identity MSO

Dignity Health Medical Network®

2023

Provider Manual

For more information:

805-604-3308 - www.Dignityhealth.org/ventura

Federal and state regulations and accreditation requirements govern the administrative operations of provider organizations (POs), such as *medical groups* and *independent physician associations (IPAs)*, with respect to their patients who are enrolled in *managed care* health plans, also known as *health maintenance organizations* (HMOs). In order for POs contracting with Dignity Health MSO to maintain their state licenses and the contractual arrangements with managed care organizations that help them meet market demands, providers employed by or under contract with them are required to meet stringent standards of performance. Providers granted panel privileges must share an ongoing commitment to participating in and complying with patient management, credentialing, utilization management and quality management program activities, which define many aspects of a provider's practice.

The information that follows highlights the key requirements for HMO practice management that are highly important and require your active participation as a provider contracting with the following Dignity Health MSO affiliated POs:

Dignity Health Medical Network - Ventura

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PART 1 (Provider ORGANIZATION INTRODUCTION):

Dear Provider,

Welcome to Dignity Health Medical Network-Ventura (formerly Valley Care IPA). We are thankful for your partnership and the quality of care you bring to our patients.

This Provider Manual is the essential tool to help answer all of your questions about working with Valley Care. The information in this manual will help you and your staff manage patients within the managed care environment. The manual explains Valley Care's policies about checking eligibility, referring to specialists, sending in claims, incentive programs, capitation payments, and more.

We will update and revise this Provider Manual periodically, and we welcome any suggestions or comments for improvement. Should you have any questions or comments please feel free to contact our team. We look forward to our continued partnership with you.

Thank you,

Sonya Araiza
COO
Dignity Health Medical Network-Ventura

PART 1 (MISSION STATEMENT / AWARDS / ACHIEVEMENTS):

Physicians, Hospitals and Payers working together for the Patient.

Dignity Health Management Service Organization (DHMSO) is a management service organization with Dignity Health Medical Network-Ventura as its primary client. DHMSO provides comprehensive practice management, billing/collections, authorizations, case management, quality management, credentialing, finance, eligibility, claims, contracting, provider relations, customer service and health education.

Providing the Highest Quality of Care for Our Members

When Dignity Health Medical Network-Ventura was established in 1994, its goal was to provide local families with a choice of physicians practicing in Santa Paula and Fillmore. Since that time, we have expanded our service area to include Camarillo, Moorpark, Newbury Park, Oxnard, Thousand Oaks and Ventura as well. Dignity Health Medical Network-Ventura is comprised of physicians who have cared for members of our community for many years and have joined together to better serve the needs of area residents. Our physicians are dedicated to providing health care of the highest quality, delivered with care and compassion.

Received highest rating score amongst Ventura County physician groups 2014

from CR Consumer Reports with CHPI California Healthcare Performance Information System

Dignity Health Medical Network-Ventura is proud to have received the highest rating score in 2014 amongst Ventura County physician groups by Consumer Reports in conjunction with CHPI. The IPA has also received numerous Best Practice Awards and has been recognized by PacifiCare's Quality Index. As these results illustrate, quality care is a priority of all Dignity Health Medical Network-Ventura providers. Dignity Health Medical Network-Ventura was recently recognized with the top 10% Recognition for Patient Experience Aware by the Integrated Healthcare Association (IHA).

Our physicians accept many insurance plans, including most HMOs and PPOs as well as Medicare and fee for service programs. If you would like to select one of the primary care physicians listed on this website, contact your insurance carrier or call the physician's office. We look forward to caring for you and your family.

Integrated Healthcare Association

Medicare Most Improved Recognition

is hereby granted to

Valley Care IPA

For improving the quality of care provided to California Medicare Advantage members

Measurement Year 2015

Lindsay Erickson
Director, Value Based P4P Program

2016 IHA MEDICARE ADVANTAGE

Jeff Rideout, MD
President & CEO

Integrated Healthcare Association

Top 10% Recognition for Patient Experience

is hereby granted to

Valley Care IPA

For patient experience performance within the top ten percent of physician organizations

Measurement Year 2016

Lindsay Erickson
Director, Value Based
P4P Program

Integrated Healthcare ASSOCIATION

Jeff Rideout, MD
President & CEO

Certificate of Recognition

Valley Care Physicians IPA Medical Associates, Inc.

is awarded this certificate in recognition of

their achievement in the 2018 Blue Shield Medicare Star Provider Incentive Program

this 18th day of June

in the year 2019.

Signed Richard Nguyen

Excellence

PART 2 (Why Choose Dignity Health Medical Network-Ventura):

A family of independent physicians, caring for you and your family.

Dignity Health Medical Network-Ventura has been committed to the highest standard of care for families in Santa Paula, Fillmore and Ventura areas since 1994.

We offer access to our local network of independent physicians and facilities. Choose from over 200 dedicated, board certified physicians practicing in their private offices. You can select your own primary care physician from our wide range of internist, family practitioners and pediatricians. Also, available to you is our network of specialists to better manage care for you and your family. You will get to know your doctor personally, at a location that is most convenient for you.

Dignity Health Medical Network-Ventura physicians accept many insurance plans, including most HMOs and PPOs as well as Medicare. Contact your insurance carrier for assistance with selecting a Dignity Health Medical Network-Ventura primary care physician.

Administrative Office Location:

1700 N. Rose Avenue, Suite 400
Oxnard, CA 93030

CUSTOMER SERVICE & PROVIDER RELATIONS CONTACT NUMBERS:

Customer Service:	(805) 604-3332 or (877) 299-5599
Provider Relations:	(805) 604-3308 or Email: dl-providerrelations.identitymso@commonspirit.org

PART 2 (DIGNITY HEALTH MSO OVERVIEW):

Below are some operational tasks performed by the administrative staff at Dignity Health MSO:

- Accounting
- Authorizations
- Benefit Interpretation/Compliance
- Capitation
- Care Coordination
- Case Management
- Claims Processing (encounters and/or payments)
- Contract Negotiations (health plan, physicians, hospitals, ancillaries)
- Customer Service
- EZCAP Usage and Maintenance
- Financial Management
- Health Plan Communication
- Legislature Compliance
- Member Eligibility
- Office Managers Education/Communication
- Physician Education/Communication
- Provider Credentialing
- Provider Relations
- Quality Management

DHMSO Contact List

Staff Name	Title	Area of Responsibility	Email Address
Sonya Araiza	COO		Sonya.Araiza@commonspirit.org
Stephanie Eugenio	Director of Finance	Finance, Capitation	Stephanie.Eugenio@commonspirit.org
Veronica Vasquez	VP, Operations & Data Engineering		Veronica.Vasquez901@ commonspirit.org
Carl Constantine, MD	Medical Director	Dignity Health Medical Network-Ventura	carl.constantine@commonspirit.org
Brianne Rodriguez, RN	Utilization Review Manager	Health Services	Brianne.Rodriguez@commonspirit.org
Dione Webster	Director of Operations, Payer Risk Management	Contracting	dione.webster@commonspirit.org dl-Contracting.identitymso@commonspirit.org
		Provider Relations	dl-Contracting.identitymso@commonspirit.org
		Customer Service (member & provider)	dl-CustomerService.identitymso@commonspiriti.org
Margaret Rivera	Claims Director	Claims	Margaret.Rivera@commonspirit.org
Robin Grimm, RN	Quality Manager	Quality Management	Robin.grimm@commonspirit.org
Traci Mackey	Credentialing Supervisor	Credentialing	Traci.mackey@commonspirit.org

PART 2 (Contracted Health Plans):

Commercial Health Plans

Aetna
(800) 756-7039
www.aetna.com

Anthem Blue Cross
(800 677-6669
www.anthem.com/ca

Blue Shield of California
(800) 442-6665
www.blueshieldca.com

Health Net
(800) 522-0088
www.healthnet.com

United Healthcare
(800) 624-8822
www.uhcwest.com

Medicare Advantage Plans

AARP® Medicare Complete®
Secure Horizons® (HMO)
(800) 338-3868
www.securehorizons.com

Anthem MediBlue Plus (HMO) and
MediBlue Dual Advantage (HMO SNP)
(855) 306-4537
www.anthem.com

Blue Shield 65 Plus HMO
(800) 260-9607
www.blueshieldcamedicare.com

Alignment Health Plan
(844) 310-2247
www.alignmenthealthplan.com

Humana HMO Gold Plus
(888) 833-2364
www.humana.com/medicare

SCAN Classic Plan (HMO)
(877) 807-7226
www.scanhealthplan.com

Contracted Hospitals – Dignity Health Medical Network-Ventura:

Camarillo
St. John's Hospital Camarillo
2309 Antonio Ave
Camarillo, CA 93010
(805) 389-5800

Ventura
Community Memorial Hospital
147 N. Brent Street
Ventura, CA 93003
(805) 652-5011

Ventura
Ventura County Medical Center
300 Hillmont Ave
Ventura, CA 93003-3099
(805) 652-6000

Oxnard
St. John's Regional Medical Center
1700 N. Rose Ave
Oxnard, CA 93030
(805) 988-2500

Santa Paula
Santa Paula Hospital
825 N. 10th Street
Santa Paula, CA 93060
(805) 933-8600

Contracted Urgent Care Centers – Dignity Health Medical Network - Ventura:

Simi Valley
Sierra Vista Urgent Care
1227 E. Los Angeles Ave.
Simi Valley, CA 93065
(805) 582-4050

Oxnard
Solar Urgent Care
2100 Solar Drive, Suite 100
Oxnard, CA 93036
(805) 988-9000

Oxnard
Las Islas Urgent Care
325 W. Channel Islands Blvd.
Oxnard, CA 93033
(805) 204-9500

Oxnard
Magnolia Urgent Care
2240 E. Gonzales Rd. Suite #110, 120
Oxnard, CA 93036
(805) 981-518

Santa Paula
CFH Santa Paula Urgent Care
242 E. Harvard Blvd. Suite #C
Santa Paula, CA 93060
(805) 525-9595

Simi Valley
Sierra Vista Urgent Care
1227 E. Los Angeles Ave.
Simi Valley, CA 93065
(805) 582-4050

Ventura
Solar Urgent Care
250 S. Mills Road, Suite 100
Ventura, CA 93003
(805) 988-9001

Ventura
West Ventura Urgent Care
133 W. Santa Clara St.
Ventura, CA 93001
(805) 641-5620

Ventura
Academic Family Medicine Urgent Care
300 Hillmont Ave., Bldg 340, Suite 101
Ventura, CA 93003-3099
(805) 652-6500

Dignity Health Medical Network-Ventura Lab Services – Quest Diagnostic Laboratories

Directory of Quest Diagnostic Laboratories
Please click on the link below to view all Quest Diagnostic Laboratories locations in Ventura County.
www.QuestDiagnostics.com

Call for more information: 866-MYQUEST (866-697-8378)

Camarillo
3801 Las Posas Rd.
Suite 208
Camarillo, CA 93010-1426
Tel: 805-389-3260, Fax: 805-987-0164
M-F 7:00 am-4:00 pm | SAT 7:30 am-11:30 am

Camarillo
500 Paseo Camarillo
Suite 103
Camarillo, CA 93010-5900
Tel: 805-484-2373
Fax: 805-484-2847
M-F 8:00 am-12:30 pm & 1:30 pm-3:00 pm;
Drug Screen: M-F 10:00 am -12:30 pm & 1:30 pm-2:30 pm

Camarillo
5800 Santa Rosa Rd.
Suite 105
Camarillo, CA 93012-7060
Tel: 805-388-3230
Fax: 805-482-4271
M-F 7:00 am - 11:30 am & 12:30 pm - 3:00 pm

Newbury Park
1000 Newbury Rd.
Suite 125
Newbury Park, CA 91320-6437
Tel: 805-480-0571
Fax: 805-498-8642
M-F 7:00 am - 12:00 pm & 1:00 pm - 4:00 pm

Ojai
1320 Maricopa Hwy.
Suite H
Ojai, CA 93023-3154
Tel: 805-646-5695
Fax: 805-646-6734
M-F 7:00 am - 12:00 pm & 1:00 pm - 3:00 pm

Oxnard
1701 North Lombard St.
Suite 106
Oxnard, CA 93030-3836
Tel: 805-983-0558,
Fax: 805-278-0541
M-F 6:00 am - 4:00 pm | SAT 7:30 am - 11:30 am

Oxnard
925 West 7th St.
Oxnard, CA 93030-6757
Tel: 805-483-8776,
Fax: 805-247-0291
M-F 6:00 am - 5:00 pm | SAT 7:30 am - 11:30 am

~~**Oxnard**~~
~~1700 N. Rose Ave.~~
~~Suite 240~~
~~Oxnard, CA 93030-7642~~
~~Tel: 805-983-6487,~~
~~Fax: 805-983-6903~~
~~M-F 7:00 am - 12:00 pm & 1:00 pm - 3:30 pm~~

Oxnard
2600 Saviers Road
Oxnard, CA 93033-6757
Tel: 805-575-7412

Fax: 805-813-8275
M-F 6:30 am – 3:30 pm

Santa Barbara
2420 Castillo St.
Santa Barbara, CA 93105-4346
Tel: 805-569-1703
Fax: 805-563-0560
M-F 8:00 am - 12:30 pm & 1:30 pm-4:00 pm |
SAT 8:00 am - 12:00 pm

Santa Barbara
3905 State St.
Suite 9
Santa Barbara, CA 93105-5101
Tel: 805-563-4328,
Fax: 805-687-4920
M - F 6:00 am - 11:00 am;
Drug Screen: M - F 8:00 am - 10:00 am

Santa Paula
957 Faulkner Rd.
Suite 111
Santa Paula, CA 93060-2506
Tel: 805-933-4456,
Fax: 805-525-8108
M-F 7:00 am - 12:30 pm & 1:30 pm - 3:00 pm

Ventura
2991 Loma Vista Rd.
Suite 102B
Ventura, CA 93003-2984
Tel: 805-648-2761
Fax: 805-643-0348
M-F 6:00 am - 5:00 pm | SAT 7:30 am - 11:30 am

Ventura
7880 Telegraph Rd.
Suite D
Ventura, CA 93004-1571
Tel: 805-659-1231,
Fax: 805-659-9747
M - F 6:30 am - 3:00 pm

Dignity Health Medical Network-Ventura Radiology Services – RadNet Radiology

(Non-County PCP Members)

Rolling Oaks Radiology - Camarillo
Digital Mammography, Ultrasound, X-Ray
3801 Las Posas Rd.
Suite 111
Camarillo, CA 93010
(805) 389-9657
Monday - Friday 8:00 a.m. - 5:00 p.m.

Rolling Oaks Radiology - Thousand Oaks
3T MRI, 64-Slice CT, PET/CT, Nuclear Medicine, X-Ray, Ultrasound, EKG, Fluoroscopy, Digital Mammography, DEXA, Contrast Enhanced Spectral Mammography (CESM)
415 Rolling Oaks Dr.
Suites #125, #160, #230
Thousand Oaks, CA 91361
(805) 778-1513
Suite 125:
MR - Monday - Friday 5:30 a.m. - 11:00 p.m., Saturday/Sunday 7:30 a.m. - 7:00 p.m.
CT, PET/CT, Nuclear Medicine - Monday - Friday 7:00 a.m. - 5:00 p.m.
Suite 160:
X-Ray, Ultrasound - Monday - Friday 7:00 a.m. - 5:00 p.m.
Suite 230 (Women's Center):
Mammography, Ultrasound, DEXA - Monday - Friday 7:00 a.m. - 6:00 p.m.
Mammography, Ultrasound - Saturday 7:00 a.m. - 5:00 p.m.

Rolling Oaks Radiology – St John's
MRI/MRA, CT, Ultrasound, Fluoroscopy, DEXA, X-Ray, Mammography
1700 N. Rose Ave.
Suite 110
Oxnard, CA 93030
(805) 3570067
Monday – Friday 8:00 a.m. – 5:00 p.m.
Age Restrictions: 6+

Rolling Oaks Radiology - Oxnard
3T MRI, 64-Slice CT, Fluoroscopy, X-Ray, Nuclear Medicine, Ultrasound, DEXA, Digital Mammography, Stereotactic Biopsies
1901 N. Rice Ave.
Suites #145, #155
Oxnard, CA 93030
(805) 604-3370
Suite 145:
MR - Monday - Friday 7:00 a.m. - 10:00 p.m.
CT, X-Ray - Monday - Friday 8:00 a.m. - 5:00 p.m.
Nuclear Medicine - 6:30 a.m. - 4:30 p.m.

Suite 155 (Women's Center):
Monday - Friday 8:00 a.m. - 5:00 p.m.

Dignity Health Medical Network-Ventura Radiology Services – RadNet Radiology (Non-County PCP Members) – *Cont'd*

Rolling Oaks Radiology - Ventura
Digital Mammography, Ultrasound, DEXA, 1.5 MRI, 64-Slice PET/CT
4516 Market St.
Ventura, CA 93003
(805) 644-7300
MRI - Monday - Friday 7:00 a.m. - 9:30 p.m.
CT, Fluoroscopy, Mammography, Ultrasound - Monday - Friday 8:00 a.m. - 5:00 p.m.
PET - 7:00 a.m. - 3:00 p.m.
DEXA - Friday 8:00 a.m. - 5:00 p.m.
X-Ray - Monday - Friday 8:00 a.m. - 5:30 p.m.
MRI, Mammography, Ultrasound - Saturday 8:00 a.m. - 3:00 p.m.

