NETWORK MEDICAL MANAGEMENT

Managed IPA's:

Access Primary Care Medical Group, Accountable Health Care IPA, Advantage Health Network IPA, Allied Pacific of California IPA, Alpha Care Medical Group, Beverly Alianza IPA, Community Family Care, Emanate Health IPA, Greater Orange Medical Group, Jade Health Care Medical Group, La Salle Medical Associates, Northern California Physicians Network

Purpose

As a regulatory requirement, provider offices must attest to doing an annual review of UM policies, updates, clinical criteria, and other programs outlined in this presentation.

The IPA and its contracted providers are assessed yearly for compliance by our partner Health Plans, CMS, and DHCS. This presentation will outline these updates and programs. Your office will be required to provide a signed attestation confirming the office staff has been educated and trained on an annual basis.

Provider Offices

IPA Contracted Providers include

- Primary Care Physicians
- OB/GYNs and all other specialty providers

Specialist Provider Office

Authorization referral processes

- REFERRALS
  - Document all work-up and treatments done and include with your request for authorization.
  - ***If the member was seen, please forward your consult and/or progress notes to the member's Primary Care Physician.***
  - Certain Health Plan contracts have an assigned hospital. Depending on the IPA, Hospital Capitated arrangements are in place for specific hospitals.
- URGENT REQUESTS
  - We encourage your office to submit urgent requests only if there is a need for medical care or services where application of the time frame for making routine or non-life-threatening care determinations could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Open Authorization Tracking

- ✓ **Open authorizations: approved referrals that have not been used by the member.**
- ➢ **What action do we need to take?**
- ❑ Your portal access allows your office to view a report of all approved referrals that have not been used by the member within 90 days from the approval date. A follow up with the member is required to determine if the member no longer requires the referral and/or if they need to be reassessed.
- ❑ ***If the member was seen, please forward your consult and/or progress notes to the member's Primary Care Physician.***

Sterilization Requirements

- STERILIZATIONS
  - Please submit the following information at the same time you submit your request for authorization.
  - A completed PM330; must have signature and date AUTHORIZATION REQUEST AND
  - Documentation that the member received a copy of the DHCS booklet (Signed DHCS booklet).
    - REFERRAL REQUEST WILL NOT BE PROCESSED UNTIL THIS INFORMATION IS RECEIVED.

The sterilization Consent Form requirements are imposed by the Federal government and can be found in California Code of Regulations, Title 22, Section 51305.4.

Resources/Programs (Medi-Cal)

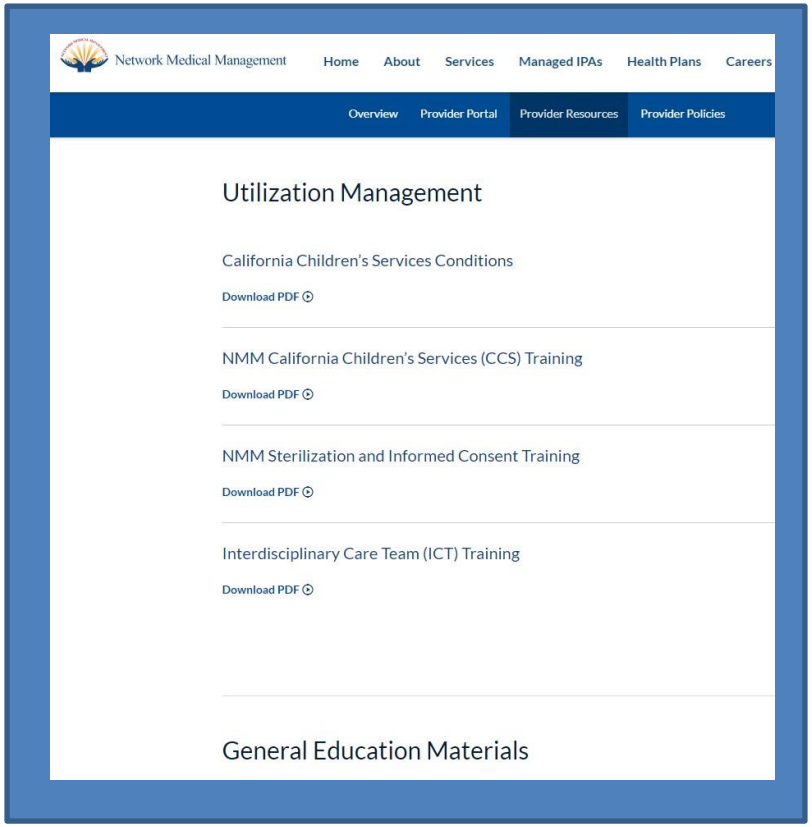
- WOMEN, INFANT AND CHILDREN'S (WIC) PROGRAM Supplemental nutritional options for children 5 and under and or your pregnant members
- CALIFORNIA CHILDREN SERVICES (CCS). For members 21 years and under. For members with catastrophic or congenital conditions to have enhanced coordinated services with specific providers.
    - If NMM Is notified that a member has CCS, we will notify your office. If your member has CCS please document this in the chart at each visit.
- *REGIONAL CARE CENTERS: Services for members with Developmental Disabilities present prior to age18*
    - LA Care Health Plan will send a monthly list of any Regional Care Center Members. If your member is on this list, we will send you a notification of this to place in the chart. Document this information at each visit.
- If your office refers a member to one of the programs discussed, please document this in your member's chart.
- Websites with additional information on the Medi-Cal Programs.
    - http://www.dds.ca.gov/rc/listings
    - http://www.publichealth.lacounty.gov/cms/ccs.htm

