As we enter the Spring season, I wanted to touch on one utilization management issue that has a significant impact on all of our patients’ care. Urgent referral is an important tool to expedite your patients’ care in an emergent or time-sensitive situation.

As a baseline on turnaround times, we have a 72-hour timeframe to render a decision on an urgent referral. However, we strive to give you an answer within 24 to 48 hours if at all possible.

To help us provide you the highest level of service for your urgent patient care needs, please note the following:

1) A phone call to me can bypass the internal review process and I can immediately review the authorization. Please make sure that the authorization has already been submitted and entered into our system.

2) Authorizations entered through our provider portal website are generally faster as they don’t need to be manually entered by our staff.

3) Pertinent medical records will be needed to render a decision. If there are no records, we will be calling to request for them. This will cause a delay in the decision rendering. Without any records, there is a high chance that the urgent referral will be denied.

4) Most importantly, please inform your staff to use urgent referrals as situation necessitates. If upon reviewing the request and situation we do not believe the request is urgent, we may call to ask for more information, or change the status to normal authorization. Routine follow-ups and Durable Medical Equipment (DME) are generally not going to be urgent.

**Urgent referrals should be utilized when the situation:**

1) Could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function, based on a prudent layperson’s judgment, or

2) In the opinion of a practitioner with knowledge of the members medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Since many of these urgent referrals are extremely important to patient care and well-being, we hope this information will better meet the urgent needs of your patients. Please contact me should you have any questions or concerns.

Thank you,

**Richard Sohn, MD**
One of the most common presenting complaints is back pain. There is a wide range of treatment and work-up for back depending on the circumstance of how the back pain occurred, physical exam findings, and of course, the patient-related variables, such as occupation, culture, family, etc.

The standard for criteria reference that we use in UM is called MCG, which is widely used in managed care settings for evaluating each case/authorization. Below are a few key points from the guidelines:

Emergent evaluation usually is straightforward with neurological compromise in regards to motor control (cauda equina, a mass effect from infection or tumor, or acute fracture).

Beyond the emergent situation, however, the criteria become more complicated. To address the most common referrals:

- **Orthopedic, Neurosurgery, and MRI referrals generally need 6 weeks of conservative care with following modalities: activity modification, NSAIDS, and physical therapy.**

- **Physical Therapy referrals are almost always indicated for back pain. However, additional physical therapy after the first round of therapy will depend on their clinical response. We will address physical therapy in a future newsletter.**

- **Pain management referrals are reserved for expected prolonged narcotic usage or management of chronic low back pain. Usually, orthopedist or neurosurgeon would need to evaluate any invasive treatment options before progressing to pain management, as “chronic” back pain may be significantly improved with surgical intervention and may not need prolonged narcotic usage.**

- **Neurology referrals are generally reserved in the acute setting with neurological compromise (cauda equina and other motor deficits). However, neurology would be needed for demyelinating disease.**

- **MRI’s are generally reserved for pain that has not responded to 6 weeks of conservative care.**

If you would like a copy of the full guidelines, please contact us. We can fax your office any guidelines that we use for determination of your cases.

It has come to our attention that many physicians may not be submitting PM 160 Forms to ensure appropriate compensation to their offices for their CHDP physicals. To ensure you receive compensation for completing PM 160, please see below:

For **CARE 1ST AND HEALTH NET** patients, send the PM 160 to **C/O MED POINT MANAGEMENT**

P.O. BOX 570280, TARZANA, CA 91357-0730

For **ANTHEM BLUE CROSS** patients, send the PM 160 directly to **ANTHEM BLUE CROSS**, P.O. BOX 60007, LOS ANGELES, CA 90060.

All PM 160 submissions should be accompanied by CMS 1500 CLAIM FORMS and should also be sent to the above Med Point Management address.

We thank you for your commitment to quality of care. **For any questions, feel free to call LIGAYA DOLAR at (562) 435-3333 ext. 315.**
It has been one year since the Medi-Cal rate cut went into effect on January 1, 2015, where a new reality has set in – we adapted to do more with much less while maintaining the stability that our physicians have come to rely on.

Even when you anticipate rate adjustments, such as a drop in premiums relative Medi-Cal Expansion (MCE) and reduction of pediatric rates, it is still a shock to work with so much less and still meet the needs of physician community.

While the physicians saw the biggest drop off in the Fee-For-Service (FFS) reimbursements, health plans have also reduced capitation rates to IPAs to reflect the reduced rates from DHCS. However, Accountable Health Care IPA has absorbed the rate reduction thus far, and kept the capitation rates to its providers constant. This is only possible because we believe our physicians should be fairly compensated for the care provided to our patients, and also that we have made efficiency a top priority.

