Golden Physicians Medical Group, Inc.

Provider Training Manual

Golden Physicians Medical Group, Inc.

PROVIDER TRAINING MANUAL

TABLE OF CONTENTS

(Number 20-24 are listed on our website at www.gpmedicalgroup.com; located on the bottom of the main page under Site Resources: Compliance Training & Resources)

Golden Physicians Medical Group, Inc.

Dear Golden Physicians Medical Group Provider,

Welcome to Golden Physicians! We would like to briefly review with you the many functions that the IPA is responsible for and your role in this important process. The IPA holds contracts with multiple HMO's or "Health Plans." The Health Plans give the IPA a portion of the monthly premium they collect for each member assigned to the IPA. The IPA is then responsible to provide health care services to these members. In order to do that, the IPA must contract with a network of PCP's, specialists, and other ancillary providers such as out patient surgery, home health, PT, radiology, pathology, and many others. The IPA is also delegated by the Health Plans for credentialing, utilization, management, quality improvement, claims and capitation payment.

The responsible use of healthcare resources is maintained by authorizing services according to current medical necessity guidelines, and since we only have access to the information you provide us with your authorization request, your active participation in this process is crucial. It is very important that you provide complete information when submitting a request so it can be reviewed and either approved or denied appropriately.

Both authorizations and claims payment are subject to the patient's eligibility at the time of service. A patient has the right to change their IPA at any time, so it is important that you check the patient's eligibility with the before each visit. You may obtain current eligibility by contacting the patient's health plan directly. We use an online portal, https://aerial.carecoordination.medecision.com/ for authorization request and tracking in addition to claims submission and tracking. A user name and password can be requested by emailing me for access at khaugh@pdtrust.com and providing the full names of the employees and email addresses. We also accept electronic claims through Office Ally (866-575-4120). When calling one of those providers, give them our Payor ID of PDT01 to get set up.

Our objective is to manage the use of healthcare resources responsibly without impeding our provider's ability to deliver appropriate, quality healthcare. If you have any questions, please feel free to contact me at (888) 909-0270 ext. 139.

Sincerely,

Karly Haugh

IPA Manager
khaugh@pdtrust.com

Golden Physicians Medical Group, Inc.

Staff Directory

Customer Service	**(888) 909-0270**

IPA Operations

Karly Haugh, IPA Manager	(888) 909-0270 x139 Fax: (760) 542-2019

Utilization Management

Mark O'Brien, DO - Medical Director	(760) 889-1763
Camille Arredondo, LVN – Case Manager	(888) 909-0270 ext.197 Fax (760) 631-7602
Karen Palmer – Compliance Officer	(888) 909-0270 ext. 114
Referral Authorization Fax Number	**(760) 909-0270**

CLAIMS

Please submit claims electronically via Office Ally. Payor ID is PDT01.

All mailed claims must be on a CMS1500 and sent to:

Golden Physicians Medical Group
PO Box 5166
Oceanside, CA 92052

Golden Physicians Medical Group, Inc.

TURNAROUND TIME STANDARDS

Golden Physicians Medical Group follows or exceeds these national standards for referral turnaround time.

- **Routine referrals** have a 5 business day decision time frame from the time a completed and signed referral has been received in IPA office. The IPA must notify the PCP office within 24 hours of that decision via FAX, email or telephone.

- **Urgent referrals** have 72 hours.

- **Emergent referrals** must have a **24 hour turnaround time** during business hours (8:00 am – 4:00 pm).

- Referrals received at the end of a business day (after 4:00 pm) will be processed as received on the next business day.

- Pended routine referrals – can pend 45 business days for commercial members or 14 calendar days for senior members. Once we receive the requested information, we have five (5) business days to make a decision.

- Pended urgent referrals – can pend 48 hours, then a decision must be made within 24 hours.

- Procedures **should not** be scheduled until authorization is approved.

Golden Physicians Medical Group, Inc.

Instructions for Aerial Care Start-Up

Golden Physician's Medical Group provides a Web Portal for On Line Referrals & Claims Submission through Aerial Care, a managed care software system. If you have internet access in your office simply follow the steps below to easily set up your on line referral process for your Golden Physicians patients.

1. Contact your Golden Physician's Representative, to obtain your login and password.
2. Go to: https://aerial.carecoordination.medecision.com/gpm/physician/LoginDefault.aspx
3. Enter your login name and password. The first time you log on, you will be asked to change your password. (You will be asked to change your password every 60 days. Be aware that when that happens, you *may* reuse the same password.) After entering your new password, you will be taken into the site.
4. The screen you will first see is called the "*dashboard*". At the top and middle of the screen, under "*Group Information*", you will see any Provider notices we have posted, as well as documents for common use.

<u>To access the Aerial Care Training information:</u>

1. Click on the word *Training* at the top of the screen.
2. If you would like to download written documentation, on the left side of the screen under Documentation click on Provider. Then click *Physicians Training*. The training materials will open up in Adobe Reader. You can then print the information or save the document to your computer.

<u>To enter a referral:</u>

1. Click on "<u>Submit Online Referrals</u>", which you will find in the far left column on your screen.
2. You may search for the patient using the ID#, Name, SSN, or DOB. We have found that the name or DOB is the easiest search options. Please note that the patient will show up with the name and DOB *that the health plan believes they have.* For this reason, if you have trouble finding the patient, you should look at their ID card to see if the health plan knows them by a different name or DOB. (Note: if the plan has any of the patient's information noted incorrectly, the <u>patient</u> must contact the plan to have that corrected.) If you do not find the patient at all, please verify their eligibility with the health plan.

3. If the patient is newly effective with Golden Physicians Medical Group, please use the *"Member Inquiry Form"* (which can be found on the dashboard under Group

Information) to report the new patient to us. We will add the patient to our system and they will soon be available to you on Aerial Care.

4. Once the correct member has been located, take note of the icon to the left of their record on the screen. If it is red, they are ineligible according to the last information provided to us by the health plan. If this is incorrect and they are still eligible under this health plan, use the *"Member Inquiry Form"* to have the patient updated by us. If the icon is green, they are eligible, and a purple "refer" button will appear to the right of their record on the screen. Click on the "refer" button to proceed with submitting a referral.

