Provider Manual

hoag.
Physician Partners

UPDATED NOVEMBER 2025

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SECTION 1

Overview

The goal of this Provider Manual is to provide you with an understanding of the policies and procedures for Hoag Physician Partners (HPP) and to act as a reference tool that operationalizes your contract and meets both the needs of you and your patients. In the event that there is a conflict between this manual and your specialty care contract, your specialty care agreement prevails.

Periodically, you will receive updates to the manual. Please follow the instruction sheet and add the materials to the sections indicated.

HPP is committed to providing quality management services, including:

- Capitation Payment
- Claims Payment
- Contract Administration
- Customer Service – Hoag Network Navigation Team
- Eligibility Verification
- Medical Authorization
- Nurse Advice
- Patient Relations
- Provider Relations Services
- Quality Assurance & Peer Review Support
- Quality Improvement
- Utilization Management

Should you need to contact us, please use the address, phone number or email below:

Hoag Physician Partners
2995 Red Hill Avenue, Ste. 200
Costa Mesa, CA 92626
(949) 791-3502
HPP.Providers@hoag.org

Mission

As a not-for-profit, faith-based organization, Hoag's mission is to provide the highest quality health care services to the communities we serve.

Vision

Hoag is a trusted and nationally recognized healthcare leader.

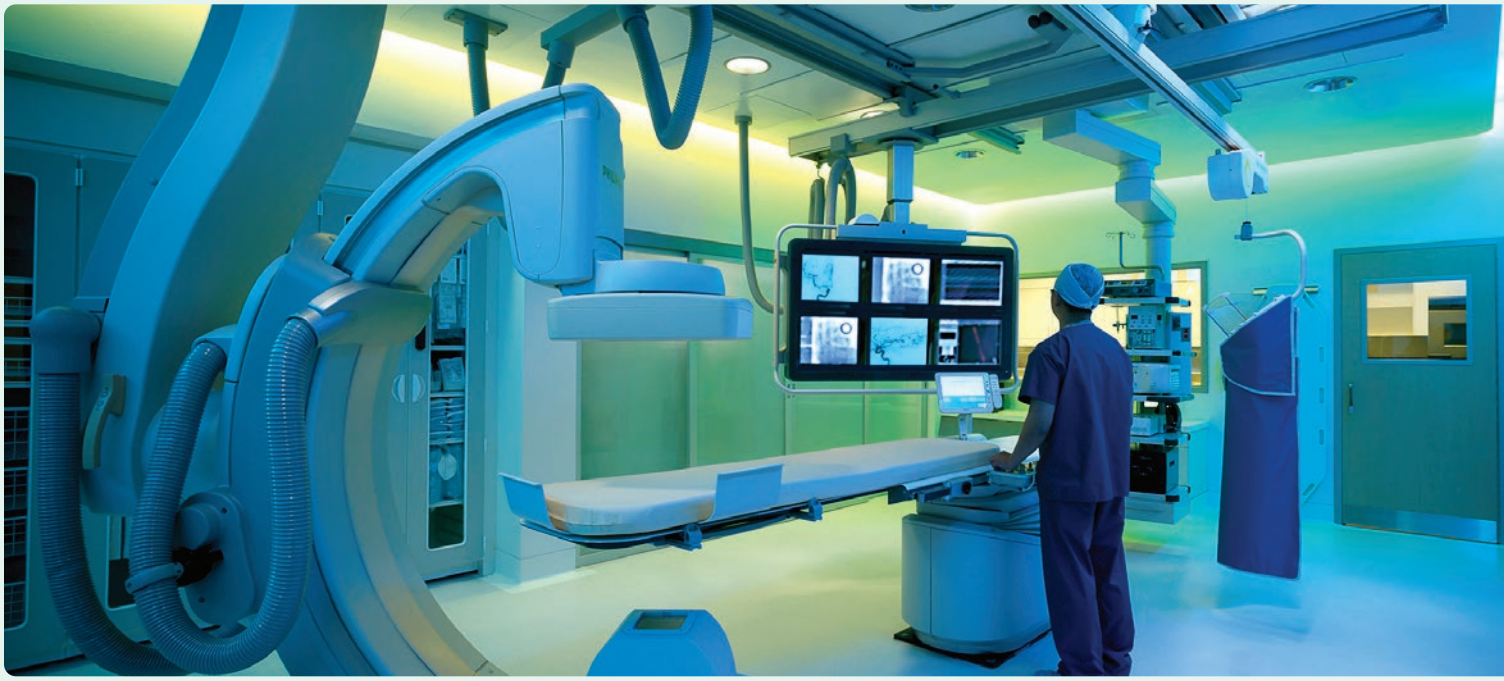
Core Values

Excellence • Respect • Integrity • Patient Centeredness • Community Benefit

SECTION 2

Physician Directory

Access our Physician Directory using the QR code below. Please use the most up-to-date QR code currently in use for the directory. These rosters are not to be used to determine referrals. Please visit Hoag.org to view HPP physician details, including addresses and phone numbers. Patients can access the most up-to-date Physician Directory using the QR code provided.



SECTION 3

Contracted Health Plans and Facilities

HMO Contracts

The following is a list of current HMO/POS contracts:

Commercial Plans

Aetna US Healthcare

Aetna Value Network

Anthem Blue Cross

Anthem Priority Select HMO

Blue Shield

Blue Shield Trio

Cigna

Cigna Select Network

United Healthcare

Senior Plans

Anthem Blue Cross

SCAN

United Healthcare

Contracted Hospitals

Hoag's Primary Hospitals:

HOAG HOSPITAL NEWPORT BEACH
1 Hoag Dr.
Newport Beach, CA 92663
(949) 764-4624

HOAG HOSPITAL IRVINE
16200 Sand Canyon Ave.
Irvine, CA 92618
(949) 764-4624

HOAG ORTHOPEDIC INSTITUTE
16250 Sand Canyon Ave.
Irvine, CA 92618
(855) 999-4651

Urgent Care

All of Hoag's Urgent Care locations are open Monday through Friday from 8 a.m. to 8 p.m. and Saturday/Sunday from 8 a.m. to 5 p.m. Some locations offer weekday extended hours from 7 a.m. to 10 p.m. You can reserve a spot online at any of the below locations by visiting www.hoagurgentcare.com.

HOAG URGENT CARE ALISO VIEJO
26671 Aliso Creek Rd., Suite 101
Aliso Viejo, CA 92656
(949) 791-3107

HOAG URGENT CARE FOOTHILL RANCH
26672 Portola Pkwy., Suite 100
Foothill Ranch, CA 92610
(949) 557-0710

HOAG URGENT CARE HUNTINGTON BEACH
19582 Beach Blvd., Suite 180
Huntington Beach, CA 92648
(714) 477-8050

HOAG URGENT CARE HUNTINGTON HARBOR
5341 Warner Ave.
Huntington Beach, CA 92649
(714) 477-8450

HOAG URGENT CARE IRVINE – LOS OLIVOS
8607 Irvine Center Dr.
Irvine, CA 92618
(949) 557-0600

HOAG URGENT CARE IRVINE – ORCHARD HILLS
3877 Portola Pkwy.
Irvine, CA 92602
(949) 557-0720

HOAG URGENT CARE COSTA MESA
1190 Baker Street, Suite 105
Costa Mesa, CA 92626
(714) 477-8460

HOAG URGENT CARE DOVE CANYON
31951 Dove Canyon Drive
Trabuco Canyon, CA 92679
(949) 557-0880

HOAG URGENT CARE JAMBOREE
4699 Jamboree Road
Newport Beach, CA 92660
(949) 557-0990

HOAG URGENT CARE IRVINE – SAND CANYON
16205 Sand Canyon Ave., Suite 100
Irvine, CA 92618
(949) 557-0000

HOAG URGENT CARE IRVINE – WOODBRIDGE
4900 Barranca Pkwy., Suite 103
Irvine, CA 92604
(949) 791-3106

HOAG URGENT CARE IRVINE – WOODBURY
6340 Irvine Blvd.
Irvine, CA 92620
(949) 559-6500

HOAG URGENT CARE – MONARCH BEACH
24060 Camino Del Avion, Suite A
Dana Point, CA 92629
(949) 557-0870

HOAG URGENT CARE – NEWPORT BEACH
500 Superior Ave., Suite 160
Newport Beach, CA 92663
(949) 791-3006

HOAG URGENT CARE – NEWPORT COAST
21115 Newport Coast Dr.
Newport Beach, CA 92657
(949) 557-0730

HOAG URGENT CARE SAN CLEMENTE
993 Avenida Pico
San Clemente, CA 92673
(949) 557-0400

HOAG URGENT CARE – TUSTIN LEGACY
15000 Kensington Park Dr., Suite 170
Tustin, CA 92780
(714) 477-8300

Hoag Ambulatory Surgery Centers

CALIFORNIA SPECIALTY SURGERY CENTER
26371 Crown Valley Pkwy.
Mission Viejo, CA 92691

HOAG ENDOSCOPY CENTER
500 Superior Ave., Suite 120
Newport Beach, CA 92663

HOAG ENDOSCOPY CENTER, IRVINE
16405 Sand Canyon Ave., Suite 110
Irvine, CA 92618

HOAG ORTHOPEDIC INSTITUTE SURGERY CENTER
22 Corporate Plaza, Suite 150
Newport Beach, CA 92660

HOAG ORTHOPEDIC SURGERY CENTER ALISO VIEJO
15 Mareblu, Suite 100
Aliso Viejo, CA 92656

HOAG SURGERY CENTER, IRVINE
16405 Sand Canyon Ave., Suite 100
Irvine, CA 92618

MAIN STREET SURGERY CENTER
280 S. Main St., Suite 100
Orange, CA 92868

NEWPORT BAY SURGERY CENTER
3333 W. Coast Hwy., Suite 100
Newport Beach, CA 92663

NEWPORT BEACH ORANGE COAST ENDOSCOPY CENTER
1525 Superior Ave., Suite 114
Newport Beach, CA 92663

NEWPORT PLAZA SURGERY CENTER
1901 Newport Blvd.
Newport Beach, CA 92663

Hoag Radiology & Imaging Services

(Refer to www.hoag.org for specific imaging services at each location)

HOAG HEALTH CENTER ALISO VIEJO
26671 Aliso Creek Rd., Suite 106
Aliso Viejo, CA 92656

HOAG HEALTH CENTER COSTA MESA
1190 Baker St., Suite 102
Costa Mesa, CA 92626

HOAG HEALTH CENTER HUNTINGTON BEACH
19582 Beach Blvd., Suite 150
Huntington Beach, CA 92648

HOAG HEALTH CENTER NEWPORT BEACH
510 Superior Ave., Suite 100
Newport Beach, CA 92663

SUE J. GROSS COMPREHENSIVE BREAST CENTER
Hoag Hospital Newport Beach
One Hoag Drive
Newport Beach, CA 92663

MARILYN HERBERT HAUSMAN ADVANCED TECHNOLOGY PAVILION
Hoag Hospital Newport Beach
Lower Campus
One Hoag Drive, Bldg. 47
Newport Beach, CA 92663

HOAG HEALTH CENTER IRVINE – SAND CANYON
16305 Sand Canyon Ave., Suite 150 & 160
Irvine, CA 92618

HOAG HEALTH CENTER IRVINE – WOODBRIDGE
4870 Barranca Pkwy., Suite 100
Irvine, CA 92604

HOAG HEALTH CENTER IRVINE – WOODBURY
6352 Irvine Blvd.
Irvine, CA 92620

HOAG HEALTH CENTER FOOTHILL RANCH
26672 Portola Pkwy., Suite 106
Foothill Ranch, CA 92610

HOAG HEALTH CENTER SAN CLEMENTE
993 Avenida Pico, Suite 140
San Clemente, CA 92673

Weekend appointments offered at several locations.

