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.

2012
Blue Shield of California
Anthem Blue Cross
Aetna Health of California

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-- 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 5 days from the request date, a second request will be sent. 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 via Cerecons or by fax within 24 hours of making the decision. All denials are communicated to the requesting provider via Cerecons or 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. Please do not resubmit the authorization prior to contacting the office.

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.**

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. If a second opinion outside of the local provider panel is desired, the request should be submitted to the health plan and 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.

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, UM policy/procedures used to make a determination is available to practitioners upon request. 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 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 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 559-735-3894 for Blue Cross and Aetna HMO patients. For Blue Shield members the hospital must notify Blue Shield directly at 800-541-6652. 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 of California/Anthem Blue Cross/Aetna

Healthplan 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 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	blueshieldca.com/providers

Laboratory Services

Patients assigned to Visalia & Exeter PCP's ONLY!

Kaweah Delta Hospital Laboratory

400 W. Mineral King Ave., Basement
Visalia, CA 93291
(559) 624-2251
Hours: Monday - Friday, 7:00 am - 6:00 pm , Saturday - 7:30 am - 4:00 pm
Please stop at the first floor information desk to register before continuing to the laboratory.

Draw Station
202 West Willow, First Floor
Visalia, CA
(559) 624-5448
Hours: Monday - Friday, 7:30 am – 4:00 pm

Draw Station
100 Willow Plaza
Third Floor, Suite 301
Visalia, CA
(559) 741-4727
Hours: Monday - Friday, 8:30 am - 12:30 pm, 1:00 pm - 5:00 pm

Draw Station
Kaweah Delta South Campus
1633 South Court Street
Visalia, CA (next to Urgent Care)
(559) 624-6087
Hours: Monday - Friday, 7:30 am - 5:00 pm

Draw Station
Sequoia Imaging Center
4949 W. Cypress Ave.
(559) 624-3200
Hours: Monday - Friday, 7:30 am - 12:00 pm, 12:30 pm - 4:00 pm

Draw Station
Exeter Outpatient Physical Therapy
131 Crespi Ave., Exeter
(559) 592-7358
Hours: Monday - Friday, 8:00 AM - 10:00 AM

Patients assigned to Tulare PCP's ONLY!

TDH Allied building
(blue roofed building west of the hospital)
869 Cherry Street

Tulare CA
M-F 7:00-18:00
Sat 7:30-12:00

Draw Site
799 Cherry Street (South of hospital)
Tulare CA
M-F 7:00-12:30

Labs for Patients assigned to PCP's OUTSIDE of Visalia Exeter or Tulare

Quest Diagnostics (HNF) 582-0308
Quest Diagnostics (Tulare) 684-1655
Quest Diagnostics (Visalia) 635-8153
Quest Diagnostics (Visalia) 738-1961
Quest Diagnostics (Prtville) 789-0105

Porterville Quest Diagnostics Draw Site

Draw Station
365 N. Pearson Dr., Ste. 4
Porterville, CA 93257
(559) 789-0105
Hours: Monday – Friday, 7:30 – 4:30 (open during lunch)

For pickups directly from Quest Diagnostics call (559) 225-1611

APPEALS PROCESS

Standard Grievance Process

A standard grievance will be resolved within 30 days. Please submit a copy of your denial notice and a brief explanation of your situation, or other relevant information to the appropriate Healthplan for appeals.

Expedited/72 hour Grievance Process

Your health plan makes every effort to resolve your grievance as quickly as possible. In some cases, you have the right to an expedited grievance when a delay in the decision making might pose an imminent and serious threat to your health, including but not limited to sever pain, potential loss of life, limb, major bodily function, or the normal timeframe for the decision making process would be detrimental to your life, or health or could jeopardize your ability to regain maximum function. If you request an expedited grievance, your health plan will evaluate your grievance and health condition to determine if your grievance qualifies as expedited. If so, your grievance will be resolved within 72 hours. If not, your grievance will be resolved within the standard 30 days.

You or someone you designate may submit your expedited grievance verbally or in writing. Specifically state that you want an expedited grievance or that you believe your health might be seriously jeopardized by waiting for the standard grievance process.

Your health plan will make a decision on your expedited grievance and will notify you in writing of the decision within 72 hours of receiving your grievance.

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.

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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*. This policy includes all Blue Shield of California, Anthem Blue Cross, and Aetna 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 of California, Anthem Blue Cross and Aetna 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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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 www.keymedical.org.

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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.