5. A referral form will come up on the screen. You will fill in the fields using a combination of typing and drop down menus. *All fields in red must be completed*, including CPT and ICD-10 codes. If you do not know a code, you can type in a description, and the system will provide a drop down menu of choices to select from.

6. You will see 2 boxes; Clinical Symptoms and Proposed Treatment. **Please provide complete information on the patient's condition** including pertinent test results. This will allow us to make a decision and respond to your request quickly.

7. Once you have completed the form, click on the "submit" button at the bottom of the screen.

8. Any applicable questions will come up on the next screen. Complete them and click on the "submit" button. (If you want to change anything on your referral, this is your last chance – click the "edit referral" button.)

9. The next screen will tell you either that your referral has been received and is being processed, or that your referral was approved. You have the chance to attach any notes or test results here, by clicking on the statement below that says "click here to add attachments".

To look up the status of a referral that you previously submitted:

1. Click on the "eligibility" tab near the top of your dashboard.
2. Enter the patient's first and last name, or DOB. Click "submit".
3. If there is more than one patient that comes up, identify the correct patient. To the far right of their record, you will see two icons. The "paper with the blue arrow" icon is the one you want to click to open the patient's record.
4. This will bring up the patient's demographic information. You will see two buttons at the top of the page. To look at their referrals, click the "member referrals" button. (The small number to the right of the button represents how many referrals are on record for this patient.) Any referrals on file for this patient will come up on the next screen. You may click on the "paper with the blue arrow" button on the far right to open the referral details.

REFERRAL FORM A – PCP

TRACKING NUMBER
IPA USE ONLY

Golden Physicians Medical Group Inc.
Fax: (760) 631-7602 Phone: (760) 330-9620

Date of Referral Request: _____/_____/_____ ☐ **Routine** ☐ **Urgent** ☐ **Emergent**

☐ **Member Request**

Patient Name: (First, Last) _____

Address: _____ City: _____ Zip: _____

Date of Birth: ____/____/_____ Phone: _____

Health Plan: _____ Patient ID#: _____

Referred To: **ICD-10:**

Specialty Type: _____

Referred By: (PCP) **Diagnoses:**

PCP OFFICE CONTACT : _____

PCP Phone: _____

PCP Fax: _____

SIGNATURE OF PCP:
(MANDATORY – WILL NOT BE PROCESSED WITHOUT MD SIGNATURE) _____

Procedures/services requested:	CPT CODE:
	CPT CODE:
	CPT CODE:
	CPT CODE:

Reason for REFERRAL: _____

Attachment(s)	
Notes:	
Lab:	
EKG/EEG:	
X-Ray	
Other:	

Place of Service: ☐ **Office** ☐ **Out-Patient** _____ ☐ **In-Patient** _____

FOR USE BY GOLDEN PHYSICIANS MEDICAL GROUP UM STAFF ONLY

☐ Authorize Date: _____ ☐ Pending Date: _____ ☐ Modified Date: _____

☐ Denied Date: _____ ☐ Not a covered benefit. ☐ T P L

Comments/Remarks: _____

UM Signature: _____ **Date:** _____

Date PCP Notified: _____ **◊Please notify member today of referral status.**

Certification does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions. This certification is good for sixty (60) days from approval date

FRM 022
Revised 090106

REFERRAL FORM B – Specialist

TRACKING NUMBER
IPA USE ONLY

Golden Physicians Medical Group Inc.
Fax: (760) 631-7602 Phone: (760) 330-9620

Date of Referral Request: _____/_____/_____ ☐ **Routine** ☐ **Urgent** ☐ **Emergent**

☐ **Member Request**

Patient Name: (First, Last) _____

Address: _____ City: _____ Zip: _____

Date of Birth: ____/____/_____ Phone: _____

Health Plan: _____ Patient ID#: _____

Referred To: **ICD-10:**

Specialty Type: _____

Referred By: **Diagnoses:**

REQUESTING PROVIDER OFFICE CONTACT NAME

PCP's Name :

Provider Phone: _____

Provider Fax: _____

SIGNATURE OF Physician:
(MANDATORY – WILL NOT BE PROCESSED WITHOUT MD SIGNATURE) _____

Procedures/services requested:	CPT CODE:
	CPT CODE:
	CPT CODE:
	CPT CODE:

Reason for REFERRAL: _____

Attachment(s)

Notes:
Lab:
EKG/EEG:
X-Ray
Other:

Place of Service: ☐ **Office** ☐ **Out-Patient** _____ ☐ **In-Patient** _____

FOR USE BY GOLDEN PHYSICIANS MEDICAL GROUP INC. UM STAFF ONLY

☐ Authorize Date: _____ ☐ Pending Date: _____ ☐ Modified Date: _____

☐ Denied Date: _____ ☐ Not a covered benefit. ☐ T P L

Comments/Remarks: _____

UM Signature: _____ **Date:** _____

Date PCP Notified: _____ **◊Please notify member today of referral status.**

Certification does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions. This certification is good for sixty (60) days from approval date **092010 FRM 022**

Golden Physicians Medical Group, Inc.

X-RAY DIRECT REFERRAL FORM

REQUEST DATE	REFERRING PROVIDER NAME	REFERRING PROVIDER TEL #

PATIENT NAME (FIRST, MI, LAST)	DOB

HEALTH PLAN	MEMBER ID #	ELIGIBILITY VERIFIED BY	DATE

REASON FOR REFERRAL

DIAGNOSIS	ICD-10

REFERRING PROVIDER SIGNATURE (MANDATORY – WILL NOT BE PROCESSED WITHOUT SIGNATURE)

NOTICE TO REFERRING PROVIDER: Please complete and sign this form and give to patient. All studies require a physician order in addition to this form.

NOTICE TO PATIENT: Your physician has approved your visit to a contracted Radiology provider. Please call the phone number provided by your physician to make an appointment and BRING THIS FORM & PHYSICIAN ORDER FORM WITH YOU TO YOUR APPOINTMENT.

NOTICE TO RADIOLOGY CENTER: **No Prior Authorization required.**

REFERRING PROVIDER MUST BE LISTED ON BOX 17 OF CMS 1500.

