KEY MEDICAL GROUP, INC.
3335 S. FAIRWAY • VISALIA, CA 93277 • (559) 735-3892 • FAX (559) 735-3894 OR (559) 734-6203

UTILIZATION MANAGEMENT
PROVIDER INFORMATION

Key Medical Group, Inc.

2014
Commercial HMO Plans
Blue Shield of California HMO
Anthem Blue Cross HMO
Aetna Health of California HMO
Health Net HMO
UnitedHealthCare HMO

Medicare Advantage
Humana

Contact us at 559-735-3892 or (800) 539-4584

Visit us at: www.keymedical.org
Provider Login: www.cerecons.com

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AUTHORIZATIONS

1. FORMS-- Key Medical Group requires that all authorization be submitted through Cerecons. Please contact our office at 559-735-3892 to obtain a username and password for our on-line system. If you do not have access to the Cerecons system, the Authorization request form must be faxed to Key Medical Group at 559-735-3894. We require that the authorization form be signed by the physician.

2. INFORMATION NEEDED-- All requests must have complete information attached for review, such as physician's progress notes, signature, laboratory and radiology results, etc... At times, the Medical Director of Key Medical Group will request further information from the requesting physician. No action will be taken on the request until the information is received.

3. TIME FRAMES-- Routine requests for authorization will be reviewed and processed within 5 business days. Retrospective requests will be reviewed and processed within 30 business days. If additional information is received, it will be reviewed and a decision will be made based on the health plan policies and guidelines and will be returned to the referring physician as well as a letter to the member.

   All denial letters state the reason for the denial, any unmet criteria guidelines, and an alternative treatment plan. The denial letter also includes the appeals process, including expedited appeals.

   If the physician's office has not heard back from Key Medical Group after a week from submitting the request, they may contact the medical group at 559-735-3892 to request the status of the authorization. Please do not resubmit the authorization prior to contacting the office.

4. WHAT REQUIRES PRIOR AUTHORIZATION?

   All in-patient admissions and most out-patient services require prior authorization. Most initial consultation with an in-panel provider will be an automatic approval, however you must still submit a request for the referral. This allows Key Medical Group to verify patient eligibility, provider contract and monitor utilization. As a result, this will eliminate any potential problems with the referral. If you need further assistance using our online portal, Cerecons, or have any questions please contact our office at (559) 735-3892.
   <u>* Gastric Bypass Consultations is not an automatic approval. Members must first meet medical criteria before gastric bypass is a benefit under the health plan.</u>

   Requests for second opinions for appropriate care will be provided within the local panel of providers. Out of area second opinions must be requested and will be managed by the health plan directly (Blue Shield, Blue Cross, etc.) and not by Key Medical Group. Once the member is seen for an out of area second opinion, any additional services out of panel will be requested to Key Medical Group by the out of area provider. Any services requested out of area that can be provided within panel, must be done in our local provider network.

   Direct Access for women to OB/GYN's. Under the HMO's, women have direct access to contracted OB/GYN's within the KMG panel. Direct access means the member can see the OB/GYN without a referral for evaluation and management services. A KMG provider can perform or request up to $500.00 worth of services. Services over $500.00 need to have prior authorization.

Criteria used for determinations- Key Medical Group uses health plan specific criteria in making authorization determinations. If health plan specific criteria is not available, Key uses Milliman criteria, specialty organization criteria (such as American Cancer society guidelines) or case matched specialist review to determine medical necessity for requested services. A copy of specific criteria or UM policy/procedures used to make a determination is available to practitioners upon request in writing. This criteria will be faxed to the provider office or will be uploaded to the specific case in the Cerecons system, whichever the provider prefers.

UM decision-making is based only on appropriateness of care and service. Key Medical Group does not compensate practitioners for denials of coverage or service. Appropriate care is to be provided within professionally recognized standards of practice that is not withheld or delayed for any reason including financial gain and/or incentive to the providers and/or others.

5. RETROSPECTIVE AUTHORIZATIONS

Retrospective authorizations are only given when the services performed were of an urgent or emergent nature. Routine office visits require prior authorization, except when the patient is seeing the primary care physician or OB/GYN. If a service was performed on an urgent/emergent basis, please indicate this on the authorization request form and submit appropriate documentation.

