PacifiCare of California

We at PacifiCare value our providers and believe we must work in partnership to provide our members with quality care and service. As part of our ongoing commitment to continuous quality improvement, this manual was designed to assist you with your clinical management activities and to define our requirements for Clinical Management Program implementation.

We would like to bring to your attention some of the additions and/or changes to the manual this year. Specifically,

- Communication Services Relating to Utilization Management (UM)
- Minimum Content of Written or Electronic Denial Notification
- Standards for Timeliness of Authorization Process
- Processing Expedited Initial Organizational Determinations
- Credentialing and Recredentialing Process and Delegation/Sub-delegation Agreement Changes Required by NCQA
- Delivery of Culturally and Linguistically Appropriate Health Care Services
- Employee Retirement Income Security Act of 1974 (ERISA)
- Health Insurance Portability Act of 1996 (HIPAA)
- Preventive Health Guidelines
- Required Reporting Grid

This manual will also provide you with updated information regarding current PacifiCare quality initiatives. In addition, we have reserved sections of this manual for the insertion of educational materials distributed at Quality Networking sessions throughout the year.

We trust that you will find this manual helpful in implementing and maintaining successful Clinical Management Programs.

This manual was reviewed and approved by the PacifiCare of California Quality Improvement Committee.

Gordon Norman, M.D., VP, Health Care Quality
Chairperson, Quality Improvement Committee
PacifiCare of California
# Table of Contents

A. Quality Management .................................................................................................................. 9
   • Program ................................................................................................................................. 10
   • Structure and Functions ....................................................................................................... 10
      • Authority and Accountability .......................................................................................... 10
      • Written Description of Program ...................................................................................... 12
      • Annual Program Evaluation ............................................................................................. 13
      • Annual Workplan .............................................................................................................. 13
      • Monitoring and Reporting ............................................................................................... 14
      • Data Collection and Trending ............................................................................................ 14
      • Access and Availability Standards ..................................................................................... 14
      • PCP Appointments and Access Standards .......................................................................... 15
      • SCP Appointments and Access Standards .......................................................................... 15
      • Behavioral Health Care Appointments and Access Standards ........................................... 15
      • Missed Appointments ........................................................................................................ 15

B. Quality Improvement Activities Update .................................................................................. 17
   • Provider Profile™ ................................................................................................................ 18
   • Quality Index™ profile .......................................................................................................... 18
   • Quality Index™ profile for Women ........................................................................................ 18
   • QI Activities .......................................................................................................................... 18
      • Disease Management Initiative ....................................................................................... 19
      • Preventive Health Initiatives ............................................................................................. 19
   • Clinical Quality Improvement Activities .............................................................................. 20
      • Diabetes Management Initiative ..................................................................................... 20
      • Improving Care of Members with Diabetes ..................................................................... 20
      • Cardiovascular Health Initiative ..................................................................................... 21
      • Improving Care for Members with Coronary Artery Disease ......................................... 21
      • Improving Care for Members with Congestive Heart Failure ....................................... 22
      • Depression Management .................................................................................................. 23
      • Improving Depression Management ............................................................................... 23
      • Asthma Management Initiative ....................................................................................... 23
      • Improving the Care of Children with Asthma .................................................................. 23
      • Senior Immunization Initiative ....................................................................................... 23
      • Improving the Rate of Pneumococcal and Flu Immunizations ....................................... 25
      • Women’s Health Initiative ............................................................................................... 26
      • Improving Breast Cancer Screening Rates ...................................................................... 26
      • Improving Cervical Cancer Screening Rate .................................................................... 27
      • Children’s Health Initiative ............................................................................................... 27
      • Improving Childhood Immunization Rates ...................................................................... 27
      • Improving Adolescent Immunization Rates ..................................................................... 28

C. Utilization Management .......................................................................................................... 30
   • Introduction to Utilization Management .............................................................................. 31
   • Documentation of Utilization Management Program .......................................................... 31
      • Purpose .............................................................................................................................. 32
      • Goals and Objectives ........................................................................................................ 32
• Program Scope and Content
• Review Function................................................................. 32
  • Pre-Service Review............................................................... 32
  • Concurrent Review ............................................................... 33
  • Post-service/Retrospective Review........................................ 33
• Review Process................................................................. 33
  • Review Criteria – Medical Guidelines for Care .................... 33
  • Decisions to Approve, Delay, Modify or Deny ....................... 34
  • Denial Notice and Appeal Process ........................................ 34
• Communication Services Relating to Utilization Management .... 34
• Ensuring Appropriate Service & Coverage ................................ 35
  • Data Sources .................................................................................. 35
  • Monitoring Relevant Utilization Data .............................. 36
• Organizational Structure .......................................................... 37
  • UM Committee Functions and Responsibilities .................. 37
• Resources Dedicated to UM ...................................................... 38
  • Roles and Responsibilities .................................................. 39
    • Role of the Primary Care Physician ................................. 39
    • Role of the UM Medical Director ..................................... 40
    • Role of the UM Nurse ..................................................... 40
    • Role of Case Manager .................................................. 41
• Implementation of UM Program: Standards and Regulatory Requirements .......... 41
  • UM Criteria – Development, Adoption, Use and Availability .......... 41
  • Decisions to Approve, Delay, Modify or Deny ....................... 42
  • Minimum Content of Written or Electronic Notification ........... 43
    • Commercial Notification .................................................. 43
    • Medicare+Choice (M+C) Notification .......................... 44
• Standards for Timeliness of Authorization Process ....................... 44
  • Commercial ................................................................. 45
  • Medicare+Choice ............................................................... 45
  • Processing Expedited Initial Organizational determinations for M+C Members ...... 45
    • 42CFR 422.570 (Title 42 of the Code of Federal Regulation part 422 section 570) . . 45
    • 42CFR 422.570 (Title 42 of the Code of Federal Regulations part 422 section 572). ................................................................. 46
• UM Timeliness Standards (Commercial HMO California) ............. 48
• UM Timeliness Standards (Centers for Medicare and Medicaid Services (CMS)) . 53
• Out of Area Review .............................................................. 56
• Post Stabilization Care ............................................................ 56
• Discharge Planning................................................................. 56
• Standing Referral/Extended Referral for Coordination of Care by Specialists .......... 56
• Second Opinion ................................................................. 57
• Direct Access to Women’s Health Services ............................ 58
• Behavioral Health Management Program ........................................ 58
  • Delegation to MBHO ......................................................... 58
  • Mental Health Parity .......................................................... 58
• Relationship Between Provider Groups and PacifiCare ................. 59
• Relationship and Coordination with PacifiCare ............................ 59
• Utilization Management Financial Relationship .......................... 59
D. Credentialing ........................................................................................................ 61
   • Program .............................................................................................................. 62
   • Initial Credentialing Process ............................................................................. 63
     • Initial Credentialing Application .................................................................... 63
     • Initial Credentialing Verification ................................................................... 64
   • Recredentialing Process .................................................................................. 70
     • Recredentialing Application .......................................................................... 71
     • Recredentialing Verification & Sanction Information ..................................... 71
     • Performance Monitoring ............................................................................... 72
   • Credentialing Committee .................................................................................. 72
   • Ongoing Monitoring of Sanctions and Complaints ......................................... 73
   • Notification to Authorities and Practitioner Appeal Rights ......................... 75
   • Assessment of Health Delivery Organizational Providers (HDOs) ............... 75
     • Skilled Nursing Facility Oversight Resource ................................................. 76
   • Sub-Delegation of Credentialing .................................................................... 77
   • Industry Collaboration Effort (ICE) Provider Group Oversight .................. 79
   • Improvement (P-GO) Project ............................................................................. 79
     • Shared Audit of Credentialing Files ............................................................... 79

E. Members’ Rights & Responsibilities .................................................................. 80
   • Member Rights and Responsibilities Statement ............................................. 81
   • Delivery of Culturally and Linguistically Appropriate Health Care Services ... 85
   • Enhancing Communication ............................................................................. 85
   • Advance Directives ......................................................................................... 86
     • Federal Law: Patient Self Determination ....................................................... 86
     • California Health Care Decision Law: Advance Directives ......................... 86
     • Resources for Information on Advance Directives ...................................... 86
   • Member Grievances ......................................................................................... 89
   • Grievance Process .......................................................................................... 89
     • Member Quality of Care Complaint Reports ............................................... 90
     • Nature of Complaint Descriptions ............................................................... 90
     • Severity Level Descriptions ......................................................................... 90
   • PMG/IPA Responsibilities: Direct Receipt of Member Complaints .............. 91
   • Member Appeals ............................................................................................ 91
   • Employee Retirement Income Security Act of 1974 (ERISA) ..................... 91
   • Independent Medical Review (IMR) ............................................................... 92
   • Appeals Data ................................................................................................... 92
   • Confidentiality of Member Information ......................................................... 93
     • Routine Consent ........................................................................................... 93
     • Special Consent ............................................................................................ 93
     • Members Unable to Give consent ................................................................ 93
   • Providing Access to Medical Records ............................................................ 93
   • Use of Measurement Data ............................................................................. 93
   • Employer Groups and Purchasers .................................................................. 93
   • Health Insurance Portability Act of 1996 (HIPAA) ....................................... 94
     • When will HIPAA Become Effective ............................................................ 94
     • Who is Required to comply with the Privacy Ruling? .................................... 94
     • What are the Basic Components of HIPAA? ............................................... 94
F. Medical Records .............................................................................................................. 97
  • Guidelines for Medical Records Compliance ............................................................ 98
  • Policies and Procedures ............................................................................................. 98
  • Confidentiality ......................................................................................................... 98
  • Availability ............................................................................................................... 99
  • Distribution of Policies & Procedures ..................................................................... 99
  • Systematic Review ................................................................................................... 99
  • Review Summary Elements ................................................................................... 99
  • Delegation ................................................................................................................ 100
  • Documentation Standards ....................................................................................... 101

G. Guidelines ................................................................................................................... 103
  • Preventive Health .................................................................................................... 104
  • Clinical Practice ....................................................................................................... 116
    • Outpatient Management of Coronary Artery Disease ........................................ 117
    • Outpatient Management of Congestive Heart Failure ...................................... 121
    • Major Depressive Disorder ................................................................................ 125
    • Diabetes Management ........................................................................................ 127
    • Outpatient Management of Asthma .................................................................... 132

H. Health Management Programs ..................................................................................... 141
  • Taking Charge of Diabetes .................................................................................... 142
  • Taking Charge of Your Heart Health ..................................................................... 143
  • Taking Charge of Depression ............................................................................... 144
  • End Stage Renal Disease (ESRD) ........................................................................... 145
  • Free and Clear Stop Smoking ............................................................................... 145

I. Required Report Submissions ....................................................................................... 147
  • Clinical Management Program Monitoring and Reporting .................................... 148
  • Authorization and Denial Logs ................................................................................. 148
  • QM Workplan ......................................................................................................... 148
  • Complaint Report/Log ............................................................................................ 148
  • UM Statistics ......................................................................................................... 148
  • Quarterly Credentialing Report ............................................................................. 148
  • Reporting Grid ........................................................................................................ 149
  • Quarterly Complaint Log ....................................................................................... 151
  • Quarterly Member Complaint Grievance Log Template ....................................... 152

J. Delegation ....................................................................................................................... 153
  • Delegation Categories ............................................................................................ 154
  • Delegation Thresholds ......................................................................................... 154
• Protected Health Information (PHI) ................................................................. 154
• Delegation Grids .............................................................................................. 156
  • Utilization Management ............................................................................... 157
  • Credentialing ............................................................................................... 162
  • Medical Records .......................................................................................... 169
• Utilization Management Annual Assessment .............................................. 171
• Credentialing Annual Assessment ................................................................ 172
• Credentialing Provider File Review ............................................................. 173
• Medical Records Annual Assessment ........................................................... 174
• Medical Record File Review .......................................................................... 175

K. Quality Networking Material ........................................................................ 176

• For those providers using a disk please refer to additional attachments
PacifiCare Resource Directory

Appeals & Grievance
- Commercial ..................................................................................... 1-800-624-8822
- Secure Horizons – Expedited Appeal ............................................. 1-888-277-4232

Behavioral Health Services ............................................................... 1-800-999-9585
- Behavioral Health Web Site .......................................................... www.pacificare.com/pbh
- Free Consultation Service ......................................................... 1-800-292-2922
- Consultation Web Site .............................................................. www.pbh.consult@phs.com

Benefits Interpretation Unit ............................................................ 1-800-329-6606
- FAX ................................................................................................. 1-714-226-2060

Clinical Trials/Investigational-Experimental .................................. 1-714-226-6797

Health Improvement ........................................................................ 1-800-915-9159
- Stop Smoking ................................................................................ 1-800-513-5131

Member Eligibility (Voice Recognition Unit) .................................... 1-800-542-8789

Prescription Solutions
- Prior Authorization .......................................................................... 1-800-711-4555
- Prior Authorization FAX ............................................................... 1-800-527-0531
- RxFAX (1-877-MDRXFAX) ......................................................... 1-877-627-9329
- Prescriptions Solutions Web Site .................................................. www.rxsolutions.com

QIS/Quality Intervention (2nd opinion) ............................................. 1-800-391-3991

Regional Customer Service Center
- Commercial ..................................................................................... 1-800-624-8822
- Secure Horizons .............................................................................. 1-800-228-2144
- Telephone Device for Hearing-Impaired (TDHI) .............................. 1-800-685-9355

Utilization Management
- Authorizations ................................................................................ 1-800-762-8456 (option 1)
- Case Management .......................................................................... 1-800-944-1211
- Out of Area ..................................................................................... 1-800-762-8456
- Skilled Nursing Unit/Medical Information Coordinator .................. 1-800-772-3258 (option 2)

Web Sites
- Commercial ...................................................................................... www.pacificare.com
- Secure Horizons ............................................................................. www.securehorizons.com

Other Valuable Sources:
- Industry Collaboration Effort (ICE), a source for common procedures used by multiple health plans to implement various regulations in California e.g. denial letters ............................................................. www.iceforhealth.org
A. Quality Management
(Required business function for all PMG/IPAs)
Quality Management

PacifiCare does not delegate Quality Improvement activities to PMG/IPAs; however, PacifiCare recognizes the need for all PMG/IPAs to establish and maintain a Quality Management (QM) Program in cooperation with PacifiCare. Maintaining a functioning QM Program is necessary to implement a successful Clinical Management Program. Ongoing monitoring and reporting is a requirement for successful QM Program implementation.

QM Program

The primary purpose of a QM Program is to monitor and report on the quality of care and service provided to members in order to facilitate continuous improvement. PacifiCare requires all contracted PMG/IPAs to have a QM Program in place that is clearly defined, and provides documented evidence of the functional operations of the Program.

In addition, all affiliated PMG/IPAs are required to collect and submit data on at least a quarterly basis. PacifiCare analyzes this data and develops and implements interventions, as appropriate.

PacifiCare’s Clinical Management Specialist will review all required submissions for compliance with standards and provide feedback regarding any required improvement.

The QM Program should include a process for resolution of identified issues and problems. Action plans should be developed after evaluating information related to a QM activity. Action plans may be developed by the QM Committee (QMC), or be brought to the Committee for approval. An action plan should be practical and directed at meeting a stated objective. The action plan should include a method of feedback of information to involved parties. Timeframes for completion and responsible party should be noted. Results of the action plan should be reported to the QMC.

The QM Program should be sufficiently organizationally separate from the fiscal and administrative management to assure that fiscal and administrative management does not unduly influence medical decisions.

To assist you in your endeavors of implementing a successful QM Program, this section includes the following items that are necessary components of a QM Program Structure:

- Authority and Accountability
- QM Committee Structure and Functions
- Written QM Program Description
- Annual QM Program Evaluation
- Annual QM Workplan
- QM Monitoring and Reporting
- Data Collection and Trending
- Access and Availability Standards

QM Program Structure and Functions

Authority and Accountability

A key component of the QM Program is the establishment of authority and accountability. The PMG/IPA Board of Directors should be ultimately accountable for the QM Program and should included the following:
• Allocation of resources required for implementing and maintaining the QM Program
• Appointing the designated physician responsible and who has substantial involvement in the program implementation
• Designated a behavioral health care practitioner who has involvement in the behavioral health care aspects of the program
• May delegate QM Program implementation and oversight to the Quality Management Committee (QMC)
• Review and approve the QM Program

PacifiCare retains accountability for review and approval of these documents to assure they are in compliance with PacifiCare standards.

**QM Committee**
The QM Committee (QMC) should be a multidisciplinary team representing the key functions of the organization including practicing physicians of various specialties, administrative representatives, the QM leader, as well as the Health Plan Coordinator. The PMG/IPA Medical Director or designee should serve as the Chairperson. The Chairperson must be a person who is trusted and respected by the staff and observes the principles of peer review. PacifiCare recommends that the PMG/IPA QMC meet on a monthly basis, or more frequently as necessary. Membership should include, but is not limited to, the following representatives:

<table>
<thead>
<tr>
<th>Medical Staff</th>
<th>Administration Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice</td>
<td>Health Plan Coordinator</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Administrator</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>Quality Management</td>
</tr>
<tr>
<td>Surgery</td>
<td>Physician Credentialing</td>
</tr>
<tr>
<td>Other High Volume Specialists</td>
<td>Medical Records</td>
</tr>
<tr>
<td></td>
<td>Ancillary Personnel</td>
</tr>
<tr>
<td></td>
<td>Provider Services</td>
</tr>
</tbody>
</table>

QMC meeting minutes must be documented and kept on file in a secure location. This documentation should provide a chronological record that supports the ongoing activity of the QM Program. Any subcommittees of the QMC are also required to keep minutes of their proceedings. QMC minutes must be contemporaneous (i.e., created at the time the activity is conducted), include topics discussed, recommended action, and follow-up. In addition, each follow-up item should identify the person responsible and anticipated resolution date. The minutes should be produced within a reasonable time, and dated and signed by the QMC Chairperson. The PacifiCare Clinical Management Specialist shall be given access to the minutes on a routine basis.

Functions of the QMC include, but are not limited to, the following:

• Review the scope, objectives, organization, and effectiveness of the QM Program at least annually, and update as necessary
• Annual evaluation of the past year’s activities
• Utilize information from the annual evaluation as well as updated regulatory requirements to develop and implement a QM Workplan for the current year which includes both the quality and safety of clinical care and quality of service
• Ensure that all monitoring and reporting activities are performed appropriately and effectively
• Report findings of QM activities to Credentialing for inclusion in physician clinical profile record
• Report findings to the Board of Directors
• Identify and implement internal opportunities for improvement, as appropriate
• Ensure interdepartmental communication and coordination
• Ensure QMC minutes contain appropriate signatures and dates
• Review and approve QM policies and procedures

Charter/Bylaws for the QMC meetings should include, but are not limited to, the following:
• A Chairperson will be appointed to chair the QMC meetings
• The QMC shall operate by majority rule. No committee member may vote in any case in which he or she is personally involved
• The physician membership shall rotate and consist of practicing physicians from the provider panel
• Ensure that employed or affiliated providers and consumers actively participate in the QM Program
• Identify members of the committee that have voting rights. Only licensed physicians have voting rights on peer review issues
• List meeting dates for entire year (or frequency of meetings)
• The QMC must develop a policy and procedure regarding their scope of responsibilities and decision-making. The relationship with the Utilization Management Committee and the Board of Directors must be established
• Attendance is to be taken at each QMC meeting
• An annual evaluation of the effectiveness of the QM Program is required during the first quarter of each calendar year
• The annual QM Workplan is required during the first quarter of each calendar year
• The written QM Program description is to be reviewed updated as appropriate, and approved at the beginning of each calendar year
• The QMC must ensure that all members sign a confidentiality statement annually
• Allow for open practitioner patient communication regarding appropriate treatment alternatives and without penalizing practitioners for discussing medically necessary or appropriate care with the patient
• Ensure continuity and coordination of care by establishing procedures for timely communication of clinical information among providers

Note: Although a calendar year is referenced, it is important to note the cyclical year utilized, if different from the calendar year, and ensure that all activities occur on an annual basis

Written QM Program Description
The written QM Program description should illustrate the program’s structure and design, and be reviewed and updated on an annual basis. The Program must be written in clear language so that all participants can understand the goals and objectives of the Program, and how they will be achieved. The QM Program should also describe interdepartmental relationships and reporting structure. The structure and functions of the QM Program include, but not limited to, the following elements:
The QM Program must be reviewed, updated as appropriate and approved by the PMG/IPA’s QMC and Board of Directors (BoD) on an annual basis. PacifiCare requirements, NCQA standards, and new state and federal regulations should be utilized to identify required elements to be included in the updated QM Program. A copy of the approved QM Program, along with the signature page, is to be submitted to PacifiCare on an annual basis. The QM Program will then be reviewed to ensure compliance with all required standards.

**Annual QM Program Evaluation**

The QM Program shall be evaluated on an annual basis. The evaluation will address all aspects of the QM Program as outlined in the QM Program Description and the overall effectiveness in improving the quality of care and service provided to the member. In addition, the evaluation should address whether the structure, organization and functioning of the QM Program is adequate to achieve improvements in care and service. The evaluation is presented to the PMG/IPA QMC and BoD for approval. A copy of the approved QM Program Evaluation, along with the signature page, is to be submitted to PacifiCare on an annual basis.

QM Program activities still in progress or requiring ongoing monitoring should be incorporated into the QM Workplan for the upcoming year.

It is recommended that a process be in place to share the outcomes of the QM Program Evaluation with participating staff and physicians. This action will raise the level of awareness of the QM Program within the organization and keep practitioners informed of the status of the Program. QM Program Evaluation information should be distributed at physician meetings, staff meetings, in provider newsletters, etc.

**Annual QM Workplan**

An annual QM Workplan must be developed during the first quarter of each year with input from functional areas and the QMC. The QM Workplan identifies QM goals and objectives, areas of program focus, and specific QM activities and programs, including monitoring, tracking and trending of previously identified issues, time frames for completion of the activities including the responsible party and evaluation of the program. The QM Workplan is submitted to the QMC for approval. A copy of the approved QM Workplan, along with the signature page, is to be submitted to PacifiCare on an annual basis.
Monitoring and Reporting
The written QM Program description should indicate the aspects of care and service that will be monitored and reported. Recommended areas to monitor include, but are not limited to, the following:

- Quality of Care issues
- Improving patient safety
- Member complaints and appeals
- Access and availability to care and service
- Referral process
- Member satisfaction
- Provider grievances
- Provider satisfaction
- Clinical outcome measurement
- Sentinel events
- High risk procedures and diagnoses
- High volume procedures
- Medical record documentation
- Compliance with preventive health standards
- Contracted and ancillary services
- Physician credentialing and peer review
- Behavioral health
- Medical office site visits
- Health education
- Continuity and coordination of care
- Over/under utilization

Data Collection & Trending
The QM Program should define information sources and pathways. Methodology for data collection should be clearly defined to ensure data integrity and reliability.

Information used for problem identification may come from internal and external sources, including audits and surveys conducted by the QM Department. Data should be tracked and trended on a regular basis. Information Systems can be an excellent resource for organizational data that can be aggregated into statistical reports providing specific information. Medical record documentation and pharmacy data are valuable information sources.

Collected data should be trended over time and measured against benchmarks. Tracked and trended data should be presented to the QMC on a regular basis for review. Opportunities for improvement should be developed and implemented.

Access & Availability Standards
PacifiCare does not delegate access and availability performance assessment activities to the PMG/IPA network, however we work in collaboration with PMG/IPAs in the process of data collection. This data is utilized in a broad framework of access analysis including member complaints, member satisfaction reports, and telephonic access reviews. PacifiCare’s QIC has
adopted access and availability standards that are updated periodically and shared with the PMG/IPA network.

The following standards for appointment access to PCPs, Specialists and Behavioral Health Care practitioners have been adopted.

**PCP Appointments & Access Standards**

- **Preventive Health Assessment** – (within 30 calendar days of request) – Health care services designed for the prevention and early detection of illness in asymptomatic people, generally including routine physical examinations, tests and immunizations.
- **Routine Primary Care** – (within 7 calendar days of request) – Primary care for non-urgent asymptomatic care conditions, (exception routine OB/GYN within 30 calendar days of request).
- **Urgent Care** – (within 24-hours) – Any clinical situation requiring timely intervention in the absence of which there is considerable risk that the situation will escalate to becoming an emergency.
- **After-Hours Coverage** – (24-hour availability) – A system used by the practitioner/provider to respond to members’ urgent needs when the office is closed.
- **Emergent Care** – (Immediate) – Emergency medical condition based on Prudent Layperson

**Specialty Care Physician Appointments & Access Standards**

- **Urgent Care** – (24 hours) – Any clinical situation requiring timely intervention in the absence of which there is considerable risk that the situation will escalate to becoming an emergency.
- **Routine Care** – (14 calendar days) – Specialty care for non-urgent asymptomatic care/conditions

**Behavioral Health Care Appointments & Access Standards**

- **Routine Services** – (10 business days) – A member is seen for a routine office visit within 10 business days
- **Urgent Services** – (48 hours) – A member with urgent needs is seen within 48 hours
- **Emergent Services: Immediate**
- **Non-Life Threatening** – (within 6 hours) – a member with emergency needs is seen immediately

**Missed Appointments**

The PMG/IPA is required to develop a policy for handling missed/failed appointments. The QMC should monitor the effectiveness of its implementation. When a patient misses an appointment, there must be a method of assessing the case and evaluating the need to contact the patient to reschedule. Patients who consistently miss appointments should be presented to the QMC for discussion.

These steps are to demonstrate a generic “How To” in developing a policy/procedure:

- All missed appointments are documented “NO SHOW” or similar wording in the chart. All missed appointment charts are held at the end of the day. The physician who was scheduled to see the patient reviews the chart.
- If upon physician review the member needs follow-up, the physician will instruct the office personnel to contact the patient either by phone or by letter, depending on the urgency.
• The office personnel are to document the physician’s review of the chart as well as the follow up (e.g., patient canceled; appointment made for tomorrow). Include physician signature in the chart.
B. Quality Improvement Activities Update
Provider Profile™
The Provider Profile™ represents a comprehensive, risk-adjusted report card that helps medical groups manage their respective performance in areas of clinical quality, utilization management, service quality and administrative affordability. A quarterly measurement of more than 80 indicators is prepared for the provider groups, measuring clinical quality initiatives, service quality initiatives, utilization and administrative efficiency. Performance is profiled with information obtained through the claims data base and encounter data reporting system (data quality initiative). Medical groups are scored on indicators that compare their performance to past trended results, as well as to network averages and national benchmarks (i.e. Quality Compass, HEDIS 3.0, and CCHRI).

The Provider Profile™ has been instrumental in helping the provider network consistently improve performance. Identification of high performance leads to the development and dissemination of best practices, while the identification of low performance leads to important learning opportunities and corrective actions.

Quality Index™
The Quality Index™ profile provides public disclosure on medical group performance in the areas of clinical quality, service and satisfaction of members, utilization data and administrative efficiencies and affordability.

The Quality Index™ profile is published semi-annually and provides consumers with a valuable tool to make informed decisions when selecting providers by reporting the relative performance achieved by the largest groups in PacifiCare’s contracted network. Groups that perform in the top 10% on any of the measures earn public recognition for their “best practice” status. This public performance disclosure has stimulated a friendly “quality competition” among providers that has benefited all members, and has set a benchmark for public accountability within the industry.

To view the most current Quality Index™ profile use the Internet address www.pacificare.com. This version of the Quality Index™ profile utilizes a searchable database system.

Quality Index™ Profile for Women
The Quality Index™ profile for Women contains the newest edition to the public report contains data specific to female patients, measuring relative provider group performance in 14 selected areas of clinical and service quality. The charts within the Quality Index™ profile for Women illustrate how provider groups address the needs of their female patients and also how satisfied the female patients are with the care they receive from their providers.

QI Activities
PacifiCare has implemented a comprehensive Quality Improvement (QI) Program that encompasses clinical and service quality improvement activities based on provider, purchaser and member feedback.

In order to identify and promote best practices throughout the provider network, PacifiCare shares quality improvement activity design and outcome analyses with the provider network. Communication of these activities is accomplished through Quality Networking Forums, bulk mailings, provider newsletter and website, Clinical Management Manual, Physicians Orientation
Packet, and discussions held at Joint Operating Committees and PacifiCare’s Quality Improvement Committee (QIC). The QIC includes representatives from provider groups and has overall responsibility for the design, implementation and evaluation of all clinical quality and health improvement activities.

In this edition of the manual we have included information regarding PacifiCare’s current key QI activities. The following activities have been selected based on their potential to make measurable differences in members’ lives:

**Disease Management Initiatives**
- Diabetes Management: *Improving the Care of Members with Diabetes*
- Cardiovascular Health: *Improving Care for Members with Coronary Artery Disease, and Improving Care for Members with Congestive Heart Failure*
- Depression Management Initiative: *Improving Depression Management*
- Asthma Management: *Improving the Care of Children with Asthma*

In each program, members with the targeted disease or condition were identified using encounter, claims and authorization data, as well as referrals by the member, provider, Customer Service or Medical Management. Program components include self-directed member educational materials, questionnaires, calendars and reminder cards. Some programs include telephone support to assist members in making lifestyle changes. Contracted providers receive tools to help them identify members with the condition or disease, and treat them appropriately.

**Preventive Health Initiatives**
- Senior Immunizations: *Improving the Rate of Pneumococcal & Flu Immunizations*
- Women’s Health: *Improving Breast Cancer and Cervical Cancer Screening Rates*
- Children’s Health: *Improving Childhood and Adolescent Immunization Rates*

Eligible members were identified using encounter and claims data. Program components include self-directed member educational materials, reminder cards, and mailings to providers.

The following QI initiatives illustrate some of the activities and improvements that are occurring at the plan level.
Clinical Quality Improvement Activities

DIABETES MANAGEMENT INITIATIVE
_Improving the Care of Members with Diabetes_

In 2001, approximately 100,000 members were identified as having diabetes. Diabetes is classified as a high–volume, chronic condition and is ranked among the top 10 outpatient diagnoses and 15 inpatient diagnoses for both commercial and Secure Horizons populations. PacifiCare has identified this activity as an opportunity to improve the health of members with diabetes, by increasing the percent of members receiving specific tests related to diabetes care (i.e. Hemoglobin A1c, LDL-C, retinal eye exams, and monitoring for nephropathy).

**Quality Indicators:**
- Hemoglobin A1c testing (HEDIS measure)
- HbA1c Poorly Controlled -- >9.5% (HEDIS measure)
- Retinal Eye Exam performed within 2 years (HEDIS measure)
- LDL-C screening (HEDIS measure)
- LDL-C controlled -- <130 mg/dL (HEDIS measure)
- Monitoring for Diabetic Nephropathy (HEDIS measure)

**Performance Results:**
- Rotated HEDIS measure for 2002 for commercial population
- All rates for the Secure Horizons population improved, with the exception of retinal eye exam, which decreased slightly
- The retinal eye exam rate for the commercial population improved

**Barrier Analysis:**
- Member’s lack of knowledge about diabetes management, i.e., signs, symptoms, risk factors of disease, consequences of poor diabetes management, daily dietary needs
- Member’s non-compliance with management regime, due to cost of supplies, forgetting self monitoring, can’t/won’t change lifestyle
- Providers have inadequate systems to identify and manage patients with diabetes due to lack of internal database systems as well as failure to receive and/or file communications from other providers (specialists and labs) into patient medical record
- Provider’s lack of awareness of a minimum standard of care for patients, i.e., variable treatment practices, PCPs not knowledgeable on treatment.
- Members lack of comparative information which would enable them to choose better performing providers
- Providers lack of comparative performance data
Accomplishments:

- Streamlined and enhanced the Taking Charge of Diabetes (TCD) Program
- More than 120,000 members participated in the program in 2002. Each member received 2 targeted mailings including Taking Charge of Diabetes (TCD) program summary materials, educational information, a wallet card that facilitates recording of tests, dates, and results.
- New in 2002: Providers were sent lists of their diabetic patients who, according to PacifiCare administrative data, were missing 1 or more of the 4 key screenings. A chart sticker for the medical record was included in order to streamline documentation and serve as reminder to the practitioner.
- Educational materials were mailed to diabetic members who also had other health problems such as cardiovascular disease, depression, and/or smoking
- PacifiCare Provider groups in the CCHRI Diabetes Quality Initiative were sent a listing of their patients with diabetes, those enrolled in the TCD Program, and patient Health Assessment results. A Diabetes Tool Kit was mailed to participating providers. Diabetes Clinical Practice Guidelines (CPG) were updated and distributed to contracted PCPs and endocrinologists.
- Medical group-specific Diabetic Retinal Exam rates were published in the Provider Profile™, the QUALITY INDEX® Profile and the new QUALITY INDEX® Profile For Women and distributed to providers and members in an effort to increase awareness and understanding of the importance of screening tests
- PacifiCare websites were updated to include “Health Topics A-Z”, a 24-hour on-line health information program that includes interactive diabetes self-management tools and information

CARDIOVASCULAR HEALTH INITIATIVE

Improving Care for Members with Coronary Artery Disease

In 2002, over 12,000 members were identified through claims and encounter data as having had an AMI, CABG, or PTCA. Myocardial infarction (MI) was the 4th most frequent admission diagnosis for Secure Horizons members and 8th for commercial members, excluding pregnancy-related admissions. Ischemic heart disease was the second most common inpatient diagnosis for commercial and Secure Horizons members.

