need to include previous PSA result(s) or document if this was the first PSA study
- Any special diagnostic study

Nephrology

- Clinical records indicating concern with signs and symptoms of same and treatment attempted
- Current pertinent lab reports; e.g., BUN, Creatinine
- Reports of any special diagnostic study performed

Neurology

- Clinical record documenting concern, a neurology exam appropriate to the concern, as well as signs and symptoms
- If referral request is secondary ALOC, mini-mental status exam should be included
- Report of previous (outside) consult/report indicating need for follow-up or further studies
- Results of any diagnostic study demonstrating concern relative to issue to be

investigated. Neurology consults should be considered prior to requesting EMG/NCS

Neurosurgery

- Clinical record documenting signs and symptoms of condition, treatment tried, and neuro exam/deficit, etc.
- Current radiology/imaging reports demonstrating concern; e.g., MRI, CT.
- Consult report (if appropriate) from Neurology or Pain Specialist, suggesting further specialty care

Oncology

- Clinical record describing medical need; e.g., signs and symptoms of concern
- Current lab results
- If hospitalized, previous to consult request, copy of H&P and discharge summary
- Operative report (if surgical procedure has been accomplished) with pathology report
- Any staging studies (reports) accomplished

Orthopedics

- Ortho consult is appropriate for:
    - Evaluation of a condition to determine surgical remedy; e.g., osteoarthritis of hip or knee for possible replacement, possible torn ligament or meniscus, for possible orthoscopic procedure
    - Evaluation of and treatment plan advertisement of an orthopedic condition that has not been amenable to or is showing progressive disability despite usual conservative management
    - Evaluation of suspected aseptic neurosis, locked knee, unstable joint, acute or sub-acute effusions
- Provider (PCP) clinical notes, to include history of concern and P.E. findings, signs and symptoms expressed by member and treatment regimen tried
- Current x-ray reports. Member should be instructed to pick up films and take to consult appointment, once request has been authorized
- Current labs pertinent to concern, as appropriate
- Any specialty procedure/study report that may have been done in or outside the group/IPA specific to the concern; e.g., MRI, previous operative notes

Pain Management

- Pain Management consults are generally appropriate for:
    - Chronic long-standing back pain
    - Pain unrelieved by conservative measures
- Current clinical notes documenting member's signs and symptoms and treatment previously tried; e.g., medication use, local injections
- Any consult (if appropriate) from neurology or neurosurgery indicating need for further specialist consultation
- X-ray or image report defining concern

Physical and Occupational Therapy

- Current clinical notes documenting member's condition and treatment previously attempted (e.g., rest, medications)
- Referral should advise therapist(s) of any specific movement limitations or restrictions (i.e., do not hyper-extend joint)

Podiatry

- Clinical record documenting signs and symptoms regarding concern and conservative management attempted
- X-ray report of feet/foot
- Copies of any previous podiatry provider reports

Pulmonary

- Clinical record documenting signs and symptoms of concern and treatment attempted
- Radiology report; e.g., chest x-ray
- 0_2 sat results
- Previous consult relative to concern or indicating need for follow-up
- Copy of any specialty diagnostic report demonstrating concern; e.g., chest CT, MRI, pulmonary function exam
- Spirometry
- Request for pulmonary rehabilitation may require Pulmonologist endorsement

Rheumatology

- Clinical record documenting signs and symptoms of concern and treatment attempted
- Lab reports documenting/demonstrating concern; e.g., Rheumatology studies, CBC with differential and platelets, chemistry panel 18, sedimentation rate, C reactive protein, rheumatoid factor, ANA
- X-ray reports documenting/demonstrating concern (if accomplished)
- Specialty reports demonstrating concern; e.g., bone density, MRI

Vascular Surgery

- Clinical record documenting signs and symptoms of concern and treatment attempted
- X-ray/Specialty study report documenting concern; e.g., U.S., previous Angiography report
- Copy of previous consult (outside IPA) indicating need for follow-up

Denials

Members and providers will receive written notification of any denial of medical treatment, service and/or procedure.

1. All denials for service will be handled in a timely manner and will be entered into the system for tracking purposes.
2. Utilization review criteria are applied consistently and the assessment information is clearly documented by the Medical Director or designee. Approval, modification, deferred or denial determinations will be based on medical necessity, benefit coverage and approved criteria and guidelines.
3. 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' processes.
4. Only providers may make an adverse determination; they will use clinical reasoning and approved criteria and/or clinical guidelines to determine medical necessity.
5. The requesting provider may at any time contact LaSalle Medical Associates IPA's Medical Director or designee during normal working hours to discuss determination of medical appropriateness.
6. Common reasons for denials:
    a. The provider is not contracted with LaSalle Medical Associates IPA
    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

Appeals

Member Appeal
It is the policy of Network Medical Management to refer all member appeals to the appropriate health plan. 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 requested information, which must be submitted within the timeframe guidelines mandated by each health plan.