As the future of Medi-Cal reimbursement remains uncertain, we are doing our best to support our physicians. We believe we have done a great job in weathering this new reality, and will continue to stay the course to the best of our ability.

- Stuart Gray

**HR ISSUES TO WATCH IN 2016**

One of the top issues for HR Departments in 2015 was employee recruitment and retention; which will continue to be a challenge into 2016. In addition to existing employment/labor regulatory compliance, the Patient Protection and Affordable Care Act also brings additional requirements, which will continue to be a concern for employers. Finally, the concept of wellness continues to evolve with employers motivated to achieve for a healthier and more productive workforce.

**Top employment issues to watch for in 2016:**

1. COMPETING FOR WORKERS
2. GENERATIONAL ISSUES
3. WELLNESS
4. REGULATION AND POLITICS
5. TECH AND PERSONAL DATA

ANNOUNCING THE

PROVIDER PERINATAL NOTIFICATION INCENTIVE PROGRAM

If you provide prenatal and postpartum care to Health Net Medi-Cal members, you could receive $50 from Health Net for submitting an Initial Prenatal Visit and Pregnancy Notification Form and $50 for submitting a Postpartum Notification Form.

**ELIGIBILITY:**

- You must be a contracted physician with Accountable Health Care IPA to serve Health Net Medi-Cal members.
- You are in good standing with Health Net and Accountable Health Care IPA.
- You perform prenatal care and postpartum care within the HEDIS® specified timeframes.
- You must accurately complete and return the Initial Prenatal Visit and Pregnancy Notification Form and Postpartum Notification Form.

Health Net will pay you $50 for each correctly completed Initial Prenatal Visit and Pregnancy Notification Form and Postpartum Notification Form.

To learn more, please contact Ligaya Dolar at ldolar@ahcipa.com or 562.435.3333 x315.
It’s a little known fact that when HIPAA was passed and signed into law 20 years ago (1996), it also created a joint anti-fraud program called Health Care Fraud and Abuse Control Program (HCFAC) between the Office of Inspector General (OIG) under Department of Health and Human Services (DHHS) and the Department of Justice (DOJ) under Attorney General.

In February 2016, it released its annual report for Fiscal Year 2015, and the results were staggering:

- In FY2015 alone, HCFAC recovered $2.4 billion dollars.
- DOJ investigated 983 criminal healthcare fraud cases; OIG investigated 800 criminal cases.
- DOJ convicted 613 defendants out of 888 prosecuted.
- FBI dismantled 144 healthcare fraud enterprises.
- Combined more than 1,400 civil healthcare fraud investigations and lawsuits.
- OIG excluded 4,112 individuals and entities from federal healthcare programs.

All this was done when HCFAC’s budget was cut by $22 million dollars in 2015.

It is clear that the amount of money recovered, and all the cases prosecuted and investigated are only the tip of an iceberg. As we all receive federal healthcare funding, we have a positive duty to report any suspected healthcare fraud, waste, or abuse activity. To that end, Accountable Health Care IPA has established a Compliance Hotline for anyone to report anonymously: (562) 277-9310. Alternatively, a Compliance email address has been established to receive electronic reporting: ComplianceOfficer@ahcipa.com

If you have any questions or concerns, please contact Jason Hu, Compliance and Privacy Officer for Accountable Health Care IPA at jhu@ahcipa.com or (562)435-3333 x350.

---

Licensure updates for providers Malpractice Insurance, State License and Drug Enforcement Administration (if applicable) are a critical part of the credentialing process and for maintaining your participation. All Health Plans contracted with Accountable Health Care IPA require all Physicians maintain current Malpractice Coverage, State License and DEA (if applicable) in order to be in compliance with NCQA guidelines. The Credentialing Team encourages all providers to promptly submit documents as requested. We appreciate your time in assisting the credentialing team on maintaining an accurate and current database. If you have any questions or concerns regarding documentation requests please feel free to contact us at (562) 435-3333 option 6.
One of the biggest misconceptions about HIPAA is that it is an obstacle to freely sharing information that is needed for patient care. However, that was never the intent. In fact, HIPAA intended to assure the public that covered entities (e.g. doctors, health plans, etc.) will share information responsibly. This is perhaps because HIPAA was written in a way that is prohibitive, since its premise is that no covered entity can use or disclose Protected Health Information (PHI) unless certain criteria is met, or an authorization was given.

Most covered entities are familiar with the three (3) main exceptions to the authorization requirement: Treatment, Payment, and Operations. These exceptions cover the majority of instances when PHI would be used or disclosed among covered entities. However, some covered entities wish to be proactive in limiting their liabilities, so they built into their Consent for Treatment a clause that allows covered entities to use PHI for other purposes, such as marketing.