Quality Indicators:

- Beta-Blocker Use (HEDIS measure)
- Cholesterol Screening (HEDIS measure)
- LDL-C Level - <130 mg/dL (HEDIS measure)
- Lipid-Lowering Agent Use
- Depressing Screening/Treatment
- MD Visit Within 6 Weeks of Discharge
- Readmission 7-30 Days Post Discharge
- Nitrate Use
- Anti-platelet Use
Performance Results:
- All measures showed improvement from 2001 for both commercial and Secure Horizons populations, with the exception of lipid-lowering agent use which showed a slight decrease

Barrier Analysis:
- Members lack knowledge/awareness of appropriate care
- Members are non-compliant with recommended care due to lack of understanding, not taking medications as prescribed, medication side effects, and not making needed nutritional changes
- Providers are non-compliant with current recommendations/guidelines, which leads to variable treatment practices and inappropriate medication treatment
- Providers lack adequate systems to link patient medical history, prescription information and treatment history, medical records are incomplete

Accomplishments:
- Almost 15,000 members were enrolled in the Taking Charge of Your Heart Health (TCYHH) CAD program. Members received 2 targeted mailings of information, including: TCYHH program materials and educational information including CAD risk reduction and lifestyle identification information. Educational materials were mailed to members who also had other health conditions, i.e., diabetes, depression, and smoking.
- Patient-specific pharmacy utilization reports were mailed to providers with information on prescribing Beta-Blocker and HMG-COA reductase inhibitors
- Coronary Heart Disease CPGs were updated and distributed to more than 1800 cardiologists. In addition, the CPGs were included in the Physicians Orientation Packet and the Clinical Management Manual, which are distributed to PCPs and providers
- Medical group-specific rates were published for the following CAD indicators: Beta Blocker usage after AMI, and cholesterol lowering drugs in the Provider Profile™ QUALITY INDEX® PROFILE and the new QUALITY INDEX® PROFILE For Women
- PacifiCare websites were updated to include “Health Topics A-Z”, a 24-hour on-line health information program that includes tools for managing heart health

CARDIOVASCULAR HEALTH INITIATIVE
Improving Care for Members with Congestive Heart Failure

Congestive Heart Failure (CHF) has been a PacifiCare Health Services, Inc., enterprise-wide quality initiative since 1999. CHF is considered one of the most prevalent, high morbidity, mortality, and cost associated diseases that affect more than 4.5 million Americans. CHF was the #1 inpatient diagnosis for Secure Horizons members in 2001 and ranked among the top 10 ER diagnoses for this population.
Quality Indicators:
- ACE Inhibitor / ARB Use
- Beta-Blocker Use
- Diuretic Use
- Digoxin Use
- MD visit w/in 6 weeks Post Discharge
- Readmission 1-30 days Post Discharge

Performance Results:
- All measures showed improvement from 2001, except Digoxin use and readmission rates

Barrier Analysis:
- Member’s lack of knowledge/awareness of appropriate CHF care, i.e., key signs and symptoms of disease
- Member’s non-compliance with recommended care, i.e., doesn’t make necessary nutritional or lifestyle change, doesn’t take medications as prescribed
- Inconsistent and variable provider treatment practices
- Lack of awareness of the prevalence of depression in patients with CHF and lack of appropriate treatment
- Inadequate provider systems to identify CHF patients and link medical, prescription and treatment history, which causes incomplete medical records

Accomplishments:
- More than 20,000 members participated in the TCYHH CHF program
- Members received 2 mailings which included a wallet card, self-care information, and CHF symptom recognition and lifestyle modification information
- Educational materials were mailed to members who were identified with other health conditions, i.e., diabetes, depression and smoking
- Mailed patient specific pharmacy information to providers, as well as information regarding prescribing ACE Inhibitor and Beta Blockers for CHF
- CHF CPGs were updated and distributed to more than 1800 cardiologists. In addition, the CPGs were included in the Clinical Management Manual and the Physician Orientation Packet which were distributed to PCPs and providers
- Published medical group-specific rates for Rx drug treatment for CHF in the Provider Profile, Quality Index Profile and the new Quality Index Profile for Women
- PacifiCare websites were updated to include “Health Topics A-Z”, a 24 hour on-line health information resource, which includes tools for managing heart health

DEPRESSION MANAGEMENT

Improving Depression Management

The annual lifetime prevalence of major depression is estimated to be about 10%. Based on this rate, approximately 20 million Americans experience a major depressive episode each year. About 30% of depressed individuals receive care for their depression through their PCP. According to administrative data, approximately 23,000 members were diagnosed with
behavioral health disorders. Of this group, depressive disorders accounted for almost 32% of all behavioral health diagnoses.

**Quality Indicators:**
- members on antidepressant medication through acute phase
- members on antidepressant medication through continuation phase

**Performance Results:**
- All measures showed improvement from 2001 in both commercial and Secure Horizons populations

**Barrier Analysis:**
- Member’s reluctance to be diagnosed with “depression” so they fail to recognize symptoms themselves and frequently neglect to see their physician, or if they see their physician they don’t discuss their problems or fears
- Member’s are non-compliant after receiving a diagnosis of depression due to social stigma and frequently don’t take or complete prescribed medications
- Variable provider treatment practices due in part to PCPs lack of knowledge regarding symptoms, treatment and prescribing guidelines for depression
- Confidentially issues can restrict open communication between member and PCP and/or between behavioral health practitioner and PCP
- Providers treating patients for other chronic diseases are unaware of high prevalence of depression as part of that disease and therefore do not screen or treat. The patient is unidentified as depressed and therefore is not referred to Taking Charge of Depression (TCDep) program

**Accomplishments:**
- Redesigning Taking Charge of Depression (TCDep) program materials were updated and distributed to members and providers
- Physician Took Kit which included a Zung Depression Screening Tool and TCDep referral form was mailed to PCPs
- Continuation of Chronic Disease/Mental Health PCP Notification. This is a mailing to providers noting patients discharged from hospitals with a diagnosis of depression or a chronic disease, i.e., AMI, CHF, PTCA, CABG, Diabetes, ESRD, which has a high rate of comorbid depression
- Notified providers of members who complete the member health questionnaire and score less than the 25th percentile on physical functioning indicating high risk for depression
- Initiation of Women’s Health Solutions that includes information about women and depression
- Website availability of the Geriatric Depression Scale and the TCDep content
- Providers notified of their members on antidepressants who failed to refill the prescription
- Letters were mailed to members on antidepressants who failed to refill prescriptions that encouraged them to continue on their medication
ASTHMA MANAGEMENT INITIATIVE --- NEW in 2002

*Improving the Care of Children With Asthma*

The latest quality improvement initiative focuses on pediatric asthma. Asthma ranks among the most common chronic conditions in the United States. It is the most common chronic illness of children and is the highest ranking cause of pediatric hospitalizations in the United States. The prevalence of asthma has been increasing since the early 1980s. Costs associated with asthma are also on the rise.

The Asthma program is a population-based behavioral change program intended to improve the quality of life and self/parent management skills, improve provider compliance with evidence based guidelines, and reduce costs through improved utilization patterns.

*Quality Indicators:*
- ER visits
- Hospitalizations and LOS
- Medication refills – IBA, IAI ratio, costs
- Rx for inhaled corticosteroids, nedocronil, cromlyn sodium, levlcotrin, or methylxanthines (HEDIS measure)

*Performance Results:*
- Baseline data collected in 2002

*Barrier Analysis:*
- Members lack understanding of the disease and are frequently noncompliant with medications and treatment plan
- Members have limited understanding of self management and appropriate tools
- Providers are not familiar with and/or not following current clinical guidelines for assessment and treatment

*Accomplishments:*
- Development and implementation of Taking Charge of Asthma (TCA) program
- Introductory member mailing which included asthma survey and information on website Health A-Z program
- Development and distribution of Asthma management CPGs to PCPs and allergists
- Introductory mailing to providers included TCA program materials and laminated quick reference cards

SENIOR IMMUNIZATION INITIATIVE

*Improving the Rate of Pneumococcal and Flu Immunizations*

Ninety percent of the more than 10,000 adults who die of influenza and pneumonia each year are age 65 or older. Approximately 95%, of Secure Horizons’ members (>380,000) were at least 65 years old in 2001.
Quality Indicators:
- members received flu shot
- member received pneumovax vaccine

Performance Results:
- The number of members who received flu shots and/or pneumovax vaccinations decreased from 2001

Barrier Analysis:
- Shortage of flu vaccine
- Vaccine distribution problems

Accomplishments:
- Targeted reminder mailing to almost 400,000 Secure Horizons members 65-85 years old, discussing flu/pneumonia facts and stressing the importance of receiving timely immunizations
- A randomly selected subgroup of members was sent additional reminder mailings. Follow-up will be conducted to see if this group had a better immunization rate
- Providers were also sent copies of the targeted member mailing (listed above) along with educational posters for their offices
- Preventive Health Guidelines were mailed to all commercial members, PCPs, and Provider groups

WOMEN’S HEALTH INITIATIVE
Improving Breast Cancer Screening Rates

In 2001, approximately 8% (>150,000) PacifiCare members were women between the ages of 52 & 69. Breast cancer is the most common cancer among women. Mammography can detect breast cancer up to two years before it can be felt in a manual breast exam. Women who have regular mammograms reduce their risk of dying from breast cancer by 44%.

Quality Indicators:
- Mammography rates (HEDIS measure)

Performance Results:
- Rates for both commercial and Secure Horizons’ members increased slightly from previous year

Barrier Analysis:
- Member is non-complaint due to failure to remember to make an appointment or to keep an appointment that has been set 3 months ahead
- Providers lack systems to identify patients needing mammograms

Accomplishments:
- Implementation of Women’s Health Solutions program that disseminates information to interested members via mail and web on-line programs
• Targeted mailings to more than 400,000 female members who may be due for a mammogram
• Direct provider mailing identifying patients who may be due for a mammogram
• Preventive Health Guidelines were mailed to all commercial members, PCPs, and providers

WOMEN’S HEALTH INITIATIVE
Improving Cervical Cancer Screening Rate

Cervical cancer is most prevalent in women between the ages of 20 and 64. More than 60% of PacifiCare’s female population, approximately 526,000 women are in this age group and are at risk. The Pap test is the single most effective cancer-screening test in medical history.

Quality Indicators:
• Pap test w/in 3 years (HEDIS measure)

Performance Results:
• Rotated measure – no data collection occurred

Barrier Analysis:
• Member is non-complaint due to failure to remember to make an appointment or to keep an appointment that has been set 3 months ahead and/or fear of procedure
• Providers lack systems and resources to send reminder notices to patients

Accomplishments:
• Implementation of Women’s Health Solutions program that disseminates information to interested members via mail and web on-line programs
• Targeted mailings to over 400,000 women whose administrative records showed they had not had a Pap test within the past 3 years
• Lists mailed to providers showing their patients who may not have had a Pap test within the past 3 years, according to administrative data
• Preventive Health Guidelines were mailed to all commercial members, PCPs and provider groups

CHILDREN’S HEALTH INITIATIVE
Improving Childhood Immunization Rates

Immunization of children during the first 2 years of life has proven to be effective in reducing the incidence of measles, mumps, rubella, polio, diphtheria pertussis, tetanus and hepatitis B.

Quality Indicators
• DPT (HEDIS measure)
• O/IPV (HEDIS measure)
• MMR (HEDIS measure)
• Hib (HEDIS measure)
• Hep B (HEDIS measure)
• Varicella (HEDIS measure)
• Combo 1 --4-DPT, 3-O/IPV, 1-MMR, 2-Hib, 2-HepB (HEDIS measure)
• Combo 2 --all antigens (HEDIS measure)

Performance Results:
• HEDIS measures were rotated in 2002 – no data collection occurred

Barrier Analysis:
• Parents lack knowledge of the recommended pediatric immunizations and childhood immunization requirements
• Parents more skeptical about the number of adverse events that have occurred following administration of immunizations, especially varicella
• Providers do not recognize or adhere to HEDIS timetable set for childhood immunizations, i.e., many antigens given either too early or too late

Accomplishments:
• More than 8,000 new baby immunization schedules and reminder cards were mailed to parents 11 months old and younger
• More than 6,000 reminder cards were mailed to parents of children 1 year old
• Preventive Health Guidelines were mailed to all commercial members, PCPs, and provider groups
• Initiation of Women’s Health Solutions program that disseminates immunization information to interested mothers. Magnetic immunization schedules are available upon request.

CHILDREN’S HEALTH INITIATIVE
Improving Adolescent Immunization Rates

Immunizations are among the most cost-effective and widely used mechanism for preventing infectious disease, i.e., reducing the incidence of measles, mumps, rubella, chickenpox and hepatitis B. The success of past immunization programs made parents and practitioners think that such diseases no longer exists. Yet, measles, rubella, and chickenpox are still some of the most infectious diseases in the world and are frequently imported into the United States by international travelers.

Quality Indicators:
• MMR (HEDIS measure)
• Hep B (HEDIS measure)
• Varicella (HEDIS measure)
• Combo 1 --MRR & Hep B (HEDIS measure)
• Combo 2 --all antigens (HEDIS measure)

Performance Results:
• HEDIS measures rotated in 2002 – no data collection occurred
Barrier Analysis:
- Parents lack knowledge/understanding of which adolescent immunizations are required and when
- Providers lack knowledge of current guidelines, which leads to variable treatment practices and timelines

Accomplishments:
- Almost 30,000 adolescent immunization reminders and questionnaires were sent to parents with children 11 years of age
- 1500 surveys were returned from parents that indicated the following reasons for their adolescent not receiving vaccines:
  - unaware of need for vaccines
  - vaccine shortage
  - no time
  - personal reasons
  - allergy to vaccine
C. Utilization Management
INTRODUCTION TO UTILIZATION MANAGEMENT (UM)

NCQA defines utilization management as the process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing any needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources. Utilization review is a formal evaluation (prospective, concurrent or retrospective) of the coverage, medical necessity, efficiency or appropriateness of health care services and treatment plans.

Although cost is a component of UM, it is PacifiCare’s philosophy that quality health care is cost effective. Appropriate UM systems should be primarily focused on providing quality, medically necessary care within a contracted provider network. Therefore, one of the primary roles of the utilization management process is to stress the importance of the determination of the medical necessity and clinical appropriateness of the health care being requested or provided, and to transition patients to the next appropriate level of care at the earliest opportunity. It is critically important that the PMG/IPA assess the clinical expertise of their physician and professional nursing staff for the development and implementation of medical criteria and treatment guidelines for the UM program.

The purpose of this section is to:

- Provide guidelines for the documentation of a UM Program
- Provide standards and regulatory requirements for implementing a UM program
- Outline the cooperative relationship between provider groups and PacifiCare to achieve optimum utilization management.

DOCUMENTATION OF UTILIZATION MANAGEMENT PROGRAM

All PMG/IPAs that are delegated to perform UM must establish and maintain a comprehensive UM Program that provides a framework for ensuring the appropriateness of medical care to ensure appropriate use of resources. The UM Program must address all facets of healthcare delivery, including behavioral health care, in order to maximize the quality of care and services delivered to members in a cost-efficient manner. The written UM Program description defines the goals, scope, structure, processes, accountabilities, information sources, and functions of the UM Program. The written UM Program is supported by written policies and procedures, which document the details of UM processes.

Success begins with positive patient-physician relationships and depends on the effective management and timely delivery of medically necessary healthcare services designed to maintain and/or return members to an optimum level of health. The PMG/IPA Medical Director should take an active role in the development and promotion of managed care systems within the PMG/IPA.

The UM Program description should at least include information related to the following components:

- Purpose
- Goals and Objectives
- Program Scope and Content
  - Review Functions (pre-service, concurrent, and post-service)
• Review Process
  • Review Criteria – Medical Guidelines for Care
  • Decisions to Approve, Delay, Modify or Deny
  • Denial Notice and Appeal Process
• Communication Services relates to UM
• Ensuring Appropriate Service & Coverage
  • Data Sources
  • Monitoring Relevant Utilization Data
• Organizational Structure
  • UM Committee Functions & Responsibilities
• Resources Dedicated to UM
  • Roles and Responsibilities

Purpose:
The purpose is a broad and brief statement regarding the reason for implementing an UM program and how it relates to the QI program.

Goals and Objectives:
Goals are statements of desired accomplishments – what the PMG/IPA wants to achieve. Objectives are statements of the mechanisms or processed that will be used to meet the goals; that is, how the goals will be met. Goals and objectives are written in quantifiable, measurable terms, such as:

Goal: Maintain a well functioning UM Program
  Objectives:
  • Maintain effective monitoring and oversight of delegated UM functions
  • Communicate results of findings, including recommendations for improvement, to PacifiCare staff and to PMG/IPAs
  • Develop opportunities for licensed staff to achieve and/or maintain certification credentials

Goal: Monitor systems, which impact delivery of care
  Objectives:
  • Analyzing UM indicators against performance goals and recognized benchmarks
  • Managing Every Patient Every Day (EPED), length of stay, admissions, ER, and quality of service
  • Monitoring the consistent application of UM criteria and practice guidelines

Program Scope and Content:

Review Functions

Pre-Service Review (also referred to as pre-certification, prior authorization, referral)
Prior assessment is performed to determine if requested care or service is appropriate for a particular member and will be covered. The basic elements of pre-service review include eligibility verification, benefit interpretation, and medical necessity review for approval of both inpatient and outpatient services and is conducted by non-clinicians and clinical staff.
For Commercial products, pre-service authorizations include non-urgent pre-service and urgent pre-service.

For Medicare+Choice (M+C) products, pre-service authorizations include standard pre-service determinations and expedited initial determinations.

For emergency services necessary to screen and stabilize a member, pre-service authorizations will not be required. This applies to cases where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.

**Concurrent Review**
Concurrent Review is a process designed to monitor appropriateness and quality of healthcare in the inpatient, transitional care and inpatient psychiatric settings, and for those members in case management programs. Appropriately licensed medical professionals perform concurrent review. Concurrent review includes, but is not limited to, the following:

- Review of medical necessity
- Appropriateness of level of care
- Assessment of quality of care
- Prevention or notation of variant bed day(s)
- Discharge planning
- Researching/coordinating alternatives to inpatient care
- Areas of healthcare appropriate for concurrent review includes, but is not limited to, the following:
  - Acute care
  - SNF/Subacute
  - Out of Network
  - Out of Area interface and post-stabilization care
  - Behavioral Health

**Post-service/Retrospective Review**
The Retrospective Review process includes reviewing medical care treatments after the service has been provided. The purposes of retrospective review may include:

Medical necessity determinations
- Utilization of appropriate level of care
- Identifying claims issues
- Eligibility verification
- Initiation of appropriate follow-up actions for utilization and quality issues
- Identifying appropriateness and administrative issues such as physician notification, emergency status of admission
- Review of claims for emergency and unauthorized services.

**Review Process**

**Review Criteria – Medical Guidelines for Care**
The UM program should specify:
• The medical criteria used in making UM decisions, either nationally recognized criteria or criteria developed by the PMG/IPA, are objective and based on sound clinical practice and published scientific evidence
• The process for development and adoption of criteria and application of policies and procedures, involving appropriately licensed practitioners
• That criteria is reviewed, revised and approved annually and by whom
• Annual review, revision and approval of written procedures for applying criteria based on individual needs and the characteristics of local delivery systems
• The right of members and practitioners to receive UM criteria upon request
• The process by which members, practitioners, and the public may obtain criteria

Decisions to Approve, Delay, Modify or Deny
Authorization decisions are made utilizing written criteria based on sound clinical evidence in conjunction with the review of relevant clinical information, and consultation with appropriate practitioners involved in the member’s care. Appropriately licensed health professionals supervise all review decisions and appropriate practitioners review any denial of care. Additionally, board certified, licensed physicians, from appropriate specialty areas, are utilized to assist in making determinations of medical necessity, as appropriate. All information to support decision-making is consistently gathered and documented.

Standards and mechanisms are in place to ensure timely decision-making, which accommodate the clinical urgency of the situation. These standards are outlined in medical management policies and procedures.

Denial Notice and Appeal Process
All decisions to deny are communicated in writing to both the member and the practitioner. These letters contain the reason for the denial, including the specific utilization review criteria or benefits provisions used in the determination and information regarding the PacifiCare appeals process. For denials based wholly or in part on benefits, the letters shall specify the provision in the contract, evidence of coverage or member handbook that excludes the service. The letter shall either identify the document and page where the provision is found, direct the grievant to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested by the enrollee. In addition, mechanisms are in place to ensure timely notification of members and practitioners, in accordance with the clinical urgency of the situation and compliance with regulatory requirements.

(Note: PacifiCare does not delegate the appeals process. PMG/IPAs are responsible to provide all requested documentation in order for PacifiCare to process appeals in a timely manner. Thus the UM program or its policies and procedures must address how the PMG/IPA handles received appeals when not delegated.)

Communication Services Relating to Utilization Management
The PMG/IPA provides the following communication services for practitioners and members:
• Availability of staff at least eight hours a day during normal business hours (excludes holidays) for in-bound calls
• Ability to receive in-bound communication (e.g., phone, voicemail, e-mail, fax) after normal business hours
• Outbound communications regarding inquiries about UM during normal business hours, unless otherwise agreed upon
• When initiating or returning calls regarding UM issues, staff identifies themselves by name, title and name of organization
• A toll-free number or staff that accept collect calls regarding UM issues. This may be a customer service or member service department
• Access to staff for callers with questions about the UM process. General inquiries may be referred to customer or member services; however, inquiries regarding specific UM cases must be triaged to and handled by UM staff (e.g., inquiries about decisions beyond the confirmation of approval or denial of care).

Availability of these services may be documented in policies and procedures (first four factors), member and provider materials (fifth and sixth factors) and sample case files (sixth factor).

Ensuring Appropriate Service & Coverage

The scope of the PMG/IPA UM Program includes the objective and systematic monitoring, evaluation, and improvement of the quality and appropriateness of care and service provided to members. Monitoring is designed to identify and pursue opportunities for improvement regarding quality and cost-effectiveness. These measures must be designed to detect both under and over utilization.

The UM Program’s scope includes, but is not limited to, monitoring and evaluation of the following:

• Services provided in inpatient hospitals, home care, skilled nursing facilities, residential treatment facilities, subacute facilities, transitional facilities and other treatment centers
• Appropriateness and medical necessity of pre-authorization decisions
• Consistency of UM decisions for pre-service, concurrent review, and post-service decisions through inter-rater reliability audits
• Timeliness of the authorization process—pre-service, concurrent and post-service
• Timeliness and completeness of documentation of denial decisions
• Adequacy of notification to members regarding denial decisions
• Adequacy of discharge planning and follow-up services
• Appropriateness of Case Management referrals
• Quality of Care issues
• Member and Provider satisfaction with the UM process
• Physician and member appeals

Data Sources

Data is systematically tracked and trended for evaluation and identification of actions for improvement, as appropriate. Numerous data sources are used in the implementation, monitoring, and evaluation of the UM Program. These include, but are not limited to, the following:

• Demographic Analysis
• Concurrent Review Data
• Re-admission Data
• Referral Data
• Access Audit Data
• Appeal and Grievance Statistics
• Home Health Reports
• Member and Practitioner Satisfaction Surveys
• Medical Record Reviews
• Pharmacy Data
• UM Reports
• Case Management Data
• Disenrollment Data
• Behavioral Health Data

Data regarding specialty utilization rates by primary care is useful in identifying additional services that can be excluded from the prior authorization list as well as possible avenues for physician education.

**Monitoring Relevant Utilization Data**

Trend analysis is a method of evaluating utilization data for purposes of problem solving, education and quality improvement. Clinical and service monitors are used to evaluate UM activities and identify opportunities for improvement. Indicators are determined through analyses of demographic and utilization information. Utilization monitors may include, but are not limited to, the following:

- Inpatient Days Per Thousand Members Per Year (PTMPY)
- Inpatient Admissions Per Thousand
- Average Length of Stay
- ER Services
- Acute Readmission (PMTPY)
- Skilled Nursing Days Per Thousand
- Skilled Nursing Average Length of Stay
- Outpatient services (PTMPY)
- Prescription Utilization Per Member Per Year (PMPY)
- HEDIS Indicators (i.e., physician contact, preventive health, etc.)
- Access concerns (PTMPY)
- Access Audit Scores
- Appeals (PTMPY)
- Member Satisfaction with referrals and timeliness of referral
- Specialty referral patterns
- Timeliness reports
- Out of area utilization
- Interrater reliability audit reports

PCP referral data is tracked by PCP and by referred specialty. PCP-specific data is shared with PMG/IPA physicians on a regular basis and outliers asked for clarification of data and/or criteria for referral. This data is used to develop action plans regarding identified areas of concern regarding either under or over utilization of services. There is a documented process to disseminate this action plan to all PMG/IPA physicians and staff.
Organizational Structure

UM Committee Functions and Responsibilities
The Utilization Management Committee (UMC) is responsible for the oversight and direction of all of the PMG/IPA’s UM activities. The functions of the UMC include, but are not limited to, the following:

- Development, approval, and annual review of the UM Program Description, Evaluation, and Workplan
- Development, approval, and annual review of UM policies, procedures, and medical criteria to be used in the evaluation of appropriate health care services
- Pre-service review of referral authorizations in accordance with the PMG/IPA UM policies and procedures
- Discussion of current inpatient activity, patient status, treatment alternatives, and possible interventions with the admitting physician regarding anticipated discharge plans
- Direction and oversight of the issuance of appropriate denial and level-of-care (LOC) letters for patients who no longer require the current level of care
- Post-service review of ER and Out-of-Plan claims to determine medical necessity and to what extent, if any, these claims will be authorized and paid
- Assessments of trends, including at least:
  - PCP referral and specialist care patterns of practice including specialist access, ancillary support services and access to preventive health services
  - Over- and under-utilization, inpatient and outpatient
  - Denial and appeal rates
  - Complaint and satisfaction data
- Implementation of actions to correct identified problems
- Communicating actions and results to appropriate staff and providers
- Assess compliance with UM processes, including:
  - Timeliness of decision-making, notification and written confirmation
  - Appropriate use and application of criteria, including interrater reliability studies
  - Use of appropriate qualified licensed health care provider in making UM decisions
- Assess effectiveness and efficiency of resource allocation and management
- Review, approve, and report quality of care service indicators for UM
- Implement clinical care management programs in collaboration with other departments
- Physician education regarding new technologies, medical guidelines, and UM policy and procedure
- Oversight of sub-delegated entities, ensuring compliance to policies, procedures and ongoing UM processes

An agenda and minutes are kept for all UMC meetings and should be readily available for reference. The PacifiCare Clinical Management Specialist will review these minutes on a periodic basis.

Membership of this committee includes, but is not limited to, the following:

- Medical Director or designated senior physician (Chair)
- UM Manager
- Behavioral Health vendor representative, if applicable
- Primary Care Physicians and Specialty Practitioners
A quorum exists when 50% of the voting members are present. Only physicians may vote on matters of medical interpretation or peer review activities.

The frequency of UMC meetings depends upon the structure of the UM process, the volume of referrals requiring review, PMG/IPA membership, and the number of procedures requiring authorization. However, PacifiCare recommends that the UMC meet at least monthly. The frequency of the UMC meetings is based on the committee’s ability to adequately address all issues scheduled for discussion and to meet timely referral turnaround time standards. The PMG/IPA should have processes in place to address issues that cannot be postponed until the scheduled meeting without exceeding turnaround time requirements.

The UMC reports to the PMG/IPA QMC on a quarterly basis. A copy of the approved UM Program, Annual Evaluation, and Workplan, along with the signature pages, are to be submitted to the PacifiCare Clinical Management Specialists on an annual basis. These documents are reviewed for compliance with PacifiCare standards and feedback given for any identified opportunities for improvement.

**Resources Dedicated to UM**

All UM staff performing or supervising pre-service, concurrent review, post-service, and case management must be medical professionals licensed in the state of California. Non-licensed personnel may screen and/or approve services based on written procedures or criteria approved by the UMC.

A California-licensed Medical Director must be available to support all utilization management functions and assist with difficult or complex utilization issues. All denials of service based on medical necessity must be reviewed by the medical director or designated physician.

Staffing must be sufficient to meet timeliness requirements for pre-service, concurrent review, post-service, emergency services, claims review, inpatient determinations and respond to requests for information related to appeals.

Interrater reliability assessment of licensed UM professionals – both physician and non-physician must be performed at regular intervals and at least annually, with appropriate interventions implemented as necessary.

Persons responsible for making utilization management decisions may include practitioners, providers, staff and sub-delegates. The PMG/IPA is responsible for distributing to all of its practitioners, providers, members and employees a written statement affirming that:

- UM decision making is based only on appropriateness of care and service and existence of coverage
- The PMG/IPA does not specifically reward practitioners or other individuals for issuing denials of coverage or service care
- Financial incentives for UM decisions makers do not encourage decisions that result in underutilization
Roles and Responsibilities

Role of the Primary Care Physician

The Primary Care Physician (PCP) is primarily responsible for providing the general health care needs of the PMG/IPA members as defined in the primary care functions guidelines or policies developed and approved by the PMG/IPA UMC.

It is important for a PMG/IPA to define PCP responsibility and the scope of the Primary Care Practice. The role of primary care provider, manager of patient care, and physician consultant/advisor dictates that the PCP provide as great a scope of primary care services as possible. Quality and continuity of care are also maintained when PMG/IPAs are able to provide a greater range of primary care services, which require fewer referrals to specialists.

In order to better define primary care functions, the PMG/IPA UMC should develop and approve a policy specifying primary care responsibilities. This policy should be reviewed and updated annually. PCPs would be expected to provide these services without referral to a specialist unless treatment modalities listed under approved primary care responsibilities policy had been exhausted without significant improvement in the condition. Selected temporary exceptions may be made for physicians whose lack of training or experience in a particular treatment or procedure might potentially result in an inadequate evaluation or treatment outcome. These physicians should then be expected to seek training and/or certification in these treatments/procedures within a specified, agreed-upon timeframe.

One resource for primary care functions can be found in Milliman & Robertson, Inc.’s “Healthcare Management Guidelines,” Volume 3 (Ambulatory Care Guidelines) under the section “Primary Care Management Guidelines.” This description of primary care functions can serve as a starting point for the development of the PMG/IPA’s own criteria, and may be modified according to the judgement and decision of the UMC based upon community practice standards and their knowledge of PMG/IPA PCP skills and expectations. Ask your PacifiCare CMS for more information regarding the Milliman & Robertson resource.

An important component of a successful UM program is the PCP’s role as manager of all health services provided to the member. This means that the PCP serves as the single point of contact, reference, resource, and consultation for all health services provided to the member. Summaries from all specialist consults and procedures should be routed to the PCP for evaluation and consultation prior to providing additional services. This ensures that there is continuity of care as well as eliminating duplication of testing and procedures. After receiving consultation information and recommendations, the PCP may submit an authorization request for any additional services to the PMG/IPA UM department for approval. The PCP is also expected to support UMC recommendations and discuss them, when needed, with their patients.

During inpatient admissions, the PCP should continue to monitor the medical necessity of services being provided and facilitate the transfer of the patient to the next lower level of care at the earliest appropriate opportunity. Discharge summaries should be copied to the PCP.

The member looks to the PCP to provide medical expertise and direction of their health care needs. The PCP’s role in successfully recognizing and addressing the needs of the member will
be of primary importance in the achievement of the health and satisfaction of members, and the success of the PMG/IPA.