Provider Appeal
The Utilization Management Committee will review all denial and appeal determinations on a regular basis. If the provider chooses to appeal the determination for a denial of a requested service, the appropriate medical information is gathered by the Utilization Management Coordinator for review by the Medical Director and/or the Utilization Management Committee.

Requesting providers must resubmit new authorization with supporting documentation with reason for appeal. If appropriate, the appeal will be reviewed at the next regularly scheduled Utilization Management Committee meeting. All expedited appeals are reviewed by the Medical Director or designee immediately, and all expedited appeal responses are made within seventy-two (72) hours. A determination to modify, reverse, or uphold the original decision will be completed and processed within five (5) days of appeal. Reversals of denials for requests for expedited appeals are processed immediately. The requesting provider shall receive written notification of the outcome.

Laboratory

All laboratory procedures for LaSalle Medical Associates IPA members must be ordered through LabCorp.

All contracted providers must have an account set up with LabCorp. Providers should call their Network Medical Management's assigned Provider Relations Representative for assistance to set up a Labcorp account.

IMPORTANT DISCLAIMER: Practices may be held responsible for all charges if they use or send a LaSalle Medical Associates IPA member to an outside/non-contracted laboratory.

Section 7: Quality Management

LaSalle Medical Associates IPA is committed to ensuring that high quality health care is provided to its members. The LaSalle Medical Associates IPA Quality Management Committee and the Network Medical Management Quality Management Department monitor and evaluate the quality and appropriateness of health care services delivered by the IPA and POD participating providers and resolve identified problems based on the prevailing professional standard of care.

How does LaSalle Medical Associates IPA Measure Quality?

Quality is measured using a wide variety of metrics which may include clinical benchmarks (e.g., mammogram rates) and non-clinical benchmarks which are also related to care (e.g., patient satisfaction). Throughout the year, providers will be given reports which display their quality metrics and show how their performance compares to that of their peers. These reports are meant to initiate an open discussion of how care can be improved for all members. Individual performance will be assessed by looking at clinical outcomes, patient satisfaction, efficiency and effectiveness of processes, communication with the member and their family, provision of health education, and the member's access to care. Issues which affect a high volume of members, occur frequently, affect specific age groups/identified risk populations, or impact the health and safety of members will be considered priorities for immediate improvement.

Quality Management Programs are prepared by Network Medical Management. The LaSalle Medical Associates IPA Medical Director and Quality Management Committee will recommend changes to these guidelines (as appropriate) and adopt and implement them.

Quality Improvement Priorities

- Providing quality health care services for all members through monitoring clinical outcomes and satisfaction
- Coordinating Quality Improvement activities to ensure the development and implementation of effective health management systems to increase overall health care standards of care and services
- Monitoring the Quality Management Program to ensure that all levels of care are consistent with professionally recognized standards of practice
- Conducting studies of outcome patterns and trends, and communicating, documenting, and trending quality issues to appropriate individuals
- Providing effective utilization of staff time and resources and minimizing duplication of efforts

Quality Audits

All practices will be audited on a routine basis by Network Medical Management and may be subject to periodic audits by health plans. Practices needing assistance preparing for audits should contact Network Medical Management's Quality Management Department at 877-282-8272 ext. 6207.

Audit results will determine priority areas of quality improvement initiatives. Priority areas may include the following:

- Services known to have an increased rate of complications or problematic conditions
-

- Documented member satisfaction outcomes, including positive or negative feedback from members, families, or referral sources
- Services which have the potential to manage risk related to the member, medical staff, employee, or facility
- A process or outcome that has the potential for significant negative financial standing if not performed well

Access to Care Standards

Health care access standards monitored by LaSalle Medical Associates IPA ensure all members have access to health care services. Network Medical Management monitors performance annually for each of these standards as part of their Quality Improvement Program, enabling them to identify areas for improvement. Additional information on Network Medical Management's access standards can be found in Section 16 of the Provider Manual (page 42).

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on eighty (80) measures across eight (8) domains related to care and service, addressing a broad range of important health issues. 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.[1]

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

Grievances and Appeals

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.

Process
If not delegated by the respective health plan for complaints or grievances, Network Medical Management's Member Services Department will forward the complaint or grievance to the health plan for assistance. If the complaint or grievance is received directly from a member that is assigned to

LaSalle Medical Associates IPA through a managed care plan that does not delegate the responsibility for handling grievances to LaSalle Medical Associates IPA, 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.

[1] www.ncqa.org/HEDISQualityMeasurement/WhatisHEDIS.aspx

Assistance to Members

Network Medical Management's Member Services Department shall assist members with questions regarding the procedures for filing a complaint or grievance. Members are not required to use any particular form or document to file a complaint or grievance in writing. Network Medical Management may assist members with processing complaint or grievance statements in writing or the member may submit a complaint or grievance statement directly to their health plan.