Dignity Health Medical Network-Ventura Radiology Services – (County PCP Members)

Moorpark
Moorpark Family Medical Clinic
612 Spring Road, Building A
Moorpark, CA 93021
(805) 523-5400
X-Ray: M-F 8:30 AM - 5:00 PM (appointment only)

Oxnard
Las Islas Family Medical Group
325 W. Channel Islands Blvd.
Oxnard, CA 93033
(805) 204-9500
X-Ray: M-F 9:00 AM - 5:00 PM

Oxnard
Magnolia Family Medical
2240 E. Gonzales Rd., Suite 110 & 120
Oxnard, CA 93036
(805) 981-5181
X-Ray: M-F 8:00 AM - 5 PM (on call Saturday and Sunday 8:00 AM - 4:30 PM)

Fillmore
Fillmore Family Medical Group
828 W. Ventura Street, Ste. 100
Fillmore, CA 93015
(805) 524-2000
X-Ray: M-F 8:00 AM - 5:00 PM (appointments encouraged)

Thousand Oaks
Conejo Valley Family Medical Group
125 W. Thousand Oaks Blvd., Ste. 300
Thousand Oaks, CA 91360
(805) 418-9100
X-Ray: M-F 8:30 AM - 12:30, 1:30 - 5:30 PM, Saturday 9:00 AM - 5:00 PM

Santa Paula
Santa Paula Medical Clinic
1334 E. Main Street
Santa Paula, CA 93060
(805) 933-1122

Santa Paula
Santa Paula Hospital
825 N. Tenth Street
Santa Paula, CA 93061
(805) 933-8682
X-Ray: M-F 7:30 AM - 4:00 PM

Ventura
West Ventura Medical Clinic
133 W. Santa Clara St.
Ventura, CA 93001
(805) 641-5600
X-Ray: M-F 8:30 AM - 5:30 PM (appointments encouraged)

Ventura
Ventura County Medical Center
3291 Loma Vista Rd.
Ventura, CA 93001
(805) 652-6080
X-Ray: M-F 7:30 AM - 4:00 PM

PART 2 (Quality Management & Credentialing & Utilization Management Committee Members):

Quality Management & Credentialing Committee:

Carl Constantine, MD
Medical Director

Megan Mescher-Cox, DO

Raj Bhatia, MD

Imelda DeForest, MD

Joel Corwin, MD

Camille Wedlow, MD

Lisa Brand, MD

Utilization Management

UM Committee Chair

Carl Constantine, MD
Medical Director

Steve Philip, MD

Steven Blakely, PhD

Carl Jonokuchi, MD

Part 3: (Primary Care Physician (PCP) Responsibilities):

Primary care services are provided by internal medicine physicians, family physicians, pediatricians or general practice physicians (Primary Care Physician [PCP]). These services may also be provided by nurse practitioners and physician assistants, under the supervision and direct monitoring of the PCP.

PCPs are responsible for the overall care of the member, including but not limited to the following:

1) Routine office visits (including after-hours visits) and related services of a physician and other health care providers received by members in the provider office. This includes evaluation, diagnosis and treatment of illness and/or injury, venipuncture, specimen collection and minor surgical procedures.

2) Visits and examinations includes consultation and time for personal attendance with the member in an emergency room, during a confinement in a hospital, skilled nursing facility or extended care facility; routine hospital admission and pre-surgical clearance (if medically indicated as determined by IPA) and coordination of inpatient care, unless the members are delegated to the inpatient team.

3) Immunizations as described in the Member's benefit plan including those immunizations described in the Professional's contract agreement with IPA.

4) Administration of injections

5) Laboratory services shall be performed by IPA contracted laboratory. Professional services include only interpretation of results. Professional shall receive no additional compensation for said interpretations.

6) Well-Child Care as customarily provided by Professional.

7) Periodic health appraisal examinations including all routine tests (including, but not limited to EKG, audiology and visual tests) performed in Professional's office.

8) Professional home visits when the nature of illness dictates, determined by Professional. Supervision of complex home care regimen involving ancillary health personnel (i.e., home health, tube feeding, antibiotics) subject to usual utilization review procedures.

9) Referral of Member to appropriate consulting physician or ancillary services as medically necessary and according to guidelines approved by IPA. Referrals must be submitted to the MSO within two (2) business days. Professional will continue to coordinate and manage the member's care with the consulting physicians.

10) Telephonic consultations with members and referral physicians.

11) X-ray services shall be performed by IPA contracted radiology providers.

12) Twenty-four (24) hour on-call coverage.

13) Coordinating of all medical care provided to members by medical sub-specialists contracted with IPA.

14) Education and family planning

Referral Submission Process:

Primary Care Physicians originate the consultation request to specialty providers via EZNET. Specialists are to request follow up care and procedures themselves via EZNET. Requests for continuation of home health, durable medical equipment and follow up or procedures by a tertiary providers are to be faxed into the UM Department at (805) 278-6815.

All referral requests are to be submitted to the IPA within 2 (two) business days upon member being seen.

Eligibility Verification:

Our Eligibility Department is responsible for ensuring members are entered in the system in an accurate and timely manner. We verify eligibility daily and run monthly reports to ensure our membership matches the various health plans.

The member ID card identifies their PCP, identification number, co-pay, and enrollment information in the health plan which is contracted for medical care and services with the IPA. This identification card is used to identify member information but does not guarantee current eligibility.

Eligibility should be confirmed at the time of service directly with the member's health plan. EZNET may be used for electronic verification of eligibility but will not be as current as a direct verification with the health plan.

Every month an updated Eligibility list will be sent to your office. This list will contain your current month membership. The Eligibility list will list the following:

Member Name
Member ID
Birthdate
Sex
Health Plan
Heath Plan Effective Date
PCP Effective Date
Benefit Option

If a member is not on this list ask for the following information:

- Membership card or health plan enrollment form
- Member's full name
- Subscriber's full name
- Subscriber's date of birth
- Member's date of birth
- Member’s address
- Member’s phone number
- Subscriber's employer and employer telephone if possible
- Effective date of coverage if known

Call the Customer Service Department with the above information for verification. If eligibility cannot be verified and the member MUST be seen, a waiver form is to be completed.

Dignity Health Medical Network-Ventura (805) 604-3308.

ADVANCED DIRECTIVES

It is the policy of Dignity Health MSO that information describing the patient's rights to formulate advance directives as well as advance directive forms and literature will be provided by providers to all adult members who may complete a Durable Power of Attorney for Health Care, or any other advance directive. Dignity Health MSO and/or provider will not refuse to treat or otherwise discriminate against a member who has completed advance directive forms. Dignity Health MSO and/or provider will honor advance directives and assist and guide patients with regard to these sensitive issues. The provider will document execution of an advance directive in the patient medical record and educate staff regarding issues concerning advance directives. An adult is defined as being 18 years of age or older.

1. The provider will become well informed about advance directives and take an active role in assisting patients to understand the benefits of these documents.
2. The provider will have advance directive forms and literature available for the member.
3. The provider will not refuse to treat or otherwise discriminate against a member who has completed an advance directive form.
4. The provider will honor advance directive forms completed by the member.
5. The provider will document discussion and/or execution of an advance directive in the member's medical record.

A downloadable version of the Advance Directive is available in English and Spanish at **www.dignityhealth.org/ventura**

Customer Service

TELEPHONE: (805) 604-3332 or (877) 299-5599

Summary:

The Customer Service Department of Dignity Health MSO is designed to assist providers, health plans, members and internal staff with questions relating to authorizations, claims, eligibility, etc.

Function:

The Customer Service Department is the liaison to all other departments within Dignity Health MSO (Authorizations, Claims, Eligibility, etc.) for providers, members, and health plan representatives. Each call is fielded by a Customer Service Representative (CSR) and documented in the Customer Service module of EZCAP for tracking purposes. If the CSR is unable to answer a question or give a specific status at the time of the call, the CSR may request assistance or direction from the department supervisor or submits an inquiry via the EZCAP system to the respective department for a reply. Turn-around-time for inquiries routed to other departments range from twenty-four (24) hours to five (5) working days based on the level of the inquiry (stat, urgent, routine, etc.). Inquiries on claims may take up to thirty (30) days.

Issues to Refer:

- Authorizations
- Claims
- Education
- Eligibility
- Health Plans
- Physicians (Primary Care Physicians and Specialists)
- Providers

Provider Relations

TELEPHONE: (805) 604-3308 FAX: (805) 918-4057

dl-providerrelations.identitymso@commonspirit.org

Summary:

The Provider Relations Department of Dignity Health MSO is designed to assist providers, health plans and internal departments resolve identified issues and provide education and orientations as needed.

Function:

The Provider Relations Department (PR) is the liaison between the providers and the internal departments at the IPA (Utilization Management, Contracting, Claims, Eligibility, etc.). PR is responsible for handing issues that are outside of the scope of the Customer Service Department. Turn-around-time for replies to inquiries routed to other departments range from twenty-four (24) hours to five (5) working days, based on the level of the inquiry (stat, urgent, routine, etc.).

Issues to Refer for Problem Resolution:

- Eligibility
- Health Plans
- Physician Office Orientations/Trainings
- Provider Manuals
- Provider Rosters (including mid-levels)
- Reimbursement
- Updates Regarding Physician Practices
- Address changes

Credentialing Process/Procedure

Dignity Health MSO ensures that HMO patients have access to providers who meet high standards and stringent qualification requirements.

Credentialing Requirements:

Credentialing requirements for providers are governed by state regulations and national accreditation standards. Through Dignity Health MSO's credentialing and privileging program, patients seeking care through affiliated IPAs are ensured that they are being treated by providers who are highly qualified and meet criteria established for medical professionals in their community.

The Credentialing Department ensures reviews each provider's qualifications when he or she first joins the panel of your IPA, and every 36 months after that. The Credentialing Department initiates the credentialing and recredentialing process, subject to stringent, mandated timeframes. The Credentialing Committee for your IPA meets regularly to evaluate the information collected and verified by the Credentialing Department and makes the final decision whether to accept a new provider on the panel or continue a provider's privileges for the next 36-month recredentialing period.

The credentialing program is mandated and governed by federal and state regulations and accrediting organizations. It is the provider's responsibility to comply with credentialing program requirements provide timely response to requests for information and inform the Credentialing Department of any changes in the information previously supplied to the Credentialing Department.

Failure to notify the Credentialing Department may be grounds for suspension or termination of the provider's privileges and employment or contract.

Nondiscrimination: In making decisions about the IPA provider panel privileges, the Credentialing Committee will not consider and shall ensure nondiscrimination of providers based on their age, race, ethnic/national identity, gender, sexual orientation or other personal factors not relevant to the provider's professional credentials, or the types of procedures (e.g., abortions) or patients (e.g., Medicaid) in which the provider specializes.

Provider Considerations: Providers are entitled to the following considerations in the credentialing/recredentialing process:

- You may review information submitted to us by primary sources in support of your application.
- You may correct erroneous information. Corrections will be reviewed by the Credentialing Department in a timely manner. You must request the correction prior to your records being reviewed by the Credentialing Committee if the information may affect the Committee's decision regarding your privileges.
- Upon request, we will inform you of the status of your application prior to the process being finalized.

LICENSURE AND DEA/CDS CERTIFICATION

LICENSURE AND DRUG ENFORCEMENT ADMINISTRATION (DEA)/CONTROLLED DANGEROUS SUBSTANCES (CDS) CERTIFICATION:

Providers are responsible for maintaining a current physician and surgeon's license to practice in the State of California. If the provider is required to have a DEA or CDS certificate, it also must be continuously current. *Failure to maintain a current license and DEA/CDS certificate is grounds for automatic termination of your contract.*

You must provide a copy of your current license and DEA certificate after each renewal.

BOARD CERTIFICATION

Providers whose specialties are subject to board certification are required to obtain their certification at the earliest possible opportunity if not certified prior to joining the provider panel. Board certification will be temporarily waived to permit the provider time to attain certification.

It is your responsibility to notify the Credentialing Department when certification has been awarded.

MALPRACTICE LIABILITY COVERAGE

At all times, providers must have current malpractice insurance in amounts established for the provider's specialty but no less than $1 million per claim / $3 million aggregate. Opened, pending or finalized malpractice actions must be disclosed on the application and fall within current guidelines established by the Credentialing Committee for allowing panel privileges. Any new cases, judgments or settlements occurring after initially credentialed or between any recredentialing review period must be reported to the Credentialing Department within fourteen (14) calendar days.

HIV/AIDS Designated Providers

People living with HIV/AIDS benefit greatly from care provided by an HIV/AIDS expert. To be considered an HIV/AIDS Designated Provider, a provider must have real-life experience caring for numerous HIV/AIDS members, special HIV/AIDS related continuing medical education and credentialing/board certification from the American Academy of HIV Medicine. You can review the HIV/AIDS experts in your network available on the website **www.dignityhealth.org/ventura.** The HIV/AIDS Designated Providers meet the criteria outlined in California law to be considered HIV/AIDS experts and attest annually to their credentials. You can request to be considered as an HIV/AIDS designated physician by completing Addendum C in your application.

OTHER CREDENTIALING REQUIREMENTS:

Other requirements for providers include the following:

Certification by the specialty board applicable for the provider's primary practice type, if such certification is available

Local hospital privileges if the provider will see or treat hospitalized patients and is not exempt from that requirement due to the nature of his or her practice

Complete and submit a signed, approved application, meet the credentialing and privileging criteria established by the Credentialing Committee and be granted panel privileges by the Credentialing Committee

Sign and agree to comply with the provisions of their employment or contracting agreement, which specify

- adherence to Dignity Health MSO policies and procedures
- abiding by Dignity Health MSO's utilization management program and quality management program requirements, including patient rights and access, referral authorization processes, standards for practice sites, medical record-keeping practices and as described in this document

AVAILABILITY OF CREDENTIALING PROGRAM DESCRIPTION:

The scope of the credentialing program is described in the complete *Credentialing Program Description*. It is available upon request by calling the **Provider Relations Department** (see **Part 2**). The policies and procedures established to support the UM program are viewable on the network shared server.

CREDENTIALING INFORMATION ACT:

Questions about the credentialing requirements and related credentialing/recredentialing policies and timeframes should be directed to the **Credentialing Department** (see **Part 2**).

MEDICAL RECORDS REQUIREMENTS AND AUDITS:

Accurate medical record documentation is essential to your PO's ongoing success, from both quality of care and financial perspectives. QM Program activities in connection with medical recordkeeping that require provider participation or cooperation include the following:

- Compliance with standardized recordkeeping protocols ensures the safety of patients and data supporting, such as compliance, are tied to financial incentives offered by contracting health plans, as well as the stability of contractual arrangements with those health plans.

- For a copy of the medical record audit standards, call the Provider Relations Department (see **Part 2**).

- Timely response to health plan inquiries and patient complaints/grievances or appeals is critical. When the QM Department requests a medical record for such purpose, response time is closely monitored by the requesting health plan. If a patient's medical record is in your office when needed, it must be promptly forwarded to the QM Department[1]. The QM Department will return the record as soon as possible.

- Data for key statewide quality of care/quality of service measurements are collected annually by contracting health plans and reported to an external vendor for analysis and ranking of your PO's performance in comparison to other medical groups and IPAs throughout the state. In some cases, the results may be published for public inspection as a guide for health plan purchasers. Consequently, favorable data have a direct positive impact on your PO's financial standing. The underlying principles for these measurements are (1) timely delivery of preventative services, (2) appropriate management of high-risk conditions, and (3) appropriate documentation of services rendered.

Your PO's QM Committee reviews the results of the above activities and determines ways to improve overall PO and individual provider performance.

FACILITY OPERATIONS REQUIREMENTS AND AUDITS:

Contracts with health plans require that assessments be performed at regular intervals. Any deficiencies at practice sites are reported to the provider and the PO's QM Committee. Serious deficiencies require the site manager or provider to submit a corrective action plan and compliance with the protocols will be re-evaluated at a later date.

For a copy of the facility audit standards, call the Provider Relations Department (see **Part 2**).

[1] Only a copy of the portion of the record relevant to the issue of the case will be required. The copy will not be returned.

ACCESS AUDIT:

Appointment access standards are set by contracting health plans (see **page 37)**. Timely access to needed medical services is monitored through various mechanisms, including appointment access data, facility operations audits, patient complaints and grievances, quality issue reports, patient satisfaction surveys and patient access audits. Results are used to identify individual provider or panel-wide access issues and develop ways to improve performance. The PO QM Committees determine any needed actions.

Accessibility of Providers

1. **After-Hours Access**- It is the policy of Dignity Health MSO to have medical services available and accessible to members 24 hours a day, seven days a week. PCPs who do not have services available 24 hours a day may use an answering service or an answering machine to provide members with clear and appropriate instruction on after-hours access to urgent or emergency medical care.

2. **Answering Service**- The provider is responsible for the answering service it uses. If a member calls after hours or on a weekend for a possible medical or behavioral health emergency, the provider is held liable for authorization of, or referral to, emergency care given by the answering service. There must be a message immediately stating, "If this is an emergency, hang up and call 911 or go to the nearest emergency room."

Answering service staff handling member calls cannot provide telephone medical advice if they are not a licensed, certified or registered health care professional. Unlicensed staff should have clear instructions on the parameters relating to the use of answers in assisting a licensed provider, as they are not permitted, under any circumstance, to use the answers to a question in an attempt to assess, evaluate, advise or make any decision regarding the condition of the member.

Dignity Health MSO encourages answering services to include the following steps when receiving a call:

- If the member is experiencing a medical emergency, instruct him or her to hang up and call 911 or proceed to the nearest emergency medical facility
- If language assistance is needed, offer the member interpreter services and question him or her according to the IPA's established instructions to access the nature and extent of the problem.
- Contact the on-call physician with the facts as stated by the member.
- After office hours, physicians are required to return telephone calls and pages within 30 minutes. If an on-call physician cannot be reached, direct the member to a medical facility where emergency or urgent care treatment by qualified health professionals can be given. This is considered authorization, which is binding and cannot be retracted. If the contracted provider is unable to meet the 30-minute call back time, a back-up triage line must be provider to the member.
- Document all calls

Other Applicable Requirements:

Interpreter Services

Interpreter services required by Section 1367.04 of the California Health & Safety Code and Section 1300.67.04 of Title 28 of the California Code of Regulations shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment.

Prior Authorization Processes

Prior authorization processes are to be completed in a manner that assures the provision of covered health care services to enrollees in a timely manner appropriate for the enrollee's condition and in compliance with the requirements of the time-elapsed access standards.

Shortage of Providers

To ensure timely access to covered health care services as required in this policy, where there is a shortage of one or more types of providers, providers are required to refer enrollees to available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs.

Furthermore, providers shall arrange for the provision of specialty services from specialists outside the provider's contracted network if unavailable within the network, when medically necessary for the enrollee's condition.

Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable copayments, co-insurance and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

ACCESS Standards:

This section summarizes the access to care standards and monitoring requirement. 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.

The IPA will distribute the DMHC access regulations to its contracted providers via this Provider Manual, the website**www.dignityhealth.org/ventura**. The IPA makes the access policies and standards available to its contracted providers on an ongoing basis on the website, through the provider manuals and through the provider portal on the website **www.dignityhealth.org/ventura**.