Role of the UM Medical Director
The UM Medical Director, who may be the PMG/IPA Medical Director, plays a vital role in both the development and implementation of UM policy and procedure. This physician should be chosen based upon his/her knowledge of medical practice, experience in managed care UM Programs, and an ability to command respect from, and interact well with, other PMG/IPA physicians. Pursuant to California Health and Safety Code 1367.01(c), the employed or designated medical director must hold an unrestricted license to practice medicine in the state of California.

The UM Medical Director is expected to provide leadership and direction for the UMC and to act as physician liaison with the PCPs and specialists in the resolution of UM issues. He/she should attend all UM meetings and assist in directing the flow and direction of issues, as well as serve as a resource for decision-making. The UM Medical Director also serves as an important resource and key contact for the PMG/IPA UM Nurse when evaluating specific cases and interfacing with PCPs or specialists. The UM Medical Director will also be responsible for interfacing with PacifiCare’s Medical Directors and clinical staff regarding benefits and administrative issues.

Also of great importance, the Medical Director should take an active role in the development and promotion of managed care systems within the PMG/IPA. This should include development of UM policies and procedures, identifying the type of criteria to be used for authorization and review, and the implementation of a regular forum in which to educate PMG/IPA PCPs on UM processes.

Role of the UM Nurse
The PMG/IPA UM Nurse plays a key role in the monitoring, tracking, and implementation of PMG/IPA utilization processes. He/she should also play an important role in the identification of health care delivery inefficiencies and assist in the development of appropriate resolutions to these problems. Some of the key responsibilities of the PMG/IPA UM Nurse include:

- Assist in the prospective review process by screening referrals for adequate information, approving specified referral authorizations according to PMG/IPA policy and procedure, and serving as a resource to the PMG/IPA staff and Medical Director for UM related issues.
- Provide concurrent review of all patients receiving care in acute care hospitals, psychiatric facilities and skilled nursing facilities for appropriateness and medical necessity. This includes on-site review whenever possible but may be supplemented with phone review of patients when on-site review is not feasible.
- Provide concurrent monitoring, tracking, and authorization of ongoing outpatient services, such as Home Health Care, therapies, and DME, for appropriateness and medical necessity.
- Assist in the retrospective review of unauthorized claims/services for payment based upon reasonable criteria developed and approved by the PMG/IPA UMC.
- Participate in the gathering and review of retrospective UM studies illustrating PMG/IPA utilization patterns, and the development of appropriate action plans aimed at minimizing over- and under-utilization, as well as quality improvement in identified areas.
• Serve as a liaison for the PMG/IPA Medical Director, the UMC, and PMG/IPA practitioners in resolving UM issues.
• Serve as liaison between the PMG/IPA and PacifiCare Clinical staff.

Role of Case Manager

The Case Manager is responsible for facilitating communication and coordination of care among all members of the health care team involving the member and family in the decision-making process in order to minimize fragmentation of the health care delivery system. The Case Manager assesses the needs of the member and educates the member and all members of the health care delivery team about case management, community resources insurance benefits, cost factors and issues in all related topics so that informed decisions may be made. The Case Manager is the link among the member, the providers, the payer and community.

IMPLEMENTATION OF UM PROGRAM: STANDARDS AND REGULATORY REQUIREMENTS

UM Criteria – Development, Adoption, Use and Availability

All utilization decisions must be guided by a standard set of criteria. PMG/IPAs are required to utilize nationally recognized criteria when making utilization decisions. Sources of national criteria include InterQual, Milliman & Robertson, American Academy of Pediatrics, U.S. Preventive Health Task Force, and Medicare Guidelines. The criteria for determining medical appropriateness must be clearly documented and include procedures for applying criteria based on the needs of individual patients and characteristics of the local delivery system. If the PMG/IPA chooses to develop criteria internally, they must document the research literature utilized to develop evidence-based criteria.

All criteria utilized by the PMG/IPA must be reviewed, updated as appropriate and approved by the PMG/IPA UM Committee at least annually. Appropriate practitioners must be involved in the development and adoption of criteria and in the development and review of procedures for applying the criteria. The PMG/IPA must have a written statement that describes how practitioners can obtain the UM criteria and makes the criteria available to its’ practitioners upon request. In addition, the PMG/IPA must make available to physicians a physician reviewer to discuss by telephone determinations based on medical appropriateness.

The California Health & Safety Code 1367.01 (a) and (b) requires every health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions shall disclose policies and procedures and a description of the process used by the Plan or entity to authorize, modify, delay or deny services to providers, enrollees, enrollee designees and the public upon request.

The California Health & Safety Code 1363.5 further requires that the UM criteria used to make decisions shall be made available to providers, enrollees and the public upon request. The PMG/IPA shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. The following disclaimer is required in the written communication when such information is disclosed to the public:
"The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

The PMG/IPA is required to document when such requests are made and to keep copies of the written communication of disclosure in order to provide evidence of compliance with the regulations.

The California Health & Safety Code 1363.5 also states that if used as the basis of a decision to modify, delay or deny services in a specified case under review, the criteria shall be disclosed to the provider and the enrollee in that specific case.

All criteria utilized by the PMG/IPA must be reviewed and approved by PacifiCare.

PacifiCare has adopted InterQual criteria for all non-delegated utilization management functions. All medical necessity appeals are also reviewed using this criteria set. Policies and procedures for the disclosure of UM processes and criteria used (e.g., InterQual) in making UM decisions are made available to the enrollees, provider/practitioner and the public upon request.

**Decisions to Approve, Delay, Modify or Deny**

All authorization decisions must be based on sound clinical evidence including, but not limited to, review of medical records, consultation with the treating practitioners, and review of nationally recognized criteria.

The criteria for determining medical appropriateness must be clearly documented and include procedures for applying criteria based on the needs of individual patients and characteristics of the local delivery system.

Board certified licensed physicians from appropriate specialty areas must be utilized to assist in making determinations of medical necessity, as appropriate.

All information to support decision-making is consistently gathered and documented.

Review of referrals and requests for authorization is a primary function of the UMC. This function may be delegated to a designated physician or UM sub-committee for the purpose of expediting authorization turnaround times. The UMC must develop and/or approve referral guidelines and a list of procedures or services that must be authorized. A designated PMG/IPA UM Nurse or staff person may approve referral authorizations based upon PMG/IPA UM Committee-approved criteria. This process can reduce the number of referrals requiring a physician’s expertise for a determination. (See subsections on Standing Referrals and Direct Access to Women’s Health Services below.)

Referrals not meeting criteria must then be reviewed by a UMC designated physician or presented to the collective UMC or subcommittee for discussion and a determination. Only a physician (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist as appropriate) may determine to delay, modify or deny services to a member for reasons of medical necessity.
Physicians should not review their own referrals
Referrals being considered for denial should be discussed with physicians qualified to make an appropriate determination
Any referral where the medical necessity or the proposed treatment plan is not clear should be clarified and discussed with the referring physician. Difficult cases may be brought to the UMC for further discussion and decision.

There may be referrals reviewed by the UMC which, in the opinion of its members, still require additional information or documentation to support medical necessity before a determination can be made. In these cases, the PCP (requesting practitioner) should be contacted as soon as possible (at least within 24 hours) to obtain the required information. Once the information is obtained, the approval/denial is made based on the supportive data. Note that time frames must be met in this process. (See subsection below on Standards for Timeliness of Authorization Process.)

Possible authorization determinations include:
- Approved as requested – No changes
- Approved as modified – Referral approved, but the requested provider or treatment plan was modified. Denial letter must be sent if requested provider is changed or specific treatment modality is changed (e.g., requested chiropractic, approved physical therapy).
- Extension – Delay decision of a specific service (e.g. need additional documentation or information or require consultation by an expert reviewer).
- Delay in Delivery – Access to an approved service is required to be postponed for a specified period of time or until a specified date. This is not the same as a modification.
- Denied – Non-authorization of a request for health care services

Reasons for denials of requests for services include, but are not limited to the following:
- Not a covered benefit – specific benefit exclusion must be noted
- Not medically necessary
- Member not eligible at the time of service
- Benefit exhausted - include specific information as to what benefit was exhausted and when
- Not a contracted provider
- Services can be provided by the PCP
- Experimental or investigation procedure/treatment
- Self referred/no prior authorization (for non-emergent post-service)

Minimum Content of Written or Electronic Notification
Written or electronic notice to deny, delay in delivery or modify a request for authorization for health care services will include the following:

Commercial Notification:
- the specific service(s) denied, delayed in delivery or modified
- the specific reference to the Plan provisions to support the decision
- the reason the service is being denied, delayed in delivery or modified, including:
  - a clear and concise explanation of the reasons for the decision, in sufficient detail so that all parties can understand the rationale behind the decision, and
  - a description of the criteria or guidelines used, reference to the benefit provision, protocol or other similar criterion on which the denial decision is based
- notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.
- clinical reasons for decisions regarding medical necessity
- contractual rationale for benefit denials
- alternative treatment options offered, if applicable (NA for retrospective review)
- a description of grievance rights and an explanation of the appeal and grievance processes, including:
  - information regarding the member’s right to appoint a representative to file an appeal on the member’s behalf
  - the member’s right to submit written comments, documents or other additional relevant information
  - information notifying the member and their treating practitioner of the right to an expedited appeal for the time-sensitive situations (NA for retrospective review)
- information regarding the member’s right to file a grievance with the DMHC, including information regarding the independent medical review process (IMR)
- information that the member may bring civil action, under Section 502(a) of Employee Retirement Income Security Act (ERISA)
- the name and direct telephone number of the health care professional responsible for the decision will be provided to the treating provider only

Medicare + Choice (M+C) Notification
All M+C written or electronic notice of adverse organization determinations are issued using CMS approved standardized notice language. Adverse Organization Determinations are written in a manner that is understandable to the member and provides the following:

- states the specific reason for the denial that takes into account the member’s presenting medical condition, disabilities and special language requirements, if any
- information regarding the member’s right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the member’s behalf (as mandated by 42CFR 422.570 and 422.566(b)(3).
- for service denials, a description of both the standard and expedited reconsideration processes and should include conditions for obtaining an expedited reconsideration, and the other elements of the appeals process
- the member’s right to submit additional evidence in writing or in person
- information regarding the member’s right to file a grievance with the Medicare carrier intermediary with jurisdiction for the State of California

Standards for Timeliness of Authorization Process
All utilization decisions must be made in a timely manner to accommodate the clinical urgency of the situation. These standards must meet state and federal regulatory requirements and NCQA standards.

The standards for timeliness are based on the strictest time frame required by NCQA and/or regulatory entities. PacifiCare’s Policy and Procedure UM-8063 Process for Authorization, Denial, Delay, or Modification of Healthcare Services based on Medical Necessity delineates the timeliness
standards adopted to meet those time frames. PacifiCare requires that delegated PMG/IPAs perform quarterly audits of the timeliness of utilization decisions and report these results to PacifiCare. These audits must include, but are not limited to, the following:

**Commercial**
- Non-urgent pre-service requests and extensions
- Urgent pre-service requests and extensions
- Urgent Concurrent
- Post-service requests and extensions (includes claims decisions based on medical necessity)

**Medicare + Choice (M+C)**
- Standard pre-service requests
- Expedited initial determinations
- Discontinuation of acute inpatient services
- Discontinuation of skilled nursing facility services
- Discontinuation of other ongoing outpatient services (e.g. Home Health Care)
- Standard post-service/retrospective requests

**Processing Expedited Initial Organizational Determinations for M+C Members**
It is the responsibility of the PMG/IPA delegated for utilization management to appropriately log and respond to requests for expedited initial determinations as specified in Title 42 of the Code of Federal Regulations, part 422 sections 570 and 572, as follows:

42CFR 422.570  (Title 42 of the Code of Federal Regulations, part 422 section 570)
Expediting certain organization determinations.

(a) Request for expedited determination. An enrollee or a physician (regardless of whether the physician is affiliated with the M+C organization) may request that an M+C organization expedite an organization determination involving the issues described in Sec. 422.566(b)(3) and (b)(4). (This does not include requests for payment of services already furnished.)

(b) How to make a request.
   (1) To ask for an expedited determination, an enrollee or a physician must submit an oral or written request directly to the M+C organization or, if applicable, to the entity responsible for making the determination, as directed by the M+C organization.
   (2) A physician may provide oral or written support for a request for an expedited determination.

(c) How the M+C organization must process requests. The M+C organization must establish and maintain the following procedures for processing requests for expedited determinations:
   (1) Establish an efficient and convenient means for individuals to submit oral or written requests. The M+C organization must document all oral requests in writing and maintain the documentation in the case file.
   (2) Promptly decide whether to expedite a determination, based on the following requirements:
      (i) For a request made by an enrollee the M+C organization must provide an expedited determination if it determines that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.
(ii) For a request made or supported by a physician, the M+C organization must provide an expedited determination if the physician indicates that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(d) Actions following denial. If an M+C organization denies a request for expedited determination, it must take the following actions:

(1) Automatically transfer a request to the standard timeframe and make the determination within the 14-day timeframe established in Sec. 422.568 for a standard determination. The 14-day period begins with the day the M+C organization receives the request for expedited determination.

(2) Give the enrollee prompt oral notice of the denial and subsequently deliver, within 3 calendar days, a written letter that—

(i) Explains that the M+C organization will process the request using the 14-day timeframe for standard determinations;

(ii) Informs the enrollee of the right to file a grievance if he or she disagrees with the M+C organization's decision not to expedite; and

(iii) Informs the enrollee of the right to resubmit a request for an expedited determination with any physician's support; and

(iv) Provides instructions about the grievance process and its timeframes.

(e) Action on accepted request for expedited determination. If an M+C organization grants a request for expedited determination, it must make the determination and give notice in accordance with Sec. 422.572.

(f) Prohibition of punitive action. An M+C organization may not take or threaten to take any punitive action against a physician acting on behalf or in support of an enrollee in requesting an expedited determination. [63 FR 35107, June 26, 1998, as amended at 65 FR 40329, June 29, 2000]

42CFR 422.572 (Title 42 of the Code of Federal Regulations, part 422 section 572)
Timeframes and notice requirements for expedited organization determinations.

(a) Timeframe. Except as provided in paragraph (b) of this section, an M+C organization that approves a request for expedited determination must make its determination and notify the enrollee (and the physician involved, as appropriate) of its decision, whether adverse or favorable, as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request.

(b) Extensions. The M+C organization may extend the 72-hour deadline by up to 14 calendar days if the enrollee requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence from noncontract providers may change an M+C organization's decision to deny). When the M+C organization extends the deadline, it must notify the enrollee in writing of the reasons for the delay and inform the enrollee of the right to file a grievance if he or she disagrees with the M+C organization's decision to grant an extension. The M+C organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than upon expiration of the extension.

(c) Confirmation of oral notice. If the M+C organization first notifies an enrollee of its expedited determination orally, it must mail written confirmation to the enrollee within 3 calendar days of the oral notification.
(d) How the M+C organization must request information from noncontract providers. If the M+C organization must receive medical information from noncontract providers, the M+C organization must request the necessary information from the noncontract provider within 24 hours of the initial request for an expedited organization determination. Noncontract providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist the M+C organization in meeting the required timeframe. Regardless of whether the M+C organization must request information from noncontract providers, the M+C organization is responsible for meeting the timeframe and notice requirements of this section.

(e) Content of the notice of expedited determination.

(1) The notice of any expedited determination must state the specific reasons for the determination in understandable language.

(2) If the determination is not completely favorable to the enrollee, the notice must—

(i) Inform the enrollee of his or her right to a reconsideration;

(ii) Describe both the standard and expedited reconsideration processes, including the enrollee's right to request, and conditions for obtaining, an expedited reconsideration, and the rest of the appeal process; and

(iii) Comply with any other requirements specified by CMS.

Effect of failure to provide a timely notice. If the M+C organization fails to provide the enrollee with timely notice of an expedited organization determination as specified in this section, this failure itself constitutes an adverse organization determination and may be appealed. [63 FR 35107, June 26, 1998, as amended at 65 FR 40329, June 29, 2000]

In addition, PacifiCare performs oversight of the delegated PMG/IPA groups, at least annually, including timeliness of utilization decisions in the above categories.

The following two grids, developed and adopted by the Industry Collaboration Effort (ICE), show the required time frames for decision, initial notification, and written notification to all applicable parties. The first grid applies the most stringent regulatory or accreditation standard to Commercial HMO files, using DMHC, ERISA, and NCQA as the sources. The second grid provides required times frames as required by CMS.
<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Decision</th>
<th>Initial Notification of Approvals and Denials (Notification May Be Oral and/or Electronic)</th>
<th>Written/Electronic Notification of Denial to Practitioner and Member</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent Pre-Service</strong> – All necessary information received at time of initial request</td>
<td>Within 72 hours of receipt of the request</td>
<td>Practitioner: Within 24 hours of the decision, not to exceed 72 hours of receipt of the request</td>
<td>Within 72 hours of receipt of the request</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Member: Within 72 hours of receipt of the request for approval decisions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If oral notification is given within 72 hours of receipt of the request then written or electronic notification must be given no later than 3 calendar days after the initial oral notification</td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Pre-Service – Extension Needed</strong></td>
<td>Additional clinical information required:</td>
<td>Practitioner: Within 24 hours of the decision, not to exceed 48 hours after receipt of the requested information</td>
<td>Within 48 hours after receipt of the requested information</td>
</tr>
<tr>
<td>• Additional clinical information required</td>
<td>Notify member and practitioner within 24 hours of receipt of request &amp; provide 48 hours for submission of requested information.</td>
<td>Member: Within 48 hours after receipt of the requested information for approval decisions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Additional information received</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• If requested information is received, decision must be made within 48 hours of receipt of information</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Additional information incomplete or not received</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• If information received is incomplete or not received, decision must be made with the information that is available within 48 hours from receipt of initial request for information</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Practitioner &amp; Member: If requested information is incomplete or not received, notice must be given within 72 hours from receipt of initial request</td>
<td></td>
<td>Within 72 hours of receipt of the request</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If requested information is incomplete or not received, notice must be given within 72 hours from receipt of initial request</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If oral notification is given within 72 hours of receipt of the request then written or electronic notification must be given no later than 3 calendar days after the initial oral notification</td>
<td></td>
</tr>
<tr>
<td>Type of Request</td>
<td>Decision</td>
<td>Initial Notification of Approvals and Denials (Notification May Be Oral and/or Electronic)</td>
<td>Written/Electronic Notification of Denial to Practitioner and Member</td>
</tr>
<tr>
<td>-----------------</td>
<td>----------</td>
<td>--------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Non-urgent Pre-Service/All necessary information received at time of initial request | Within 5 business days of receipt of request | Practitioner: Within 24 hours of the decision
Member: Within 2 business days of the decision for approvals | Within 2 business days of making the decision |
| Non-urgent Pre-Service/- Extension Needed | Additional clinical information required: Notify member and practitioner within 5 business days of receipt of request & provide up to 45 calendar days for submission of requested information
Additional information received
If requested information is received, decision must be made within 5 business days of receipt of information | Practitioner: Within 24 hours of the decision
Member: Within 2 business days of the decision for approvals | Within 2 business days of making the decision |
| Additional information in complete or not received
- If information received is incomplete or not received, decision must be made with the information that is available within 45 calendar days from receipt of initial request for information | Practitioner & Member: If requested information is incomplete or not received, notice must be given within 45 calendar days from receipt of initial request for information | Note
- If requested information is incomplete or not received, notice must be given within 45 calendar days from receipt of initial request for information |
<p>| Require consultation by an Expert Reviewer | Require consultation by an Expert Reviewer: If a consultation is required by an expert reviewer, upon the expiration of the 5 business days or as soon as you become aware that you will not meet the 5 business day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer and the anticipated date on which a decision will be rendered (no more than 15 calendar days from the date of the notice) | | Within 15 calendar days from the date of the notice |</p>
<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Decision</th>
<th>Initial Notification of Approvals and Denials (Notification May Be Oral and/or Electronic)</th>
<th>Written/Electronic Notification of Denial to Practitioner and Member</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent Concurrent</strong>—(i.e., inpatient, ongoing/ambulatory services)</td>
<td>Within 24 hours of receipt of the request</td>
<td>Practitioner: Within 24 hours of receipt of the request</td>
<td>Within 24 hours of receipt of the request</td>
</tr>
<tr>
<td>Requests involving both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved and the request is made at least 24 hours prior to the expiration of prescribed period of time or number of treatments</td>
<td></td>
<td>Member: Within 24 hours of receipt of the request for approval decisions</td>
<td></td>
</tr>
<tr>
<td><strong>Exceptions:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• If the request is not made at least 24 hours prior to the expiration of prescribed period of time or number of treatments, and request is urgent, default to <em>Urgent Pre-service</em> category</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• If the request to extend a course of treatment beyond the period of time, or number of treatments previously approved by the health plan/PMG/IPA does not involve urgent care, default to <em>Non-urgent Pre-service</em> category</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• If oral notification is given within 24 hour of request, then written/electronic notification must be given no later than 3 calendar days after the oral notification</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of Request</td>
<td>Decision</td>
<td>Initial Notification of Approvals and Denials (Notification May Be Oral and/or Electronic)</td>
<td>Written/Electronic Notification of Denial to Practitioner and Member</td>
</tr>
<tr>
<td>-----------------</td>
<td>----------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Post-Service</strong> - All necessary information received at time of request (decision and notification is required within 30 calendar days from request)</td>
<td>Within 30 calendar days of receipt of request</td>
<td>Not applicable</td>
<td>Within 30 calendar days of receipt of request</td>
</tr>
<tr>
<td><strong>Post-Service</strong> Extension Needed</td>
<td>Additional clinical information required: Notify member and provider within 30 calendar days of receipt of request &amp; provide up to 45 calendar days for submission of requested information</td>
<td>Not applicable</td>
<td>Within 15 calendar days of receipt of requested information</td>
</tr>
<tr>
<td></td>
<td>Additional information received</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• If requested information is received, decision must be made within 15 calendar days of receipt of requested information</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Additional information incomplete or not received</td>
<td></td>
<td>Note</td>
</tr>
<tr>
<td></td>
<td>• If information is incomplete or not received, decision must be made with the information that is available within 45 calendar days from receipt of initial request for information</td>
<td></td>
<td>• If requested information is incomplete or not received, notice must be given within 45 calendar days from receipt of initial request for information</td>
</tr>
<tr>
<td>Type of Request</td>
<td>Decision</td>
<td>Initial Notification of Approvals and Denials (Notification May Be Oral and/or Electronic)</td>
<td>Written/Electronic Notification of Denial to Practitioner and Member</td>
</tr>
<tr>
<td>----------------</td>
<td>----------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| • Require consultation by an Expert Reviewer | **Require consultation by an Expert Reviewer:**  
If a consultation is required by an expert reviewer, upon the expiration of the 30 calendar days or as soon as you become aware that you will not meet the 30 calendar day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer and the anticipated date on which a decision will be rendered (no more than 30 calendar days from the date of the notice) | | Within 30 calendar days from the date of the notice |
# Utilization Management Timeliness Standards
## Centers for Medicare and Medicaid Services (CMS)

<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Decision</th>
<th>Initial Notification of Approvals and Denials (Notification may be oral and/or electronic)</th>
<th>Written/Electronic Notification of Denial to Practitioner and Member</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard Pre-Service Authorization</strong></td>
<td>As soon as medically indicated, within a maximum of 14 calendar days after receipt of request</td>
<td>Practitioner: Within 14 calendar days after receipt of request or no later than upon expiration of extension</td>
<td>Within 14 calendar days after receipt of request</td>
</tr>
<tr>
<td><strong>Extensions</strong></td>
<td><strong>May extend up to 14 calendar days.</strong></td>
<td><strong>Extensions</strong></td>
<td><strong>Extensions</strong></td>
</tr>
<tr>
<td></td>
<td><strong>If extended, the decision is required within a maximum of 28 calendar days after receipt of request</strong></td>
<td><strong>Practitioner &amp; Member:</strong> When the timeframe is extended, the member must be notified in writing of the reasons for the delay, and inform the member of the right to file a grievance if they disagree with the decision to grant an extension (within 14 calendar days of receipt of request)</td>
<td><strong>Maximum of 28 calendar days after receipt of request if an extension was warranted</strong></td>
</tr>
<tr>
<td></td>
<td><strong>NOTE:</strong> Extension allowed only if member requests or the organization justifies a need for additional information and how the delay is in the interest of the member</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Expedited Initial Determinations</strong></td>
<td><strong>Within 72 hours after receipt of request (includes weekends &amp; holidays)</strong></td>
<td><strong>Practitioner &amp; Member:</strong> Within 72 hours after receipt of request or no later than upon expiration of extension</td>
<td><strong>Within 72 hours after receipt of request</strong></td>
</tr>
<tr>
<td>(<em>see footnote</em>)</td>
<td><strong>Promptly decide whether to expedite – determine if applying the standard timeframe could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function</strong></td>
<td><strong>Note:</strong> Oral notification applies to the member also</td>
<td><strong>Oral notification to be followed by written notification within 3 calendar days of oral notification</strong></td>
</tr>
<tr>
<td></td>
<td><strong>If submitted as expedited but determined not to be expedited, then non-urgent standard timeframe applies</strong></td>
<td><strong>Practitioner &amp; Member:</strong> If request is not deemed to be expedited, give member prompt oral notice of the denial to expedited the request</td>
<td><strong>If request is not deemed to be expedited, follow up written notification to be delivered to member within 3 calendar days of oral notification</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Automatically transfer the request to the standard timeframe</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>The 14 day period begins</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of Request</td>
<td>Decision</td>
<td>Initial Notification of Approvals and Denials (Notification may be oral and/or electronic)</td>
<td>Written/Electronic Notification of Denial to Practitioner and Member</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>with the day the request was received for an expedited determination</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Extensions</strong></td>
<td><strong>Extensions</strong></td>
<td><strong>Extensions</strong></td>
</tr>
<tr>
<td></td>
<td>• May extend up to 14 calendar days.</td>
<td>Practitioner &amp; Member: When the timeframe is extended, the member must be notified in writing of the reasons for the delay, and inform the member of the right to file a grievance if they disagree with the decision to grant an extension (within 72 hours of receipt of request)</td>
<td>Maximum of 17 calendar days after receipt of request if an extension was warranted</td>
</tr>
<tr>
<td></td>
<td>• If extended, the decision is required within a maximum of 17 calendar days after receipt of request</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• <strong>NOTE:</strong> Extension allowed <em>only</em> if member requests or the organization justifies a need for additional information and how the delay is in the interest of the member</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discontinuation of Acute Inpatient Services (NODMAR)</td>
<td>• Continue coverage of inpatient care until attending physician concurs with discharge</td>
<td>Attending Physician responsible for member’s hospital care &amp; must concur before issuance of NODMAR.</td>
<td>Member remains entitled to inpatient hospital care until s/he receives NODMAR.</td>
</tr>
<tr>
<td>(Concurrent)</td>
<td></td>
<td></td>
<td>• No later than day before hospital coverage ends</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Obtain acknowledgement of receipt from member, member’s representative, or witness of member’s refusal to sign</td>
</tr>
<tr>
<td>Discontinuation of SNF Services (SNF NONC)</td>
<td>• Prior to actual discharge of member or discontinuation of service</td>
<td>• The day prior to discontinuation of service</td>
<td>Member remains entitled to SNF care until s/he receives NONC</td>
</tr>
<tr>
<td>(Concurrent)</td>
<td></td>
<td></td>
<td>• No later than the day before coverage ends</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Obtain acknowledgement of receipt from member, member’s representative, or witness of member’s refusal to sign or document phone notification to the member’s representative of the discontinuation of service followed by NONC sent certified mail</td>
</tr>
<tr>
<td>Type of Request</td>
<td>Decision</td>
<td>Initial Notification of Approvals and Denials (Notification may be oral and/or electronic)</td>
<td>Written/Electronic Notification of Denial to Practitioner and Member</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------</td>
</tr>
<tr>
<td>Discontinuation of Other Ongoing Outpatient Services (Home Health) (Concurrent)</td>
<td>• Prior to discontinuation of service</td>
<td>• Prior to discontinuation of service</td>
<td>Issue prior to discontinuation of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Notice required when the Member objects to discontinuation of Home Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Obtain acknowledgement of receipt from member, member’s representative, or witness of member’s refusal to sign or document phone notification to the member’s representative of the discontinuation of service followed by NONC sent certified mail</td>
</tr>
<tr>
<td>Standard Post-service/Retrospective Authorization</td>
<td>Within 14 calendar days after receipt of request</td>
<td>Practitioner: Within 14 calendar days after receipt of request or no later than upon expiration of extension</td>
<td>Within 14 calendar days after receipt of request</td>
</tr>
<tr>
<td>Note: Requests for payment that occur through claims follow separate claims processing timeframes.</td>
<td><strong>Extensions</strong>&lt;br&gt;• May extend up to 14 calendar days&lt;br&gt;• If extended, the decision is required within a maximum of 28 calendar days after receipt of request&lt;br&gt;• <strong>NOTE:</strong> Extension allowed <strong>only</strong> if member requests or the organization justifies a need for additional information and how the delay is in the interest of the member</td>
<td><strong>Extensions</strong>&lt;br&gt;Practitioner &amp; Member: When the timeframe is extended, the member must be notified in writing of the reasons for the delay, and inform the member of the right to file a grievance if they disagree with the decision to grant an extension (within 14 calendar days of receipt of request)</td>
<td><strong>Extensions</strong>&lt;br&gt;Maximum of 28 calendar days after receipt of request if an extension was needed</td>
</tr>
</tbody>
</table>

*Note Health Plans may stipulate the process members must follow to file expedited requests and may coordinate processing of expedited initial determinations*
Out of Area Review
Out of Area emergent or urgent care cases are reviewed telephonically by PacifiCare for level of care, intensity of service, quality of care, and planned transfer date. Additionally, communication with the primary care physician is maintained to assure appropriate, expeditious care, and transfer of the member to his/her medical service area when the member is medically stable. PacifiCare retains accountability for Out of Area emergent and urgent care management for most contracted providers. The PMG/IPA is responsible for working cooperatively with PacifiCare in arranging physician to physician communication and the return of the patient to the in-plan provider. Out of Area trends are reviewed to identify patterns and potential quality of care concerns.

Post Stabilization Care
Members are allowed to receive post-stabilization care for medically necessary, non-emergency services needed to ensure that the enrollee remains stabilized from the time the treating hospital requests authorization until such time as the enrollee is discharged, a contracting medical provider arrives and assumes responsibility for the enrollee’s care, or a treating physician or a contracting medical provider agree to another arrangement. The PMG/IPA is responsible for working cooperatively with PacifiCare in arranging physician to physician communication and the return of the patient to the in-plan provider.

Discharge Planning
Discharge Planning is coordination of a patient's continued care needs when discharged from the inpatient setting. The initial evaluation for discharge planning begins at the time of notification of inpatient admission. Any post discharge requirement for DME, Home Health, placement needs, should be identified as early as possible before or during a patient stay to ensure availability for a timely discharge. A comprehensive discharge plan includes, but is not limited to, the following:

- Assessment of needs
- Plan development
- Plan implementation
- Evaluation of effectiveness

Standing Referral/Extended Referral for Coordination of Care by Specialists
The PMG/IPAs will support the provision of standing referrals for members with chronic conditions requiring ongoing specialty care. The PCP may request a standing referral to a specialist or specialty care center. This would apply to those members requiring continuing specialty care over a prolonged period of time, and/or extended access to a specialist for a member due to a life threatening, degenerative or disabling condition that requires coordination of primary care by a specialty care physician. The specialty care physician will serve as the coordinator of the member’s care.

The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the PCP with regular reports on the health care provided to the member. A request for extended specialty referral requires that the PCP determine in consultation with the specialist (if any) and the PMG/IPA that the member’s condition or disease requires specialized medical care over a prolonged period of time and is life-threatening, degenerative or disabling requiring that the specialist coordinate the member’s health care. For an
extended specialty referral, the requesting PCP or specialist should specify what health care services each of them shall manage.

When authorizing a standing referral to a specialist for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, a health care service plan must refer the enrollee to an HIV/AIDS specialist. When authorizing a standing referral to a specialist for the purposes of having that specialist coordinate the enrollee’s health care for an enrollee who is infected with HIV, a health care service plan must refer the enrollee to an HIV/AIDS specialist (California Health & Safety Code 1367.16 and 1300.67.00). Nothing in these regulations should be construed to indicate that referrals must be made to HIV/AIDS specialists. However, the PMG/IPA must have a written process for extended referrals to HIV/AIDS specialists when the PCP and PMG/IPA Medical Director agree that diagnosis and/or treatment of the patient’s condition requires the expertise of an HIV/AIDS specialist. To comply with these requirements, the PMG/IPA must identify practitioners within their group that qualify as HIV/AIDS specialists and wish to be listed as such. If there are no such practitioners within the PMG/IPA, then the PMG/IPA must have available a mechanism to refer to a qualified HIV/AIDS specialist outside of the group.