Responsible Staff

LaSalle Medical Associates IPA's Medical Director or designee(s) shall have primary responsibility for overseeing the complaint and grievance process and recommending policy and procedural changes to the LaSalle Medical Associates IPA Utilization Management and Quality Management Committees. Network Medical Management's Quality Management Department will ensure that all complaints and grievances are addressed within the specified timelines and manage policies and procedures governing the complaint or grievance process.

Health Education

Providers seeking resources for health education should contact the member's health plan or call Network Medical Management's Health Education Department at (626) 282-0288. The Health Education Department will help guide providers to resources and programs for members.

Practices seeking health education materials should fill out the Material Needs Form (page 50) and fax it to (626) 943-6383.

Section 8: Encounter Data and Claims Submissions

Encounter Data Submission Guidelines

LaSalle Medical Associates IPA defines encounter data as the documentation of covered medical services performed by capitated providers (PCPs) and sub-specialists capitated for designated services. Providers are required to submit their encounter data within thirty (30) days from date of service. Providers must certify the completeness and truthfulness of their encounter data submissions, as required by the Department of Managed Health Care (DMHC). LaSalle Medical Associates IPA requires that providers submit all professional encounter data for the following reasons:

- Compliance with regulatory reporting requirements of the DMHC
- Compliance with NCQA-HEDIS reporting requirements
- Provide the IPA with comparative data
- Produce the Provider Profile and Quality Index
- Utilization management oversight

Providers must submit encounter data on a monthly basis. LaSalle Medical Associates IPA encourages providers with large volumes to submit encounter data more frequently, and 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 (pages 28-29 include instructions on filling out the CMS 1500 form).

All data records must include the most current industry standard diagnosis, 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 the patient population, especially when it comes to prevalent diseases, treatment outcomes, preventive medicine, etc.

Encounter data submission benchmarks by line of business are as follows:

Commercial = 1.5 up to 2.0 office visits PMPY
Medi-Cal = 3.5 office visits PMPY
Medicare = 2.5 up to 3.0 office visits PMPY

There are three methods of submitting encounter data to Network Medical Management:

1. **Preferred:** Network Medical Management Web Portal: Refer to the *Web Portal User Guide*
2. Office Ally (clearing house): Payor ID: NMM02
3.
4. CMS 1500 form. Complete all sections in CMS 1500-like format for a clean encounter submission. This method of submission is the least desirable.

Providers should use the highest 5-digit code, if applicable.

Claims Submission Guidelines

All claims for services provided to members of LaSalle Medical Associates IPA must be submitted using one of the following methods:

1. **Preferred:** Network Medical Management Web Portal: Refer to the *Web Portal User Guide*
2. Office Ally (clearing house): Payor ID: NMM02
3. Paper claims; via USPS to the following address:
   Network Medical Management
   LaSalle Medical Associates
   9700 Flair Dr.
   El Monte, CA 91731

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 submitted via Network Medical Management Web Portal, Office Ally, or CMS 1500 hardcopy billing form must include the following information:

- Member's name
- Member's birth date
- Member's address
- Member's account number
- Diagnosis or nature of illness or injury (please use the appropriate code number and highest 5-digit code applicable)
- Referring or ordering provider (if applicable)
- Prior authorization number for procedures requiring professional review organization (PRO), prior approval, or attach Treatment Authorization Request (TAR)
- Month, day, and year for each procedure service or supplies
- Procedures, services or supplies (CPT/HCPCS/HDC Code/Modifier)
- Charges
- Days or units
- Rendering provider ID-UPIN, State License, and Tax ID if it uniquely identifies the provider
- Federal tax ID number
- Provider license or UPIN Number
- Total charge
- Amount member paid on submitted charge
- Balance due
- Signature of provider or supplies, including degrees or credentials (submitting paper)
- Provider billing name, address, zip code

- Name and address of the facility if the services were performed in a hospital, clinic, laboratory, etc.

Practices should note that payment is dependent on the submission of sufficient documentation (i.e., Operative Report, Patient Progress Report, notes and/or any other information on medical services or supplies). If information is insufficient, the claim may result in non-payment.

Section 09: Confidentiality and Disclosure of Medical Information

Protecting the privacy of all members is essential to LaSalle Medical Associates IPA and Network Medical Management. Information about our members must be maintained in the strictest confidence in compliance with Sections 1374.8 and 1399.900 et seq. of the California Health and Safety Code (www.ca.gov/HealthSafety/LawsAndRegs.html), Section 56.10 of the California Civil Code (www.leginfo.ca.gov/.html/civ_table_of_contents.html), and the Health Insurance Portability and Accountability Act (HIPAA). The HIPAA of 1996 addresses the efficiency and effectiveness of data exchange for financial and administrative transactions and the security and privacy of health care information. Key components of the regulations are: 1) privacy 2) transactions and code sets 3) security 4) unique identifiers, and 5) enforcement. HIPAA regulations require health plans, providers and health care clearinghouses to protect the privacy of protected health information (PHI). A summary of the HIPAA Privacy Rule can be found at:

www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html;

To ensure the most up-to-date information, providers should visit:
www.hhs.gov/ocr/privacy/index.html.