Commercial Non-Emergent Medical Appointment Access Standards

Appointment Type	Time-Elapsed Standards
Non-Urgent Care appointments for Primary Care (PCP)	Must offer the appointment within 10 business days of the request
Non-Urgent Care appointments with Specialists 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 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 Standards
Non-Urgent appointments for with a mental health care provider	Must offer the appointment within 10 business days of the request
Non-Urgent Care appointments with a non-physician mental health care provider	Must offer the appointment within 100 business days of the 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	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

Medi-Cal Non-Emergent Medical Appointment Access Standards

Appointment Type	Time-Elapsed Standards
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 the request
Adult physical exams and wellness checks	Must offer the appointment within 30 calendar days of the request
Non-Urgent appointments with Specialist physicians (SCP Regular or Routine)	Must offer the appointment within 15 business days of the request
Urgent Care appointments that do not require prior authorization (includes appointment with any physician, Nurse Practitioner or Physician Assistant in office)	Must offer the appointment within 24 hours of the request
Urgent Care appointments that require prior authorization (SCP)	Must offer the appointment within 96 hours of the request
First Prenatal visit	Must offer the appointment within 5 business days of the request
Child physical exam and wellness checks with PCP	Must offer the appointment within 10 business days of the request
Non-Urgent Care appointments for ancillary services (for diagnosis or treatment of injury, illness or other health condition)	Must offer appointment within 15 business days of the request
Initial Health Assessment (members 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

Assessment of Compliance- Dignity Health MSO has a documented system for monitoring and evaluating appointment availability and accessibility of care and services. Dignity Health MSO monitors appointment access to care and provider availability standards through member and provider surveys annually. Information obtained from customer service telephone access, triage and screening services and appeals and grievances measures performance, confirms compliance and ensures the provider network is sufficient to provide appropriate accessibility, availability and continuity of care to IPA members. Dignity Health MSO monitors compliance of its appointment access standards as follows:

- *Provider Appointment Access Survey*- Annual medical appointment survey to assess member access to care and service; specific elements include preventive care, routine care and urgent care.
- *Member Satisfaction Survey*- Annual surveys to determine whether members are satisfied with the accessibility of health care services.
- *Provider Satisfaction Survey*- Annual survey to solicit from IPA provider's perspective and concerns regarding compliance with the access standards to evaluate satisfaction with the time-elapsed access regulations set forth.
- *Member Grievance Detail*- Tracked and trended to identify issues with access and is monitored monthly in the UM/QM Committee meetings.

Corrective Actions- Providers with access falling below standards for the first time are subject to the following corrective actions, which may be implemented by the QM Manager without QM Committee approval:

- advisory notice of failure to meet standards and expectations for improvement.
- re-audits over the ensuing three- to six-month period, as directed by the QM Manager, based on extent of non-compliance and other factors, such as patient complaints and grievances and results of patient satisfaction surveys.

Providers with access falling below standards from one audit period to the next are subject to the following corrective actions:

- **Operations-level corrective actions that may be implemented upon direction of QM Manager**: The QM Manager may authorize advisory notification that the provider's access must meet standards within the next designated audit period.
- **QM Committee approved corrective actions**: Upon approval by the QM Committee and Board of Directors, these additional actions may be invoked:

1. restrictions on new patients (PCPs) or referrals (specialists) if appointment does not comply with standards within the next designated audit period (requires approval by the respective PO QM Committee and UM Committee)
2. suspension or termination of contract for persistent access issues resulting in patient complaints or poor performance on access-related elements of patient satisfaction surveys (requires QM Committee and Board of Directors approval, with involvement of the Provider Relations Department and the Contracting Department).

Preventive Care Services and Periodic Follow Up Care

Preventive care services and periodic follow up care including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

Advance Access

A primary care provider may demonstrate compliance with the primary care time-elapsed access standards established herein through implementation of standards, processes and systems providing advance access to primary care appointments as defined herein.

Appointment Rescheduling

When it is necessary for a provider or enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs and ensures continuity of care consistent with good professional practice and consistent with the objectives of this policy.

Extending Appointment Waiting Time

The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards or practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the member.

PHYSICIAN SUPERVISION OF NON-PHYSICIAN Practitioners:

California state law assigns physician's responsibility for direct oversight of the following non-physician practitioners in their practice sites:

- Physician Assistants (PAs)
- Nurse Practitioners (NPs, RNPs, CRNPs)

The Credentialing Department monitors the licenses of physician assistants and nurse practitioners practicing in contracting physicians' offices. Contracting physicians who permit physician assistants or nurse practitioners to treat their managed care patients are responsible for ensuring that the practitioner's license is current. A copy of the agreement between the physician and the practitioner must be provided to the Credentialing department upon time of credentialing and updated as needed.

Physicians must ensure that non-physician practitioners confine their treatment of your PO patients to services that fall within the scope of their license. Medical records documentation must reflect that all services falling outside the scope of a non-physician practitioners license were performed by a physician. For example, if the report of a physician's services is prepared by a non-physician practitioner, it must be initialed by the physician. Accurate documentation ensures that the procedure is reimbursable and protects providers from claims that provided services are outside of the scope of the provider's license.

Other supervision requirements for non-physician providers include the following:

- The supervising physician has continuing responsibility for all medical services provided by the health professional under his or her supervision. Note: Effective 7/1/01, California licensed physician scan supervise a PA without MBC approval. The exception is those physicians who are expressly prohibited by the Medical Board of California (MBC) from supervising a PA. [CCR, Title 16-Division 13.8-Physician Assistant Practice Act-Section 3502; Board of Registered Nursing, Nursing Practice Act, Rules and Regulations, Article 8].

- PAs may perform medical services set forth by the regulations of the MBC when the services are rendered under the appropriate supervision of a licensed physician. [CCR Title 16: Division 13.8-Physician Assistant Practice Act-Section 3502]
  - At all times, the supervising physician must be physically or electronically available to the PA for consultation, except in emergency situations.
  - The supervising physician must not supervise more than two PAs at one time.

- Prescribing of drugs and/or devices by NPs must be in accordance with standardized procedures or protocols developed by the NP and supervising physician. [Board of Registered Nursing, Nursing Practice Act, Rules and Regulations, Article 8].
  - The supervising physician is not required to be physically present; availability by telephone is adequate.
  - The supervising physician must not supervise more than four NPs at one time.

Provider Portal (EZNET):

The EZNET Portal is available on the Dignity Health Medical Network-Ventura website (www.dignityhealth.org/ventura**)**. The information available is helpful and easy to access. If you are currently a Dignity Health Medical Network-Ventura provider and need to obtain a log in and password, please submit request by using our EZ-NET User Application Form that can be found on our provider portal.

You will be able to log into the portal to submit and track referrals and check claim status.

The Provider Portal also includes:

Claim / Procedure Dispute Procedures

- Provider Dispute Resolution Notice
- Provider Dispute Resolution Request Form
- Provider Dispute Resolution FAQs
- Medicare Advantage Plan Non-Contracted Provider Payment Appeal Process

Training Resources

- California Mandated Reporting Requirements for Abuse
- Code of Conduct
- Fraud Waste and Abuse
- HIPAA
- Safety
- Bloodborne Pathogens

Provider Communications

- Provider Newsletter
- Health Plan Communications
- Utilization Management Clinical Practice Guidelines
- Utilization Management Policies & Procedures
- Quality Management Policies & Procedures
- Credentialing Policies & Procedures
- Utilization Management Program Description
- Quality Management Program Description
- Credentialing Program Description

By logging in to this secure system, you are assuming responsibility for maintaining the integrity and security for the protected health information contained within. You are responsible for the privacy and confidentiality of any Dignity Health Medical Network-Ventura and Dignity Health MSO data to which you have been granted access. You are bound by the Business Associate Agreement between VC (Covered Entity) and the office that you are employed by (Business Associate).

Part 4 - Health Services:

Dignity Health MSO is delegated by Dignity Health Medical Network-Ventura to conduct a comprehensive utilization management (UM) program for members enrolled in HMO health plans. Valley Care panel providers are contractually required to participate in and comply with UM program activities. The Utilization Management Program Description is available on ***www.dignityhealth.org/ventura***

UM PROGRAM RESPONSIBILITY

The IPA delegates responsibility for meeting UM program requirements specified by contracting health plans to Dignity Health MSO. Our UM Department is responsible for UM program activities, the scope of which currently extends to the customary array of utilization management/utilization review and health management services now accepted as integral to managed health care in the United States. The Utilization Management Committees, which report to the Boards of Directors, are the governing bodies for the UM program.

AVAILABILITY OF UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

The scope of the UM program is described in the complete *Utilization Management Program Description*. It is available on the Dignity Health Medical Network-Ventura website (**www.dignityhealth.org/ventura**) or upon request by calling the **Provider Relations Department** (see **Part 2**). The policies and procedures established to support the UM program are also available on the website. The following information summarizes the UM program.

UM DEPARTMENT BUSINESS HOURS

The UM Department is your primary source for UM program information and requirements.

Daily UM Department business hours are 8:00 a.m. – 5:00 p.m., Monday through Friday Pacific Time (PT). We observe the customary national holidays, when our offices are closed for business. The UM Department staff makes outbound calls and receives incoming calls regarding UM activities only during those hours. If you are a hospital, skilled nursing facility, rehabilitation or home health care case, a Case Manager may provide you with a number for direct contact.

After normal business hours, on weekends and holidays, you should contact the 24-hour nurse line. Providers who are connected to Dignity Health MSO's computer system (EZNET) may also submit authorization requests and view the status of a request electronically.

REQUIREMENTS FOR SPECIALTY CARE, ANCILLARY SERVICE AND INPATIENT REFERRALS

HMO members must meet their health plan's UM requirements in order for the services to be eligible for coverage. *As their physician, you are responsible for initiating the UM process on your HMO patients' behalf.*

Services Subject to Review. The UM Department is delegated the authority by contracting health plans to review and authorize their HMO patient referrals for elective inpatient care (acute, skilled nursing and rehab facility), most specialty care (including behavioral health services, but only Anthem Blue Cross Medicare Advantage HMO health plan), and most ancillary services. The requirements extend to services to be provided by contracting and affiliated providers, as well as by noncontracting providers when the needed services are not available from within Dignity Health MSO's contracting PO provider panels or affiliated providers.

PCPs must obtain authorization prior to referring their patients to contracting specialist. Contracting specialists are required to obtain authorization for continuing care prior to services beyond those originally authorized being rendered.

Services Not Subject to Review. Certain services are not subject to review, depending upon the type of HMO health plan in which the patient is enrolled. As a general rule, treating physicians may order the services listed below directly from the designated provider for their HMO members. Services received by HMO plan members under conditions other than those indicated below that have not been authorized in advance usually are not eligible for coverage, regardless of whether they are received from a provider or vendor having a contractual arrangement with your PO.

Primary Care Services. Most services rendered for HMO members within the primary care practice setting are not subject to review (see contract document: PCP out of CAP grid for services requiring an authorization). The PCP determines when services are required outside the primary care setting and requests the necessary authorizations from the UM Department.

Emergency Services. Emergency services generally do not require prior authorization; however, emergency facility services that do not conform to emergency services/conditions guidelines established by the State of California Health and Safety Code (for Commercial and state-funded health plan members) or by the Center for Medicare-Medicaid Services (for Medicare Advantage health plan members), as applicable for the patient's age group, are evaluated in the claims payment process. They must be forwarded to the UM Department for post service review by the Medical Director. Emergency medical and behavioral health services that are necessary to screen and stabilize a member will not be denied. Any services not authorized by the patient's PCP/treating physician that do not meet emergency criteria are subject to denial of the claim. Decisions are made after obtaining all necessary information, such as an ER summary or medical record, regarding the presenting symptoms and the discharge diagnosis.

Diagnostic and Routine Preventive Screening Lab Tests. Prior authorization is not required for lab services ordered by an authorized provider to (1) diagnose or monitor an HMO member's condition, or (2) when ordered in connection with age-appropriate routine preventive screening services, such as FDA-approved cervical cancer screening tests (i.e., Pap smears and thin prep tests). Coverage for lab services is subject to the member's plan of benefits, and MCO's are responsible for complying with any legislation or regulations pertaining to such services. Prior authorization is required for genetic testing, to ensure member has the benefit.

Radiology/Imaging Services. Requests for advanced imaging's are directed by the treating/ordering provider to the contracted imaging vendor.

The vendor/facility evaluates the request against agreed upon preservice review guidelines. Those falling outside the guidelines for authorization by the vendor are forwarded to the UM Department. If the request is for imaging services not subject to preservice review by the UM Department, the vendor proceeds with scheduling and providing the requested imaging.

Exception: Requests for use of non-contracting imaging vendors and facilities must be submitted to the UM Department for review.

OBGYN and Well-Woman Services. HMO members are not required to obtain authorization for routine office-based OBGYN care, including annual well-woman preventive care exams. However, they must receive the services from an OB/Gyn specialist on the provider panel for your PO. Surgical procedures, hospital admission, or other complex services require prior authorization.

Behavioral Health Services. Behavioral health services for Commercial HMO and some Medicare Advantage HMO health plan members are not included in the range of services for which your PO is financially responsible, as they are provided under separate "carve-out" arrangements with behavioral health provider organizations.

Direct Referral Specialists. Selected PCPs may refer their members to some contracted specialists without prior authorization. PCPs eligible for direct referrals are selected based on their history of compliance with review requirements and protocols. The specialties to which they may refer must be approved by the UM Committee and

Board of Directors and/or have capitation agreements. *PCPs are still required to enter the referral in the EZNET system.*

Direct referral utilization is monitored through post service review.

Internal Referral Specialists. County PCPs may refer to County Specialists without prior authorization. County Specialists may refer to other County Specialists without prior authorization. *PCPs are still required to enter the referral in the EZNET system. Certain exclusions apply, see "VCMC External Referral Guideline".*

Services Coordinated Through Members' Health Plans. A range of services are coordinated by the UM Department through the affected member's health plan, which is responsible for determining a member's eligibility for the services and interfacing with the UM Department, based on the outcome of the health plan's evaluations. When you submit an authorization request for such services, the UM Department must await the health plan's determination, so please allow ample time for the request to be processed. The following types of services are subject to health plan review of your authorization request:

- Cancer clinical trials
- Experimental or investigational treatments
- Organ transplantations

The patient's health plan also may become involved in the following types of cases:

- Requests for second opinions from specialists who are not affiliated with your PO (the member has the option of selecting one who has a contract with the member's health plan)
- Services of providers outside the local service area that are medically necessary due to an emergency

DECISION-MAKING POLICIES

The UM program is consistent with the administration requirements and clinical standards established by managed care organizations in the State of California to ensure compliance with state and federal regulations. It is designed to ensure that HMO patients receive the quality health care they deserve and expect while preserving the financial integrity of the IPAs. A copy of the criteria and/or policy used to make UM decisions is available on the website (www.dignityhealth.org/ventura**)** or by calling the IPA Customer Services Department at 805-604-3332.

The foundation of the UM programs are uniformity, consistency and timeliness. The program relies on established standardized decision-making criteria and guidelines that are based on sound medical evidence. UM Department clinical staff reviews them regularly to be certain that they reflect the needs of our members. We also make sure that our clinical decision-makers — physicians, nurses and other health professionals — consistently apply the criteria for all members. *Contracting health plans routinely monitor our UM review activities for compliance with established requirements. Failure to comply with requirements may jeopardize the IPAs contractual arrangements with HMO health plans.*

The UM Department makes these promises to you and your members when it comes to making utilization management decisions about health care services:

Only board-certified physicians and qualified health professionals are permitted to make utilization management decisions about the health care services our patients receive.

Utilization management decisions are based solely on the appropriateness of care and service and each patient's own health plan benefits. We do not reward our decision-makers for denials of coverage, services or care.

We do not offer our decision-makers any financial incentives to limit, restrict or discourage use of health care services.

The IPA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age, sexual orientation, disability or method of payment. Dignity Health Medical Network-Ventura does not exclude people or treat them differently because of race, color, national origin, sex, age, sexual orientation, disability or method of payment.

Case reviews are conducted to determine whether the services are covered by the member's plan of benefits, if covered, the services meet the criteria and guidelines for medical necessity and/or appropriateness of clinical or medical services and meet any applicable conditions of coverage.

Review requests are screened to verify the member's eligibility for HMO health plan benefits and identify the UM requirements applicable for that member. Then, depending upon the applicable requirements for the services being reviewed, the request is either authorized, if further review is not required, or it is directed to the Utilization Review Nurse for evaluation. Any case having the potential for denial is forwarded to the Medical Director or a specialty-specific physician reviewer for final determination.

Medical necessity determinations include:

- Decisions about covered medical benefits defined by the organization's Certificate of Coverage or Summary of Benefits

- Decisions about pre-existing conditions, when the member has creditable coverage and the organization has a policy to deny pre-existing care or services

- Decisions about care or services that could be considered either covered or not covered, depending on the circumstances

- Decisions about dental surgical procedures that occur within or adjacent to the oral cavity or sinuses and are covered under the member's medical benefits.

- Benefit determinations are decisions on requests for medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits plan. (Source: NCQA 2016 UM 1 Element A)

UM DECISION-MAKING CRITERIA AND GUIDELINES

The UM Department does not conduct a scripted clinical screening. When evaluating a case, UM Review Nurses, Case Managers and Physician Reviewers are required to consider information pertinent to the individual's clinical/medical needs, including the treating/ordering provider's recommendation. They also must observe the terms of coverage under the member's specific benefit plan. They further must base their review determinations on established clinical criteria recognized within the medical community-at-large as appropriate for the medical specialty or other clinical discipline relevant to the services subject to the review.

The standardized decision-making guidelines and criteria currently in use include the following resources, as applicable for the requested services:

Plan Eligibility and Coverage (benefit plan package)
Medicare Advantage:

☐ Medicare Criteria
- National Coverage Determinations (NCD)
- Local Coverage Determinations (LCD)
- Local Coverage Articles (LCA) (Active/Retired)
- Medicare Claims Processing Manual
- Medicare Benefit Policy Manual
- Medicare Managed Care Manual
- CMS Drug Compendia
- National Government Services (NGS) home health and hospice.

☐ Health Plan Criteria

☐ Standard reference compendia, including but not limited to
- MCG Ambulatory Care
- MCG Inpatient & Surgical Care
- MCG General Recovery Care
- Complete Guide to Medicare Coverage Issues

☐ Other established clinical practice guidelines and criteria that are
- evidence-based
- commonly applied by the medical specialty or other clinical discipline appropriate for the services subject to review

Commercial:

☐ Health Plan criteria

☐ Standard reference compendia, including but not limited to
- MCG Ambulatory Care
- MCG Inpatient & Surgical Care
- MCG General Recovery Care
- Complete Guide to Medicare Coverage Issues

☐ Other established clinical practice guidelines and criteria that are
- evidence-based
- commonly applied by the medical specialty or other clinical discipline appropriate for the services subject to review

Examples include:

- practice guidelines or criteria from the federal government
- practice guidelines or criteria from nationally recognized professional associations or societies that have been developed by a peer review or consensus process, including but not limited to:
  1. American Hospital Formulary Service-Drug Information
  2. American Medical Association Clinical Practice Guidelines
  3. American Medical Association Drug Evaluation
  4. American Psychiatric Association Practice Guidelines
  5. American Psychological Association Practice Guidelines
  6. American Dental Association Accepted Dental Therapeutics
  7. United States Pharmacopoeia-Drug Information
  8. American Physical Therapy Association Guide to Physical Therapist Practice
  9. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Proceedings of the Mercy Center Consensus Conference
  10. Clinical Practice Guideline No. 1, Vertebral Subluxation in Chiropractic Practice
  11. Up-To-Date Website – Evidence-Based Clinical Decision Support at the Point of Care
  12. National Guideline Clearinghouse http://www.guideline.gov

Proprietary Referral Guidelines and Protocols
Dignity Health MSO also develops proprietary guidelines to promote consistent referral practices among IPA or Medical Group Providers.