6. PROVIDERS

Please see attached list of our in network providers as reference when referring out patients. Please keep in mind, this information changes from time to time, if you would like a recent copy, call our office at (559) 735-3892 to request a copy.

HOSPITALIZATIONS
INPATIENT ADMISSIONS

a. ELECTIVE ADMISSIONS

Elective inpatient stays require prior authorization. The process is the same as for all authorizations. The request is submitted to the Key Medical Group with all information documenting the medical necessity for the admission.

NOTIFICATION

Hospitals are required to notify Key Medical Group (KMG) once a patient is admitted by faxing a face sheet to (559) 334-0112. When the face sheet is faxed, KMG will return the fax with a confirmation tracking notification number. If the face sheet is not returned within 48 hours contact KMG at 559-735-3892 to confirm receipt. Patients must meet appropriate medical requirements to be inpatient.

Blue Shield of California Members

Key Medical Group no longer authorizes in-patient services for members with Blue Shield insurance. Please contact Blue Shield directly at (800) 541-6652, opt 6.

b. EMERGENT ADMISSIONS

If a patient is admitted from the physician's office, an authorization request form will need to be submitted notifying Key Medical Group of the admission, however you do not need to wait for an authorization number to admit the patient on an urgent/emergency basis. For patients who are admitted on an emergency basis, the hospital must notify Key Medical Group of the admission.

OUTPATIENT SERVICES

Outpatient services are considered to be any/all of the following:

- Outpatient testing such as CT, MRI, Endoscopy, Colonoscopy, etc.
- Imaging studies.
- Outpatient surgical procedures.
- X-rays/ ultrasounds over $500.reimbursement
- Physical Therapy
- Home Health Care
- Durable medical equipment
- In-office procedures (even at the Primary Care Physicians office) that are over $500 reimbursement

The above services all require prior authorization. If a request is urgent, please indicate this on the authorization request. However, urgent or stat requests are only to be used when any delay in service might result in placing the patient’s health in serious jeopardy or serious impairment of bodily functions. Services must be provided at the appropriate contracted facility for the health plan.

Please submit an authorization request for these services, along with the documentation of medical necessity. If a patient is an in-patient, the hospital discharge planning department will supply this information.

LANGUAGE ASSISTANCE:

All of the Key Medical Group health plans have translators available to you to interpret for your patients if needed. Below is a grid of the plans and contact information:

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	1-800-525-3148	1-877-287-0117	Nicki Theodorou at 415-645-8264 Megan Rooney at 650-279-6091	N/A
Anthem Blue Cross	Spanish, Chinese (traditional), Vietnamese, Tagalog, Korean	1-888 254-2721	1-888 254-2721	1 800 677-6669	www.anthem.com/ca Note: Cultural & Linguistic resources are available on the Provider Home Page, under Provider Services
Blue Shield of California	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	Spanish, Chinese, Vietnamese, Korean, Tagalog, Armenian, Russian, Farsi	1-800-675-6110 TDD: 1-800-431-0964			
Humana	Spanish	1-800-457-4708			www.humana.com/provider/medical-providers/education/language-assistance-program
United Health Care	Spanish, Chinese, Vietnamese, Tagalog, Armenian, Japanese	1-866-633-2446	1-866-633-2446		www.unitedhealthcareonline.com

Laboratory Services

Laboratory services must be provided by your designated laboratory provider. Primary care provider's (PCP) location determines which laboratory facility patients must use in accordance to their health plan. Members assigned to Visalia and Exeter PCPs must go to Kaweah Delta District Hospital, members assigned to Tulare PCPs must go to Tulare Regional Medical Center, and members assigned to Porterville, Hanford, Lindsay, Corcoran, Dinuba, and Lemoore must go to Quest Diagnostics. If laboratory services are performed other than the designated facility, the member could be held financially responsible for the payment. Listed below are the following draw sites available.