To schedule an appointment, please call
(949) 764-5573.

Online Booking can be found: https://www.hoag.org/specialties-services/other-programs-services/radiology-imaging-services/

SECTION 4

Role of Physicians

Hoag Physician Partners (HPP) Code of Conduct

Purpose of the Code of Conduct

The Hoag Physician Partners (HPP) Code of Conduct ("Code") provides guidance for all who represent HPP, ensuring that our actions reflect the highest ethical and legal standards. Providers are responsible for maintaining appropriate licensure for their practice and for any individuals under their direct supervision. They must also restrict their practice to the scope of their licensure.

The Code embodies Hoag's Core Values and supports our commitment to providing safe, high-quality, and ethical care. It applies to all relationships and interactions, including those with:

- Patients
- Colleagues and employees
- Physicians and allied health professionals
- Contractors, vendors, and community partners

Adherence to the Code is mandatory. Any conduct that violates applicable laws, regulations, or Hoag policies may result in changes to participation in the network.

HPP Code of Conduct and Professional Standards

This Code of Conduct outlines the professional standards and ethical expectations for all physicians and providers affiliated with HPP. It reflects Hoag's Mission, Vision, and Core Values and reinforces our collective responsibility to uphold integrity, excellence, and trust in all aspects of care. Physician providers must also abide by the Code of Ethics established by the Judicial Council of the American Medical Association and all relevant plan policies.

HPP physicians are expected to exercise good judgment, honesty, respect, and ethical standards in all professional interactions—with colleagues, patients, and the community. Each physician is accountable for understanding, implementing, and practicing professional and ethical standards, Performance Expectations, and Core Values in all aspects of care delivery and professional conduct.

Professional and Ethical Standards

STANDARD	KEY EXPECTATIONS
Patient-Centered Care	Prioritize patient safety, dignity, and well-being. Ensure informed consent and shared decision-making. Providers must not discriminate based on race, color, national origin, religion, sex, sexual orientation, disability, physical handicap, or available benefits. Promote equitable access, provide culturally sensitive care, and eliminate bias and discrimination.
Principles of Partnership	Maintain honesty, respect, and transparency in clinical and administrative interactions.
Conflict of Interest	Avoid situations where personal or financial interests compromise clinical judgment or patient care.
Compliance	Follow all laws, regulations, and organizational policies, including HIPAA and privacy requirements.
Communication	Communicate professionally, respectfully, and constructively. Respond promptly to inquiries from patients, HPP, IPA, and affiliated organizations.
Clinical Excellence	Commit to ongoing professional development, evidence-based practice, and participation in peer review and quality improvement.
Stewardship	Use healthcare resources judiciously & responsibly and cost-effectively without compromising quality.

Performance Expectations

HPP is committed to supporting productive, responsive, and high-performing physicians who contribute to the success of the organization and the well-being of our patients. Physicians are expected to meet or exceed performance standards consistent with organizational expectations and best practices in patient care.

Primary Care Physicians

Health maintenance organizations (HMOs) require their members to select a primary care physician (PCP) at the time of enrollment. PCPs practice in one of the following areas:

- Family Medicine
- General Practice
- Internal Medicine
- Pediatrics

PCPs have the following responsibilities:

- Provide care or arrange for their members' routine, emergency and urgent care needs 24 hours a day, seven days a week
- Coordinate appropriate referrals for specialty care, hospitalization and ancillary services
- Assure continuity of patient care
- Participate in quality improvement, utilization management, credentialing, and provider relations programs

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

Routine Office Visits

- Well baby care (Family medicine/pediatrics), including developmental assessment and enrollee/parent education
- Complete physicals as outlined in participating plan guidelines (Please refer to plan timeline for athletic, school, camp or insurance physicals)
- Tuberculosis skin test/Mantoux
- Preventive medical care, including health risk identification and reduction and periodic screening

Office Visits for Treatment of Acute and Chronic Illness with related services provided in Professional's office

- Injections (I.e., antibiotics, allergy medications, vitamins, hormone, flu vaccine, etc.) and immunizations
- Eye and ear screening exams, including routine screening of auditory and visual acuity
- Office GYN (Pap smears, breast exams, birth control, vaginitis, etc.)
- Proctoscopy
- Diagnosis of alcohol/chemical dependency
- Recognition of psychological problems, including routine outpatient management of anxiety and depression
- Allergy treatment (In conjunction with a treatment plan from allergist if appropriate); not including sensitivity testing or antigen preparation
- Ear irrigation
- Care of colds, flu and other minor illnesses
- Treatment of uncomplicated, venereal diseases
- Diagnosis, treatment and follow-up of uncomplicated hypertension, urinary tract infections, otitis, conjunctivitis and other uncomplicated infectious diseases
- Management and follow-up of uncomplicated controlled diabetes mellitus
- Care of routine and uncomplicated skin, rheumatic and orthopedic conditions

Minor Injuries

- Burn care (First and second degree)
- Suturing simple lacerations up to 5 centimeters in length (Excluding facial and hand lacerations in which plastic repair is deemed necessary)
- Suture removal
- Treatment of epistaxis

Minor Office Surgical Procedures

- Biopsy or removal of cysts, moles and growths (Except facial)
- Electrosurgical/cryosurgical destruction of lesions (Except facial)
- Simple incision and drainage procedures

Miscellaneous Supplies Related to Treatment in Professional's Office

- This includes dressing, ace bandages, simple splints, and other routine supplies

Inpatient and Outpatient Hospital Care

- Visits and examinations as medically necessary or required at participating skilled nursing facility

Telehealth (phone or video) consultations with enrollees, as needed

Home Visits, when necessary, as determined by Professional

Electrocardiograms

Twenty-Four (24) Hour On-Call Coverage to include development, maintenance and communication of arrangements. This allows enrollees to contact a physician familiar with the plan's procedures to evaluate acute medical problems by phone.

Recommend and coordinate the care of consulting specialists, while remaining the enrollee's advocate and care manager.

Direct access to Women's Health Services

Under the requirements of applicable laws and regulations, Professional shall permit direct access to Hoag's health specialists for routine and preventative services and screening mammography.

Vaccines

Under the requirements of applicable Medicare laws and regulations, Professional shall permit direct access for the influenza vaccine and shall not impose cost-sharing for influenza vaccine or pneumococcal vaccine.

Health Assessments

Under the requirements of applicable Medicare laws and regulations and the HPP Provider Manual, Professionals shall cooperate with Hoag and Medicare Advantage organizations regarding the conduct of health assessments for new enrollees within ninety (90) days of enrollment. One visit that will be important to schedule for your Medicare Advantage HMO seniors is an Annual Health Assessment (AHA). During this visit, you or a Nurse Practitioner will review your patient's health history and create a personalized plan and road map to help them stay healthy. This visit will include a review of their new and current health conditions and prescriptions, discuss necessary screenings, personalized health advice and more.

Laboratories

Hoag's contracted laboratories should provide all laboratory services. Laboratory services provided in the Professional's office are included under the capitation fee, unless the contract dictates otherwise.

Radiology

All radiology services should be provided by the Hoag's contracted facility. Radiology services provided in the Professional's office are included under the capitation fee, unless the contract otherwise.

SECTION 5

Patients' Rights and Responsibilities

Patient Rights

Members have rights and associated responsibilities in the course of their health care service delivery. All contracted health plans have formal statements of member rights and responsibilities. The following represents some of the rights a member has:

- Receive care that is respectful of your personal beliefs, cultural, and spiritual values
- An explanation in terms that you can understand and have any questions answered concerning your symptoms, diagnosis, prognosis, and treatment
- Appropriate assessment and management of your symptoms, including pain
- Know your: diagnosis, prognosis, testing, and treatment, risks of treatment, common side effects of medications and financial considerations associated with medical care
- Know the contents of your medical records through interpretation by the provider
- Know your health care team
- Develop a collaborative plan to prevent your medical problem from recurring
- Choose or change your provider
- Refuse to be examined or treated and be informed of the consequences of such decisions
- Be assured of the confidential treatment of disclosures and records and approve/refuse the release of such information, except when a release of specific information is required by law or is necessary to safeguard you or the community
- Be informed and provide consent to participate in research conducted
- Participate in consideration of an ethical issue that may arise in the provision of your care
- Provide feedback on the services you receive

Patient Responsibilities

- Provide information about your current symptoms, including pain and medications
- Provide information about your medical and mental health history
- Ask questions if you do not understand the directions or treatment given by a provider
- Keep appointment or notify the provider within a reasonable time frame if you need to cancel
- Be respectful of others and other's property while a HPP provider location
- Limit the use of mobile devices while at HPP

SECTION 6

Credentialing

Credentialing

It is our policy to credential all contracted physicians and mid-level clinicians under National Committee for Quality Assurance (NCQA), Centers for Medicare and Medicaid Services (CMS), California Department of Managed Health care (DMHC) and individual health plan standards to ensure quality providers for our network and members.

The contracted provider is responsible for sending any information requested by the Enterprise Credentialing Department within time frames specified on the request to comply with these standards. Failure to do so can result in termination of contract and removal from the directory.

It is a requirement that physician's files are kept current. Any changes, including, but not limited to, change of office hours, address, phone, fax or tax identification number, should be reported by the physician's office to the Provider Relations Department. The information will be processed and changed in our database, then forwarded to the respective health plans. This process may take up to 30 days to record all changes. All physician information is kept strictly confidential.

Physicians and mid-level clinicians are re- credentialed at least every 36 months. Those practitioners who are also Hoag Medical Staff members, however, will be recredentialed at the time of their reappointment process for medical staff membership and privilege renewal (At least every 24 months) to reduce the administrative burden on those practitioners. This process requires the submission of the completed application for renewal with all supporting documents as requested. Please note: the re-credentialing process, including the practitioner application, will be completely electronic, so maintaining an accurate email address is imperative.

