Our Physicians

Health Excel IPA - providing physicians with a collaborative environment, focused on taking care of the patient through clinical protocols for maximum efficiency, and ultimate healthcare.

Health Excel IPA looks towards the future for new innovative healthcare, cutting edge technology, and providing the best patient care possible.

Independence allows the physician to focus on what matters most—the patient.

PROVIDER MANUAL

Exceptional Doctors
Individual Care

HEALTH EXCEL
IPA

TABLE OF CONTENTS

INTRODUCTION

I am pleased to welcome you to Health Excel IPA. As an organization, we look forward to working with you and providing your practice with many new contracting opportunities and a variety of administrative benefits aimed at reducing the costs associated with private practice.

The purpose of provider manuals in general, is to provide physicians with information about the functions of an organization they are contracted with. Information such as guidance on IPA policies and procedures, the functions of provider services, member and physician rights/responsibilities, claims, referrals, prior authorizations, eligibility, and appeals & grievances. The focus of this manual is to provide guidance on all of these functions as they relate to Health Excel IPA. The manual will be updated regularly and will also be available on our website at www.healthexcelinc.com. Health Excel IPA reserves the right to revise material in this manual at any time, in order to provide our physicians with the most updated practice guidelines available.

About Health Excel IPA

Health Excel IPA is focused on bringing independent groups of physicians together in a common alliance. Each group will still function independently, while simultaneously being able to participate in a collaborative environment with fellow physicians. The goal of Health Excel is to provide enhanced healthcare services to patients and payers all across San Diego.

The Health Excel network consists of over 1,550 physicians, hospitals, urgent care centers, imaging, labs and pharmacies. Patients can easily find qualified physicians and ancillary services throughout the San Diego County, covering Chula Vista, San Diego, La Jolla, Encinitas, Carlsbad, and Oceanside.

The IPA functions as a clinically integrated model of care guided by an evidence-based approach to medicine, with member physicians implementing clinically based guidelines that focus on quality outcomes. The IPA has developed practice standards and protocols to govern treatment and utilization of services. With the increasing government emphasis on measuring quality, it is critical to the success of any physician organization to demonstrate quantifiable outcomes.

As a company, we strive to provide innovative products and services, promote the health and wellness of our membership, and support the communities we serve. We welcome you to our family and look forward to working with you.

Thank you again for joining Health Excel IPA,

Thomas C. Sounhein, CEO

CONTACT Health Excel IPA

Corporate Office

Mailing Address:	Health Excel 9850 Genesee Avenue, Suite 900 La Jolla, CA 92037
Office Address:	Health Excel (same as above) 9850 Genesee Avenue, Suite 900 La Jolla, CA 92037
Website:	www.healthexcelinc.com

Provider Services/Customer Service

Phone:	(858) 452-1279
Fax:	(858) 587-1642
Hours:	Monday through Friday, 8:00 a.m. to 5 p.m. PST

Contact Provider Services for:

- Eligibility verification
- Network participation
- Benefit information

Contracted Health Plans:

See our Health Excel Website for a complete listing of plans offered,
At www.healthexcelinc.com

Claims Correspondence Address:

(Questions on claim processing or payment):

Prospect Medical Systems

Main Phone Number: 1-833-914-0586

- Claims: Dial main number, then Press Prompts 1,8
- Eligibility: Dial main number, then Press Prompts 1,6
- Eligibility Fax: Fax (714) 560-5270
- Inpatient Care Team: Dial Main number, then press Prompts 1,1
- Inpatient Team Fax: Fax (714) 938-5155
- Provider Relations: Dial main number, then Press Prompts 1,7
- STAT Authorizations: Dial main number, then Press Prompts 1,4

Authorizations (routine): Please request via the Aerial Care provider portal

Claims/Encounter Data: Office Ally: Provider ID **PROSP**

Claims Mailing Address: P.O. Box 11466
Santa Ana, CA 92711-1466

Provider Disputes: P.O. Box 11466
Santa Ana, CA 92711-1466
Attn: Provider Disputes Resolution

CONTACT Health Excel (cont.)

Provider Services & Network Development

Address: Health Excel IPA
9850 Genesee Avenue, Suite 900, La Jolla, CA 92037
Phone: (858) 452-1279
Fax: (858) 587-1642

Provider Services Team

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Taylar Neff
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Provider Relations Team

Maile Freitas Harrison
Provider Relations Manager (out on maternity leave 5/25/20-10/25/20)

Health Excel Provider Credentialing/UM & Quality Review

Brittany Friend, UM & Credentialing Manager
Phone (858) 452-1279 x105
Fax (858) 587-1642
Email bfriend@ximedinc.com

Prospect UM Management/Quality Review

Rosa Catalano, Senior Vice President of Healthcare Services
Phone (714) 796-5741
Email Rosa.Catalano@prospectmedical.com

QUALITY IMPROVEMENT PROGRAM

Our Mission, Vision, and Commitment to Our Members

In today's health care environment, effective medical management requires continuous data analysis. To meet these demands, we've developed a collaborative care management platform that streamlines data collection, applies clinical rules, and provides physicians direct portal access to assist with patient management. The system allows us to more intelligently administer medical management services, which reduces costs, and improves health care quality.

The QI Program is a systematic process of monitoring and evaluating the quality and the effectiveness of our patient care. Our Quality Improvement (QI) Program drives organizational improvement for excellence through efficiency, stabilizing health care costs, and building trust and recognition in the community to improve the health status and satisfaction of our members. We are committed to our members and providers through our dedication to professional standards, evidence-based medicine, and ethical practice behavior. The IPA maintains practice standards and protocols to govern treatment and utilization, along with services focused on always putting the patient first. On an ongoing basis, we integrate clinical advances, and implement innovative technology to enhance medical care through collaboration and communication.

Program Structure

The QI Committee provides a process for promoting and achieving excellence in all areas and at all levels of the organization. The QI Committee has oversight for the processes and resources that are reviewed throughout the calendar year. The QI Committee relies on industry standards set by regulators or accrediting organizations and best practices to guide them throughout the year. The use of data collection and analysis is critical to identifying populations, problem-solving and process improvement. Our UM and Quality Management teams will perform regular training and site visits to assist physicians with all the requirements for each contracted Health plan.

This approach enables us to focus on issues of appropriateness, efficiency, and safety, as well as health outcomes and the satisfaction of our members and their providers. This is achieved by continuous monitoring of our performance with objective, measurable performance standards. The QI Program promotes accountability and ensures identification and evaluation of issues that might impact performance, and focuses on improving the health care and administrative services provided to our customers.

In addition to Health Excel's commitment to quality and excellence, Prospect Medical Systems also has a comprehensive program in both Quality Improvement and Utilization Management. Both programs strive towards continually promoting the quality of healthcare service.

Objectives

- Monitor the QI Program quarterly to assess progress and resource allocation
- Develop, review, and report on the annual QI Program work plan
- Assess and evaluate effectiveness of health plan activities
- Monitor Quality of Care for all members, including responding to and facilitating resolution of member complaints
- Assess and evaluate delegated activities
- Monitor and align accreditation with process improvement teams

Procedures

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

Commercial & Medicare Non-Emergent Medical Appointment Access Standards

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

Behavioral Health Emergent & Non-Emergent Appointment Access Standards

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

ACCESS TO CARE STANDARDS (cont.)

HEALTH EXCEL IPA

Medi-Cal Non-Emergent Medical Appointment Access Standards

Access Measure	Time-Elapsed Standard
Access to PCP or designee	24 hours a day, 7 days a week
Non-urgent Care appointments for Primary Care (PCP Regular and Routine, excludes physicals and wellness checks)	Must offer the appointment within 7 business days of request
Adult physical exams and wellness checks	Must offer the appointment within 30 calendar days of request
Non-urgent appointments with Specialist physicians (SCP Regular and Routine)	Must offer the appointment within 15 business days of request
Urgent Care appointments that do not require prior authorization (includes appointment with any physician, Nurse Practitioner, Physician's Assistant in office	Must offer the appointment within 24 hours of request
Urgent Care appointments that require prior authorization (SCP)	Must offer appointment within 96 hours of request
First Prenatal Visit	Must offer the appointment within 10 business days of request (2 weeks)
Child physical exam and wellness checks with PCP	Must offer the appointment within 10 business days of request
Non-urgent appointments for ancillary services (diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment within 15 business days of request
Initial Health Assessment (enrollees age 18 months and older)	Must be completed within 120 calendar days of enrollment
Initial Health Assessment (enrollees age 18 months and younger)	Must be completed within 60 calendar days of enrollment

Medicare Dental Appointment Access Standards

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

MEMBER RIGHTS and RESPONSIBILITIES

PURPOSE

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

POLICY

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

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

MEMBER GRIEVANCES/ APPEALS PROCESS

Health Excel IPA provides a grievance and appeals process to offer members a variety of options in which they can express concerns or dissatisfaction with either the medical care or the services provided. Health Excel will work closely with each of the health plans to follow their rules for resolving the situation. Health Excel will investigate the issues and work towards a solution that is satisfactory to both the member and the health plan, regardless of the type of grievance that is filed.

Grievances/Complaints are when a member expresses concern or dissatisfaction in quality of care. Members can file complaints/grievances based on the following: claim disputes or denials, changes/terminations of benefits, balance billing, billing for non-covered services, co-pay disputes, and concerns over provider's quality of care.

Requesting a Grievance/Appeal

Claims grievances may be requested by either the Health Excel IPA member or his/her authorized representative. Providers, and/or IPA Plan facilities that provided services may submit a grievance, but will be required to obtain patient's signed authorization. Health Excel IPA will generally resolve complaints within 60 calendar days. However, If the patient's medical condition requires more immediate attention, the grievance may be expedited and Health Excel IPA will attempt to resolve it within 72 hours.

Once an appeal has been submitted to the health plan by the member, the health plan will then process either a standard or an expedited appeal, and notify the member directly. All health plan contact information, including address, telephone and FAX number can usually be found on the back of the member's health plan identification cards.

Department of Managed Health Care (DMHC)

In addition to the complaint processes described above, members also may contact the California Department of Managed Health Care (DMHC). The DMHC is the Agency responsible for the regulations of health care services plans. Members may contact the DMHC as follows:

Department of Managed Health Care (California)

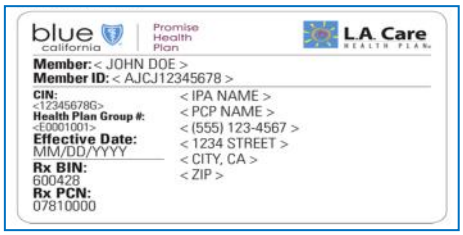
Address:	**980 9th Street, Suite 500**
	Sacramento, CA 95814
General Information:	**1-888-466-2219 (Phone)**
	1-916-255-5241 (Fax)
Health Plan Division:	**1-916-324-8176 (Phone)**
	1-877-525-1295 (Toll Free)
Complaint Forms:	**www.DMHC.com**

MEMBER IDENTIFICATION (ID) CARDS

Health Excel IPA members receive ID cards containing information needed by health providers to check member's eligibility and benefits, as well as submit claims. ID cards typically include the member name, member ID number, the group number, and Health Excel IPA contact information. ID cards will be generated by the health plan, and mailed to members directly.

Health Plan Insurance Card Samples

Blue Shield Promise of California

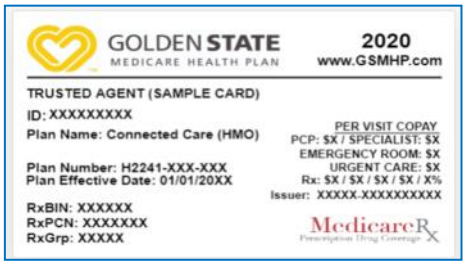


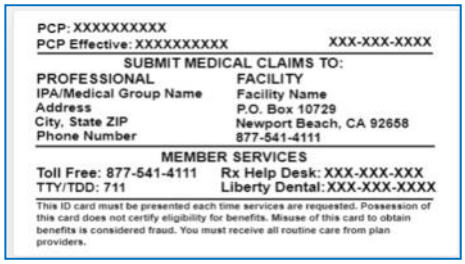
Brand New Day

Alignment Health Plan

Imperial Health Plan

Golden State Medicare Health Plan





MEMBER & PHYSICIAN RESOURCES

Health Excel IPA provides updated resources information for members, and compliance information for physician providers on our website. The following items are displayed on our website at **www.healthexcelinc.com**

MEMBER RESOURCES

Member Rights and Responsibilities
Explains members rights and responsibilities, including designating others when the patient is unable to represent themselves fully for patient care.

Language Assistance Program Contacts
Contact information for patients with alternative language requirements.

Preventive Services Task Force – Published Recommendations
https://www.uspreventiveservicestaskforce.org/BrowseRec/Index

American Academy of Pediatrics
https://www.aap.org/en-us/Pages/Default.aspx

American College of Obstetrics and Gynecology
https://www.acog.org/

Department of Managed Health Care
https://www.dmhc.ca.gov/HealthCareinCalifornia/ResourceList.aspx#preventive

National Institutes of Health – Health Topics
https://www.nih.gov/health-information

PHYSICIAN RESOURCES

Program Trainings

- California Children's Services (CCS)
- Child Health and Disability Prevention Program (CHDP)
- Chronic Care Improvement Program (CCIP)
- Comprehensive Perinatal Support Services Programs (CPSP)
- Department of Health Services Programs
- Special Needs Program

Provider/Staff Training

- Cultural Linguistics Training
- Fraud, Waste and Abuse Training
- HIPAA Privacy, Breach Notification and Compliance

ANNUAL PHYSICIAN COMPLIANCE TRAINING

Health Excel IPA and Prospect Medical Systems require annual physician compliance training. Prospect Medical Systems offers various training modules on their website as required by our affiliated health plans and regulatory agencies. Training is mandatory and a required part of participation with Health Excel IPA, for all primary care physicians, specialists, ancillary providers, nurse practitioners and physician assistants. EXISTING contracted providers – training must be completed every calendar year. NEWLY Contracted Providers – training must be completed within 10 business days of becoming effective.

For additional health plan specific resources, please visit your contracted health plan website(s) regularly to retrieve valuable information, review tools and receive updates to manage your member's health.

TRAINING MODULES

1. Visit https://training.prospectmedical.com to view copies of each applicable health plan training module.

2. Review all Health Plan Trainings
   - Alignment Health Plan
   - Brand New Day
   - Blue Shield/Promise Health Plan
   - Golden State Health Plan

3. Review the Program Trainings:
   - Chronic Care Improvement Program
   - Department of Health Services Program
   - Special Needs Program

4. Review all trainings listed under All Staff Trainings
   - Cultural Linguistics
   - Fraud, Waste and Abuse
   - HIPAA Privacy, Breach Notification and Compliance

5. Complete the OIG/SAM/Medi-Cal Exclusions Screening Attestation

6. **Each provider must complete the required attestations and fax or e-mail the attestation forms to: Fax (714) 560-7613 or E-mail providerinfo@prospectmedical.com**

CREDENTIALING

Overview

The Health Excel IPA Credentialing Program evaluates practitioner's professional credentials in accordance with federal, state and NCQA requirements to ensure that they are adequately qualified to provide service to Health Excel IPA members. Health Excel IPA will not discriminate in terms of participation, reimbursement, or indemnification, against any healthcare professional who is acting within the scope of his or her license or certification under state law. Only licensed and qualified applicants who meet the IPA's standards and participation requirements are accepted or retained in Health Excel IPA's network. The credentialing process is administered by Health Excel IPA or by entities delegated by Health Excel IPA that agree to credential practitioners in accordance with Health Excel IPA's criteria.