Kaweah Delta Hospital-Draw Sites

Members assigned to Primary Care Providers in Visalia & Exeter

Visalia

400 W. Mineral King, basement
Phone: (559) 624-2251
Hours: Mon-Fri, 7:00 am-6:00 pm
Sat, 7:30 am-4:00 pm
*Patients need to stop at first floor Information desk to register before Continuing to the laboratory.

202 W. Willow, first floor
Phone: (559) 741-4727
Hours: Mon-Fri, 7:30 am-4:00 pm

100 Willow Plaza, third floor Ste 301
Phone: (559) 741-4727
Hours: Mon-Fri, 8:30 am-12:30 pm
1:00 pm-5:00 pm

Kaweah Delta South Campus (next to Urgent Care)
1633 S. Court St
Phone: (559) 624-6087
Hours: Mon-Fri, 7:30 am-5:00 pm

Sequoia Imaging Center
4949 W. Cypress Ave
Phone: (559) 624-3200
Hours: Mon-Fri, 7:30 am-12:00 pm
12:30 pm-4:00 pm

Exeter

Exeter Outpatient Physical Therapy
131 Crespi Ave
Phone: (559) 592-7358
Hours: Mon-Fri, 8:00 am-12:00 pm
1:30 pm-4:30 pm

Tulare Dist. Hospital-Draw Sites

Members assigned to Primary Care Providers in Tulare.

Tulare

Allied Service Building
869 N Cherry
Phone: (559) 685-3472
Hours: Mon-Fri, 6:15 am-6:00pm
Sat, 7:30 am-12:00 pm

Tulare Regional- Alternate Collection Site
799 Cherry St
Phone: (559) 68/5-3855
Hours: Mon-Fri, 6:15 am-6:00 pm

Quest Diagnostics- Draw Sites

Members assigned to Primary Care Providers in Corcoran, Dinuba, Hanford, Lemoore, Lindsay & Porterville

1120 N Irwin St Hanford, CA 93230
Phone: (559) 582-0308
Hours: Mon-Fri, 7:00 am-4:00 pm

365 Pearson Dr. Ste 4 Porterville, CA 93257
Phone: (559) 789-0105
Hours: Mon-Fri, 7:30 am-11:30 am, 12:30 pm-4:30 pm

1122 Rose Ave, Ste 2 Selma, CA 93662
Phone: (559) 891-1358
Hours: Mon-Fri, 7:00 am-4:00 pm

APPEALS PROCESS

All appeals/grievance for denied services are handled directly through the health plan. A provider or patient may file an appeal. Information on where or who to contact to file an appeal/grievance will be outlined in the patient's denial letter. A copy of the denial letter will be sent to the requesting provider.

Expedited/72 hour Grievance Process

An expedited appeal would be requested if it is determined that a delay in the decision making process might pose an imminent and serious threat to the patient's health. If it were determined by the health plan that an appeal meets this criteria, an expedited review would apply to the case. An appeal may be filed either by telephone, writing and with some health plans, online. Once an appeal is in process, the health plan will notify Key Medical Group and will request a copy of the denial and any notes we've received pertaining to the case.

Every health plan follows different guidelines and procedures. For more information please refer to the health plan's Appeals & Grievance process available through their website. For more information or direct links to our affiliated health plans please type the link below.
www.keymedical.org/services-filinganappeal

Department of Managed Health Care Complaint Process

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

ELECTRONIC CLAIMS-OFFICE ALLY

When billing commercial HMO plans such as Aetna, Blue Cross, Blue Shield, Health Net, or United Health Care please review the Payor ID you have listed in your billing system and make sure you are sending claims electronically to IP082 (zero-eight-two).

For Humana Medicare Advantage electronic claims please send to IP083 (zero-eight-three). As a reminder correct coding initiative edits and guidelines must be followed when billing Key Medical Group.

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AUTHORIZATION SIGNATURE REQUEST

Please be advised that all Health Plans require a physician signature on the original request for authorization for services if faxed to Key Medical Group. A stamped signature from the Physician is acceptable, but we can no longer accept signatures from ANYONE other than the requesting physician. Should we receive a request from a physician without his/her signature, it will be returned to the requesting provider prior to approval being granted. For Cerecons requests, the electronic signature submitted with the authorization from the MD office is sufficient.