Please note that this is specifically prohibited by HIPAA under 45 CFR §164.508(b)(3), which states “an authorization for use or disclose of PHI may not be combined with any other document to create a compound authorization” except under very narrow circumstances.

Nor can a covered entity condition providing treatment or other services on a patient giving authorization for use or disclose PHI (45 CFR §164.508(b)(4)). Therefore, if your Consent for Treatment has a PHI authorization clause and a patient objects to that clause, you will be violating HIPAA by refusing to provide treatment. You are technically in violation of HIPAA by including the PHI authorization clause in the Consent for Treatment.

If you intend to use PHI for purposes other than Treatment, Payment, or Operations, and more specifically, if you plan to disclose psychotherapy notes, to sell PHI, or to use PHI for marketing purposes, a separate authorization MUST be obtained from each patient. Just because a patient signed the Consent for Treatment does not authorized the use of PHI for those purposes.

If you have any questions or concerns, please contact Jason Hu, Compliance and Privacy Officer for Accountable Health Care IPA at jhu@ahcipa.com or (562)435-3333 x350.
It has many names and takes on many forms: Initial Health Assessment (IHA), Annual Health Assessment (AHA) or Staying Healthy Assessment (SHA), Individual Health Education Behavioral Assessment (IHEBA).

Whatever it may be called, the Affordable Care Act requires that each patient should have one done every year, except the IHA should be done for new patients within 120 days.

It is a comprehensive physical exam to accomplish the following:

• Create a complete health profile for each patient
• Evaluate existing medical conditions
• Screen for other medical conditions based on the patient’s medical history and other risk factors
• Address all chronic conditions the member had in the previous year that still warrant continuing treatment.

This is currently a focused audit and enforcement area from DHCS, as it noted that many plans maintain poor documentation that this requirement has been met. Physicians who failed to administer one for his/her patients are at risk of receiving low performance low scores and corrective action plans when audited. Forms are available on the DHCS websites for SHA [www.dhcs.gov/formsandpubs/forms/Pages/StayingHealthy.aspx] in several languages.

There is a bonus incentive attached to the completion and submission of IHA or AHA for Medicare advantage and SNP members from AHCIPA as well as directly from the health plans. Inquire from our Provider Relations and Business Development Representatives for details on IPA bonus incentives, (562) 435-3333 x316.

Inquire directly from the health plans on their bonus incentive, for Brand New Day (BND) Quality Bonus Program, inquire at (657) 400-1900. For Central Health Medicare Plan at (866) 314-2427 ext. 2221.
Accountable Health Care IPA (AHCIPA) conducts audits and 100% review of our Medicare Advantage members. The following are some recommendations for a well-organized medical record keeping system which will showcase your physician’s effective patient care:

- A doctor’s progress notes should have all the elements of 3 required components:
  - a) Diagnosis
  - b) Status
  - c) Plans

- Treatment plans should be consistent with the working diagnosis.

- Laboratory and other studies should be ordered as appropriate.

- Physicians are required to submit Initial/Annual Health Assessment, especially SNP’s. There is a bonus incentive tied up with the submission of IHA/AHA.

- Physicians should consistently address all HEDIS/STAR measures that are applicable for the patient’s age and noted in the progress notes especially the IHA and AHA.

- Encounter data should be submitted for all patient visits, not only because there is a bonus incentive attached for its submission, but the data is also used to meet criteria for Pay for Performance, HEDIS/STAR, and Risk Adjustments.
Below is a listing of the network support personnel in the AHCIPA Business Development and Provider Services Departments. These employees are here to provide operational assistance with any issues or concerns. Please feel free to contact them at (562) 435-3333 and enter in their extension.

**Business Development Department**
- **Fabiola Mirsec**, Business Development Rep. .................. Ext. 458

**Provider Services Department**
- **Jacqueline Del Toro**, Provider Service Representative........ Ext. 316
- **Nuvia Chavez**, Provider Service Representative............. Ext. 227

**Support Services**
- **Sonja Reyes**, Provider Services Coordinator .................. Ext. 499

---

**Language Assistance Program (LAP) Reminder**

As you know, Los Angeles County has one of the most culturally diverse populations in the country. Because of this, all health plans have established Language Assistance Programs to serve their members with Limited English Proficiency (LEP). Please use the following information to contact each patient’s health plan directly, or call Accountable Health Care’s member services to facilitate (562) 435-3333 option 5.

- **Anthem Blue Cross** 1-888-254-2721
- **Brand New Day** 1-866-255-4795
- **Care1st Health Plan** 1-800-544-0088
- **Central Health Medicare Plan** 1-866-314-2427
- **Cigna** 1-800-806-2059
- **Health Net** 1-800-522-0088