Credentialing Process

Health Excel IPA, or its delegated designees, must credential all physicians (MDs, DOs), dentists, (DDSs, DMDs), podiatrists (DPMs), chiropractors (DCs), clinical psychologists (PhD, PSY.D.), other licensed behavioral health practitioners (LCSWs, MFCCs, MFTs, MHCs, Psych. RNs), allied and ancillary health practitioners (PAs, NPs, CNMs, NMWs, CRNAs, acupuncturists, PTs, AUs, SPs, OPTs, OTs) and such other practitioners who are authorized by law to deliver health care services to Health Excel IPA members. Healthcare Delivery Organizations (HDOs), which include hospitals, skilled nursing facilities (SNFs), home health agencies, dialysis centers, laboratories and ambulatory surgical centers, must be credentialed by Health Excel IPA or its delegated designees prior to rendering care to Health Excel IPA members. Health Excel IPA is responsible for credentialing all practitioners (excluding certain hospital-based practitioners) and HDOs with whom it contracts directly.

Non-Discrimination Policy - Credentialing and Re-Credentialing

IPA will not consider age, sex, religion, race, creed, color, national origin or sexual orientation when determining a practitioner's qualification to provide health care services to members. Additionally, selection and retention criteria will not discriminate against health care professionals who service high-risk populations or those who specialize in treating costly conditions.

The Credentialing Staff/Credentialing Committee reviews each credentialing application to ensure that all the required information is included.

This information consists of the following:

- ◊ Work history (continuous of at least five years) without gaps
- ◊ Application questionnaire
- ◊ Name of primary admitting facility, if applicable. If no hospital staff privileges, evidence of ability to have a patient admitted by a Health Excel IPA practitioner

Signed attestation by the applicant to the correctness and completeness of the application which includes:

- ◊ Release of information (signed and dated)
- ◊ Copy of current malpractice insurance face sheet including minimum coverage as required in contract or as required by law
- ◊ Current medical license or certification number
- ◊ ECFMG certificate, as applicable
- ◊ Copy of current DEA License and current State License
- ◊ Copy of CV
- ◊ Practitioner's Rights

CREDENTIALING (cont.)

Organizations Provider Credentialing

For HDOs, Health Excel IPA will confirm that the organizational provider:

- ◊ Meets all state and federal licensing and regulatory requirements in good standing
- ◊ Has proof of adequate liability insurance
- ◊ Has evidence of accreditation or site visit by a recognized accrediting body or current CMS certification

Notification of Discrepancy

Practitioners will be notified in writing, via letter or fax, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of a practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certifying expiration when one or more of these examples have not been self-reported by the practitioner on his/her application form. Practitioners will be notified of the discrepancy at the time of the primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing or is protected from disclosure by law.

If a practitioner believes that erroneous information has been supplied to Health Excel IPA by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice along with a detailed explanation to Health Excel IPA. Notification to the IPA must occur within 48 hours of Health Excel IPA notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of his or her credentialing file. Upon receipt of notification from the practitioner, Health Excel IPA will re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioner's credentials file. The practitioner will be notified in writing, via letter or fax that the correction has been made to his or her credentials file. If, upon re-review, primary source information remains inconsistent with the practitioner's notification, the Credentialing Department will so notify the practitioner via letter or fax.

The practitioner may then provide proof of correction by the primary source body to Health Excel IPA's QM Department via letter or fax at the address above within 20 working days. The Credentialing Department will re-verify primary source information if such documentation is provided. If, after 10 working days, primary source information remains in dispute, the practitioner will be subject to Adverse Action, up to administrative denial/termination.

Primary Source Verification for Credentialing

For non-delegated credentialing, the Credentialing Department obtains and reviews information on the application and verifies the information for primary sources.

Applicant Office Site Evaluation

Health Excel IPA does not have a policy that routinely conducts an office site evaluation for each applicant PCP or OB/GYN or high-volume practitioner as a condition of credentialing or re-credentialing, but those visits may be conducted in response to a complaint about the specific facility. If a site visit is conducted, a corrective action plan (CAP) may be requested at the time of visit detailing any non-compliance. Applicants considered non-compliant in any critical criteria do not pass the site evaluation and an action plan is implemented. A second site evaluation is scheduled to ensure implementation of the action plan. Applicants who refuse to allow an office site evaluation, who fail to provide corrective documentation as needed, or who fail two consecutive site evaluations do not meet Health Excel IPA standards for participation and are referred to Health Excel IPA's Board of Directors Committee for suspension from the provider network.

CREDENTIALING (cont.)

Re-credentialing Application

The re-credentialing process provides a mechanism for updating and re-verifying a practitioner's license and professional status within every three years.

Provider Credentialing Rights

The decision to credential or re-credential a practitioner is based on the information assembled, including, but not limited to, the information gathered through a completed application and primary source verification. Credentialing/re-credentialing criteria are used to establish consistent, clear objectives for the credentialing/re-credentialing of practitioners. The credentialing/re-credentialing decision to approve or deny the applicant is determined by the Credentials Committee. Health Excel IPA credentialing decisions are not based on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes. This does not preclude Health Excel IPA from including in its network practitioners who meet certain demographic or specialty needs.

During the credentialing process:

- You may request information regarding the status of your application at any time.
- You will be promptly notified of information that varies significantly from the information you have provided, and you will be given the opportunity to submit updated/additional documentation or corrections.
- Notification of the Credentialing Committee decision regarding your application will be sent via written letter promptly after the meeting at which your application is presented.

Note: Approval of your credentialing application is not indicative of health plan contract effective dates. Contact Brittany Friend, UM & Credentialing Manager, at 858-452-1279 or email bfriend@ximedinc.com for your official effective date.

COMPLIANCE PROGRAM

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

Privacy

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

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

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

Fraud, Waste, and Abuse (FWA)

The government has increased investigations of fraudulent activities in health care, with respect to both providers and beneficiaries. State and federal authorities have prosecuted numerous healthcare providers for various fraudulent practices, and also mandated health care entities to establish anti-fraud programs. Following this mandate and resultant industry trends, Prospect's Compliance Program contains policies and practices designed to detect and investigate incidents of fraud and abuse. Such policies include disclosure of such instances to health plans and government agencies or contractors, as appropriate. As a health care provider, your diligence and cooperation is critical to the effectiveness of our anti-fraud and abuse efforts.

Health care fraud includes, but is not limited to, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit. Thus, any intentional deception or misrepresentation that a provider, member, employee, supplier or other entity makes knowing that such action could result in an unauthorized payment, benefit, denial, or other illegal action would be classified as health care fraud. Other examples of health care fraud include overutilization of items and services, fraud in applications for health care benefits for beneficiaries, doctor shopping and identity theft.

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

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

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

CLAIMS PROCEDURES

CLAIMS

Health Excel IPA offers several methods for claims submission. The following highlights the available options.

Electronic Claim Submission Methods

- Aerial Care—offers online claims status
- Office Ally—offers file upload, and online claims entry

Paper Claim Submissions

If you choose to submit paper claims, the claim must be submitted using industry-standard formats, on industry standard forms (HCFA form 1500), using the required specific code set as promulgated by HIPAA. The claim submission must communicate all of the following required elements to ensure accurate and timely claim payment:

- Who was treated and why
- Services provided
- Date of service
- Amount billed for those services
- Where those services were rendered
- Who rendered those services

The above data is also essential for state, national, and accrediting body reporting requirements.

Coding Requirements

- Healthcare Common Procedure Coding System (HCPCS) for Ancillary Services Procedures
- Code on Dental Procedures and Nomenclature (CDT)
- Current Procedural Terminology (CPT-4) for Physicians Procedures
- International Classification of Diseases, ICD-10 for dates of service Oct. 1, 2015, and thereafter
- National Drug Codes (NDC)
- Codes maintained by the National Uniform Billing Committee (NUBC) for institutional use
- National Provider Identifier (NPI)
- Taxonomy
- Other specific coding requirements as determined by the standard format

Claims Filing Address

Paper claims should be submitted to the following claims filing address, unless otherwise stated on the member's ID card:

Prospect Medical Systems
P.O. Box 11466
Santa Ana, CA 92711-1466

CLAIMS & ENCOUNTER DATA SUBMISSION INSTRUCTIONS

As required by Assembly Bill 1455, the California Department of Managed Health Care has set forth regulations establishing certain claim settlement practices and the process for resolving claims disputes for managed care products regulated by the Department of Managed Health Care.

Claims for services provided to members assigned to Prospect Medical must be sent to the following:

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

Via Office Ally: **www.Officeally.com**
Provider ID **PROSP**

The following is a list of claim timeliness requirements, claims supplemental information and claims documentation required by Prospect Medical Systems.

- **Contracted Providers**: Contracted providers are required to submit claims within **90 days from the date services were rendered**, or according to the time specified in the contract, whichever date is longer. **All encounter data must be sent to Prospect Medical within 30 days from the date services were rendered.**

- **Non-Contracted Providers**: Non-contracted providers are required to submit claims within **180 days from the date services were rendered**, except as required by state or federal law or regulation.

- **Hospital-Based Physicians**: Hospital-based physicians are required to submit claims within **365 days from the date services were rendered**.

- **Corrected claims** that are resubmitted because Prospect has contested the original claim for additional information (e.g. medical records, correct modifier, invalid ICD-10 code) must be submitted to Prospect within **45 business days from date of determination to be eligible for reconsideration.** Corrected claims or claims submitted with additional information will be **denied for untimely filing if received more than 45 business days after original claim's denial has been generated**.

CLAIMS PROCEDURES (cont.)

CATEGORIES OF REFERRALS

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

- STAT — A referral for a condition that threatens loss of life, loss of limb, loss of bodily function or substantial impairment.
- Urgent or Emergent—A serious condition that threatens loss of life, loss of limb, loss of bodily function or substantial impairment.
- Routine Referral—Limited physical exam, follow-up to acute or chronic medical or surgical condition, not life or limb threatening.

CONTINUITY OF CARE

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

- Continuing care for pregnancy
- Acute condition
- Terminal illness
- Mental Health
- Care of a newborn between birth and 36 months covered for 12 months from the contracted termination date

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

ACCEPTABLE PROOF OF TIMELY FILING

When submitting a claim with an approved retro-authorization, the claim must be submitted within 45 calendar days from the date the retro-authorization was approved by Prospect Medical.

ACKNOWLEDGEMENT OF CLAIM RECEIPT

Prospect Medical will acknowledge receipt of all contracted provider claims via the web portal Aerial Care.

CLAIM STATUS

To determine if your claim has been received by Prospect and to check the status of a claim, please log into Aerial Care and search for the claim under the Claims Status feature.

You may also obtain claims status or determine if your claim has been received by Prospect by calling the Claims Department.

ACCEPTABLE PROOF OF TIMELY FILING

Acceptable documentation for proof of timely filing must be a confirmation receipt from Office Ally or Aerial Care. If you submit paper claims, please refer to Aerial to confirm that your claim has been received by Prospect. You will not receive written documentation of proof of receipt for paper claims from Prospect, since all contracted providers have the ability to view claims status on-line through Prospect on-line portal, Aerial Care.

All claims and encounter data must be submitted on a properly completed CMS 1500 claim form. The information must include the following:

- Patient's name
- Patient's address
- Patient's date of birth
- Patient's insurance company
- Patient's ID number
- Date of Service(s)
- Place of Service
- CPT code(s) and/or HCPCS
- ICD-10 code(s)
- NDC Number for drugs where contract rates are a percentage of AWP
- Name of Rendering Physician
- State License number of Rendering Physician must be present in box 24k
- Itemized Charges
- Tax I.D. Number of Contracted Entity
- Authorization Number in box 23
- No more than six lines of service on one claim
- For referred and/or ordered services, the name of the referring or ordering physician and the NPI or UPIN numbers must be present in box 17 and 17A
- Emergency Services shall include any necessary medical records to make a proper determination of the emergency service rendered.
- If Provider is understood to be and identified as a 'Direct Access' provider, a copy of the direct referral form must be attached to the CMS 1500 form.
- If member was treated under the Blue Shield Direct Access + Program, a copy of the member's ID card must be provided.
- Urgent Care providers must bill with the term 'Urgent Care' in box 23 and place service code 20.

For Institutional Providers, the following is required:

- Claims must be submitted on UB 04 Claim Form with all entries stated as mandatory by NUBC and required by federal statute and regulations and any state-designated data requirements included in statutes or regulations.
- Appropriate Revenue, CPT, ICD-10, and HCPCS
- Copies of invoices when billing for miscellaneous drugs and/or supplies
    - Patient's name
    - Patient's date of birth
    - Patient's ID number
    - Place of Service
    - ICD-10 code(s)
    - Charges
    - Patient's address
    - Patient's insurance company name
    - Date of Service(s)
    - CPT code(s)
    - Name of Admitting Physician
    - Tax I.D. Number
- Emergency Services shall include any necessary medical records to make a proper determination of the emergency service rendered.

CLAIMS PROCEDURES (cont.)

SUBMITTING AUTHORIZATIONS

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

All routine requests shall be submitted via Aerial Care:

- When submitting a referral via Aerial Care and you search for a member, this step will verify eligibility for you. If a member is not eligible then it will not allow you to submit a referral.
- Include as much information as possible regarding the diagnosis and reason for the request.
- Attach a consult letter, test results, office notes, etc. You are now able to attach medical records via Aerial Care, please refer to the online tools of the provider manual for step by step instructions. All medical records and test results must have patient identification and must be legible for Prospect's Medical Management department to make accurate and timely decisions regarding your request. **(Include Physician prescription for any DME, Drug, SNF or Custodial patient order.)**
- Please be clear and specific as to what you are requesting. (i.e., consult, procedure, Outpatient Surgery and In-Patient Surgery, etc.) CPT codes must be listed.
- Do not schedule a procedure or surgery before your request is authorized.

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

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

All medical necessity denial decisions will be determined by a Physician Reviewer in accordance with review criteria. The Physician Reviewer is available to discuss determination by calling (833) 914-0586. A written notification will be sent to both the member and provider within 1 business day of denial determination.

Out-Of-Network Referrals

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

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

STAT/Urgent Referral Requests

- **DO NOT FAX OR MAIL STAT OR URGENT REQUESTS. DO NOT USE AERIAL FOR STATS.**
- Sometimes a "STAT" or "Urgent" referral is indicated. If you feel a "STAT" or "Urgent" referral is medically indicated, **contact Prospect's Medical Management Department at Prospect Medical 1-833-914-0586 and press prompts 1, 4 for STAT referrals**.
- If you feel the diagnosis represents a potentially life-threatening emergency, send the patient directly to the nearest emergency room.

CLAIMS PROCEDURES (cont.)

PRIOR AUTHORIZATION

What is a prior authorization?

Prior authorization is the process of receiving written approval from Health Excel IPA prior to services or products being rendered. The provider requests and submits the prior authorization. Services are still subject to all plan provisions including, but not limited to, medical necessity and plan exclusions.

When is prior authorization needed?

Prior authorization is generally required for all services. Please refer to member's Evidence Of Coverage to determine exclusions, limitations and benefit maximums that may apply to a particular procedure, medication, service, or supply.

A prior authorization is generally not required for:

- Emergency care or urgent care at an emergency or urgent care facility

Prior authorization process:

Based on the medical complexity of services, we expect preferred providers to follow prior authorization guidelines. We encourage members to verify prior authorization as requested by their provider and approved by Health Excel IPA.

Provider should verify member eligibility and benefits by calling Member Services at 858-452-1279.

Members should review their health plan for specific authorization requirements, excluded services/treatments, and referral requirements.

Prior authorization is required for most inpatient admissions:

Different standards apply depending on whether the admission is elective or acute.