Thank you for your cooperation with this requirement.

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SPECIALIST CONSULTATIONS

On January 2000, KMG instituted a new policy in which all referrals to specialists for initial patient **consultation (99243)** will be automatically authorized to in-panel providers*. Vision consults for medical conditions are also automatic. Ophthalmologists do not routinely use medical codes (99243) for consultations. Ophthalmologists who prefer to use new patient vision codes 92002-92004 can do so with a referral from another Key Medical Group provider, on the initial visit. Routine vision referrals are excluded, as member benefits must be confirmed prior to authorization.
*** Gastric Bypass Consultations are not an automatic. Members must first meet medical criteria before gastric bypass is a benefit under the health plan.**

The authorization request form will still need to be submitted, but you will **not** have to wait for an authorization number before making the appointment. This will allow the Primary Care Physician or specialist to make the appointment while the patient is still in the office. It will also free the specialist from requiring an authorization before seeing the patient. If the specialist you are referring to requires a higher level consult than 99243 those requests will have to be reviewed by the medical director.

The authorization request form will still need to be submitted to allow KMG to keep track of utilization and to make sure the referral is to a **contracted provider.** Please note that this is for consultations only; not procedures, special tests or specialists follow-up care. Those services will still require authorization (services up to $500.00 can be performed with each evaluation and management authorization code, $500.00 is reimbursed fees not billed charges).

No paperwork will be faxed to M.D. offices for initial consultation.

Specialist to specialist consults within the KMG panel are also considered automatic, follow the directions above.

Please contact the UR Department at 735-3892, if you have any questions.

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AFTER HOURS PATIENT CARE

We are implementing a new policy beginning January 2000 to compensate physicians for seeing patients after regular office hours or on weekends for urgent care needs. The on-call physician will be compensated fifty dollars for seeing the patients either in his office or at the ER (instead of the ER physician) during non-office hours. Hopefully, this policy may reduce the high ER utilization we currently have. .

The billing to Key Medical Group for this care will need to document the date, time, location, medical diagnosis and one of three CPT codes used to document after hours care:

		Code to use
1)	After hours prior to 10 p.m.	99050
2)	After 10 p.m.	99052
3)	Sundays/Holidays	99054

If you have questions or concerns regarding this policy, please contact Key Medical Group offices at 735-3892.

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HIV/AIDS Providers

Provider's with expertise in the area of AIDS/HIV treatment with a background in an appropriate specialty, advanced education in the field of AIDS/HIV and a willingness to provide services to the members of Key Medical Group are available for Key Members.

Annually Key will send questionnaires to those identified physicians to confirm their willingness to continue to provide services to AIDS/HIV members and to update information regarding their ongoing education in the field.

As of 12/08/2008 Dr. Daniel Boken is the in panel HIV/AIDS specialist for Key. Dr. Boken can be reached at 559-624-2735.

For information about standing referrals to Dr. Boken, please contact Key Medical at 559-735-3892.

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Maternity Care and Delivery Billing

It is the policy of Key Medical Group that providers report what they know at the end of any visit. If the OB-GYN knows the patient is pregnant, the claim must report the patient as pregnant and include the pregnancy diagnosis (V22.0-V22.2). If a patient takes a home pregnancy test or thinks she may be pregnant and comes into the office for confirmation, the OB-GYN will determine whether the complaints relate to the pregnancy. If the complaint does relate to the patient being pregnant, the provider should code the service as part of the global OB package. If the signs and symptoms, were because the patient was pregnant, then the OB record would begin.

Providers billing an office visit and a pregnancy test with the diagnosis of 626.0 (Absence of Menstruation – Amenorrhea), should know the outcome of the pregnancy test before the patient leaves the office. In this instance, the provider would need to start the OB record and code the claim with the diagnosis of 626.0 and V22.0-V22.2. A claim with both 626.0 and V22.0-V22.2 would be included in the total OB reimbursement.