Plain X-RAY Films and UGI		Ultrasound, Dexa, Doppler
☐ Chest	☐ Hip	☐ DXA Scan
☐ Knee	☐ Ankle	☐ Doppler
☐ Forearm	☐ Foot	☐ Ultrasound: location_____
☐ Hand	☐ Wrist	
☐ Lumbar Spine	☐ Plain Abdominal	
☐ Plain Sinus–3 views	☐ UGI	
☐ Other Skeletal Films: _____		

Mammography	Studies that REQUIRE Prior Authorization
☐ 77067– SCREENING, BILATERAL	CT/CTA, MRI/MRA, PET, IR, Diagnostic Vascular Radiology and OTHER DIAGNOSTIC RADIOLOGY
☐ 77066– DIAGNOSTIC, BILATERAL	
☐ 77065– DIAGNOSTIC, UNILATERAL	
☐ 77063 – SCREENING BREAST TOMOSYNTHESIS, BILATERAL	

P. O. Box 5166 • Oceanside, CA 92052 • Phone: (888) 909-0270 • Fax: (760) 631-7602

EXHIBIT B

PRIMARY CARE PHYSICIAN SERVICES

Scope of Services

A Primary Care Physician (PCP) in managed care is responsible for all eligible services required by the patient, except when precipitous emergency circumstances preclude the primary physician's role.

The primary care physician's services are personal, and his/her responsibility is comprehensive, i.e. all required services including preventive services.

The PCP should provide those services which can be provided appropriately within his or her skills and obtain consultation when additional knowledge or skills are required. Consultation may consist of telephonic advice from a specialist or may involve referral for services.

When care by one or more specialists is required, the responsibility of the PCP is to coordinate all services, not only his/her own, but also all services by all specialists.

Primary Care Services shall include, but are not limited to:

A. Routine office visits (including after-hours office visits) and related services of a physician and other health care providers received by Enrollees in Physician's office. This includes evaluation, diagnosis and treatment of illness and injury, including but not limited to: specimen collection; simple minor surgery and laceration repair; punch, excisional and shave biopsies; uncomplicated ingrown toenail removal; control of nasal hemorrhage; aspiration and injection or trigger points/joint; and all related written documentation.

B. Visits and examinations. This includes consultation time and time for personal attendance with the patient at an emergency room (except for Emergency Room between 5:00 p.m. and 8:00 a.m.) or during a confinement in a hospital (including critical care visits), skilled nursing facility, or extended care facility.

C. Immunizations and injections (including injectables) shall be provided by Physician but shall be subject to payment in accordance with IPA's Fee Schedules.

D. Urinalysis and finger stick glucose and stool for occult blood. All other laboratory services shall be performed by IPA contracted laboratory(s). If any other laboratory services are provided in Physician's office, no additional payment shall be made.

E. Periodic health appraisal examinations, including all routine tests performed in Physician's office, as determined pursuant to accepted practice guidelines as adopted by IPA.

F. Miscellaneous supplies related to treatment in Physician's office. This includes but is not limited to: gauze, tape, minor surgery trays, injection trays, bandages, and other routine medical supplies.

1. Non-routine supplies billed to shall be paid by IPA in accordance with a fee schedule adopted by IPA. Payment is subject to usual utilization management procedures.

G. Physician home visits when the nature of illness dictates, as determined by Physician.

1. Supervision of complex home care regimen involving ancillary health personnel (e.g. home TPN, tube feeding, antibiotics) may warrant additional payment to Physician as determined by IPA. Payment is subject to usual utilization management procedures.

H. Referral of Enrollee to appropriate consulting physician or ancillary services as medically necessary and according to guidelines established by IPA.

I. Telephone consultations with Enrollees and referral physicians.

J. Twenty-four (24) hour on-call coverage. Physician is responsible for making financial arrangements with the covering physician.

K. All medical care (exclusive of procedures) provided to Enrollees by medical sub-specialists who execute this Agreement.

L. Health Education.

M. Family Planning – Physician agrees to ensure that a Enrollee's Family Planning information and records are confidential as required by State law.

N. Cultural/Linguistic Sensitivity – Physician shall address the special health needs of Enrollees who are members of specific ethnic and cultural populations and those with disabilities.

This list shall not be all-inclusive and additional Primary Care Services may be included as determined by IPA in its sole and absolute discretion.

Laboratory

All laboratory services should be provided by IPA's designated contracted laboratory(s) Quest Diagnostics. Laboratory services provided in the physician office are included under capitation. Expenses for PCP referral to non-capitated/non-contracted labs without prior authorization from IPA will be deducted from PCP's capitation for the total amount paid.

Radiology and Other Imaging

All radiology and other imaging services should be provided by IPA's designated contracted

facility. Radiology services provided in the physician office are included under capitation.

Any additional lab and radiology expenses incurred by IPA or a Plan due to a referral to non-capitated or non-contracted labs or to an imaging center without prior authorization from IPA may be deducted from Provider's compensation

Golden Physicians Medical Group, Inc.

Golden Physicians Medical Group IPA
Retro Authorization Request

As a contracted provider with Golden Physicians Medical Group, you are required to obtain prior authorization for all services unless it is specifically addressed in your contract.

Claims that are received for services where prior authorization has not been obtained will be denied for no authorization.

We realize that there may be times when obtaining prior authorization would only delay a patient's treatment (i.e. urgent or emergent appointments). In those instances, please complete an authorization request as you normally would; indicate what date the patient was seen and why authorization was not obtained prior to the patient being seen. Fax or submit it via Aerial Care to the IPA UM department as normal. As long as we receive your request within 30 days of the services, we will process the request as a normal referral.

Golden Physicians Medical Group, Inc.

Eligibility Research Request

Date: _____ IPA: **Golden Physicians Medical Group**

PCP: _____ Contact: _____ Phone: _____ Fax: _____

The following members are effective per the health plan but are not showing on my capitation list. Please research and verify that patients are eligible. We request that you fully complete all fields. Any incomplete information may be delayed. Please be reminded that although enrollment data is current, you may find some members who are new to the HMO plan and/or Provider. **MEMBERS LOADED AFTER CAPITATION WILL APPEAR ON THE NEXT CAPITATION REPORT WITH ANY RETRO DUE. RETROACTIVE/DELETE WILL ONLY GO BACK UP TO SIX (6) MONTHS**.

This form will be faxed back to the provider within 10 business days.

