UMG - HEALTH CARE HERALD

News From ProMed Health Care Administrators & Upland Medical Group
Winter 2007

President's Message

By Jeereddi A. Prasad, M.D., President

I wish all of you a happy and healthy New Year. This is the time of open enrollment. Inter Valley enrollment is growing gradually. UMG has concluded Secure Horizon contract. This gives access to two major Senior contracts to our providers.

We are very optimistic about the group's growth in 2008. I thank all of you for the support.

Thank you.

ACTION
HAVING THE WORLD'S BEST IDEA will do you no good unless you act on it. People who want milk shouldn't sit on a stoop in the middle of a field in hopes that a cow will back up to them.
CURTIS GRANT
writer

INSIDE THIS ISSUE

Provider Services

By: Dawn Tumser, Provider Relations Supervisor

HEALTH EDUCATION

ProMed's Contracted HMO's make available to your members a wide variety of health education materials in mandated state health topics that have been reviewed for cultural sensitivity, appropriate reading level, and medical accuracy.

Materials are available in the following languages: English, Spanish, Armenian, Chinese, Farsi, Khmer, Vietnamese, Russian, and Korean.

Topics include:

- Birth Control Options
- Controlling High Blood Pressure
- Controlling your Cholesterol
- How to Breastfeed
- How to Prevent the Spread of Tuberculosis
- Nutrition During Pregnancy
- What are STDs?
- What is Asthma?
- What is Prenatal Care?
- What is Type 2 Diabetes?

If you would like to order copies of these Health Education Topics, please contact Dawn Tumser at (909) 932-1045 Ext. 4673.

PROVIDER UPDATES

New Providers
Truong Duong, MD – Electrophysiology
Surjit Kahlon, MD – Peds Neurology
Sachin Patel, MD – Orthopedic Surgeon
Peter Samaan, MD – Family Practice

Provider Address Changes

Jaffar Tremazi, MD
1904 N. Orange Grove Ave.
Pomona, CA 91767
(909) 469-1823

Providers No Longer with UMG
Tamuyen Nguyen, MD
Richard Chang, MD

NCQA UM Standards

By: Kit Thapar, M.D., ECO/CMO

All providers are reminded that medical necessity decision-making is based on appropriateness of care and service and not based on benefit design or coverage. IPA does not compensate physicians or nurse reviewers for denials. IPA does not offer incentives to encourage denial of coverage or service and notes that special concern and attention should be given to the risk of underutilization.

a) Availability of UM criteria
The criteria used in the determination of medical appropriateness of services are clearly documented and include procedures for applying criteria in an appropriate manner. This criteria application process includes procedures, which recognize the needs of individual patients and the characteristics of the local delivery system. This information is available, upon request to providers.

IT'S AMAZING how much we are creatures of habit and resistant to change. A radio announcer on KLOS in Los Angeles, about 30 minutes after a major earthquake, made these conflicting statements:

"The telephone company is urging people to please not use the telephone unless it is absolutely necessary in order to keep the lines open for emergency personnel. We'll be right back after this break to give away a pair of Phil Collins concert tickets to caller number 95."

MICHAEL HODGIN
1001 More Humorous Illustrations For Public Speaking
Zondervan Publishing House

UMG News in Review – Qtr. 3, 2007 Memos

By Karen Harvey, Executive Assistant

UPDATED PROCESS WITH NEW BLUE CROSS INJECTABLE VENDOR – October 25, 2007

We have received numerous calls regarding my memo dated September 26, 2007 transitioning injectable medications to Blue Cross California Care's (BCCC) new vendor PrecisionRX Specialty Solutions. First, let me apologize for the confusion. We have made the following change to ensure you don't have continued problems obtaining injectables for your BCCC members.

Effective immediately, ProMed Health Care Administrators will resume authorizing all your injectable medications for BCCC members. If the member meets the health plan medical criteria for the injectable requested, the authorization will be modified to PrecisionRX and faxed to your office. You must still obtain the medication through PrecisionRX. They will dispense the medication either to your office or to the patient's home with the authorization we will provide.

We realize this transition has not been smooth; however, BCCC has instructed us that we must use the new vendor. They will no longer allow us to pay your claims and seek reimbursement. We appreciate your continued patience and cooperation.

If you have any questions, please don't hesitate to call our Customer Service department at
(909) 932-1045, press option 1.

Documentation and Coding – November 29, 2007

PacifiCare has contracted with a physician who is also a certified coder to provide a monthly newsletter on Documentation and Coding.