Second Opinions
As mandated in California Health & Safety Code Section 1383.15, the plan and any entity with which it contracts for services that include utilization review or utilization management functions must have policies and procedures regarding the provisions of or authorization for member/provider requests for second opinions.

A second opinion is consultation and evaluation only and must be rendered by a qualified health care professional as defined by California Health & Safety Code Section 1383.15. A Qualified Health Care Professional is a PCP or Specialist who is acting within his/her scope of practice and who possesses a clinical background, including training and expertise related to the member's particular illness, disease, or condition(s) associated with the request for second opinion.

If any one of the following five criteria apply, the member qualifies for authorization of second opinion:

1. Member questions reasonableness or necessity of a recommended surgical procedure(s).
2. Member questions diagnosis or care plan for a condition that threatens loss of life, limb, bodily function or substantial impairment, including but not limited to serious chronic condition.
3. Clinical indications are unclear or complex/confusing; there are conflicting test results; or the physician has been unable to diagnose condition and the member requests an additional diagnosis.
4. Member’s clinical condition is not responding to prescribed treatment within a reasonable period of time given the condition and the enrollee requests a second opinion regarding the diagnosis or continuance of the treatment.
5. Member has attempted to follow the care plan or has consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

Second opinion may be with a PCP or Specialist of the member's choice from the same PMG/IPA. Requests for PMG/IPA non-contracted providers are referred to PacifiCare.

If a second opinion differs from the initial opinion, coverage for third opinion is available, if requested.

March 2003  57
If a request for second opinion is requested and not authorized, the PMG/IPA must issue a denial letter. Member self-directed care is not covered.

**Direct Access to Women’s Health Services**
The PMG/IPAs adopt a model for allowing a member the option to seek obstetrical (OB) and gynecological (GYN) physician services, directly from a participating obstetrician and gynecologist (GYN) or directly from a participating Family Practice physician and/or surgeon designated as providing OB/GYN services.

**Behavioral Health Management Program**
Behavioral Health (BH) Management Programs are designed to promote the appropriate diagnosis, treatment and referral of BH disorders commonly seen in primary care and to evaluate the appropriate use of psychopharmacological medications.

**Delegation to MBHO**
In order to achieve more effective BH programs, PacifiCare delegate’s BH care and service to PacifiCare Behavioral health Inc., (PBH) an NCQA fully accredited MBHO, which provides services to commercial and Secure Horizons membership.

**Mental Health Parity**
Commercial members have benefits, as stipulated under California Health & Safety Code 1374.72 known as Mental Health Parity. The mental health parity stipulates that specific severe mental illnesses (SMIs) and serious emotional disturbances of children (SEDs) must be covered benefits at parity – that is, on an equal basis – with all covered physical diseases as covered under the general medical plan.

Medicare+Choice members are exempt from the State-required Mental Health Parity, as they receive similar benefits under their core Medicare coverage as Original (Fee for Service) Medicare members.

PBH manages care for members who have an SMI or SED as defined by CA Health & Safety Code 1374.72.
- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder
- Major depressive disorder
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder (autism)
- Anorexia nervosa
- Bulimia nervosa
- Serious Emotional Disturbances (SED) as defined in the *Diagnostic and Statistical Manual for Mental Disorders* and the Child Health and Welfare Code.

When a Commercial member is referred by the PMG/IPA to a behavioral health provider for crisis visits, and that provider determines the member may have SMI or SED the provider
inquires into the member’s eligibility for benefits covered under California Health & Safety Code 1374.72.

If a Commercial member believes he/she qualifies for mental health parity coverage and calls PBH, the member will be seen and a determination will be made regarding diagnosis. If it is determined that the member does NOT have SMI/SED, then:

- The member is sent back to the PCP or PMG/IPA if she/he has no other behavioral health coverage.
- The member with behavioral health supplemental coverage is given a choice of receiving treatment from a PBH provider or returning to their PMG/IPA for treatment.

Member Referral or PCP Referral to PBH: Call (800) 999-9585
Physician Consultative Services at no cost: Call (800) 292-2922
or www.pbh.consult@phs.com

RELATIONSHIP BETWEEN PROVIDER GROUPS AND PACIFICARE

Relationship and Coordination with PacifiCare

PacifiCare views the relationship with its contracted PMG/IPAs as a partnership. Success as a company is directly linked with the success of contracted PMG/IPAs. PacifiCare’s Clinical Management Specialists and Medical Management staff are charged with the shared responsibility of overseeing the ongoing utilization status and serving as a resource for the evaluation and improvement of utilization systems in contracted PMG/IPAs. They are also responsible for sharing utilization data and working to develop action plans for identified areas of concern to PacifiCare or its regulators.

PacifiCare Medical Management staff may contact the PMG/IPA for status updates on members, particularly those in acute care hospitals or skilled nursing facilities. Due to contractual relationships with some PMG/IPAs, Medical Management staff may play a more active role in the utilization process. He/she may be involved in the authorization of referral requests and/or the concurrent review and authorization of hospital services.

Utilization Management Financial Relationship

The financial relationship between PacifiCare and the PMG/IPA is specific and defined contractually. PacifiCare receives the premiums from employers, Centers for Medicare and Medicaid Services (CMS), or individual enrollees from which it retains a percentage for the costs of administering and marketing the plan, and for services for which PacifiCare is financially responsible. The balance of the premium is split into “pools” of money and covers the professional and hospital services provided to the members. For some contracts, there may also be a pool of money related to pharmacy utilization.

The Professional Services pool represents a per-member-per-month (PMPM) percentage of the premium prepaid on a monthly basis to the PMG/IPA to provide professional medical services to the member. These services include physician office visits, outpatient lab and x-ray services, as well as other services specified in the contract.
The Institutional Services represents the remaining budgeted per-member-per-month (PMPM) amount of the premium retained by PacifiCare for payment of services. Some examples of Hospital Control Program services are acute hospitalizations, outpatient surgeries, skilled nursing facilities, ambulance services, home health services, and ER services. Depending upon the PMG/IPA/Hospital Utilization, PacifiCare and the PMG/IPA may share in the year-end surplus or deficit in the Hospital Program.

PacifiCare aligns financial relationships to promote appropriate decisions on the coverage of care and service. UM decision making is based only on appropriateness of care and service. Sometimes the public view capitation as an incentive to limit approval of needed care. PacifiCare and its contracted providers are not allowed to use incentives, which could encourage barriers to care and service. In addition, under- and over-utilization is monitored closely.
D. Credentialing
Credentialing
Credentialing/recredentialing activities may be delegated to PMG/IPAs that demonstrate compliance with PacifiCare’s standards for credentialing/recredentialing. PacifiCare conducts ongoing oversight of all delegated PMG/IPAs to ensure continued compliance with standards. In compliance with NCQA standards, PacifiCare retains the right, based on quality issues, to approve, suspend and terminate individual practitioners, providers, and sites in situations where it has delegated decision making.

Credentialing Program
PacifiCare requires that all network practitioners be initially credentialed and then recredentialed every three years. All PMG/IPAs that are delegated to perform Credentialing, must establish and maintain a Credentialing (CR) Program in compliance with PacifiCare requirement, Centers for Medicare and Medicaid Services (CMS) and Department of Managed Health Care (DMHC) regulations, and National Committee of Quality Assurance (NCQA) standards. The CR Program must address all facets of the process for credentialing/recredentialing practitioners including, but not limited to, the following:

- Written CR Program Description
- Confidentiality
- Initial Practitioner Credentialing
- Practitioner Office Site Review Process
- Practitioner Recredentialing
- Establishing and Maintaining a Credentialing Committee
- Ongoing Monitoring of Sanctions and Complaints
- Peer Review/Disciplinary Action
- Assessment of Organizational Providers
- Sub-delegation of Credentialing, as applicable

All delegated PMG/IPAs must establish a CR Program or written policies and procedures that identifies practitioners who fall under its scope of authority and action. There must be a system to periodically review and update, as necessary, its policies and procedures. At a minimum the policies & procedures must define:

- The type of practitioners credentialed and recredentialed: MDs, DOs, DDSs, DCs, DPMs, Behavioral Health, & other licensed independent practitioners with whom it contracts or employs and who fall within its scope of authority and action
- The process used to ensure that credentialing and recredentialing are conducted in a non-discriminatory manner. The credentialing and recredentialing process does not allow for decision based solely on an applicant’s race, ethnic/national identity, gender, age, or sexual orientation. Additionally, selection and retention criteria contain an affirmative statement regarding nondiscrimination against health care professionals who serve high-risk populations or those who specialize in treating costly conditions
- The criteria and the primary source verification used to meet these criteria
- The decision-making process for credentialing and recredentialing, including how advice is received from participating practitioners
- A standard timeframe for recredentialing
- The extent of any sub-delegated credentialing and/or recredentialing arrangements/ agreements

March 2003 62
• The right of practitioners to review the information submitted in support of their credentialing applications
• The process to notify practitioner of any information obtained during the credentialing process that varies substantially from information provided by the practitioner
• The process to ensure that practitioners are notified of the CR/ReCR decision within 60 calendar days of the Credentialing Committee’s decision
• The practitioner’s right, upon request, to be informed of the status of their credentialing or recredentialing application
• The practitioner’s right to correct erroneous information
• The notification process to practitioners of their rights
• The medical director’s direct responsibilities and participation in the credentialing program
• The process to ensure confidentiality of all information obtained in the credentialing process
• The process to ensure confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. Physician credentialing/recredentialing files are maintained for each practitioner and kept in a secured location with limited access.
• The process to sub-delegate credentialing, as applicable.

**Initial Credentialing Process**

**Initial Credentialing Application**

*Time Limit: The application must be signed and dated within 180 days of the credentialing decision*

A completed credentialing application includes a current, signed, and dated attestation (within 180 days of committee approval date) by the practitioner regarding the following questions/statements:

• Reasons for any inability to perform the essential functions of the position, with or without accommodation
• Lack of present illegal drug use
• History of loss of license and felony convictions
• History of loss or limitation of privileges or disciplinary activity, including a history of all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the practitioner has had privileges
• Clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility
• Current malpractice insurance coverage (*Coverage must be effective at the time of the credentialing decision*)

The delegated PMG/IPA must collect current, adequate malpractice insurance meeting PacifiCare’s requirements through one of the following means:

• Attestation by the practitioner on the application (see Initial Credentialing Application section), or the practitioner must indicate on the application the dates and amount of current malpractice insurance coverage, with the practitioner attesting to this information
• A copy of the current professional liability policy face sheet showing a current expiration date, and the amount of coverage. Copy may be obtained from the malpractice insurance carrier or the practitioner.
• PacifiCare requires the following amount of coverage:
- MDs, DOs, DCs, DPMs - $1M per occurrence/$3M per aggregate coverage
- BH Practitioners - $1M per occurrence/$1M per aggregate
- Dentists - $100,000 per occurrence/$300,000 per aggregate

- The correctness and completeness of the application. Faxed, digital, electronic, scanned or photocopied signatures meet the intent of the element. Signature stamps do not meet the intent of the element.

PacifiCare has approved the California Participating Physician Application (CPPA), developed by a consortium of health care representatives, including PacifiCare, whose intent was to reduce the amount of duplication of credentialing applications required of practitioners. PacifiCare encourages delegated PMG/IPAs to use the CPPA as it meets NCQA & regulatory requirements; however, the delegated PMG/IPA may use its own credentialing application as long as it meets the requirements, as assessed during PacifiCare’s pre-delegation & annual delegation audits.

Initial Credentialing Verification
The delegated PMG/IPA verifies credentialing information through primary sources, unless otherwise indicated. The delegated PMG/IPA may use oral, written, or Internet data to verify information. Use of Internet verification must be a Web site of an appropriate NCQA-approved source for that element. If an approved primary source directs a delegated PMG/IPA to a Web site that is not controlled by the source, NCQA will accept the information, provided that the delegate obtain a letter directly from the source that attests to the accuracy and the timeliness of the information on the Web site. The delegated PMG/IPA needs to obtain this letter only once. Oral and Internet Web site verification requires a note in the credentialing file that is dated and either signed or initialed by the PMG/IPA staff person who verified the credential(s), & if oral verification, additionally, the name of the staff person at the source confirming verification. For internet and electronic verifications, NCQA uses the date noted in the credentialing file by the delegated PMG/IPA staff person who verified the credentialing element.

The same process must be used for electronic credentialing files. Written verification may take the form of a letter or documented review of cumulative reports released by the primary sources of credentialing data. For written verification, the 180-day time limit begins with the date on the letter or report verifying the credentials, not when the PMG/IPA received the letter. Where applicable, the PMG/IPA must use the latest cumulative report, as well as the periodic updates released by the primary source. The date on which the report was queried and volume used must be noted in the file. If the delegated PMG/IPA uses an automated system to track credentialing activities, collection and reporting, there must be a mechanism to identify the individual verifying the information and the date of the verification, the source, and the report date, if applicable. The delegated PMG/IPA must provide evidence that each credentialing element was verified or received, as applicable, before the credentialing decision, including those items that are not subject to a time limit.

The delegated PMG/IPA that sub-delegates to Credentialing Verification Organizations (CVOs) or other types of organizations that collect and verify credentialing information are responsible for ensuring that no time-sensitive credentialing elements are more than 180 calendar days at time of credentialing decision. The delegated PMG/IPA must maintain a summary sheet in each practitioner’s file that states the elements verified by a CVO. The summary sheet may be in the form of a checklist, and does not need to include the initials of the verifying individual. If clearly stated in the delegated agreement, CVOs may retain original attestations or documents.
The delegated PMG/IPA must verify and submit all the following credentials to the Credentialing Committee for review within the specified time limits. All elements should be dated upon receipt of verification.

- **A current valid unrestricted California state license to practice**  
  *Verification time limit: 180 days prior to Credentialing Committee’s decision and licensure must be in effect at the time of the credentialing decision.*

  Must confirm the practitioner holds a valid, current state license to practice. The license must be in effect at the time of the credentialing decision. The delegated PMG/IPA must verify a practitioner’s license in the state(s) where the practitioner sees PacifiCare and/or Secure Horizons members. Verification must come directly from the appropriate state-licensing agency, showing date of issue (if delegated PMG/IPA plans on using Licensing Agency as primary source for License Sanction Information element, 5-year history is required to be documented) and current expiration date. If the delegated PMG/IPA uses the Internet to verify licensure, the website must be from the appropriate state licensing agency.

- **A valid DEA certificate verified through one of the following means:**  
  *Verification time limit: Certificate must be effective at the time of the credentialing decision.*

  For practitioners who prescribe medications, the delegated PMG/IPA verifies a DEA through one of the following means:

  - copy of DEA  
  - entry in the National Technical Information Service (NTIS) database  
  - entry in the American Medical Association (AMA) Physician Master File

  If the practitioner’s DEA is *pending*, the delegated PMG/IPA may credential the practitioner provided the delegated PMG/IPA has adopted and implemented a process under which other DEA-certified contracted practitioners write all prescriptions that require a DEA number for the prescribing practitioner until the practitioner has a valid DEA certificate.  
  If a practitioner states that he/she does not prescribe, this requirement is not applicable.

- **Education and training from medical school/residency/fellowship.**  
  *Verification time limit: None*

  The delegated PMG/IPA must verify only the highest level of credentials attained, except for dentists who provide care under medical benefits. If a physician is board certified in practicing specialty, verification of that board certification fully meets this element because specialty boards verify education and training. For practitioners who are not board certified in practicing specialty, verification of completion of residency in practicing specialty fully meets this requirement. For those individuals who have not completed a residency program in practicing specialty, verification of graduation from medical school meets this requirement.

  Because medical boards verify education and training, verification of board certification in practicing specialty fully meets this requirement. For medical board-certified physicians in their practicing specialty/ies, the delegated PMG/IPA is not required to verify education or residency training in practicing specialty/ies.

  Verification of dental boards and non-physician specialty boards does not meet this requirement. Unless that specialty board uses primary sources to verify education or training, then the
delegated PMG/IPA, at least annually, must obtain written confirmation from the appropriate specialty board that it conducts primary source verification of education and training.

Any one source of the following list is an acceptable method of verification of education and training in practicing specialty, according to practitioner type shown:

- Medical board certification (MD, DO) in practicing specialty, or
- Completion of residency training in practicing specialty, by one of the following sources:
  - Primary source verification from training facility (MD, DO, DC, DDS, DPM, nonphysician behavioral health practitioners) or
  - AMA Physician Master File (MD, DO) or
  - AOA Official Osteopathic Profile Report or AOA Physician Master File (DO)
- If no confirmation of education and training via board certification in practicing specialty (MDs & DOs only), or
- Residency in practicing specialty is incomplete, the delegated PMG/IPA must verify graduation from medical school/applicable college or appropriate specialty training/education

Graduation from medical school/applicable college

- Primary source verification from medical school/applicable college (MD, DO, DC, DDS, DPM, nonphysician behavioral health practitioners), or
- AMA Physician Master File (MD, DO), or
- AOA Official Osteopathic Profile Report or AOA Physician Master File (DO), or
- Confirmation from the state-licensing agency if the PMG/IPA provides recent evidence (annually) that the state agency conducts primary verification of graduation from medical school. The PMG/IPA must receive written verification at least annually from the state-licensing agency that it performs primary verification (MD, DO)

- Board Certification
  
  Verification time limit: Any NCQA-recognized source is valid for up to one year, unless it is a source with more than one edition, verification must also be based on the most current edition. Verification of board certification for chiropractors does not apply.

If a practitioner states that he or she is board certified, the delegated PMG/IPA must verify board certification by one of the following sources according to practitioner type:

- Entry in the ABMS Official Directory of Board Certified Medical Specialists available in publication, CD-Rom, through the ABMS CertiFACTS Online, ABMS Certifax service (MD, DO), and the online-subscription service, www.theboardcertifieddocs.com
- Entry in the American Osteopathic Association (AOA) Official Osteopathic Profile Report or AOA Physician Master File (DO)
- Confirmation from the appropriate specialty board (MD, DO, DPM, DDS, nonphysician behavioral health).
- Confirmation from registry using primary sources, as confirmed annually (nonphysician behavioral health)
- AMA Physician Master File (MD, DO)
- Entry in the podiatric specialty board master file (DPM)
• For foreign board certification, confirmation from the Accreditation Council for Graduate Medical Education (ACGME), if the delegated PMG/IPA obtains a letter from ACGME that states the foreign board primary source verified the education and training of every board-certified practitioner.

The ABMS Certified Doctor Verification Program, accessible through the ABMS web site, is intended for consumer reference only and is not an acceptable source for verification of board certification.

• **Work history**
  
  *Verification time limit: 180 days prior to Credentialing Committee’s decision*

  The delegated PMG/IPA must obtain a minimum of five years of work history on the application or the curriculum vitae, including dates & address locations. The PMG/IPA is not required to verify work history from primary sources. NCQA recommends a review and clarification either verbally or in writing of any work history gap of 6 months or more. Verbal communication must be appropriately documented in the credentialing file, including a note dated, either signed or initiated by PMG/IPA staff confirming information, and the name of person at the office confirming gap information. Any work history gap that exceeds 1 year must be clarified in writing from the practitioner.

• **Malpractice History**
  
  *Verification time limit: 180 days prior to Credentialing Committee’s decision*

  The delegated PMG/IPA must obtain written confirmation from the NPDB or the malpractice carrier of the past 5 years of history of malpractice claims, which resulted in settlements or judgments paid by or on behalf of the practitioner. The delegated PMG/IPA does not need to obtain confirmation from carrier for practitioner who had hospital insurance policy during a residency or fellowship during the past 5 years.

• **Initial Sanction Information**
  
  The delegated PMG/IPA must show evidence that before making a credentialing decision; the following sanction information was received from a recognized monitoring organization & included in the credentialing files:

  - **Sanctions, Restrictions on Licensure, &/or Limitations on Scope of Practice**
    
    *Verification time limit: 180 days prior to Credentialing Committee’s decision*

    If a practitioner was licensed in more than 1 state in the most recent 5 year period, the query must include all states in which he or she worked.

    The PMG/IPA reviews information for the most recent 5-year period available through the data source regarding any previous or current state sanctions, restrictions on licensure, and/or limitations on scope of practice by one of the following sources according to practitioner type:

    - Appropriate state licensing agency (MD, DO, DC, DDS, DPM, non-physician behavioral health)
    - NPDB (MD, DO, DDS)
    - FSMB (MD, DO)
• Federation of Chiropractic Licensing Board’ Chiropractic Information Network – Board Action Databank (CIN-BAD) (DC)
• Federation of Podiatric Medical Boards (DPM)

• Medicare/Medicaid Sanctions
  
  Verification time limit: 180 days prior to Credentialing Committee’s decision

  The delegated PMG/IPA reviews for previous sanction activity by Medicare and Medicaid for the most recent 3-year period through data sources. The PMG/IPA should compare the sanction activity with their panel of practitioners to identify those practitioners that have sanction activity. Those identified practitioners may not provide services to Secure Horizons members. This may be discussed at your peer review committee, regarding the severity of the sanction and appropriate corrective action.

  A mechanism must be in place to verify the practitioner’s Medicare/Medicaid provider status from a query of one of the following:

  • NPDB
  • Cumulative Sanctions Report available over the Internet
    • www.oig.hhs.gov/FRAUD/exclusions/database.html.
    • Follow directions provided to download
  • Medicare/Medicaid Sanctions and Reinstatement Report
  • State Medicaid agency or intermediary and the Medicare intermediary
  • FSMB
  • Office of Personnel Management’s Federal Employees Health Benefits Program debarment record. Practitioners identified on this sanction report may not provide care for PacifiCare or Secure Horizons members
  • AMA Physician Master File

  The Medicare/Medicaid Sanction query is not applicable for dentists.

• Medicare Opt-Out

  According to Section 4507 of the Balanced Budget Act of 1997, certain Medicare physicians and practitioners are permitted to "opt out" of Medicare for two years for all covered items and services that he or she furnishes to Medicare beneficiaries. In a private contract, the Medicare beneficiary agrees to give up Medicare payment for services furnished by the physician or practitioner, and to pay the physician or practitioner without regard to any limits that would otherwise apply to what the physician or practitioner could charge.

  An M+C organization may only contract with physicians who are approved for participation in the Medicare program and who have not opted out of providing services to Medicare beneficiaries. An OPT OUT is a decision by a physician to enter into private contracts with patients for the payment and delivery of health care services rather than participate in the Medicare program. If a physician opts out of Medicare, no services rendered by that individual are covered by Medicare and no Medicare payment will be made to that practitioner.
System should include:

- Quarterly review of report, which can be obtained at www.medicarenhic.com; click on California Physicians/Suppliers, Accept then on General Information, then select Medicare Opt Out Providers.
- Notification of practitioners identified on report that they will not be reimbursed for care provided to Medicare members, which may include termination of contract for M+C products.
- Notification of claims department not to pay claims x2 years, as of the effective date of opt-out as stated in report.

- **Initial Credentialing Site Visit**
  
  *Time Limit: The site visit must occur before the credentialing decision.*

The delegated PMG/IPA has a process for assessing the quality, safety, and accessibility of the offices of all primary care practitioners (PCPs), obstetricians/gynecologists (OB/Gyns) and high-volume behavioral health practitioners and ensure they meet the PMG/IPA’s office site standards. The PMG/IPA must specify a methodology for identifying potential high-volume behavioral health practitioners.

If the practitioner has more than 1 site, the PMG/IPA must review each site as outlined below. The PMG/IPA needs to review medical/treatment record keeping practices at only one site for multiple site practices.

The structured site visit review process must include these elements:

- A standard site visit review form that is filled out at the time of, or shortly after, each site visit
- The assessment will include the following criteria;
  - physical accessibility
  - physical appearance
  - adequacy of waiting and examining room space
  - adequacy of equipment
  - availability of appointments
  - adequacy of the medical/treatment record keeping. Discussion with office staff regarding documentation practices, forms and methods used to keep information consistent, maintenance of confidentiality, organization and documentation practices. The PMG/IPA may review a “blinded” or model medical/treatment record in place of an actual record.
  - A set of thresholds or standards of acceptable performance for the criteria

The delegated PMG/IPA reviews the quality of the site where care is provided by establishing the following:

- Sets standards for office sites and establishes thresholds for acceptable performance against the standards
- Conducts an initial site visit that evaluates the site against the PMG/IPA’s standards
- Staff and group model facilities: each practitioner’s credentialing files does not need to contain a copy of the facility site assessment; the delegated PMG/IPA may file the assessment separately and have it available. However, the delegated PMG/IPA must provide documentation that the results were reviewed at credentialing and provide documentation of the site assessment at the time of a survey.
- Conducts an initial evaluation of the medical/treatment record keeping practices at each site to ensure conformity with the PMG/IPA’s standards
- Revisits sites with deficiencies at least every six months from date of the initial site visit until sites meet the established performance standards/thresholds
- Implements a process to track the opening of new sites
- Follows the same procedures as for an initial site visit when a PCP, OB/Gyn, or high volume behavioral health practitioner relocates or opens a new site
  - An office site review is not required if the practitioner relocates to an office that has already been evaluated and meets established thresholds of compliance; however, documentation of the visit must be included in the file prior to the Credentialing Committee review.
  - An office site review for a relocated office must be conducted prior to the practitioner’s recredentialing date. Documentation of the new site visit should be included in the recredentialing file.
- Procedures for detecting deficiencies after the initial site visit, which must include monitoring of member complaints and other data, if available, at least on a semi-annual basis (every 6 months). When new deficiencies are identified, it is necessary to re-evaluate the site, institute actions for improvement, and document follow-up visits for those sites that have subsequent deficiencies, as applicable.

Recredentialing Process

Recredentialing shall be conducted at least every 36 months (3 years).

The delegated PMG/IPA formally recredentials its practitioners at least every 3 years through information verified from primary sources, unless otherwise indicated. The delegated PMG/IPA identifies any changes that may have occurred since the last credentialing process that may affect the care provided to members. The recredentialing process identifies and evaluates any changes in the practitioner’s licensure, training, experience, current competence, or health status that may affect the practitioner’s ability to perform the delivery of healthcare services.

Recredentialing is the formal process through which the delegated PMG/IPA updates, re-verifies and reviews all pertinent practitioner credentialing information and qualifications, assesses the practitioner’s performance over the previous three (3) years through multiple sources, in order to determine whether to approve the practitioner’s continued provision of health care services to members.

The recredentialing cycle begins with the date of the initial credentialing decision and counts to the 36th month, not the day.
Example: Initial credentialing decision June 5, 2000, recredentialing decision June 30, 2000. This meets the 3 year recredentialing timeframe, as counted to the 36th month, not the day.

**Recredentialing Application**

*Time Limit: The application must be signed and dated within 180 days of the recredentialing decision.*

A completed recredentialing application includes a current, signed, and dated attestation (within 180 days of committee’s decision date) by the practitioner regarding the following questions/statements:

- reasons for any inability to perform the essential functions of the position, with or without accommodation;
- lack of present illegal drug use;
- history of loss or limitation of privileges or disciplinary activity, including a history of all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the practitioner has had privileges;
- current malpractice insurance *coverage* (*coverage must be effective at the time of the credentialing decision*): collected in the same manner as was required for the initial credentialing process
- the correctness and completeness of the application. Faxed, digital, electronic, scanned or photocopied signatures meet the intent of the element. Signature stamps do not meet the intent of the element.

By completing a recredentialing application, the practitioner signifies his or her continuing agreement to abide by all of the delegated PMG/IPA’s policies and procedures. The recredentialing application form shall request that the practitioner update the same information as was required on the initial credentialing application form. Falsification of the recredentialing application may result in immediate termination of the practitioner’s participation in the delegated PMG/IPA’s network.

PacifiCare accepts the California Participating Physician Application (CPHA). PacifiCare encourages delegated PMG/IPAs to use the CPHA as it meets NCQA & regulatory requirements; however, the delegated PMG/IPA may use its own recredentialing application as long as it meets the needed requirements, as assessed during pre-delegation & annual delegation audits.

**Recredentialing Verification & Sanction Information**

*Time Limit: Within the same specified time limits prior to the recredentialing decision as referenced in the initial credentialing process*

Upon receipt of a completed recredentialing application, the delegated PMG/IPA shall collect and re-verify the practitioner’s professional credentials and qualifications through primary sources of verification, or otherwise noted methodology, in the same manner as was required for the initial credentialing process, with the *exception* of board certification and education/training, provided the practitioner’s practicing specialty has not changed nor board certification expired, and shall document the information in the practitioner’s credentialing file. Should a practitioner choose to let the board certification in practicing specialty expire at recredentialing, it is not necessary for the delegated PMG/IPA to verify education and training at recredentialing for this previously board certified practitioner. Primary source recredentialing information shall be collected and re-verified.
through primary sources of verification within the specified NCQA time limits prior to the
Credentialing Committee review and decision of the practitioner’s recredentialing application.

**Performance Monitoring**

*Primary Care Physicians (PCPs) & High-Volume Behavioral Health Practitioners only*

The delegated PMG/IPA incorporates information from quality improvement activities and member
complaints from the previous three (3) year period in its recredentialing decision-making process to
reappraise the professional performance, judgment and clinical competence of its primary care
practitioners (PCPs) and behavioral health practitioners. For behavioral health, each delegated
PMG/IPA uses objective criteria to identify its high-volume practitioners.

The performance monitoring information shall include review of the previous 3 years of data from
the following sources:

- Information from Quality Improvement (QI) Activities
  Examples include the following practitioner or practice-site specific data:
  - Adverse events
  - Data from QI activities related to NCQA QI 4- QI 12
  - Data from QI activities related to HEDIS measures
- Member complaints

The delegated PMG/IPA reassesses practitioner performance individually or as part of a group.
There must be documentation that the delegated PMG/IPA has reviewed the recognized
performance data sources. The delegated PMG/IPA may use a checklist with an affirmative
statement that indicates that is has reviewed the data. The delegated PMG/IPA does not need to
include copies of actual quality reviews in the individual credentialing files. However, the delegated
PMG/IPA must document:

- Affirmative assessment of each data source reviewed, even if there are no findings. For
  example, the PMG/IPA must query for member complaints and note in the practitioner’s file if
  none were found
- Indication how the quality information is incorporated into files of practitioners who have
  known quality issues

**Credentialing Committee**

The delegated PMG/IPA must designate a Credentialing Committee that uses a peer review process
to make recommendations regarding credentialing decisions. The CR Committee, which includes
representation from a range of participating practitioners, obtains meaningful advice and expertise
from these participating practitioners and makes the final decision for practitioners’ credentialing
and recredentialing. Only physicians shall vote on matters of medical interpretation or peer review.

The Credentialing Committee must review the practitioner’s credentialing and give thoughtful
consideration to the credentialing elements before making recommendations about a practitioner’s
ability to deliver care. At a minimum, the committee must receive and review the following:

- Files of practitioners that meet delegated PMG/IPA criteria: A list of names of all practitioners
  who meet the established PMG/IPA criteria are presented to the Credentialing Committee for
  review. Practitioner files can be available for review by the committee upon request.
• Files of practitioners not meeting the delegated PMG/IPA’s credentialing or recredentialing criteria: The credentials of practitioners who do not meet the established PMG/IPA criteria are presented to the Committee for review. The information provided to Committee shall include all documentation and verifications of the identified credentialing or recredentialing criteria issues. The Credentialing Committee may request that further information be obtained from any persons or organizations, including the practitioner, in order to assist the committee with the evaluation process.

• Interview with Practitioner: The delegated PMG/IPA Credentialing Committee may, but is not required to, personally interview the practitioner and address any questions that may have arisen about the application.

• Determination of Approval or Denial: Upon completion of its review and evaluation of all the practitioner’s credentialing or recredentialing information, including but not limited to health status and malpractice history, all verifications of credentialing and recredentialing information from primary sources, the results of the on-site office visits and structured review, and the data resulting from the practitioner/provider profile, as applicable, the Credentialing Committee shall make a decision regarding approval, denial, or termination of the practitioner to provide health care services to members.

• Reporting Requirement: If a practitioner’s recredentialing application is denied based upon deficiencies in the practitioner’s professional competence, conduct or quality of care, the PMG/IPA shall submit any and all required reports to the National Practitioner Data Bank and the State Medical Board, as applicable.