Membership Information (Please Print Clearly):

Member Name	Date of Birth	Health Plan	Member ID#	Effective Date	*****CAP Month missing*****

ALL INFORMATION MUST BE COMPLETED **FAX REQUEST TO: (760) 542-2019** **ATTN: Provider Relations**

Golden Physicians Medical Group, Inc.

CONTRACTED ANCILLARY PROVIDERS

Please refer your patients ***only*** to the below contracted facilities. If you need to refer your patients to another facility, please contact Karly Haugh, IPA Manager, (888) 909-0270 ext 139.

RADIOLOGY:

Imaging Healthcare Specialists **Scheduling P# (858) 658-6500**	**Valley Radiology Consultants** **Scheduling P# (877) 393-1933**
La Maestra – Community Health Imaging **Scheduling P# (619) 269-1299**	**San Diego Imaging** **Chula Vista P# (619) 397-6577** **Escondido P# (760) 743-3873** **Kearny Mesa P# (858) 634-5900** **Oceanside P# (760) 630-0014**
Sharp and Children's MRI Center **(858) 939-4550**	**Alvarado Hospital Medical Center** **Scheduling P# (800) 258-2723**
Paradise Valley Hospital **P# (619) 470-4321**	

LABORATORY:

- ☐ **Quest Diagnostics is to be utilized for all laboratory services.**

Golden Physicians Medical Group, Inc.

MEMORANDUM

Date: July 9, 2019

To: Golden Physicians Medical Group (GPMG), Inc. Providers

From: Paul Hernandez, Executive Director on behalf of GPMG

Subject: GPMG URGENT CARE CENTERS

Golden Physicians has contracted with Concentra Health for Urgent Care Services. Concentra Health Urgent Care has 13 clinics located throughout San Diego County and is available for after-hours care. Please inform patients to utilize our Urgent Care Services as an alternative to Emergency Care Services for Non-Emergent Needs such as a cough, sore throat or upset stomach. Please see below a listing of the contracted urgent care clinics for Golden Physicians Medical Group:

Carlsbad - Concentra Health 5810 El Camino Real, Suite A, Carlsbad, CA 92008 Phone: 760-929-8269 Fax: 760-929-8556 Hours: 7:00AM – 6:00PM (Mon-Fri)	**Hillcrest – Concentra Health** 3930 Fourth Avenue, Suite 200, San Diego, CA 92103 Phone: 619-297-9610 Fax: 619-297-2244 Hours: 7:00AM – 7:00PM (Mon-Fri)	**AFC Urgent Care of Bonita** 760 Otay Lakes Road, Chula Vista, CA 91910 Phone: 619-821-2300 Fax: 619-821-2301 Hours: 8:00AM-8:00PM (Mon-Sun)
Chula Vista - Concentra Health 542 Broadway, Suite G, Chula Vista, CA 91910 Phone: 619-425-8212 Fax: 619-425-1604 Hours: 8:00AM – 6:00PM (Mon-Fri)	**Mission Valley- Concentra Health** 5333 Mission Center Rd., Suite 100, San Diego, CA 92108 Phone: 619-295-3355 Fax: 619-542-1317 Hours: 8:00AM – 6:00PM (Mon-Fri)	**AFC Urgent Care of San Diego-Balboa** 5671 Balboa Ave. San Diego, CA 92111 Phone: 858-800-2880 Fax: 858-256-2727 Hours: 8:00AM-8:00PM (Mon-Sun)
Escondido – Concentra Health 860 West Valley Parkway, Suite 150, Escondido, CA 91025 Phone: 760-740-0707 Fax: 760-740-0730 Hours: 7:00AM – 7:00PM (Mon-Fri)	**Kearny Mesa – Concentra Health** 5575 Ruffin Road, Suite 100, San Diego, CA 92123 Phone: 858-277-2744 Fax: 858-277-3085 24 Hours, 7 Days	**AFC Urgent Care of San Diego-Mira Mesa** 8260 Mira Mesa Blvd #A, San Diego, CA 92126 Phone: 858-900-3550 Fax: 858-757-9177 Hours: 8:00AM-8:00PM (Mon-Sun)
La Mesa - Concentra Health 8090 Parkway Drive, La Mesa, CA 91942 Phone: 619-697-3093 Fax: 619-697-3135 Hours: 8:00AM – 5:00PM (Mon-Fri)	**Miramar – Concentra Health** 7590 Miramar Road, Suite C, San Diego, CA 92126 Phone: 858-549-4255 Fax: 858-549-4552 Hours: 8:00AM – 5:00 PM (Mon-Fri)	**AFC Urgent Care of San Diego- Rio SD** 8590 Rio San Diego Dr. #111, San Diego, CA 92109 Phone: 619-736-4600 Fax: 619-542-9796 Hours: 8:00AM-8:00PM (Mon-Sun)

Golden Physicians Medical Group, Inc.

National City - Concentra Health 102 Mile of Cars Way, National City, CA 91950 Phone: 619-474-9211 Fax: 619-474-2000Hours: 7:00 AM – 7:00PM (Mon-Fri)	**Sorrento Mesa – Concentra Health** 10350 Barnes Canyon Road, Suite 200, San Diego, CA 92121 Phone: 858-455-0200 Fax: 858-455-0044 Hours: 8:00AM – 5:00PM (Mon-Fri)	**AFC Urgent Care of Santee** 10538 Mission Gorge Rd #100, Santee, CA 92071 Phone: 619-456-0033 Fax: 619-456-0095 Hours: 8:00AM-8:00PM (Mon-Sun)
Oceanside – Concentra Health 3910 Vista Way, Suite 106, Oceanside, CA 92056 Phone: 760-941-2000 Fax: 760-941-4900 Hours: 7:00AM – 7:00PM (Mon-Fri)	**San Marcos – Concentra Health** 740 Nordahl Rd., Ste. 131, San Marcos, CA 92069 Phone: 760-432-9000 Fax: 760-741-0746 Hours: 8:00AM – 5:00PM (Mon-Fri) 8:00AM -5:00PM (Sat, Sun)	**South Bay Urgent Care INC.** 1628 Palm Ave. San Diego, CA 92154 Phone: 619-591-9999 Fax: 619-941-2078 Hours: 9AM-8PM (Mon-Fri) 10AM-6PM (Sat-Sun)
Santee – Concentra Health 9745 Prospect Ave., Suite 100, Santee, CA 92071 Phone: 619-448-4841 Fax: 619-448-8700 Hours: 7:00AM – 5:00 PM (Mon-Fri)		

Thank you for your cooperation. We appreciate your ongoing commitment to providing the highest quality health care to Golden Physicians Medical Group, Inc. members.