If provider is treating a member with the diagnosis of 626.0 (Absence of Menstruation – Amenorrhea) and it is not related to Obstetrics then Key Medical Group will reimburse fee-for-service (FFS) as per the provider contract.

Key Medical Group will conduct retrospective reviews on all total OB claims. Claims submitted and paid as FFS which should have been paid under the total OB care, will be deducted from the final reimbursement.

Providers who disagree with any claim determination have the right to appeal to Key Medical Group through the Provider Dispute Resolution Process. You can find the PDR forms on our website at.

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Medicare Primary Members

Key Medical Group does not require prior authorization for in-panel professional services when a member has Medicare insurance as primary to their Healthplan. All services must be covered by Medicare. Services not covered by Medicare must have prior authorization in order for Key Medical Group to cover the services.

Inpatient or Outpatient facility services must have prior authorization. The healthplan pays the facility fees and a prior authorization is required.

Please contact Key Medical Group at 559-735-3892 if you have any questions.

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Policy: CPT CODING

The Key Medical Group follows all CPT coding guidelines. It is the policy of the Key Medical Group to approve consultations and follow up visits prospectively. KMG routinely approves a level 3 (99243 or 99213) visit prospectively unless documentation is submitted that the Physician knows, based on the complexity of the case, that the visit will follow CPT guidelines for a level 4 or level 5 visit.

PROCEDURE TO OBTAIN HIGHER REIMBURSEMENT:

If a Key Medical Group physician evaluates a KMG member and the visit follows CPT guidelines for reimbursement higher than the pre-certified level 3 the physician may bill for the higher level. Documentation must be submitted with the claim that the visit did follow CPT guidelines for the higher level. This documentation is normally submitted in the form of physician office notes from the visit. The notes and the CPT code submitted are then reviewed by a Physician Reviewer to ascertain that the visit did meet the higher level CPT guidelines. If the visit did meet guidelines, the visit will be paid at the higher level.

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POLICY: SCREENING FOR PERIPHERAL VASCULAR DISEASE

POLICY: Key Medical Group follows the U.S. Preventative services Task Force guidelines for this testing. This guideline says that routine screening testing for low risk adults is not recommended. Key Medical Group can only approve ankle-brachial index testing under the following conditions:

1. The patient is symptomatic. This can include leg pain when walking or non-healing wounds.

2. Patients who are at high risk of PAD, such as smokers, non-exerciser, overweight, diabetic or hypertensive.

It is Key Medical Group's policy that the member must be evaluated by the primary care physician for PAD prior to testing. There must be documentation of symptoms or risk factors. All ankle-brachial index testing requires prior authorization through Key Medical Group. Key Medical Group will not approve PAD testing as a routine part of screening for cardiovascular disease.

Claims submitted to KMG without prior authorization, unless it is an emergency situation will not be considered for payment even on an appeal. In case of a medical emergency, an authorization request must be submitted in a timely manner. Prior authorization requirements still apply even if the patient is Medicare primary.

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POLICY: USE OF ULTRASOUND GUIDANCE FOR JOINT INJECTIONS

Policy: It is the policy of Key Medical Group that the use of ultrasound guidance for aspiration and injections of glucosteroids will be reserved for large joints and sites that are anatomically difficult to access. All requests for ultrasound guided injections or aspirations, regardless of cost will require prior authorization. Documentation of medical necessity for the ultrasound guidance will need to be provided for authorization to be considered. This policy applies to all providers (PCP's and specialists).

Per UpToDate Medline Abstract for reference 19 states: "There was no significant difference in clinical outcome between the group receiving US-guided injections and the group receiving CE (clinical experience) -guided injections." The results of using ultrasound guidance for aspiration and injection of peripheral joints is not clinically different than the results without using the guidance except in cases such as difficult to access joints like the spine or shoulders or dry tap of a joint. A well trained clinician should be able to give these injections with accuracy and ultrasound guidance should not be used routinely.

Claims submitted to KMG without prior authorization, unless it is an emergency situation will not be considered for payment even on an appeal. In case of a medical emergency, an authorization request must be submitted in a timely manner. Prior authorization requirements still apply even if the patient is Medicare primary.