Programs/Materials for Annual Review

Updates/Guidelines

- ❑ Initial Health Assessment (IHA)
- ❑ Contracted provider (PCP / SPC) responsibilities
- ❑ Contracted specialist requirements
- ❑ NMM Standards of conduct
- ❑ UM Provider Updates
- ❑ California Children's Services (CCS)
- ❑ Child Health and Disability Prevention Program (CHDPP)
- ❑ Comprehensive Perinatal Service Program (CPSP)
- ❑ Early Start, Early Intervention, Developmentally Disabled (ES/EI/DD)
- ❑ Specialty Referral Tracking
- ❑ Standing Referral requirements
- ❑ Sterilization: PM330 and DHCS Education Booklet requirement
- ❑ Advance Directives
- ❑ Language Assistance Program (LAP)
- ❑ Screening, Brief Intervention and Referral to Treatment (SBIRT)
- ❑ Hospice / Palliative Care
- ❑ Behavioral Health Therapy (BHT)

*Audit guidelines under Medi-Cal/DHCS



IPA Policies and Clinical Criteria

Quality Management Program & Policies

Quality Management Program, Policies and Procedures are available upon request to members and providers by calling our Customer Service department at (877) 282-8272 Opt. 1, Monday-Friday between 9:00 AM to 5:00 PM PT.

Financial Incentive Attestation

Network Medical Management's procedures for reviewing appropriateness of care are aimed at promoting quality of care and efficiency within the health care delivery process. We recognize the need for concern about the potential for under-utilization and appropriately review, which includes, but is not limited to bed day reports, lengths of stay reports, pharmacy usage reports and data on member concerns regarding access to services.

As a matter of policy, associates who make utilization management coverage decisions for Network Medical Management may not be compensated or given other incentives to make denial decisions. Utilization decision making is based only on appropriateness of care and services.

Utilization Management Policies

Procedures and Criteria are disseminated to members and provider upon request by calling our Customer Service department at (877) 282-8272 Opt.1, Monday through Friday between 9:00 AM to 5:00 PM PT. For the hearing impaired, please call our TTY telephone at 877-735-2929, Monday through Friday between the hours of 8:30 AM to 5:00 PM PT.

A requesting practitioner may call Network Medical Management to discuss a denial, deferral, modification, or termination decision with the physician (or peer) reviewer at (877) 282-8272 ext. 6195; Monday through Friday between the hours of 9:30 AM to 2:30 PM PT. All calls will be returned within 24 hours.

- Financial Incentive Attestation
- Quality Management (QM)
- Utilization Management (UM)