Golden Physicians Medical Group, Inc.

Office Update Request Form

Golden Physician's Medical Group IPA must maintain accurate information in the provider database. This updated information will be forwarded to health plans affiliated with Golden Physician's Medical Group IPA. Please complete, provide any changes, and fax this form to:

Provider Relations (888) 909-0270 ext 139

Physician's Name: _____

Additional Physicians: _____
(*in same office contracted with IPA*)
_____

Effective Date: _____

Address _____

City, State, Zip _____

Phone ( ) _____ Fax ( ) _____

Tax ID Number _____

Hospital Affiliations _____

Office Hours: M _____ T_____ W _____ Th _____ F _____ Sat _____ Su _____

Languages Spoken _____

Patient Ages _____ All Ages _____ Newborn - 18 _____ 18 & up _____ Other: _____

Office Manager/Contact: _____

****

PCPs ONLY:

Does your office provide Well Woman Exams to members? _____

Does your office provide EKGs to members? _____

****

Authorized Signature _____ Title _____
Office Manager/Supervisor or Physician

Date _____ Phone Number: _____

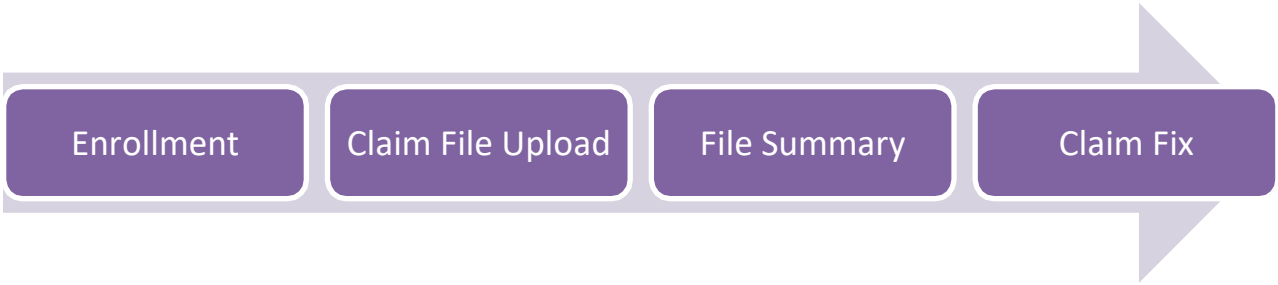
Office Ally

There are 2 options for claims submission via Office Ally:

- File upload, which allows for the upload of an ANSI837 Professional or Institutional Claim file, either via web portal or SFTP.
- Online Claim Entry, which is claim submission via manual entry into an Online CMS1500 or UB04 Claim form.

Payer ID: PDT01

Claim Submission Process:



Enrollment: Contact Office Ally for enrollment and access at (360) 975-7000. Select option 1. Or visit https://cms.officeally.com/Register/Register.aspx to complete the Enrollment Form online.
Claim File Upload: Log onto officeally.com. Hover over the Upload Claims option on the left side of the screen. Select Upload HCFA, to upload a Professional Claim file, or select Upload UB04 to upload an Institutional Claim file. Click Select File. Browse for your file and click Open. Click Upload. You will receive an upload confirmation page with your File ID number. Alternately, Office Ally does offer an option for SFTP file submission. Contact Office Ally at (360) 975-7000, option 1 to request SFTP. You will need to be prepared to provide the following information: Office Ally User Name, Contact Name, Email, Software Name, Format being submitted and whether you would like to receive 999/277s.
File Summary: Within 24 hours, your file summary will be available. This report is the receipt of the claims submitted. To view the available reports, select Download File Summary under Download listed on the left side of the screen. Dates listed with a pink background are dates that have reports that have not yet been viewed. Click on the date to view the available reports for that date. Click on the View link to review the report. Then click Open.
Claim Fix: If a claim receives an error and cannot be processed it will be made available in Claim Fix. You can view any claims in Claim Fix by selecting the Claim Fix option on the left side of your screen then clicking "Repairable Claims". Click on any date which has a pink background. Click the Correct link to view and fix the data on the claim. Click Update to save the changes and resubmit the claim. Once all of your claims for a specific date have been corrected the background for that date will change to white.

Online Claim Entry:

Enrollment: Contact Office Ally for enrollment and access at (360) 975-7000. Select option 1. Or visit https://cms.officeally.com/Register/Register.aspx to complete the Enrollment Form online.
Claim Entry: To view a detailed video which will walk you through the process, log onto the Office Ally Website at www.officeally.com. Click on Training Videos on the Menu Bar and then select the "Online Claim Entry" video under Service Center. To submit your claim(s) via Online Claim Entry, click the Online Claim Entry option under Claims, on the

left side of your Office Ally screen, after you have logged onto the site.

Claim Batching: After online claims are submitted they will be "Awaiting Batch". Claims can take 1-3 hours to be reviewed and batched. While a claim is in this status you can view, edit or delete the claim by selecting Claims Awaiting Batch under the Online Claim Entry option on the left side of the screen.
File Summary: Within 24 hours, your file summary will be available. This report is the receipt of the claims submitted. To view the available reports, select Download File Summary under Download listed on the left side of the screen. Dates listed with a pink background are dates that have reports that have not yet been viewed. Click on the date to view the available reports for that date. Click on the View link to review the report. Then click Open.
Claim Fix: If a claim receives an error and can not be processed it will be made available in Claim Fix. You can view any claims in Claim Fix by selecting the Claim Fix option on the left side of your screen then clicking "Repairable Claims". Click on any date which has a pink background. Click the Correct link to view and fix the data on the claim. Click Update to save the changes and resubmit the claim. Once all of your claims for a specific date have been corrected the background for that date will change to white.