Credentialing Process

Required for all contracted and employed practitioners

Initial applications

- Applications for initial credentialing are obtained by calling or emailing the Hoag Hospital Medical Staff Services Department or the Hoag Enterprise Credentialing Department
- A link to the pre-application questionnaire is then sent to the requester. The questionnaire must be completed and submitted for evaluation against the minimum requirements. This evaluation of the information provided and a response to the potential applicant for initial credentialing will occur within 7 days of receipt
  - If minimum requirements are met, a link to the online application is provided
  - If minimum requirements are not met, the potential applicant for initial credentialing will be informed of the specific reason. The application cannot be released and any options he/she might have to remediate the decision are provided
- Required primary source verification is conducted and documented within each practitioner credential file
- The practitioner will be notified if any information obtained during the credentialing process varies substantially from the information provided to

Hoag's Medical Staff Services and/or Enterprise Credentialing Departments by the practitioner. This notification will be made by email and/or telephone

  - All applicants have the right to be informed of the status of their application
  - Credentialing decisions are made in a non-discriminatory manner
  - Notices to applicants of initial credentialing and re-credentialing decisions will be made within 60 days of the decision by email

Re-credentialed at least every 36 months

- The link for applications for re-credentialing are sent via email 6 months in advance of the expiration date of the current appointment and is due within 30 days of receipt

The Hoag Enterprise Credentialing Department will monitor for:

- The currency of licensure, DEA, and Professional liability insurance
- Medicare sanctions
- Sanctions or limitations on licensure
- Past and current reports and recommendations on the quality of care provided to its members

For questions regarding your credentialing application, please email Credentialing@hoag.org.

SECTION 7

Provider Relations

Our Provider Relations Department is committed to serving our providers in the most effective manner possible. The primary goal of the Provider Relations Department is to facilitate clear and consistent communication between the IPA and its contracted providers .

The Provider Relations Department provides the following services, which include but are not limited to, the following:

- New provider orientations
- Coordinating resolution of provider grievances
- Coordinating regularly scheduled office manager meetings
- Processing provider changes of address
- Processing provider phone number changes or additions
- Processing provider fax number changes or additions
- Processing provider change of Tax I.D. number
- Hospital affiliation changes
- Addition of a new provider in your office
- Addition of a new nurse practitioner or physician assistant in your office
- Distributing rosters for both primary care physicians and specialists

We encourage providers to contact Provider Relations at hpp.providers@hoag.org with any questions and concerns. Our staff is committed to responding promptly to any questions and concerns. They are available to meet with individual physicians and offices as needed.

Demographic Changes

All demographic changes, physician changes, additions or terminations must be reported by email to JointheNetwork@hoag.org.

To Add New Providers

If your practice is adding a new provider, please contact JointheNetwork@hoag.org.

Questions?

Please email HPP.Providers@hoag.org.

SECTION 8

Eligibility

Patient Eligibility

Eligible individuals are those who have enrolled in the health plan and meet all the applicable eligibility requirements.

Eligibility Verification

It is the provider's responsibility to confirm the member's eligibility upon request for services.

You can verify eligibility via the following methods:

- **Preferred method:** Contact the health plan directly (Via the health plan website or using the eligibility phone numbers for each health plan listed on page 20)
- You may also contact Hoag Physician Partners at (800) 684-0717

Please note: Members can be eligible even if their names do not appear on the eligibility list. It is the responsibility of all provider offices to verify eligibility before providing services.

Eligibility Guarantee

Please do not turn away a member who does not present health plan identification upon seeking services at your office. Please take the time to utilize all of the appropriate resources to verify eligibility. When in doubt, use the Eligibility Guarantee Form (See template on page 18).

To guarantee payment, the office must check eligibility two days before the scheduled appointment. Evidence of eligibility check must be entered into members' charts. If the member was not eligible, the office must submit supporting documentation with the claim.

Eligibility Guarantee Form Template

(Physician's office letterhead)

I, **(NAME OF PATIENT)**

hereby certify that I am eligible for

(NAME OF HMO)

through **(MONTH/DAY/YEAR)**

with **(EMPLOYER GROUP)**

I have chosen **(PCP)**

to be my medical provider. I understand that if the above is not true or if I am not eligible under the terms of my employer's Medical and Hospital Subscriber Agreement, I am liable for all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services received within 30 days of receiving a bill from the above noted IPA.

(SIGNATURE OF MEMBER OR GUARDIAN)

OFFICE USE ONLY

Eligibility Verified by:

(OFFICE PERSONNEL VERIFYING ELIGIBILITY) **(DATE)**

(HMO MEMBER SERVICES REPRESENTATIVE) **(DATE)**

Member Verified: Yes No

Employer Verified: Yes No

Transfers/Disenrollment/Removal of Members

To contact Patient Relations, please call (949) 764-5275.

Physicians may terminate the doctor/patient relationship for cause by following the procedure listed below. Patients may never be discharged based on age, religion, gender, ethnicity, sexual orientation, race, disability, gender identity, gender expression, or medical diagnosis.

Examples of just cause must be fully documented, including direct quotes, and include but are not limited to:

- Violent/aggressive behavior
- Letter of Intent to Sue or legal action initiated
- Fraudulent Behavior
- Rude, disruptive, violent, bullying, demeaning, threatening, dishonest, illegal, litigious, drug-seeking, or non-cooperative behavior with staff or providers, whether in person, virtually, or on the phone
- Repeated failure to keep appointments (Three or more within 12 months)
- Non-compliance or refusal to comply with the physician's recommended treatment plan, counsel, or procedure

A practice that has cause to disenroll a member from their practice must follow these steps:

- Send one or more warning letters describing the issue (e.g., no-show, inappropriate behavior, or noncompliance) and giving the patient the opportunity to meet expectations and correct the behavior within a specified time period, if applicable
- If there is no response or change in behavior after the warning letter(s), or if the reason for disenrollment potentially warrants immediate dismissal, contact Patient Relations to discuss next steps. Be prepared to provide all supporting documentation to Patient Relations
- The physician will notify Patient Relations and submit Patient Dismissal Request Form and all supporting documentation, i.e., collection notices, medical records with a notation of incident(s), any counseling done by a physician, etc
- Patient Relations will submit all pertinent information to the member's health plan.
- The health plan will review the documentation and decide to:
  - Document the transfer and not disenroll the member from the assigned PCP and IPA
  - Disenroll the member from HPP, depending on the severity and frequency of the cause
- If the decision is to disenroll the member, the documentation from the provider, as well as a letter from network management, will be evaluated by the health plan, who will then notify Patient Relations of their response
- If the health plan grants the request, send a letter notifying the member, certified with return receipt. Patient Relations can provide an appropriate discharge letter template. Continue to provide care for 30 calendar days after the date the certified letter was received by the member.
- The provider should check the eligibility list to ensure the patient was reassigned. Please remember the information on the e-lists does not show transfers until 30-60 days after the fact, Therefore, it is recommended that the provider's office track and communicate with the appropriate health plan that the patient has been reassigned to another physician. This is in case the member does not contact the health plan at all. In most cases, the patient calls the health plan themselves, but be prepared to show proof of the certified letter to the health plan if there has been no communication

Eligibility Phone Numbers

HEALTH PLAN	PHONE NUMBER
Aetna US Health Care	(800) 624-0756
Anthem – Blue Cross	(800) 676-2583
Blue Shield of California	(800) 541-6652
Blue Shield	(800) 676-2583
Cigna	(800) 882-4462
SCAN	(877) 270-7226
United Healthcare	(877) 842-3210

SECTION 9

Providers & Members – Customer Service

Claims – Provider Services

Status of Claims

Providers may check claims' status by logging into the EpicCare Link Portal. If you need additional assistance, you can call our Claims Line at (855) 538-0841. The Claims Line is staffed Monday through Friday from 8 a.m. to 12 p.m. and 1 p.m. to 4 p.m.

When calling for status on a claim, please have the following information available:

- Patient's name
- Patient's ID number
- Patient's date of birth
- Patient's health plan
- Date(s) of service
- Authorization number, if applicable

Pulling Remittance Advice

A PDF remittance advice document can be found within Remittance Advice Search in EpicCare Link.

- Search via Claim ID, Member ID, or Provider in EpicCare Link
- Select the hyperlink within the Check Number
- PDF of Remittance Advice will open and available to Print or Download

Customer Service – Hoag Network Navigation Team

Our Hoag Network Navigation Team is available to answer any questions or concerns you may have regarding health care services provided by Hoag or our physicians. If you have general questions or need help with locating our facilities, please call (800) 400-HOAG (4624).

Provider Relations

Email: HPP.Providers@hoag.org

- Demographics Updates
- Provider Support

Epic Link Support

Email: HPP.Providers@hoag.org

- Login and Technical Issues
- Password resets
- New user requests

Utilization Management

Email: UMTeamHoagClinic@hoag.org
Phone: (949) 791-3490
Routine Fax: (949) 791-3491
Expedited Fax: (949) 791-3492
Inpatient Fax: (949) 791-3489
Address:** P.O. Box 3499, Costa Mesa CA 92628

- Referral status
- Referral entry support
- CPT/HCPCs code look up
- AARG questions
- Locating in-network providers

**Address for UM, Care Mgmt, Med Records

Claims

Phone: (855) 538-0841
Inbasket: Tapestry Link
Address: P.O. Box 1260, Costa Mesa CA 92628
Provider Disputes: P.O. Box 2010, Costa Mesa CA 92628

- Payment Status
- Submission and Resubmission Questions
- Denial Questions
- Benefit/patient liability questions related to claim paid or denied.

Enrollment

Email: Eligibility@hoag.org
Phone: (949) 734-4763
Fax: (949) 791-3529
Inbasket: Tapestry Link

- Enrollment Updates
- Enrollment Questions
- Please contact the health plan for patient benefit questions.

SECTION 10

Laboratory Services

For **Hoag Medical Group** and **Hoag Physician Partners** managed care patients (HMO), please direct them to Quest Diagnostics Services.

Quest Laboratories

If your office draws blood for Quest, you can coordinate directly with Quest for supplies and pick-up. Please call (833) 648-2042 to contact the Quest Diagnostics concierge team to set up courier service.

Appointments and locations are available on the Quest website:

https://appointment.questdiagnostics.com/patient/confirmation

Please use the Quest Diagnostics Test Directory to search for available tests:

https://testdirectory.questdiagnostics.com/test/home

Hoag patients (FFS) can obtain laboratory services at Quest Laboratories and Hoag Laboratories.

Quest Laboratories

If your office draws blood for Quest, the office will need to make arrangements with Quest for supplies and pick-up.

Appointments and locations are available on the Quest website:

https://appointment.questdiagnostics.com/patient/confirmation

Hoag Laboratories

Hoag Laboratories are located at:

Hoag Health Center Newport Beach
510 Superior Ave., Suite 100
Newport Beach, CA 92662

Hoag Health Center Irvine – Sand Canyon
16305 Sand Canyon Ave., Suite 270
Irvine, CA 92618

Appointments can be made by calling (949) 764-5600.