Ongoing Monitoring of Sanctions and Complaints
The delegated PMG/IPA is required to implement policies and procedures for the ongoing monitoring of practitioner sanctions and complaints between recredentialing cycles (during the 3-year interval between reverification of credentials). The PMG/IPA must take action against the practitioners when it identifies occurrences of poor quality.

The PMG/IPA identifies and, when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing. It is required to have a policy and procedure that addresses the ongoing monitoring and use of the following types of information within 30 calendar days of its release.

• Medicare and Medicaid sanctions
  The delegated PMG/IPA must use approved sources of sanction information listed under “Initial Sanction Information” section of this Manual.
  A mechanism must be in place to verify the practitioner’s Medicare/Medicaid provider status from a query of one of the following:
  • NPDB
  • Cumulative Sanctions Report available over the Internet
    • www.oig.hhs.gov/FRAUD/exclusions/database.html.
    • Follow directions provided to download
  • Medicare/Medicaid Sanctions and Reinstatement Report
  • State Medicaid agency or intermediary and the Medicare intermediary
  • FSMB
- Office of Personnel Management’s Federal Employees Health Benefits Program debarment record. Practitioners identified on this sanction report may not provide care for PacifiCare or Secure Horizons members.
- AMA Physician Master File

The Medicare/Medicaid Sanction query is not applicable for dentists.

- State sanctions or limitations on licensure

Licensure sanction &/or limitation reports: The delegated PMG/IPA conducts routine reviews of licensing board action reports from each professional licensing board for practitioners who fall within its scope of credentialing. Resources for such include but are not limited to, the following:

- Medical Board of California: “Hotsheet” updated monthly: www.medbd.ca.gov or call 916-263-2382
- Osteopathic Medical Board of California, updated quarterly: www.dca.ca.gov/osteopathic, go to Enforcement Actions or call 916/263-3100
- Board of Behavioral Science Examiners: “BBS News”, updated semi-annually (Spring and Fall): www.bbs.ca.gov or call 916-445-4933

The delegated PMG/IPA conducts routine checks of formal actions, complaints, investigations (i.e. 805 report/accusations) filed with the Medical Board of California. The credential/recredential file must contain evidence of review and follow-up activity related to the information received from the Medical Board of California.

- Complaints

PacifiCare does not delegate complaints to PMG/IPAs, therefore reports regarding complaints would come from PCC. The delegated PMG/IPA would be expected to have mechanisms in place to review practitioner-specific complaints and the practitioner’s history of issues, as applicable.

- Eligibility for payment under Medicare and Medicaid (aka Medicare Opt-Out)

The delegated PMG/IPA must have procedures in place to routinely identify practitioners who opt out of Medicare for 2 years. The PMG/IPA should compare the Medicare Opt-Out report with their panel of practitioners to identify those practitioners that have opted out of Medicare. Those identified practitioners may not provide services to Secure Horizons members.

The delegated PMG/IPA implements the policy and procedure by regularly obtaining and reviewing documentation on sanctions and complaints, which includes the following elements:

- The delegated PMG/IPA is responsible for reviewing the documentation within 30 calendar days of its release
- For member complaints, the delegated PMG/IPA must have a mechanism in place to investigate practitioner-specific complaints upon receipt of the complaint from PacifiCare and evaluate both the specific complaint and the practitioner’s history of issues, if applicable.
• Documentation of review and investigation may be in the form of a checklist, log or an initialed and dated report

The delegated PMG/IPA implements appropriate intervention when it identifies occurrences of poor quality, which may include:

• If a PMG/IPA practitioner is listed on a report or other information source, or if the delegated PMG/IPA determines there is evidence of poor quality that could affect the health and safety of its members, the delegated PMG/IPA must have a process for reassessing the practitioner’s ability to perform the services that he/she is under contract to provide. If the delegated PMG/IPA becomes aware of conditions at a site which suggests compromised safety or other concerns related to the care delivery setting, the delegated PMG/IPA is expected to perform a site visit as soon as possible to assess the facility and identify corrective actions
• The delegated PMG/IPA’s policies and procedures must address a full range of actions that depend on the nature of the adverse circumstances
• The delegated PMG/IPA must provide evidence that it follows these policies and procedures when applicable. Documentation of how findings are used may be documented in committee minutes, credentialing files, or other documentation of actions taken against the practitioner

Notification to Authorities and Practitioner Appeal Rights
The delegated PMG/IPA has policies and procedures for when it alters the conditions of the practitioner’s participation with the PMG/IPA based upon issues of quality of care and service and reports such actions to the appropriate authorities. The delegated PMG/IPA uses objective evidence and patient care considerations to decide on the means of altering a practitioner’s relationship with the PMG/IPA if that practitioner does not meet the delegated PMG/IPA’s quality standards. These policies and procedures define the range of actions that the delegated PMG/IPA may take to improve performance prior to termination

• The procedures for, and evidence of implementation of, as appropriate, reporting of a practitioner’s suspension or termination to appropriate authorities, including state agencies, as appropriate. For those delegated PMG/IPAs that participate in the NPDB, there must be a mechanism by which they meet its notification requirements
• A well-defined appeal process for instances in which the delegated PMG/IPA chooses to alter the conditions of the practitioner’s participation based on issues of quality of care and/or service, including:
  • A process for notifying practitioners of any action and reasons to suspend or terminate his or her participation status
  • The notification to the practitioner must give the practitioner the right to appeal, defining the steps of the appeal process, including timing for requesting a fair hearing
  • The majority of the hearing panel members are peers of the affected practitioner

The delegated PMG/IPA has evidence of implementation of reporting practitioner suspension or termination to the appropriate authorities, when appropriate.

Assessment of Health Delivery Organizational Providers (HDOs)
The delegated PMG/IPA has written policies and procedures for the initial and ongoing assessment of organizational providers with which it intends to contract. The delegated PMG/IPA includes at least the following medical and behavioral health care providers:
• Hospitals
• Home health agencies
• Skilled nursing facilities
• Free-standing surgical centers
• Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential, or ambulatory setting

The delegated PMG/IPA confirms that the organizational provider is in good standing with state and federal regulatory bodies, and

• For each provider providing services to Medicare enrollees, the delegated PMG/IPA must confirm the provider is approved for participation in Medicare

The delegated PMG/IPA confirms that the provider has been reviewed and approved by an accrediting body; or

• If an accrediting body has not approved the organizational provider, the delegated PMG/IPA develops and implements standards of participation, including conducting a site visit to assure compliance with the identified standards of participation. If the organizational provider has not been accredited, the delegated PMG/IPA must conduct an on-site quality assessment. However, the delegated PMG/IPA can substitute a CMS or state review in lieu of a site visit. The delegated PMG/IPA must verify the review has been done, meets the delegated PMG/IPA’s standards, and must obtain the report from the institution.

• With the exception of “outpatient settings” as defined in California Health & Safety Code, Section 1248 et seq., as accreditation or Medicare certification is required,

At least every 3 years, the delegated PMG/IPA confirms that the organizational provider continues to be in good standing with the state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body.

The delegated PMG/IPA notifies licensing and/or disciplinary bodies or other appropriate authorities when a provider’s affiliation is suspended or terminated because of quality deficiencies.

Skilled Nursing Facility Oversight Resource
The delegated PMG/IPA may review information related to contracted SNF performance annually from, but not limited to, the following two sources.

• California Advocates for Nursing Home Reform (CANHR)
  Web site www.CANHR.org
• CMS- Nursing Home Compare Report
  Web site www.medicare.gov/

These resources contain information on all SNFs in California, including:

• Profiles of service
• Citations
• Complaints
• Deficiencies
• Summary information about nursing homes during their last State Inspection
This information should not be used as the sole measure of quality of care in SNFs. Information in these databases should be interpreted carefully and used in conjunction with other sources. For additional information about the complete inspection report and the SNF’s corrective action plan (CAP), if applicable, contact the State Survey Agency.

Based upon guidelines the delegated PMG/IPA identifies issues requiring further follow up with the directly contracted SNFs.

**Sub-Delegation of Credentialing**

If the delegated PMG/IPA sub-delegates any credentialing and/or recredentialing activities, there is evidence of oversight of the delegated activity. The delegated PMG/IPA (delegate) is accountable for credentialing and recredentialing its practitioners, even if it sub-delegates all or part of these activities.

There is a mutually agreed upon document describing all sub-delegated activities, including the following:

- The responsibilities of the delegated PMG/IPA (delegate) and the sub-delegate
- The specified sub-delegated activities;
- At least semi-annual (twice a year) reporting by the subdelegated to the delegated PMG/IPA (delegate), which may be in the form of joint meetings or conferences and must include at a minimum:
  - Subdelegate’s progress in conducting credentialing and recredentialing activities
  - Activities carried out to improve performance
  - It may also include the following
    - Lists of credentialed and recredentialed practitioners
    - Analysis of data
    - Committee meeting minutes
    - Reports designed exclusively for this relationship

At a minimum, the document must clearly delineate which organization, the delegate or sub-delegate, performs each of the following activities:

- Accepts application along with reapplication and attestation
- Collects all data elements from approved sources
- Conducts site visits and medical record-keeping review
- Makes decisions on initial credentialing
- Collects and evaluates performance information for recredentialing
- Makes decisions on recredentialing
- The process by which the delegated PMG/IPA (delegate) evaluates the sub-delegate’s performance
- The remedies, including revocation of the delegation, available to the PMG/IPA (delegate) if the sub-delegate does not fulfill its obligations

The delegated PMG/IPA that sub-delegates to Credentialing Verification Organizations (CVOs) or other types of organizations that collect and verify credentialing information are responsible for ensuring that no time-sensitive credentialing elements are more than 180 calendar days at time of credentialing decision. The delegated PMG/IPA must maintain a summary sheet in each practitioner’s file that states the elements verified by a CVO. The summary sheet may be in the
form of a checklist, and does not need to include the initials of the verifying individual. If clearly stated in the delegated agreement, CVOs may retain original attestations or documents.

The delegated PMG/IPA (delegate) retains the right, based on quality issues, to approve new practitioners, providers, and sites and to terminate or suspend individual practitioners or providers. Although, PacifiCare retains the FINAL authority to approve new practitioners, providers, and sites and to terminate or suspend individual practitioners or providers.

There is evidence that the delegated PMG/IPA (delegate):

- Evaluates the sub-delegate’s capacity to perform the sub-delegated activities prior to sub-delegation
- Evaluates annually whether the sub-delegate’s activities are being conducted in accordance with the PMG/IPA (delegate)’s expectations, NCQA standards, & applicable regulatory requirements.
  - Annual evaluation includes a file audit (at a minimum 50 files or 5%, whichever is less with a minimum of 10 CR and 10 ReCR files, or the 8/30 rule) & evaluation of the sub-delegate’s performance according to the delegated PMG/IPA (delegate)’s expectations, NCQA standards, & applicable regulatory requirements.
  - The delegated PMG/IPA (delegate) evaluates regular reports as referenced above in the Delegation Agreement, at a minimum semi-annually. Each report must show evidence of substantive evaluation, through review and analysis of the reports, by the delegated PMG/IPA (delegate) each time. For NCQA-accredited or certified sub-delegates the only required reporting are the names and/or files of the practitioners processed by the sub-delegate.
  - The delegated PMG/IPA (delegate) and the sub-delegate follow up on opportunities for improvement.

When sub-delegates have access to the delegated PMG/IPAs (delegates) protected health information (PHI) on members or practitioners, or create such information in the course of their work, the mutually agreed upon delegation document must ensure that the information will remain protected. This does not apply if there is no delegation arrangement, or if the delegation arrangement does not involve the use, creation or disclosure of PHI. However, if the delegation arrangement includes the use of PHI by the sub-delegate, the delegation document also includes the following provisions:

- A list of the allowed uses of PHI
- A description of sub-delegate safeguards to protect the information from inappropriate use or further disclosure
- A stipulation that the sub-delegate will ensure that any sub- sub-delegates have similar safeguards
- A stipulation that the sub-delegate will provide individuals with access to their PHI
- A stipulation that the sub-delegate will inform the organization if inappropriate uses of the information occur
- A stipulation that the sub-delegate will ensure PHI is returned, destroyed or protected if the delegation agreement ends.

This requirement applies to all delegation agreements entered into after April 15, 2003 (if new delegation agreement). Effective July 2004, this requirement will apply to ALL delegation agreements.
Industry Collaboration Effort (ICE) Provider Group Oversight Improvement (P-GO) Project

Shared Audit of Credentialing Files
The Industry Collaboration Effort (ICE), in cooperation with the California Department of Managed Health Care (DMHC), the Centers for Medicare and Medicaid Services (CMS), NCQA and participating health plans have developed and implemented a program specifically designed to significantly reduce the number of audits of groups by health plans for oversight of delegated credentialing. Health Plans developed and adopted a common format in which to share results of credentialing oversight assessments with each other. With medical group agreement, an NCQA-accredited Health Plan may post the group's credentialing annual assessment results on the ICE website in a protected library. Other Health Plans may access those results instead of performing a separate on-site credentialing oversight assessment. During the 2002 pilot project, PacifiCare and Aetna shared the results of about 40 audits representing over 60 medical groups. These groups underwent one audit for both Aetna and PacifiCare, rather than two. Health Net and CIGNA have begun participating in 2003, and Blue Cross is anticipated to begin in 2003. Potentially, other non-accredited Health Plans could access the results posted by an NCQA-accredited Health Plan and use the results in lieu of an onsite audit. If your group wants to share your oversight assessments with other contracting health plans, contact the ICE administrator at www.iceforhealth.com
E. Member’s Rights & Responsibilities
PacifiCare/Secure Horizons Medicare+Choice (M+C) Plan
Member Rights and Responsibilities
Statement for 2003

As a member of PacifiCare/Secure Horizons M+C Plan you have the right to receive information about, and make recommendations regarding, your rights and responsibilities.

You have the right to:

Timely, Quality Care
• Choose and seek care through a qualified Contracting Primary Care Physician and Contracting Hospital. PacifiCare/Secure Horizons can advise you if a specific contracted Primary Care Physician is not accepting new patients at a particular time. Your Contracting Primary Care Physician will discuss with you the Contracting Hospital that best fits your needs in the event you need hospital services.

• Timely response to your requests for covered healthcare services; access to your Contracting Primary Care Physician; and referrals to contracted specialists for covered services when Medically Necessary.

• Receive emergency services when you, as a prudent layperson acting reasonably, believe that an emergency medical condition exists. Payment will not be withheld in cases where you have acted as a prudent layperson with an average knowledge of health and medicine in seeking emergency services.

• Receive urgently needed services when traveling outside the Plan’s service area or in the Plan’s service area when unusual or extenuating circumstances prevent you from obtaining care from your Contracting Primary Care Physician.

• Discuss with your contracting provider the full range of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.

• Participate actively in decision-making regarding your health with your Contracting Medical Provider.

• Receive reasonable continuity of care, including information about continuing health care requirements following discharge from inpatient or outpatient facilities. And to know, in advance, the time and location of an appointment, as well as the physician providing care.

• Receive information about your medications – what they are, how to take them and possible side effects.

• Be advised if a physician proposes to engage in experimental or investigational procedures affecting your care or treatment. You have the right to refuse to participate in such research projects.
Treatment with Dignity and Respect

• Be treated with dignity and respect and have your right to privacy recognized.

• Exercise these rights regardless of your race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for your health care. Expect these rights to be upheld by PacifiCare/Secure Horizons and Contracting Medical Providers.

• Refuse any treatment or leave a medical facility, even against the advice of a physician. Your refusal in no way limits or otherwise precludes you from receiving other Medically Necessary covered services for which you consent.

• Complete an advance directive, living will or other directive and provide it to your Contracting Primary Care Physician or medical provider to include in your medical record. Treatment decisions are not based on whether or not an individual has executed an advance directive.

Information About PacifiCare/Secure Horizons M+C Plan and Their Contracting Medical Providers

• Receive information about PacifiCare/Secure Horizons M+C Plan and the covered services under your Plan.

• Receive information about your Contracting Practitioners and Providers involved in your medical treatment, including names and qualifications.

• Receive information from your Contracting Medical Providers about an illness, the course of treatment and prospects for recovery in language that you can understand. This may include information about any proposed treatment or procedures necessary for you to give an informed consent or to refuse a course of treatment. Except in case of an Emergency, this information shall include a description of the procedure or treatment, the medically significant risks involved, any alternate course of treatment or non-treatment and the risks involved in each, and the name of the person who will perform the procedure or treatment.

• Receive information regarding how medical treatment decisions are made by your Contracting Primary Care Physician, medical group or PacifiCare/Secure Horizons, including payment structure.

• Receive and examine a billing explanation for non-covered services, regardless of payment source.

• Request information about PacifiCare/Secure Horizons M+C Plan Quality Improvement Program, its goals, processes and/or outcomes.

Timely Problem Resolution

• Submit complaints and request appeals, without discrimination, about PacifiCare/Secure Horizons or care provided to you.
• Expect problems to be fairly examined and appropriately addressed within the timeframes set by the Plan.

• Choose to have a service or treatment decision, if it meets certain criteria, reviewed by a physician or panel of physicians who are not affiliated with PacifiCare/Secure Horizons. This process is referred to as an independent external review.

**Protection of Privacy in All Settings**

• Know that PacifiCare/Secure Horizons protects the privacy and security of personal health information in all settings from unauthorized or inappropriate use via its policies and procedures and agreements with Contracting Providers.

• Know that when you or your legal representative sign your application/Individual election form, you provide routine consent to PacifiCare/Secure Horizons. Routine consent covers the use of your personal health information needed for Plan operations, such as: treatment, coordination of care, use of measurement and survey data to improve care and service, utilization review, billing or fraud detection.

• Know that PacifiCare/Secure Horizons does not disclose medical information related to your mental health, genetic testing results and drug and alcohol abuse treatment records, to third parties without your special consent/authorization or as required or permitted by law.

• Know that if you are unable to give consent, you may extend your rights to any person who has legal responsibility to make decisions on your behalf, regarding your medical care or the release of personal health information.

• Review your medical records. If you would like to review, correct or copy your medical records, you should contact your Contracting Primary Care Physician or other health care provider who created the medical record directly.

• Know that PacifiCare/Secure Horizons may accommodate employer requests for information by providing de-identified aggregated data. Only as permitted by law, PacifiCare may release information to self-funded employers where needed to administer the provisions of the plan. If required to supply this information to self-funded employers, they agree to protect the individual’s data from internal disclosure that would affect the individual.

**Your responsibilities are to:**

• Review information regarding covered services, any exclusions, deductibles or copayments and policies and procedures as stated in your member materials or Evidence of Coverage.

• Provide PacifiCare/Secure Horizons, your physicians, other health care professionals and Contracting Medical Providers, to the degree possible, the information needed to provide care to you.
• Follow treatment plans and care instructions as agreed upon with your Contracting Medical Provider. Actively participate, to the degree possible, in understanding and improving your own medical and/or behavioral health condition and, in developing mutually agreed upon treatment goals.

• Behave in a manner that supports the care provided to other patients and the general functioning of the facility.

• Accept your financial responsibility for Plan Premiums, any other charges owed, and any copayment or coinsurance associated with services received while under the care of a physician or while a patient in a facility.

• Ask your Contracting Primary Care Physician or PacifiCare/Secure Horizons questions regarding your care. If you would like information about Contracting Medical Providers or have a suggestion, complaint or payment issue, we recommend you call the PacifiCare/Secure Horizons Customer Service Department at (PacifiCare 1-800-642-8822 or for the hearing impaired TTY/TDD/TDHI 1-800-442-8833. Our Customer Service Representatives are available Monday through Friday from 7:00 am to 9:00 pm) or (Secure Horizons 1-800-228-2144 or for the hearing impaired TTY/TDD/TDHI 1-800-685-9355. Our Customer Service Representatives are available Monday through Friday from 7:00 am to 7:00 pm.)
Delivery of Culturally and Linguistically Appropriate Health Care Services
There is a growing body of evidence that cultural and language barriers have a direct impact on health care delivery and health care outcomes. Effective clinical management is contingent upon clear communication.

As such, PacifiCare requires its participating providers have mechanisms to ensure its members who are sensory impaired and/or have limited English proficiency skills have an equal opportunity to access and participate in all services. Interpretative and/or auxiliary aide services must be made available, at no cost to the member upon member request. Members have the right to a certified medical interpreter or sign language interpreter to translate health information accurately, who must respect the member’s privacy and keep all information confidential.

Family members have a valid role in providing member support, however they are not trained health care interpreters. Family members often edit the member’s message, add their own opinions, answer for the member and may impede the development of the patient-practitioner relationship. Members may be reluctant to discuss certain problems in front of a family member. Family and friends of limited English proficiency or hearing impaired members should be asked to provide interpretive services only after alternative, no cost methods have been explained and the member still chooses family/friend interpretation.

Interpretive services should be made available whenever you as a provider believe that language or cultural difference may be causing a barrier to clear communication between you and the member or whenever the member needs to:
- Explain their symptoms or medical history
- Understand their diagnosis and treatment options
- Choose among treatments
- Understand instructions regarding medications, medical equipment, or follow-up care.

Enhancing Communication
The stress of an illness or stress associated with a physician office visit can further interfere and inhibit a member’s ability to communicate, which is compounded for members with limited English proficiency. Providers are encouraged to consider the following as a means of reducing member stress associated with health care encounter:
- Allow for a longer appointment time
- Provide non-verbal reassurance
- Use the member’s name and pronounce it correctly
- If possible, try to ensure that the member always sees the same staff
- Provide clear and simple instructions
- Check back with the member to determine member’s understanding of what has been communicated
Member Decision-Making Participation – Advance Directives

Federal Law: Patient Self Determination
The PMG/IPA must develop a policy and procedure intended to enable compliance with the Patient Self-Determination Act (the “Act”, as contained in the Omnibus Budget Reconciliation Act of 1990), which became law on December 1, 1991. The Act requires health care providers/facilities to provide information on the member’s rights to formulate advance directives that will impact decisions about their own health care.

The purpose of the Act is to protect each adult patient’s right to participate in health care decision making to the maximum extent of his or her ability and to prevent discrimination based on whether the patient has executed an Advance Directive for health care.

All members must be informed of their right to make choices about their medical treatment, including the right to accept or refuse medical or surgical treatment and the right to formulate an advance directive. Practitioners/providers must inform members’ of their medical condition and all available treatment options, including treatments, which may not be a covered benefit under the member’s health plan. In addition, members must be informed of the risks and benefits of each treatment option.

The adult patient’s medical record must have documentation indicating whether or not the patient has executed an Advance Directive. The Advance Directive document must be signed by the patient and witnessed. Practitioners/providers may not make treatment conditional or otherwise discriminate on the basis of whether an individual has executed an advance directive.

Medicare law gives members the right to file a complaint with the state survey and certification agency if the member is dissatisfied with the organization’s handling Advance Directives and/or if a practitioner/provider fails to comply with advance directive instructions. The member may write the Department of Health Services, 1800 Third Street, Suite 210, P.O. Box 94234-7320 or call the State of California’s Ombudsman Office at 1-916-323-6681.

California Health Care Decision Law: Advance Directives
An “Advance Directive” is a written instruction given by an adult patient, 18 years or older, having capacity, relating to the provision of health care in the event that the patient becomes incapacitated. The California Health Care Decisions Law (AB 891) provides for the creation, form and revocation of advance health care directives, and for the manner of making health care decisions for patients without surrogates. The Advance Health Care Directive is the legally recognized document for appointing a health care “agent” and/or issue binding “health care instructions” in California. The Health Care Decisions Law also established a registry system through which California residents who have executed a written advance directive may register, amend or revoke the information in the advance directive with the California Secretary of State. This information can then be obtained by health care providers, public guardians, or other authorized individuals from the Secretary of State’s office.

Under California law, patients with capacity may designate or disqualify another person to act as a surrogate to make health care decisions by personally informing the supervising health care provider verbally or in writing. The supervising health care provider is defined by law to mean the primary physician who has undertaken primary responsibility for the patient’s care. Thus, the
primary care physician, hospitalist or specialist may or may not be the primary physician depending upon the situation. The verbal designation of a surrogate must be promptly recorded in the patient’s medical record and is effective only during the course of treatment or illness or during the stay in the health care facility when the designation is made.

California law imposes additional obligations for physicians including but not limited to the following:

- If possible, physicians must promptly communicate to the patient the decision and identity of the person making the decision before implementing a health care decision.
- Practitioners having knowledge of the existence of an Advance Health Care Directive, revocation, or a designation or disqualification of a surrogate must promptly document the information in the patient’s medical record.
- If the Advance Directive is in writing, the physician must request a copy. If it is furnished, a copy of the advance directive must be maintained in the patient’s medical record.
- Supervising health care providers are required to comply with an individual health care instruction of the patient and with reasonable interpretation of the instruction made by the person authorized to make health care decisions for the patient.

In the absence of controversy, or unless, otherwise specified in a written Advance Health Care Directive, a determination that a patient lacks or has recovered capacity, or that another condition exists that affects an individual health care instruction or the authority of an agent or surrogate, shall be made by the supervising health care provider. A supervising health care provider must make reasonable efforts to notify the agent or surrogate if the provider knows of a revocation of a power-of-attorney for health care or disqualification of a surrogate, and document in the patient’s medical record accordingly.

The immunities for physicians and other health care professionals acting pursuant to the California Health Care Decisions Law have also been broadened. Physicians are immune from civil, criminal or disciplinary action for “acting in good faith” and in accordance with generally accepted health care standards, including but not limited to, any of the following conduct:

- Complying with a health care decision of a person that the provider believes in “good faith” has the authority to make a health care decision for a patient, including the decision to withhold or withdraw care.
- Complying with an advance health care directive and assuming the directive was valid when made and has not been revoked.
- Declining to comply with a health care decision of a person based on the belief that the person then lacked authority.
- Declining to comply with an individual health care instruction or health care decision for reason of conscience or institutional policy, or if the care would be medically ineffective or contrary to generally accepted health care standards.

If the physicians or other health care providers declines to comply with a patient’s advance directive or surrogate decision-maker’s health care decision, the health care provider must:

- Promptly notify the patient, if possible and any person then authorized to make health care decisions for the patient; and
- Unless the patient or person then authorized to make health care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to
another health care provider or institution that is willing to comply with the instruction or decision; and

- Provide continuing care to the patient until a transfer can be accomplished or until it appears that a transfer cannot be accomplished. In all cases, appropriate pain relief and palliative care must be continued.

The PMG/IPA Advance Directive Policy should include procedures for an audit of the medical records to ensure compliance with state and federal regulations. Practitioners within the PMG/IPA must be educated about his or her responsibilities concerning this process and have Advance Directive forms available for member use. PacifiCare’s Clinical Management Specialist can assist with any other information required.

**RESOURCES FOR INFORMATION ON ADVANCE DIRECTIVES**

Resources for services may be available gratis or for a fee.

- **California Health Care Association**
  1215 K Street, Suite 800
  Sacramento, CA  95814-1100
  (916) 443-7401
  FAX:  (916) 552-7596
  Web Site: www.calhealth.org
  (Advance Health Care Directive Forms available in English and Spanish language and may be downloaded from the Web Site)

- **California Medical Association**
  Post Office Box 7690
  San Francisco, CA  94120-7690
  415- 541-0900
  www.cmanet.org
  (Advance Directive Kit includes an Advance Health Care Directive form, wallet cards and information which answers the questions commonly asked about advance directives)

- **Partnership for Caring – National Office**
  1620 Eye Street NW, Suite 202,
  Washington, DC 20006
  202-296-8071
  Fax: 202-296-8352
  Hotline: 800-989-9455
  pfc@partnershipforcaring.org
  (Provides State specific advance directive document with guidebook, question and answer booklets, videos, and legal references)
Member Grievances

PacifiCare acknowledges that member disputes may arise with the health plan or its participating providers, especially related to coverage issues. PacifiCare respects the rights of its members to express dissatisfaction regarding quality of care/services and to appeal any denied claim/service. All members receive clear instructions on how to file a grievance with PacifiCare.

PacifiCare does not delegate authority or responsibility for processing member grievances to its participating providers, however, PacifiCare does require its participating providers assist in resolving grievances. Participating providers are required to immediately forward any member grievance (complaint, appeal or quality of care concern) to PacifiCare for processing. PacifiCare makes Complaint Forms, that the member may use to help state and explain their grievance, available for use at the Participating Provider office sites. Complaint Forms are available upon request, by contacting the Clinical Management Specialist. Participating providers are also required to comply with all final determinations made by PacifiCare regarding member grievances.

PacifiCare has established appeals and complaint processes to ensure for the timely, thorough and appropriate review and evaluation for resolution of all member grievances. These processes include the following:

- Appropriate interaction with member
- Documentation of member concerns
- Steps to follow toward resolution
- Quality Management/Peer Review of pertinent findings
- Timely response to the member regarding findings
- Identification of quality of care complaints
- Capturing data at the provider level
- Tracking and trending aggregated grievance data quarterly
- Reporting results

Grievance Process

Complaints received by PacifiCare that involve quality of care issues are thoroughly investigated and assigned severity levels, descriptor, outcome and corrective action plan codes. If the complaint involves an imminent and serious threat to the health of the member, the case is referred to the Quality Management department for immediate action. Complaints are investigated by identifying and requesting relevant medical records/information necessary to make a determination. Quality of care complaints determined as a severity Level 0 or Level I by the clinical reviewer do not require a written response from the provider group. Complaint cases recommended as severity Level II or Level III require a PacifiCare Medical Director Review and a written response from the provider group to address the identified quality of care concern(s). PacifiCare’s Medical Director may recommend peer review and if so, the case is forwarded to the Regional Peer Review Committee (RPRC) for review, severity level determination and assignment of corrective action plan(s) as appropriate. Provider group input is sought prior to assigning a severity Level II or III to a case. All cases reviewed at the RPRC may be represented by the involved PMG/IPA

- Categories and descriptors, which reflect the case review findings, are assigned to objectively and systematically monitor, evaluate and improve the quality and safety of clinical care and quality of service provided to PacifiCare members. The results of the quality of care review are considered a confidential component of PacifiCare’s Quality Improvement Program and are utilized in the recredentialing process.
Member Quality of Care Complaint Reports

The Clinical Management Specialist monitor provider groups by reviewing the quarterly Closed Cases Report for each provider group. These reports include provider specific trended quality of care case investigations by nature of complaint and severity level. The Cases Closed by Provider/Level Report displays the total number of quality review cases closed by severity level as compared to the provider network.

Quality of Care Case Reports are mailed quarterly to the PMG/IPA’s designated contact. The PMG/IPA’s Quality Management Committee (QMC) is encouraged to review the reports to monitor individual complaint case outcome, evaluate and identify trends, and pursue opportunities to improve operational processes, health outcomes, member and practitioner satisfaction.

Nature of Complaint Descriptions

- **Access:** member has difficulty reaching medical staff or personnel during or after hours, is unable to obtain an appointment in a timely manner or waiting time is prolonged.
- **Art of Caring:** member perceived care rendered in less than a caring attitude or manner.
- **Complications:** member experienced complications related to practitioner/provider and/or iatrogenic situations.
- **Delay in Diagnosis:** member is not diagnosed in a timely manner for treatment which may lead to untoward effects depending on the disease entity.
- **Delay of Referral:** member not referred to appropriate provider or practitioner in a timely manner.
- **Delay of Treatment:** member’s treatment has not been delivered in a timely manner either for the symptoms control or for definitive treatment.
- **Denial of Referral:** member is denied a referral to another practitioner or provider for services that appear to be medically indicated.
- **Denial of Services:** member has been denied specific services.
- **Miscellaneous:** all others that do not fit into the other categories.
- **Misdiagnosis:** member appears to have incorrect diagnosis based on the nature of signs and symptoms.
- **Treatment Plan:** member’s documented treatment plan inappropriate, not complete enough to treat identified process or not within community standards of care.

Severity Level Descriptions

- **Level 0:** No quality of care issue identified. Assignment of Level 0 may be determined by the Clinical Reviewer (CR) and does not require PacifiCare Medical Director review.
- **Level I:** Minor quality of care issue identified. Generally a Level I case will be a minor departure from the Standard of Care with a low likelihood of a potential serious adverse outcome. Such complaints indicate a need for provider education or information regarding the identified issue. Assignment of Level I may be determined by the CR and does not require PacifiCare Medical Director review.
- **Level II:** Moderate quality of care issue identified. Generally a Level II case will be a moderate departure from the Standard of Care with a moderate likelihood of a potential serious adverse outcome. All Level II cases require PacifiCare Medical Director review. All Level II cases are referred to RPRC for reporting/tracking of assigned CAP or review/recommendation of CAP.
• Level III: Serious quality of care issue identified. Generally a Level III case will be a serious departure from the Standard of Care with a high likelihood of a potential serious adverse outcome. All Level III cases require PacifiCare Medical Director and RPRC participating physician review.