The purpose of this newsletter is to provide information that can be utilized to increase documentation and coding practices, which will facilitate a more accurate patient health status. Each month a new subject will be addressed.

UMG News in Review *continued on page 3*

Please recall, CMS (Center for Medicare and Medicaid Services) reimbursement to IPAs is based on the morbidity of Medicare enrollees. Therefore, failure to code patient medical conditions appropriately will decrease payments to IPA physicians from CMS.

It is ProMed's intention to share these newsletters monthly with our contracted IPA PCPS. Additionally, each month's topic will also be shared with our appropriate contracted specialists. I have also attached a copy of the Coding class held at the Corona Regional Medical Center, August 14, 2007 from 9-1.

November 2007 Topic: Ruling Out Diagnoses

If you have any questions or suggestions on specific coding or documentation issues you may:

- Contact Angelice Wilson: angelice.Wilson@phs.com OR
- Contact Dr Kit Thapar or myself at ProMed.

New Laboratory Vendor *** Effective 2/1/08*** - December 4, 2007

Effective 2/1/08, Pomona Valley Medical Group (PVMG) and Upland Medical Group (UMG) will switch from Quest Diagnostics Laboratory to Lab Corporation of America (Lab Corp). We are communicating this change early to ensure a smooth transition. Additional information as received will be forthcoming.

Attached please find a flier (see page 5) that you can provide to your UMG patients communicating the transition from Quest Diagnostics Laboratory to Lab Corp.

- *If your patients need lab services prior to 2/1/08, please provide them with a Quest Diagnostics lab form and attach the flyer so they are aware of the 1/31/08 expiration date. All Quest Diagnostics lab forms will expire 1/31/08.*
- *Lab Corp will be contacting your offices within the next few weeks to provide you with new Lab Corp forms and locations for your members.*
- *If your patients do not require lab tests before 2/1/08, please refrain from providing lab forms until you receive the new forms from Lab Corp. All Lab Corp referral forms will be valid effective 2/1/08.*

If you have any questions, please don't hesitate to call our Customer Service department at either number below:

PVMG: (909) 932-1045, press option 1
UMG: (909) 291-4400, press option 1.

HMO DISEASE MANAGEMENT PROGRAMS – December 11, 2007

Disease Management programs are available thru the HMOs to assist you with managing your at Risk patients. Some of these programs include management for; Asthma, Diabetes, COPD, CAD and CHF to name a few. HMO Clinical Practice Guidelines for each program are also available on their websites.

ProMed is committed to help our health care providers render the best care possible for your patients. We encourage you to take advantage of these programs as well as encourage your patients to contact their HMO for enrollment in the Disease Management programs.

HEALTH PLAN	WEB SITE ADDRES	DISEASE MGMT. PHONE NUMBER
Aetna	www.aetna.com	1-866-269.4500
Blue Cross of California	www.bluecrossca.com	1-800-522.5560
Blue Shield	www.mylifepath.com	1-877-289.4415
Cigna	www.cigna.com	1-800-344-7421
InterValley Health Plan	www.intervalley.com	1-800-251-8191 ext 448
PacifiCare / Secure Horizon	www.pacificare.com	1-877-840-4085 Commercial & Seni

NO LIONS ARE EVER CAUGHT in mousetraps. To catch lions you must think in terms of lions, not in terms of mice. Your mind is always creating traps of one kind or another, and what you catch depends on the thinking you do. It is your thinking that attracts to you what you receive.

THOMAS DREIER
Writer

MDQuickFax™

Helping doctors get useful information, quickly.

Zack Gerbarg, MD, CPC (certified professional coder), editor

Diagnosis Documentation and Coding: Ruling Out Diagnoses

Physicians face the common problem of not always being able to make a definitive diagnosis. How should you approach diagnosis documentation and coding in this situation?

When you suspect a diagnosis or are in the process of evaluating a patient, there are several things you can do to document and code this in your progress note:

- Document the patient's symptoms and signs and select diagnosis codes that correspond to them, typically ICD-9 codes in the range from 780 to 799. Some examples include:

ICD-9 code	Documentation
780.4 786.05	Dizziness, light-headedness, or vertigo
786.50 790.4	Shortness of breath
	Chest pain
	Non-specific elevation of transaminase levels

- For example, if a patient presents with intermittent chest pain, document the symptom as "intermittent chest pain" or "chest pain, rule out angina" and use the ICD-9 code for unspecified chest pain (786.50).
- If you then do a stress test which is abnormal, you can document the more definitive diagnosis of angina (ICD-9 code 413.9), but if you rule out angina, then the diagnosis stays as the symptom of chest pain.
- Once you make a definitive diagnosis, you should not submit the ICD-9 code for a symptom that relates to that diagnosis. In the example above, a patient with angina who has chest pain would only have the ICD-9 code for angina submitted with the claim.