SECTION 11

Claims

Submission of Encounters and Payable Claims

- Services that are covered under a physician's capitation are referred to as encounters. Encounters are required to be submitted on a CMS 1500 claim form for all services provided to capitated patients within 30 days of the date of service
- For services not included as capitated responsibilities, submit a completed CMS 1500 claim form within 90 days from the date of service, along with a copy of the authorization form or number
- **Preferred Method:** All encounters and payable claims should be submitted electronically using Hoag Physician Partners EDI Payer ID "HPPZZ." Hoag Physician Partners EDI vendor Office Ally will work with any provider's EDI clearing house for EDI claims submission
- If a paper claim is required, the claim should be submitted to the following address

Hoag Clinic
P.O. Box 1260
Costa Mesa, CA 92628

Processing Timeline

- Maximum 64 calendar days for processing Commercial claims
- Maximum 60 calendar days for processing Contracted Medicare claims
- Maximum 30 calendar days for processing non-contracted Medicare claims
- Member eligibility will be verified and the provider will be reimbursed at the contracted rate within the appropriate timeline
- To avoid any delays in claims processing, please make sure that the claim is complete and accurately documented

Claims Provider Dispute

Providers can request a reconsideration of a claim previously paid or denied by submitting a Provider Dispute Resolution (PDR) request to:

Hoag Clinic
Attention: Claims Provider Dispute Resolution
P.O. Box 2010
Costa Mesa, CA 92628

Encounter Data

The CMS 1500 is the required format for billing submission. The following information shall be included:

- Enrollee's full name
- Enrollee's full address
- Enrollee's date of birth
- Enrollee's sex
- Enrollee's plan affiliation
- Diagnostic code and description (ICD-10 / CPT Code)
- Date of service
- Place of service
- Procedures, services or supplies furnished
- Physician's name (not the name of the Physician's Group)
- Physician's address
- Physician's telephone number
- Charges

Non-Authorized Services

- Hoag will not be financially responsible for services rendered without prior authorization
- Commercial denial letters are sent within 30 days
- Medicare denial letters are sent within 60 days

No Balance Billing of Patients

According to the Knox-Keene Health Care Service Plan Act of 1975:

Provider shall look only to IPA for compensation for primary care services and any other covered services and shall at no time bill, charge, collect a deposit from or seek compensation from Enrollees or Plans for primary care services or Covered Services, including without limitation, nonpayment by IPA or any plan insolvency of IPA or any Plan. No surcharge to any enrollee shall be permitted.

Provider shall bill and collect all co-payments and deductibles specifically permitted in an Enrollee/Plan contract from Enrollee. Provider may further bill and collect all charges from an Enrollee for those non-covered services provided to an enrollee; provided, however, before providing said non-covered services, provider shall obtain written acknowledgment from the Enrollee that said services are not covered under the Enrollee.

SECTION 12

Hoag Clinic's Clinical Quality Improvement Program

Hoag Clinic's Clinical Quality Improvement Program monitors, tracks, and evaluates the ongoing performance of preventive care, chronic disease, and medication management measures using HEDIS and PQA specific guidelines.

HEDIS and PQA

What are HEDIS and PQA?

The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of performance measures that focus preventive services, chronic disease management, and patient satisfaction overseen by the National Committee for Quality

Assurance (NCQA). NCQA is a national organization that helps improve healthcare quality. The Pharmacy Quality Alliance (PQA) is a national organization dedicated to improving medication safety, adherence, and appropriate use.

Both PQA & NCQA are essential to ensure that we follow evidence-based standards of care so that our members receive high quality of care. Thus, it is vital that our providers understand HEDIS specifications and guidelines in addition to the clinical workflows around them.

HEDIS measures focus on chronic disease management, prevention, screening, conditions across all body systems, access to care, satisfaction with care and utilization of specific procedures and care settings.

Hoag Clinic participates in health plan specific quality & /value-based programs and the Integrated Healthcare Association (IHA) Align. Measure. Perform. (AMP) program.

How to Submit HEDIS Data: Claims and Encounters

1. The preferred method of data submission for all HEDIS information on a claim (HCFA 1500), which is an efficient and highly automated claims process that ensures prompt and appropriate payment for your services.
2. If any information is not captured via claims and encounters, Hoag Clinic Population Health/ Quality Improvement Team will partner with provider offices to obtain visit notes, lab results and procedure notes to close open care gaps. The preferred method of receiving this information is via remote access to Hoag Clinic's managed care visit charts or record retrievals via EpicCare Link. We may also accept them via Fax or Secure File Transfer (SFT).
3. General HEDIS Tips to Improve Scores:
   - Use appropriate billing and documentation codes and submit your encounters promptly.
   - Utilize monthly performance care gap reports and Cozeva to identify patients who have gaps in care.
   - Avoid missed opportunities, regardless of the reason for the visit, and take the opportunity to close care gaps.
   - Schedule follow-up visits before the patient leaves the office.
   - Provide patient with the necessary follow-up care items, such as radiology and laboratory orders.

To assist physician practices in closing HEDIS quality care gaps, Hoag Physician Partners encourages physicians to perform a comprehensive assessment for all patients annually.

Cozeva

Cozeva is a cloud-based product. Recommended web browsers include Google Chrome, Mozilla Firefox, Apple Safari or Internet Explorer version 11.0 or higher.

Cozeva utilizes population health registries to display performance on quality measures and risk adjustment performance by interfacing with clinical data. Providers and their supporting team members access Cozeva by navigating to www.cozeva.com. For new account access and in-office training, contact your provider relations representative.

Registries: Displays practice/provider performance across all measures

Search Bar: Can be used to search for Providers or Patients/Members

- Some additional options to search patients:
  - Demographic information
  - Test date
  - Weighted Care Gap
  - Compliancy
  - Events
- Current – Patients who are attributed to the provider in the current quarter
- Other – Patients with historical attribution, previous claims or other related interactions with the provider

Dashboard**:** Populates measure performance, which can be drilled down to Patient Panel, and displays demographic information, care opportunities and encounters across the network.

Detailed Care Opportunity History: Displays all relevant service and diagnosis codes, descriptions, corresponding provider or specialist results and service date(s).

Member Data: Available detailed patient information.

- Medications
- Lab Results
- Immunizations
- Claims
- Procedures
- Other misc. data

Medication Adherence Measures: Cozeva displays a comprehensive list of medications for patients and will flag overdue medication measures as part of HEDIS and CMS Start programs.

To improve these measures, please discuss with patients barriers for obtaining and adhering to medication regimens, switching to home delivery, and prescribing 90-100 day fills.

Navigation:

- Practice View – Some users in Cozeva have Practice level access. Performance is aggregated for each measure across all associated providers within the practice. The numerator and denominator values are combined for all providers in this view.
- Provider View – Practice users can switch to a single Provider view by selecting a provider's name from any measure list / Providers list or typing a provider's name into the search bar.

Quality Improvement Reporting

The intent is to improve HEDIS measures rates using frameworks in:

- Health plan specific quality/value-based programs
- IHA Align, Measure and Perform (AMP Commercial)
- Medicare CMS Stars

Chronic Condition Management

Working with Active Conditions (HCCs): Cozeva displays HCCs identified through past diagnoses and suspect HCCs that meet suspect model criteria in the Active Conditions registry.

- Confirm and disconfirm non-addressed HCCs for patients via the Supplemental Data tool
  - HCC Lookup Tool
    - › HCC to ICD10 Conversion
    - › ICD9 to ICD10 Conversion

Risk Adjustment

The Center for Medicare and Medicaid Services (CMS) defines "Risk Adjustment" as a method to calculate capitation rates on a patient's health and the likelihood of health care services used and the costs of healthcare services. In a risk-adjusted payment model, the more severe or complex a diagnosis, the higher the risk value assigned to it. A risk adjustment value is assigned to each diagnosis code that falls into the payment model.

Hospital and physician claims are the main sources of data that drive the risk adjustment model, but all providers of care must review their diagnosis coding practices ensuring they are presenting an accurate clinical picture of the patient. Likewise, the documentation in the medical record must support the coding.

- CMS's reimbursement ("Risk Model") is based on additive acute and chronic conditions (HCCs) submitted by a qualified risk adjustable provider; MD, DO, NP, and PA.
- Reimbursement pays for care which reflects member severity of illness based upon ICD-10 reporting
- Accurate capture of the severity of illness depends on:
  - Documentation to the highest degree of specificity
  - Complete documentation must match billing and timely encounter submission
- Health status is re-determined each year based on documentation (Diagnoses reported through claims/encounter data)

A best practice guideline to ensure accurate coding and reporting of HCCs is to see your patients on an annual basis for a comprehensive visit.

Annual Health Assessment (AHA) Program for Medicare Advantage HMO Membership

To ensure that physician offices are accurately capturing the acuity of their Medicare Advantage HMO population, Hoag Physician Partners encourages physicians to participate in the Annual Health Assessment Program. The AHA is a comprehensive visit a mid-level provider or above is expected to address all HCC and quality care gaps and provide the necessary documentation to support the diagnosis(es), also known as MEAT "Monitor, Evaluate, Assess, or Treat".

Physician offices are encouraged to utilize Cozeva to identify the applicable HCC and quality care gaps.

All diagnoses are subject to coding audit and review; documentation that fails to support a diagnosis will be deleted from the claim and encounter. Provider offices are responsible for any necessary claim corrections deemed appropriate by Hoag Clinic. Provider offices must submit the following to Hoag Clinic Risk Adjustment via EpicCare Link:

1. AHA Questionnaire
2. AHA Progress Note
3. Corresponding claim form (CMS-1500)
4. Cozeva's Disconfirmed HCCs

Provider offices can submit the AHA documentation via Secure File Transfer (SFTP), fax at 949-764-5199, or secure email at HoagClinicRiskAdjustment@hoag.org.

The AHA forms are located in Hoag EpicCare Link.