Criteria and guidelines are developed and approved by your UM Committee based on current standards of practice within our medical community for the requested services.

In the absence of consistent guidelines, a Reviewer's medical judgment based on professional experience may be considered as definitive.

Standardized guidelines are evaluated annually to ensure that the most current versions appropriate for PO members are used in the UM process.

Application of Criteria and Guidelines by Reviewers. Information sources for review decision making are monitored and evaluated annually by the IPAs UM Committee. Reviewers are informed of requirements for considering appropriate information and applying relevant medical and scientific evidence in their case evaluations and are supplied with information and documents pertinent to the individual's medical needs. Their written opinions are evaluated to ensure that that they include citation of the specific clinical criteria applied in the review.

Review clinicians receive training in requirements for applying pertinent clinical criteria and providing appropriately documented written opinions. The IPAs Medical Director also assists individuals needing access to the latest medical research findings, studies, practice guidelines and other clinical reference materials when requested in order to complete their reviews.

CASE MANAGEMENT:

INFORMATION REQUIRED FOR CASE REVIEWS

Requests for review must be submitted to the UM Department by the member's PCP or treating provider on the appropriate form. The forms can be found starting on page 48 or you may call Providers Relations for assistance in getting the form.

Request forms must be fully completed to include the following *minimum* data elements or be accompanied by a supplemental sheet with relevant information, as applicable for the case submitted for review:

Minimum Information Required for Case Reviews

Category	Minimum Data Elements	
Patient Information	Name	Sex
	Date of birth	Health plan
Diagnosis/Treatment Information	Primary diagnosis	Surgical assistant requirements
	Secondary diagnosis	Anesthesia requirements
	Tertiary diagnosis	Proposed admission or service date(s)
	Multiaxial diagnosis	Proposed procedure/service date(s)
	Proposed procedure(s), treatment(s) or service(s)	Proposed length of stay and frequency/ duration of services
Clinical Information	Sufficient to support the medical necessity/ appropriateness and level of service proposed	Contact person for detailed clinical information
Facility Information	Name	Type of Facility (inpatient, outpatient, special unit, SNF, rehab, office/clinic, home health agency, etc.)
	Location	
Category	**Minimum Data Elements**	
Concurrent (Continuing Care) Information)	Additional days/services/procedures proposed, with frequency and duration of services	Reasons for extension, including clinical information sufficient to support medical necessity/appropriateness and level of service proposed
	Diagnosis (same/changed)	Discharge plans
Category	**Minimum Data Elements**	
For Admissions to Facilities Other Than Acute Medical/Surgical Hospitals, Include	History of present illness	Prognosis
	Current special assessment reports	Patient treatment plan and goals

For Special Situations:	Additional information sufficient to support health insurance carrier/plan requirements, such as: • Second opinion information • Information in support of the need for a procedure, drug, device or other therapy

Treatment plans must be appropriate, time-specific and updated periodically.

INITIATING A CASE REVIEW

1. **Fax review requests directly to the Dignity Health MSO UM Department** (see **Part 2.** UM-related inquiries, including referral requests, are received and outbound responses provided only during normal business hours of 8:00 a.m. – 5:00 p.m., weekdays and non-holidays only. If the services are beyond the scope of those customarily screened and authorized by UM Department non-clinical staff, the Utilization Review Nurse will further evaluate the request. If additional information is needed, the Utilization Review Nurse will contact you and provide a direct phone or fax number. See **Part 2** for phone and fax numbers.

2. **Allow the UM Department sufficient time to perform a fair review of the requested services.** Federal and state regulations mandate the time frames for completing a review. *Referral review requirements and response time frames are mandated by federal and state regulations and accreditation regulations.* The UM Department strives to exceed those standards and makes every effort to complete reviews in advance of the required timeframe.

3. **Submit complete records supporting the need for the referral and promptly respond to requests from the UM Department for additional information when needed.** If requested information is not supplied, the request is at risk for being denied and may need to be resubmitted to be given further consideration.

REPORTING EMERGENCY INPATIENT ADMISSIONS

Dignity Health Medical Network-Ventura member hospital admissions may be coordinated through the hospitalist or managed directly by the PCP. The facility will notify the UM Department on the next business day. Dignity Health Medical Network-Ventura has a dedicated nurse liaison available 24/7, if you need to get in touch with someone outside normal operating house, you can contact the nurse liaison at (805) 918-4151.

The UM Department will follow up on the admission on the next business day. At the beginning of the next business day, the Case Manager checks with the facility's admitting office to identify any patients admitted in the off-hour period and performs an evaluation of the member's need for continuing inpatient care. If the member can be discharged, the Case Manager issues the appropriate denial notifications. You will be contacted if additional information is needed.

When a member is admitted to a facility following emergency treatment, continued care will be authorized until the treating provider believes that the member may be safely discharged, a treatment plan has been agreed upon with the treating provider, and both the treating provider and the member (or member's representative) have been given 24 hours' advance notice that coverage will be discontinued. For Medicare Advantage HMO health plan members, the authorization will be provided within one hour of receiving a request from a non-contracting facility.

Out-of-Area Emergency Admissions. To accommodate post-stabilization care needs subsequent to emergency treatment by out-of-area/non-contracting hospitals, the facilities customarily attempt to contact the patient's PCP/treating physician or behavioral health provider, as applicable.

Post-Emergency Stabilization Services Following Discharge. PCPs and treating physicians have the authority to order post-emergency stabilization services from contracting ancillary providers/suppliers, such as skilled nursing facilities, home health agencies and medical suppliers. Such services ordered by the PCP/treating provider will be authorized by the Case Manager on the next business day, and the patient's need for continuing services will be evaluated.

AUTHORIZED REFERRAL PROVIDERS

As a matter of policy, referrals are authorized only to providers affiliated with your PO.

Your PO's contracting provider network also extends to tertiary facilities and major medical centers designated by contracting health plans for use by their members when needed services are not available locally.

Use of Non-Contracting Providers. Your PO accommodates the need for services not available within their networks of affiliated providers and providers.

For Commercial members, medically necessary use of non-contracting providers is permitted when a contracting provider capable of providing the needed services is not available. These services must be authorized and a special agreement will be executed with the provider.

For Medicare Advantage members, a special agreement is not required if the provider is Medicare certified. However, authorization may be required.

If the needed services are not available in-network, the Review Nurse or Case Manager will locate a non-contracting provider appropriate for the patient.

AUTHORIZATION PROBLEMS

Providers are entitled to the following considerations in the review process:

1. If you have not received a response within the time frames indicated above, you may call the **Provider Relations Department** (see **Part 2**) to request a status.[2] If you are connected to Dignity Health MSO's computerized referral system EZNET, you may obtain status information online by going to www.dignityhealth.org/ventura and logging into the provider portal.

2. Peer-to-Peer – you may discuss a case submitted for review and denial decisions (if the status of the authorization is in "QM – Denial Review") with your PO's Medical Director or other physician who made the determination. If you can provide information that you believe was not considered at the time a denied request was reviewed, the case will be given immediate reconsideration.

3. All denials are subject to appeal once the member letter has been issued. *Appeals must be directed to the member's health plan, as required by our contractual arrangements with them.* You may file the appeal on behalf of your patient and encourage you to do so if your input will help with the decision. The health plan will notify us and direct a response within a time frame appropriate for the patient's medical needs.

Case Managers facilitate transition/discharge calls for all Senior and at-risk Commercial members discharged from acute or skilled nursing facilities (SNF).

[2] This number is dedicated to provider inquiries. Patients may call the Customer Service Department for information and assistance (see **Part 2**).

HOW TO DISPUTE A DENIED SERVICE

If you or the member believe that this determination is not correct, you or the member have the right to appeal the decision by contacting the member's health plan as listed on the back of their identification card. The health plan requests that you submit your appeal within 180 days from the postmark date of the denial notice. The member or someone the member designates (their authorized representative) may submit your appeal verbally or in writing. The member may call your health plan to learn how to name your authorized representative.

There are two types of appeals: *standard and expedited*.

Standard Appeal Process

A standard appeal will be resolved within 30 days. Your health plan will notify you in writing of the decision within 30 calendar days of receiving your appeal.

Expedited/72-hour Appeal Process

Your health plan makes every effort to resolve your appeal as quickly as possible. In some cases, you have the right to an expedited appeal when a delay in the decision making might pose an imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb, major bodily function, or if the normal timeframe for the decision-making process would be detrimental to your life, health or could jeopardize your ability to regain maximum function. If you request an expedited appeal, your health plan will evaluate your appeal and health condition to determine if your appeal qualifies as expedited. If so, your appeal will be resolved within 72 hours. If not, your appeal will be resolved within the standard 30 days.

Submitting Your Appeal

Please submit a copy of your denial notice and a brief explanation of your situation, or other relevant information to your health plan. Your health plan will document and process your standard or expedited appeal and provide you with written notification of the decision. You may write, call or fax your appeal to your health plan. Health plan address, telephone and FAX number is listed on the back of your identification card.

CARE COORDINATION

Dignity Health MSO has developed a Care Coordination Program to support your efforts to engage members and improve their health.

The Care Coordination program provides personalized outreach and support to members with chronic conditions and other serious medical issues that would benefit from registered nurse lead teams that have access to a wide variety of resources which includes other clinical and social support professionals. Ongoing member engagement and support may be conducted in-person, co-visits with primary care providers or by telephone.

Our Care Coordination Teams work closely with complex, high risk and rising risk members to promote better management of their health by:

- Developing personalized goals and shared action plan
- Help to maintain regularly scheduled office visits
- Providing medication reconciliation and adherence education
- Coordination across the continuum of care, from ER, acute inpatient or SNF admissions to home
- 90 Day Member Satisfaction Survey with Care Coordination Services

Our unique Care Coordination Program is physician-directed, which means we are an extension of your own care practice. Once you refer a member to our program you will be updated following each Care Coordination Team interaction, including sharing of care plans, outreach reports and documentation of a patient's progress.

Care Coordination Model – 4 Categories

To meet the individual needs of your members, Care Coordination has 4 categories that will clearly define a member's current health status, their health literacy, social and economic barriers, issues with non-compliance and medication management.

1) Wellness/Stable – provides one-touch episodic coordination of care for members not enrolled in Care Coordination but referred to appropriate services, transition calls for members discharged from ED or Inpatient facilities.

2) Rising Risk – provides intervention for members who have rising risk and require Care Coordination services on a regular basis. This category is not time limited and may assist with a board range of services. Goals include improving health outcomes, increasing appropriate utilization and improve the member's self-management skills.
   - Level 1 – Minimum contact is once per month not including initial assessment
   - Level 2 – Minimum contact is twice per month not including initial assessment

3) Complex Care – provides intervention and care coordination for those members with complex or multiple chronic conditions that have modifiable risk factors.
   - Level 1 – Minimum contact is once per month not including initial assessment
   - Level 2 – Minimum contact is twice per month not including initial assessment
   - Level 3 – Minimum contact is four times per month not including required initial assessment

   Palliative Care – this level of Care Coordination Services provides one-touch coordination of care with the goal of referring to appropriate Palliative Care or Hospice Care services but may continue as listed above

- Level 2 – Minimum contact is twice per month not including initial assessment
- Level 3 – Minimum contact is four times per month not including required initial assessment

Care Coordination Referrals:

- Appropriate referrals include members with:
  - 2 or more co-morbidities
  - Acute complicated disease process
  - Acute inpatient or SNF admission
  - Frequent emergency room or urgent care utilization
  - Non-compliance with previous treatment plan
  - Social or economic barriers
  - Other special needs as identified by health care provider

- **Referral Process:**
  - Care Coordination Referrals may be received via fax, secure email, shared electronic medical record (EMR), telephonically by providers, care managers, payer sources or direct member referral.
    - RN Line: 805-918-4134
    - Direct Line: 805-918-5299
    - Direct Fax: 805-856-0385
    - Via Cerner: CCSA-IDMG-Ventura
    - Email: carecoordinationvc@identitymso.com

- **Screening Process:**
  - All member referrals are reviewed and assessed using a screening tool that will categorize a member's individual need for Care Coordination based a multitude of factors but not limited to a recent catastrophic event, medical, behavioral health diagnosis or recent inpatient admission. Once the member has been identified as appropriate for one of the 4 categories member outreach will begin.

- **Outreach:**
  - Member outreach is performed by phone with a minimum of three (3) attempts within two (2) weeks. If no return call, member and provider receive a letter explaining Care Coordination Services and information on how to reach the department if desired.
  - If member is reached and Care Coordination Services are declined, provider receives letter notifying of member decline.
  - If member is reached and agrees to Care Coordination Services, assessment is started, and face-to-face visit is scheduled with RN Coordinator.
  - If member is inpatient or in Skilled Nursing Facility (SNF), introduction to Care Coordination Services are done in person or telephonically to assist with transition of care, including timely follow-up appointments in outpatient setting, home care needs addressed appropriately (ADLs, Transportation, DME, Home Health Services and medication reconciliation at time of discharge.

- **Initial Visit:**

- Initial RN visit occurs telephonically, face-to-face in home, or other designated site, to complete a comprehensive assessment which includes; medication reconciliation, assessment of health status, clinical history, ADLs, PHQ-9, cultural and linguistic needs/preferences, caregiver resources, evaluation of benefits, barriers and resources, life planning activities.
- Following the initial visit and completion of the comprehensive assessment, the RN Care Coordinator will develop a care plan with patient centered long and short-term goals and complete a leveling tool to determine minimum member contact per month.
- Results of initial visit are documented, summarized and provided to the Primary Care Provider within 72-hours.

- **Ongoing Care Coordination Services:**
  - Initial RN assessment and care plan will determine if ongoing support will be face-to-face, telephonic and delivered by RN, LVN, MSW or Health Coach/Navigator as supervised by the RN Team lead. Frequency of interactions will be determined by the leveling tool, but not less than once a month.
  - Ongoing monitoring and reassessment of member's individual needs in managing their health care more effectively is documented upon each intervention and shared with health care provider.
  - Care Coordination staff will review individual member's gaps in care and assist with addressing available preventative care services with Primary Care Provider.
  - Care Coordination will schedule and complete a 90-day member satisfaction survey.
  - Care Coordination staff may attend Primary Care Provider or Specialist visits if requested by member and receive advance approval of health care provider.
  - Care Coordination may attend educational classes if requested by member, such as monthly Diabetic Education classes offered by community resources to reinforce knowledge and understanding of their disease process and assist with member compliance.
  - Members are encouraged to contact their Care Coordination team for any issues or concerns regarding their health care needs.

- **Ending Care Coordination Services:**
  - Members enrolled in Care Coordination services may be considered "ever-enrolled" as they can move between the various levels within a category. Reason's to discontinue services may include the following;
    - Member's desire to terminate services
    - Provider's desire to terminate services
    - Health insurance termination
    - Election of hospice benefits
    - Decision to end Care Coordination Services will be documented with a summary of goals met or reason for discontinuing services and shared with Primary Care Provider
    - Members are encouraged to reach out to Care Coordination if there is a change in condition or new clinical needs are identified that would benefit from additional Care Coordination Services

Direct Referrals (non-County PCP Members):

Primary Care Physicians (PCPs) can refer members to designated specialties without prior authorization from the IPA.

A. The Utilization Management Committee is responsible for:

- designating PCPs who may issue direct referrals
- designating specialties that may accept direct referrals from designated PCPs, based on current utilization, member specialty care needs and compliance with EZNET software use.
- ensuring the accuracy of the specialists authorized to receive direct referrals (see Attachment 1)
- issuing updates to PCPs as they occur

B. PCPs are responsible for:

- enrolling in the Direct Referral Program
- verifying patient eligibility through health plan website portals prior to issuing the referral
- referring members only to designed direct referral specialties
- enter the direct referral into EZNET and upload all pertinent clinical documents into EZNET

C. The Utilization Management Department is responsible for post-service audit of all Direct Referrals monthly to report to Utilization Management Committee.

Guidelines for Direct Referrals:

A. PCPs may direct refer their members for specialty services when all of the following requirements are met:

- the PCP is authorized to issue direct referrals
- patient is referred only to designated specialties for which prior authorization requirements are waived
- PCP cannot refer to himself or a member of his/her group
- PCP's office confirms both the specialist's direct referral status and the patient's eligibility prior to issuing the direct referral

B. Specialists may accept PCP direct referrals when all of the following requirements are met:

- specialist practices in one of the designated direct referral specialties
- direct referral specialist's office confirms the patient's eligibility prior to issuing the direct referral

C. Direct referrals may specify the following:

- Specialist Consultation: The specialist is authorized to see the patient for a consult. The Specialist must submit a request for further follow up testing to PCP.
- Procedure/Testing only: The Specialist is authorized to perform only the test(s) or procedure(s) specified by the PCP. *Unless specified by the PCP, procedure/testing-only referrals do not include an office visit or consult.*

D. The Direct Referral Authorization form is considered a doctor's order and must be signed and dated by the requesting physician.

E. Specialty services must be initiated within 60 calendar days from the date the referral was signed by the PCP and is valid for 90 days.

F. The services of direct referral specialists are subject to post-service review.

G. The IPA pays only for services of designated direct referral specialists that are covered by the patient's health plan.

1. PCP Direct Referral Procedure

1.1 Verify the following prior to issuing a direct referral

- Patient's eligibility — Call the Customer Service Department at (805) 604-3332.
- Specialist's direct referral status — Check the Direct Referral Guideline on the Valley Care website or Call the Provider Relations Department (805) 604-3308 to determine whether the specialist is permitted to accept direct referrals.

1.1.1 If both the specialist's direct referral status and the patient's eligibility cannot be verified, the direct referral may not be issued. Complete the Prior Authorization Request section of the Referral Authorization form and submit it to the Authorizations Departments which will further research patient eligibility and refer eligible member to a contracting specialist.

1.2 If the specialist's direct referral status and patient's eligibility have been verified, enter patient information into EZNET and upload all patient information, lab work, testing and x-rays the specialist or ancillary provider requires in order to provide the service.