Other Important Information:

- Member and Provider information on Office Ally is updated weekly.
- Claims submitted via Office Ally are received by the IPA the business day after successful submission and processing by Office Ally.
- Office Ally offers to Print and mail any claims that can not be submitted electronically. If you are interested in this service contact Office Ally or access the "Update Printing Option Form" available on the Office Ally website under Resource Center, Office Ally Forms & Manuals then Account Management.
- Technical Support is available at (375) 975-7000, option 2.
- Office Ally offers Free Training. To utilize this service contact Office Ally at (360) 975-7000 Option 5.

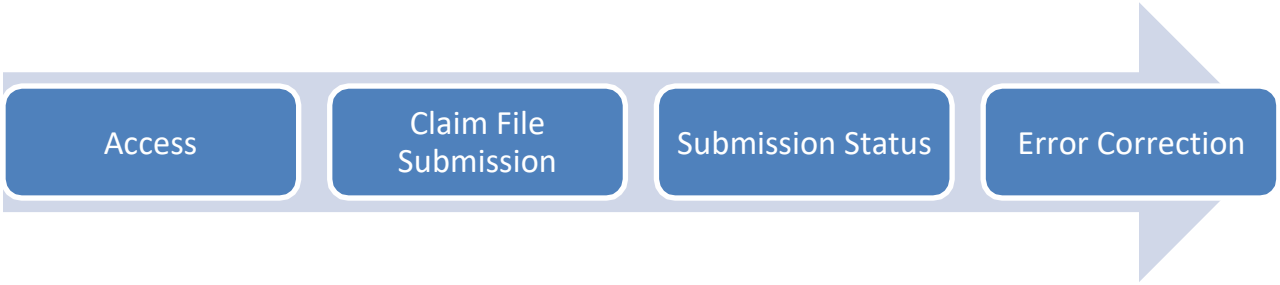
Smart Data Solutions

Claim Submission Options:
There are 2 options for claims submission via Smart Data Solutions:

- File upload, which allows for the upload of an ANSI837 Professional or Institutional Claim file.
- Online Claim Entry, which is claim submission via manual entry into an Online CMS1500 or UB04 Claim form.

Payer ID: PDT01

Claim Submission Process:



Access: Contact Smart Data Solutions (855)297-4436 to obtain access.
Claim File Submission: Once you have access to the SDS Quick Claim Portal, you can submit a Claim file by clicking the Upload New File option.
Submission Status: You can check the status of any submitted batch by clicking on Batch History on the Main screen.
Error Correction: From main screen you can click on View Rejected documents, to review and correct any claims that were rejected.

Online Claim Entry:

Access: Contact Smart Data Solutions (855)297-4436 to obtain access.
Claim Entry: Once you have access to the SDS Quick Claim Portal, you can submit a Claim online by clicking the Key New Claim option. Enter your claim information and click Save.
Submission Status: You can check the status of any submitted batch by clicking Batch History on the Main screen.
Error Correction: From main screen you can click on View Rejected documents, to review and correct any claims that were rejected.

Other Important Information:

- Member and Provider information with Smart Data Solutions Aerial Care is updated every Friday.
- Claims successfully submitted via Smart Data Solutions are received by the IPA the following business day.
- Both Professional and Institutional Claims can be submitted via SDS.

CPT CODES THAT ARE TO BE USED FOR SPECIALISTS

SPECIALITY	NEW PT	ESTAB PT
ALLERGY	99203	99213
CARDIAC SURGERY	99204	99213
CARDIOLOGY	99204	99214
CARDIOVASCULAR SURGERY	99205	99214
COLORECTAL SURGEON	99203	99213
DERMATOLOGY	99203 Accutante TX 99204	99213 Accutante TX 99214
ENDOCRINOLOGY	99204	99214
ENT	99204	99214
GASTROENTEROLOGY	99203 Screening colonoscopy/ Medical DX/99205 & 99214 liver diagnosis	99213
GENERAL SURGERY	99203	99213
INFECTIOUS DISEASE	99204	99213
NEPHROLOGY	99205	99214
NEUROLOGY	99204	99214
NEUROSURGERY	99205-BR	99214
ONCOLOGY	99204	99214
ORAL SURGERY	99203	99213
ORTHOPEDICS	99203	99213
ORTHOPEDICS-FRACTURE CARE	99203	99213 AS NEEDED
ORTHOPEDICS SPINE SURGEON	99203	99213
PLASTIC SURGERY	99203	99212 routine nail care/99213 for med dx
PODIATRY	99203	99213
PULMONARY	99205	99214
RADIATION THERAPY	99205	99214
RHEUMATOLOGY	99204	99214
THORACIC	99204	99213
UROLOGY	99203	99213
VASCULAR SURGERY	99204	99213

This list specifies what level code will be approved by Specialty. If higher code is requested, referral will be downgraded to level on this list. If, at the time of service, it is determinded the patient meets a higher level of care, provider will bill applicable CPT code with supporting medical records for review.

Access to Care Standards

Primary Care Physician (PCP)	Standard
Emergency (Serious condition requiring immediate intervention)	Immediately (office, UCC, ER)
Urgent (Condition that could lead to a potentially harmful outcome if not treated)	Within 48 hours (office, UCC)
Non-Urgent (routine) (visit for symptomatic but not requiring immediate diagnosis and/or treatment)	Within 10 business days
Adult or Pediatric Health Assessment / Physical (Physical: periodic health evaluation with no acute medical problem) (Preventive: for prevention and early detection of disease, illness, condition)	Within 30 calendar days, unless more prompt exam is warranted
IHA (18 months and older) IHA (under 18 months)	Within 120 days of enrollment Within 60 days of enrollment
Waiting Time in physician office	Less than 30 minutes
After-hours Access	Answering Service or service w/ option to page Provider
• Enrollee with life threatening medical problem must have access to health care twenty-four (24) hours per day and 7 days per week. • After hours answering system or voice mail should instruct members that if they feel they have a serious acute medical condition, to seek immediate care by calling 911 or going to the nearest Emergency Room. • Member must be assured that a Health Care Professional (Dr., Advice Nurse, PA, NP) will communicate with them within 30 minutes.	
Telephone Triage and Screening (urgent and routine) • Telephone triage is available 24 hours a day and 7 days a week	Within 30 minutes

Specialty Care Provider (SCP)	Standard
Urgent referral (includes Behavioral Health)	Within 96 hours
Non-Urgent / routine (includes Behavioral Health)	Within 15 business days from time of PCP request