PMG/IPA Responsibilities: Direct Receipt of Member Complaints
PMG/IPAs must develop and implement policies and procedures (P&Ps) to address those situations when a member complains directly to the provider. The P&Ps must address the group’s processes for re-directing all member complaints to PacifiCare.

PacifiCare requires submission of a quarterly Member Complaint Report/Log, which includes member identification, status of the complaint (open or closed), and an assigned severity level utilizing PacifiCare’s Severity Levels Descriptions and a brief description of the actions taken. PacifiCare’s QM clinical staff review the PMG/IPA Complaint Report/Logs, which are cross-referenced with PacifiCare’s internal databases to ensure member complaints received by participating providers have been reported to PacifiCare for investigation and resolution.

Member Appeals
PacifiCare does not delegate authority or responsibility for processing member appeals to its participating providers.

All denial letters issued by PacifiCare’s participating providers must refer the member to PacifiCare to appeal denial determinations. Members have the right to appeal the determination of any denied service or claim by filing a grievance with PacifiCare. PacifiCare’s Appeals department notifies the participating provider group of the member appeal upon receipt of the appeal. Information and medical records relevant to the appeal will be requested to make a determination. For standard appeals, PacifiCare is required to make and issue written appeal determinations within thirty (30) calendar days of receipt of the member appeal. For expedited appeals, PacifiCare is required to make and issue the written appeal determination as expeditiously as the member’s medical condition requires, but no later than seventy-two (72) hours, following receipt of the expedited appeal request. PacifiCare works closely with its participating providers to achieve satisfactory resolution for all involved parties within the designated timeframes.

Employee Retirement Income Security Act of 1974 (ERISA)
ERISA regulations apply to all “claims,” filed on or after July 1, 2002. ERISA categorizes “claims” as follows:

- Pre-service coverage requests
- Concurrent care requests
- Post-service requests

ERISA establishes new standards for the processing of claims. The new standards are intended to ensure more timely benefit determinations, to improve access to which a benefit determination is made, and to assure members will be afforded a full and fair review of denied claims.

For the purposes of medical management, PacifiCare members agree that the Provider/Practitioner will be their “authorized representative” (pursuant to ERISA) regarding receipt of approvals of requests for health care services.
The timeframe for member submission of a formal appeal is extended to within one-hundred-eighty (180) days of receipt of the initial written denial determination. Members may submit written comments, documents, records and any other information relating to their appeal regardless of whether the information was submitted and considered in the initial determination. Members are also entitled to access and copies of documents and other information relevant to their appeal.

In addition, members may have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act if all required reviews of the member’s claim have been completed and the claim has not been approved.

**Independent Medical Review**

Commercial HMO/POS members have the right to request an Independent Medical Review (IMR) of disputed health care services from the Department of Managed Health Care (DMHC) if they believe that the health care services have been improperly denied, modified or delayed by PacifiCare or one of its contracting providers, based on a determination that the service(s) are not medically necessary.

Eligibility for IMR normally requires the member first submit a grievance to the health plan and the disputed decision must be upheld or remain unresolved after thirty (30) days or three (3) days in the case of an urgent grievance requiring expedited review. The member will not be responsible for the costs of the IMR. The IMR process is in addition to any other procedures or remedies that are available to members. The decision not to participate in the IMR process may cause the member to forfeit any statutory right to pursue legal action against PacifiCare regarding the disputed health care service.

**Appeals Data**

On a quarterly basis, PacifiCare distributes provider appeals data reports specific to the PMG/IPA. The Benefit Appeals Reporting System (BARS) provides information regarding individual closed appeals cases, and summarizes closed appeal cases by product and service type for each group. PacifiCare recommends the group’s Utilization Management Committee (UMC) and Medical Director(s) review the BARS utilization management reports to identify and pursue opportunities to improve operational processes, whereby improving member and provider satisfaction with the UM process.
Confidentiality of Member Information

Members have a right to be protected against unauthorized disclosure and use of information pertaining to them. This right shall be protected by a presumption against disclosure and applies to all settings. The procedure for the handling and flow of medical records, reports, and other written materials throughout the participating provider organization shall ensure that these records, reports, and materials are at no time accessible to unauthorized entities. Member’s medical information must not be released unless:

- Written consent, either routine or special, from the member has been obtained from the member
- The information has been authorized by law; or
- When there is a valid insurance-related, plan-related, or health-related need to know by a person whose job description or position in PacifiCare has the authority to request and evaluate any member-specific issues.

Routine Consent - Upon enrollment, each member or his/her authorized representative shall sign a routine consent statement as part of the Individual Election/Enrollment form. Routine consents do cover the use of identifiable information that is needed for treatment, coordination of care, quality assessments, utilization reviews, fraud detection, and specific and known oversight reviews, such as federal, state, and accreditation.

Special Consent - To the extent that member information is to be used outside the scope of a routine consent, a special consent form must be signed prior to the use and/or disclosure of that information. The form must contain: (1) reason for disclosure and use of the information; (2) length of time for which the consent is valid; and (3) signature of the member and date. A copy of consent form shall be kept in the member’s medical record or case file.

Members Unable to Give Consent - For members unable to give consent, the Provider must state how it determines the individual who may authorize the release of information, authorize the member’s care and treatment, and have access to information about the member.

Providing Access to Medical Records - Members may access their medical records at any time by contacting their Provider directly. Members shall be given the opportunity to review their medical records in a timely fashion. Confidential information shall be faxed only when no other options are available.

Use of Measurement Data - The Plan shall inform participants in peer review and/or quality improvement activities (1) of the immunities available to them under the Federal Health Care Quality Improvement Act and related state laws and (2) that such immunities may be compromised, thereby exposing participants to liability, if participants improperly disclose confidential peer review and/or quality improvement information outside of the professional review proceedings. The release of quality improvement information shall, in no instance, include member identifiers. Release of information shall be in accordance with state and federal laws.

Employer Groups and Purchasers - Individual member data shall not be shared with employers, even self-insured employers, unless required by law or authorized by special member consent.
Health Insurance Portability Act of 1996
“HIPAA”

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides the first comprehensive federal protection for the privacy of health care information. Its purpose is to provide the following protections for the use and disclosure of Protected Health Information (PHI):

- Requires covered entities to inform consumers about how their health information will be used and/or disclosed;
- Defines how protected health information may be used or disclosed;
- Places restrictions on the amount of information used and disclosed to the “minimum necessary”;
- Limits the release of protected health information without authorization;
- Give patients access to their own health records and the right to request amendments and/or make corrections;
- Establishes administrative requirements for implementation of the Privacy Rule.

When Will HIPAA Become Effective?

<table>
<thead>
<tr>
<th>Standard</th>
<th>EFFECTIVE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uniform Electronic Transaction Standards</td>
<td>October 2003</td>
</tr>
<tr>
<td>Privacy Rule</td>
<td>April 14, 20003</td>
</tr>
<tr>
<td>Security Rule</td>
<td>Early 2004*</td>
</tr>
<tr>
<td>Unique Identifier</td>
<td>Early 2004**</td>
</tr>
</tbody>
</table>

* Not yet finalized
**Unique identifiers will be established for all providers, employers, plans and individuals. The individual health identifier has become very controversial and is on hold. The only unique identifier that has been established by CMS is the Employer Identifier issued by the IRS.

Who is Required to comply with the Privacy Ruling?

Covered entities (CE’s) are required to comply with the HIPAA regulations and include:

- Health Plans
- Health Care Clearinghouses
- Health Care Providers who submit information electronically

What are the Basic Components of HIPAA?

There are four basic components of the Privacy Rule:

- Use and Disclosure
- Notice of Privacy Practices
- Patient/Member Rights
- Administrative Rule
**What are Permitted Uses and Disclosures under the Privacy Rule?**

HIPAA permits covered entities to use and/or disclose Protected Health Information (PHI) for the purposes of:

- Treatment
- Payment, and
- Health Care Operations, or also known as TPO

If a use and/or disclosure is not within these parameters, a written authorization from the patient is required. Patients are given the right to request restrictions on the use of their information in limited instances, such as the use of psychotherapy notes.

**What does HIPAA Require?**

**NOTICE OF PRIVACY PRACTICES**

- Healthcare organizations and providers are now obligated to explain to their patients (by issuing a Notice of Privacy Practices) how their information will be used and disclosed. There is mandated Department of Health and Human Services language that must be included in the Notice of Privacy Practices, and there are specific requirements for distributing the Notice.

  - Health Plans must provide notice:
    - No later than April 2003
    - At the time of enrollment
    - Within 60 days of a material revision of the notice
    - No less frequently than once every three years

  - Healthcare Providers must provide notice:
    - No later than the date of the first service delivery
    - Have notice available at physical delivery site
    - Post notice in a clear and prominent location
    - Upon revision, make notice available

**PATIENT/MEMBER RIGHTS**

The Privacy Rule grants patients greater control over their Protected Health Information.

**ADMINISTRATIVE RULES**

There are a number of administrative requirements in order to comply with the HIPAA Privacy Rule, such as:

- Assigning a Privacy Official;
- Documenting “minimum necessary” requirements;
- Have, apply and document sanctions against members of its workforce who violate the rules;
Providing and documenting training of all employees;
Ensuring there is a comprehensive complaint system;
Developing/revising policies and procedures

**BUSINESS ASSOCIATE AGREEMENTS**

Your organization should establish policies and procedures to protect patients from unwarranted use and disclosure of individually identifiable health information.

- Define a process for identifying business associates;
- Create a process to obtain business associate contracts;
- Prepare a policy that can implement contract termination for continued inappropriate use and/or disclosure of PHI.

**Where Can You Get Further Information?**

**Department of Health and Human Services**
HIPAA/Administrative Simplification
http://aspe.hhs.gov/adminsimp

**Centers for Medicare and Medicaid Services (CMS)**
http://www.cms.hhs.gov/hipaa

**HIPAA Office of Civil Rights (OCR)**
http://hhs.gov/ocr/hipaa

**American Health Information Management Assoc.**
http://www.ahima.org

**California Healthcare Association**
www.calhealth.org

**URAC/American Accreditation Healthcare Comm.**
http://urac.org

**HIPAAAdvisory**
http://hipaadvisory.com

**Hill Physicians Medical Group**
www.hillphysicians.com

**Disclaimer:** This page contains helpful links that are not the responsibility of, or under the control of, PacifiCare Health Systems. These web site links have been provided to assist you in acquiring additional information regarding HIPAA Administrative Simplification Rules.
F. Medical Records
Guidelines for Medical Records Compliance

Medical records are the data source that documents the services provided to our members and verifies the quality of the healthcare provided by participating practitioners. This documentation is frequently used to assess the quality of care by the PMG/IPA QMC, PacifiCare, and regulatory review entities. Medical record documentation is used in the resolution of member grievances and appeals related to their healthcare. The medical record is a legal document subject to discovery during litigation.

Policies and Procedures

PacifiCare requires that the PMG/IPA have written policies and procedures regarding requirements for confidentiality, medical record keeping practices and medical record documentation standards that are approved by the QMC and distributed to participating practitioners. The goal of these policies is to ensure that medical records are maintained in a manner that is current, detailed, and organized and permits effective and confidential patient care and quality review. Policies and procedures which cover the following topics are required:

- Medical Record Confidentiality and release of Medical Records, including behavioral health care records
- Medical Record Content and Documentation Standards
- Medical Recordkeeping Practices (i.e., medical records are maintained in a current and organized manner)
- Storage, maintenance, archiving, retrieving and disposal of medical records
- Advance Directives
- Distribution of Medical Record Policies and Procedures to PMG/IPA Staff and Practitioners
- Process for improving medical records, including any action taken

The PMG/IPA may adopt medical record content and documentation standards based upon national or PacifiCare standards. Medical record documentation policies must reflect the following, including, but not limited to:

- All services provided directly by the Primary Care Physician
- All ancillary services
- Diagnostic testing
- Therapeutic services
- Specialty physician and hospital reports
- Health education and preventive health services provided to the member

Confidentiality

PacifiCare recognizes that the information contained in medical records are highly confidential. All PMG/IPAs and individual practitioners must have policies and procedures to ensure the confidentiality of member information. Employees with access to medical record information must have signed and dated confidentiality statements on file. Medical records are to be stored in a location secure from public access. Any request to release medical records require patient consent prior to release to any source. Release of behavioral health care records require patient consent, patient waiver of notification, or written notification as required by State law.
Availability
In addition to assuring that medical records are maintained in a confidential manner, member’s medical records must also be available at the time of an appointment. Medical Record documentation facilitates communication, coordination, and continuity of care to promote the most efficient and effective treatment of the member. All PMG/IPAs and practitioners must have systems for retrieving, archiving, purging and disposing of records to ensure availability and confidentiality.

Medical records of PacifiCare members must be available to PacifiCare representatives upon request for quality improvement and peer review purposes.

Distribution of Medical Record Policies and Procedures
PMG/IPAs must have a systematic process for the review and approval of medical record policies and procedures by the QMC every year. The PMG/IPA is also expected to have a process in place for the distribution of medical record policies and procedures to staff and practitioners. This may be in the form of a policy and procedure manual, or a provider manual, which is updated periodically.

Systematic Review of Medical Records
PMG/IPA must have a systematic medical record review process in place in order to be delegated for medical record review. The purpose of the process is to ensure compliance with established medical record documentation standards. The PMG/IPA is also required to provide evidence of actions taken for improvement of medical record documentation when deficiencies are identified.

A Medical Record Workplan must be developed annually. This may be part of the QI Work Plan. The Workplan should include a schedule to be implemented to ensure the medical record review from a sample of Primary Care Physicians. PacifiCare requires annual review of PCP medical records.

In order to be delegated for medical record review, the PMG/IPA must supply documented evidence of the completed and scored medical record reviews, including a mechanism for feedback of results to the individual PCP. The results of practitioner-specific medical record data should be reviewed by the appropriate PMG/IPA practitioner committee. Necessary actions for improvement should be documented in the minutes. The PMG/IPA must conduct focused follow-up to improve medical records of PCPs who perform poorly against documentation standards.

Medical Record Review Summary Elements
PacifiCare performs an annual oversight review process for medical record review practices at the PMG/IPAs delegated by PacifiCare for the medical record review process. Completed PMG/IPA Medical Record Review Tools are evaluated for compliance with PCC standards. Elements include patient demographic information, health history, details of ongoing clinical issues, and plan for treatment.

PacifiCare aggregates medical record review data to design plan-wide interventions to address opportunities for improvement. PacifiCare has identified two additional elements requiring special attention for improvement of medical record documentation:
• For members referred to behavioral health services, there is documentation of patient approved exchange of information between PCP and Behavioral Health Practitioner
• There is documentation of discussion between PCP and members 18 years of age and older, informing members of their right to formulate advance directives

**Delegation of Medical Records**
Delegation is based on the assessment of the PMG/IPA’s development and implementation of policies and procedures, as well as performance of the annual review of the medical records of appropriate practitioners. The annual review must be conducted utilizing a review tool inclusive of PacifiCare required elements. Actions for improvement must be implemented at the individual practitioner level, as appropriate, and may be implemented at the PMG/IPA level.

PacifiCare currently delegates the medical record review process to the PMG/IPA after an initial assessment of medical record policies, procedures and practices. The PMG/IPA may further delegate the medical review process to a subcontracted entity. Sub-delegation by the PMG/IPA requires a Delegation Agreement that includes:

• Delineation of responsibilities of both parties
• Delegation activities specified
• Reporting frequency
• Process to evaluate performance of delegate
• Remedies if delegate does not perform
Medical Record Documentation Standards

PacifiCare requires each contracted provider group to develop written standards for medical records. The standards for medical record documentation must, at a minimum, meet PacifiCare’s standards. The following standards were developed using the NCQA Medical Record Guidelines, regulatory requirements and the assistance of representatives from participating medical groups.

1. Each page in the medical record contains the patient’s name or ID number
2. Personal biographical data include the address, employer, home and work telephone numbers, and marital status as applicable
3. All entries in the MR contain the author’s identification. Author identification may be a handwritten signature, an initials-stamped signature, or a unique electronic identifier
4. All entries are dated
5. The record is legible to someone other than the writer
6. Significant illnesses and medical conditions are indicated on the problem list
7. Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record
8. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses
9. For patients 14 years and older, there is appropriate notation concerning the use of cigarettes, alcohol, and substances (for patients seen three or more times, query substance abuse history)
10. The history and physical exam identifies appropriate subjective and objective information pertinent to the patient’s presenting complaints
11. Laboratory and other studies are ordered, as appropriate
12. Working diagnoses are consistent with findings
13. Treatment plans are consistent with diagnoses
14. 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
15. Unresolved problems from previous office visits are addressed in subsequent visits.
16. There is no evidence of under or over utilization of consultants
17. If a consultation was requested, there is a note from the consultant in the record
18. For members referred to behavioral health services, there is documentation of patient-approved exchange of information between PCP and Behavioral Health practitioners/providers.
19. Consultation, lab, and imaging reports in the chart are initialed by the PCP to signify review. Consultation, abnormal lab, and imaging study results have an explicit notation in the record of follow-up plans for abnormal results. (Review and signature by professionals other than
PCPs, such as nurse practitioners and physician assistants, do not meet this requirement. If the reports are presented electronically, or by some other method, there is also representation of physician review.)

*20. There is no evidence in the medical record that the patient was placed at inappropriate risk by a diagnostic or therapeutic procedure

21. Immunization records for children are up to date, or an appropriate history is noted in the medical record for adults

22. There is evidence of preventive screening and services offered in accordance with PacifiCare practice guidelines

23. There is documentation of discussion between PCP and members’ 18 years of age and older informing members of their right to formulate advance directives

* Six core elements identified by PacifiCare
G. Guidelines
Preventive Health Guidelines

PacifiCare recognizes the need for consistency between health plans regarding preventive health guidelines. PacifiCare engages in an active process of choosing Preventive Health (PH) guidelines appropriate to its membership and its operation. This process includes involving practitioners in the consideration of PH guidelines and the use of established sources of research and recommendations.

The guidelines contained in this section are based on the U.S. Preventive Healthcare Screening Task Force and the American Academy of Pediatrics recommendations. The guidelines are approved by PacifiCare’s QIC based on feedback by practicing physicians from our network. The guidelines are updated with each release of the new U.S. Preventive Health Task Force recommendations as well as with any additional regulatory requirements.

PacifiCare utilizes these guidelines as the standard to measure performance across the network through our QI activities related to preventive health. These guidelines are communicated to our members on an annual basis through member communication as well as to practitioners through the provider newsletter, Direct Line.
### PREVENTIVE HEALTH RECOMMENDATIONS FOR 2003
DEVELOPED BASED ON SCIENTIFIC EVIDENCE
ADOPTED BY PHP TECHNOLOGY ASSESSMENT AND GUIDELINE COMMITTEE 2/13/03

<table>
<thead>
<tr>
<th>ASSESSMENT</th>
<th>0–10 years</th>
<th>11–24 years</th>
<th>25–64 years</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>• Clinical assessment during office visit from age 3 years</td>
<td>• Clinical assessment during office visit</td>
<td>• Periodic screening</td>
<td>• Periodic screening</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening</td>
<td>• At least every 3 years for women who are or have been sexually active or beginning at age 21; interval as recommended by physician based on risk factors</td>
<td>• At least every 3 years for women who have a cervix; interval as recommended by physician based on risk factors</td>
<td>• May discontinue regular testing after age 65 in women who have had adequate recent screenings in which test results have been normal and who are otherwise not at risk</td>
<td>•</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlamydia Infection</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening</td>
<td>• Routine for sexually active females</td>
<td>• Routine for sexually active females age 25 and younger</td>
<td>• Routine for asymptomatic females at increased risk for infection</td>
<td>• Routine screening with interval determined by method. Potential screening options include home Fecal Occult Blood Test (FOBT), flexible sigmoidoscopy, the combination of home FOBT and flexible sigmoidoscopy, colonoscopy, and double-contrast barium enema</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>• Remain alert for possible signs</td>
<td>• Routine screening for adults</td>
<td>• Routine screening for adults</td>
<td>• Routine screening for adults</td>
</tr>
</tbody>
</table>

March 2003

105
<table>
<thead>
<tr>
<th>ASSESSMENT</th>
<th>0–10 years</th>
<th>11–24 years</th>
<th>25–64 years</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>and symptoms of depression&lt;sup&gt;7&lt;/sup&gt;</td>
<td>• Remain alert for possible signs and symptoms of depression in younger patients&lt;sup&gt;7&lt;/sup&gt;</td>
<td>• Screening of adults with hypertension or hyperlipidemia&lt;sup&gt;8&lt;/sup&gt;</td>
<td>• Screening of adults with hypertension or hyperlipidemia&lt;sup&gt;8&lt;/sup&gt;</td>
</tr>
<tr>
<td>Diabetes-Type 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Screening of adults with hypertension or hyperlipidemia&lt;sup&gt;8&lt;/sup&gt;</td>
<td>• Screening of adults with hypertension or hyperlipidemia&lt;sup&gt;8&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td></td>
<td></td>
<td></td>
<td>• At physician discretion&lt;sup&gt;9&lt;/sup&gt;</td>
</tr>
<tr>
<td>Height and Weight</td>
<td>• Growth chart plotted during office visit from birth on&lt;sup&gt;10&lt;/sup&gt;</td>
<td>• Periodically&lt;sup&gt;10&lt;/sup&gt;</td>
<td>• Periodically&lt;sup&gt;10&lt;/sup&gt;</td>
<td>• Periodically&lt;sup&gt;10&lt;/sup&gt;</td>
</tr>
<tr>
<td>Lead Testing</td>
<td>• Screening for elevated levels of lead in the blood at age 12 months for all children at increased risk of lead exposure&lt;sup&gt;11&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lipid Disorder Screening</td>
<td>• Routine screening beginning at age 20 if other risk factors for coronary heart disease exist&lt;sup&gt;12&lt;/sup&gt;</td>
<td>• Routine screening for males age 35 and older and females age 45 and older&lt;sup&gt;12&lt;/sup&gt;</td>
<td>• Routine screening for younger adults if other risk factors for coronary heart disease exist&lt;sup&gt;12&lt;/sup&gt;</td>
<td>• Routine screening</td>
</tr>
<tr>
<td>Osteoporosis Screening&lt;sup&gt;13&lt;/sup&gt;</td>
<td></td>
<td>• Routine screening beginning at age 60 for women at increased risk of osteoporotic fracture&lt;sup&gt;13&lt;/sup&gt;</td>
<td></td>
<td>• Routine screening for women&lt;sup&gt;13&lt;/sup&gt;</td>
</tr>
<tr>
<td>Prostate Cancer Screening</td>
<td></td>
<td>• Discuss risks and benefits of screening with medical professional&lt;sup&gt;14&lt;/sup&gt;</td>
<td></td>
<td>• Discuss risks and benefits of screening with medical professional&lt;sup&gt;14&lt;/sup&gt;</td>
</tr>
<tr>
<td>Tuberculosis Screening</td>
<td>• All persons at increased risk of developing tuberculosis&lt;sup&gt;15&lt;/sup&gt;</td>
<td>• All persons at increased risk of developing tuberculosis&lt;sup&gt;15&lt;/sup&gt;</td>
<td>• All persons at increased risk of developing tuberculosis&lt;sup&gt;15&lt;/sup&gt;</td>
<td>• All persons at increased risk of developing tuberculosis&lt;sup&gt;15&lt;/sup&gt;</td>
</tr>
<tr>
<td>Vision Screening</td>
<td>• Screening for amblyopia and strabismus between ages 3 and 4&lt;sup&gt;16&lt;/sup&gt;</td>
<td>• Refer high risk individuals for evaluation by eye specialist; frequency at physician discretion&lt;sup&gt;16&lt;/sup&gt;</td>
<td>• Refer high risk individuals for evaluation by eye specialist; frequency at physician discretion&lt;sup&gt;16&lt;/sup&gt;</td>
<td>• Refer high risk individuals for evaluation by eye specialist; frequency at physician discretion&lt;sup&gt;16&lt;/sup&gt;</td>
</tr>
<tr>
<td>COUNSELING</td>
<td>0–10 years</td>
<td>11–24 years</td>
<td>25–64 years</td>
<td>65+ years</td>
</tr>
<tr>
<td>------------</td>
<td>------------</td>
<td>-------------</td>
<td>-------------</td>
<td>-----------</td>
</tr>
</tbody>
</table>
| **Dental Health**<sup>17</sup> | • Regular dental care  
• Floss, brush with fluoride toothpaste daily  
• Daily fluoride drops or tablets for children living in areas with inadequate fluoridation | • Regular dental care  
• Floss, brush with fluoride toothpaste daily  
• Daily fluoride drops or tablets for children living in areas with inadequate fluoridation | • Regular dental care  
• Floss, brush with fluoride toothpaste daily | • Regular dental care  
• Floss, brush with fluoride toothpaste daily |
| **Diet and Exercise**<sup>18</sup> | • Encourage breastfeeding of infants; diet of iron-enriched formula and foods  
• Over age 2, limit fat and cholesterol, maintain caloric balance and emphasize fruits, vegetables, and grain products containing fiber  
• Regular physical activity | • Limit fat and cholesterol, maintain caloric balance and emphasize fruits, vegetables, and grain products containing fiber  
• Adequate calcium intake (women)  
• Regular physical activity | • Limit fat and cholesterol, maintain caloric balance and emphasize fruits, vegetables, and grain products containing fiber  
• Adequate calcium intake (women)  
• Regular physical activity | • Limit fat and cholesterol, maintain caloric balance and emphasize fruits, vegetables, and grain products containing fiber  
• Adequate calcium intake (women)  
• Regular physical activity |
| **Hormone Replacement Therapy** | | | • Counsel women approaching menopause regarding alternatives to prevent chronic disease<sup>19</sup> | |
| **Injury Prevention/Patient Safety**<sup>20</sup> | • Federally approved child safety seats appropriate for the child’s age and size  
• Safety belts when not covered by state child safety seat laws<sup>21</sup>  
• Safety helmet for high speed activities  
• Smoke detectors  
• Flame retardant sleepwear  
• Place infants on their backs to sleep  
• Hot water heater temperature <120–130°F  
• Window/stair guards, pool fence  
• Restrict access to drugs, toxic substances, firearms and matches | • Safety belts<sup>21</sup>  
• Safety helmet for high speed activities  
• Smoke detectors  
• Restrict unauthorized access to firearms  
• CPR training for caretakers of high risk individuals  
• Water safety | • Safety belts<sup>21</sup>  
• Safety helmet for high speed activities  
• Smoke detectors  
• Restrict unauthorized access to firearms  
• CPR training for caretakers of high risk individuals  
• Water safety | • Safety belts<sup>21</sup>  
• Safety helmet for high speed activities  
• Smoke detectors  
• Restrict unauthorized access to firearms  
• CPR training for caretakers of high risk individuals  
• Measures to reduce risk of falling  
• Water safety |
<table>
<thead>
<tr>
<th>COUNSELING</th>
<th>0–10 years</th>
<th>11–24 years</th>
<th>25–64 years</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommended Topic:</strong></td>
<td><strong>Recommended Topic:</strong></td>
<td><strong>Recommended Topic:</strong></td>
<td><strong>Recommended Topic:</strong></td>
<td></td>
</tr>
<tr>
<td>• Syrup of Ipecac on hand</td>
<td>• Pregnant women should be advised to seek their first prenatal visit in the first trimester or as soon as pregnancy is known(^{22})</td>
<td>• Pregnant women should be advised to seek their first prenatal visit in the first trimester or as soon as pregnancy is known(^{22})</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Poison control phone number</td>
<td>• To reduce the risk of neural tube defects in newborns, all women not planning but still capable of pregnancy should take a multivitamin containing 0.4mg of folic acid daily(^{23})</td>
<td>• To reduce the risk of neural tube defects in newborns, all women not planning but still capable of pregnancy should take a multivitamin containing 0.4mg of folic acid daily(^{23})</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• CPR training for caretakers of high-risk individuals</td>
<td>• Water Safety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Water Safety</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prenatal Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sexual Behavior(^{24})</strong></td>
<td>• Sexually Transmitted Disease: All adolescent and adults advised of risk factors and counseled about effective measures to prevent infection</td>
<td>• Sexually Transmitted Disease: All adults advised of risk factors and counseled about effective measures to prevent infection</td>
<td>• Sexually Transmitted Disease: All adults advised of risk factors and counseled about effective measures to prevent infection</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Unintended pregnancy: Contraception</td>
<td>• Unintended pregnancy: Contraception</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Substance Use and Substance Abuse(^{25})</strong></td>
<td>• Effects of passive smoking</td>
<td>• Regular screening for tobacco-use status and problem drinking</td>
<td>• Regular screening for tobacco-use status and problem drinking</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Anti-tobacco message</td>
<td>• Strongly advise tobacco-users to quit</td>
<td>• Strongly advise tobacco-users to quit</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Avoid underage drinking and illicit drug use</td>
<td>• Avoid alcohol/drug use while driving(^{21}), swimming, boating, etc.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Avoid alcohol/drug use while driving(^{21}), swimming, boating, etc.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Immunizations

#### Table: Immune Agent and Age Group Information

<table>
<thead>
<tr>
<th>Immune Agent</th>
<th>0–10 years</th>
<th>11–24 years</th>
<th>25–64 years</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diphtheria, Tetanus, acellular Pertussis</strong></td>
<td>2, 4, 6, 15–18 months and 4–6 years</td>
<td>Once at 11–12 years; then every 10 years</td>
<td>Booster every 10 years</td>
<td>Booster every 10 years</td>
</tr>
<tr>
<td><strong>Tetanus Diphtheria</strong></td>
<td>Once at 11–12 years; then every 10 years</td>
<td>Booster every 10 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Haemophilus Influenza type B</strong></td>
<td>2, 4, 6 and 12–15 months</td>
<td>All children and adolescents through age 18 living in areas with rates at least twice the national average, 2 doses: 2nd dose 6–18 months after 1st dose; adults at increased risk: 2 doses</td>
<td>All adults at increased risk, 2 doses: 2nd dose 6–18 months after 1st dose; consult your physician</td>
<td>All adults at increased risk, 2 doses: 2nd dose 6–18 months after 1st dose; consult your physician</td>
</tr>
<tr>
<td><strong>Hepatitis A</strong></td>
<td>For children ≥ age 2 years living in areas with rates that are at least twice the national average, 2 doses: 2nd dose 6–18 months after 1st dose; consult your physician</td>
<td>All children and adolescents through age 18 living in areas with rates that are twice the national average, 2 doses: 2nd dose 6–18 months after 1st dose; adults at increased risk: 2 doses</td>
<td>All adults at increased risk, 2 doses: 2nd dose 6–18 months after 1st dose; consult your physician</td>
<td></td>
</tr>
<tr>
<td><strong>Hepatitis B</strong></td>
<td>1st dose soon after birth and before discharge; 2nd dose 1 month after 1st dose; 3rd dose 4 months after 1st dose and at least 2 months after the 2nd dose, but not before 6 months of age</td>
<td>11–12 years if not previously immunized</td>
<td>All adults with medical, behavioral, occupational or other high risk indications</td>
<td>All adults with medical, behavioral, occupational or other high risk indications</td>
</tr>
<tr>
<td><strong>Influenza</strong></td>
<td>For children ≥ 6 months with increased risk of complication or transmission to high risk persons, annually in fall or winter</td>
<td>All children and adults at increased risk for complications or transmission to high risk persons, annually in fall or winter</td>
<td>All adults beginning at age 50 and others at increased risk for complications or transmission to high risk persons, annually in fall or winter</td>
<td>Annually, in fall or winter</td>
</tr>
<tr>
<td><strong>Measles, Mumps, Rubella</strong></td>
<td>12–15 months and 4–6 years</td>
<td>If second dose not completed: then 2nd dose at 11–12 years old</td>
<td>Based on vaccine history</td>
<td>Consider for adults with medical indications</td>
</tr>
<tr>
<td><strong>Meningococcal</strong></td>
<td></td>
<td>Education about disease and benefits of vaccination for incoming or current college freshmen, particularly those living in dormitories</td>
<td>Consider for adults with medical indications</td>
<td>Consider for adults with medical indications</td>
</tr>
</tbody>
</table>

Note: The 2003 ACIP recommendations include a catch-up schedule for children and adolescents who start late or who are >1 month behind. Refer to [www.cdc.gov/nip](http://www.cdc.gov/nip) for additional information.
<table>
<thead>
<tr>
<th>IMMUNIZATIONS</th>
<th>0–10 years</th>
<th>11–24 years</th>
<th>25–64 years</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inactivated Polio Vaccine</td>
<td>- 2, 4, 6–18 months and 4–6 years&lt;sup&gt;26&lt;/sup&gt;</td>
<td>- All children ≥ 2 years at increased risk for pneumococcal disease&lt;sup&gt;39&lt;/sup&gt;</td>
<td>- All adults at increased risk for pneumococcal disease&lt;sup&gt;39&lt;/sup&gt;</td>
<td>- All persons ≥ 65 years; second dose if initial vaccination was ≥ 5 years previously and &lt;65 years&lt;sup&gt;39&lt;/sup&gt;</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>- All children ≥ 2 years at increased risk for pneumococcal disease&lt;sup&gt;39&lt;/sup&gt;</td>
<td>- All children and adults at increased risk for pneumococcal disease&lt;sup&gt;39&lt;/sup&gt;</td>
<td>- All adults at increased risk for pneumococcal disease&lt;sup&gt;39&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td>- All women of childbearing age should be screened for rubella susceptibility or, if nonpregnant, may be offered vaccination without screening&lt;sup&gt;40&lt;/sup&gt;</td>
<td>- All women of childbearing age should be screened for rubella susceptibility or, if nonpregnant, may be offered vaccination without screening&lt;sup&gt;40&lt;/sup&gt;</td>
<td>- All women of childbearing age should be screened for rubella susceptibility or, if nonpregnant, may be offered vaccination without screening&lt;sup&gt;40&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td>- 12–18 months&lt;sup&gt;40&lt;/sup&gt;</td>
<td>- Susceptible persons ≥13 years at risk for exposure or transmission: 2 doses 4 weeks apart&lt;sup&gt;41&lt;/sup&gt;</td>
<td>- Susceptible persons at risk for exposure or transmission: 2 doses 4 weeks apart&lt;sup&gt;41&lt;/sup&gt;</td>
<td>- Susceptible persons at risk for exposure or transmission: 2 doses 4 weeks apart&lt;sup&gt;41&lt;/sup&gt;</td>
</tr>
<tr>
<td>Pneumococcal conjugate vaccine (PCV7)&lt;sup&gt;42&lt;/sup&gt;</td>
<td>- ≤6 months – 3 doses, 2 months apart beginning at age 2 months; 1 dose at 12–15 months; For unvaccinated children: - 2–6 months – 3 doses, 2 months apart beginning at age 2 months and 1 dose at 12–15 months; - 7–11 months – 2 doses, 2 months apart; 1 dose at 12–15 months; - 12–23 months – 2 doses, 2 months apart; - 24–59 months with SCD, asplenia, HIV infection, chronic illness or immunocompromising condition – 2 doses, 2 months apart&lt;sup&gt;42&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

These recommendations are not to be confused with the benefits covered by PacifiCare/Secure Horizons as defined in the member’s Evidence of Coverage/Disclosure Form. Nothing in these guidelines should be construed to establish a new benefit under PacifiCare or indicate a change in federal or state required benefits. The PacifiCare/Secure Horizons member’s Evidence of Coverage/Disclosure Form should be consulted for the specific coverage and limitations of benefits.