SECTION 13

EpicCare Link

Functions:

1. Authorization Submission
2. Authorization Status Search
3. Claims Inquiry
4. Reference Documents
5. Secure Messaging
6. Patient/Member Records

What EpicCare Link Can Do

- Reduce the cost of patient-related information by eliminating all faxes, voicemails and phone calls
- Expand access beyond business hours – 7 days a week, 24 hours a day

Features

1. In Basket
   - Secure messaging to other providers
   - Secure messaging to MSO operations
2. Patient List
   - Patient Demographics
   - Patient Active Insurance Information
   - Patient authorizations
   - Patient medical history
   - Members not found in EpicCare Link should be requested to be added using the form found on www.hoag.org/hpp
3. Referrals and Authorizations
   - Inquiries
   - Submissions
   - Retro Authorizations
   - Decision Notification
     - › Providers and/or providers staff are responsible for checking the portal regularly for referral decisions
   - Utilization Management Turn Around Times:
     - › Commercial – 5 business days
     - › Medicare Advantage – 14 calendar days
4. Urgent Authorization Requests
   - Good Reason – The member's health is life-threatening, and action must be taken immediately
   - Bad Reason – The office forgot to submit an authorization request, and the member has an appointment the same day
   - If an urgent request does not meet the criteria indicated above, the request will be processed as a standard authorization
5. Claims
   - Search for claims and claims status
   - Search for Remittance Advice
6. Important Reference Documents
   - AARG guidelines
   - Important forms and patient forms
   - EpicCare Link training materials
7. Site Administrators
   - Add new users to site
   - Delete users from site
   - Complete annual user and site demographics audit
   - Reset Passwords

Policies & Procedures

Patient Access to Care and Services Guidelines
All Providers are required to provide medical service using the following medical need criteria:

Appointments & After-Hours Access

Care/Route	Standard
EMERGENT (A serious condition requiring immediate intervention/Requires immediate access to call)	Immediate
URGENT CARE Urgent Care to a primary care physician (PCP)	Urgent: No Prior Auth Required: 2 days Urgent: Prior Auth Required: 4 days
NON-URGENT SYMPTOMATIC (Includes primary care)	Within 10 business days of request for a PCP
ROUTINE NON-SYMPTOMATIC (Preventive Care/Health Assessment/Well Baby Exams)	Within 15 business days
SPECIALISTS VISITS	Within 15 business days
MENTAL HEALTH APPOINTMENT (Non-physician)	10 business days
ANCILLARY PROVIDER APPOINTMENT	15 business days
AFTER HOURS ACCESS	24 hours coverage, with Answering service (Live person), OR Answering System with an option to page, OR Message - referring a member to an urgent care center (Including the phone number)
OFFICE WAIT TIME	<30 minutes
TELEPHONE CALL WAIT TIME	<30 seconds
ANNUAL FLU VACCINE	Direct access to an in-network physician for the annual flu vaccine (If the sole purpose of the visit is for vaccine no co-payment is required)
MAMMOGRAPHY SCREENINGS	Direct access for mammography screenings

Women's Health Specialist Services/Pregnancy

Care/Route	Standard
ROUTINE & PREVENTATIVE HEALTH SERVICES FOR WOMEN	Direct access to in-network women's health specialist without referral authorization (Women's health specialist is defined as a gynecologist, certified nurse-midwife, obstetrician, or other qualified health care providers who can provide routine & preventive care)
URGENT PREGNANCY SITUATIONS	Within 24 hours
FIRST PRENATAL VISIT	Every effort will be made to complete the first prenatal visit within the first trimester
1ST TRIMESTER	Within 14 calendar days
2ND TRIMESTER	Within 7 calendar days
3RD TRIMESTER	Within 3 working days
HIGH-RISK PATIENT	Within 3 working days

- Members with life-threatening medical problems have access to acute medical care 24 hours per day, every day of the year
- Determinations for continuing care from a specialist will be based upon an agreed-upon treatment plan by the Primary Care Physician (PCP), specialist, and Medical Director (Or designee) within 3 business days of the request and referrals will be made within 4 business days of the treatment plan agreement
- The organization does not limit or restrict a provider from discussing treatment options of care with patients
- The Provider Relations Department monitors the physician network to ensure a sufficient number of PCPs and high-volume specialty practitioners are in the geographic distribution area

Advance Directives

- Providers have an obligation to provide members with sufficient information regarding their medical condition, any proposed medical procedures and their right to formulate advance directives
- Providers are required to provide advance directive information/forms for those adult (Over 18 years of age) members expressing an interest in preparing an advance directive document
- Providers will discuss with the member or an incompetent member's surrogate regarding a "Do Not Resuscitate" (DNR) order
- Complete documentation in the medical record is required whether life-sustaining procedures are withheld or withdrawn
- All completed documents and/or copies are required to be in the member's medical record, i.e., Durable Power of Attorney for Health Care Decision, declaration, or non-statutory living will, etc

Advance Directive Patient Self-Determination Act (PSDA)

- The Patient Self-Determination Act is a federal law designed to raise public consciousness concerning advance directives. An advance directive is a written statement, completed in advance of a serious illness, about how one would want medical decisions made for them if they are incapable of making them. The two most common forms of advance directives are the Living Will and the Durable Power of Attorney for health care
- Physicians are urged to discuss advance directives with their patients and to retain a copy of the advance directives in the patient's medical records

Confidentiality of Members' Information and Release of Medical Information

- Providers will give members (Or their legal guardians) the opportunity to approve or deny the release of identifiable personal information
- Consent information for members is made available by the provider through the medical group (I.e., consents for the use of medical information, accessing their medical records, protecting access to their medical information)
- All requests for member medical information will be reviewed by the appropriate person(s), (Physician, office manager, medical records supervisor) to determine if access will be allowed
- Release of member medical information must be documented in the medical record with the appropriate accompanying documents
- Disclosure of member medical records and information by a provider is permitted without member authorization only when specifically authorized by law
- Members may request a copy of their medical records by completing the appropriate release form. Providers should follow policy guidelines concerning time frames

- Member's access to mental health records may be limited (See policy for details)
- Providers must educate their staff about the approved member confidentiality policy
- All Professional personnel involved with a member's care and related activities will sign a confidentiality statement

Member's Rights and Responsibilities

- Providers and their staff will follow and honor this policy regarding the rights and responsibilities of all members
- A Member's Rights and Responsibilities list will be posted in all provider waiting rooms
- All member information provided in the provider's offices would be readable, easily understood, and, as needed, in the languages of the major population groups served

Member Complaint Process

- Complaints are categorized into two general areas:
  - Quality of care, including but not limited to delayed/denied referrals, provider availability, access, and medical care
  - Administrative complaints, including situations that do not have a direct impact on quality of care but require some investigation, i.e., delay/error in claims payment, issues related to individual behavior, etc
- Verbal or written complaints/concerns can be received via the provider's office, Hoag Administrative offices, the member's health plan or through Hoag Clinic Patient Relations
- Any member verbally complaining to the provider's office should be instructed to contact their health plan directly (In accordance with health plan contractual agreements)
- Any written complaint received from a member at the provider's office or the Hoag Administrative office must be emailed to Hoag Clinic Patient Relations within the same business day at HCPatientRelations@hoag.org or mailed to:

Hoag Physician Partners
Attn: Hoag Clinic Patient Relations
PO Box 3499
Costa Mesa, CA 92628

Medical Record Guidelines

- Providers are required to maintain a centralized medical record for each member, which includes documentation of care provided within and referred outside the provider network
- Providers are required to maintain policies/procedures addressing the release of member information to any internal or external person
- Member's medical records must include legible, dated documentation along with member identification, including name, age, employer, occupation, work and home telephone numbers, address, insurance information and marital status. Every page must contain the member name or ID number
- The medical record is a legal document, and its contents are confidential and must be kept secured in locked storage areas or areas not accessible to the public
- The following information must be documented in the medical record:
  - Medication allergies and adverse reactions are noted in a consistent, prominent place. Otherwise, no known allergies or history of adverse reactions are noted
  - Past medical history for members seen more than three times is easily identifiable. This documentation includes serious accidents, operations and childhood illnesses

- For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, surgeries and childhood illnesses
- Documentation includes the use of cigarettes, alcohol and substance abuse for members age fourteen years and older (Query substance abuse history for members seen three or more times)
- Problem lists are used for members with significant illnesses and/or conditions, which should be monitored. A chief complaint and diagnosis or probable diagnosis are included
- The history and physical records include appropriate subjective and objective information pertinent to the member's presenting complaints
- There is documentation of an exam appropriate for the condition
- All medication prescribed: list name, dosage, quantity, duration, frequency, refill status and ICD-10 code
- Medications given on-site: list name, dosage, route, as well as the site given and whether the member had a reaction to the medication. Immunizations given on-site will also document the manufacturer's lot number and the expiration date
- Laboratory and other studies are appropriately ordered
- Treatments, procedures and tests and results are documented
- Working diagnoses are consistent with findings
- Treatment plans are consistent with diagnoses
- Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed
- Unresolved problems from previous office visits are addressed in subsequent visits
- Member education, recommendation and instructions given are included
- Pediatric members' (14 years of age and under) records have a completed immunization record or notation of immunizations up to date
- An immunization history has been noted for adults
- Preventive screening and services are offered and documented following Hoag clinical practice guidelines
- Under- and overutilization of consultants is evaluated
- Consultant notes are present as applicable
- Consultation, lab, x-ray, etc., reports are initialed by the physician upon review. Abnormal results include notation of follow-up plans in the progress notes
- There is no evidence that the member is placed at an inappropriate risk by a diagnostic or therapeutic problem
- For members referred to behavioral health services, there is documentation of member approval or disapproval for the exchange of information between the PCP and the Behavioral Health practitioners

- All ordered procedures and referral notes must be returned and filed in the medical record within ten days of the visit/procedure. Providers must review and initial all test results and consultations and document follow-up treatment for abnormal results in the progress notes

Medical Record Retention

- Member medical records must be retained as long as there is a medical, legal or administrative need for subsequent member care, education, medical research, review and evaluation of Professional service and/or defense of Professional or other liability actions
- Member medical records or reproduction of microfilmed/fiche records must be retained for a minimum of 10 years following the member's last encounter or for the life of the member, plus two years after his/her death. (See policy for regulating agencies and state/federal law)
- Specific procedures will be followed with respect to medical records should the medical group cease operation or if ownership changes (See policy for details)

Preventive Health Program for Members

- The Hoag Clinic's Quality Advisory Commission (HCQAC) works with the medical groups to develop, implement and evaluate preventive health programs aligned with regulatory requirements and national recommendations.
- Preventive health programs include guidelines on the following:
  - Infants up to 24 months
  - Children and adolescents – two through 19 years of age
  - Adults – 20 through 64 years of age
  - Seniors – age 65 and older
  - Prenatal and postpartum guidelines
- Preventive health guidelines are distributed to members on an annual basis
- Providers are notified of any updates to the preventive health services program. Health plans are also given a description of the program

Credentialing Quality of Care Peer Review Process

- A confidential peer review process is conducted through the Credentialing and Peer Review Committee (CPRC)
- The CPRC conducts investigations for standard evaluations, reviews, audits, significant complaints (Those that involve potential harm to a member or represent serious deficiencies in the performance of duties), at the request of health plans or another payor contracted with the medical group, specific cases or procedures as requested by the Medical Director, any organization systematic problems relating to quality of member care or to identify/define areas of excellence within the organization
- The CPRC implements corrective action plans for providers when specific problems arise (See policy for details)

Plan for the Reduction, Suspension or Termination of Provider Status

Termination

- If a practitioner is terminated for administrative reasons, Hoag Physician Partners will seek the agreement of the practitioner to continue to provide care for patients under the contractual terms and conditions in effect prior to the termination. If the practitioner agrees to this, Hoag Physician Partners will, at the patient's request, authorize continuation of care by the terminated practitioner as follows:
  - For an acute condition, defined as being of limited duration and requiring prompt medical attention for the duration of the acute condition

Continuity and Coordination of Care

Continuity of care directly impacts the quality of care and treatment planning over time. It is the process by which the patient and their physician-led care team are cooperatively involved in ongoing health care management toward the shared goal of high quality, cost-effective and timely medical care. Continuity of care is consistent with quality patient care provided by a primary care and/or the specialist in addressing the patient's condition. The continuity of care team helps primary care physician's gain their patients' confidence and enables them to be more effective patient advocates. The primary care physician's role, as a cost-effective coordinator of patients' health services, is to promptly recognize problems as soon as possible, such as, specialist availability or access to care, on-going treatment and educational needs of the patient. Continuity of care is rooted in a long history of patient care and treatment between the provider and patient and it can integrate new information and decisions to treat the member holistically and efficiently, without extensive investigation or record review.