Behavioral Health Provider (based on Plan contracts)	Standard
Urgent	Within 96 hours
Routine	Within 15 business days
Non-physician BH	10 business days

Ancillary Services	Standard
Urgent (for diagnosis and treatment)	Within 96 hours
Routine (for diagnosis and treatment)	Within 15 business days

PHYSICIANS DATATRUST

INTEROFFICE MEMORANDUM

TO: PCP, SCP, Clinical Services and Administrative Staff

FROM: Lisa Serratore, Chief Executive Officer

CC: Evelyn Jimenez, IPA Manager, CVPG
Karly Haugh, IPA Manager, GPMG
Renee LaMarsh, IPA Administrator, GTCIPA
Mary Beltran, IPA Administrator, Noble AMA IPA
Leesa Johnson, VP of IPA Operations, St. Vincent IPA

DATE: January 15, 2022

RE: Affirmative and Impartiality Statements

AFFIRMATIVE STATEMENT

As a utilization management organization, Physicians DataTrust on behalf of Citrus Valley Physicians Group, Golden Physicians Medical Group, Greater Tri Cities IPA, Noble AMA IPA, and St. Vincent IPA, ensures that all decisions are made based on the available medical information at the time of the request. Should a member ask to see the criteria utilized to make a medical decision; the statement below is attached to that guideline, as required by the National Committee for Quality Assurance (NCQA):

Decisions regarding requests for medical care are based on the medical necessity of the request, the appropriateness of care and service and existence of coverage. There is no monetary reward for non-approval of services. Compensation for individuals who provide utilization review services does not contain incentives, direct or indirect, for these individuals to make inappropriate review decisions.

Utilization review criteria, based on reasonable medical evidence and acceptable medical standards of practice (i.e. MCG and/or applicable health plan guidelines) are used to make decisions pertaining to the utilization of services. Review Criteria are used in conjunction with the application of professional medical judgment, which considers the needs of the individual patient and characteristics of the local delivery system.

IMPARTIALITY STATEMENT

All participating practitioners are ensured independence and impartiality in making referral decisions which will not influence hiring, compensation, termination, promotion or any other similar matters.

These statements are also on our websites: www.cvpg.org, www.gpmedicalgroup.com, www.gtcipa.com, , www.nobleamaipa.com, and www.stvincentipa.com, along with other valuable information for our contracted providers and our members, and can be printed, if needed. Our business hours are Monday through Friday, 9:00a.m. to 5:00p.m. and Administrative staff can be reached at (760) 941-7309 or (800) 458-2307 during business hours. Should you have a question for the Utilization Management Department after hours, you may call (760) 941-7309 or (800) 458-2307 and leave a message for someone to call you back the next business day.

FDR COMPLIANCE PROGRAM REQUIREMENTS

What is an FDR?

FDR is a Centers for Medicare & Medicaid Services (CMS) acronym for first tier, downstream, or related entity.

A **first tier entity** is a party with a written arrangement with a Medicare Advantage (MA) plan to provide administrative or health care services to Medicare-eligible individuals. Independent Physicians Associations (IPAs) are considered first tier entities.

A **downstream entity** is a party with a written arrangement, below the level of the arrangement between the MA plan and a first tier entity, to provide administrative or health care services to Medicare-eligible individuals. Your organization is considered a downstream entity.

Your subcontractors might also be considered downstream entities. Not all subcontractors are downstream entities.

A **related entity** is a party that holds common ownership or control of a Medicare Advantage plan.

FDR employee refers to employees, temporary employees, volunteers, consultants, and members of an organization's governing body (such as a Board of Directors).

FDR Responsibilities

As a first tier entity, the IPA is responsible to fulfill the terms and conditions in our contracts with MA plans, including compliance program requirements. As a downstream entity, you are responsible to adhere to these requirements as well. This includes ensuring that your downstream entities also comply with all applicable requirements.

You must keep evidence of your compliance with these requirements for at least 10 years. This may include employee training records, exclusion screening results, or proof of the way you oversee your downstream entities. You may be asked to complete an attestation or audit to verify your adherence to these requirements.

If you or your downstream entities fail to meet compliance program requirements, it may lead to retraining, corrective actions, or other sanctions. If you discover a compliance issue, you must take quick action to fix and report the issue. And, you need to prevent it from happening again.

FDR Compliance Requirements

Standards of Conduct and/or Compliance Policies

As a downstream entity, you must provide standards of conduct and/or compliance policies to your employees and downstream entities. The material(s) must include:

- Your commitment to comply with all applicable federal and state laws, ethical behavior, and compliance program requirements;

- The requirement for employees and downstream entities to report compliance and FWA concerns, and all available reporting methods;
- The requirement to report compliance and FWA concerns (that impact the IPA) to Physicians DataTrust; and
- Your zero-tolerance policy for retaliation or intimidation in response to good faith reporting of noncompliance, FWA, or other misconduct.

You must provide this material within 30 days of hire or contracting, annually thereafter, and when the materials are updated. You must also save proof that you provided the material, such as a sign-in sheet, electronic acknowledgement, or signed attestation.

The PDT Code of Conduct and PDT's "Reporting Compliance & FWA Concerns" poster are available at https://pdtrust.com/compliance. You are not required to use these materials.

General Compliance Training & Fraud, Waste, and Abuse Training

As a downstream entity, you must conduct General Compliance training and Fraud, Waste, and Abuse (FWA) Training with your employees and downstream entities. You may use the two training modules developed by CMS, or another version of these training materials, as long as they include all of the concepts from the CMS versions.

You must conduct this training within 30 days of hire or contracting, annually thereafter, and when the materials are updated. You must also save proof that you conducted the training. If you use training logs, reports, or sign-in sheets as evidence of completion, they must include names, dates, and training topics.

The CMS training modules are available at https://pdtrust.com/compliance. You are not required to use these materials.

OIG/GSA Exclusion Screenings

Federal law prohibits Medicare, Medicaid, and other federal healthcare programs from paying for items or services provided by a person or entity excluded from these federal programs. So, before hiring or contracting and monthly thereafter, you must check two exclusion lists. This will help confirm that your employees and downstream entities aren't excluded. The two exclusion lists are:

1. Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) List of Excluded individuals and Entities (LEIE) https://oig.hhs.gov/exclusions/
2. General Service Administration (GSA) System for Award Management (SAM) https://sam.gov

Your organization must maintain evidence that you've screened your employees and downstream entities against both lists. This may include screenshots, input lists, or reports from a third-party vendor. The evidence must show the person or entity's name, the date, the list that was checked, and the outcome of the screening.