1.2.1 Provide a copy of the referral form to the patient to take to the specialist appointment.

1.2.2 The PCP or the member may schedule the appointment with the direct referral specialist or ancillary provider.

2. Specialist Direct Referral Procedure (Designated Specialist Only)

2.1 A specialist must have an EZCAP approved authorization before treating members under the direct referral program. Providing specialty services without a referral will result in denial of payment (except for emergency situations). Charges denied for lack of referral are not the responsibility of the member.

2.1.2 Verify patient eligibility prior to initiating services by contacting the health plan directly or call the Customer Service Department.

2.2 If further treatment is needed based on evaluation of the patient, specialist is required to submit a request via EZNET directly to the IPA with supporting clinical documentation.

Individual PCP direct referral patterns are monitored to determine whether they are appropriately direct referring members to the direct referral specialists according to current referral guidelines, based on the monthly post service audit being done.

- Monthly audit results and trends are review by UM Committee

- PCP with noncompliant referral patterns will be reported to the UM Committee for review and recommendations.
- Direct Referral pattern reports and data are included in the PCP's recredentialing file.

Internal Referrals (County PCP Members):

Primary Care Physicians (PCPs) or County Specialties can refer members to designated specialties without prior authorization from the IPA.

A. The Utilization Management Committee is responsible for:

- designating specialties that may accept Internal referrals from designated County PCPs/specialist, based on current utilization, member specialty care needs and compliance with EZNET software use.
- ensuring the accuracy of the specialists authorized to receive Internal referrals (see Attachment)
- issuing updates to PCPs as they occur

B. PCPs are responsible for:

- verifying patient eligibility through health plan website portals prior to issuing the referral
- referring members only to designated Internal referral specialties
- enter the internal referral into EZNET and upload all pertinent clinical documents into EZNET

C. The Utilization Management Department is responsible for post-service audit of all Internal Referrals monthly to report to the Utilization Management Committee.

Guidelines for Internal Referrals:

A. PCPs may internally refer their members for specialty services when all of the following requirements are met:

- the PCP/Specialist is a rostered, county provider
- patient is referred only to designated specialties for which prior authorization requirements are waived
- PCP cannot refer to themselves
- PCP's office confirms both the specialist's Internal referral status and the patient's eligibility prior to issuing the Internal referral

B. Specialists may accept Internal referrals when all of the following requirements are met:

- Internal referral specialist's office confirms the patient's eligibility prior to issuing the Internal referral

C. Internal referrals may specify the following:

- Specialist Consultation: The specialist is authorized to see the patient for a consult. The Specialist must submit a request for further follow up testing to PCP.
- Procedure/Testing only: The Specialist is authorized to perform only the test(s) or procedure(s) specified by the PCP. *Unless specified by the PCP, procedure/testing-only referrals do not include an office visit or consult.*

D. The Internal Referral Authorization form is considered a doctor's order and must be signed and dated by the requesting physician.

E. Specialty services must be initiated within 60 calendar days from the date the referral was signed by the PCP and is valid for 90 days.

F. The services of internal referral specialists are subject to post-service review.

G. The IPA pays only for services of designated internal referral specialists that are covered by the patient's health plan.

1. PCP Internal Referral Procedure (County PCP)

1.1 Verify the following prior to issuing an internal referral;

- Patient's eligibility — Call the Customer Service Department at (805) 604-3332. The patient's eligibility also may be checked in the patient's eligibility in the EZNET Portal if the PCP's office is connected to that system.
- Specialist's internal referral status — Check that the specialist is a County provider on the Valley Care website or Call the Provider Relations Department (805) 604-3308 to determine whether the specialist is permitted to accept internal referrals.

1.1.1 If both the specialist's internal referral status and the patient's eligibility cannot be verified, the internal referral may not be issued. Complete the Prior Authorization Request section of the Referral Authorization form and submit it to the Authorizations Departments which will further research patient eligibility and refer eligible member to a contracting specialist.

1.2 If the specialist's internal referral status and patient's eligibility have been verified, enter patient information into EZNET and upload all patient information, lab work, testing and x-rays the specialist or ancillary provider requires in order to provide the service.

1.2.1 Provide a copy of the referral form to the patient to take to the specialist appointment.

1.2.2 The PCP or the member may schedule the appointment with the internal referral specialist or ancillary provider.

2. Specialist Internal Referral Procedure (County Specialist Only)

2.1 A specialist must have an EZCAP approved authorization before treating members under the Internal Referral program. Providing specialty services without a referral will result in denial of payment (except for emergency situations). Charges denied for lack of referral are not the responsibility of the member.

2.1.2 Verify patient eligibility prior to initiating services by contacting the health plan directly or call the Customer Service Department.

2.2 If further treatment is needed based on evaluation of the patient, specialist is required to submit the request via EZNET with supporting clinical documentation.

Individual PCPs and County Specialists internal referral patterns are monitored to determine whether they are appropriately referring members to the internal referral specialists according to current referral guidelines, based on the monthly post service audit being done.

- Monthly audit results and trends are review by UM Committee
- PCP/Specialists with noncompliant referral patterns will be reported to the UM Committee for review and recommendations.
- Internal Referral pattern reports and data are included in the PCP's recredentialing file.

Authorization Inquiry Form:

Download this fillable form at www.dignityhealth.org/ventura

VALLEY CARE IPA

AUTHORIZATION INQUIRY FORM

Incomplete Inquiry forms WILL NOT be processed.

Inquiry Turnaround Time is 2 Business Days**

Please FAX ONLY to (805) 278-6815

**Must check EZ-NET for inquiry status (INQUIRIES Note). If Urgent, please follow urgent process.

Name of person submitting: _____ Contact Phone #: _____

Member Name: _____ DOB: _____

Health Plan: _____ ID Number: _____

Requesting Provider: _____ Auth #: _____

Check the box below that applies to your request:

- ☐ Change CPT/HCPC Code: _____
- ☐ Add CPT/HCPC Code: _____
- ☐ Change Rendering Provider: _____
- ☐ Change Facility: _____
- ☐ Change Quantity: _____
- ☐ Home Health - Start of Care Date: _____

- All other change requests must be submitted under new authorization request (be sure to provide original authorization number on resubmission).
- Member insurance changes require new authorization submission prior to services being rendered (be sure to provide original authorization number on resubmission).
- Authorization extensions should be requested through Valley Care IPA Customer Service at: dl-customerservice@identitymso.com
  - Note – the authorization must still be valid to extend and can only be extended one (1) time.

Prescription Drug Prior Authorization Process:

Requests for Prescription Drug Prior Authorization may be submitted using Form 61-211: Prescription Drug Prior Authorization Request Form. Use of this form is not mandatory. Providers have the option to submit prescription drug requests using the internal pre-service authorization form.

- Only the minimum amount of material information is necessary to complete the request is required.
- IPA may not require the requesting provider to submit additional forms other than Form 61-211 or a completed internal pre-service authorization form; however, the requesting provider may choose to submit additional attachments to the form.

Form 61-211: Prescription Drug Prior Authorization Request Form is available electronically on the IPA website for those who choose to use it.

- Requesting provider may submit the form electronically but is not required to.

Should a prescription drug authorization request need to be forwarded to the health plan, as is the case for experimental/investigational drug requests, Form 61-211: Prescription Drug Prior Authorization Form may be required. If the health care service plan requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the plan shall request only the information reasonably necessary to make the determination (Source: CA H&SC 1367.01(g)). The UM staff will ensure that the information needed to make a determination of medical necessity has been collected prior to submitting to the requesting health plan.

Requesting provider is notified of the following:

- Request is approved
- Request is denied as not medically necessary
- Request is denied as not a covered benefit
- Request is denied as missing clinical information
- Request is denied as Member is no longer eligible for coverage

Timeframe for review and response is 24 hours for urgent and 72 hours for non-urgent requests of approval, denial including denial for missing information.

Notification is delivered in the same manner as the request was submitted or another mutually agreeable method of notification.

If the requesting provider is not notified within 24 hours for urgent and 72 hours for non-urgent, the request is deemed approved (e.g., Administrative Approval).

Denial notices for medical necessity, benefit exclusion or missing clinical information will include an accurate and clear written explanation of the specific reasons for denying the request and the appropriate appeals process.

Upon written request, the provider and/or member have the right to request the utilization management policies, procedures, and criteria used to authorize, modify, or deny healthcare services to members or person designated by members or to the public.

The IPA will make all efforts to comply with the mandatory timeframe as required by the law. If there is a legitimate safety concern for a prescription drug requiring prior authorization and it takes longer than the required timeframes noted above, then the IPA does not have to “automatically” approve the drug. However, the IPA will ensure there is not a systemic issue with their process that prevents these types of prior authorizations from receiving timely review and approval/disapproval as evidenced in EZCAP documentation.

The member may proceed to an immediate independent review instead of the routine appeal process if desired. The member will notify their health plan of the request for an expedited appeal based on Pharmacy request.

- Requests may not be pended if additional information is required. The request must be denied on the basis that additional information is needed.
- ICE CSDN may be used.

A copy of the Prescription Prior Authorization Request Form is available on the website at **www.dignityhealth.org/ventura.**

QUALITY MANAGEMENT:

The Quality Management (QM) Program is an ongoing, comprehensive, and integrated program. It objectively and systematically monitors and continuously evaluates all aspects of the delivery of health care services. Its purpose is to identify opportunities to improve care and services, as well as resolve identified problems in the delivery of care and service in all departments Assessment of standards objectives and outcomes provide an ongoing basis upon which patient care related issues are evaluated, upgraded, and improved for the benefit of the member, providers and staff. The PO QM Committees, which report to their respective board of Directors, are the governing body for the QM Program.

PO providers are contractually required to participate in and cooperate with QM program activities. Many of those activities doucs on improving the operational aspects of delivering health care services. Operations activities are monitored continuously and systematically to assess corporate-wide and individual performance and to identify areas for focal performance improvement.

The QM Department has established conflict of interest policies to ensure that employees, contracting providers, and vendors avoid conflicts of interest. Individuals involved in handling of member information and records may not accept a case for review if an actual or potential conflict of interest exists that could compromise the independence or objectivity of the review process. Individuals subject to conflict of interest in treatment decisions as applicable for the QM Department is designed to ensure objectivity and staff are expected to refrain from any activity, interest or relationship that is not compatible with their obligations to the organization, members, or providers it serves, would bring personal or financial gain to the individual, has an adverse effect on the organization or would influence treatment decisions.

QM Case and Peer Review activities, conflict of interest policies directly apply to all individuals involved in evaluating member care, making treatment decisions and all related processes. Individuals who are involved in treatment decisions may not have a material, professional, familial, or financial conflict of interest regarding health plan or other entity whose case is reviewed, member case which is reviewed, attending, treating or ordering provider or any other health care professional previously involved in a case reviewed, facility at which the recommended treatment would be provided, developer or manufacturer of principle drug, device, procedure or other therapy recommended for a member whose case is reviewed.

The QM Department staff who are involved in treatment decisions must ensure that their authorization or denial of medical treatment or services will not in any way be dependent upon financial relationships, fiduciary responsibilities, or compensation arrangements. They will not accept compensation or financial incentives based on the authorization or denial of medical treatment or services or personal financial gain or other personal considerations will not influence their clinical decisions.

QUALITY MANAGEMENT PROGRAM DESCRIPTION

The scope of the QM Program is described in your PO's Quality Management Program Description. It is available upon request. If you are connected to Dignity Health MSO's computer system, the policies and procedures established to support the QM Program are viewable on the provider portal of the website **www.dignityhealth.org/ventura** For further information, contact the Provider Relations Department (see **Part 2**)[3].

[3] This number is dedicated to provider inquiries. Patients may call the Customer Service Department (see **Part 2**).

Appeals & Grievances:

The QM Department has established requirements and related procedures for accepting, investigating and responding to requests for an appeal review of an adverse review determination for Managed Care members, including but not limited to Medical, Pharmacy and Dental.

Appeal level reviews are performed when an initial level review results in denial of the requested services for an HMO health plan member.

Information about appeal rights and the procedures for requesting an appeal review are provided with each denial notification issued to members and the provider requesting the services that were denied. Appeals may be filed by the member, the member's authorized representative, or a provider who is a party to the original reviewed case.

- The IPA is *not delegated* to accept, initiate investigation of or respond to requests for appeal review of adverse utilization management determinations that are received directly from any party other than the HMO member's health plan.
- Requests for appeal review received directly from any party other than an HMO member's health plan must be immediately forwarded on the day received to the health plan's staff designated as responsible for management of their members' appeals.
- The member may proceed to an immediate independent review instead of the routine appeal process if desired for Pharmacy denials. The member will notify their health plan of the request for an expedited appeal based on Pharmacy request.
- When notified of an appeal by an HMO health plan or an authorized independent medical review (IMR) organization, the IPA supports the health plan appeal process by collecting applicable information and records used for the initial review and any other documentation available in the member's medical record that may assist the health plan in reaching a determination and providing it to the health plan within the time frame specified.
- When provided the opportunity to contest a health plan's overturn of a provider reviewer's initial level determination, the same reviewer who issued the initial denial may not conduct an appeal review.
- Members are allowed to have continued coverage (concurrent care only) pending the outcome of an internal appeal if an ongoing course of treatment was approved and denial, reduction or termination of such course of treatment ends before the period of time or number of treatments are completed.

Health plan overturn decisions may be challenged. If the overturn decision does not appear to be consistent with the facts of the case and the overturn has a financial impact on the IPA due to the division of financial responsibility for the denied service(s), the QM Coordinator collaborates with the provider to determine whether the overturn should be challenged. If the provider agrees to challenge, prepare a challenge letter and submit it to the health plan within 24 hours of receiving the overturn decision.

Appeals Review Timeliness Standards

Type of Appeal	Response to Health Plan Time Frame	Oral/Written/Electronic Notification of Overturns to Practitioner and Member Time Frame
Expedited Preservice and Concurrent Appeal Reviews	As specified by health plan, but not to exceed 72 hours following receipt of the health plan's appeal request	Within 24 hours of notification by health plan of original denial overturn. If provider or member is notified orally, written notification must follow within 24 hours of the oral notification.
Routine Preservice and Concurrent Appeal Reviews	As specified by health plan, but not to exceed 10 calendar days following receipt of the health plan's appeal request	Within 2 business days of notification by health plan of original denial overturn. If provider or member is notified orally, written notification must follow within 24 hours of the oral notification.
Post-Service Appeal Reviews	As specified by health plan, but not to exceed 30 calendar days following receipt of health plan's appeal request	Within 3 business days of receipt of notification by health plan of original denial overturn. If provider or member is notified orally, written notification must follow within 24 hours of the oral notification.

PROVIDER SATISFACTION SURVEYS:

The QM Department will conduct a Provider Satisfaction Survey annually per NCQA requirements with results being presented to the QM/UM Committee meeting for review and recommendation. The Surveys will request information regarding the physician's level of satisfaction or dissatisfaction with Dignity Health MSO administrative services and provider medical record coordination.

The Survey is a tool for contracted IPA providers to provide feedback as to their level of satisfaction with Dignity Health MSO's administrative services, ancillary services and provider feedback with coordination of medical records as well as to improve the quality of services delivered to providers by determining areas of satisfaction and dissatisfaction. Improvement of processes involving providers will improve the quality of care to the members in accordance with regulatory requirements.

A sample of the Survey is available on the next page.

2023 ANNUAL DIGNITY HEALTH MEDICAL NETWORK-VENTURA PHYSICIAN SATISFACTION SURVEY

***Note: Please answer all applicable questions. Individual responses will be kept strictly confidential and data will only be used in aggregate. For questions that do not apply to your organization, please select N/A.**

Thank you.

Directions for Completion:

Physician and/or Office Manager please respond to the questions and rate your level of satisfaction or dissatisfaction for the statements below. If you have any comments or suggestions, please contact the Provider Relations Department at **(805) 604-3308**. Thank you.

Are you a PCP or a Specialist for **Dignity Health Medical Network-Ventura**?

○ Non-County PCP ○ County PCP ○ Specialist

Please indicate who is completing this survey?

○ Physician ○ Office Manager

PLEASE USE THE SATISFACTION/DISSATISFACTION SCALE BELOW FOR QUESTIONS 1 THROUGH 22. PLACE A ☑ IN THE BOX TO THE RIGHT OF QUESTION THAT BEST DESCRIBES YOUR SATISFACTION LEVEL.

Scale Definition:	*Very Satisfied*	*Satisfied*	*Neutral*	*Dissatisfied*	*Very Dissatisfied*	*Not Applicable*
As a Dignity Health Medical Network-Ventura Provider, I am:						
1. Given adequate information regarding which PCP and Specialist providers are in the IPA's network. (available at www.dignityhealth.org/ventura)	☐	☐	☐	☐	☐	☐
2. Satisfied with **Dignity Health Medical Network-Ventura** Practice & Referral Guidelines. (available at www.dignityhealth.org/venturawww.dignityhealth.org/ventura)	☐	☐	☐	☐	☐	☐
3. Satisfied with radiology services. ○ RadNet ○ County	☐	☐	☐	☐	☐	☐
4. Satisfied with laboratory services. ○ Quest ○ County	☐	☐	☐	☐	☐	☐
5. (**PCPs only answer this question**) Satisfied with timeliness and completeness of the consult reports provided to me by IPA specialists.	☐	☐	☐	☐	☐	☐
6. **(Specialists only answer this question)** Satisfied with timeliness and completeness of the information (history, test results, etc.) provided to me by the referring IPA physician.	☐	☐	☐	☐	☐	☐
7. Given adequate information regarding **Dignity Health Medical Network-Ventura's** referral process.	☐	☐	☐	☐	☐	☐
8. Satisfied that the prior authorization requests are processed in a timely manner (this does not include those referrals that require obtaining additional information from the physician's office).	☐	☐	☐	☐	☐	☐

9. Has the implementation of the Direct Referral Process helped with efficiency and patient satisfaction?	☐	☐	☐	☐	☐	☐
*Scale **Definition:***	***Very Satisfied***	***Satisfied***	***Neutral***	***Dissatisfied***	***Very Dissatisfied***	***Not Applicable***

As a Dignity Health Medical Network-Ventura Provider, I am:

10. Satisfied with the explanation and wording of UM denials.	☐	☐	☐	☐	☐	☐
11. Satisfied with the ability to speak with a Medical Director and/or Physician Reviewer to further discuss a denied referral determination.	☐	☐	☐	☐	☐	☐
12. The nurses provide prompt and adequate responses to my needs and concerns regarding my patients.	☐	☐	☐	☐	☐	☐
13. Care Management team has made an impact with assisting in the management of the patients in my practice.	☐	☐	☐	☐	☐	☐
14. (**PCPs only answer this question**) Satisfied with the level of communication that occurs when a patient transitions from a skilled nursing facility to home.	☐	☐	☐	☐	☐	☐
15. (**PCPs only answer this question**) Satisfied with the level of communication that occurs when a patient is discharged from the hospital to a skilled nursing facility or to home.	☐	☐	☐	☐	☐	☐
16. Given adequate information regarding **Dignity Health Medical Network-Ventura's** claims process.	☐	☐	☐	☐	☐	☐
17. Satisfied that my claims are processed in a timely manner. (60 calendar days)	☐	☐	☐	☐	☐	☐
18. Satisfied that my eligibility list is timely and accurate.	☐	☐	☐	☐	☐	☐
19. Satisfied that my capitation check is timely and accurate.	☐	☐	☐	☐	☐	☐
20. Given a prompt and adequate response to my needs and concerns by the Member/Provider Services Staff.	☐	☐	☐	☐	☐	☐
21. Satisfied that the Provider Relations staff response time back to me with a return telephone call (when requested) in a timely manner.	☐	☐	☐	☐	☐	☐
22. Satisfied with the frequency and information provided by the Provider Relations Representative during site visits.	☐	☐	☐	☐	☐	☐
23. How satisfied are you with the EZNET program?	☐	☐	☐	☐	☐	☐

24. Please list 3 things that you like about Valley Dignity Health Medical Network-Ventura.

1._____

2.