PHI includes information about a member's physical or mental condition, medical history or treatment and/or any one of the following:

- Social Security Number
- Family identification number
- Member number
- Address, or
- Any other member identification number or detail that would allow identification of the individual member

Some of the most important considerations and issues that practices should be aware of when dealing with confidentiality and PHI are listed as follows:

1. Except to the extent expressly authorized by the member, LaSalle Medical Associates IPA practices may not intentionally share, sell or otherwise use any medical information for any purpose not necessary to provide the health care services to the member.
2. All personal and clinical information related to members is considered confidential. This may include, but is not limited to:
    a. Medical information relating to physical or medical condition.
    b. Medical history or medical treatment that provides sufficient detail to allow identification of the member and/or any one of the following:
        i. Social Security Number
        ii. Family identification number
        iii. Member name
        iv. Medical information collected during the utilization management process for the purposes of managing the quality of health care resources
        v. Claims records or files containing data pertaining to claims or certification of requested services, including member grievance materials, and
        vi. Member data collected during the enrollment and underwriting process
3. The fact that a member is established with LaSalle Medical Associates IPA is not considered confidential.

4. 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 unattended if any computer screen displays member or provider information.
5. Electronic, facsimile, or written clinical information received is secured, with limited access to employees to facilitate appropriate patient care. No confidential information or documents will be left unattended (e.g., open carts, bins, trays) at any time. Hard copies of all documents will not be visible during breaks or time spent away from desks.
6. Written clinical information will be stamped “confidential” with a warning that the information release is subject to State and Federal law.
7. 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.
8. 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.
9. 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.
10. 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.

Privacy and Health Information Disclosure

Privacy regulations establish basic rights for members and their PHI. Regulations propose that members have a right to receive a written notice of information practices of the entity, and that they have a right to request and amend inaccurate or incomplete PHI. The entity must provide a means for individuals to lodge complaints about the entity's information practices.

Covered entities must designate a privacy official, develop a privacy training program for employees, implement safeguards to protect PHI from misuse, and develop a system of sanctions for employees and business partners who violate the entity's policies and procedures.

Confidential Information: Release to the Member

1. No written request is required for information/documents that the member would normally have access to, such as copies of claims.
2. LaSalle Medical Associates IPA will substantiate the identity of the individual member by identifying their ID number, date of service, etc. before releasing any information.
3. A written request signed by the member or representative will be required to release medical records.
4. All requests for confidential information not directly related to scope of the member 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 only those 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 10: Initial Health Assessment

An "initial health assessment," or a visit that occurs soon after a member enrolls, is the key to early identification of health problems, treatment, and establishing a strong relationship between the provider and the new member. For many members who are new to managed care or are unfamiliar with the importance of preventive care, initial health assessments don't always take place.

Initial Health Assessment Requirements

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

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.

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.

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

- Schedule every new member for the initial health assessment within the identified timeframe (see ”Mandated Timeframes” section below).
- 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.
- Provide documentation of all attempts to schedule an initial health assessment, including the follow-up or missed and broken appointments, and periodic preventive screenings.

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 provider is responsible for adequately documenting appropriate referrals made to linked and carved-out service programs, including CCS, Department of Mental Health, Regional Centers, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Supplemental Services as well as basic care management/care coordination efforts.

Mandated Timeframes

Initial health assessments are age dependent and shall 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 11: California Children's Services Program

The California Children's Services (CCS) program is a state and county-funded program that serves children under the age of 21 who 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 Network Medical Management 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 www.dhcs.ca.gov/services/ccs/Pages/ProgramOverview.aspx

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 provider 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.

Section 12: Cultural and Linguistic Services

Overview

Culturally and linguistically appropriate services areas include:

1. Identification of Limited English Proficient (LEP) and hearing impaired members and recording language preferences/American Sign Language in medical charts.
2. Posting signs at all member key points of contact to inform LEP and hearing impaired members on the availability of free interpreter services.
3. Ability to access interpreter services through Network Medical Management and or health plans for medical and non-medical points of contact.
4. 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.
5. 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.
6. Attend and/or promote cultural competency training/resources for providers and staff. Ensure qualifications of bilingual staff are kept on file.
7. 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.
8. 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 a practice needs materials it should fill out the Material Needs Form (page 50) and contact the Quality Management department at (626) 282-0288.

Practices should contact Network Medical Management's Customer Service Department at (877) 282-8272 or the member's health plan to obtain more information on how to access cultural and linguistic services for members of LaSalle Medical Associates IPA.

Documentation

Providers should document any instances of a member using a relative as an interpreter or refusing the use of interpreter services 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, including 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 interpreter's name, operator code number and vendor.