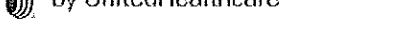
One of the few situations when you can add an addendum to your progress note in the medical record is when you get the results from a test that confirms a diagnosis. This typically should be within several weeks of the patient visit.

- In this situation, you can write an addendum to the existing progress note – state the date, the test result, the definitive diagnosis, and the follow up plan and then sign your name. You can resubmit your claim with the new diagnosis information.

Do not use a definitive diagnosis code until a diagnosis is confirmed. As one example, we have seen a number of cases where a diagnosis code for HIV infection (ICD-9 code 042) has been submitted with a claim when the physician is ordering a screening test to rule out the diagnosis. It is all right to document "rule out HIV" in the progress note, but you should also document any symptoms or signs and submit the appropriate diagnosis codes.

Basic principles of diagnosis coding:
Every patient should be seen at least once each year with all significant medical diagnoses reviewed and documented in the medical record which is dated and signed by a physician. **A claim or encounter for each physician visit should be submitted that includes specific codes for all diagnoses that are documented in the medical record.**

The information and examples provided above are minimal documentation to support diagnosis coding as only one part of a complete progress note. Final decisions about diagnosis coding should be based on review of standard reference materials.



ATTENTION ALL

UPLAND MEDICAL GROUP

MEMBERS.

THE ATTACHED QUEST LABORATORY REFERRAL IS ONLY VALID UNTIL 1/31/08.

EFFECTIVE 2/1/08, ALL LABORATORY SERVICES MUST BE PROVIDED BY:

LABORATORY CORPORATION OF AMERICA. (LAB CORP)

IF YOU DO NOT USE THIS REFERRAL PRIOR TO 1/31/08, YOU NEED TO CONTACT YOUR PRIMARY CARE PHYSICIAN TO OBTAIN A NEW REFERRAL FORM FOR LABORATORY CORPORATION OF AMERICA.

WE APOLOGIZE FOR ANY INCONVENIENCE THIS MAY CAUSE AND APPRECIATE YOUR MEMBERSHIP. IF YOU HAVE ANY QUESTIONS, PLEASE CALL CUSTOMER SERVICE AT (800) 281-8886.

THANK YOU!

Medical Record Standards

By: Cyndy Locatelli, QM Coordinator

1. Chart Organization

The record is to be maintained as follows:

1) Each member medical record must be individually trackable.
2) The record is secured to maintain confidentiality. Paper clips are not acceptable.
3) Every page in the record contains the member name or ID number.
4) All entries contain author identification and are legible and dated.
5) There is a section for Biographic/Personal data. *There should be evidence this data is reviewed and updated every two years.* Data elements contain Address, Employer to include phone number, DOB, emergency contact, including phone number, marital status.