Elective admissions: Providers must submit a prior authorization request a minimum of three days prior to an elective (non-emergency) hospital admission or admission to a residential treatment program for treatment of alcoholism, drug abuse, or nervous or mental disorders.

Acute admissions: Facility must notify Health Excel IPA within two days of an acute (direct or emergency) admission. Notification may be provided in writing or by calling the phone number located on the member ID card or by calling Member Services.

Providers should submit clinical information to support the admission. Information requested for concurrent review should be sent within 24 hours of our request.

Inpatient admissions include a member's admission to:

- Inpatient hospital
- Hospice inpatient facility
- Inpatient rehabilitation facility
- Skilled nursing facility, when Medicare is not primary
- Inpatient and residential facility for Behavioral Health Services

REFERRALS

Under applicable Health Excel IPA plans, referrals may be required when a preferred provider sends the member to a non-preferred specialty provider or facility for health care services to treat a covered illness or injury.

Please contact Prospect Medical Systems (PMS) to determine whether a referral is needed. If so, Health Excel IPA requires that you complete a Referral Authorization Request Form prior to services being rendered.

The referral must be submitted via Aerial Care, and must also meet the following criteria:

1. Requested by a preferred physician;
2. Received by PMS in writing or by telephone prior to health care services being provided;
3. Approved by PMS;
4. Valid for the period of time specified by Health Excel IPA.

Please see the Aerial Care User Guide on pages 40-50.

ADDITIONAL RESOURCES

Health Excel IPA has included a variety of Resources. In the following pages, you will find the enclosed materials:

Laboratory Locations

- Listing of LabCorp Patient Service Centers in the San Diego Area

Emergency/Urgent Care Locations

- Listing of Emergency/Urgent Care Centers

Imaging/Radiology Locations

- Listing of Imaging/Radiology Centers in the San Diego Area

Surgery Centers/Ancillary Services

- Listing of Surgery Centers in the San Diego Area
- Listing of additional Ancillary Services, including DME and Home Health

Additional Forms:

- Auto Approval Guide
- Office Update Request Form
- Treatment Authorization Form

HEALTH EXCEL IPA

Auto-Approval Quick Reference Guide (as of 6/1/2020) - Page 1

Description	ICD-10	CPT Code	CPT Description	Criteria
CARDIOLOGY				
Chest Pain	R07.1 – R07.9 I20.9	99204 or 99244 93000, 93010 or 93015	Initial Consult w/EKG	--
Angina	I20.0 – I20.9, I25.110-I25.119, I25.700-I25.799	99204 or 99244 93000, 93010 or 93015		
Pacemakers	I44.0 – I45.9 I47.0 – I50.9	99204 or 99244	Initial Consult	Age > 21
Testing Facility for PCPs	Code Dx	93000, 93306, 93351, 99302, 93325, or 93015	EKG, Stress Tests, Other Cardiac Tests	Age > 21: Only Test; No Consult
Not all Cardiology providers participate as a testing only site. Please verify w/provider first.				
OB / GYN				
Well Women Exam – Pap Smear	Z01.411-Z01.419, Z12.4	99203 or 99243 88164 - 88167 or 88155 or 88141	Consult w/Pap Smear	Age >14; Once a Year
Ectopic Pregnancy	O00.0 – O00.91 or P01.4	99203 or 99243 76801 or 76805	Initial Consult w/ Ultrasound	Age >14
Spontaneous Abortion	O03.0 – O03.9	99203 or 99243	Initial Consult	
OBs must have privileges at contracted facilities.				
NEPHROLOGY				
Proteinuria	R80.0 – R80.9	99204 or 99244 w/ 99214	Initial Consult w/ 1 Follow Up	--
Hematuria	R31.0 – R31.9			
Renal Calculus	N20.0			
Renal Vascular Disorders	N28.0			
CKD/ESRD	N18.4 – N18.6			
NEUROLOGY				
Seizures	G40.001-G40.919, R56.00 – R56.9	99203 or 99243	Initial Consult	--

Description	ICD-10	CPT Code	CPT Description	Criteria
FAMILY PLANNING				
Insertion of IUD	Z30.430	J7297 - J7301 58300	IUD w/ Insertion	Age > 14
Removal of IUD	Z30.432	58031	Removal of IUD	
Sterilization	Z30.2	99203 or 99243	Initial Consult	
SENSITIVE SERVICES				
Abortion Sensitive Services	Code Dx	59840 76816	Abortion Procedure w/ OB U/S	Medi-Cal Only
ORTHOPEDICS				
Fracture Care, Sprains, Dislocations, Crushing Injury	S22.*, S32. S59.299, S62.-S63.92, S87.00-S87.82, S89.001-S89.399	99204 or 99244	Initial Eval w/Cast	--
*Insert appropriate character based on location of injury. Under 21 may auto-approve to CCS providers.				
GASTROENTEROLOGY				
Colon Screening	Z12.11 – Z12.13	99203 or 99243	Initial Consult	Age > 50
Hemorrhoids	K64.0 – K64.9			Age > 21
GENERAL SURGERY				
Any Cholelithiasis/ Cholecystitis	K80.0 – K80.21, K80.40 -K81.0, K81.2, K80.81, K81.9	99203 or 99243	Initial Consult	--
Breast Mass	N63			
Inguinal Hernia Eval	K40.00-K40.91			
Acute Abdomen	R10.10 – R10.9, R16.0 – R16.2, R18.0, R19.30 – R19.37			

HEALTH EXCEL IPA

HEALTH EXCEL IPA

Auto-Approval Quick Reference Guide (as of 6/1/2020) - Page 2

Description	ICD-10	CPT Code	CPT Description
OPHTHALMOLOGY			
Diabetes	E10.311-E10.39, E11.311-E11.39, E13.311-E13.39	99203, 99243 92002, or 92004	Initial Consult
Cataracts	H25.011 - H26.9		
Glaucoma	H40.001 - H40.89		
Conjunctivitis	H10.011 - H10.9, B30.0 - B30.9, A74.0		
Eyelid Inflammation, Blepharitis	H01.001 - H01.9, H00.011-H00.19		
Foreign Body	T15.00 - T15.92		
Retinal Detachment	H33.001 - H33.059 H33.40 - H33.43		
Corneal Ulcer	H16.001 - H16.079		
Other Retinal Disorders	H35.00 - H35.09		
ENT			
Cerumen Inspection	H61.20 - H62.23	69210	Cerumen Impaction/Wax Removal
Epistaxis/ Nose Bleeds	R04.0	30901, 30903, 30905	Epistaxis Control
UROLOGY			
Tortion of Testis	N44.00 - N44.04	99203 or 99213	Initial Consult
Cystitis	N30.20 - N30.21	99204 or 99244	
Elevated PSA	R97.2		
Impotence	N52.0 - N52.9		
Hydronephrosis	N13.1 - N13.39		
Overactive Bladder	N32.81		
Peyronie's Disease	N48.6		
Testicular Cancer**	D40.10 - D40.12		
PCP's OFFICE OR PULMONOLOGIST			
Spirometry Testing – COPD	J40 - J44.9	94010, 94375 94014 - 94016, 94060, 94070,	Spirometry Testing
PODIATRY			
Diabetes	E10.40 - E10.628, E11.40 - E11.628, E13.40 - E13.628	99203, 99243 or 11730 - 11732	Initial Consult/ Nail Removal

Description	ICD-10	CPT Code	CPT Description
PHYSICAL THERAPY			
PT Evaluation	Dx Determines	97161 (x1)	Initial Eval +1.5
ULTRASOUND			
Abdominal or Pelvic Pain/Swelling/Mass	R10.0 - R10.9, R19.00 - R19.09	76700	Abdominal Ultrasound
Disorders of Female Reproductive System	N80.0 - N98.9 D25.0 - D26.9 (Other Dx May Apply)	76856	Pelvic Ultrasound
Abdominal Pain/ Other Male Urinary Disease	R10.0 - R10.9, N00 - N39.9, N48.0 - N53.9	76770	Retroperitoneal Ultrasound
Goiter	E01.0 - E07.9	76536	Thyroid Ultrasound
Inflammatory Disease Ovary/Uterus	N70.01 - N74	76830	Transvaginal Ultrasound
Pregnancy	Z33.1 - Z34.93 Z3A.00 - Z3A.49	76801, 76805, 76811, or 76815 - 76817	Uterine Ultrasound
Hydrocele/Mass	N43.0 - N43.3	76870	Scrotum Ultrasound
Other Disorders of Testis	N43.40 - N45.4		
Male Urinary Disease	N00 - N39.9		
Undescended Testis	Q53.00 - Q53.9		
Other Urinary System	R30.0 - R39.9		
Deep Vein Thrombosis	I80.00 - I80.9, I82.401 - I82.5Z9	93970 - 93971 or 93965 or 93922 - 93923	Doppler Ultrasound
Ultrasounds	Code Dx	76641 - 76642, or 76872	Breast/Transrectal Ultrasound
RADIOLOGY			
Breast Screening for Women Over 40	Z12.31 - Z12.39	77067	Screening Mammo
		G0202	Digital Screening Mammo
Osteoporosis in Women 67+ w/Hx of Fracture	Z87.310	77080, 77085, 78350-78351, G0130	DXA Bone Density Scan
Syncope	R55	70460	Head CT Scan

CPT Code	CPT Description	CPT Code	CPT Description	CPT Code	CPT Description	CPT Code	CPT Description	CPT Code	CPT Description
74000	Abdominal X-ray	74270	Colon X-ray	73501-73530	Hip X-Ray	72170 or 72190	Pelvis -X-Ray	72070 – 72080	Spine X-Ray
73600 or 73610	Ankle X-Ray	73070 or 73080	Elbow X-Ray	73060	Humerus X-Ray	71100 or 71101	Ribs X-Ray	73590	Tib/Rib X-Ray
73650	Calcaneus X-Ray	73551, 73552	Femur X-Ray	73560 or 73562	Knee X-Ray	72081 – 72084	Scoliosis X-Ray	73660	Toe X-Ray
72040 or 72050	Cervical X-Ray	73620	Foot X-Ray	72100 or 72110	Lumbosacral X-Ray	73030	Shoulder X-Ray	74241 or 74247	Upper GI X-Ray
71010 or 71020	Chest X-Ray	73090	Forearm X-Ray	70160	Nasal X-Ray	70210	Sinus X-Ray	74420	Urography X-Ray

HEALTH EXCEL IPA

TREAMENT AUTHORIZATION REQUEST FORM

HEALTH EXCEL IPA

TREATMENT AUTHORIZATION FORM

****** Please fax this request to (714) 938-5154*****

DO NOT FAX URGENT / STAT REFERRALS.
PLEASE CALL (833) 914-0586, OPTION 1, 4 AND SPEAK TO A CASE MANAGER.

STATEMENT TO PROVIDER: This referral is for requested services only. Further care must be authorized. Payment will not be made for services that have not been authorized. CLINICAL INFORMATION AND ICD-10 CODES MUST BE INCLUDED WITH THIS REQUEST. If you have any questions, please contact us at (833) 914-0586.

Date of Request _____ **Total # of pages submitted** _____

PATIENT INFORMATION **Please Type or Print Legibly**

Name _____ **DOB** _____ **Sex** ☐ M ☐ F

Address _____

Phone Number _____ **Healthplan** _____

ID Number _____ **PCP Name** _____

Requesting Physician _____

Phone Number _____ **Fax Number** _____

SERVICE INFORMATION

Referral Provider Name _____ **Facility** _____

Specialty _____ **Phone Number** _____ **Outpatient** _____

Address _____ **Inpatient** _____

SERVICES REQUESTED

☐ Consult Only ☐ Follow-up Visit ☐ Procedure ☐ OB Care / EDC _____

REASON FOR REQUEST: Documentation of medical necessity (test results, progress notes, etc), ICD-10 codes and clinical information must be provided prior to submitting this request.

CPT CODE
CPT CODE
CPT CODE
CPT CODE
CPT CODE
CPT CODE
ICD-10 CODE
ICD-10 CODE
ICD-10 CODE
ICD-10 CODE
ICD-10 CODE

Clinical Information:

Prospect Medical Systems: 600 City Parkway West, Ste 800 Orange, CA 92868

PROSPECT MEDICAL

OFFICE UPDATE REQUEST FORM

HEALTH EXCEL IPA

Health Excel IPA must maintain accurate information in our provider database. This updated information will be forwarded to health plans affiliated with Health Excel IPA. We want to confirm the information we have on file matches what is returned on this form. Please complete, provide any changes, attach updated W-9, and fax or email this form to:

Fax to Provider Services/Credentialing: (858) 587-1642, or bfriend@ximedinc.com

Physician's Name: _____

Additional Physicians: _____
(*in same office contracted with IPA*)

_____

Effective Date: _____
(If there has been an address change)

Address: _____

City, State, Zip:_____

Phone: ( ) _____ Fax: ( ) _____

Tax ID Number: _____
(**PLEASE ATTACH W-9 TO THIS FORM - it is required that we get an updated W-9 to confirm TIN**)

Billing Address: _____

Hospital Affiliations: _____

Office Hours: M _____ T_____ W _____ Th _____ F _____ Sat _____ Sun_____

Languages Spoken:_____

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

Office Manager/Contact: _____

****

PCPs ONLY:

Does your office provide Well Woman Exams to members? _____

Does your office provide EKGs to members? _____

****

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

Date: _____ Phone Number: _____

HOSPITALS

For Emergency Care, Health Excel offers a variety of Hospitals and locations within our network. Contact the location nearest to you right away should you need emergency care.

SCRIPPS HOSPITALS - www.scripps.org

Scripps Memorial Hospital La Jolla
9888 Genesee Avenue
La Jolla, CA 92037
(858) 626-4123

Scripps Green Hospital
10666 N Torrey Pines Rd
La Jolla, CA 92037
(858) 554-9100

Scripps Memorial Hospital Encinitas
354 Santa Fe Drive
Encinitas, CA 92024
(760) 633-6501

Scripps Mercy Hospital
4077 5th Avenue
San Diego, CA 92103
(619) 294-8111

Scripps Mercy Hospital Chula Vista
435 H Street
Chula Vista, CA 91910
(619) 691-7000

PRIME HEALTHCARE HOSPITALS

Alvarado Hospital Medical Center
6655 Alvarado Road
San Diego, CA 92120
(800) 258-2723
www.alvaradohospital.com

Paradise Valley Hospital
2400 E. Fourth Street
National City, CA 91950
(619) 470-4321
www.paradisevalleyhospital.net

TRI-CITY MEDICAL CENTER

Tri-City Medical Center
4002 Vista Way
Oceanside, CA 92056
(760) 724-8411
www.tricitymed.org

FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

The Health Excel Network has three Federally Qualified Health Centers (FQHCs), providing multiple specialties of care, at multiple locations per FQHC.