Facility Signage

DHS requires that practices post important signs in the threshold languages such as the "free interpretation services" poster. Practices can refer to health plans' websites for downloadable signs in a variety of languages. For any signage needs, practices can contact Network Medical Management's Quality Management Department at (877) 282-8272 ext. 6207.

Section 13: Credentialing and Re-credentialing Policy and Procedure

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

Procedure

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: Network Medical Management uses the approved California Participating Physician Application (CPPA) and the Council for Affordable Quality Health care (CAQH) application. These applications will require the provider to provide information on:
    a. Reasons for inability to perform the essential functions as a provider, with or without accommodation
    b. Lack of present illegal drug use
    c. History of loss of license and felony convictions
    d. History of loss or limitations of privileges or disciplinary activities
    e. 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:
    a. Curriculum Vitae (CV)
    b. A copy of current State Medical or Dental License(s) (pocket license)
    c. A copy of a valid DEA certificate (if applicable)
    d. 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
    e. Clear copies of permit to supervise/operate radiology/fluoroscopy (if applicable)
    f. Board Certification Certificates (if applicable)
    g. Certificates of Degree Completion (i.e., medical or dental school)
    h. Internships and Residency certificates of completion
    i. A copy of Educational Commission for Foreign Medical Graduates (ECFMG), if applicable
    j. CPR or PALS Card
    k. Activity Report from another clinic/hospital for the previous two years
    l. 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)
    m. Addendum A
    n. Addendum B (as applicable)
    o. Addendum C
    p. Provider Rights
    q. HIV Designation Form
    r. Completed Privileging form (as applicable)
    s. Delegation of Service Agreements (mid-levels) (as applicable)
    t. Forms of identification issued by state or federal agency
    u. Social Security Card
    v. National Provider Identifier
    w. 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, Network Medical management will obtain and verify information. 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:
    a. 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
    b. The right to respond to information obtained during the credentialing process, which varies substantially from the information provided to Network Medical Management by the applicant
    c. The right to correct information provided to Network Medical Management which the applicant considers to be erroneous
    d. The right to be informed upon request of the status of his/her credentialing/recredentialing application
7. 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.
8. Length of appointment: Providers will be credentialed for an initial period of not to exceed three years (36 months).
9. Errors and Omissions: The providers will be immediately notified in writing of any occurrence. A copy of the official report (if applicable) will be sent to the provider along with a letter of explanation.
10. All documents received will be date stamped and initialed.

All questions regarding credentialing and/or re-credentialing should be directed to Isela Ochoa at (877) 282-8272 ext. 6267.

Section 14: Medical Records Policy and Procedure

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.

Policy
It is the policy of Network Medical Management to ensure that the medical record is maintained in a manner that is consistent with legal requirements and permits effective, timely and confidential care and service. It is the policy of Network Medical Management to distribute this policy to all providers and to ensure its providers comply with these standards.

1. The records serve as the basis for planning and maintaining the quality of care. Records that are devoid of pertinent medical information may impact other treating providers 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)
2. Reimbursement for services may be limited or denied unless documentation supports the level of care that the provider is charging for.
3. Incomplete medical records documentation may interfere with the ability to perform peer review and therefore maintain quality health care delivery and may subject the provider to disciplinary action or severe sanction by outside review agencies.
4. The medical records are often a provider's best evidence in a professional liability lawsuit. Inadequate medical records may undermine a provider's ability to defend themselves.
5. It is recommended that each practice employ a process for ensuring that pertinent medical information pertaining to medical and non-medical services rendered to members is available at each 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 Medicare 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 member's condition and course of treatment, should those facts ever come into question. (10 years for Medicare 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).
6. 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 alongside 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).

7. The chart should be maintained and organized in the following manner:
    a. An individual record is maintained for each member. Each member medical record will be individualized, format standardized, organized and secure and permit effective confidential member care and quality review.
    b. Each member 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 member number established for use on clinical site. Electronically maintained records and printed records from electronic systems contain member 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 the member is a minor, the emergency contact must be a parent or guardian. If the member 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 member 18 years of age and over.
    k. Documentation to occur within 24 hours of member 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 provider such as home health nursing reports, specialty provider 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.

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. 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 if that member 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 providers participating in member's care and information on services they render.
u. Evidence of appropriate 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.
v. Missed/failed appointments, 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. Provider documents intervention in the medical records.
w. 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).
x. Documentation shall substantiate medical care rendered.
y. 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.
z. 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.
aa. The member's primary language will be noted in the medical record.
bb. Linguistics needs for non-English speaking 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.
cc. Tracking of record location when out of filing system will be accomplished way of a tickler system indicating chart whereabouts.
dd. Medical record data obtained between visits will be forwarded to the PCP's office for review and incorporation into the member's chart.
ee. Adult members (18 years and older) who inspect their medical records are allowed to provide a written addendum to the records if the member believes that the records are incomplete or inaccurate. This addendum is included when disclosed to other parties.
ff. Medical records will be transferred among providers 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 provider furnishing a referral service will report appropriate information to the referring provider in a timely manner. Also the record contains referral notes from medical providers to behavioral health providers (as applicable) and documented evidence of clinical feedback (i.e. consultations report inclusive of diagnosis, treatment plan, and psychopharmacological medication, as applicable) Providers will request information from other treating providers 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.