25. Please list 3 things that you would like to see improved withDignity Health Medical Network-Ventura.

1._____

2.

26. Any other comments regarding this physician's survey orDignity Health Medical Network-Ventura?

_____

Access to Care:

Health plans ensure the provider network has adequate capacity and availability of licensed health care providers to offer members appointments within established time elapsed access standards. The health plan and its participating providers are required to demonstrate that, throughout the geographic regions of the plan's service area, a comprehensive range of primary, specialty, institutional and ancillary care services are readily available and accessible at reasonable times to all plan members. This includes, but is not limited to, practitioner and provider availability waiting time and appointment access with established standards for:

- Hours of operation and after-hours service
- Facility access
- Emergency and urgent care services
- Appointment availability and waiting time
- Number (ratio) and geographic distribution of primary, specialty, emergency, behavioral and ancillary services; and health care facilities (such as hospitals)

Accessibility of Providers

1. **After-Hours Access**- It is the policy of Dignity Health MSO to have medical services available and accessible to members 24 hours a day, seven days a week. PCPs who do not have services available 24 hours a day may use an answering service or an answering machine to provide members with clear and appropriate instruction on after-hours access to urgent or emergency medical care.

2. **Answering Service**- The provider is responsible for the answering service it uses. If a member calls after hours or on a weekend for a possible medical or behavioral health emergency, the provider is held liable for authorization of, or referral to, emergency care given by the answering service. There must be a message immediately stating, "If this is an emergency, hang up and call 911 or go to the nearest emergency room."

   Answering service staff handling member calls cannot provide telephone medical advice if they are not a licensed, certified or registered health care professional. Unlicensed staff should have clear instructions on the parameters relating to the use of answers in assisting a licensed provider, as they are not permitted, under any circumstance, to use the answers to a question in an attempt to assess, evaluate, advise or make any decision regarding the condition of the member.

   Dignity Health MSO encourages answering services to include the following steps when receiving a call:

   - If the member is experiencing a medical emergency, instruct him or her to hang up and call 911 or proceed to the nearest emergency medical facility
   - If language assistance is needed, offer the member interpreter services and question him or her according to the IPA's established instructions to access the nature and extent of the problem.
   - Contact the on-call physician with the facts as stated by the member.
   - After office hours, physicians are required to return telephone calls and pages within 30 minutes. If an on-call physician cannot be reached, direct the member to a medical facility where emergency or urgent care treatment by qualified health professionals can be given. This is considered authorization, which is binding and cannot be retracted. If the contracted provider is unable to meet the 30-minute call back time, a back-up triage line must be provider to the member.
   - Document all calls

Assessment of Compliance- Dignity Health MSO has a documented system for monitoring and evaluating appointment availability and accessibility of care and services. Dignity Health MSO monitors appointment access to care and practitioner availability standards through member and provider surveys annually. Information obtained from customer service telephone access, triage and screening services and appeals and grievances measures performance, confirms compliance and ensures the provider network is sufficient to provide appropriate accessibility, availability and continuity of care to IPA members. Dignity Health MSO monitors compliance of its appointment access standards as follows:

- *Provider Appointment Access Survey*- Annual medical appointment survey to assess member access to care and service; specific elements include preventive care, routine care and urgent care.
- *Member Satisfaction Survey*- Annual surveys to determine whether members are satisfied with the accessibility of health care services.
- *Provider Satisfaction Survey*- Annual survey to solicit from IPA provider's perspective and concerns regarding compliance with the access standards to evaluate satisfaction with the time-elapsed access regulations set forth.
- *Member Grievance Detail Log*- Tracked and trended to identify issues with access.

Corrective Actions- Providers with access falling below standards for the first time are subject to the following corrective actions, which may be implemented by the QM Manager without QM Committee approval:

- advisory notice of failure to meet standards and expectations for improvement
- re-audits over the ensuing three- to six-month period, as directed by the QM Manager, based on extent of non-compliance and other factors, such as patient complaints and grievances and results of patient satisfaction surveys

Providers with access falling below standards from one audit period to the next are subject to the following corrective actions:

- **Operations-level corrective actions that may be implemented upon direction of QM Manager**: The QM Manager may authorize advisory notification that the practitioner's access must meet standards within the next designated audit period.
- **QM Committee approved corrective actions**: Upon approval by the QM Committee and Board of Directors, these additional actions may be invoked:

1. restrictions on new patients (PCPs) or referrals (specialists) if appointment does not comply with standards within the next designated audit period (requires approval by the respective PO QM Committee and UM Committee)
2. suspension or termination of contract for persistent access issues resulting in patient complaints or poor performance on access-related elements of patient satisfaction surveys (requires QM Committee and Board of Directors approval, with involvement of the Provider Relations Department and the Contracting Department).

Exceptions:

Preventive Care Services and Periodic Follow Up Care

Preventive care services and periodic follow up care including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

Advance Access

A primary care provider may demonstrate compliance with the primary care time-elapsed access standards established herein through implementation of standards, processes and systems providing advance access to primary care appointments as defined herein.

Appointment Rescheduling

When it is necessary for a provider or enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs and ensures continuity of care consistent with good professional practice and consistent with the objectives of this policy.

Extending Appointment Waiting Time

The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards or practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.

PART 5 (FINANCE):

TELEPHONE: (805) 604-3308 FAX: (805) 918-4057 or dl-providerrelations.identitymso.@commonspirit.org

The Finance department is responsible for the calculation and payment of all capitation.

The capitation rate is based upon a fixed dollar amount multiplied by the number of members enrolled with their PCP for the month. It may also be based on a percent of the IPA's capitation revenue for each member. The capitation amount also includes any adjustments for members who are retroactively enrolled or disenrolled with the PCP. Capitation is paid regardless of whether or not the member receives care.

Additional compensation for services rendered that are not part of the capitation will be reimbursed according to your contract.

The reports that will come with each capitation check will list the following:

Period:	Month that capitation applies to
Member number:	Health plan eligibility number
Member Name:	Member's last name and first name
Birth Date:	Date of Birth
Age:	Member's age
Sex:	Member's sex
Effective Date:	Member's effective date with the PCP
Amount:	Capitation dollars received for the member

For Specialty Capitation, the IPA has entered into agreements with certain specialty providers whereby they are paid an amount of capitation per member per month in lieu of fee-for-service reimbursement for services they will render to their assigned patients.

The following describes the calculation methodology used to compute the monthly capitation payment:

Current Month Members: Member from the current month's eligibility list

Retroactive Members: Retroactive additions or deletions for the prior five (5) months

Net Member Months: Current month eligibility plus/minus retroactivity for prior five (5) months.

Total Due by HP: Total capitation due to provider by health plan

Capitation checks are mailed on or before the 25th of the month for the current month.

Explanation of Payments (EOP):

A sample EOP found is attached and reads from left to right and line by line. Below is an explanation of each column.

Member #:	Health plan eligibility number
Patient #:	Member's account number on bill
Claim #:	Provider group claim reference number
Member Name:	Member's last name and first name
Provider:	Provider name
Group #:	Health plan employer identification number
Service Code:	RVS procedure code
Service Dates:	Dates of service
Diagnosis:	ICD10 Code
Charged:	Amount billed for the procedure
Allowed:	Amount allowed for the procedure
Discount:	Discount amount for procedure
Deduct:	Member's deductible
Copay/Coins:	Member's co-pay to be collected by Provider
Not Allowed:	Disallowed dollar amount
Prepaid:	N/A
Withhold:	Withheld dollar amount based on Provider's contract
COB:	Dollar amount paid by other insurance
Paid:	Dollar amount of write off
EP Codes:	Three digit code for explanation of payment codes (see bottom of EOP for a more detailed explanation of EP codes)

PART 6 - CONTRACTING & NETWORK DEVELOPMENT:

TELEPHONE: (805) 918-4586 FAX: (805) 918-5762 or dl-contracting.identitymso@commonspirit.org

Summary:

The Contracting & Network Development Department of Dignity Health MSO is responsible for contract negotiations and providing contract information which will assist the providers.

Issues to Refer:

Contracts (primary care, specialist, ancillary, hospitals, health plans, etc.)

Letters of Agreement (specific patient, one (1) time contract)

Prospective providers

Questions regarding provider's or IPAs contracted responsibilities

Questions regarding interpretation of contract rates

Third party liability & workers' compensation cases

DOFR disputes

Roster/directory management

Provider database management

Shared risk auditing

Function:

It's the Contracting & Network Development Department's function to ensure that there is adequate provider representation to service our membership. Recruitment of providers is based on current and anticipated needs and from information provided by other departments (Health Services, Credentials, Quality Management and Provider Relations). The department negotiates contracts with providers and prospective providers based upon decisions made by the Boards of Directors.

PHYSICIAN COMPENSATION:

Each PO receives a fixed monthly pre-payment from their contracted health plans and the PO pays their contracted PCPs capitation. The PO pays PCP capitation from these monies. The capitation rate is based upon a fixed dollar amount multiplied by the number of members enrolled with their PCP for the month. It may also be based on a percent of the IPA's capitation revenue for each member. The capitation amount also includes any adjustments for members who are retroactively enrolled or disenrolled with the PCP. The PCP accepts the capitation as payment in full, except for applicable copayments and/or co-insurance for all capitated-covered services provided by the doctor to the member. Capitation is paid regardless of whether or not the member receives care.

Additional compensation for services rendered that are not part of the capitation will be reimbursed according to your contract less any applicable co-payments and/or co-insurance. Please note: Payments for Medicare members are being paid for with Federal Funds, and as such, payments for such services are subject to laws and applicable to individuals or entities receiving Federal Funds.

The Capitation by Detail Report reads left to right and line-by-line. Below is an explanation of each column:

Period:	Report for the Month
Member #:	Health plan eligibility number
Member Name:	Member's last name and first name
Birth Date:	Date of Birth
Age:	Member's age
Sex:	Member's sex
EFFDAT:	Member's effective date with the PCP
EXPDAT:	Member's termination date
Period:	Report for the Month
Amount:	Capitation dollars received for the member
S/C:	Medicare Advantage member = S / Commercial member = C
HMO:	Member's health plan
Group:	Meridian's internal code
Member: Current:	Current member months
PCP:	Total member months for which PCP is receiving capitation
Eligible Members:	Current members' eligible

BILLING INSTRUCTIONS:

Standard claim forms must be submitted every time services are provided to a member, whether these are payable fee-for-service claims or capitated encounter claims. It is a contractual obligation and a regulatory requirement that the PO must receive these claims/encounters and supply full encounter records to the health plans to which the members belong. It also assists the PO in tracking eligibility, capitation and compensation rates to determine if the capitation is appropriate for the population.

Federal and state law requires health plans to report services provided to their members. The encounter is the interaction between the member and the physician. Contractually, the provider is required to report medical services to the PO members monthly. The PO then reports these encounters to the health plans.

1. Please use a separate claim form (electronic or paper) for each member visit.

2. All claims must be submitted no later than 90-days from the date of services. Provider shall certify to the best of their knowledge, information, or believe, as to accuracy, completeness and truthfulness of the encounter data submitted.

3. Please indicate all services provided on the forms along with your charges.

4. Please complete the form entirely and legibly, if not it may be returned.

The following information is required to ensure the timely reimbursement of claims:

Patients full name	Member Name	Subscriber employer
Member date of birth	Subscriber number	Member identification number
Eligibility number	Diagnosis	RVS/CPT Code(s)
ICD-10 Code(s)	Procedure codes	Authorization number
Co-payment amount	EOB from primary ins. (if applicable)	Date of service(s)
Provider name	Amount billed	Billing Provider Tax ID number
Referral authorization #	Physician name and signature	Name of PO
Rendering Provider NPI#	Health Plan	

Do not bill the member. PO members are not to be billed for authorized covered services, except for allowable co-payments and deductibles.

CLAIM & ENCOUNTER SUBMISSION:

Claims Submission

Federal and State regulations require health plans to report specific data regarding services rendered to their members. Providers are contractually required to report services rendered to members monthly to the IPA. The IPA will then report these as "encounters" to the health plans.

1. Please use a separate claim form for each member visit.

2. Please complete the claim forms entirely and legibly to ensure timely reimbursement of claims.

3. Any missing or omitted information may lead to a delay in the claims processing or cause the claim to be rejected and/or returned.

By submitting a claim, the provider is certifying that the data submitted is to their best knowledge, information, or belief as to the accuracy, completeness and truthfulness.

Complete claim elements include:

✓ Insured's identification number (ID#)	✓ Patient's full name
✓ Patient's date of birth	✓ Patient's Address
✓ Insured's name	✓ Insurance plan name
✓ Diagnosis - ICD10 code(s)	✓ Prior authorization number
✓ Date(s) of service	✓ Place of service
✓ Procedure code(S) - CPT, HCPC	✓ Billed amount for each service
✓ Days or Units	✓ Federal Tax-ID number
✓ National Provider Identification number	✓ Signature of physician or supplier
✓ Service Facility Location	✓ Physician billing name and address
✓ Primary Carrier EOB (if applicable)	

Hospital claims must also include:

✓ Admitting physician	✓ Date of admission and discharge
✓ Emergency room reports (if applicable)	

Paper claims must be submitted on a completed CMS-1500 or UB-04 claim form and mailed to:

Dignity Health Medical Network-Ventura
C/O Dignity Health MSO

PO Box 51840
Oxnard, CA 93031

Electronic (EDI) Claims

The IPA accepts claims via Electronic Data Interchange (EDI) using Office Ally. Office Ally is a full-service clearinghouse, offering a web-based service to electronically transmit your claims to the IPA at no charge to the provider/supplier. Dignity Health Medical Network-Ventura Payer ID for Office Ally is: VCIPA

For more information, contact Office Ally at www.Officeally.com or call (360) 975-7000 (option 3).

Claims Timeliness Guideline:

Claims for contracted providers must be submitted within ninety (90) days from the date of service, unless otherwise specified in the provider's contract. Initial claims received over ninety (90) days will be denied for untimely filing. Providers may submit documentation for consideration of extenuating circumstances.

Collection of Copayments and Co-Insurance:

- Copayments – Most members' health coverage requires the member to pay an out-of-pocket fixed amount (copayment) for which the provider of service is obligated to collect. The copayment may vary for PCP and specialists and is dependent on the service rendered and/or per the member's benefit plan. The copayment amount can be found on the member's insurance identification card.
- Co-Insurance – Members may also be responsible for a percentage (co-insurance) of a contracted fee for certain services. Any applicable co-insurance can be verified by contacting the member's health plan.
- MOOP – Most health plans set a limit on the amount a member may pay out-of-pocket for medical services rendered in a policy period (usually a calendar year). This is called the Maximum Out-of-Pocket (MOOP). In the event the member has met their MOOP during the calendar year, no further co-payments are required.

Copayments and co-insurance amounts are deducted prior to payment on all fee-for-service claims.

Claims Payment:

- Claims that are the financial responsibility of the IPA are processed and paid within forty-five (45) working days of the stamped received date for commercial plan members.
- Claims for Medicare Advantage plan members are processed and paid within sixty (60) calendar days for contracted providers.

Claim payments are generated on a weekly basis. Checks are dated and issued every Thursday. An exception occurs when a holiday falls on a Thursday, then the checks will be mailed the previous business day.

Corrected Claim Submission:

If you are resubmitting a corrected claim for processing, please refer to below process:

Electronic Submission (Preferred Method):
Electronic corrected claims should be routed to DHMSO via Office Ally with frequency "7" and "Corrected Claim Number" noted in box 19.

You must submit a corrected claim within ninety (90) days of the submission of the original claim. When doing so, the provider office submitting will need to disable the "Duplicate Claim" filter feature on their Office Ally account. If this is not disabled, Office Ally will reject the claim as a duplicate. Below are the steps to disable duplicates:

1. Log in to www.officeally.com
2. After logging in, on the left-hand side of the page, there will be a list of blue links. Towards the bottom of the page there will be a category title "My Settings". Under that category will be a link title "Admin Section".
3. On the next page, select how long you would like to turn off the duplicate for (e.g., the next 24 hours, 48 hours or permanently).
4. Put your name in the box below so there is record of who chose to turn off the filter.

5. Click the button that says, “Turn Off DePuping”.
6. Another box will pop up asking “Are you sure?” Click “OK”
7. Once this is completed, you can resubmit your claims as necessary.

Paper Copy Submission:

Hardcopy corrected claims should be routed to DHMSO with “Corrected Claim” noted in box 19 of HCFA.

Frequency “7” must be listed on the claim along with the original claim number (next to the field where the frequency is listed). If this is not listed, the claim will be denied as a duplicate.

If you have any questions, please contact Dignity Health Medical Network-Ventura and Provider Services at (805) 604-3308. Thank you.

DUAL COVERAGE AND COB:

Sometimes a member is covered by insurance other than the managed care policy. A physician may be entitled to collect additional monies from the member if he/she has other coverage. Health plans also coordinate payment for medical services if a member has dual coverage. When covered services are provided to a member who has dual coverage, the determination of the order in which benefits are payable and the order in which they are recovered is referred to as “coordination of benefits” (COB).

1. Instruct the office staff to inquire if the member has other coverage and document the information in member’s chart.
2. Determine which plan is the primary and secondary payor when coordinating benefits between two health plans. There are established rules to determine the primary payor. Please call your Provider Relations Representative if you need assistance.
3. The Birthday Rule is used to establish which health insurance plan is primary for children. The parent whose birthday (month and day only) falls closest to January is considered primary.