SAN YSIDRO HEALTH CENTERS - www.syhc.org

San Ysidro Health Line (619) 662-4100 (See Website for Additional Locations)

San Ysidro Health Chula Vista
678 3rd Avenue
Chula Vista, CA 91910
Monday-Friday 8am-5pm

San Ysidro King-Chavez Health Center
950 South Euclid Avenue
San Diego, CA 92114
Monday-Friday 8am-5pm
Saturday 8am-4pm

San Ysidro Health Paradise Hills
2400 East 8th Street
National City, CA 91950
Monday-Friday 8am-5pm

San Ysidro Health Center
4004 Beyer Boulevard
San Ysidro, CA 92173
Monday-Friday 8am-7:30pm
Saturday 8:30am-2pm

LA MAESTRA COMMUNITY HEALTH CENTERS

www.lamaestra.org

Hope Clinic
4171 Fairmount Avenue
San Diego, CA 92105
(619) 269-1269
Monday-Friday 8am-5:30pm

El Cajon First Street
165 South First Street
El Cajon, CA 92109
(619) 312-0347
Monday-Friday 8am-5:30pm

National City
217 Highland Avenue
National City, CA 91950
(619) 434-7308
Monday-Friday 8am-5:30pm

El Cajon Broadway
1032 Broadway
El Cajon, CA 92019
(619) 795-5991
Monday-Friday 8:30am-5:30pm

NEIGHBORHOOD HEALTHCARE- www.nhcare.org

Neighborhood Healthcare El Cajon
855 E Madison Avenue
El Cajon, CA 92020
(619) 440-2751

Neighborhood Healthcare Lakeside
10039 Vine Street
Lakeside, CA 92040
(619) 390-9975

Neighborhood Healthcare Escondido
460 N. Elm Street
Escondido, CA 92025
(760) 520-8100

Neighborhood Healthcare Poway
13010 Poway Road
Poway, CA 92064
(858) 218-3000

EMERGENCY/URGENT CARE

For Emergency Care, please go to the hospital listed on your plan, or go directly to the nearest hospital.

Emergency Medical Care is defined as a health care service provided by a health care provider to treat a medical emergency.

A medical emergency is a medical condition that manifests itself by acute and abnormal signs and symptoms of sufficient severity, including severe pain, to lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

1. Serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child;
2. Serious impairment to the person's bodily functions; or
3. Serious dysfunction of one or more of the person's body organs or parts.

Health Excel IPA provides coverage for emergency services provided to a member by network, or non-network providers, subject to the terms of the member's benefit plan.

Emergency Care Guidelines

Emergency medical care does not include non-emergency, urgent care, routine health care, dental, or maintenance treatment, services and supplies, and/or routine medical exams.

Emergency hospital admissions are not subject to prior authorization requirements stated in the member's benefit plan. However, if a member is admitted on an emergency basis, the provider or the member should notify us within two (2) business days of the admission date.

A copayment may apply to a member's use of a hospital emergency room. The copayment amount applies to each member for each visit to the hospital emergency room or any other facility charge as an extension of the hospital emergency room, including urgent care rooms.

After any applicable hospital emergency room copayment amount is applied, Health Excel will apply benefits as stated in the member's benefit plan for the emergency room fee billed by the hospital for use of the hospital emergency room. This does not include miscellaneous hospital expenses and other health care services provided during the visit to the hospital emergency room.

If a member receives health care services from an urgent care facility within a hospital, applicable copayments as stated in the member's benefit plan may apply.

Hospital emergency room copayment may be waived for emergency room visits if the member is admitted as a resident patient to the hospital directly from the hospital emergency room.

Urgent Care is defined as care received for an illness or injury with symptoms of sudden or recent onset that require medical care the same day. See Urgent Care information on next page.

MD TODAY URGENT CARE

Health Excel IPA Urgent Care Centers - quick and convenient care for when you need it the most. Health Excel IPA offers MD Today Urgent Care, with two convenient locations in San Diego, and more coming soon. Find excellent care with quick and convenient access. Contact the location nearest to you right away should you need urgent care.

Website: www.mdtoday.com

MD Today - Scripps Ranch Urgent Care

10605 Scripps Pkwy, Ste C
San Diego, CA 92131
Phone (858) 622-0554
Fax (858) 622-1417

Monday to Friday 8 a.m. to 8 p.m.
Saturdays/Sundays 9 a.m. to 3 p.m.
*Open all holidays, except Thanksgiving and Christmas

MD Today - Carmel Valley Urgent Care

3830 Valley Centre Drive, Suite #702
San Diego, CA 92130
Phone (858) 720-0554
Fax (858) 622-1417

Monday to Friday 8 a.m. to 8 p.m.
Saturdays/Sundays 9 a.m. to 3 p.m.
*Open all holidays, except Thanksgiving and Christmas

SERVICES OFFERED:

- **Injuries**
- **Illnesses**
- **Coughs**
- **Colds**
- **Infections**
- **Sports Physicals**
- **Worker's Compensation**
- **Pulmonary Functions Testing**
- **First Aid**
- **Lacerations**
- **Drug Screens**
- **TB Testing**
- **Minor Fractures**
- **X Rays**
- **DOT Physicals**

AMERICAN FAMILY CARE (AFC) URGENT CARE

Health Excel IPA Urgent Care Centers - quick and convenient care for when you need it the most. Health Excel IPA offers American Family Care (AFC) urgent care centers, with five convenient locations in San Diego, and more coming soon. Find excellent care with quick and convenient access. Contact the location nearest to you right away should you need urgent care. Physician(s) are on site.

Website: www.afcurgentcare.com

AFC Urgent Care Locations Throughout San Diego
Open 8AM – 8PM Monday to Sunday, no appointment needed

AFC Urgent Care Chula Vista
760 Otay Lakes Road
Chula Vista, CA 91910
(619) 304-4634

AFC Urgent Care Clairemont
5671 Balboa Ave
San Diego, CA 92111
(858) 295-3283

AFC Urgent Care Mira Mesa
8260 Mira Mesa Blvd, Suite A
San Diego, CA 92126
(858) 247-3552

AFC Urgent Care Mission Valley
8590 Rio San Diego Drive, Suite 111
San Diego, CA 92108
(619) 304-9606

AFC Urgent Care Santee
10538 Mission Gorge Rd., Suite 100
Santee, CA 92071
(619) 304-8170

SERVICES OFFERED:

Urgent Care
Primary Care
Digital X-Ray Services
Lab Work
Routine Check Ups
Occupational Health and Worker's Comp
Sports/School Physicals
Vaccines-Travel Medicine
Immigration Physicals
Vaccines– Immunizations
Physicals—DOT
Drug Testing
Sports Injuries

URGENT CARE CENTERS

Health Excel IPA Urgent Care Centers - quick and convenient care for when you need it the most. Health Excel IPA offers Oceanside Urgent Care, and South Bay Urgent Care. Find excellent care with quick and convenient access. Contact the location nearest to you right away should you need urgent care.

OCEANSIDE URGENT CARE

616 S. Coast Hwy
Oceanside, CA 92054
Phone (760) 433-1800
Fax (760) 231-9900
Website: www.oceansidemedicine.com

Monday to Friday	9 a.m. to 5:30 p.m.
Saturdays	9 a.m. to 3 p.m.
Sundays	appt. only

SERVICES OFFERED:

- **Injuries**
- **Illnesses**
- **Coughs**
- **Colds**
- **Weight Loss**
- **First Aid**
- **Lacerations**
- **Drug Screens**
- **Women's Health**
- **Vitamin Bar**
- **Infections**
- **Accidents**
- **X Rays**
- **EKG Testing**
- **Sports Physicals**

SOUTH BAY URGENT CARE

1628 Palm Avenue
San Diego, CA 92154
Phone (619) 591-9999
Fax (619) 941-2078
Website: www.southbayurgentcare.com

Monday to Friday	9 a.m. to 8 p.m.
Saturdays/Sundays	10 a.m. to 6 p.m.

SERVICES OFFERED:

- **Injuries**
- **Illnesses**
- **Coughs**
- **Colds**
- **First Aid**
- **Lacerations**
- **Drug Screens**
- **Fractures**
- **Infections**
- **Accidents**
- **X Rays**
- **Flu/Strep Testing**

SURGERY CENTERS/ LABORATORY/PHARMACY

SURGERY CENTERS

Magnolia Surgery Center
463 N Magnolia Ave
El Cajon, CA 92020
(619) 359-8380

UCSD Medical Center Surgery
9300 Campus Point Drive
La Jolla, CA 92037
(858) 657-8630

UC San Diego Surgical Specialties
4520 Executive Drive
San Diego, CA 92121
(858) 657-8860

Surgery Center of California
835 Third Avenue, Suite C
Chula Vista, CA 91911
(619) 425-7755

Rattner Vascular Medical Center ASC
995 Gateway Center Way, Suite 207
San Diego, CA 92102
(619) 263-9729

La Jolla Endoscopy
9850 Genesee Avenue, Suite 980
La Jolla, CA 92037
(858) 412-7190

UCSD Ambulatory Surgery Center
8929 University Center Lane
San Diego, CA 92122
(858) 554-0220

Scripps Ambulatory Surgery Center
9850 Genesee Avenue, Suite 100
La Jolla, CA 92037
(858) 626-4428

Cabrillo Surgery Center
7695 Cardinal Court, Suite 220
San Diego, CA 92123
(858) 278-8835

San Diego Access & Surgery Center
6402 El Cajon Boulevard, Suite 100
San Diego, CA 92115
(619) 582-4490

LABORATORY

LABCORP
(All locations in San Diego)
Visit www.labcorp.com for your nearest location, or to schedule an appointment

PHARMACY

CVS PHARMACIES
(All locations in San Diego)
Visit www.cvs.com for your nearest location, or to schedule an appointment

Palm Care Pharmacy
505 N Mollison Avenue, Suite 102
La Jolla, CA 92021
(619) 457-0545

Eldahmy Wellness Pharmacy
1985 National Avenue, Suite 1103
San Diego, CA 92113
(619) 331-1111

IMAGING/RADIOLOGY CENTERS

HEALTH EXCEL IPA

IMAGING HEALTHCARE SPECIALISTS (IHS)

ALVARADO
Alvarado Court Medical Building
6386 Alvarado Court, Suite 121
San Diego, CA 92120
Tel: 619-229-2299
Fax: 866-558-4329

ENCINITAS
North Coast Health Center
477 N. El Camino Real, Suite A-102
Encinitas, CA 92024
Tel: 760-452-7150
Fax: 866-558-4329

POWAY
12620 Monte Vista Road, Suite A
Poway, CA 92064
Tel: 858-487-9729
Fax: 866-558-4329

CHULA VISTA/SOUTH BAY
Gateway
333 H Street, Suite 1095
Chula Vista, CA 91910
Tel: 619-409-9119
Fax: 866-558-4329

VISTA
1000 Vale Terrace Drive
Vista, CA 92084
Tel: 858-888-4444
Fax: 866-558-4329

GOLDEN TRIANGLE
Regents Medical Plaza
4150 Regents Park Row, Suite 195
La Jolla, CA 92037
Tel: 858-622-6464
Fax: 866-558-4329

TRI-CITY
3601 Vista Way, Bldg. A, Suite 101
Oceanside, CA 92056
Tel: 760-631-7505
Fax: 866-558-4329

HILLCREST
150 W. Washington St
San Diego, CA 92103
Tel: 619-295-9729
Fax: 866-558-4329

LOGAN HEIGHTS
1809 National Avenue,
Suite 2104
Logan Heights, CA 92113
Tel: 866-558-4320
Fax: 866-558-4329

KEARNY MESA
3939 Ruffin Road, Suite 102
San Diego, CA 92123
Tel: 858-658-6500
Fax: 866-558-4329

VALLEY RADIOLOGY CONSULTANTS MEDICAL GROUP

CARLSBAD
6185 Paseo Del Norte, Suite 110
Carlsbad, CA 92011
Tel: 760-494-0556
Fax: 760-858-2020

ESCONDIDO
255 North Elm Street, Suite 102
Escondido, CA 92025
Tel: 760-739-5400
Fax: 760-858-2020

RANCHO BERNARDO/POWAY
15725 Pomerado Road, Suite 101
Poway, CA 92064
Tel: 858-485-6500
Fax:760-858-2020

ADMINISTRATION/MEDICAL RECORDS
613 W. Valley Parkway, Suite 330
Escondido, CA 92025
Tel: 760-739-5400
Fax: 760-858-2020

SKILLED NURSING FACILITIES, PHYSICAL THERAPY, HOME HEALTH & DME

SKILLED NURSING FACILITIES/SNF

San Diego SNF Hospitalists
3863 Clairemont Drive
San Diego, CA 92117
(858) 500-2693

Ensign Skilled Nursing
29222 Rancho Viejo Road, St 127
San Juan Capistrano, CA 92675
(949) 487-9500

PHYSICAL THERAPY

La Mesa Physical Therapy Group
5648 Lake Murray Boulevard
La Mesa, CA 91942
(619) 464-1352

San Diego Spine & Sport
3760 Convoy Street, Suite 100
San Diego, CA 92111
(858) 573-9368

E & L Physical Therapy Mgt, dba PRN
2650 Camino Del Rio North, Ste 200
San Diego, CA 92128
(619) 295-3000

Girard Physical Therapy and Hand Center
9333 Genesee Avenue, Suite 350A
San Diego, CA 92121
(858) 455-6460

HOME HEALTH AGENCIES

Guardian Angel Home Care
3505 Camino Del Rio South #220
San Diego, CA 92108
(619) 640-4383

Uni Care Home Health
1510 S. Escondido Blvd., Suite 101
Escondido, CA 92025
(760) 510-0090

DURABLE MEDICAL EQUIPMENT (DME)

Kadence Healthcare
7554 Trade Street
San Diego, CA 92121
(858) 569-6994
www.kadencehealthcare.com

Special Care
9511 Ridgehaven Court
San Diego, CA 92123
(858) 694-5800
www.specialcaredme.com

Preston Wound Care
Phone (888) 619-6863
Fax (866) 599-6972
www.prestonwoundcare.com

Shield HealthCare of California
Phone (800) 765-8775
Fax (888) 349-1499
www.shieldhealthcare.com

Prism Medical Products
Phone (888) 244-6421
Fax (800) 975-6321
www.prism-medical.com

Hanger Prosthetics & Orthotics West, Inc. dba Hanger Clinic
7720 Cardinal Court
San Diego, CA 92123
Phone (858) 292-7448
Fax (858) 292-0927
www.hangerclinic.com

DIALYSIS CENTERS

FRESENIUS KIDNEY CARE

Fresenius Kidney Care
Hillcrest
3960 3rd Ave
San Diego, CA 92103
Help Line 1-800-881-5101
Phone (619) 299-3900

Fresenius Kidney Care
Raven Dialysis
499 Raven St
San Diego, CA 92102
Help Line 1-800-881-5101
Phone (619) 263-1518

Fresenius Kidney Care
National City
303 W 26th St
National City, CA 91950
Help Line 1-800-881-5101
Phone (619) 474-8151

Fresenius Kidney Care
Kearny Mesa
7927 Ostrow St
Ste A
San Diego, CA 92111
Help Line 1-800-881-5101
Phone (858) 571-0232

Fresenius Kidney Care
Paradise
6919 Paradise Valley Rd
San Diego, CA 92139
Help Line 1-800-881-5101
Phone (619) 475-2872

Fresenius Kidney Care
Gateway East
720 Gateway Center Dr
Ste B
San Diego, CA 92102
Help Line 1-800-881-5101
Phone (619) 264-4100

Fresenius Kidney Care
College
5961 University Avenue
Ste 317
San Diego, CA 92115
Help Line 1-800-881-5101
Phone (619) 286-0821

Fresenius Kidney Care
San Diego DS Home—JV
7907 Ostrow St
Ste B
San Diego, CA 92111
Help Line 1-800-881-5101
Phone (858) 571-0428

Fresenius Kidney Care
Balboa South Bay Home Therapies
340 4th Ave
Ste 18
Chula Vista, CA 91910
Help Line 1-800-881-5101
Phone (619) 420-1798

Fresenius Kidney Care
Rai Care Center
Mission Gorge-San Diego
7007 Mission Gorge Rd
San Diego, CA 92120
Help Line 1-800-881-5101
Phone (619) 229-1070

AERIAL CARE QUICK START

Instruction for Aerial Care Start-Up

Health Excel IPA provides a Web Portal for On Line Referrals & Claims Submission through Aerial Care, a managed care software system. If you have internet access in your office simply follow the steps below to easily set up your on line referral process for your Health Excel IPA patients.