If your employee or downstream entity matches with a person or entity found on one of these lists, you must investigate potential match, and document the outcome of your investigation.

False match:

- Document that the match is false. This can be as simple as a note on the screening results that says "false match."
- Save the source documentation, such as a screenshot, that shows the person or entity name, the date, the source, and the information that proves that the match is false.

Confirmed match:

- Immediately remove the person or entity from direct or indirect work supporting IPA business
- Notify Physicians DataTrust at compliance@pdtrust.com, or by phone at (562) 860-8771, ext. 114

Detailed instructions on how to conduct OIG/GSA exclusion screenings, and how to document having done so, are available at https://pdtrust.com/compliance.

Downstream Entity Oversight

As a downstream entity, you must monitor the compliance of your downstream entities. If you choose to subcontract with other parties for services for IPA business, you must make sure they abide by all requirements that apply to you as a downstream entity. This includes ensuring that:

- Written agreements between you and a downstream entity include all CMS-required provisions
- The downstream entity complies with the requirements described in this guide
- The downstream entity complies with applicable operational requirements

You must conduct enough oversight (auditing and monitoring) to ensure your employees and downstream entities are complaint. You must:

- Retain evidence of this oversight
- Ensure that a root cause analysis is conducted for any deficiencies
- Implement corrective actions to prevent recurrence of noncompliance

Not every subcontractor is a downstream entity. Only subcontractors that provide administrative or healthcare services for Medicare beneficiaries, such as a third-party biller, are considered downstream entities. The following types of subcontractors are NOT downstream entities:

- Housekeeping/custodial
- Grounds and maintenance
- Machine repair or servicing

For help identifying which of your subcontractors are downstream entities, please contact Physicians DataTrust at compliance@pdtrust.com, or by phone at (562) 860-8771, ext. 114.

Who must comply?

Organizations providing healthcare services or certain administrative services must uphold an invidual's right to privacy. This means adhering to requirements set forth by the Centers for Medicare & Medicaid Services (CMS), HIPAA and the HITECH Act, the Gramm-Leach-Bliley Act, the IPA, and the IPA's affiliated health plans.

Under HIPAA, health plans, health care clearinghouses, and health care providers are considered **covered entities**.

Subcontractors that perform activities involving the use or disclosure of protected health information (PHI) are considered **business associates**. These activities include creating, receiving, maintaining, transmitting, processing, accessing, or storing PHI.

A covered entity may be a business associate of another covered entity.

Workforce members are employees, volunteers, trainees, and any other persons under the direct control of a covered entity or business associate, regardless of payment.

Your Responsibilities

As a business associate, the IPA is responsible to fulfill the terms and conditions in our contracts with covered entities, and to meet regulatory requirements for patient privacy and information security. As a subcontractor to the IPA, you are responsible to adhere to these requirements as well. This includes:

- Upholding the Business Associate Agreement (BAA) provisions set forth by the IPA,
- Ensuring your subcontractors also uphold these privacy and security standards.

You must keep evidence of your compliance with these requirements for at least 6 years. This may include employee training records, policies, risk assessments, documentation of privacy/security incidents, or proof of the way you oversee your subcontractors. You may be asked to complete an attestation or audit to verify your adherence to these requirements.

If you or your subcontractors fail to meet privacy and security requirements, it may lead to retraining, corrective actions, or other sanctions. If you discover a privacy or security issue, you must take quick action to fix and report the issue. And, you need to prevent it from happening again.

Privacy/Security Requirements

Offshore Operations

Offshore operations refers to operations conducted outside of the United States or United States Territories. An offshore subcontractor provides services performed by workers located offshore. This includes:

- American-owned companies with operations performed outside of the United States
- Foreign-owned companies with operations performed outside of the United States

If any of your employees or subcontractors perform work offshore, and that offshore work includes receiving, processing, transferring, handling, storing, or accessing PHI on the IPA's behalf, you must notify Physicians DataTrust at compliance@pdtrust.com, or by phone at (562) 860-8771, ext. 114.

Physicians DataTrust may be required to report these operations to the IPA's affiliated health plans. And, Physicians DataTrust may require your organization to develop additional controls to ensure PHI is protected in the course of offshore business.

More information about offshore operations is available at https://pdtrust.com/compliance.

Privacy & Security Training

As a subcontractor to the IPA, your organization must maintain policies and procedures to uphold privacy and security requirements. And, you must train your workforce and business associate subcontractors on these policies and procedures, as necessary and appropriate for them to carry out their assigned duties in compliance with privacy and security requirements.

The policies, procedures, and training materials must include the requirement and the method(s) for workforce members and business associates to report privacy and security concerns. And, your policies and procedures must include a provision to report privacy and security concerns (that impact the IPA) to Physicians DataTrust without delay.

You must conduct this training prior to granting access to PHI, annually thereafter, and when there are changes to privacy and security policies. You must also save proof that you conducted the training. If you use training logs, reports, or sign-in sheets as evidence of completion, they must include names, dates, and training topics.

PDT Privacy/Security Training is available at https://pdtrust.com/compliance. You are not required to use these materials.

Subcontractor Oversight

As a subcontractor to the IPA, you must monitor the compliance of your business associate subcontractors. If you choose to subcontract with other parties for IPA business, you must make sure they abide by all requirements that apply to you as a subcontractor of the IPA. This includes ensuring:

- A written service agreement and BAA are in place prior to involvement with IPA business
- The business associate subcontractor complies with the requirements described in this guide
- The business associate subcontractor complies with all applicable privacy and security standards

PDT's BAA template is available at https://pdtrust.com/compliance. You are not required to use this BAA template.

Not every subcontractor is a business associate. Only subcontractors that create, receive, maintain, transmit, process, store, or access PHI are considered business associates. The following types of subcontractors are not business associates:

- Housekeeping/custodial
- Grounds and maintenance
- Machine repair or servicing

For help identifying which of your subcontractors are business associates, please contact Physicians DataTrust at compliance@pdtrust.com, or by phone at (562) 860-8771, ext. 114.