   Example: Father’s date of birth is 6/17/54

   Mother’s date of birth is 2/27/56

   The mother’s insurance is considered primary in this case.

4. If the parents are divorced or legally separated, the insurer of the parent who had been ordered by the court to take responsibility for the health care of the child/children is primary.

5. If the parents are divorced or legally separated and the court has awarded joint custody without designating who has responsibility for providing health care of the child/children, the birthday rule applies

When the PO is primary, the secondary plan should be billed for covered services. Do not bill the member, except for the co-payment and/or co-insurance, even if the secondary plans have denied the claim. The PCP has been paid for these services through capitation.

Specialists should coordinate COB with the IPA.

REMITTANCE ADVICE (RA) – previously known as EXPLANATION OF BENEFITS "EOB":

The sample RA found in Part 2 under Finance reads from left to right and line by line. Below is an explanation of each column.

Member #:	Health plan eligibility number
Patient #:	Member's account number on bill
Claim #:	Provider group claim reference number
Member Name:	Member's last name and first name
Provider:	Provider name
Group #:	Health plan employer identification number
Service Code:	RVS procedure code
Service Dates:	Dates of service
Diag:	ICD10 Code
Charged:	Amount billed for the procedure
Allowed:	Amount allowed for the procedure
Discount:	Discount amount for procedure
Deduct:	Member's deductible
Copay/Coins:	Member's co-pay to be collected by Provider
Not Allowed:	Disallowed dollar amount
Prepaid:	N/A
Withhold:	Withheld dollar amount based on Provider's contract
COB:	Dollar amount paid by other insurance
Paid:	Dollar amount of write off
EP Codes:	Three digit code for explanation of payment codes (see bottom of EOB for a more detailed explanation of EP codes)

ENCOUNTER DATA SUBMISSION:

Federal law requires health plans to report services provided to their members. The encounter is the interaction between the member and the physician. Contractually, the Provider is required to report medical services to the IPA monthly for their members. The IPA then reports these encounters to the health plans.

NOTE: Encounter forms must be completed for all services including inpatient visits.

Use the same claim submission process as listed previously. Encounter claims are sent in the same method as other claims to the same locations noted.

Part 7 – Incentives – Lightbeam Analytics:

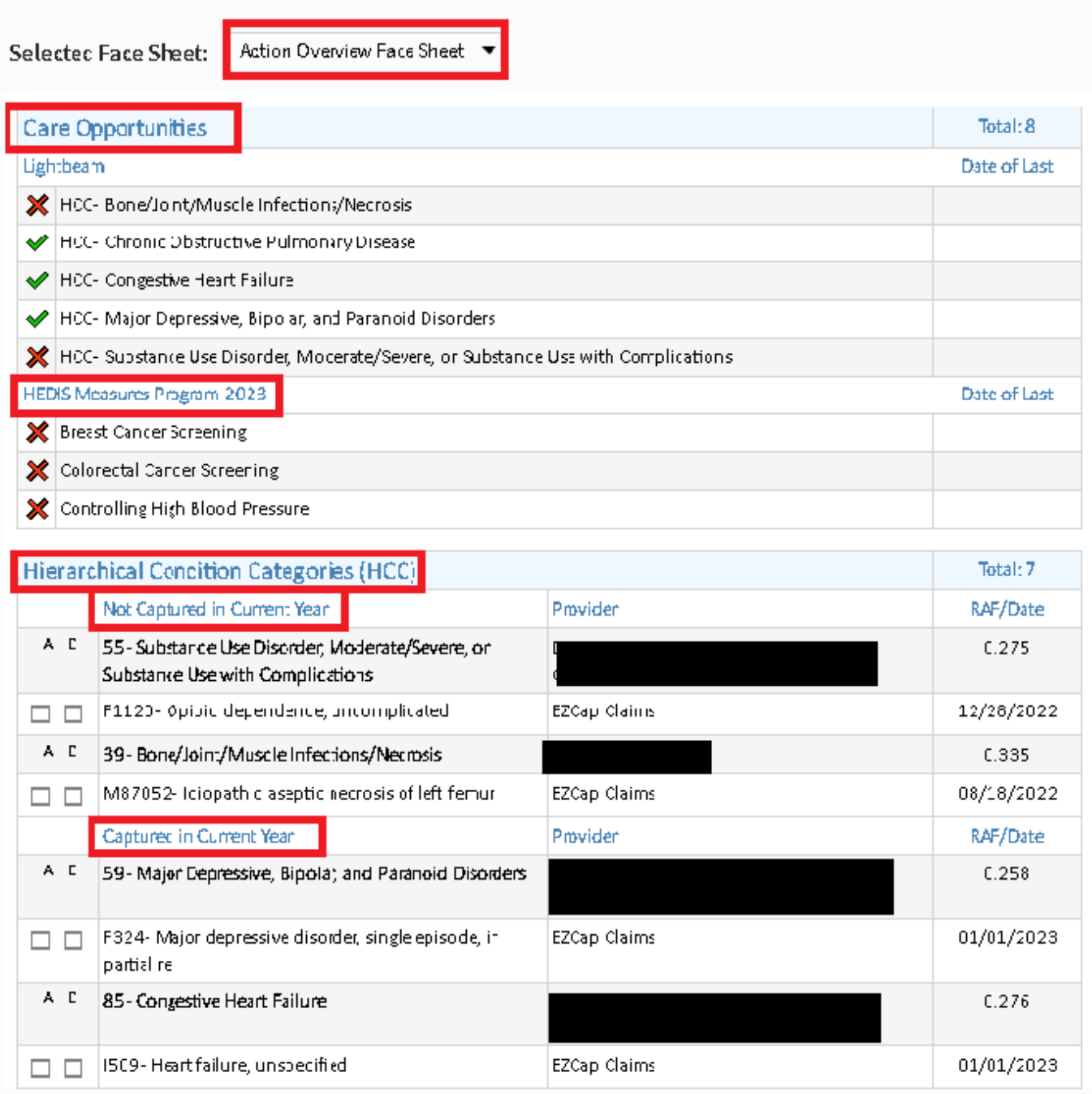
Dignity Health MSO has implemented Lightbeam to help with population health for Dignity Health Medical Network-Ventura. The application is accessible via the Internet. Lightbeam should be used to access Care Gap reports for HMO members and help identify reported HCC's for Medicare Advantage members. For complete patient reports of Annual Wellness Visits, Member Without Visits, Care Gap & HCC Reports please contact the Incentives Department directly at incentives.identitymso@commonspirit.org.com.

Objective:
To access the Incentives Face Sheet for Gaps in Care (Quality Measure Reporting) and the HCC Face.

Procedure:
Follow these simple steps to view this information in NextGen EHR.

1) At the Lightbeam URL window enter credentials: https://identity.lightbeamhealth.com/Account/Login
   a. For the initial login type your **work email address** that you've provided to Dignity Health MSO for correspondence.
   b. Type the default password of "**L1ghtbeam!**"
   c. Click "Sign In" (*this will only have to be entered **ONE TIME** for single sign-on to connect going forward*

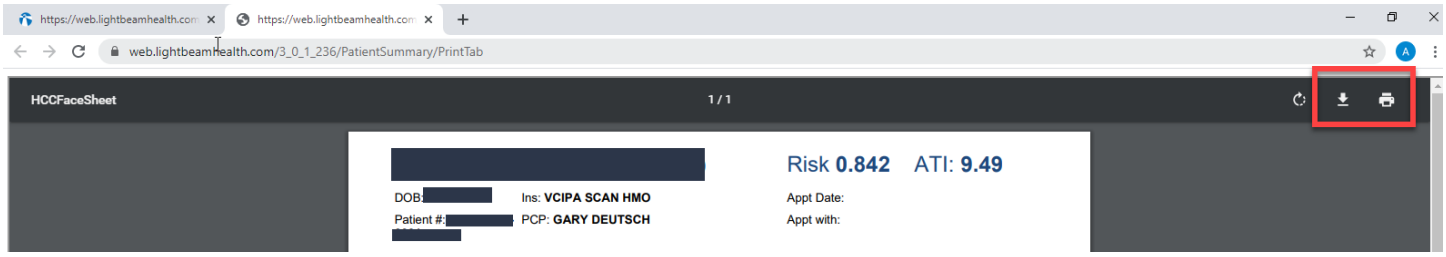
2) Click on Action Overview Facesheet.



3) If you choose to Print the Facesheet(s), click on the orange Printer Button at the top right corner

4) It will open up a new web tab

   d. Select the printer Icon to print to a network printer or the download button to download as PDF


https://web.lightbeamhealth.com
https://web.lightbeamhealth.com
web.lightbeamhealth.com/3_0_1_236/PatientSummary/PrintTab
HCCFaceSheet
1 / 1
[redacted]
DOB: [redacted]
Patient #: [redacted]
[redacted]
Ins: VCIPA SCAN HMO
PCP: GARY DEUTSCH
Risk 0.842
ATI: 9.49
Appt Date:
Appt with:

Part 8 - STATEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES:

Certain rights and responsibilities are conveyed to HMO members by federal and state law, as well as by accreditation organizations. Many of those rights and responsibilities are directly related to UM program activities. The following is the statement of patient rights and responsibilities advocated by our POs, all of which directly or indirectly affect Dignity Health MSO's and your relationships with your patients.

We honor our patients' rights. All of our patients are entitled to be treated in a manner that respects their rights. We recognize the specific needs of our patients and maintain a mutually respectful relationship with them. This is our commitment to the rights of our patients and individuals other than the patient who have legal responsibility for making health care decisions for the patient.

As our patient, you have the right to:

1. Receive health care services regardless of your race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment.
2. Receive information about us and our services, affiliated doctors, health care professionals and providers, and patients' rights and responsibilities, as well as information about your health plan's coverage for services you may need or are considering.
3. Be treated with respect and recognition of your dignity and right to privacy.
4. Be represented by parents, guardians, family members or other conservators if you are unable to fully participate in treatment decisions.
5. Have information about our contracting physician and provider payments agreements, as well as explanation for any bills you receive for services not covered by us or your health plan.
6. Receive health care services without requiring you to sign an authorization, release, consent or waiver that would permit us to disclose your medical information. We will treat information about you, including information about services and treatment we provide, as confidential according to all current privacy and confidentiality laws.
7. Have round-the-clock access, seven days a week, to your primary care physician or on-call physician when your primary care physician is unavailable.
8. Know the name and qualifications of the physician who has primary responsibility for coordinating your care, and the names, qualifications, and specialties of other physicians, and non-physicians who are involved in your care.
9. Have a candid discussion of medically appropriate or necessary treatment options for your condition, regardless of the cost, the extent of benefit coverage or the lack of benefit coverage. To the extent permitted by law, this includes the right to refuse any procedure or treatment. If you refuse a recommended procedure or treatment, we will explain the effect that may have on your health.
10. Actively participate in decisions regarding your health care and treatment plan and receive services at your own expense if we deny coverage. The decision to receive a particular service or treatment rests with you and your treating physician or health care professional.
11. Receive complete information, before receiving care and in terms you can understand, about an illness, proposed course of treatment or procedure, and prospects for recovery, so that you may be well informed when consenting to refuse a course of treatment. This includes:
    - Being able to request and receive information about how medical treatment decisions are made by physicians, health care professionals or providers and our administrators, and the criteria or guidelines applied when making such decisions.
    - An explanation of cost of the care you will receive and what you will be expected to pay out of your own pocket.

Except in emergencies, this information will include a description of the procedure or treatment, the medically significant risks involved, any alternate course of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.

12. Receive information about your medications – what they are, how to take them and possible side effects.
13. Reasonable continuity of care and to know the time, location of appointment, the name of the physician providing care and to be informed of continuing health care requirements following discharge from inpatient or outpatient facilities.
14. Be advised if a physician proposes to engage in experimental or investigational procedures affecting their health care or treatment. Patients have the right to refuse to participate in such research projects.
15. Upon request, obtain a copy or summary of the Utilization Management Program Description and the Quality Management Program Description that we publish annually.
16. Voice complaints or appeals about us or the care we provide.
17. Be informed of rules regarding patient conduct in any of the various settings where you receive health care services as our patient.
18. Complete an advance directive, living will or other instructions concerning your care in the event that in the future you become unable to make those decisions while receiving care through our physicians, health care professionals and providers.
19. Make recommendation about these patients' rights and responsibilities policies.

Our members share responsibility for their care. In keeping with honoring our members' rights, we have expectations of our patients. You have a responsibility to:

1. Be familiar with the benefits, limitations and exclusions of your health plan coverage.
2. Supply your health care provider with complete and accurate information which is necessary for your care (to the extent possible).
3. Be familiar and comply with our rules for receiving routine, urgent and emergency care.
4. Contact your primary care physician (or covering physician) for any care that you may need after that physician's normal office hours, including on weekends and holidays.
5. Be on time for all appointments and notify the physician or other provider office as far in advance as possible for appointment cancellation or rescheduling.
6. Obtain an authorized referral form from your primary care physician before making an appointment with a specialist and/or receive any specialty care.
7. Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible and inform your physician and health care provider if you do not understand the information they give you.
8. Follow treatment plans and instructions for care you have agreed on with your physician and health care professional and report any changes.
9. Accept your share of financial responsibility for services received while under the care of a physician or while a patient at a facility.
10. Treat your physician and health care provider and their office staff with respect.
11. Contact our Customer Service Department or your health plan's Customer Service Department if you have questions or need assistance.
12. Respect the rights, property and environment of your physicians and health care providers, their staff and other patients.

PROVIDER-PATIENT RELATIONSHIPS:

We support mutually satisfactory provider-patient relationships through the availability of culturally and linguistically appropriate providers, equitable balancing of providers' patient caseloads, patients' continuing care needs, and setting expectations for their relationships with patients.

Patients' Rights to Appropriate Providers. As evidenced above, every effort is made to provide HMO patients with providers in an array of specialties appropriate for the unique and current composition of both the medical and cultural needs of patients.

Interpreter Services. We encourage physicians to have the ability, either personally or through their office staff, to communicate in many different languages and serve as interpreters when needed, including ***American Sign Language (ASL)***. Anyone performing such services should be sufficiently proficient in the patient's language to properly interpret medical terms and information. *You may not charge for any interpreter services, including the use of professionals.* If they wish, patients must be permitted to use their own interpreters, including professionals.

The POs managed by Dignity Health MSO hold contracts with ***Life Signs*** for onsite interpreter services and Language Line Services for linguistic services, but they must be authorized in advance through the UM Department. Once authorized, your office may make the arrangements with ***Life Signs*** by calling **(213) 550-4210**. Their fax number is **(213) 550-4205**.

Language Assistance Program (LAP). For linguistic assistance, we offer the Language Assistance Program (LAP). The following page has the health plan telephone contact information to assist you as needed.

For the hearing impaired, Dignity Health MSO also uses the ***California Relay Service*** available through all telephone companies for patients who wish to contact our offices. The toll-free number is **800-735-2929 (TTY)** or **888-877-5378 (TTY)**. Your office also should use the service when needed.

Health Plan Name	Plan LAP Threshold Languages (Other than English)	Plan Interpreter Access	Plan Translation Access (Vital Non-Standard Documents)	Plan Contact For Questions related to Interpreter/ Translation	Additional Resources
Aetna	English, Spanish	800-525-3148	877-287-0117	Nicki Theodorou at 415-645-8264 Megan Rooney at 650-279-6091	N/A
Alignment Health Plan	Spanish, Chinese (traditional),	866-634-2247 (TTY 711)			
Anthem Blue Cross	Spanish, Chinese (traditional), Vietnamese, Tagalog, Korean	888 254-2721	888 254-2721	800-677-6669	www.anthem.com/ca Note: Cultural & Linguistic resources are available on the Provider Home Page, under Provider Services

Health Plan Name	Plan LAP Threshold Languages (Other than English)	Plan Interpreter Access	Plan Translation Access (Vital Non-Standard Documents)	Plan Contact For Questions related to Interpreter/ Translation	Additional Resources
Blue Shield	Spanish, Chinese (Traditional), Vietnamese	Providers: Over-the-phone interpretation 800-541-6652, follow IVR menu; On-site interpretation services call 800-541-6652, dial "0" and speak to a Provider Services Agent to arrange for an interpreter.	Please fax Language Services Request Form & and document requiring translation to 209-371-5838	Email: LanguageAssistance@ blueshieldca.com or call your Provider Relations representative	www.blueshieldca.com/providers
Health Net	Oral translations in all languages, print translations Spanish and Chinese	Call the number on the member's ID card or HMO, PPO, POS, Medicare Supplemental members 800-522-0088, After hours and weekends 800-546-4570. The following are 24/7 access numbers: Individual and Family Plan (IFP) members 800-839-2172. Healthy Families, Healthy Kids or AIM members please call 888-231-9473. MediCal members 800-675-6110	Translation access questions contact Diana M. Carr, Manager C&L services at 626-683-6307	800-522-0088 Customer Contact Center, after hours and weekends 800-546-4570	
Humana					accessibility@humana.com.
SCAN		800-559-3500 (TTY 711)			https://scan.cqfluencyvri.com
United Healthcare	Spanish, Chinese	800-730-7270 Spanish; 800-938-2300 Chinese; 800-624-8822 English (and All Other Languages)	800-730-7270 Spanish; 800-938-2300 Chinese; 800-624-8822 English (and All Other Languages)	800-730-7270 Spanish; 800-938-2300 Chinese; 800-624-8822 English (and All Other Languages)	www.pacificare.com www.pacificarelatino.com www.pacificareasia.com

Practice Closures: PCP practices are not limited to a set number of HMO patients. In order for a PCP to close his or her practice to new patients, the PCP must complete a special form for review by the Board of Directors of your PO. The Board evaluates whether an increase in patient census and or a significant imbalance in the type of patients customarily seen by that provider exists.

Continued Care Following Provider Termination: Contracting specialists are required to notify the Contracting Department at least 90 days in advance when terminating their contracts.

This requirement is governed by state and federal law. It is very important you provide that advance notice so that patients who have been under your care can be notified well in advance of the termination effective date of their right to continue to receive care from you.

HMO patients whose specialist's employment or contractual arrangement terminates[4] are entitled by law to continue care with that provider after the termination date, provided the terminating provider agrees to continue such care under the same contractual terms of the terminating agreement or other terms that may be negotiated for an agreed upon period. The patient must meet specific criteria to qualify for the continuation, which differ somewhat depending upon whether the patient is enrolled in a Commercial HMO plan or a Medicare Advantage HMO plan. The duration of the continued care varies.