8. Disclosure of Medical Information/HIPPA
   The expanded definition of "individually identifiable" (includes name, address, phone number, SS number, email address, etc):
   a. Prohibition of requiring a member as a condition to receiving health care services to sign an authorization, release, consent or waiver permitting disclosure of medical information subject to confidentiality protection under the law.
   b. Medical information is release after member authorization and in accordance with applicable Federal or State law.
   c. A member has the right to authorize/deny the release of PHI beyond uses for treatment, payment or health care operations
   d. Disclosures and security measures for PHI meet the requirements under HIPPA
   e. In the event of improper use or disclosure of PHI steps will be taken to notify the health plan by self-reporting.

9. Health Maintenance Documentation should include the following:
   a. Appropriate adult past medical history documentation, which includes:
      i. Smoking habits
      ii. Alcohol use
      iii. Substance abuse history
      iv. Family planning, reproductive health history
      v. Surgical procedures
      vi. Illnesses and serious accidents
      vii. Discharge summaries from hospitalized members
      viii. Inpatient hospital admissions

   b. Appropriate Children/Adolescents past medical history documentation, which includes:
      i. Smoking history
      ii. Alcohol usage/history of substance abuse for members over 12 years of age
      iii. Surgical procedures
      iv. Childhood illnesses
      v. Personal/psychosocial/family history
      vi. Completed and current record
      vii. 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

10. Pediatric Preventive Services Documentation should include the following:
    a. Referral to Health Assessment Procedure to notify beneficiary to receive a health assessment:

i. For members under the age of 18 months, the provider (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.
ii. 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.

11. Initial Health Assessment documentation for Medi-Cal (CHDP PM 160 INF) and Healthy Families (Staying Healthy Assessment form) members should include:
    a. Health developmental history
    b. Unclothed physical examination
    c. Assessment of nutritional status
    d. Inspection of ears nose, mouth, throat, teeth and gums (any referrals if applicable which include but not limited to: dental care, eye care)
    e. Vision screening
    f. Hearing screening
    g. Tuberculosis testing, laboratory testing for anemia, diabetes, and urinary tract infections
    h. Testing for sickle cell trait and lead poisoning
    i. Immunizations appropriate to age following recommendations of: Advisory Committee on Immunization Practices of the American Academy of Pediatrics
    j. Health education and anticipatory guidance

12. 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.

13. 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. Member 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

14. 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 15: Provider Appointment Access Standards

Purpose
To define the standards for member access to routine/specialty appointments, preventive care, after hours, emergency care, telephone access and behavioral health needs.

Policy
It is the policy of Network Medical Management to provide access to members in accordance with California Managed Health Care Coalition, health plan and NCQA standards. Network Medical Management has adopted the DMHC access standards. Network Medical Management will make these Access Standards and any updates available via the Provider Manual and fax blasts.

Access Criterion-Appointment Type	NMM Time-Elapsed Standard
Preventive Care Appointment	Within 15 calendar days – 20 days for Medicare members and 30 calendar days for Medi-Cal for adults and within 10 calendar days for children (or with-in 120 days for adults of enrollment)
Specialty Appointment	Within 14 calendar days
Routine Primary Care Appointment	Within 7 calendar days
Access to PCP	24 hours a day, 7 days a week for all LOB
Urgent Care Appointment (PCP & SPC)	Within 24 hours If the urgent care appointment does not require prior authorization it is within 48 hours (24 hrs for Medi-Cal) and if it does require prior authorization it is within 96 hours of the request for appointment, with some exceptions
Non-urgent Appointment (PCP & SPC)-excludes physicals and wellness checks	Non urgent appointments for PCP: within 10 business days (7 days for Medi-Cal) and SPC: within 15 business days of the request for appointment (15 days for Medi-Cal), with some exceptions
Well Child Exams/Physicals	Within 2 weeks
Non-urgent, acute illness	3 days or as directed by the provider
Timely Access-Advanced Access (PCP)	Includes appointments with a PCP or other qualified primary care provider such as NP or PA within the same or the next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the member prefers not to accept the appointment offered within the same or the next business day.
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. • 1st prenatal visit must offer the appointment within 5