Continuity of care is facilitated by a physician-led, team-based approach to health care which can include the primary care provider, specialist involved in patient care, care navigators, and other members of the health care team. The goal of this is to reduces the fragmentation of care, understanding barriers to care and looking for alternatives to solve identified barriers thus improves patient safety and quality of care. The American Academy of Family Physicians supports the role of primary care physicians in providing continuity of care to their patients in all settings, both directly and by coordination of care with other health care professionals.

Special Needs Plan (SNP)

A portion of Hoag members are enrolled in a Chronic Conditions Special Needs Plan (C-SNP), a Centers for Medicare & Medicaid Services (CMS) Medicare Advantage coordinated care plan catered to special needs individuals and designed to provide targeted care. C-SNP members are identified to have chronic and disabling disorders, including but not limited to diabetes, cardiovascular disorders, and neurologic disorders, that require a higher level of care coordination and support.

Program Goals & Purposes

- Improve access and affordability to members' health care needs
- Improve coordination of care and ensure appropriate delivery of services through the alignment of the Individualized Care Plan (ICP) and recommendations from a multidisciplinary team called the Interdisciplinary Care Team (ICT)
- Maximize efficiency and minimizing disruption to a members care during their healthcare setting transitions
- Ensure appropriate utilization of services for preventative health and chronic conditions
- Improve member health outcomes

Health Risk Assessment

A Health Risk Assessment (HRA) is a member health questionnaire that provides an overview of health risks and quality of life. The assessment includes the following components and is used to triage priority and risk of the member, as well as, as aid in development of the care plan.

- Demographic information
- Self-assessment of health status and Activities of Daily Living (ADL)
- Functional status and pain assessment
- Medical conditions and history
- Biometric values
- Psychosocial risks
- Behavioral risks

Individualized Care Plan

An Individualized Care Plan (ICP) is designed to be member-focused and includes identified health problems, goals, barriers, and interventions. ICPs are either updated on an annual basis or updated sooner based on feedback from the Interdisciplinary Care Team (ICT).

Interdisciplinary Care Team

The Interdisciplinary Care Team (ICT) includes individuals participating in the member's care, including but not limited to the member and their family/caregiver, care managers, primary care provider (PCP), and any specialists. The ICT meets on a regular basis at least annually to discuss member care needs and review the member's ICP.

Care Manager Role and Responsibilities

- Identify eligible SNP members, members in need of annual HRA updates, changes in status of condition, and/or care transition events
- Gather clinical records and review member cases
- Schedule and coordinate ICT meetings
- Develop, implement, maintain, and coordinate care plans
  - Create and update care plans based on ICT attendee feedback and recommendations
  - Develop care plan goals in collaboration with members
  - Prioritize 3-6 main problems with specific, measurable, and time-bound goals
  - Send new or updated care plans to members and their providers, including information and resources that may aid in supporting members and their care plan goals
  - Schedule periodic re-evaluations and care plan follow-ups

Provider Role and Responsibilities

- Assist care managers in the development member care plans
- Attend ICT meetings to provide expertise and input regarding member care and care plans
- Review care plans prior to first visits with members and when care managers notify of care plan updates
- Anticipate that updated care plans will be provided when members have any change in care settings ("Transitions of care")
  - Care managers or navigators will assist in arranging patient follow-up care

Preventive Services & Health Maintenance

Hoag Physician Partners is committed to assisting its members to the highest level of wellness and self-care. To achieve this goal, the physicians and staff are committed to providing preventive health measures, such as, immunizations and routine health screenings. Another key component in achieving this goal is patient education. Hoag Physician Partners has adopted the Blue Cross of California preventive screening and immunizations recommendations for healthy children, adolescents, adults, seniors and pregnancy. Please see the following.

AGES 0-2 YEARS	
Screening/Immunization	**Frequency**
DTaP (Diptheria, tetanus, acellular pertussis)	At 2, 4, 6, 15-18 months
Height, weight, hearing	To be performed
Hematocrit, for anemia or polycythemia	At 6-12 months and 15 months-5 years for high risk for iron deficiency
Hepatitis A	24 months-12 years (2 doses, the second administered 6-18 months after the first)
Hepatitis B	At birth At 1-2 months (1-2 month after first dose) And at 6-18 months
Hib	At 2, 4, 6, 12-15 months
Influenza	At 6 months And at 12 months after the first immunization is administered
IPV (Inactivated polio virus)	At 2, 4, 6-18 months
Lead screening	At 9-12 months and 24 months under state law
MMR (Measles, mumps, rubella)	At 12-15 months
Ocularprophylaxis	After birth, no later than 1 hour
PKU	After birth, before discharge
Pneumococcal Conjugate (PCV13)	2, 4, 6, months, booster 12-15 months
Rotavirus (RV) RV-1 (2 dose series) RV-5 (3 dose series)	At 2 months At 4 months At 6 months for 3 dose series
Varicella (Chickenpox)	At 12-15 months

ADDITIONAL RECOMMENDATIONS
Breastfeeding infants-follow-up after discharge-48~72 hours after birth
Congential hypothyroidism – After birth, optimally between 2-6 days
Hemoglobinopathy – Discuss with “at-risk” patients
TB Screening – to be performed for high-risk population

COUNSELING
Nutrition, Injury Prevention, Dental Health

AGES 3-11 YEARS	
Screening/Immunization	Frequency
DTaP (Diptheria, tetanus, acellular pertussis)	At 4-6 years
Height, weight, blood pressure, hearing, vision	To be performed
Hematocrit, for anemia or polycythemia	At 15 months – 5 years for high risk for iron deficiency
Hepatitis A	2-12 years (2 doses, the second administered 6-18 months after the first)
Human papillomavirus (HPV)	Recommend at age 11-12; 2 dose series at 0, 6-12 months (Minimum interval: 5 months; repeat dose if administered too soon
Influenza (IIV) or	Annual vaccination 1 or 2 doses up to 8 years
Influenza (LAIV)	Annual vaccination 1 dose for 9 years and older
IPV (Inactivated poliovirus)	At 4-6 years
MMR (Measles, mumps, rubella)	At 4-6 years
Td booster	At 11-16 years
Varicella (Chickenpox)	At 12-18 months (Once, for healthy children who have not had a history of varicella infection)

ADDITIONAL RECOMMENDATIONS
TB Screening – To be performed for high-risk population

COUNSELING
Nutrition, Exercise, Injury Prevention, Substance Avoidance (Tobacco, Alcohol, drugs), Dental Health

AGES 12-19 YEARS	
Screening/Immunization	**Frequency**
Chlamydia screening (For sexually active females, past or present)	To be performed
Height, weight, blood pressure, hearing, vision	To be performed
Hepatitis A	To be performed – 12-18 years – High Risk only
Hepatitis B	At the current visit, then next dose at 1 and 6 months
Human papillomavirus (HPV)	Recommend at age 11-12; 2 dose series at 0, 6-12 months (Minimum interval: 5 months; repeat dose if administered too soon Age 15 or older at initial vaccination: 3-dose series at 0, 1-2 months, 6 months (Minimum intervals: dose 1 to dose 2: 4 weeks/dose 2 to dose 3: 12 weeks/dose 1 to dose 3: 5 months; repeat dose if administered too soon
Influenza (IIV) or Influenza (LAIV)	Annual vaccination 1 dose only
MMR (Measles, mumps, rubella) (If no previous 2nd dose)	At 11-12 years
Meningococcal	At 11-12 years At 16 years
Pap Test (Females at age 18 or earlier if active past or present and if the cervix is present)	Annually until two consecutive negative sexually tests then every 3 years
Rubella serology or vaccination (For women of childbearing age, without proof of immunization/ immunity)	Once
Td booster (Tetanus, diphtheria)	At 11-16 years
Varicella (For adolescents without proof of immunization or immunity)	At 11-12 years

ADDITIONAL RECOMMENDATIONS
Preconception counseling
Counseling on sexually transmitted disease, HIV and birth control
TB Screening – To be performed for high-risk population

COUNSELING
Nutrition, Exercise, Injury Prevention, Substance Avoidance (Tobacco, Alcohol, drugs), Sexual Behavior (Conception, Sexually Transmitted Diseases, HIV Preventive Education), Dental Health, Mental Health (Depression)

AGES 20-39 YEARS	
Screening/Immunization	**Frequency**
Blood Pressure	Every year
Chlamydia screening (For women at high risk)	<25 – every year >25 – periodically for high-risk assessment
Height and weight	Every year
Hepatitis A (HepA)	2 or 3 doses depending on vaccine
Hepatitis B	2 or 3 doses depending on vaccine
Human papillomavirus (HPV)	Ages 20-26: 2 or 3 doses depending on age at initial vaccination or condition
Influenza inactivated (IIV) or influenza recombinant (RIV) or Influenza live, attenuated (LAIV)	Annually, each season
Measles, mumps, rubella (MMR)	1 or 2 doses depending on indication (If born in 1957 or later
Pap Test	Women aged 21-29 should have a PAP test every 3 years. Women aged 30-39 should have a Pap and HPV co-test every 5 years or a Pap test every 3 years
Pneumococcal conjugate (PCV13)	1 dose
Pneumococcal polysaccharide (PPSV23)	1 or 2 doses depending on indication
Rubella serology or vaccination (For women of childbearing years without proof of immunization/ immunity)	Once
Total cholesterol and HDL cholesterol test	Discuss risks with the patient.
Men age 20-35 and women age 20-45 Men at age 35 and older and women at age 45 and older	Discuss frequency and testing options with the patient but at least every 5 years
Tetanus, diphtheria, pertussis (Tdap or Td)	1 dose Tdap, then Td or Tdap booster every 10 years
Varicella	High Risk – 2 doses – 4-8 weeks apart

ADDITIONAL RECOMMENDATIONS
Women should discuss with their physician about taking 400 micrograms of folic acid to decrease the risk for fetal congenital disabilities of the brain or spine
Men should be counseled about testicular self-examination for cancer
TB Screening – To be performed for high-risk population
Preconception counseling
Women should be counseled about the risk factors of osteoporosis