References: American Academy of Pediatrics (AAP), Centers for Disease Control and Prevention (CDC) and US Preventive Services Task Force (USPSTF). Unless otherwise specified, please note that the designations for each recommendation reflect the evidence rating assigned by the USPSTF. Designations: (A) strongly recommends the service based on good evidence; (B) recommends the service based on fair evidence; (C) makes no recommendation for or against the service based on fair evidence but concludes the balance of benefits and harms is too close to justify a general recommendation; (D) recommends against the service in asymptomatic patients based on at least fair evidence that the service is ineffective or that harms outweigh benefits; (I) insufficient evidence for or against the service based on evidence that the service is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

1The AAP recommends a clinical assessment of blood pressure during office visits from age 3. The USPSTF recommends blood pressure screening during office visits for children and adolescents (B).

2The USPSTF recommends periodic screening for hypertension for all persons age 21 and older (A).

3The USPSTF recommends screening mammography, with or without clinical breast examination, every 1 to 2 years for women age 40 and older (B). The USPSTF further recommends women be informed of potential benefits, limitations, and possible harms of mammography in making decisions about when to begin screening.

4The USPSTF strongly recommends cervical cancer screening for all women who are or have been sexually active and who have a cervix (A). Direct evidence to determine the optimal starting and stopping age and interval for screening is limited. Indirect evidence suggests most of the benefit can be obtained by screening within 3 years of onset of sexual activity or age 21 (which ever comes first) and screening at least every 3 years. The USPSTF recommends against routinely screening women older than age 65 for cervical cancer if they have had adequate recent screening with normal Pap smears and are not otherwise at high risk for cervical cancer. (D) The USPSTF recommends against routine Pap smear screening in women who have had a total hysterectomy for benign disease. (D) The USPSTF concluded that the evidence is insufficient to recommend for or against the routine use of new technologies to screen for cervical cancer. (I)

5The USPSTF strongly recommends routinely screening all sexually active women age 25 and younger and other asymptomatic women at increased risk for infection, for chlamydial infection (A).

6The USPSTF strongly recommends that clinicians screen men and women 50 years of age and older for colorectal cancer (A). Potential screening options include home FOBT, flexible sigmoidoscopy, the combination of home FOBT and flexible sigmoidoscopy, colonoscopy, and double-contrast barium enema. Each option has advantages and disadvantages that may vary for individual patients and practice settings. The choice of specific screening strategy should be based on patient preferences, medical contraindications, patient adherence, and available resources for testing and follow-up. Clinicians should talk to patients about the benefits and potential harms associated with each option before selecting a screening strategy. The optimal interval for screening depends on the test. Annual FOBT offers greater reductions in mortality rates than biennial screening but produces more false-positive results. A 10-year interval has been recommended for colonoscopy on the basis of evidence regarding the natural history of adenomatous polyps. Shorter intervals (5 years) have been recommended for flexible sigmoidoscopy and double-contrast barium enema because of their lower sensitivity, but there is no direct evidence with which to determine the optimal interval for tests other than FOBT.

7The USPSTF recommends screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment and follow-up (B). Many formal screening tools are available. Asking two simple questions about mood and anhedonia (“Over the past 2 weeks, have you felt down, depressed or hopeless?” and “Over the past 2 weeks, have you felt little interest or pleasure in doing things?”) may be as effective as using longer instruments. All positive tests should trigger full diagnostic interviews that use standard diagnostic criteria to determine the presence or absence of specific
depressive disorders. The optimal interval for screening is unknown. The USPSTF concluded evidence is insufficient to recommend for or against routine screening of children or adolescents for depression (I).

The USPSTF recommends screening for type 2 diabetes in adults with hypertension or hyperlipidemia. (B)

The USPSTF concluded there is insufficient evidence to recommend for or against routine screening of newborns for hearing loss during the postpartum hospitalization (I). The USPSTF recommends screening older adults for hearing impairment by periodically questioning them about their hearing, counseling them about the availability of hearing aid devices and making referrals for abnormalities when appropriate. The optimal frequency of such screening has not been determined and is left for clinical discretion. (B).

The APA and USPSTF recommend periodic height and weight measurements plotted on growth chart (B).

The USPSTF recommends screening for elevated lead levels by measuring blood lead at least once age 12 months for all children at increased risk for lead exposure (B).

The USPSTF strongly recommends routinely screening men age 35 and older and women age 45 and older for lipid disorders and treating abnormal lipids in people who are at increased risk of coronary heart disease (A). The USPSTF recommends routinely screening younger adults for lipid disorders if they have other risk factors for coronary heart disease (B).

The USPSTF recommends that women aged 65 and older be screened routinely for osteoporosis. The USPSTF recommends that routine screening begin at age 60 for women at increased risk of osteoporotic fractures (B). The exact risk factors that should trigger screening in this age group are difficult to specify based on evidence. Lower body weight (weight <70kg) is the single best predictor of low bone mineral density. There is less evidence to support the use of other individual risk factors (for example, smoking, weight loss, family history, decreased physical activity, alcohol or caffeine use, or low calcium and vitamin D intake) as a basis for identifying high-risk women younger than 65. At any given age, African-American women on average have higher bone mineral density (BMD) than white women and are thus less likely to benefit from screening. Among different bone measurement tests performed at various anatomical sites, bone density measured at the femoral neck by dual-energy x-ray absorptiometry (DXA) is the best predictor of hip fracture and is comparable to forearm measurements for predicting fractures at other sites. Other technologies for measuring peripheral sites include quantitative ultrasonography (QUS), radiographic absorptiometry, single energy x-ray absorptiometry, peripheral dual energy x-ray absorptiometry, and peripheral quantitative computed tomography. Recent data suggest that peripheral bone density testing in the primary care setting can also identify postmenopausal women who have a higher risk of fracture over the short term (1-year). Further research is needed to determine the accuracy of peripheral bone density testing in comparison with DXA. The optimal interval for repeated screening is unknown. Because of limitations in the precision of testing, a minimum of 2 years may be needed to reliably measure a change in BMD; however, longer intervals may be adequate.

The USPSTF does not recommend routine screening for prostate cancer. Patients who request screening should be given objective information about the potential benefits and harms of early detection and treatment. Despite the absence of firm evidence of effectiveness, some clinicians may opt to perform prostate screening for other reasons. Clinicians should not order the PSA test without first discussing the potential, but uncertain, benefits and possible harms.

The USPSTF recommends screening by tuberculin skin testing for all persons at increased risk of developing tuberculosis (A).

The USPSTF recommends vision screening for amblyopia and strabismus once before entering school (preferably between age 3–4 years) (B). There is insufficient evidence to recommend for or against routine screening by primary care practitioners for elevated intraocular pressure or early glaucoma (C). Recommendations to refer high-risk patients for evaluation by eye specialist may be based on the substantial prevalence of unrecognized glaucoma in these populations, the progressive nature of untreated disease, and expert consensus that reducing intraocular pressure may slow the rate of visual loss in patients with early glaucoma or severe intraocular hypertension. Populations in whom the prevalence is >1% include blacks over age 40 and whites over age 65. Patients with family history of glaucoma, patients with diabetes, and patients with severe myopia are also at increased risk. The optimal frequency for glaucoma screening has not been determined and is left to clinical discretion.

Counseling patients to visit a dental care provider on a regular basis is recommended by the USPSTF based on evidence for risk reduction from such visits when combined with personal oral hygiene (B). The AAP recommends regular dental care beginning at 3 years. Clinicians caring for children should ascertain
the fluoride concentration of their water supply. For children living in an area with inadequate water fluoridation (<0.06 ppm), the prescription of daily fluoride drops or tablets is recommended (A).

18 The USPSTF recommends counseling to promote regular physical activity for all children and adults to prevent coronary heart disease, hypertension, obesity, and diabetes (A). Adults and children over age 2 should limit dietary intake of fat (A) and cholesterol (B), maintain caloric balance in their diet (B), and emphasize fruits, vegetables, and grain products containing fiber (B). Parents should be encouraged to offer breastfeeding to their infants (A) and to include iron-enriched foods in their diet (B). Clinicians who lack the time or skill to perform a complete dietary history, to address potential barriers to changes in eating habits, and to offer specific guidance on meal planning and food selection and preparation, should either have patients seen by other trained providers in the office or clinic or should refer patients to a registered dietician or qualified nutritionist for further counseling.

19 The USPSTF recommends against the routine use of estrogen and progestin for the prevention of chronic conditions in postmenopausal women (D). The USPSTF concludes that the evidence is insufficient to recommend for or against the use of unopposed estrogen for the prevention of chronic conditions in postmenopausal women who have had a hysterectomy (I). Clinicians should develop a shared decision-making approach to preventing chronic diseases in perimenopausal and postmenopausal women. This approach should consider individual risk factors and preferences in selecting effective interventions for reducing the risks of fracture, heart disease, and cancer. Clinicians should discuss with patients other effective strategies for preventing osteoporosis and fractures.

20 Injury prevention is addressed under USPSTF recommendation for periodic counseling. (B).

21 The CDC Task Force on Community Preventive Services strongly recommends interventions to increase use of child safety seats, increase safety belt use and reduce alcohol-impaired driving.

22 The American College of Obstetricians and Gynecologists (ACOG) recommends prenatal care beginning early in pregnancy and continuing through the postpartum period.

23 The USPSTF recommends that to reduce the risk of neural tube defects in newborns, all women not planning but still capable of pregnancy should take a multivitamin containing 0.4mg of folic acid daily (B).

24 The USPSTF recommends that all adolescent and adult patients be advised about risk factors for sexually transmitted disease and counseled appropriately about effective measures to reduce risk of infection (B). Periodic counseling about effective contraceptive methods is recommended for all women and men at risk for unintended pregnancy (B).

25 The USPSTF recommends pregnant women and parents with children living at home also should be counseled on the potentially harmful effects of smoking on fetal and child health (A). Screening to detect problem drinking and hazardous drinking is recommended for all adults and adolescents (B). All adolescents and adults who use alcohol or other drugs should be advised to avoid engaging in potentially dangerous activities while intoxicated (B). The US Public Health Service recommends all patients should be asked if they use tobacco and should have their tobacco-use status documented on a regular basis. Evidence has shown that this significantly increases rates of clinician intervention (A). All physicians strongly advise every patient who smokes to quit because evidence shows that physician advise to quit smoking increases abstinence rates (A). All clinicians should strongly advise patients who use tobacco to quit (B).

26 The ACIP Schedule (Jan–Dec 2003), updated annually by the CDC’s Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), and the AAP, is recommended. The schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines. Combination vaccines may be used whenever the combination is licensed for use for any components of the combination that are indicated and its other components are not contraindicated. Providers should consult the manufacturers’ package inserts for detailed recommendations. Information on vaccine supply and statements on specific vaccines can be found at www.cdc.gov/nip.

27 DTaP is the preferred vaccine for all doses, including completion of a series begun with whole cell DTP according to ACIP guidelines. The fourth dose may be administered as early as 12 months, provided 6 months have elapsed since the 3rd dose and if the child is unlikely to return at age 15–18 months. The ACIP recommends that, whenever feasible, the same brand of DTaP vaccine be used for all doses in the vaccine series. When unknown or not available, any of the licensed vaccines can be used.
The ACIP recommends Td vaccination at 11–12 years of age if at least 5 years have elapsed since the last dose of DTP, DtaP or DT. Subsequent Td boosters are recommended every 10 years thereafter. Tetanus prophylaxis in routine wound management if other than clean or minor wound and >5 years since last dose.

The ACIP recommends only FDA-approved combination products for primary Haemophilus influenza type B (HiB) vaccination in infants 2, 4 or 6 months.

The ACIP recommends Hepatitis A vaccination for persons, ≥2 years, who are at increased risk for infection (travelers, men who have sex with men, illegal-drug users, occupational risk, clotting-factor disorder, chronic liver disease – consult ACIP) and anyone wishing to obtain immunity. Children ≥2 years, living in areas where rates of hepatitis A are at least twice (≥20 cases per 100,000 population) the national average, should be routinely vaccinated. Vaccination should be considered for children living in areas where rates of hepatitis A are ≥10 <20 cases per 100,000 population) the national average. The schedule is determined based on vaccine formulation and age. Contact local public health authority for current recommendations.

The ACIP recommends all infants receive the 1st dose of hepatitis B vaccine soon after birth and before hospital discharge; the 1st dose may also be given by age 2 months if the infant is born to a hepatitis B surface antigen (HbsAg)-negative mother. The 2nd dose should be at least 1 month after the 1st dose. The 3rd dose should be administered at least 4 weeks after the 1st dose and at least 2 months after the 2nd does, but not before 6 months of age. Infants born to HbsAg-positive mothers should receive hepatitis B vaccine and 0.5 ml hepatitis B immune globulin (HBIG) within 12 hours of birth at separate sites. The 2nd dose is recommended at 1 month of age and the 3rd dose at 6 months of age. Infants born to mothers whose HbsAg status is unknown should receive hepatitis B vaccine within 12 hours of birth. Maternal blood should be drawn at the time of delivery to determine the mother’s HbsAg status; if the HbsAg test is positive, the infant should receive HBIG as soon as possible (no later than 1 week of age).

The ACIP recommends all children and adolescents who have not been immunized against Hepatitis B should be begin the Hepatitis B vaccination series during any visit (refer to Catch-up Schedule). Immunization status should be routinely evaluated during preadolescents (age 11-12 years). The ACIP recommends administering 3 doses of Hepatitis B for persons with medical (hemodialysis patients and patients who receive clotting-factor concentrates), behavioral (injecting drug users, persons with more than 1 sex partner in 6 months, persons with a recently acquired STD, clients in STD clinics and men who have sex with men), occupational (health-care and public-safety workers who have exposure to blood), or other indications (household contacts and sex partners of persons with chronic Hepatitis B infection, clients and staff of institutions for the developmentally disabled, international travelers who will be in countries with high or intermediate prevalence of chronic Hepatitis B infection for more than 6 months, inmates of correctional facilities). The 2nd dose should be administered 1-2 months after the 1st does and the 3rd dose should be administered 4-6 months after the 1st dose.

The ACIP recommends influenza vaccination for any person ≥6 months, who because of age or underlying medical condition, is at increased risk for complications of influenza. Groups at increased risk include: residents of nursing home or other chronic care facilities; adults or children who have chronic disorders of pulmonary or cardiovascular systems or who have required regular medical follow-up or hospitalization because of chronic metabolic disease (including diabetes), renal dysfunction, hemoglobinopathies, or immunosuppression; children or adolescents receiving long-term aspirin therapy; and women who will be in the 2nd or 3rd trimester of pregnancy during the influenza season. Care givers to persons at high risk, persons in institutional settings, providing essential community services and other persons who wish to reduce the likelihood of becoming ill with influenza, should be considered for vaccination. Healthy children age 6-23 months are encouraged to receive influenza vaccine if feasible because children in this age group are at substantially increased risk for influenza-related hospitalizations.

The ACIP recommends the 2nd MMR vaccination at 4–6 years of age but vaccine may be administered during any visit provided at least 4 weeks have elapsed since receipt of the 1st dose and that both does are administered beginning at or after 12 months of age. Those who have not previously received the 2nd dose should complete the schedule by the 11–12 years old visit.

The ACIP recommends, for the measles component, 2 doses of MMR for adults with one or more of the following conditions and without vaccination history: adults born after 1956, persons vaccinated with killed measles virus vaccine 1963-1969, students in post-secondary education institutions, health care workers, susceptible international travelers to measles endemic countries. For the mumps component, 1 dose of MMR should be adequate protection. See Rubella recommendations.

The ACIP recommends that providers of medical care to incoming and current college freshmen, particularly those who plan to or already live in dormitories and residence halls, should, during routine medical care, inform these students and their parents about meningococcal disease and the benefits of vaccination.
ACIP does not recommend that the level of increased risk among freshman warrants any specific changes in living situations for freshman. College freshman who want to reduce their risk for meningococcal disease should be administered vaccine. The ACIP recommends considering vaccination for persons with medical (adults with terminal complement component deficiencies, with anatomic or functional asplenia) or other indications (travelers to countries in which disease is hyperendemic or epidemic. Revaccination at 3-5 years may be indicated in persons at high risk for infection.

The ACIP recommends an all-inactivated poliovirus (IPV) vaccination at 2, 4, 6–18 months and at 4–6 years. For children who have already received oral polio vaccine (OPV) but have not completed the series, the additional doses should be IPV. If accelerated protection is needed, the minimum interval between doses is 4 weeks, although the preferred interval between the 2nd and 3rd doses is 2 months. All children who received three doses of IPV before age 4 years should receive a 4th dose before or at school entry. The 4th dose is not needed if the 3rd dose is administered on or after the 4th birthday.

The ACIP recommends pneumococcal vaccine for all immunocompetent persons who are 65 years and older with 2nd dose if vaccine was administered under age 65 years and more than 5 years previously (A). Additionally vaccination is recommended, for persons age 2–64 years with chronic cardiovascular disease, chronic pulmonary disease, diabetes, or functional/anatomic asplenia (A). For persons > 10 years with asplenia, single revaccination ≥ 5 years after previous dose. For persons ≤ 10 years with asplenia, consider revaccination 3 years after previous dose (A).

The USPSTF recommends screening for rubella susceptibility by history of vaccination or by serology for all women of childbearing age (B). Alternatively, all susceptible nonpregnant women of childbearing age should be offered vaccination against rubella without screening (B).

The ACIP recommends vaccination at any visit on or after the first birthday for susceptible children, i.e. those who lack a reliable history of chickenpox (as judged by a health care provider) and have who have not been immunized. Susceptible persons age ≥ 13 years at high risk for exposure or transmission should receive 2 doses, given at least 4 weeks apart.

The ACIP recommends all children age ≤ 23 months should be vaccinated with PCV7. Infant vaccination provides the earliest possible protection, age 2–6 months and age 7–23 months (B). Children age 24–59 months should receive PCV7 vaccination if they are at high risk for pneumococcal infection caused by an underlying medical condition. This recommendation applies to the following groups: children with sickle cell disease and other sickle cell hemoglobinopathies, including hemoglobin SS, hemoglobin S-C, or hemoglobin s-β-thalassemia, or children who are functionally or anatomically asplenic (B); children with HIV infection (B); children who have chronic disease, including chronic cardiac and pulmonary disease (excluding asthma), diabetes mellitus, or CSF leak; and children with immunocompromising conditions including a) malignancies, b) chronic renal failure or nephrotic syndrome; c) those children receiving immunosuppressive chemotherapy, including long-term systemic corticosteroids; and d) those children who have received a solid organ transplant (C). The ACIP further recommends that PCV7 vaccination (1 dose) be considered for all other unvaccinated children age 24–59 months with priority given to children age 24–35 months, children of Alaska Native, American Indian or African-American descent, and children who attend group day care centers (B). Modified recommendations apply during periods of shortage. See MMWR 12/21/02.
Clinical Practice Guidelines

PacifiCare Clinical Practice Guidelines (CPGs) are evidence-based guidelines promulgated by PacifiCare to help practitioners make decisions about specific clinical situations. These guidelines are identified by category in relation to disease, procedures, drugs, devices and preventive health. All guidelines contain a clinical component, which relates to one or more of the areas identified above. PacifiCare utilizes these guidelines as the standard to measure performance through quality initiatives.

Nationally recognized guidelines and standards are utilized as major sources in the development of PacifiCare Clinical Guidelines, including the U.S. Preventive Services Task Force, the American Diabetes Association Guidelines, the American Cancer Society Guidelines, and the American Academy of Pediatrics.

PacifiCare recognizes the need for clinical practice guidelines that are adopted as close to the site of care delivery as possible. To this end, PacifiCare has adopted the role of agent as well as developer of clinical practice guidelines for a complex, geographically dispersed network by adopting a multi-level methodology of utilizing practice guidelines.

PacifiCare has an extensive process committed to the development and adoption of all practice guidelines for use by the PMG/IPA network. This process begins with the identification of the need for a new or updated guideline based on specific populations for whom the guideline is intended (high risk/high volume acute and chronic conditions), high cost, high utilization, inconsistency in use of a procedure, identified quality issues, plan demographics. A search of the literature of published scientific and professional journals for existing guidelines based on scientific evidence or expert consensus is done. The participating practitioner input into the development and review of the guideline, is incorporated into a draft and distributed to network practitioners, of appropriate specialties, for their review.

The following clinical guidelines have been approved by PacifiCare’s Quality Improvement Committee:

- Outpatient Management of Coronary Artery Disease
- Outpatient Management of Congestive Heart Failure
- Guideline for the Treatment of Major Depressive Disorder
- Diabetes Management Guidelines for 2002
- Outpatient Management of Asthma 2002
# Outpatient Management of Coronary Artery Disease

*Adopted by the Technology Assessment and Guideline Committee on 12/13/01*

## MEDICATIONS

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>RECOMMENDATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beta-Blockers</td>
<td><strong>Indicated in post-MI, unstable angina, and non-ST segment MI. Prescribe to all patients without a contraindication to beta-blocker therapy, except low risk patients (i.e., those without previous infarction, anterior infarction, advanced age or complex ventricular ectopy). Treatment should begin within a few days of the event and continued indefinitely.</strong>  &lt;br&gt;<strong>Contraindications:</strong>  &lt;br&gt;- Cardiogenic shock  &lt;br&gt;- Overt heart failure  &lt;br&gt;- Sick sinus syndrome  &lt;br&gt;- History of asthma/severe COPD  &lt;br&gt;- Hypersensitivity to beta-blockers  &lt;br&gt;- HR &lt; 50 bpm  &lt;br&gt;- P-R interval &gt;.24 seconds  &lt;br&gt;- Second or third degree AV block  &lt;br&gt;Cautions:  &lt;br&gt;- Use is intended as long term therapy  &lt;br&gt;- Abrupt discontinuation should be avoided  &lt;br&gt;- Self monitor for evidence of hypotension and bradycardia  &lt;br&gt;Cautions:  &lt;br&gt;- Contraindications; Concomitant sildenafil (Phosphodiesterase type 5 inhibitors)</td>
</tr>
<tr>
<td>Nitrates</td>
<td><strong>Indicated in treatment and prophylaxis of angina.</strong>  &lt;br&gt;<strong>Patients should be given oral, sublingual or spray NTG and instructed in its use.</strong>  &lt;br&gt;<strong>Contraindications:</strong> Concomitant sildenafil (Phosphodiesterase type 5 inhibitors)</td>
</tr>
<tr>
<td>Aspirin/Antiplatelet Drugs</td>
<td><strong>Indicated in post-MI, unstable angina, non-ST segment MI. Prescribe 81 to 325 mg/d in the absence of contraindications.</strong>  &lt;br&gt;<strong>Relative Contraindications:</strong>  &lt;br&gt;- Blood dyscrasias  &lt;br&gt;- Severe hepatic disease  &lt;br&gt;- Active GI Bleeding  &lt;br&gt;<strong>Absolute Contraindications:</strong>  &lt;br&gt;- Hypersensitivity to salicylates  &lt;br&gt;Antiplatelet Drugs (e.g., clopidogrel, dipyridamole, or ticlopidine)  &lt;br&gt;Consider alternative antiplatelet therapy for patients who demonstrate aspirin resistance (e.g., those that experience subsequent cardiovascular events) or those with aspirin hypersensitivity (e.g., contraindication to use of salicylates).</td>
</tr>
<tr>
<td>Anticoagulation Therapy</td>
<td>Consider long-term anticoagulation post-MI for the following patients:  &lt;br&gt;- Post-MI patients who are unable to take aspirin daily* or other antiplatelet agents  &lt;br&gt;- Post-MI patients with persistent atrial fibrillation  &lt;br&gt;- Post-MI patients with left ventricular thrombus  &lt;br&gt;*If patient is receiving antiplatelet therapy, specific formulas contain antithrombin properties that may preclude further anticoagulation requirements.</td>
</tr>
<tr>
<td>Digoxin Use</td>
<td><strong>Indicated in patients with heart failure due to left ventricular systolic dysfunction (EF &lt;35-40%) who are not adequately responsive to ACE inhibitors and diuretics and in patients with atrial fibrillation or who require additional rate control.</strong>  &lt;br&gt;<strong>Precautions and Close Monitoring:</strong>  &lt;br&gt;- Elderly patients  &lt;br&gt;- Patients with impaired renal function</td>
</tr>
</tbody>
</table>
### Outpatient Management of Coronary Artery Disease (continued)

#### MEDICATIONS

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>RECOMMENDATIONS</th>
</tr>
</thead>
</table>
| ACE Inhibitors         | Indicated in post-MI stable high-risk patients (elderly, anterior infarction, previous infarction), CHF, LV dysfunction (EF <40%), hypertension, or diabetes unless contraindicated.**  
Continue indefinitely for all patients with left ventricular systolic dysfunction (EF ≤40%) or symptoms of heart failure.  
Use as needed to manage blood pressure or symptoms in all other patients.  
Contraindications:                                                                                                     |
|                        | - History of intolerance or adverse reaction to ACE inhibitors  
- Elevated levels of serum potassium (K+ >5.5 mEq/L)  
- Renal artery stenosis  
- Symptomatic hypotension  
- Shock  
- Pregnancy                                                                                                             |
|                        | Precautions and Close Monitoring:                                                                                                                                     |
|                        | - SBP <90 mmHg  
- Elevated levels of serum creatinine (Scr >3) or creatinine clearance <30 ml/min                                                                                      |
|                        | **Refer to PHP Diabetic Clinical Practice Guideline.                                                                                                                   |
| Cholesterol-Lowering Agents | • Advise all patients with CAD to follow the AHA Step II diet.                                                                                                           |
|                        | • Patients with LDL levels >130 mg/dL despite the AHA Step II diet should be placed on drug therapy with the goal of reducing LDL to <100 mg/dL.                                                                 |
|                        | • Patients with normal plasma cholesterol levels who have a HDL cholesterol level of <40 mg/dL should receive therapy designed to elevate the HDL level, such as increased physical activity. |

#### TESTS

<table>
<thead>
<tr>
<th>FUNCTION</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventricular Function</td>
<td>Assess LVEF in acute coronary syndrome and coronary disease patients during hospital or outpatient evaluation, if appropriate.</td>
</tr>
<tr>
<td>Stress Test</td>
<td>Perform a stress test in appropriate (i.e., adult patients with an intermediate pretest probability of CAD based on gender, age, and symptoms, undergoing initial evaluation with known CAD, before discharge for prognostic assessment, activity prescription, or evaluation of medical therapy, before and after revascularization) patients, timing to be determined by practitioner.</td>
</tr>
</tbody>
</table>
## Lipid Profile

Perform cholesterol profile at 4-6 weeks following AMI and repeat 3 months following initiation of therapeutic lifestyle changes (TLC) and/or drug management to determine adherence and response to therapy.

**Test in fasting state and include:**
- Total Cholesterol
- Triglycerides
- LDL
- HDL

**Target Values:**
- Cholesterol <200 mg/dL
- Triglycerides <150 mg/dL
- LDL <100 mg/dL
- HDL >40 mg/dL

### Category of CAD risk based on lipoprotein levels in adults:

<table>
<thead>
<tr>
<th>Risk</th>
<th>LDL</th>
<th>HDL</th>
<th>Triglycerides</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>&gt;130 mg/dL</td>
<td>&lt;40 mg/dL</td>
<td>&gt;200 mg/dL</td>
</tr>
<tr>
<td>Borderline</td>
<td>100-129 mg/dL</td>
<td>&gt;60 mg/dL</td>
<td>150-199 mg/dL</td>
</tr>
<tr>
<td>Low</td>
<td>&lt;100 mg/dL</td>
<td>&gt;60 mg/dL</td>
<td>&lt;150 mg/dL</td>
</tr>
</tbody>
</table>

Once cholesterol goal has been achieved, measure lipid profile at least every 4 to 6 months to monitor response and adherence to drug therapy for one year. Long-term monitoring entails annual lipoprotein analyses.

## Psychology Assessment

**Depression Screen**
A high index of suspicion for depression should be maintained. When indicated, formal evaluation should be performed and treatment initiated.

## Education and Counseling

### Smoking Cessation
Assessment of smoking status at each visit.
- All smokers should be counseled on tobacco cessation at each visit. Refer to stop smoking program and if necessary, recommend smoking cessation aids.
- Follow up on progress at each visit.

### Education and Self-Management Principles
This includes:
- Nutrition Counseling
- Weight Management
- Exercise/Physical Activity

- Advise all patients with CAD about symptoms of AMI and instruct how to seek help if symptoms occur.
- Advise patient and family on lower sodium, lower fat, lower cholesterol and higher fiber diet.
- Recommend AHA Step II diet, which is low in saturated fat and cholesterol (<7% of total calories as saturated fat and <200 mg/d cholesterol).
- Advise patient to achieve or maintain healthy weight (BMI of 25.0-30.0 is considered overweight, BMI >30.0 is considered obese).
- Advise patients on the appropriate type, level of intensity, and frequency of a regular exercise/physical activity program (e.g., walking, housework, climbing stairs). For certain patients a referral to a monitored exercise program may be appropriate.
- Advise patient when to return to previous levels of activity, sexual activity, driving, and employment.