Generally speaking, the continuation may be provided under the following circumstances:

Patients who are in active treatment for a serious chronic or acute medical condition

Patients who are pregnant

Children between birth and 36 months whose care was initiated with the terminating provider

Patients for whom surgery or another procedure has been authorized prior to the provider's termination in connection with a documented course of treatment and recommended by the terminating provider

Patients being treated for a terminal illness

Patient Requests to Change PCPs and Voluntary Transfers from a PO: HMO patients' requests to change their chosen PCP are honored in most instances. Exception to this policy may be made if there is evidence that the patient's request is an attempt to subvert acceptable medical practices, such as compliance with treatment recommendations and plans or prescription-seekers. In such instances, the patient's health plan is requested to disenroll the patient from the medical group/IPA entirely.

Requests from HMO patients for voluntary departures from your PO are directed to the patient's health plan. Reports of such transfers provided by the health plans are reviewed to identify underlying issues with providers or the organization as a whole.

Terminating a Physician-Patient Relationship: Providers are entitled to set expectations for their relationships with patients, and Dignity Health MSO has the right to maintain viable business relationships with their providers' patients. Patients who do not collaborate with their providers or Dignity Health MSO in maintaining a mutually satisfactory relationship are subject to transfer of their affiliation to another provider or, in extreme cases, another medical group/IPA. Under certain circumstances, physicians may terminate their relationship with a patient due to behaviors that affect or interfere with treatment objectives.

[4] This policy does not apply to specialists whose contractual arrangements are involuntarily terminated for cause, nor to those (a) relocating out of the area and no longer available within a reasonable distance to members or (b) leaving practice.

Consistent with health plan policies, three levels of severity have been established to quantify the degree of the patient's offenses so that any action taken is appropriate for the offense. For details of the circumstances when disciplinary action may be taken against an HMO patient, please contact the Dignity Health MSO's **Provider Relations Department** (see **Part 2**).

Part 9 - Compliance, Attestation & Training:

Federal law prohibits entities that participate in federal health care programs (including Medicare, Medicaid, and other governmental programs), such as Dignity Health MSO, from entering into or maintaining certain relationships with individuals or entities that have been excluded from participation in federal health care programs. The Medicare statute also excludes from coverage any item or service that has been ordered, supervised, or furnished by an individual or entity during time when the individual or entity has been excluded from the federal program.

The purpose of this policy is to set forth the procedures Dignity Health MSO follows in determining whether potential and current Dignity Health MSO employees and/or contractors are excluded from participation in such federal programs.

POLICY:

Dignity Health MSO will perform initial, monthly and/or ongoing exclusion reviews to ensure that employees, vendors, contractors, and physicians have not been sanctioned or excluded from participating in any federal health care program as prohibited by federal law.

For purposes of this policy, an "ineligible individual/entity" is anyone who:

a. Is currently excluded, debarred, or otherwise ineligible to participate in the federal health care programs or in federal procurement or non-federal procurement programs; or
b. Has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred, or otherwise declared ineligible.

If Dignity Health MSO identifies an ineligible individual/entity in the Exclusions verification process, the MSO Legal Counsel will be contacted for advice and direction on proceeding with an appropriate course of action.

PROCEDURE:

The following screening procedures will be conducted by various Dignity Health MSO departments.

a. Human Resources Screening
b. Screening Prior to Hire

Prior to the hiring of any Dignity Health MSO employee, the Human Resources Department will screen all potential employees by:

1. Requiring applicants to disclose whether they are ineligible; and
2. Reviewing the United States General Services Administration List of Parties Excluded from Federal Programs ("GSA Exclusion List") and the United States Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities ("OIG Exclusion List").

The Human Resources Department shall notify the Compliance Office and MSO Legal Counsel of any matches found during any of the above screening processes. If a potential employee is determined to be an Excluded Individual, the individual will no longer be eligible for hire.

1. At hire

After hire, all employees are required to complete the Code of Conduct training, and sign the "*Acknowledgement of Standards of Business Conduct Handbook*" (Appendix A) included in the Corporate Compliance Handbook to certify that the employee has not been excluded, has no knowledge of an impending exclusion, and agreement to notify the Compliance Office if they should become aware of their potential exclusion.

2. Annual Screening

Upon the effective date of this policy, and annually thereafter, Dignity Health MSO will screen all current employees to verify that all existing employees have not been excluded from federal programs since the last review.

If Dignity Health MSO identifies that a current employee is an ineligible individual/entity in the Exclusions verification process, MSO Legal Counsel will be contacted for advice and direction on proceeding with an appropriate course of action.

3. Credentials Verification

a. Annual Screening. The Dignity Health MSO Credentialing Department shall, on an annual basis, conduct a cross-reference screening of the OIG Exclusion List database with current active:

i. Physician/practitioners in the Dignity Health MSO Medical Staff Services database.
ii. Non physician; any licensed staff and/or person responsible for or involved in patient care to be run monthly by Human Resource department

b. Monthly Screening. The Credentialing Department shall, on a monthly basis, review the updated List of Excluded Individuals on the OIG Exclusion List and compare it to the current active practitioners in the Medical Staff Services database.

Initial Appointment/Reappointment Screening. The Credentialing Department shall query the OIG Exclusion List as part of its primary source verification process for each application for appointment to the medical staff in accordance with the Credentialing Department policies and procedures. Potential medical staff members will be required to, as part of the appointment/reappointment process, warrant that the applicant has not been excluded from a federal health care program.

The Credentialing Department shall notify the Compliance Office and MSO Legal Counsel of any matches found during any of the above screening processes.

4. Accounts Payable

The Dignity Health MSO Accounts Payable Office ("Accounts Payable") shall screen all new vendors/contractors who have submitted a request for payment for services rendered to Dignity Health MSO.

Upon the effective date of this policy, and annually thereafter, Accounts Payable will screen all current vendors to verify that all existing vendors and contractors have not been excluded from federal programs over the course of the year since the last review.

Accounts Payable shall notify the Compliance Office and MSO Legal Counsel of any matches found during any of the above screening processes.

5. Purchasing

Prior to completing a contract for services, the Dignity Health MSO Materials Management Department ("Material Management") will screen all potential vendors and contractors. Potential contractors will be required to warrant that none of the vendor's employees have been excluded from a federal health care program.

Materials Management shall notify the Compliance Office and MSO Legal Counsel of any matches found during the above screening processes.

6. Compliance Office

The Compliance Office shall request annual reports from the above departments regarding their screening activities and may audit each department's files, as necessary.

Confidentiality Agreements:

Confidentiality and Conflict of Interest Statement for Board Committee Members, Board Committee Guests, Physician Reviewers

As a member of the Dignity Health Medical Network-Ventura provider network charged with the duties of evaluating and improving the quality of care rendered and/or financial and business affairs, I recognize that confidentiality is vital to the free, candid and objective discussions necessary for effective management. Therefore, I agree to respect and maintain the confidentiality of all discussions, deliberations, records, and other information generated in connection with all Board Committees and other IPA-related activities, and I understand that by signing this agreement I am binding myself by contract to maintain such confidentiality. I agree that I will not make any disclosure of such confidential information except to person (s) authorized to receive such information.

Furthermore, I am relying on every other member of the Board Committee to similarly preserve the confidentiality of these activities. I understand that other Board Committee members entered or will enter into agreements identical to this one and I am beneficiary of such agreements. I enter into this agreement for the express benefit of the other members of the Board Committee, providers in the network and other individuals involved in the business affairs and for the express benefit of the IPA.

I also agree that should a conflict of interest occur with respect to any matter being reviewed or brought before the Board Committee, I will report the conflict of interest to the Chairperson of the Committee or the person requesting review. I will then refrain from casting a vote on any related issue(s) or absent myself from discussion or activity. A Board Committee member may be deemed to have a conflict of interest if he/she has involvement in the care of the patient, and/or fiduciary interest or other involvement in the issue under discussion, which impairs objectivity.

Utilization decision making is based on appropriateness of care and services and existence of coverage. Dignity Health Medical Network-Ventura and Dignity Health MSO do not offer financial incentives based on the review of authorization requests or utilization management decision making, nor encourage denials that result in underutilization. Providers in the network are ensured independence and impartiality in making referral decisions.

Name of Board Committee (QI, UM, Credentialing, Board of Directors, etc): _____

Name: _____

Signature: _____

Date: _____

ACKNOWLEDGMENT OF STANDARDS OF BUSINESS CONDUCT

My signature on this form acknowledges that I have received from Dignity Health MSO and agree to read the Dignity Health MSO Compliance Handbook.

I confirm that I have not been excluded by the federal government from participation in any governmental program nor, to the best of my knowledge, have I been proposed for exclusion. I agree to notify the Compliance Officer or the Human Resource office immediately upon my receiving written or verbal notification that

I am proposed for exclusion from any governmental health program.

Name (please print)	Signature
Date	Department

CONFIDENTIAL INFORMATION

Please be advised that any employee or party accessing confidential protected health information is obligated to abide by the laws and regulations as required by the HIPAA Privacy Standards. Any unauthorized disclosure of confidential information is strictly prohibited.

HIPAA

Local HIPAA Compliance Liaison, Cheryl Stempson:

- Questions
- Complaints
- Incidents
- Patient Requests or Restrictions

Email: cheryl.stempson@commonspirit.org

Part 10 – How to Contact Us:

If you have questions about requirements or procedures or need assistance, please contact the appropriate Dignity Health MSO Department as indicated below:

Provider Relations:

- Phone: (805) 604-3308
- Fax: (805) 918-4057
- Email: dl-providerrelations.identitymso@commonspirit.org

Customer Service:

- Phone: (805) 604-3308 or (877) 299-5599
- Fax: (805) 918-4095
- Email dl-customerservice.identitymso@commonspirit.org

WAIVER FORM:

I have enrolled in _____ health plan.
(Health Plan Name)

I understand my eligibility status does not appear on the current eligibility list provided to _____

_____.
(Provider Name)

If eligibility is not established is not established in the next 60 days, I assume full responsibility for all charges incurred by dependents and myself.

_____ _____
Today's Date Patient's Date of Birth

_____ _____
Print Patient Full Name Patient Signature

_____ _____
Subscriber's Full Name Employer

_____ _____
Subscriber's Date of Birth Employer Telephone Number

_____ _____
Subscriber's Social Security Number Witness Signature

Verification of Eligibility Requested by: _____ Date:_____
(Provider's Name)

Health Plan Representative: _____ Temporary Authorization #: _____
(Name)

Dependents Covered:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Effective Date: _____ Co-Payment Amount: _____

APPENDIX – SAMPLE MEMBER INTRODUCTION LETTER FOR PRIMARY CARE PHYSICIANS:

Dear Member:

We welcome you to our office and are pleased you have chosen us as your Primary Care Physician (PCP).

Because HMO health plans (managed care organizations) are different from other forms of health insurance, we have found it helpful to provide some guides as to the best use of your plan.

We are members of a Provider Group, which contracts with health plan to provide Provider Services within the plan benefits. As such, we act as the PCP.

There are some basic rules governing the care, which will prevent any misunderstanding of how this system works for you.

We operate on an appointment system, so please call if you need medical care. You should be able to be seen in a timely manner. Please call in advance for routine appointments. If you are ill, we may be able to advise you over the telephone or we may need to see you. Please be prepared to come to the office whenever we can schedule you. It may also be that you may have to wait a day unless your illness is severe and/or quite acute. We will do our best to accommodate you promptly when you call. Be sure to make it clear to the nurse or receptionist you have an acute problem if you think your need for medical care is urgent.

There are providers on call 24 hours a day, every day of the year. It may not be your own doctor's associates. If you should require medical services when the office is closed immediately, and the doctor on call will advise you on the best course of action. It is of utmost importance you call before going to the emergency room, whenever possible.

We provide primary care service, which include all basic medical care, including well women examinations. Specialty care, such as surgery requires a referral from your PCP when medical indicated. If a member decides to go to a specialist without an approved referral, it may be the member's responsibility to pay the Provider for the service.

If your plan has a co-payment requirement, you must pay this fee at the time service is provided.

Specialty Providers must obtain authorization for additional services by contacting your PCP (this could include, but is not limited to, services such as laboratory, x-ray, surgical procedures, follow-up visits, etc.). Failure to obtain an authorization could result in a denial of reimbursement to the provider of service.

We understand many of our members have seen Specialty Providers in the past as a regular source of care. However, unless it is medically indicated and authorized, routine visits to those Specialty Providers may not be covered by your plan.

We also understand this is a change for many people who have been accustomed to choosing their own doctor for a particular problem. However, unless it is medically indicated and authorized, routine visits to those Specialty Providers may not be covered by your plan.

We also understand this is a change for many people who have been accustomed to choosing their own doctor for a particular problem. However, in order to provide cost effective coverage without large out of pocket costs to you, your plan requires your PCP direct your care. We encourage you to discuss these matters with us so we may address your expectations.

Additionally, please remember the decision making is based only on appropriateness of care and service and the providers in our group or other individuals conducting utilization review for denials of coverage or services are not

compensated to encourage barriers to care or service. Also, financial incentives for the decision makers do not encourage denials of coverage or service, nor are incentives used to reward in appropriate restriction of care as special concern must be kept in mind regarding the risk associated with under-utilization. According to your health plan agreement, if you have other insurance coverage, you are obligated to inform us so we may coordinate the benefits.

We feel this is an excellent plan, which provides you with high quality, affordable medical care. Should you require such services, we have the finest specialty and sub-specialty Providers available to you in our community.

We encourage your participation in making decisions regarding your medical care, and your active participation in disease prevention and wellness. It is your right and responsibility to access regular physical examinations and preventive services such as health screening tests and immunizations, and to participate in health education and health maintenance activities. With your cooperation, we are committed to provide you with quality health care.

If you have any questions regarding the benefits to which you are entitled, please refer to your plan benefits booklet, or call your health plan directly.

Sincerely,

Provider Organization (Dignity Health Medical Network-Ventura)

GLOSSARY:

Annual: Refers to a 12-month period, with a 2-month grace period.

Benefit Plan: Refers to the specific services available to an enrollee under the HMO agreement with the employee.

Capitated Services: Those services listed in the Covered Services of the IPA/Medical Group and hospital contracts which IPA/Medical Group and hospital are each responsible for providing a fixed amount of reimbursement per member per month.

Capitation: A prepaid monthly fee made to the IPA/Medical Group and hospital for each enrollee in exchange for the provision of comprehensive health care services to enrolled members.

Concurrent Review: Review of a patient's chart, including verification of necessity of treatment and need for continued treatment, conducted during the course of treatment.

Conversion Factor: The dollar amount to be applied to each relative value unit in a relative value scale to determine the payment amount for physician services.

Co-Payment: A charge to a patient receiving medical care which is required by the health plan to be collected by the Provider of care.

Coordination of Benefits (COB): When a patient is covered by two or more group health plans, coordination of benefits divides the responsibility of payment between the health plans so that the coverage combined will pay up to 100% of hospital and professional services within the limits of all contracts.

Dependent: Includes spouse and children of the subscriber who receive coverage through the subscriber's health plan.

Eligibility: A determination of whether a member is covered by the health plan for medical services.

Enrollee: Any person, or eligible dependent, who is enrolled in the health plan.

Evidence of Coverage: Description of health insurance benefits as well as limitations and exclusions provided to each member by the health plan.

Fee for Service: A method of payment to physicians for all services authorized based on a specific dollar amount for each service.

Health Care Financing Administration (HCFA): The federal agency responsible for administering Medicare and overseeing states' administration of Medicaid.

Health Maintenance Organization (HMO): A prepaid health plan licensed by the appropriate state agency (for example, in California, HMOs are regulated through the Department of Managed Health Care (DMHC).

Individual Plan: A benefit plan available to individual members who chose their eligibility for coverage through their employer.

Independent Physicians Association (IPA): A network of private practice physicians and allied health professionals established to facilitate referrals and to contract with HMO's and other third-party payors.

Medical Assistant (MA): An individual trained to perform a minimal amount of nursing duties and laboratory procedures, as well as front-office duties.

Member: A subscriber or dependent entitled to receive medical services from Providers.

National Committee for Quality Assurance (NCQA): A Washington DC group that develops HMO accreditation standards.

Non-Covered Services: Health care services which are not benefits under the subscriber's evidence of coverage.

Nurse Practitioner (NP): A nurse with additional extensive training who is licensed to perform duties beyond the scope of the nursing profession.

Open Enrollment: The Annual period during which employees of a company may change their health insurance coverage.

Out of Area: The geographic area identified per health plan contract to be outside of the regular service area of the IPA/Medical Group (typically a 30-mile radius from PCP site).

Participating Physician: A legally qualified physician who has entered into an agreement with the HMO or with one of the hospitals or physician groups to provide physician services to enrollees of the HMO.

Per Diem Rates: Cost figures negotiated with Providers to cover specific services rendered in a 24-hour period beginning at 12am or for a one-day admission.

Pre-Admission Review Program: A process by which the Provider Group will arrange for the admission of Enrollees to the primary hospital or referral to other hospitals.

Premium: Refers to the fee paid by an employer to the health plan as compensation for the provision of health care services.

Primary Care Physician (PCP): Is the Provider Group physician selected by an Enrollee to render first contact medical care and may include physicians whose training is in family practice, general practice, internal medicine and pediatrics.

Primary Hospital: Is the hospital selected by the HMO and the Provider Group where the majority of Enrollees' inpatient care is to be provided.

Provider: Physicians, hospitals and other health care professionals providing health care related services to health plan Enrollees.

Quality Management: The process established to ensure that the quality of medical services rendered meets or exceeds objective standards developed by knowledgeable health professionals and that services provided are medical necessary and provided in a timely manner.

Remittance Advice (RA): Written explanation of benefits, pertaining to claim processing.

Referral: The process by which the PCP directs an Enrollee to seek and obtain covered services from other contracted health professionals.

Retrospective Review: Review conducted following the patient's treatment.

Service Area: The geographic area identified per health plan contract to be within a certain mile radius of the IPA/Medical Group (typically within a 30-mile radius from PCP site).

Shared Risk Services: The inpatient and other patient care services which are subject to a formula for determining the amount and distribution of risk sharing incentives between the IPA/Medical Group, primary hospital and HMO.

Stop Loss: An insurance program limiting the financial liability of a Provider group for any given member.

Subscriber: The adult who selects coverage by HMO through his/her employer.

Subscriber Group: Is the organization, firm or other entity contracting with HMO's to arrange health care services for employees and their dependents.

Subrogation: The assumption by a third party (as a second creditor) of another's legal right to collect a debt or damages.

Utilization Management (UM): The process established to assure that services rendered are medically necessary and provided in the most cost-effective manner, consistent with the maintenance of high-quality standards of practice.