COUNSELING
Nutrition, Exercise, Injury Prevention, Substance Avoidance, Sexual Behavior (Conception-Sexually Transmitted Diseases, HIV Preventive Education), Dental Health, Mental Health (Depression)

AGES 40-64 YEARS	
Screening/Immunization	**Frequency**
Blood Pressure	Every year
Beginning at age 50, Fecal Occult blood testing (FOBT) and/or colonoscopy	FOBT: Every Year Colonoscopy: Every 10 years if normal. If not, discuss test interval with your patient
Height and weight	Every year
Hepatitis A (HepA)	2 or 3 doses depending on vaccine
Hepatitis B	2 or 3 doses depending on vaccine
Influenza inactivated (IIV) or influenza recombinant (RIV) or Influenza live, attenuated (LAIV)	Annually, each season
Mammogram or mammogram with an annual clinical breast exam (For women 50-69 years) Women 40 and over should talk with their physician about mammography and the detection of breast cancer	Every 1-2 years
Measles, mumps, rubella (MMR)	1 or 2 doses depending on indication (If born in 1957 or later)
Pap Test	A Pap test and HPV co-test every 5 years or a Pap test every 3 years
Pneumococcal conjugate (PCV13)	1 dose
Pneumococcal polysaccharide (PPSV23)	1 dose
Rubella serology or vaccination (For women of childbearing years without proof of immunity/ immunization)	Once
Tetanus, diphtheria, pertussis (Tdap or Td)	1 dose Tdap, then Td or Tdap booster every 10 years
Total cholesterol and HDL cholesterol test Women age 20-45 Men at age 35 and older and women at age 45 and older	Discuss risk with patient Discuss frequency and testing options with the patient but at least every 5 years
Varicella (Chickenpox)	2 doses
Zoster recombinant (RZV) (preferred) or Zoster live (ZVL)	2 doses 1 dose

ADDITIONAL RECOMMENDATIONS
Physicians should discuss menopause and hormone replacement therapy with perimenopausal and menopausal patients
Physicians should discuss with their female patients about taking 400 micrograms of folic acid to decrease the risk for fetal congenital disabilities of the brain or spine
Preconception counseling
TB Screening - To be performed for high-risk population

COUNSELING
Women should be counseled about the risk factors for osteoporosis
Physicians should discuss risk factors for stroke and coronary artery disease for prevention
Men should be counseled about the known risks and benefits of prostate cancer screening. African American men are at increased risk
Nutrition, Exercise, Injury Prevention, Substance Avoidance, Sexually Transmitted Diseases, Hormone Replacement Therapy, Dental Health, Mental Health (Depression)

AGES 65 AND OVER	
Screening/Immunization	Frequency
Blood Pressure	Every year
Fecal occult blood testing or colonoscopy	FOBT: Every year Colonoscopy: Every 10 years if normal. If not, discuss test interval with your patient
Height, weight, vision, hearing	Every year
Hepatitis B vaccine (For high risk individuals)	At the current visit, then at 1 and 6 months
Influenza IIV or RIV or LAIV	Annually, each fall season
Mammogram or mammogram with annual clinical breast exam (For women ages 65-69)	Every 1-2 years 70+ years: clinical discretion
Pap Test	Discuss frequency with your patient
Pneumococcal polysaccharide	1 dose
Tetanus, diphtheria, pertussis (Tdap or Td)	Once every 10 years
Total cholesterol and HDL cholesterol test	Discuss frequency and testing options with the patient but at least every 5 years
Varicella (Chickenpox)	2 doses

ADDITIONAL RECOMMENDATIONS
TB Screening – To be performed for high-risk population

COUNSELING
Men should be counseled about the known risks and benefits of prostate cancer screening
Women should be counseled about the risk factors for osteoporosis
Physicians should discuss risk factors for stroke and coronary artery disease for prevention
Women at age 70 should continue to be counseled about mammography and breast cancer detection
Nutrition, Exercise, Injury Prevention, Substance Avoidance, Sexually Transmitted Disease, Medication Use, Hormone Replacement Therapy, Dental Health, Mental Health (Depression)

PREGNANCY	
Screening	**Frequency**
Alpha-Fetoprotein	To be performed
Blood Pressure	Initial visit, and all follow-up visits
Chlamydia screen	<25 years; >25 per risk factor Assessment Discuss with your patient
Chorionic villus screening (CVS) and counseling or amniocentesis and counseling > 35 years of age	Discuss with your patient
D (Rh) incompatibility	First visit repeat 24-28 weeks for unsensitized D negative
Glucose tolerance test GDM screening	To be performed
Gonorrhea culture	To be performed according to ACOG & American Diabetes Association
Group B streptococcal bacteria	To be performed – High Risk according to ACOG At initial visit and last trimester
Hematocrit	First visit
Hepatitis B surface antigen (HbsAg)	First visit
History of genital herpetic lesions	Discuss with your patient
Influenza Vaccination	To be performed on women who will be beyond the first trimester or pregnancy (Greater than or equal to 14 weeks gestation) during the influenza season
Multiple marker testing	<13 weeks 15-18 weeks
Offer HIV counseling & screening	
Prenatal care	To be performed within the first 14 days of pregnancy diagnosis. (Medi-Cal recommends the first 7 days)
Postpartum visit	To be performed within three to six weeks following delivery of pregnancy diagnosis
RPR/VDRL	First visit
Rubella serology	First visit
Ultrasonography	To be performed – high-risk population
Urine culture or urinalysis for bacteria	First visit
Vaccination history (General)	First visit
Weight	Discuss with patient

ADDITIONAL RECOMMENDATIONS
Physicians should discuss with their female patients about taking 400 micrograms of folic acid to decrease the risk for fetal congenital disabilities of the brain or spine

Health Education

- Education is the key to the prevention of illness and complications of that illness. All members have the right to be educated about their health and health maintenance. It is the responsibility of the PCP or designee to inform the patient of available programs
- Informal education takes place at every visit to the office and should be documented in the patient record as such
- Education may be one on one or in-group setting presented by the doctor, the nurse or other qualified staff members
- Appropriate educational materials such as pamphlets, videos or other handouts should be given to the patient with an explanation of their purpose. These materials should be reading level appropriate as well as in the primary language of the member whenever possible
- Education provides patients and the public with an opportunity to learn, share, cope and discover in an inviting and compassionate environment. Hoag offers a full slate of free community education classes for everyone, from newly diagnosed cancer patients to those seeking tips on living healthier lifestyles
- Patients can visit hoag.org/education to view the schedule and sign up to attend classes or review the Hoag for Life newsletter
- Health plans offer a wide variety of health education classes for their members. Refer to the telephone number in the provider manual for the current class schedules
- Educational materials are also available from the health plans at no cost to the provider. We encourage the distribution of these materials to the members
- Documentation of all patient education and referrals to outside classes should be made in the patient's medical record. If the patient refused education, or readiness to learn is assessed and found to be lacking, this should also be documented in the medical record
- Random audits of the medical records will be conducted by the Quality Management Department to measure compliance with this policy

Education Referral Policy

- The importance of member education in health maintenance is the key to illness prevention. A method for referring members to an educational program and tracking that referral is also key to this process
- The PCP or designee, or other members of the health care team, as appropriate, may initiate a referral for formal education. Education may be obtained by participation in either individual or group settings
- The member may be referred to the local hospital programs, classes sponsored by the individual health plans or those classes offered by the IPA or medical group

Listing of Suggested Policies & Procedures for Administration of a Provider's Office

The following is a list of suggested policies and procedures for you to create and use in the administration of your office(s). Consider your own specific office needs and circumstances when reviewing this list, as you may need to create additional procedures and policies beyond those listed.

If you would like sample copies of any of the policies listed below, please contact Provider Relations at 949-791-3502.

- Appointment/Scheduling Procedure
- Missed/Broken Appointments and Follow-Up Procedure
- Referral Appointments and Follow-Up Procedure
- Telephone Triage
- Fire and Disaster Plan
- Bomb Threat
- Evidence of Fire Inspection

- Medical Testing and Consult Referral Reports Review and Follow-Up Procedure
- Infection Control
- Bio-Hazardous Waste
- Autoclaving/Steam Sterilization
- Cold Sterilization
- Blood Borne Pathogen/Exposure Control Plan
- Communicable Disease Protocol
- Sharps Container
- Health Education, Disease State Management
- Employee Safety and Injury Prevention Program
- Hazardous Communication Plan
- Preventive Health Procedures-OB/GYN, Adults, Pediatrics
- Lead Toxicity Testing
- CDPH Requirements
- Chart Documentation/Summary/Detail
- Completion of Authorization to Release Medical Records
- Storing and Filing of Medical Records
- Consent Form Procedure
- Human Sterilization Consent
- HIV Testing Consent and Disclosure
- Child Abuse/Neglect Reporting
- Domestic Violence Reporting
- Elder/Dependent Adult Abuse Reporting
- Medication-General Policy
- Drug Sample Policy
- Narcotic Keys
- Accounting for Controlled Drugs
- Management for Controlled Drugs
- Injectables
- Handling Medical Emergencies
- Access and Appearance (Exam room)
- Access for the Physically Disabled
- Office Evaluation Guidelines
- Office Audit Tool
- Licensure/Certification Protocol: Physician Assistant
- Job Descriptions for Nurse Practitioner, Medical Assistant, Triage Nurse, Receptionist/ Scheduling Clerk, Receptionist/Front Desk
- CLIA Lab License
- Radiation Safety
- Radiology Safety Precautions Against Electrical and Mechanical Hazards
- Radiology Monitoring Devices
- Maximum Permissible Dose
- Apron/Glove Monitoring
- Patient Safety
- Radiology Hazardous Chemicals

SECTION 14

Utilization Management

Referral/Authorization Process

All referrals received by the Utilization Management (UM) Department will be processed following all regulatory and contracted health plan standards for the amount of time allowed to process referral/authorization requests. The IPA will make utilization decisions in a timely manner and will accommodate the urgency of individual situations. The authorization/denial determinations will be based on medical necessity and will reflect the appropriate application of the IPA's approved practice guidelines and criteria.