2. Documentation Element Guidelines (Asterisk items are required for review)

1) Each page in the record contains the patient's name or ID number. Chart contents are secured.
2) There is personal biographic data that information should be updated every two (2) years. For Pediatric members, at least one parent's employer is to be documented.
3) All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, unique electronic identifier or initials.
4) All entries are dated.
5) ** ***The record is legible to someone other than the writer.***
   ** ***Primary Language Documented***
   ** ***Interpreter Request Documented***
6) *Medication allergies and adverse reactions are noted in a consistent, prominent place. If the patient has no known allergies or history of adverse reactions this is appropriately noted.*
7) *Problem lists are used for members with significant illnesses and/or conditions that should be monitored. A chief complaint and diagnosis or probable diagnosis is included.*
8) Past medical history for patients seen more than three times is easily identifiable. This documentation includes serious accidents, operations, substance use, sexual activity, if applicable, and childhood illnesses. For children and adolescents (18 and younger) past medical history relates to prenatal care, birth, operations and childhood illnesses.
9) * *For patients (14 years and older), there is appropriate notation concerning the use of cigarettes, alcohol and substance use and history and sexual activity, if applicable (For patients seen three or more times, query substance, alcohol and tobacco abuse history)*
10) The history and physical records include appropriate subjective and objective information pertinent to the member's presenting complaints.
11) Laboratory and other studies are appropriately ordered.
12) There is documentation of an exam appropriate for the condition.
13) * *Working diagnoses are consistent with findings.*
14) * *Treatment plans are consistent with diagnoses.*
15) Notes have a notation, when indicated, regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed.
16) * *Unresolved problems from previous office visits are addressed in subsequent visits.*
17) * *Consultation, lab and imaging reports filed in the chart are initialed by the practitioner who ordered them to signify review. Review and signature by other professional* ***does not*** *meet this requirement. If the reports are present electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal lab and imaging results have an explicit notation in the record of follow up plans.*
18) An immunization record for children is up to date or an appropriate history has been made in the medical record for the adults.
19) There is evidence that preventive screening and services are offered in accordance with guidelines and are age and gender specific.
20) All medication prescribed list name, dosage, frequency and duration.
21) * *Medications given on-site list name, dosage, route as well as the site given and whether the patient had a reaction to the medication. Vaccines administered also indicate manufacturer and lot number of vial.*
22) *For members over age 18, and after 3 visits, there is presence of an advance directive or evidence of education about advance directive.*

ACCESS STUDY
September 2007

PCPs

The ProMed QM Department recently surveyed a random 20 PCPs for a multiple of 120 calls for an access survey. This survey is mandated by the HMOs. ***The benchmark goal for all criteria is 100%.*** Below are the criterion used and the results of the survey.

Criteria	Cr 1: Telephone Access; # of minutes for a personal response	Cr 2 : # days for Routine/preventive exam. Includes PE, well baby exam	Cr 3: # days for non-urgent exam	Cr 5: Urgent Exam:	Cr 6: # minutes for wait time for scheduled appt to see MD
Std	**45 seconds**	**30 calendar days**	**7 calendar days**	**Within 24 hrs**	**Within 30 minutes**
PCP scores	**88.33%**	**100%**	**100%**	**96&**	**78.33%**

PCPs please note the low compliance on telephone access, urgent exam and actual wait time in the office. We would appreciate it if you could share this information with your staff regarding the actual access guideline standards for these areas.

The ProMed QM Department would like to thank all the PCPs involved and share this information with all of our contracted PCPs.

SPECIALISTS

The ProMed QM Department recently surveyed a random 24 Specialists for a total of 144 encounters for an access survey. This survey is mandated by the HMOs. ***The benchmark goal for all criteria is 100%.*** Below are the specialist criterion used and the results of the survey.

Criteria	Cr 1: Telephone Access; # minutes for a personal response	Cr 4 # days for specialty referral non urgent appt from time PCP requests referral	Cr 5: Urgent Exam:	Cr 6: # minutes for wait time for scheduled appt to see MD
Std	**45 seconds**	**14 calendar days**	**Within 24 hrs**	**Within 30 minutes**
SPC scores	**100%**	**75%**	**100&**	**84.02%**

Specialists: Please note the low compliance for routine specialist initial routine appointments and actual wait time in the office. We would appreciate if you could share this information with your staff regarding the actual access guideline standards for these areas.

ProMed Offices Closed

By Mary Dodds, Executive Assistant

ProMed Health Care Administrator offices including the corporate offices of Pomona Valley Medical Group and Upland Medical Group will be closed on the following dates:

Tuesday, January 1, 2008 New Year's Day
Monday, February 18, 2008 President's Day

As always, an on-call case manager (nurse) is available. The on-call nurse can be reached by calling the regular office number (909-932-1045) and following the prompts to speak with the on-call nurse. If you have any questions about ProMed's Holiday schedule, please call Mary Dodds at 909-932-1045 x 4401.

Special Dates

NEW YEAR'S DAY

TUESDAY, JANUARY 1, 2008

MARTIN LUTHER KING, JR. DAY

MONDAY, JANUARY 21, 2008

CHINESE NEW YEAR

THURSDAY, FEBRUARY 7, 2008

LINCOLN'S BIRTHDAY

TUESDAY, FEBRUARY 12, 2008

VALENTINE'S DAY

THURSDAY, FEBRUARY 14, 2008

PRESIDENT'S DAY

MONDAY, FEBRUARY 18, 2008

ST. PATRICK'S DAY

MONDAY, MARCH 17, 2008

EASTER

SUNDAY, MARCH 23, 2008

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