



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.

2005

Blue Shield of California

Visit us at: www.keymedical.org

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AUTHORIZATIONS

1. **FORMS--** Key Medical Group requires that all authorization requests be faxed on the Key Medical Group form to the medical group. Telephone authorizations are not given for non-emergent services. The forms must be complete and include ICD-9 and CPT codes. A physician signature on the form is a requirement of all health plans and must be on the form in order for the medical group to process. Please use the form included with this packet.
2. **INFORMATION NEEDED--** In addition to the information on the authorization request form, any notes from the physician, or test results documenting the condition would be appreciated. At times, the Medical Director of Key Medical Group will request further information from the requesting physician. This will be requested either via fax or telephone. No action will be taken on the request until the information is received.
3. **TIME FRAMES--** Once the request is received by Key Medical Group it will be processed and reviewed within 2 working days of receipt for routine authorizations, 1 working day for urgent and 30 days for retrospective requests. If further information is requested by the Medical Director, the request will be pended until the information is received. Routine requests that do not have all the necessary information needed to make a medical necessity decision when received by the UM Department will be placed in pending. Additional information will be requested upon review. If the information is not received within 24 hours, a second request will be sent within 48 hours of the initial request. A letter will also be sent to the member notifying them of the delay in determination and the reason for the delay. The case will then be pended for up to 45 days. If no information is received within 45 days, the case will be closed and written notification will be sent to the member and the requesting provider of the "lack of information". The letter to the patient will include the information needed, the Physician reviewers name and contact number and grievance and appeal information. If the needed information is received, the authorization request will be reviewed within 24 hours and a decision will be made and communicated to the requesting provider within 24 hours of the decision. A letter will also be sent to the member notifying them of the authorization within 2 working days. Authorizations to the Physician for approved services will specify the service approved, the facility the service is approved at and CPT/HCPCS codes approved.

All patient management determinations are communicated by fax within 24 hours of making the decision. All denials are communicated to the requesting provider by fax and by mail to the patient within 24 hours of the determination. 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 48 hours from submitting the request, they may contact the medical group at 559-735-3892 to request the status of the authorization. Fax machines are not perfect, and sometimes things get lost! Please do not re-fax the request as this can actually slow down the processing of the request.

4. WHAT REQUIRES PRIOR AUTHORIZATION?

All elective in-patient admissions, outpatient surgeries, Imaging studies over \$500 (such as MRI and CT, nuclear medicine studies, X-rays over the \$500. limit), follow up specialist visits, durable medical equipment, office procedures over \$500, physical therapy, home health care and initial consultations with specialists outside of the local provider panel require prior authorization.

Initial consultation* with a local, in panel provider do not require prior authorization, however, an authorization request form is required to be faxed to Key Medical Group notifying the medical group of the referral. This allows Key Medical Group to verify patient eligibility, provider contract and monitor utilization. That way, we can notify you if there are any potential prOBlems with the referral. If specialists request an authorization number you may ask them to contact Key Medical Group at 559-735-3892, the UM staff will remind the provider of the automatic authorizations. (see page 10 for more information)
*** Gastric Bypass Consultations are not an automatic. Members must first meet medical criteria before gastric bypass is a benefit under the health plan.**

Members with Access+ can self-refer to any KMG specialist on the first visit for a \$30.00 copay. The member does not need to contact their PCP under Access+. Please note on your claim form Access + or self-referral.

Member requests for a second opinion about appropriate care will be provided within the local panel of providers. If a qualified local provider cannot be OBtained, Key Medical Group will work with the health plan in locating a provider within the health plan network. The authorization will be given by the health plan, not the medical group. If a second opinion request is denied, notification will be made within 24 hours of the determination.

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.

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 providers for health plan specific information on in- plan local providers.

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. The same 48 hour time frames apply. A copy of the authorization is faxed to both the requesting physician and the hospital where the admission is planned.

NOTIFICATION

Hospitals are required to notify Key Medical Group once a patient is admitted by faxing a face sheet to 559-734-9309. 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. KMG will require a medical review within 24 hours. The hospital UM Department is required to call KMG. A confidential voicemail can be left at 559-735-3892, ext 250. Patients must meet appropriate medical requirements to be inpatient.

Blue Shield

Blue Shield members assigned to KMG, hospitals will contact KMG directly for certification, see notification section.

All services performed during the course of the stay, such as testing, surgery and specialist consultation are covered under the same authorization for the admission. Separate authorization is not required.

If a stay appears questionable, the Key Medical Group medical director will review the case, and if indicated, speak with the physician directly.

b. EMERGENT ADMISSIONS

For patients who are admitted on an emergency basis, the hospital notifies Key Medical Group of the admission. If a patient is admitted from the physician office, an authorization request form is submitted, notifying the medical group of the admission but you do not need an authorization number to admit the patient on an urgent basis. The medical group will Obtain review from the hospital utilization review department and days are certified based on that review. See above section for notification requirements.