	business days of request for Medi-Cal members. Confidentiality will be maintained in a manner that respects the privacy and dignity of the individual.
Ancillary Services	Non-urgent services for the diagnosis or treatment of injury, illness, or other health condition: within 15 business days of the request for appointment, with some exceptions
Emergency Care (In & Out of Area)	Immediate disposition of member to the appropriate care setting
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 every day
Telephone Access	Live person answers within 30 seconds, 24/7, call wait times to be answered <30 seconds, call abandonment rate quarterly average within 5%
Member Service Contact	By telephone
Waiting Time (PCP and SPC)	Preferably not to exceed 15 minutes in office waiting time for scheduled appointments otherwise no greater than 30 minutes.
Appointment Waiting Time	The time from the initial request for health care services by member or the member's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or medical group (if delegated) and completing any other condition or requirement of the plan or its contracting providers.
Initial Health Assessment (enrollee age 18 months and older)	Must be completed within 120 calendar days
Initial Health Assessment (enrollee age 18 months and younger)	Must be completed within 60 calendar days
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)
Behavioral Health Access Criterion	Network IPA/Medical Group Standard
Life-threatening Needs	A member with life-threatening emergency needs is seen immediately.
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. If it does not require prior authorization it is within 48 hours & if it does, 96 hours from the request for appointment, with some exceptions.
Non-Urgent Appointment	Non-urgent appointments with a mental health care provider: within 10 business days of the request for an appointment (with some exceptions) and with a mental health care provider; within 10 business days of the request, with some exceptions.
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.
Follow-up Care Post-Hospitalization for Mental Illness	One follow-up encounter with a mental health provider within 7 calendar days after discharge and one follow-up encounter with a mental health provider within 30 calendar days after discharge (must provide both).

Network Medical Management defines the above criteria as follows:

1. Preventive care: Care or services provided to prevent disease/illness and/or its consequences. For example, an annual physical exam, immunizations, or a disease screening program.
2. Specialty care: Medical care provided by a specialist, such as a cardiologist or a neurologist.
3. Routine primary care: Services that include the diagnosis and treatment of conditions to prevent further complications and/or severity. These are non-acute or non-life or limb threatening.
4. Urgent care: Care given for a condition(s) that could be expected to deteriorate into an emergency or cause prolonged impairment, such as acute abdominal pain, fever, dyspnea, serious orthopedic injuries, vomiting, and persistent diarrhea.
5. After-hours non-urgent phone call: Examples include a Rx refill, questions regarding current treatment plan or problem identified.
6. After-hours emergency/urgent phone call: A call made for a life-threatening illness or accident requiring immediate medical attention for which delay could threaten life or limb.
7. Waiting time: the period from scheduled appointment time until seen by provider in exam room (assuming that member arrives on time). The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.
8. Ancillary services: Include, but not limited to, the provisions of pharmaceutical, laboratory, optometry, prosthetic, or orthopedic supplies or services, suppliers of durable medical equipment, home-health service providers, and providers of mental health or substance abuse services.
9. Triage or screening: The assessment of a member's health concerns and symptoms for the purpose of determining the urgency of the member's need for care.

Providers are encouraged to accept walk-in members in case of unforeseen circumstances, and should let members know of their office policy for same day appointments. Members have access to their provider or designee twenty-four (24) hours a day, seven (7) days a week.

Section 16: Forms and Additional Attachments

Eligibility Request Form

Please fill in this form for eligibility inquiry. Photocopies of the member's insurance card, health plans web site eligibility print out or any other supporting information will help expedite the process.

Please fax to: (626) 943-6352

Date: _____ Provider's Name: _____

Provider's Office Contact Person: _____ Provider's Office Contact Number: _____

Provider Fax number: _____ Email: _____

*Member's eligibility status will be verified and returned through fax or email

Last Name	First Name	DOB	Member ID #	Health Plan	Line of Business:	Gender	Address: (Must input for correct authorization)	Phone #	Membership Effect Date
					☐ MCAL ☐ POS ☐ Commercial ☐ Senior/Medicare				
					☐ MCAL ☐ POS ☐ Commercial ☐ Senior/Medicare				
					☐ MCAL ☐ POS ☐ Commercial ☐ Senior/Medicare				

LaSalle Medical Associates Web Portal New Account Registration Form

*Please fill out all required entries and fax completed form to: **(626) 943-6350**

*Vendor/Group Name:	*Tax ID:
*Office Contact/Manager:	Group NPI (if applicable):
*Best Contact Phone Number and Extension:	Office E-Mail Address:
*Best Time to Contact:	Current Web Portal User ID (if applicable):

*Please list all providers (physicians) affiliated under this vendor/group (attach additional sheets if required)			
Provider Name	NPI	Provider Name	NPI
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

What areas of the Web Portal will your office need access to? (Please circle all that apply)

- Eligibility
- Authorization (view)
- Authorization (submit)
- Claims (view)
- Claims (submit)

Will your office be authorizing an outside biller to access the data noted above? Yes No

If yes, please note the outside billing company's information below:

Billing Company:	Billing Contact Person:
Biller Phone Number:	Best Time to Contact:

Authorized Signature:_____Print Name:_____Date: _____

Provider Signature:_____Print Name:_____Date: _____

Direct Referral for Radiological Services Form

Please submit a copy with claim.
Referrals DO NOT guarantee eligibility.

Date of Service ___/___/___

Please check eligibility before rendering services.