How to Access Aerial Care

1. Aerial Care is compatible ONLY with Internet Explorer 9, 10, or 11.
2. Access the Aerial Care website, and click *Physician* below the Prospect Medical Group Link.
3. Under For Providers, click on **Provider Login (Aerial Care)** Link
4. Enter **Login Name** and Password, click **Continue**

***Note - Aerial Care access is granted to providers that have a contracted status with Health Excel IPA. To obtain a Login and password, or to schedule training for your office, please contact Health Excel IPA at (858) 452-1279, or any of the Providers Services staff members located on page 5 of this Provider Manual.**

Viewing Eligibility Information

1. Click on the **Eligibility** tab and complete at least one of the fields and click **Submit**
2. Eligibility search result will appear providing eligibility status –
   Green icon = Eligible and **Red icon = Not Eligible**
3. View and sort eligibility information based on desired criteria in **Search** or **Advanced Search**
4. Click on icon to view member information and eligibility details

Referral Submission, Referral Status, and Referral Modification

1. Click **Submit Online Referral** located to the left side of the dashboard
2. Fill in one or more fields and click **Search**
3. Member search result will appear. Click **Refer** located to the right side of the screen
4. Select appropriate referral **Specialty**
5. Only routine referral submissions can be submitted online. **STAT/URGENT request must be called in to Medical Mgmt. at (833) 914-0586, prompt 1 for Providers, prompt 4 for STAT/Urgent Referrals.**
6. Select the appropriate Place of Service
7. Enter CPT code(s), Service Unit(s), and ICD-10 code(s), click on **Add Next** to enter additional codes
8. Enter your **Clinical Symptoms/Findings** in box
9. Enter your **Treatment Plan** in box
10. Submit referral by clicking **Submit Referral**
11. To add attachments, click on icon, select the file to be attached using the "Browse" button, add comments about the file in the "Description" box (optional), then click on **Save Attachment**. The attachment will be forwarded to our Medical Management Team
12. **Verify referral status**, click Referrals tab
13. The status column illustrates the referral status
14. Click on icon to view referral details
15. Enter your modification request (changes to CPT codes, ICD-10 codes, referral extensions, Facility/ Provider modifications, etc.) in **Comments** box, click **Save Comments**. Medical Management will acknowledge your request and can be viewed under the **Referral Alerts** tab on the dashboard.**

Claim Status **(note: you may search by entering data in any of the search fields)**

1. Click **Claims** on the top menu bar, then click **Claim Status** on the dropdown menu
2. The status column illustrates the claim status (A for approved, P for Pending)
3. Click on icon to view the details

***Note: DME, Home Health, and Injectable Drug referral submissions must be requested on a Treatment Authorization Request Form located on Aerial Care under My Links section/Provider Tools link.**

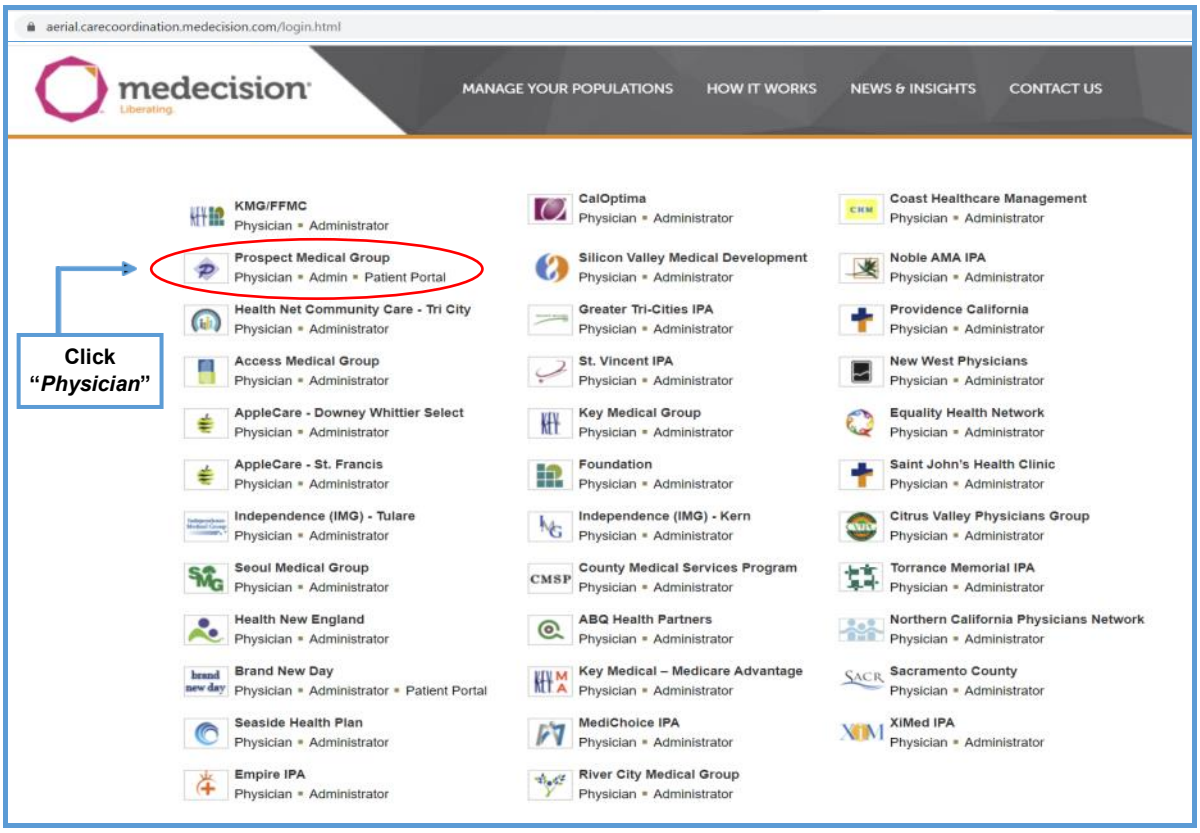
System Requirements:

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

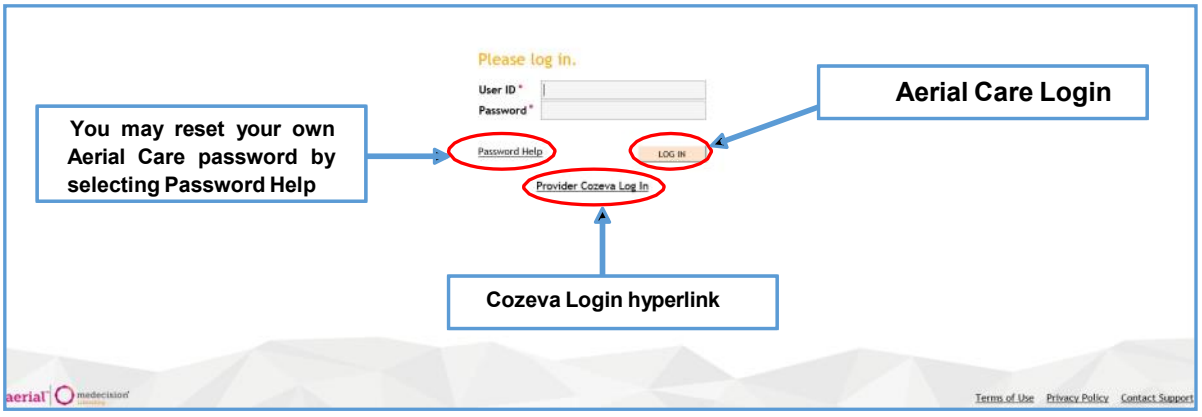
- **Internet Explorer 11**: Available at no cost to you by downloading from: *windows.microsoft.com/en-us/**internet-explorer/download-ie***
- **Adobe Reader** (most current version): Available at no cost to you by downloading from http://www.adobe.com/products/reader/.

Log-In Instructions:

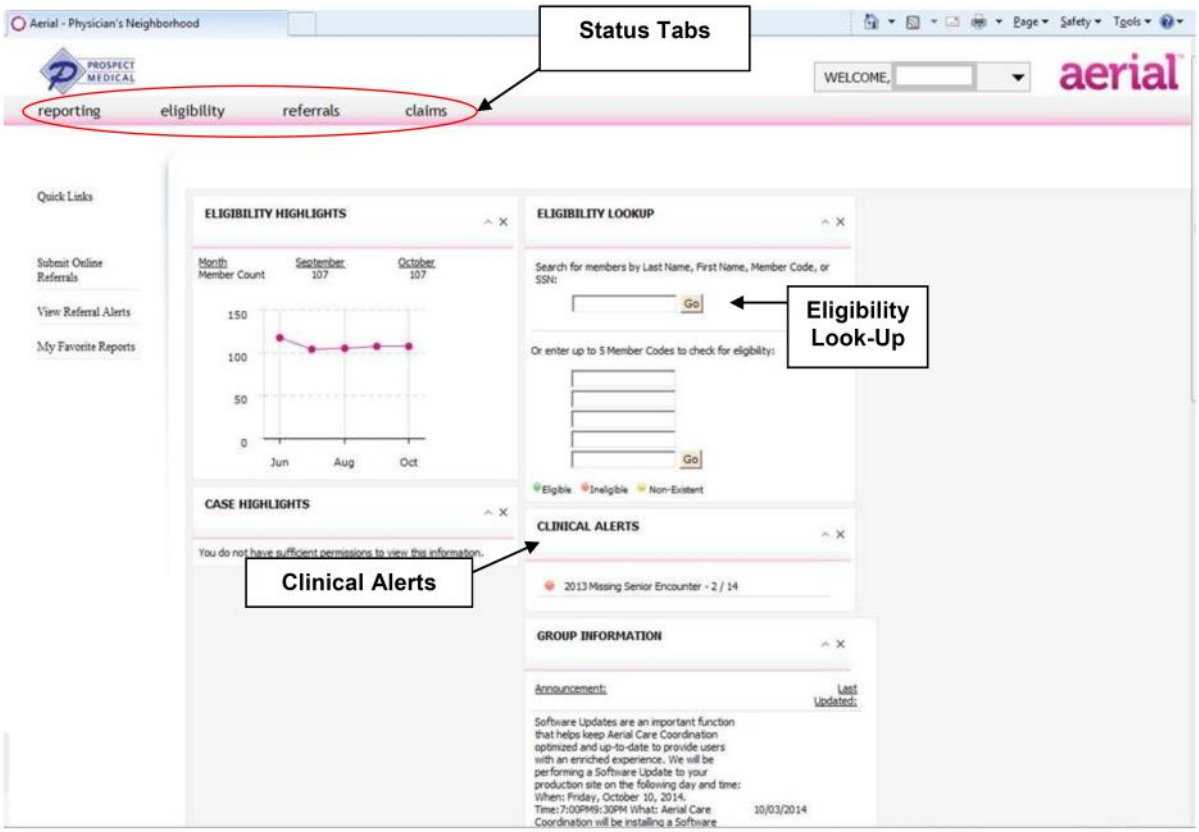
1. Go to https://aerial.carecoordination.medecision.com/login.html - find Prospect Medical Group in the upper left corner, and click the *Physician* link.



2. Log in using the User ID and Password provided to you by Health Excel. If you do not have a user name and password, contact Health Excel Provider Services at 858-452-1279.



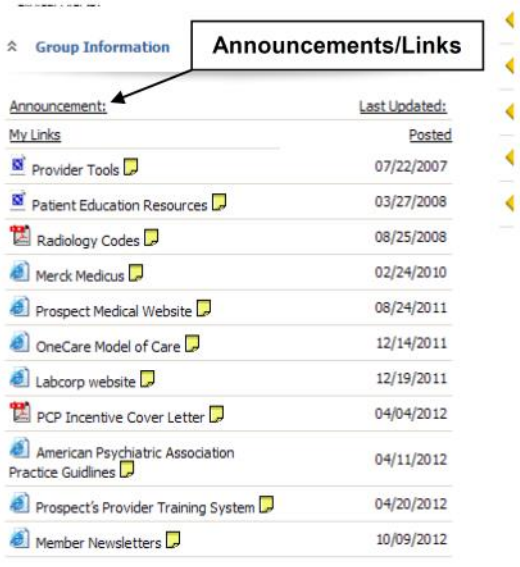
DASHBOARD OVERVIEW



MY LINKS

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

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



VERIFY ELIGIBILITY

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

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

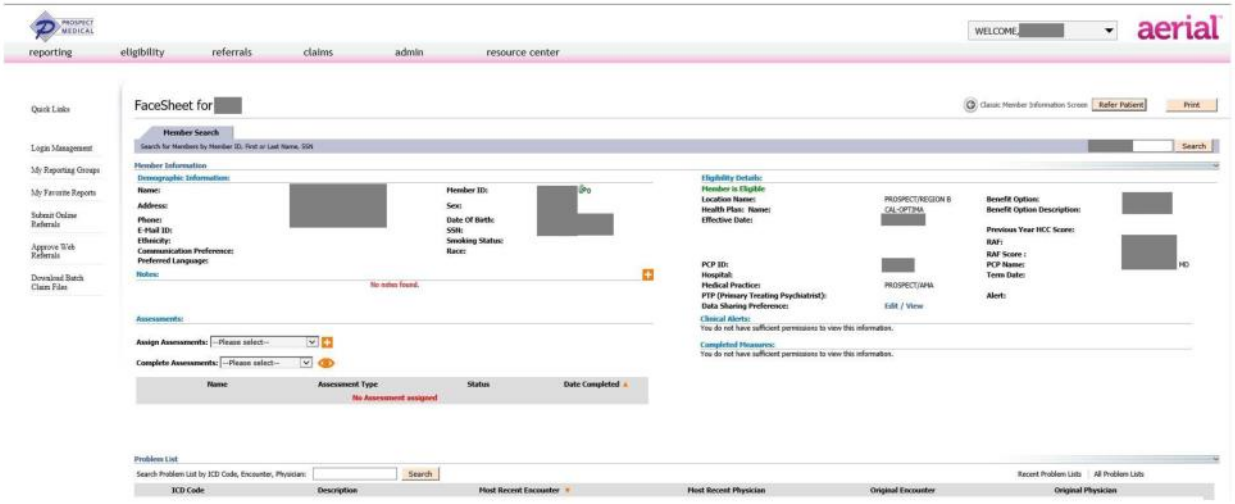
Select the member that matches your search criteria (date of birth, member id number, etc.).

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

Member's information will appear.