- Referrals arrive by mail, fax, electronically EpicCare Link or phone to the UM Department
  - Upon arrival, all authorizations are date stamped
  - Eligibility is verified by computer data supplied by health plans; current eligibility lists and/or by calling the health plans for benefit verification and explanation. Emergent and urgent requests take precedence and are given to a UM Nurse for immediate attention
- The referral request is checked for complete information such as:
  - Member's name
  - Member's health plan
  - Member ID #
  - Requesting provider
  - Services which are required as a result of an accident are specified as such and the location of the accident is noted (Work, home, auto, and other)
  - Diagnosis (ICD code)
  - Clinical history/findings which justify the requested procedure
  - Attempted treatment and other consults
  - Requested care procedure, or test (CPT-4)
  - Description of service (Inpatient, outpatient, or office)
- It is important to submit a referral request with your most recent clinical notes or as much information as possible to help us provide you and your patient with the best turn-around possible. If we do not receive enough information, we will reach out to your office to attempt to obtain the information needed to make the most informed decision. Please help us to provide you and your patient with the best possible service in the least amount of time
- If at any time you would like to obtain Utilization Management policies, procedures or the criteria used to authorize, modify or deny a referral request, please call our Utilization Management Department at (949) 791-3490
- All denials based upon medical necessity are conducted by a licensed physician or behavioral health practitioner. If you disagree with the determination, you may contact the reviewer directly to discuss the case. In the denial letter issued to you, there will be inclusion of the name of the physician or behavioral health reviewer and their direct contact information
- UM decision making is based on appropriateness of care and service and existence of coverage. Hoag Physician Partners does not specifically reward practitioners or individuals for issuing denials of coverage, does not offer incentives that would encourage barriers to care and services and does not encourage decisions that result in the risk of under-utilization
- Hoag Physician Partners ensures independence and impartiality in making referral determinations that will not influence hiring, compensation, termination, promotion and any other similar matters

Authorization Request Form

- EpicCare Link is the preferred method for submissions of an authorization request, along with supporting documentation
- EpicCare Link is the preferred method for Auto Approval entries and distribution to a member while in the office
- If EpicCare Link is not available, the Authorization Referral Form must be completed and submitted preferably by fax to your assigned by fax to the provided fax numbers below
- Please see the below request for faxing or mailing
- Mailing the Authorization Request Form as an alternate method:

Referral Submissions

- EpicCare Link is the preferred method for submissions of an authorization request, along with supporting documentation
- Referral status can be found on EpicCare Link
- Auto Approval Rule Guidelines (AARG) can also be found on EpicCare Link
- If EpicCare Link is not available, the Authorization Referral Form must be completed and submitted preferably by fax to your assigned by fax to the provided fax numbers below
- Please see the below request for faxing or mailing

Hoag Physician Partners
Attn: UM Dept
PO Box 3499
Costa Mesa, CA 92628

Purpose of Fax Number	Fax Number
Routine/Standard Requests	(949) 791-3491
Urgent/Expedited Requests	(949) 791-3492
Inpatient Admission Notification	(949) 791-3489

Radiology Referrals

- No prior authorization required for certain list of codes when sent to any Hoag or Hoag affiliated radiology site or breast center. List of codes available upon request
- Any other radiology codes will require prior authorizations either by EpicCare Link entry or use of the prior authorization form
  - The radiological provider submits a copy of the referral with the claim when billing the IPA. The Claims Department is directed to automatically pay all claims submitted with any/all of the codes listed on the approved prior authorization form when done at the appropriate contracted facility

Grievance/Appeals

Grievance

- Members may contact the Member Services line to file a complaint. The Member Services representative will document the call and ask the member if they prefer a warm transfer to their health plan or the number to Hoag Clinic Patient Relations to file a complaint
- Complaints will be filed and referred to at the time of each physician's re-credentialing
- If a member does file a complaint with the health plan, Hoag Physician Partners will be notified and must submit supporting documentation and a response from the physician for whom the complaint has been filed

Appeals

- If a member receives a denial of a requested service, the member can file an appeal
- The health plan will contact the UM department for any information they need. The patient needs to contact their health plan directly. The contact information will be on the letter.
- The health plan may determine to uphold a decision or overturn a decision (When a decision is overturned, the denied service must be authorized)

Direct Access to OB/GYN Services

The IPA will allow members the option of seeking obstetrical and gynecological physician services directly from a participating OB/GYN physician or Family Practice physician who is designated to provide OB/GYN services.

- All IPA members will be allowed to self-refer to contracted OB/GYN providers within the IPA's network without prior authorization
- Services which can be rendered by an OB/GYN or designated Family Practice physician without prior authorizations are as follows:
  - Annual well-woman exams
  - Pap smears
  - Pelvic exams
  - Breast exams
  - Consults for OB and GYN medical services
- Prior authorization is required for follow up visits, procedures, and surgeries unless specifically spelled out in the Provider Manual, provider contract, or by UM policy
- Prior authorization is required to seek treatment outside of the IPA network. Prior authorization is required for all tertiary and quaternary referrals
- Members may not be imposed with a higher co-payment for direct access to OB/GYN services
- A list of contracted OB/GYN providers will be given to members upon request

Direct Access to Breast Center

Mammograms are set up as auto-authorization. Once a mammogram has been performed and additional testing is required, the radiologist has the option to perform additional testing without authorization from the IPA.

Second Opinions

Assembly Bill 12 provides members who meet specific criteria with a second opinion consultation by an appropriately qualified health care professional. The member must receive a first opinion rendered by his/her primary care physician or through a referral to an in-network specialist and must meet established criteria.

All Medicare and Commercial members requesting a second opinion must be referred to their health plan for approval to an out-of-network specialist consult.

A second opinion consists of one office visit for a consultation or evaluation only. The member must obtain all follow-up care through his/her assigned IPA.

Criteria for a Second Opinion

- Member is questioning the reasonableness or necessity of a recommended surgical procedure
- Member is questioning a diagnosis or plan of care for a condition that threatens the loss of life, loss of limb, loss of bodily function or substantial impairment, including but not limited to a serious chronic condition
- Member feels clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results or the treating health Professional is unable to diagnose the condition and the member requests an additional diagnosis
- The treatment plan in progress is not improving the medical condition of the member within an appropriate period given the diagnosis and plan of care. The member is requesting a second opinion regarding the diagnosis or continuance of the treatment
- Member has attempted to follow the plan of care or has consulted with the initial provider concerning serious concern about the diagnosis or plan of care

Primary Care Physician Second Opinions

- The member must have received a first opinion through his/her primary care physician or a referral initiated by the primary care physician. The IPA is responsible for authorization and claims payment for second opinion consultations when the member requests a second opinion based on care received from his/her primary care physician
- The IPA must authorize a second opinion consultation to an appropriate health care Professional within their provider network

Specialist Care Second Opinions

- If a member requests a second opinion consultation based on care received through an authorized referral to a specialist within the IPA network, the member may choose any health care Professional from the IPA's network to render the second opinion. If the health care Professional is contracted with the members assigned IPA, the IPA is responsible for authorization and claims payment for the second opinion consultation
- Member requests for second opinions about care from a specialist will be provided by an appropriately qualified health care Professional of the member's choice from any IPA within the network of the same or equivalent specialty
- If the health care Professional is not contracted with the member's assigned IPA, the member should be referred to the health plan for authorization of the request and payment of claims related to the request
- Health plans will authorize a second opinion by an appropriately qualified health Professional when no participating contracted provider is available. The member's ability to travel to the non-contracted provider will be considered

UM/QM Committee Members

- Chairman, plus at least two other physician members (The Medical Director is designated as the Chairman.)
- Must be licensed to practice medicine in the state of California

Peer Review Committee

- Chairperson, plus at least two other physician members
- All committee members must be HPP physicians in good standing

HEALTH PLAN NAME	CONTACT INFORMATION
Aetna	(800) 525-3148 www.aetna.com (Information located at bottom of website)
Anthem	Phone: Located on back of Member ID Card Reference: Anthem Provider Manual Page 11 www.anthem.com (Information located at the bottom of the page)
Blue Shield of CA	(866) 346-7198 (Located on back of member ID card) Reference: BSC Provider Manual Section 4.2 page 16 to 26 www.blueshieldca.com (At the bottom under Member Support click "Contact Us" and there is a section for language assistance near the bottom of page)
Cigna	(800) 559-3500 (TTY:711) or (800) 806-2059 www.cigna.com (Go to bottom of page, select "Member Resources," select "Programs and Resources for Language/Interpreters Assistance")
SCAN	(800) 559-3500 (TTY:711) www.scanhealthplan.com (At bottom of page, "contact us" identifies interpreter services) memberservices@scanhealthplan.com
UHC	(888) 383-9253 (TTY:711) http://UHC.com ("Language Assistance" located at the bottom of the page))

SECTION 15

National Help Agency Hotlines

AL-ANON Family Group Headquarters	(888) 425-2666	www.al-anon.org
Alcoholics Anonymous 24–Hour Help Line	(800) 970-9040	www.aa.org
Alzheimer's Association	(800) 272-3900	www.alz.org
American Addiction Centers	(888) 334-0259	www.americanaddictioncenters.org
American Cancer Society	(800) 227-2345	www.cancer.org
American Council of the Blind	(800) 424-8666	www.acb.org
American Diabetes Association	(800) 342-2383	www.diabetes.org
American Dietetic Association	(800) 877-1600	www.eatright.org
American Heart Association	(800) 242-8721	www.heart.org
American Liver Foundation	(800) 465-4837	www.liverfoundation.org
American Lung Association	(800) 586-4872	www.lung.org
Athletics & Fitness Association of America	(800) 446-2322	www.afaa.com
American Parkinson Disease Association	(800) 223-2732	www.apdaparkinson.org
American Sudden Infant Death Syndrome	(800) 232-7437	www.sids.com
Arthritis Foundation	(844) 571-4357	www.arthritis.org
Asthma & Allergy Foundation of America	(800) 727-8462	www.aafa.org
California Smokers Help Line	(800) 987-2908	www.nobutts.org
California Coalition for Youth	(800) 843-5200	www.calyouth.org
Centers for Disease Control & Prevention	(800) 232-4636	www.cdc.gov
Cystic Fibrosis Foundation	(800) 344-4823	www.cff.org
Domestic Violence Hotline	(800) 799-7233	www.thehotline.org
Drug Help Services		www.drughelpcenters.com
Epilepsy Foundation	(800) 332-1000	www.epilepsy.com
Hepatitis Foundation International	(800) 891-0707	www.hepatitisfoundation.org
Mental Health America	(800) 969-6642	www.mentalhealthamerica.net
Multiple Sclerosis Association of America	(800) 532-7667	www.mymsaa.org
Muscular Dystrophy Association	(800) 572-1714	www.mda.org
National Council on Alcoholism & Drug Dep.	(800) 622-2255	www.ncadd.org
National Institute of Deafness	(800) 241-1044	www.nidcd.nih.gov
National Osteoporosis Foundation	(800) 231-4222	www.nof.org
National Spinal Cord Injury Hotline	(800) 962-9629	www.spinalcord.org
National Stroke Association	(800) 787-6537	www.stroke.org
National Women's Health Information Center	(800) 994-9662	www.womenshealth.gov
Planned Parenthood Federation of America	(800) 230-7526	www.plannedparenthood.org
Poison Control Center	(800) 222-1222	www.poisonhelp.org
Prevent Child Abuse America	(800) 244-5736	www.preventchildabuse.org
Sexually Transmitted Disease Hotline	(800) 456-2323	www.stdcheck.com
Substance Abuse & Mental Health Services	(800) 662-4357	www.samhsa.gov

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