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. These requests will be processed on a same-day basis. 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 form 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.

APPEALS PROCESS

All appeals for denied services are handled directly through Blue Shield of California. For standard appeals the health plan has 30 days to review and for expedited appeals 72 hours. A provider or patient may file an appeal. 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 patients health. If it were determined by Blue Shield that an appeal meets this criteria, an expedited review would be done. An appeal may be filed either by telephone or in writing.

To request an expedited appeal by telephone or in writing:

Call the grievance and appeal unit at 1-877-665-6736 or fax your request to 925-543-9554. The Grievance and appeal unit will document the verbal request in writing.

Please write to:

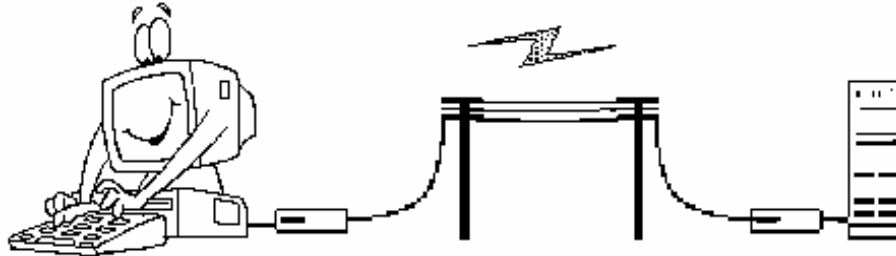
Blue Shield of California
Northern Grievance Resolution Department
P.O. Box 639018
Folsom, CA 95763-9018

The request must be submitted within 60 days of receipt of the denial.

Note: In addition to the process described above, you may also contact the California Department of Managed Care (DMC). The California Department of Managed Care is responsible for regulating health care plans. The department has a toll free number (1-800-400-0815) to receive complaints regarding health care plans. If you have a grievance against the health plan, you should first telephone the plan and use the plan's grievance process before contacting the department. If you need help with a grievance which has not been satisfactorily resolved, or has remained unresolved for more than 30 days, you may call the department for assistance.

**IF YOU HAVE ANY QUESTIONS REGARDING THE
AUTHORIZAITONS PROCESS, PLEASE FEEL FREE TO CONTACT
THE KEY MEDICAL GROUP AT (559) 735-3892, 8 AM TO 5 PM
MONDAY THROUGH FRIDAY.**

Key Medical Group
Now Accepts HCFA Claims & Encounters
Electronically, and At No Charge



You may now submit your claims and encounters *electronically* to Mosaic IPA and Key Medical Group, and Office Ally will assist you at no charge in setting up electronic transmissions.

Why?

- Save Form, Printing and Mailing Costs
- Save Time
 - Increase Efficiency and Accuracy
 - Receive 'Immediate' Member Eligibility Checks
 - Instant Acknowledgement of Claims Submission

What is required?

- A completed Payor and Provider Contract
- A computer with any medical billing software, and an Email Account
- All fields required on HCFA1500s are required electronically

If you are interested in EDI just call Office Ally,
Office Ally - Attention: Judy Collard
1107 S. Coast Hwy.
Laguna Beach, CA 92651
(949) 464-9129

**Contact Brandi Guinn, MS, Administrator of Managed Care
for more information from Key Medical Group at 559-735-3892, ext
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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. 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.

Thank you for your cooperation with this requirement.



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*. This policy includes all Blue Shield HMO members. 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. This policy pertains all Blue Shield HMO patients.

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:

- 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 me through the Key Medical Group offices at 735-3892.



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No Prior Authorization Required

The Key Medical Group Utilization Review Department has identified the following procedures as not requiring prior authorization:

Arthroscopy (29800-29909)
Breast Biopsy (19000-19291)
Herniorrhaphy (Inguinal and Femoral) (49500-49999)
Cholecystectomy (Lap. And Open) (56300, 56340-56342, 47562)
Circumcision (54150, 54152, 54160, 54161)
Transrectal Ultrasound with Biopsy of the Prostate (76942)
Prostate Biopsy (55700)
Skin Biopsy (11100-11101)
Sterilization, Elective Female (58600-58615) Male (55250)
Thyroidectomy (60210-60270)
Partial Toenail Excision (11730, 11750)
Needle Aspiration of Breast Mass (88170)
Mastectomy/Lumpectomy for Breast Cancer (19000-19125, 19160-19180, 19200-19291)
Lower Extremity Venous Doppler Study to r/o DVT (93922-93924)
Flexible Sigmoidoscopy (45300-45339)
Mammography (76090-76092)
OB Referral for Pregnancy (59400-59430)

Please begin to implement the Automatic Authorization Services immediately. If you have any questions please contact (559) 735-3892. **No** authorization form needs to be faxed into the UR Department.



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 www.keymedical.org.



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Blue Shield of California Medicare Primary Members.

Key Medical Group does not require prior authorization for professional services when a member has Medicare primary to Blue Shield. 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. Blue Shield of California 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 precertified 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.