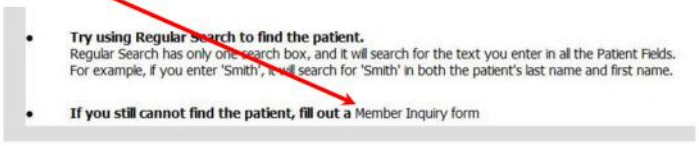
Green Icon = Eligible
Red Icon = Not Eligible

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

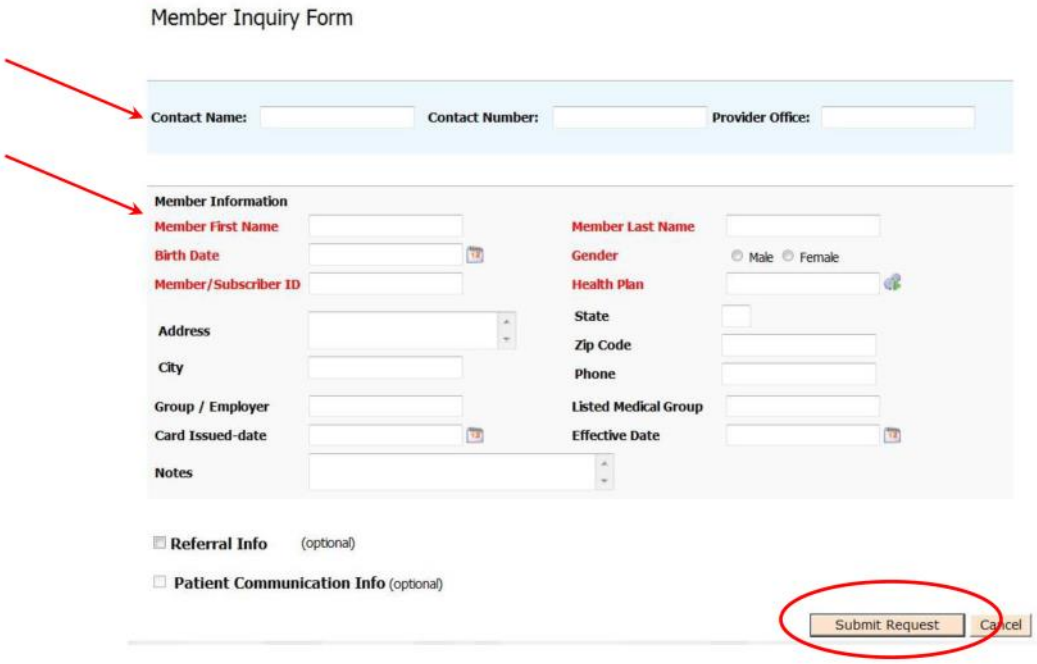


AERIAL CARE USER GUIDE (cont.)

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



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



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

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

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

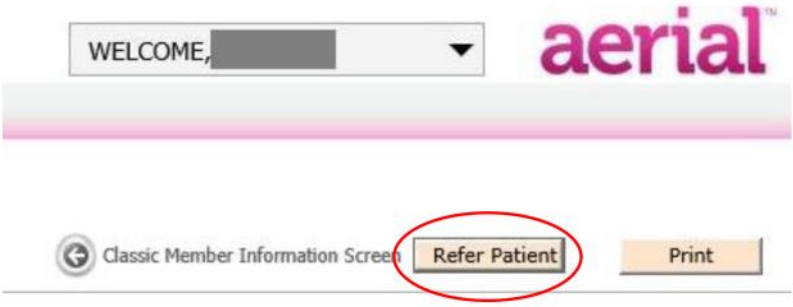
If you are having trouble with Aerial Care, please contact us! **Aerial Care Technical Support: (800) 708-3230, prompt 1, prompt 7 or e-mail ProviderInfo@prospectmedical.com**.

REFERRALS

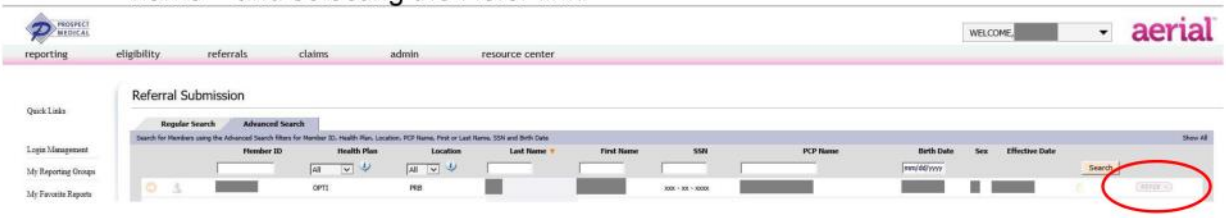
Referral Protocols

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

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

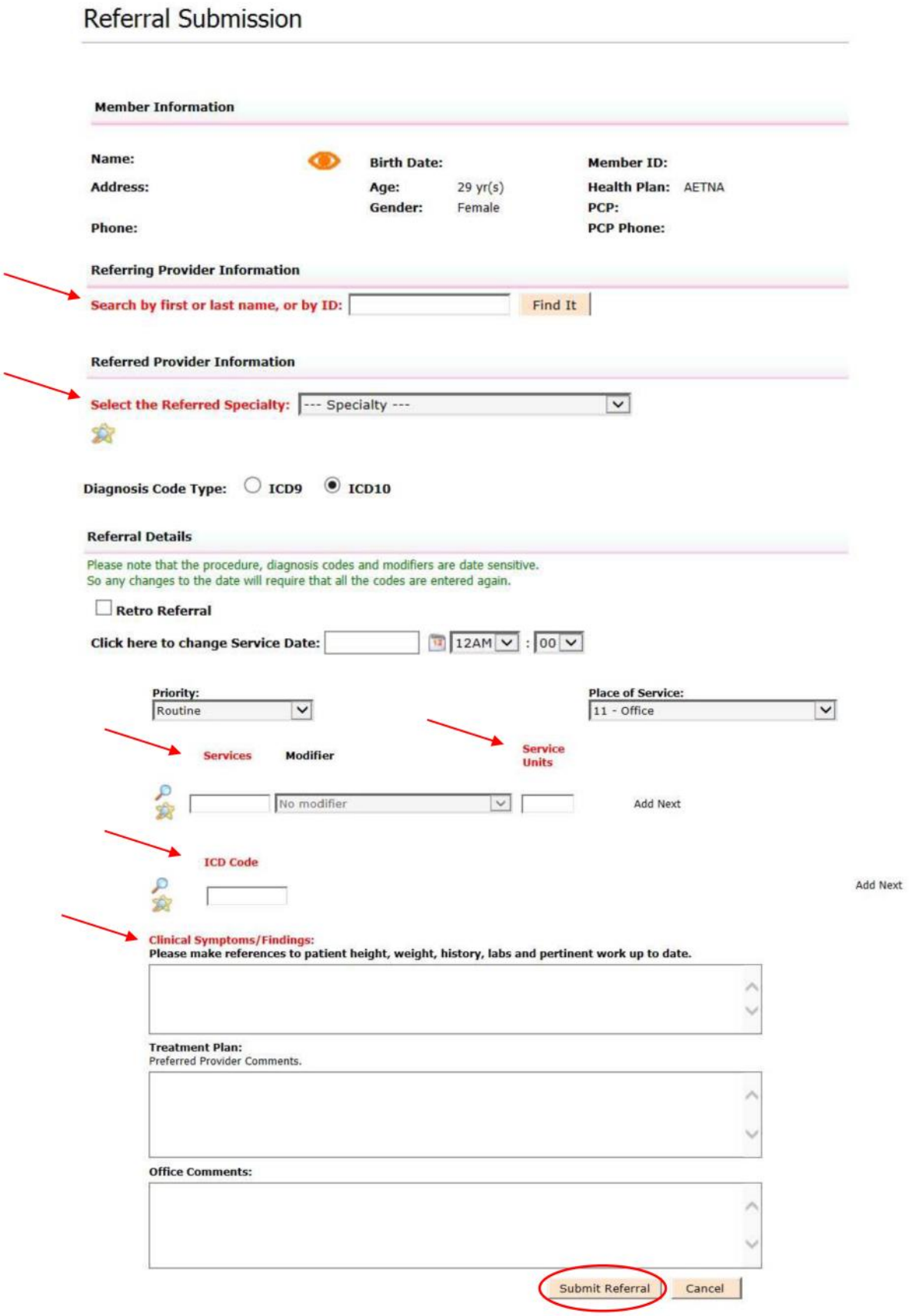


- Submit a referral from the Referral Online Submission tab after searching for member name – and selecting the Refer link.



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

AERIAL CARE USER GUIDE (cont.)

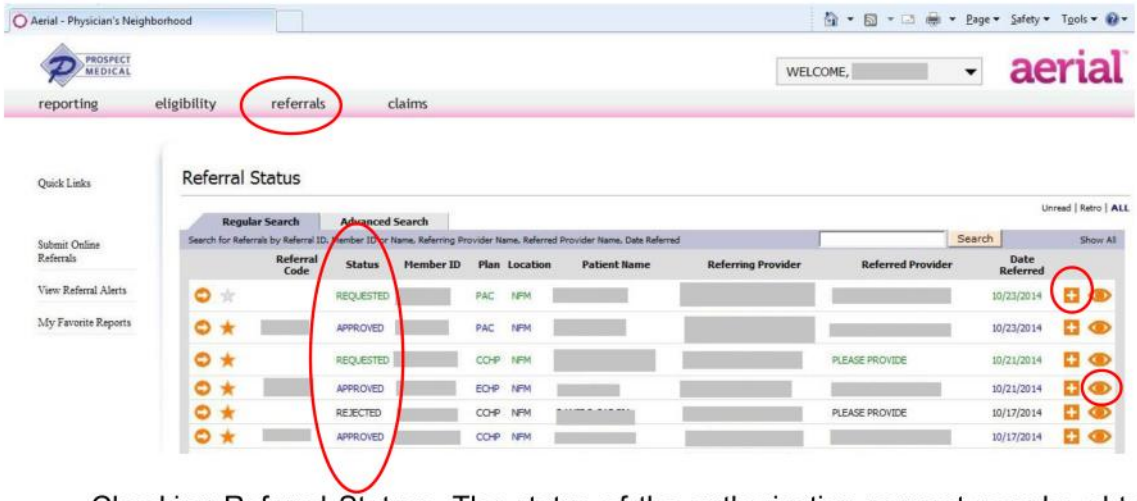


AERIAL CARE USER GUIDE (cont.)

HEALTH EXCEL IPA

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

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



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

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

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

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

Type your request and click Save Comments tab.

The following can be requested:

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

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

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

Auto-Approval Rules

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

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

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

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

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

Obstetrics/Gynecology

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

Physical Therapy/Occupation Therapy:

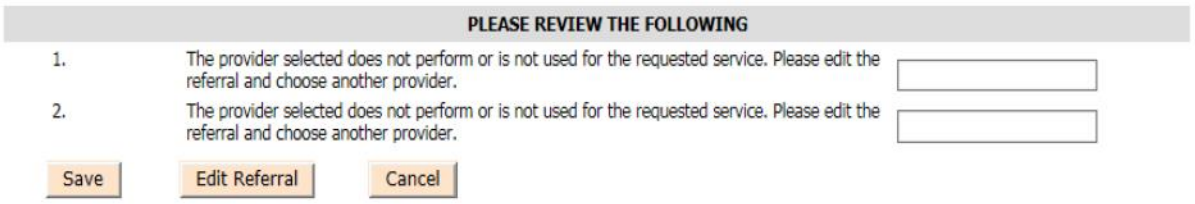
- Procedure codes for auto approval are 97001 (1 unit), 97003 (1 unit) and 97110 (6 units). Provider is responsible for verifying benefits prior to rendering service.

Radiology:

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

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

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

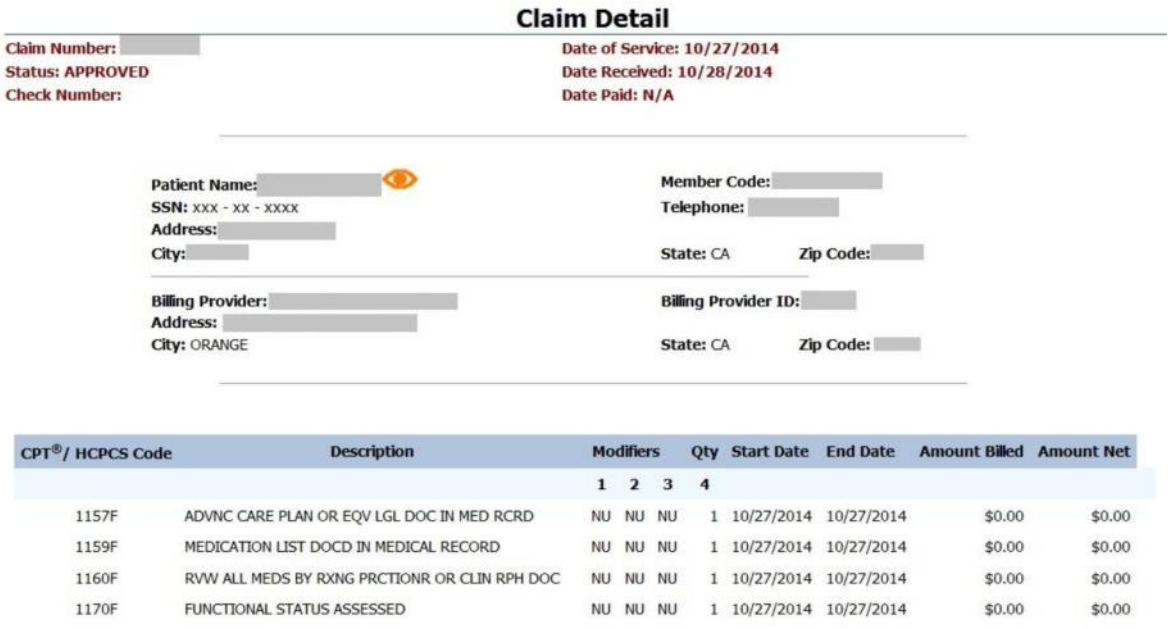


CLAIM STATUS AND DETAILS

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

Verifying Claim Status

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



Claim Detail

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

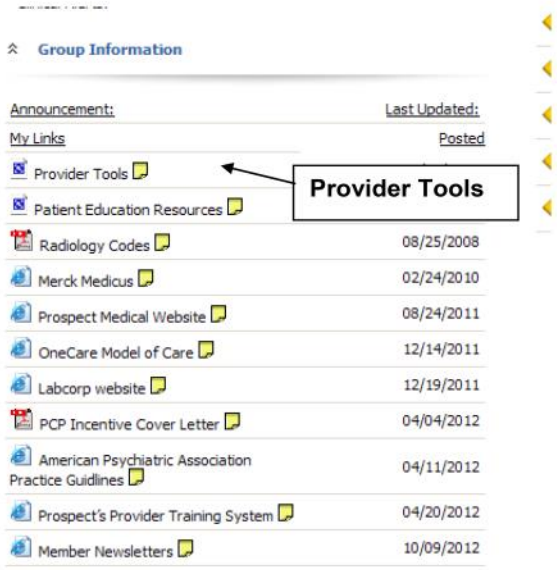
Patient Name:
SSN: xxx - xx - xxxx
Address:
City:
Member Code:
Telephone:
State: CA Zip Code:

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

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

PROVIDER TOOLS

Provider Tools is accessed via the Aerial Dashboard.



Network Updates includes links to:

- Provider Bulletins and Operational Updates
- Current Provider Manual
- Health Plan Updates
- LabCorp of America

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

Frequently Asked Questions

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

Aerial is optimized for Internet Explorer 11 due to specific limitations found on other internet browsers known to impede the performance of Aerial. Download Internet Explorer 11.

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

Accessing Aerial through a shortcut does not allow you to receive updates. It is important that you access Aerial by keying in the website in the address line on Internet Explorer 11 at https://aerial.carecoordination.medecision.com/login.html; and selecting Physician Login link.

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

You will not be able to verify eligibility for a member assigned to another physician. When your office is responsible for verifying eligibility for multiple providers, you may request a "Super User" account to be set up with one user and one password to view member information for all physicians. Please contact Network Management at (833) 914–0586, prompt 1 for Providers, prompt 7 for Aerial Care assistance.

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

The Eligibility Lookup feature conducts a search based on the member information inserted into the fields provided. If any of the inserted information mismatches, your member eligibility search result will be match not found. Less is more in this case. Try entering only three letters from the member's first name and last name then proceed to conduct your member eligibility search.

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

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

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

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

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

Aerial does not recognize that multiple tabs are being used and will freeze because of this.

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

Provider must be contracted with the same network that the member is enrolled in, to be given rights to view eligibility and submit referrals.