Status of Referral: ( ) Routine

Patient Name: _____ _____ Date of Birth: _____
Last name First name

Address:_____

Phone # ( ) ____- _____ Health Plan: _____ Member ID: _____

Performing Specialist:_____ Specialty: **Radiology**

Address: _____ Tel # ( ) _____ - _____

Reason for Referral: (Diagnosis/Findings + ICD9 Code) ICD 9: _____._____
Findings_____

It is important to include relevant data with this request- e.g., progress notes, lab reports, x-rays reports etc.
All other radiological services not listed below require prior authorization

Direct Referral to Radiology Services

Head:
- ☐ Skull (70250)
- ☐ Sinus (70220)
- ☐ Mandible (70110)
- ☐ Facial Bones (70140) (70150)

Chest:
- ☐ Chest – 1 view (71010)
- ☐ Ribs (L, R, Both) (71110)
- ☐ Chest – 2 view (71020)
- ☐ Sternum (71120)

Breast:
- ☐ Mammogram (77057) (age 40 and above once every 2 years)

Spine:
- ☐ Cervical Spine (72040)
- ☐ Lumbosacaral Spine (72100)
- ☐ Thoracic Spine (72072)
- ☐ Sacrum – Coccyx (72220)

Abdomen:
- ☐ X- Ray Abdomen (74000)
- ☐ X- Ray Pelvis (72170)

Extremities:
- ☐ Femur (73550)
- ☐ Clavicle (73000)
- ☐ Forearm (73090)
- ☐ Knee (73562)
- ☐ Scapula (73010)
- ☐ Wrist (73110)
- ☐ Humerus (73060)
- ☐ Shoulder (73030)
- ☐ Tibia/Fibula (73590)
- ☐ Elbow (73080)
- ☐ Hip (73520)
- ☐ Hand (73130)
- ☐ Ankle (73610)
- ☐ Foot (73630)
- ☐ Toe (s) (73660)

Primary Care Physician: (Print only): _____Tel #: ( ) ____- _____

PCP Signature: _____ Date: _____

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: ☐ Checking ☐ 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

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:_____

Request/Refusal for Interpretive Services Form

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)

Patient's Rights and Responsibilities

It is the Patient's Right to:

1. Exercise these rights without regards to sex or cultural, economic, educational or religious background or the source of payment for the member's care.
2. Considerate and respectful care.
3. Knowledge of the name of the provider who has primary responsibility for coordinating the member's care and the professional relationships of other providers who see the member
4. Receive information from the member's provider about the member, the course of treatment and the member's prospects for recovery in terms that the member can understand.
5. Receive as much information about any proposed treatment/procedure the member 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 member'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 member 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 their care. Member's written permission shall be obtained before medical records can be made available to anyone not directly concerned with their care.
9. Receive timely response to requests for services, including evaluations and referrals.
10. Leave the facility even against the advice of the member's provider.
11. Continuity of care, advance notice of time and location of appointment and provider providing medical care.
12. Be advised if facility/personal provider 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 their provider or a delegate of their provider of his continuing health care requirements following the member's discharge from the facility.
14. Examine and receive an explanation of the member's bill regardless of source of payment.
15. Have all member's rights apply to the person legally responsibility to make decisions regarding medical care.
16. Acquire information desired about a member's 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 a member receives through their plan's grievance and appeal procedures, and to receive a timely response to any complaints or inquiries regarding benefits or care.
19. Discuss (and complete) an advance directive, living will or other health care directive with a provider.
20. Receive a second opinion when deemed necessary by the contracting medical group.
21. Receive emergency service when the member, as a prudent layperson, believe that a life-threatening emergency occurred. Payment will not be withheld in such cases.
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 their provider(s).
2. Provide, to the extent possible, information that the medical group and its providers need in order to care for the member.
3. Contact their provider 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 being treated for any form of ***breast cancer***, or prior to performance of a biopsy for breast cancer, your provider 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 members of the advantages, disadvantages, risks and descriptions of procedures.

Be informed

If you are being tested for any form of ***prostate cancer***, or prior to performance of a biopsy for prostate cancer, your provider 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 members of the advantages, disadvantages, risks and descriptions of procedures.

Emergency Services

If a practice receives a call from a LaSalle Medical Associates IPA member, they should determine whether the member should call 9-1-1, go to the nearest emergency room, urgent care center, or to the practice. Only licensed personnel should handle triage of members.

- If it is determined that the member is in a life-threatening emergency, they should be instructed to hang up the phone and dial 9-1-1 immediately.
- If it is determined that the member is stable enough to go to the nearest emergency room, urgent care center, or to their primary care provider's practice to be evaluated, the practice should instruct the member to be transported by another person. A member should never be instructed to drive himself/herself in the event of a life-threatening situation.

To seek care coordination for non-life threatening situations after 5:00pm or on weekends, the provider and/or the member can call Network Medical Management at (877) 282-8272 and speak to an on-call provider or Case Manager.