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

Only Direct Referral Providers will be showing on the drop-down list and are contracted within the same network that the member is enrolled in.

Communication

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

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

Procedure

1. Quality Management activities are reported to the Quality Committee of Prospect Medical Systems monthly.
2. The Quality Management Committee determines what quality related issues are to be communicated to providers.
3. This information is communicated to each contracted provider using a newsletter format and is distributed at least quarterly.

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

Peer Review Activities

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

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

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

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

Peer Review Activities (cont.)

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

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

Retrospective Review:

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

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

Corrective Actions: Problems identified by the activities previously described are managed at the discretion of the Committee, as necessitated by the severity of the problem. All corrective actions are reviewed by the Committee and documented in the minutes.

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

- A written response to the issues raised by the inquiry within 3 days of receiving request for response from the Q.M. Manager.
- Provider may be asked to attend a meeting of the Quality Committee for the purpose of open discussion of the issues identified and any necessary remedial measures.

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

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

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

PERFORMANCE PROGRAMS DEPARTMENT

The Performance Programs Department is responsible for HCC Risk Adjustment, CMS Stars, and HEDIS programs, through HCC Risk Adjustment Analysts and HCC Risk Adjustment Specialists, and Quality Care Coordinators that reach out to members with reminders of their preventative care to help meet STARS and HEDIS requirements.

Annual Wellness Visit, HCC and Risk Adjustment Factor (RAF)

An **Annual Wellness Visit (AWV)** is a yearly appointment with the primary care provider (PCP), designed to create or update a personalized prevention plan, and perform a health risk assessment.

HCC (**H**ierarchical **C**ondition **C**ategory) coding is a risk-adjustment model originally designed to estimate future health care costs for patients. Hierarchical condition category relies on ICD-10 coding to assign risk scores to patients. Each HCC is mapped to an ICD-10 code. Along with demographic factors (such as age and gender), insurance companies use HCC coding to assign patients a **Risk Adjustment Factor (RAF)** score. Using algorithms, insurances can use a patient's RAF score to predict costs. For example, a patient with few serious health conditions could be expected to have average medical costs for a given time. However, a patient with multiple chronic conditions would be expected to have higher health care utilization and costs.

How HCC Risk Adjustment Works

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

HEDIS/STAR RATINGS

The Healthcare Effectiveness Date and Information Set **(HEDIS)** is widely used to measure and improve health care quality and is relied on by government regulators, health plans, provider organizations, employers and others to identify quality and compare plan performance. The accuracy of collecting, measuring and reporting HEDIS is vital to benchmarking and improving quality.

The **STAR** measures are made up of performance measure from HEDIS data. CMS uses a five-star quality rating system to measure the experiences Medicare beneficiaries have with their health plan and health care system. Health plans are rated based on a scale of 1 to 5 stars, with 5 being the highest. These ratings are then published on the Medicare Plan Finder. The Star Rating programs is intended to raise the quality of care for Medicare beneficiaries, strengthen beneficiary protections, and help consumers compare health plans more easily.

HCC Risk Adjustment Contact Numbers

Office Number: (714) 796-4269
Fax Number: (714) 560-7331

HEDIS (Medi-Cal) Quality Team Contact Numbers

Office Number: (714) 796-4205
Fax Number: (714) 560-5295

STARS (Medicare) Team Contact Numbers

Office Number: (714) 796-4205
Fax Number: (714) 560-4282

ANNUAL WELLNESS VISIT (AWV) GUIDE 2020

HEALTH EXCEL IPA

PROSPECT MEDICAL

Provider Annual Wellness Visit (AWV) Guide 2020

The Prospect Annual Wellness Visit (AWV) has two parts:

1. Prospect Assessment Form (PAF)
2. Progress (SOAP) Note of the face-to-face visit with the *same* date of service.

How to use the Prospect Assessment Form (PAF)

The 2 page PAF simplifies the AWV.

It is prefilled with the member's data and PCP information.

The diagnoses and STAR measures are specific to each member. Both pages must be completed properly.

Page 1 is mostly informational *and* aids in documenting the AWV.

Page 2 (See Opposite Page) has the AWV Questionnaire arranged to help you quickly review their responses and address issues you may find.

Page 1 (1) Fill out **DATE OF SERVICE** on the top right of the page.

(2) *Review* **Persistent Conditions Peviously Documented** Assess these diagnoses listed in your Progress (SOAP) Note. Note some diagnosis may relate to conditions of the same etiology. If a condition is no longer present, check "No" (2a.) Address other significant conditions or complications identified that may not be listed.

(3) *Review* **Suspect Conditions to Evaluate** If a condition or complication related to these disease groups are present in your member, please address them in your Progress (SOAP) Note. If a condition has resolved or is not present, please check "No".

(4) *Review* **5 STAR Measure Alerts** Close the "Gaps in Care" by either: a) Ordering/performing the measure if appropriate. b) Provide chart documentation/ medical records that validates it has been completed and attach it to the Progress (SOAP) note.

Page 1 **Required Assessment (Dark Blue Headings)**

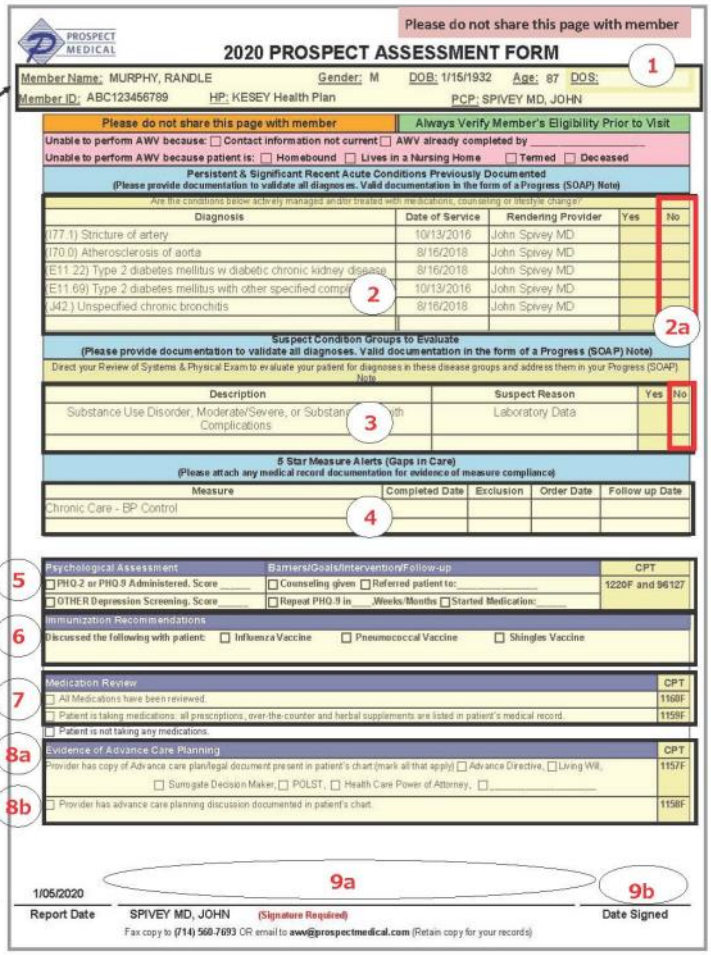
If these sections are blank it only means we do not currently have data for the patient. Address significant conditions and gaps in care you come across.

5) **Psychological Assessment** (Capture both 1220F and 96127 CPTs)

Screen the member for Depression. The PHQ-2 or PHQ-9 is the most commonly used screening tool. But you may use any valid screening tool. Record the score 5a in the form and address any findings on the right side of the form 5b or the Progress (SOAP) Note if you have more to document. (Please keep the completed depression screening tool in your member files for audit purposes. You do not need to send it in)

6) **Immunization Recommendations:** Please *discuss* all 3 vaccinations and check the appropriate boxes.

7) **Medication Review** (Capture both 1160F and 1159F CPTs) Review medications in the chart and with the member and update in your records. Check both boxes for:


Please do not share this page with member

2020 PROSPECT ASSESSMENT FORM (1)

Member Name: MURPHY, RANDLE Gender: M DOB: 1/15/1932 Age: 87 DOS:
Member ID: ABC123456789 HP: KESEY Health Plan PCP: SPIVEY MD, JOHN

Please do not share this page with member | Always Verify Member's Eligibility Prior to Visit

Unable to perform AWV because: ☐ Contact information not current ☐ AWV already completed by ____
Unable to perform AWV because patient is: ☐ Homebound ☐ Lives in a Nursing Home ☐ Termed ☐ Deceased

Persistent & Significant Recent Acute Conditions Previously Documented
(Please provide documentation to validate all diagnoses. Valid documentation in the form of a Progress (SOAP) Note)
Are the conditions below actively managed and/or treated with medications, counseling or lifestyle change?

Diagnosis	Date of Service	Rendering Provider	Yes	No
(I77.1) Stricture of artery	10/13/2016	John Spivey MD		
(I70.0) Atherosclerosis of aorta	8/16/2018	John Spivey MD		
(E11.22) Type 2 diabetes mellitus w diabetic chronic kidney disease	8/16/2018	John Spivey MD		
(E11.69) Type 2 diabetes mellitus with other specified compli (2)	10/13/2016	John Spivey MD		
(J42.) Unspecified chronic bronchitis	8/16/2018	John Spivey MD		

(2a)

Suspect Condition Groups to Evaluate
(Please provide documentation to validate all diagnoses. Valid documentation in the form of a Progress (SOAP) Note)
Direct your Review of Systems & Physical Exam to evaluate your patient for diagnoses in these disease groups and address them in your Progress (SOAP) Note

Description	Suspect Reason	Yes	No
Substance Use Disorder, Moderate/Severe, or Substanc ith Complications (3)	Laboratory Data		

5 Star Measure Alerts (Gaps in Care)
(Please attach any medical record documentation for evidence of measure compliance)

Measure	Completed Date	Exclusion	Order Date	Follow up Date
Chronic Care - BP Control (4)				

(5) Psychological Assessment	Barriers/Goals/Intervention/Follow-up	CPT
☐ PHQ-2 or PHQ-9 Administered. Score ____	☐ Counseling given ☐ Referred patient to: ____	1220F and 96127
☐ OTHER Depression Screening. Score ____	☐ Repeat PHQ-9 in ____Weeks/Months ☐ Started Medication: ____	

(6) Immunization Recommendations			
Discussed the following with patient:	☐ Influenza Vaccine	☐ Pneumococcal Vaccine	☐ Shingles Vaccine

(7) Medication Review	CPT
☐ All Medications have been reviewed.	1160F
☐ Patient is taking medications: all prescriptions, over-the-counter and herbal supplements are listed in patient's medical record.	1159F
☐ Patient is not taking any medications.	

(8a) Evidence of Advance Care Planning	CPT
Provider has copy of Advance care plan/legal document present in patient's chart (mark all that apply) ☐ Advance Directive, ☐ Living Will, ☐ Surrogate Decision Maker, ☐ POLST, ☐ Health Care Power of Attorney, ☐ ____	1157F
(8b) ☐ Provider has advance care planning discussion documented in patient's chart.	1158F

1/05/2020 (9a) (9b)
Report Date SPIVEY MD, JOHN (Signature Required) Date Signed
Fax copy to (714) 560-7693 OR email to awv@prospectmedical.com (Retain copy for your records)

7a) "All Medications have been reviewed" (1160F) and

7b) "Member is taking medications: all prescriptions....(1159F)"

8) **Evidence of Advance Care Planning**: Capture 1157F and/or 1158F)

8a) If present, indicate that the Advance Care Plan is in the member chart and (1157F)

8b) During this visit, initiate or continue the Advance Care conversation. This discussion can be very short if the member is not ready to discuss this sensitive issue but we need to at least broach the topic as respectfully as we can. It is rare to come to a final plan at the end of one visit. Advance Care Planning may take several visits and involve other family members. Document what you are able to achieve during this visit in your progress note. (1158F)

9) Sign 9a and date 9b on the bottom of the page. Ensure signature and credentials of the *rendering* provider are present.

2020 Provider Version 1.0

Use G0438 (Initial) or G0439 (Subsequent) for billing the AWV

ANNUAL WELLNESS VISIT (AWV) GUIDE 2020

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Provider Annual Wellness Visit (AWV) Guide 2020

Page 2 Member AWV Questionnaire

The AWV questionnaire is to be filled out by the physician while they are in the exam room with the patient. It is the white portion of the page on the left hand side.

1) Fill in the **Date of Service** on the top right side. (A)

2) Fill in the member's responses to the questionnaire. Please pay particular attention to their responses involving:

   Falls (3288F CPT) (B)

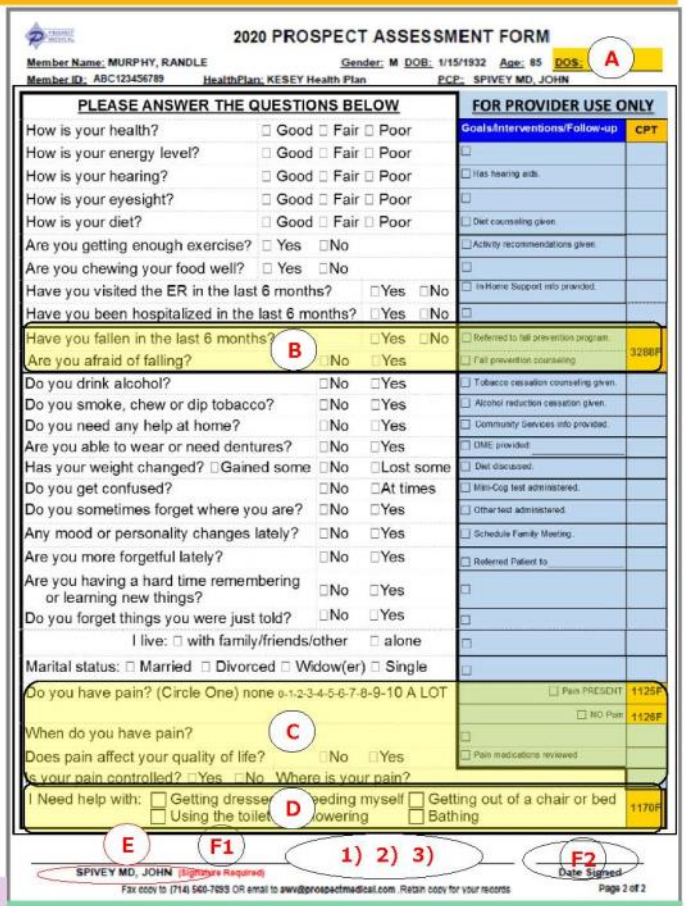
   Pain (1125F or 1126F CPT) (C)

   Functional Status or ADLs (1170F) (D)

3) Please address any issues on the light blue side of the form, of the **Goals/Interventions/Follow-up** section. Check appropriate boxes you may pursue. You can also fill in any plans you may have and/or document additional plans you have in your Progress (SOAP) notes.

4) If the provider performing the AWV is other than the one listed on the prefilled form (E) ***then*** this rendering provider's **1)** printed name, **2)** printed credential (ie MD, DO, NP, APRN, PA) and **3)** signature must be included along with the date (F2) it was signed on the bottom of ***each*** page of the PAF. This should also be the provider of record on the Progress (SOAP) Note.

5) Sign (F1) and date (F2)



OFFICE BILLER CHECKLIST for Claim Completion

- ☐ Use **G0438** (Initial) **OR G0439** (Subsequent) for billing the AWV.
- ☐ A Z code is the first diagnosis code to be entered.
  - **Z00.01** (**with** abnormal findings)
  - **OR Z00.00** (**without** abnormal findings)
- ☐ Prioritize HCC Diagnosis Codes in filling the diagnosis codes.

  Include all CPT codes captured in the PAF forms:
  - ☐ Depression Screening (**1220F** and **96127**)
  - ☐ Medication Review (**1160F** and **1159F**)
  - ☐ Advance Care Planning (**1158F** and if applicable **1157F**)
  - ☐ Fall Assessment (**3288F**)
  - ☐ Pain Screening (1125F **OR** 1126F)
  - ☐ Functional Status (**1170F**)
- ☐ Capture all appropriate codes for BMI, Systolic and Diastolic Blood Pressure, and when appropriate for HgbA1C levels, and screenings for Breast and Colon Cancer.

  For additional information refer to the 2018 Prospect AWV Billing Guide and the HEDIS/STAR CPT Guide.

OFFICE STAFF CHECKLIST after the AWV is completed

Prior to sending BOTH the PAF and Progress (SOAP) Note please ensure:

- ☐ Dates of Service for PAF form and Progress Notes are the same.
- ☐ All appropriate HCC conditions are addressed in the Progress (SOAP) note with MEAT.
- ☐ Supporting documentation from the chart (or other sources) for closed Gaps in Care are included.
- ☐ Open Gaps-In-Care have been ordered, scheduled or completed.
- ☐ All assessments and screening have been completed and properly documented in the PAF or Progress (SOAP) Note.
- ☐ **ALL pages of the PAF** have the rendering provider's 1) printed name 2) printed credential (MD, DO, PA, NP, APRN) and 3) signature
- ☐ **The Progress (SOAP) Note from Electronic Medical Record** has been signed off and includes the provider's 1) printed name and 2) printed credential (MD, DO, PA, NP, APRN).
- ☐ **ALL Pages** of the **Paper** Progress (SOAP) Note have the rendering provider's 1) printed name 2) printed credential (MD, DO, PA, NP, APRN) and 3) signature.

Questions? Please call us at (714) 796-4219 or email us at awv@prospectmedical.com

CMS Validation Process

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

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

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

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

Chart Mechanics and Documentation Considerations

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

Authentication by the Provider

All dates of service must be signed (with credentials) and dated by the physician (provider) or an appropriate physician extender (e.g., nurse practitioner).

The credentials for the provider of services must be somewhere on the medical record:

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

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

- Handwritten signatures, or
- Electronic signature.

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

Types of Acceptable (Provider) Physician Signatures and Credentials

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

Additional Documentation Information

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

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

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

Active CVA vs. History of CVA

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

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

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

EXAMPLES: CVA with dysphagia
Hemiplegia due to CVA

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

Patient Status

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

- Amputation Status
- Dialysis Status
- Ostomy Status (i.e. Gastrostomy or tracheostomy)
- Long Term Drug Use (Insulin, Anticoagulants, Tamoxifen, Femara, Lupron, Aspirin)

Although you may not be treating the patient directly for the condition, the patients' existing condition does affect your medical decision making and treatment planning and therefore should be documented. Without appropriate documentation and claim submission, conditions such as the above will be considered resolved as of January 1st of each year.

PERFORMANCE PROGRAMS DEPARTMENT

HEALTH EXCEL IPA

Appropriate ICD-10 Diagnosis, CPT Procedure, Level II CPT and HCPC Code Usage

Centers for Medicare and Medicaid Services (CMS) no longer has a 90-day grace period for incorrect code submission, therefore, it is vital that each year you update your code books.

ICD-10 – Effective October 1st of each year ICD-10 diagnosis code changes take effect. These code changes are effective for dates of service October 1 thru September 30 of each year.

CPT / HCPC – Effective January 1st of each year CPT and HCPC code changes take effect. These code changes are effective for dates of service January 1 thru December 31 of each year.

Be sure to update your code books to help reduce the number of rejected and/or denied claims.

Chart Audits and Medical Record Requests

The Performance Programs Department is one of several departments which may request a chart audit or medical record for Prospect Medical.

Chart Audits

The Prospect Health Services' Performance Programs Department and/or your Medicare Advantage Health Plan will audit your Medicare Advantage member charts at least once annually. This audit involves all Medicare Advantage members enrolled with you as their Primary Care Physician and the audit will involve dates of service for two consecutive calendar years. These audits may be performed directly by Prospect Health Services, the Medicare Advantage Health Plan or by a company that has been contracted to perform the audit for us. In either case, we ask you and your staff to cooperate with Prospect Health Services, the Medicare Advantage Health Plan and/or the contracted vendor by working together to schedule the audit as soon as possible. If required, scheduling may be done in multiple sessions within a 2-week time frame.

Medical Record Requests

The Prospect Health Services' Performance Programs Department may request medical records for selected patients or dates of service for special audits. When requesting these charts, we are looking for documentation for specific patients and specific dates of service or date ranges. These types of audits usually are requested and responded to via fax, unless otherwise instructed.

QUALITY MEASURES
HEDIS (Medi-Cal) and STARS (Medicare)

HEALTH EXCEL IPA

Diabetes Care (CDC) - HbA1c/Neph Screening	CPT	Secondary CPT	ICD-10	Result Required
Most recent hemoglobin A1c level less than 7.0%	83036	3044F		X
Most recent hemoglobin A1c level 7.0%- 9.0%	83036	3045F		X
Most recent hemoglobin A1c level greater than 9.0%	83036	3046F		X
Nephropathy Screening- Positive Microalbuminuria test result	82042-82043	3060F		X
Nephropathy Screening- Negative Microalbuminuria test result	82042-82043	3061F		
Nephropathy Screening-Random Urine (UA)	81000			X
Retinal Eye Exam	2022F			X
Negative Retinal Eye Exam	3072F			
Diabetes Care (CDC) & Controlling Blood Pressure (CBP)	**CPT**	**II CPT**	**ICD-10**	**Result Required**
Most recent systolic blood pressure less than 130 mm Hg	3074F			X
Most recent systolic blood pressure 130 - 139 mm Hg	3075F			X
Most recent systolic blood pressure greater than or equal to 140 mm Hg	3077F			X
Most recent diastolic blood pressure less than 80 mm Hg	3078F			X
Most recent diastolic blood pressure 80-89 mm Hg	3079F			X
Most recent diastolic blood pressure greater than or equal to 90 mm Hg	3080F			X
Adult BMI (ABA) 20 yrs. and Older	**CPT**	**Secondary CPT**	**ICD-10**	**Result Required**
Body Mass Index 19.0-19.9 or less, adult	3008F		Z68.1	X
Body Mass Index 20.0-20.9, adult	3008F		Z68.20	X
Body Mass Index 21.0-21.9, adult	3008F		Z68.21	X
Body Mass Index 22.0-22.9, adult	3008F		Z68.22	X
Body Mass Index 23.0-23.9, adult	3008F		Z68.23	X
Body Mass Index 24.0-24.9, adult	3008F		Z68.24	X
Body Mass Index 25.0-25.9, adult	3008F		Z68.25	X
Body Mass Index 26.0-26.9, adult	3008F		Z68.26	X
Body Mass Index 27.0-27.9, adult	3008F		Z68.27	X
Body Mass Index 28.0-28.9, adult	3008F		Z68.28	X
Body Mass Index 29.0-29.9, adult	3008F		Z68.29	X
Body Mass Index 30.0-39.9, adult	3008F		Z68.30	X
Body Mass Index 31.0-31.9, adult	3008F		Z68.31	X
Body Mass Index 32.0-32.9, adult	3008F		Z68.32	X
Body Mass Index 33.0-33.9, adult	3008F		Z68.33	X
Body Mass Index 34.0-34.9, adult	3008F		Z68.34	X
Body Mass Index 35.0-35.9, adult	3008F		Z68.35	X
Body Mass Index 36.0-36.9, adult	3008F		Z68.36	X
Body Mass Index 37.0-37.9, adult	3008F		Z68.37	X
Body Mass Index 38.0-38.9, adult	3008F		Z68.38	X
Body Mass Index 39.0-39.9, adult	3008F		Z68.39	X
Body Mass Index 40.0-44.9, adult	3008F		Z68.41	X
Body Mass Index 45.0-49.9, adult	3008F		Z68.42	X
Body Mass Index 50.0-59.9, adult	3008F		Z68.43	X
Body Mass Index 60.0-69.9, adult	3008F		Z68.44	X
Body Mass Index 70 or greater, adult	3008F		Z68.45	X

QUALITY MEASURES
HEDIS (Medi-Cal) and STARS (Medicare)

HEALTH EXCEL IPA

Pediatric (WCC) BMI Percentile Required for 19 yrs. and Under	CPT	Secondary CPT	ICD-10	BMI % Required
BMI, pediatric, less than 5th percentile for age	3008F		Z68.51	X
BMI, pediatric, 5th percentile to less than 85th percentile for age	3008F		Z68.52	X
BMI, pediatric, 85th percentile to less than 95th percentile for age	3008F		Z68.53	X
BMI, pediatric, greater than or equal to 95th percentile for age	3008F		Z68.54	X
Counseling for Nutrition	97802-97804		Z71.3	
Counseling for Physical Activity	G0447		Z71.89	
Colorectal Cancer Screening (COL) 50 - 75 yrs.	**CPT**	**Secondary CPT**	**ICD-10**	**Result Required**
FOBT-Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces	82270			
FOBT-Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces	82274			
FOBT-Fecal occult blood test, immunoassay, 1-3 simultaneous determinations	G0328			
FIT-DNA	81528			
Flexible Sigmoidoscopy	45330-45335			
Flexible Sigmoidoscopy	45337-45338			
Colonoscopy	44388-44394			
Colonoscopy- with transendoscopic stent placement	44397			
CT Colonography	74263			
Breast Cancer Screening (BCS) 50-74 yrs.	**CPT**	**Secondary CPT**	**ICD-10**	**Result Required**
Mammography; unilateral	77065			
Mammography; bilateral	77066			
Screening mammography, bilateral (2-view film study of each breast)	77067			
Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary condition. *(Use 77063 in conjunction with 77067)*	+77063			
Mammogram w/ Tomosynthesis: unilateral	77061			
Mammogram w/ Tomosynthesis: bilateral	77062			
Care for Older Adults (COA) All Four Criteria Required	**CPT**	**II CPT**	**ICD-10**	**Result Required**
Advance Care Planning document present in medical record **OR** Discussion		1157F or 1158F		
Medication list documented in medical record **AND** reviewed by prescribing practitioner or clinical pharmacist		1159F & 1160F		
Functional Status Assessment- Daily Activity Log		1170F		
Pain Present **OR** no pain present (Pain Scale Required)		1125F or 1126F		

PERFORMANCE PROGRAMS REWARDS

HEDIS (Medi-Cal) and STARS (Medicare)

HEALTH EXCEL IPA

Health Excel IPA and Prospect Medical Systems are pleased to facilitate processes for you to generate accurate risk scores to encourage preventive care & screening measures. Please see below for details on the incentives offered.

2020 Provider Incentive

Measure:	HEDIS (Medi-Cal)	STARS (Medicare)	Incentive Payout
Prevention and Screening			
Breast Cancer Screening	X	X	$25
Colorectal Cancer Screening	X	X	$25
Cervical Cancer Screening	X		$25
Osteoporosis Management in Women Who Had a Fracture		X	$25
Chlamydia Screening in Women	X		$25
Childhood Immunization Status **Combo 10**: DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV, Influenza	X		$25
Immunizations for Adolescents **Combo 2**: Meningococcal, Tdap, HPV	X		$25
Well Child Visits in the First 15 Months of Life (6+ visits required)	X		$15
Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (one visit)	X		$25
Adolescent Well-Care Visits (one visit)	X		$25
Diabetes Care			
HbA1c Control ≤9% (last test of year only + must be in range)		X	$25
HbA1c Control <8% (last test of year only + must be in range)	X		$25
Nephropathy Screening	X	X	$25
Controlling Blood Pressure <140/90 mmHg	X	X	$20
Care for Older Adults			
Care for Older Adults (Medication Review, Pain Assessment, Functional Status Assessment & Advance Care Planning)		X	$25
Medication Management			
Medication Reconciliation Post Discharge		X	$25

COZEVA

We are pleased to bring you the Cozeva software program to help you track all your patient's quality measures. The Cozeva application contains all the HCC, CMS STAR and HEDIS program components. For login and password assistance, or to schedule your training, please contact Health Excel at (858) 452-1279, or Cozeva Support at (877) 862-7048.

Why use Cozeva?

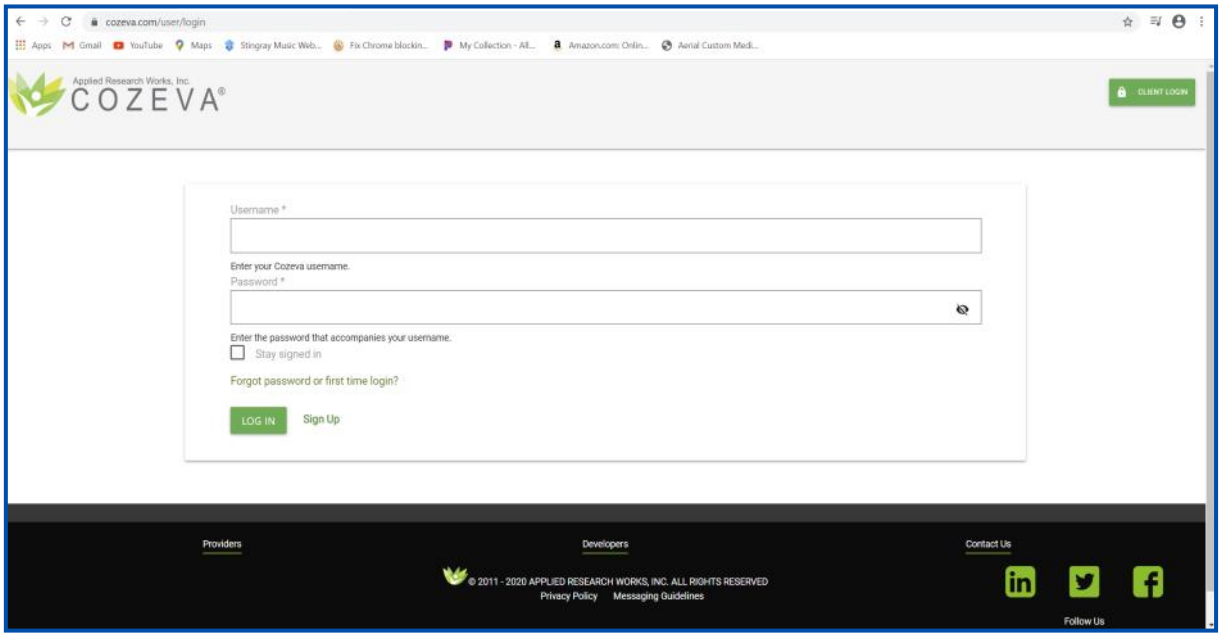
- Check your patient's upcoming, due and past due Quality Measures
- Search by one or many patients at a time
- Search by one or many Quality Measures at a time
- Check your HCC Suspect lists
- View, print or download detailed patient information
- Enter supplemental data directly into Cozeva
- Run your own reports
- Check your entire office's current Star Rating at a glance

How to Access Cozeva:

Once you receive your logon information go to: www.cozeva.com to log into your account.

- Enter your Login ID.
- Enter your temporary password.
- Click "Sign On." The first time you sign on you will be prompted to create a new password.

For additional information please contact your Health Excel IPA Network Managers (see page 5).



REVISIONS

Version	Date Revised
1 .0	8/17/2018
1 .1	9/22/2018
1 .2	8/1/2020