### Blood Pressure Control
Monitor BP every office visit.
- Target adults: goal is <140/90 mmHg.
- Preferred goal is ≤ 130/85 mmHg.
Outpatient Management of Coronary Artery Disease (continued)

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>RECOMMENDATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glycemic Control</td>
<td>For patients who are diabetics, quarterly testing is recommended if poorly controlled or if therapy has changed. ** Target HbA1c &lt;7.0% and reevaluate treatment regimen in patients &gt;8.0%. ** Refer to PHP Diabetes Clinical Practice Guideline.</td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>Consider cardiac rehabilitation or a monitored exercise program for those patients who may be at higher risk for infarction or sudden death.</td>
</tr>
</tbody>
</table>

As a guideline, this document is intended to provide information to aid health care providers and is not a substitute for clinical judgement in treating individual patients. It is subject to updates pending the release and review of additional data, based upon changes in scientific knowledge and technology.

References:
Outpatient Management of Congestive Heart Failure
Adopted by the Technology Assessment and Guideline Committee 4/11/02

**PHYSICAL ASSESSMENT**

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>Assess at each visit and review patient’s self-reported daily weight record.</td>
</tr>
<tr>
<td>Jugular venous pressure</td>
<td>Examine the patient for neck vein distention at each visit.</td>
</tr>
<tr>
<td>Cardiac gallop</td>
<td>Assess at each visit and auscultate the heart for a third heart sound.</td>
</tr>
<tr>
<td>Peripheral edema</td>
<td>Examine the patient for signs of edema at each visit.</td>
</tr>
<tr>
<td>Lung sounds</td>
<td>Assess lung sounds for pulmonary rales at each visit.</td>
</tr>
</tbody>
</table>

**PSYCHOLOGICAL ASSESSMENT**

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression Screen</td>
<td>A high index of suspicion for depression should be maintained. Assess regularly and initiate treatment as needed.</td>
</tr>
</tbody>
</table>

**MEDICATIONS**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE inhibitors</td>
<td>Prescribe to all patients with left-ventricular systolic dysfunction (EF &lt;35% to 40%) unless contraindicated or has been shown unable to tolerate treatment.</td>
</tr>
<tr>
<td></td>
<td><strong>Contraindications</strong></td>
</tr>
<tr>
<td></td>
<td>• History of intolerance or adverse reaction to ACE inhibitors (i.e. angioedema, agranulocytosis, acute renal failure)</td>
</tr>
<tr>
<td></td>
<td>• Elevated levels of serum potassium &gt;5.5 mEq/L</td>
</tr>
<tr>
<td></td>
<td>• Renal artery stenosis</td>
</tr>
<tr>
<td></td>
<td>• Symptomatic hypotension</td>
</tr>
<tr>
<td></td>
<td>• Shock</td>
</tr>
<tr>
<td></td>
<td>• Pregnancy</td>
</tr>
<tr>
<td>Hydralazine/nitrate or</td>
<td>Consider prescribing to patients with left ventricular systolic dysfunction who can not tolerate ACE inhibitors. Should not be used for the treatment of heart failure in patients who have no prior use of ACE inhibitors.</td>
</tr>
<tr>
<td>Angiotensin II receptor</td>
<td>blocker</td>
</tr>
<tr>
<td>Diuretic Use</td>
<td>Prescribe to all patients with symptoms of heart failure who have evidence for or a predisposition to fluid retention. Not intended as monotherapy, even if symptoms of heart failure are well controlled, but should generally be combined with an ACEI and a β-blocker.</td>
</tr>
</tbody>
</table>
### Outpatient Management of Congestive Heart Failure (cont.)

<table>
<thead>
<tr>
<th>MEDICATIONS (Cont.)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Spironolactone</strong> Consider prescribing to patients with left ventricular systolic dysfunction (LVEF &lt;35%), with recurrent or NYHA class IV symptoms. Treatment with spironolactone is in addition to standard therapy. Serum potassium concentration should be monitored after the first week of initiation, at regular intervals thereafter and after any change in dose of medications that may effect potassium balance. Spironolactone should be used with caution in patients with impaired renal function and hepatic disease and should be withheld when serum creatinine is greater than 2.5mg/dL.</td>
</tr>
<tr>
<td><strong>Digoxin Use</strong> Consider prescribing to patients to improve the clinical status of heart failure due to left ventricular systolic dysfunction and who have chronic atrial fibrillation. Digoxin should be used in conjunction with diuretics, ACE inhibitors, and β-blockers. Precaution and close monitoring in the elderly and in those with impaired renal function.</td>
</tr>
<tr>
<td><strong>β-blocker Use</strong> All patients with stable NYHA class II or III heart failure due to left ventricular systolic dysfunction (LVEF &lt;35 to 40%) should receive a β-blocker (Carvedilol and Metoprolol are FDA approved for use in heart failure) unless contraindicated or has been shown unable to tolerate treatment. β-blocker therapy should be in addition to pre-existing treatment of an ACE inhibitor and diuretic(s), and may be used together with digoxin or vasodilators. Carvedilol is FDA approved for use in patients with severe heart failure (NYHA class IV). β-blockers should not be used in patients with acutely decompensated heart failure. <strong>Contraindications</strong></td>
</tr>
<tr>
<td>- History of Asthma</td>
</tr>
<tr>
<td>- Severe COPD</td>
</tr>
<tr>
<td>- HR&lt;50 bpm</td>
</tr>
<tr>
<td>- Second or third degree AV block</td>
</tr>
<tr>
<td>- Severe hepatic impairment</td>
</tr>
<tr>
<td>- Hypersensitivity to β-blockers</td>
</tr>
<tr>
<td>- Cardiogenic shock</td>
</tr>
<tr>
<td>- Sick sinus syndrome</td>
</tr>
<tr>
<td>- Raynaud’s syndrome</td>
</tr>
</tbody>
</table>
### MEDICATIONS, CONT.

<table>
<thead>
<tr>
<th>β-blocker Use (cont.)</th>
<th>Precautions and Close Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• IDDM</td>
</tr>
<tr>
<td></td>
<td>• HR&lt;60 bpm</td>
</tr>
<tr>
<td></td>
<td>• PVD</td>
</tr>
<tr>
<td></td>
<td>• SBP &lt;100mmHg</td>
</tr>
<tr>
<td></td>
<td>• P-R interval &gt; .24 seconds</td>
</tr>
</tbody>
</table>

Diuretic dosing should be optimized before and during initiation of β-blocker therapy. β-blocker therapy should be initiated in very low doses followed by gradual increases after initial doses have been well tolerated.

Patients receiving β-blockers should be advised to:

- monitor for evidence of hypotension, bradycardia, fluid retention or worsening heart failure during the titration phase
- side effects may occur during initiation of therapy but do not prevent long term use
- improvement may require 2-3 months of therapy
- β-blocker use is intended as long term therapy
- abrupt discontinuation should be avoided

### TESTS

| Evaluation of ventricular function | Perform echocardiography or other studies to evaluate cardiac structure and function and repeat as clinically indicated. |

### EDUCATION/COUNSELING

<table>
<thead>
<tr>
<th>Routine Weight Monitoring</th>
<th>Educate patient to routinely monitor weight and maintain a weight log. Instruct patient on weight variances that should be reported to the provider.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptom Recognition</td>
<td>Educate patient of symptoms to report to provider that may indicate worsening condition.</td>
</tr>
<tr>
<td>Smoking/Tobacco</td>
<td>Assess smoking status at each visit. All smokers should be counseled on tobacco cessation. Refer to stop smoking program and, if necessary, recommend smoking cessation aids. Follow up on progress at each visit.</td>
</tr>
<tr>
<td>Alcohol</td>
<td>Discourage alcohol use.</td>
</tr>
<tr>
<td>Low sodium diet</td>
<td>Advise patient/caregiver on lower sodium diet. The most commonly recommended limit is 2000 mg of sodium daily. Consider referring to a dietitian if extremely low sodium diet is prescribed or if patient/caregiver fails to adhere to diet after initial instructions.</td>
</tr>
<tr>
<td>Activity and exercise</td>
<td>Advise patient to follow an appropriate exercise regimen. Encourage regular exercise. Counsel on recreation, leisure, and work activity. Address sexual activity, sexual difficulties, and coping strategies.</td>
</tr>
</tbody>
</table>

This guideline is intended to provide information to aid health care providers and it is not a substitute for clinical judgment in treating individual patients. It is subject to updating pending the release and review of additional data, based upon changes in scientific knowledge and technology.
Outpatient Management of Congestive Heart Failure (cont.)

References:


## Major Depressive Disorder Guidelines
*Adopted by the Technology Assessment Guideline Committee 4/12/01*

<table>
<thead>
<tr>
<th>INTERVENTION</th>
<th>RECOMMENDATION</th>
</tr>
</thead>
</table>
| Stage I: Acute Phase: Assessment and Treatment Planning (1-2 visits) | • Make diagnosis using DSM-IV criteria  
• Possible alternative diagnoses have been ruled out  
• Assess complaint severity, suicide/homicide risk  
• Obtain history (previous episodes, family history, precipitating factors)  
• Assess current and previous substance abuse  
• Reassure and educate patient and family that condition is medical and progress is good with treatment  
• Empirical trial of antidepressant medication should be considered with regular assessment as needed. Symptomatic response expected within 4-6 weeks  
• Evaluate patient for depression caused by concurrent medical disorder (such as hypothyroidism):  
  • Treat optimally the general medical condition and re-evaluate  
  • Consider concurrent treatment of depression |
| Stage I: Acute Phase: Medication Treatment | • Patients with moderate to severe or melancholic symptoms, psychosis, elevated suicide or homicide risk need medication  
• Selection of antidepressant depends on:  
  • Short/long term side effects  
  • Prior response to medication  
  • First-degree relatives’ responses to medication  
  • Concurrent medical illness  
  • Concomitant non-psychotropic medications  
  • Likelihood of adherence based on history  
  • Type of depression  
  • Effectiveness if given once/day vs. multiple times/day  
  • Interference in life style from treatment  
  • Cost of medication  
  • Consideration of patient concerns |
| Stage I: Acute Phase: Consideration for Addition of Psychotherapy | • Consider adding psychotherapy for those with:  
  • Chronic depression  
  • Poor inter-episode recovery  
  • History of chronic psychosocial problems, in and out of depressive periods.  
  • History of treatment adherence problems  
• If the patient has additional non-mood mental disorder, consult with a psychiatrist regarding treatment options - transfer to psychiatrist or obtain ongoing consultation |
### Major Depressive Disorder Guidelines (cont’d.)

<table>
<thead>
<tr>
<th>INTERVENTION</th>
<th>RECOMMENDATION</th>
</tr>
</thead>
</table>
| **Stage I: Acute Phase:**  
Repeat Evaluation  
Every 4-6 Weeks  
During Months 1-3 | • Frequency of visits depends on severity of symptoms  
• If little or no symptomatic relief by 6 weeks (4 weeks if severely ill):  
  • Reassess diagnosis  
  • Reassess adequacy of treatment  
• Recommended options:  
  • Assess adequacy of dosage and compliance  
  • Continue medication at corrected dose  
  • Discontinue first medication and start another  
  • Switching antidepressant medication is preferred to augmentation and should not be attempted until there has been an adequate trial of first medication  
  • Add adjunctive treatment (augment with a second medication)  
  • Addition of psychotherapy  
• If some symptoms persist, do not change medication - re-evaluate at week 12  
  • Consider referral to psychiatrist if:  
    • Failure to respond fully to two or more adequate trials of antidepressant medications  
    • Symptoms are intense, prolonged, or severely melancholic  
    • Marked functional impairment  
    • Psychotic symptoms are present  
    • Clinical need for immediate response  
    • Suicide/homicide risk persists or emerges |
| **Stage II: Continuation Phase (4-9 Months)** | • Educate patient and support system that symptoms can recur  
• Objective is to decrease likelihood of relapse and relieve persisting symptoms  
• Dosage remains the same for 4-9 months after achieving full remission  
• For those with previous episode(s), continuation of treatment should be for at least 9 months  
• Evaluate every 1-3 months  
• Patients at high risk for relapse (e.g., history of 3 or more depressive episodes, persistent residual symptoms) should be considered for Stage III maintenance |
| **Stage III: Maintenance Phase (Indefinite Length)** | • Educate patient that symptoms can recur  
• Objective is to prevent new episodes  
• Low risk patient (Major Depressive Disorders, recurrent with 2 or fewer episodes) should be considered for discontinuation with tapering and with careful monitoring for relapse.  
• Those with 3 or more episodes of MDD are appropriate for maintenance  
• Consultation with a psychiatrist should be considered for patients needing maintenance therapy  
• Psychotherapy generally not useful at this stage unless patient unable to take medication |

**References**  
# Diabetes Management Guideline

*Adopted by the Technology Assessment and Guideline Committee 4/11/02*

## ROUTINE EXAMINATION

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>RECOMMENDATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Visits</strong></td>
<td>Individuals with diabetes should be seen at least quarterly until achievement of treatment goals. Thereafter, frequency may decrease as long as patient continues to meet goals. More frequent visits are required if not meeting glycemic target, or BP control, or have evidence of microvascular or macrovascular complications, or/and undergoing intensive insulin therapy.</td>
</tr>
</tbody>
</table>
| **Blood Pressure Testing and Control** | Every routine visit – at least semi-annually
- Target adults: goal is BP ≤130/80
- Children: correlate to age-adjusted 90th percentile |
| **Weight** | Every routine diabetes visit
- Children: target age-related normative values |
| **Foot Examination** | Visual inspection at every contact with health care professional is recommended.
- Annual examination should be performed to identify high-risk foot conditions. A comprehensive assessment should include: protective sensation, foot structure and biomechanics, neurological, vascular status, and skin integrity. Neurological status includes quantitative somatosensory threshold test using monofilament or vibratory sensation.
- A multidisciplinary approach is recommended for persons with foot ulcers and high risk feet, especially those with a history or prior ulcer or amputation. |
| **Retinal Eye Examination (cont.)** | Comprehensive dilated examination by ophthalmologist or optometrist knowledgeable and experienced in management of diabetic retinopathy is recommended.
- Initial testing is recommended:
  - Within 3-5 years after diagnosis of Type 1 diabetes once patient is 10 years of age or older
  - At time of (or shortly after) diagnosis of Type 2 diabetes
  - Prior to conception and during 1st trimester of pregnancy, for women with pre-existing diabetes
- Annual testing is recommended for both Type 1 and Type 2 diabetic patients thereafter. Abnormal findings necessitate more frequent follow up. |
| **Depression** | Probe for emotional/physical factors linked to depression routinely; treat aggressively with counseling, medication and/or referral. |
## Diabetes Management Guidelines (cont.)

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>RECOMMENDATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preconception Counseling</td>
<td>Preconception counseling is recommended to all women of childbearing age in order to optimize self-management skills. In particular, A1C test levels that are &lt;1% above the normal range are desirable.</td>
</tr>
<tr>
<td>Hemoglobin A1C (A1C) A1C Testing and Control</td>
<td>A1C testing is recommended at initial visit and at least two times per year thereafter in diabetics with stable glycemic control. Quarterly testing is recommended for patients who are poorly controlled or whose therapy has changed. Target goal &lt; 7.0% and reevaluate treatment regimen in patients &gt;8%</td>
</tr>
<tr>
<td>Proteinuric Screening</td>
<td>Microalbuminuria screening is recommended for:</td>
</tr>
<tr>
<td></td>
<td>• Type 1 diabetic individuals - to begin at puberty and &gt; 5 years diabetes duration</td>
</tr>
<tr>
<td></td>
<td>• Type 2 diabetic individuals – to begin at the time of diagnosis</td>
</tr>
<tr>
<td></td>
<td>Thereafter, annual microalbuminuria screening is recommended in place of routine urinalysis, in the absence of previously diagnosed proteinuria.</td>
</tr>
<tr>
<td></td>
<td>Definitions of abnormalities in albumin excretion:</td>
</tr>
<tr>
<td><strong>Category</strong></td>
<td><strong>24-h collection (mg/24 h)</strong></td>
</tr>
<tr>
<td>Normal</td>
<td>&lt;30</td>
</tr>
<tr>
<td>Microalbuminuria</td>
<td>30-299</td>
</tr>
<tr>
<td>Clinical albuminuria</td>
<td>≥ 300</td>
</tr>
<tr>
<td>Two of three specimens collected within a 6 month period should be abnormal before considering a patient to have crossed one of these diagnostic thresholds.</td>
<td></td>
</tr>
</tbody>
</table>

### ROUTINE TESTING

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>RECOMMENDATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lipid Testing and Control</td>
<td>At least annually and more often if needed. However, in adults with low-risk lipid values, it is acceptable to repeat lipid assessment every 2 years.</td>
</tr>
<tr>
<td></td>
<td>In children &gt; 2 years of age, after diagnosis and when glucose control is established; if values are considered low risk and there is no family history then repeat testing can be every 5 years.</td>
</tr>
<tr>
<td></td>
<td>Target Values:</td>
</tr>
<tr>
<td></td>
<td>• Cholesterol &lt; 200 mg/dL</td>
</tr>
<tr>
<td></td>
<td>• Triglyceride &lt; 150 mg/dL</td>
</tr>
<tr>
<td></td>
<td>• LDL &lt; 100 mg/dL</td>
</tr>
<tr>
<td></td>
<td>• HDL &gt; 45 mg/dL men and &gt;55 mg/dL women</td>
</tr>
<tr>
<td></td>
<td><em>Refer to PHP Outpatient Management of Coronary Artery Disease guideline</em></td>
</tr>
</tbody>
</table>
## Diabetes Management Guidelines (cont.)

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>RECOMMENDATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Immunizations</strong></td>
<td>Influenza – Annually for individuals with diabetes, age &gt; 6 months with a competent immune system. It should not be given to individuals with hypersensitivity to chicken eggs or additional components of the vaccine. Pneumovax – All individuals with diabetes. Immunization is once per lifetime with a revaccination for individuals ≥ 65 years who were previously immunized when they were less than 65 years and if the vaccine was administered more than 5 years ago.</td>
</tr>
</tbody>
</table>
| **Testing for Coronary Heart Disease** | Cardiovascular risk factors should be assessed at least annually. Risk factors include: dyslipidemia, hypertension, smoking, a positive family history of premature coronary disease, presence of micro-/macroalbuminuria. In patients without prior history of an event or symptoms strongly suggesting CHD, screening exercise stress testing is warranted for diabetic patients with the following:  
  - Typical or atypical cardiac symptoms  
  - Abnormal Resting EKG  
  - History of peripheral or carotid occlusive arterial disease  
  - Sedentary lifestyle, age ≥ 35 years and plans to begin vigorous exercise program  
  - Two or more risk factors listed above  
 Patients with abnormal exercise ECG and patients unable to perform an exercise ECG require additional/alternative testing. Type of testing and need for referral to a cardiologist depend on severity of underlying or suspected disease. |
| **Diabetic Agents**    | Insulin and oral hypoglycemic therapy selection based on recommendations of PHP National Pharmacy and Therapeutics Committee.                                                                                   |

## MEDICATIONS

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>RECOMMENDATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetic Agents</strong></td>
<td>Insulin and oral hypoglycemic therapy selection based on recommendations of PHP National Pharmacy and Therapeutics Committee.</td>
</tr>
</tbody>
</table>
| **Anti-hypertensive Agents** | Initial drug therapy for hypertension may be with ACE inhibitors, ARBs, beta-blockers, or diuretics. Additional drugs may be chosen from these classes or another drug class.  
In patients over age 55 years, with hypertension or without hypertension but with another cardiac risk factor (history of cardiovascular disease, dyslipidemia, microalbuminuria, smoking), an ACE inhibitor (if not contraindicated) should be considered to reduce the risk of cardiovascular events. |
## Diabetes Management Guidelines (cont.)

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>RECOMMENDATION</th>
</tr>
</thead>
</table>
| ACE Inhibitor/ARBs Use for Proteinuria | In the treatment of albuminuria/nephropathy, both ACE inhibitors and ARBs can be used:  
  - In hypertensive and nonhypertensive type 1 diabetics with microalbuminuria or clinical albuminuria, ACE inhibitors are the initial agents of choice  
  - In hypertensive type 2 diabetics with microalbuminuria or clinical albuminuria, either ACE inhibitors or ARBs can be used  
  - If one class is not tolerated, the other should be substituted  
If ACE Inhibitors or ARBs are used, monitor serum potassium levels for the development of hyperkalemia.  
Captopril is the only ACE inhibitor approved by the FDA for the treatment of diabetic nephropathy; the effect of ACE inhibitors appear to be a class effect, so choice of agent may depend on cost and compliance issues. There are no ARBs approved by the FDA for diabetic nephropathy. |
| Aspirin Use | Use aspirin therapy in individuals with diabetes who have evidence of large vessel disease. Consider aspirin therapy as a primary prevention strategy in high-risk men and woman age >30 with Type 1 or 2 diabetes and other cardiovascular risk factors. Use enteric-coated aspirin in doses of 81-325 mg/day. |
| Education and Self-management Principles | Initially  
  - Medical Nutrition Therapy (MNT)  
  - Exercise/Physical Activity  
  - Weight Management  
  - Self-monitoring of Blood Glucose (SMBG)  
Each routine visit  
Assessment to include:  
Annually to include:  
MNT: People with diabetes should receive individualized MNT as needed to achieve treatment goals, preferably provided by a registered dietitian  
Physical Activity: A regular physical activity program, adapted to any complications, is recommended for all patients with diabetes who are capable of participating  
SMBG: Instruct the patient in SMBG and routinely evaluate the patient’s technique and ability to use data to adjust therapy  
  - Status  
  - Compliance  
  - Nutrition and exercise regimen  
  - Diabetes knowledge  
  - Self-management skills |
Diabetes Management Guidelines (cont.)

References


March 2003
Diabetes Management Guidelines (cont.)


---

**Outpatient Management of Asthma**
*Adopted by the Technology Assessment and Guideline Committee 10/10/02*

<table>
<thead>
<tr>
<th>ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency of visits</strong></td>
</tr>
<tr>
<td>Schedule regular visits, every 1-6 months.</td>
</tr>
<tr>
<td><strong>At each regular or unplanned visit, assess:</strong></td>
</tr>
<tr>
<td><strong>Signs &amp; Symptoms</strong></td>
</tr>
<tr>
<td>Signs and symptoms of asthma</td>
</tr>
<tr>
<td><strong>Pulmonary Function</strong></td>
</tr>
<tr>
<td>Lung sounds, respiratory status and peak flow</td>
</tr>
<tr>
<td>Use appropriate reference populations for adolescents</td>
</tr>
<tr>
<td><strong>Functional Status</strong></td>
</tr>
<tr>
<td>Quality of life/ functional status (missed school/ work, reduced activity, sleep disturbances)</td>
</tr>
<tr>
<td><strong>Medications</strong></td>
</tr>
<tr>
<td>Usage, understanding, compliance and technique</td>
</tr>
<tr>
<td><strong>Exacerbation History</strong></td>
</tr>
<tr>
<td>History of exacerbations since last visit</td>
</tr>
<tr>
<td><strong>Severity</strong></td>
</tr>
<tr>
<td>Classify Asthma Severity (See attachments A, B)</td>
</tr>
<tr>
<td><strong>Referral to Specialist (Pulmonologist, Allergist)</strong></td>
</tr>
<tr>
<td>Recommended for patients &gt; 3 yrs of age if there are difficulties achieving or maintaining control of asthma or if the patient requires step 4 care. <em>Consider</em> for patients who require step 3 care. Recommended for patients &lt; 3 yrs of age if the child requires step 3 or 4 care. <em>Consider</em> if the child requires step 2 care</td>
</tr>
<tr>
<td><strong>Psychosocial</strong></td>
</tr>
<tr>
<td>For patients with significant psychiatric, psychosocial, or family problems that interfere with therapy, consider a Mental Health referral</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TESTING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Spirometry</strong></td>
</tr>
<tr>
<td>Spirometry is recommended</td>
</tr>
<tr>
<td>(1) at the time of initial assessment,</td>
</tr>
<tr>
<td>(2) after treatment is initiated and symptoms and PEF have stabilized,</td>
</tr>
<tr>
<td>(3) at least every 1 to 2 years,</td>
</tr>
<tr>
<td>(4) to evaluate the response to change in therapy</td>
</tr>
</tbody>
</table>
### Outpatient Management of Asthma (cont.)

| **Peak Flow Monitoring** | Monitor Peak Expiratory Flow (PEF) at each routine visit. Useful for patients generally > 5 yrs old  
• Instruct patients how to establish their personal best PEF and use as the basis for their action plan.  
• Check technique every visit.  
 Short-term monitoring (twice daily for 2-3 weeks):  
• to establish the patient’s personal best PEF;  
• evaluate response to therapy changes;  
• identify relationship between changes in PEF and exposure to irritants or allergens;  
• during exacerbations  
 Long-term daily monitoring is recommended for patients with:  
• moderate-to-severe persistent asthma,  
• poor symptom perception,  
• a history of severe exacerbations  
For patients with asthma symptoms but normal spirometry, assessment of diurnal variation in PEF over 1-2 weeks is recommended |
| **Allergens** | For patients with persistent asthma, consider skin testing or in vitro testing to assess sensitivity to perennial indoor allergens. Immunotherapy may be appropriate for some patients. |

### MEDICATIONS

Severity determines treatment. See: Stepwise Approach to Managing Asthma - Attachment A (Adults and Ages ≥5yrs), Attachment B (Infants & children ≤ 5 yrs)

| **Stepwise Approach** | Use a Stepwise Approach to gain and maintain control  
To gain control, either  
1) start with high-dose therapy and step down (*preferred*) or  
2) start at appropriate step and gradually step-up therapy  
Gain control as quickly as possible, then step down treatment to the least medication necessary to maintain control  
Monitor to ensure that control is achieved |
| **All Asthmatics** | Need an inhaled short-acting beta2-agonist for exacerbations. |
| **Persistent Asthma** | Requires both long-term control and quick relief medications |
| **Intermittent Asthma** | No daily long-term control medications  
Quick relief medications: Short acting inhaled beta2- agonists as needed to treat symptoms  
Inhaled beta2- agonists, cromolyn or nedocromil shortly before exercise (5-15 mins) for Exercise Induced Bronchospasm (EIB) |
### Outpatient Management of Asthma (cont.)

| Steroids  | Inhaled corticosteroids (ICS) are the most potent inhaled anti-inflammatory agent; most effective long-term therapy for persistent asthma. ICS are well tolerated and safe at the recommended dosages. Before increasing ICS dose, add-on therapy with another class of controller is preferred. Higher doses of ICS may be associated with possible, but not predictable, growth retardation (children) and systemic effects.  
  - Local adverse effects: Oral candidiasis, dysphonia, reflex cough and bronchospasm  
  - Use Spacer/holding chamber, and mouth washing after use, to decrease local side effects and systemic absorption  
  - For children, monitor growth  
  - For postmenopausal women, consider calcium and Vitamin D supplements; ERT where appropriate |
| Non Steroid | Long-acting inhaled beta2-agonists: Adjunctive therapy to ICS for maintaining control. Also prevents exercise-induced bronchospasm (EIB).  
  - Does not replace anti-inflammatory therapy  
  - Do not use to treat acute symptoms or exacerbations  
  - Inhaled are longer acting and have fewer side effects than oral sustained release beta2-agonists |
|            | Cromolyn Sodium and Nedocromil: Anti-inflammatory agents with sound safety profiles.  
  - Can be used as preventive treatment prior to exercise or unavoidable exposure to known allergens  
  - Clinical response is less predictable than response to ICS |
|            | Leukotriene modifiers: Although further clinical study is needed to establish role in therapy, may be considered as an alternative to low-dose ICS for long-term control of mild persistent asthma; alternative adjunctive therapy for moderate:  
  - Montelukast: adults and children ≥2yrs  
  - Zafirlukast: adults and children ≥ 5 yrs  
    - Monitor prothrombin times closely for patients receiving zafirlukast and warfarin  
  - Zilueton: adults and children ≥12yrs  
    - Liver enzyme monitoring is recommended with Zilueton; monitor warfarin, propanolol and theophylline dosing |
### Mediation Class: Initial Relief Medications

<table>
<thead>
<tr>
<th>Non Steroid</th>
<th>Methylxanthines: (Theophylline)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sustained release theophylline as adjuvant to ICS for long-term control and prevention of symptoms, especially nocturnal symptoms</td>
<td></td>
</tr>
<tr>
<td>• Monitor serum concentration routinely due to significant toxicities</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Short-acting inhaled beta2-agonists</th>
<th>Short-acting inhaled beta2-agonists (IBA) are the most effective medication for relieving acute bronchospasm; drug of choice for acute symptoms and exacerbations, and preventing EIB</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increasing use or the use of &gt;1.2 beta2-agonist canisters/month may indicate inadequate control</td>
<td></td>
</tr>
<tr>
<td>• Regularly scheduled, daily use of short-acting beta2-agonists is generally not recommended</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Systemic Corticosteroids</th>
<th>Systemic corticosteroid, for moderate to severe exacerbations. Use at lowest effective dose. Continue short-term therapy until patient achieves 80% PEF personal best or symptoms resolve (usually 3-10 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential adverse side-effects are generally not observed during short course of therapy. Time to action: 2-3 hours.</td>
<td></td>
</tr>
</tbody>
</table>

| Anticholinergic | Ipratropium bromide may provide some additive benefit to inhaled beta2-agonists in severe asthma exacerbations. Alternative bronchodilator for patients who do not tolerate inhaled beta2-agonists. Time to action: 45 minutes. |

| Influenza Vaccine | Recommended annually for patients with persistent asthma |

### Varicella Vaccine

- Recommended for:
  - children ≥12months (See Preventive Health Guidelines)
  - children requiring episodic systemic corticosteroid therapy and who have not had clinical varicella

- Do not administer to patients on immunosuppressive doses, unless the dosage is discontinued for >1 month

### OTHER

<table>
<thead>
<tr>
<th>Aerosol Delivery Devices</th>
<th>MDI: For &gt; 5yrs old. (&lt; 5 yrs old with spacer/holding chamber and face mask for some children)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breath-actuated MDI:</td>
<td>For &gt;5yrs old</td>
</tr>
<tr>
<td>DPI:</td>
<td>Most consistent effects with &gt;5yrs. May use for 4 yr olds</td>
</tr>
<tr>
<td>Spacer/Holding Chamber:</td>
<td>For &gt; 4yrs old; ≤4yrs, with a spacer/face mask. Recommend use with ICS by MDI</td>
</tr>
<tr>
<td>Nebulizer with face mask:</td>
<td>For ≤2yrs and patients who cannot use other devices. Delivery method of choice for Cromolyn</td>
</tr>
</tbody>
</table>

- Optimal inhaler technique > 5 yrs old: Either open mouth with inhaler 1-2” away or with spacer/holding chamber
- Children’s ability to use different devices may vary considerably. Tailor the delivery device to the child.
Outpatient Management of Asthma (cont.)

<table>
<thead>
<tr>
<th>EXACERBATIONS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Exacerbations</td>
<td>Severity determines the treatment. Primary therapies include</td>
</tr>
<tr>
<td></td>
<td>• Repetitive administration of short-acting beta2-agonist</td>
</tr>
<tr>
<td></td>
<td>• Early introduction of systemic corticosteroids</td>
</tr>
<tr>
<td></td>
<td>• Oxygen supplementation</td>
</tr>
<tr>
<td></td>
<td>Rapid deterioration can occur. Special attention is required for:</td>
</tr>
<tr>
<td></td>
<td>• Patients at high risk for asthma-related death</td>
</tr>
<tr>
<td></td>
<td>• Infants, due to greater risk for respiratory failure</td>
</tr>
<tr>
<td></td>
<td>Early treatment, according to a written action plan to guide self-</td>
</tr>
<tr>
<td></td>
<td>management, is especially important for patients with moderate to</td>
</tr>
<tr>
<td></td>
<td>severe persistent asthma</td>
</tr>
<tr>
<td>Exacerbations due to Viral Illness</td>
<td>Mild symptoms: Consider Inhaled Beta2-agonist q4-6 hrs x24hrs, or</td>
</tr>
<tr>
<td></td>
<td>longer as needed.</td>
</tr>
<tr>
<td></td>
<td>• If therapy needs to be repeated more than q6 weeks, a step-up</td>
</tr>
<tr>
<td></td>
<td>in long-term care is recommended</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EDUCATIONAL AND COUNSELING</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Education &amp; Self-management</td>
<td>Teach self-management, and reinforce at <em>every</em> opportunity:</td>
</tr>
<tr>
<td></td>
<td>• Basic facts about asthma</td>
</tr>
<tr>
<td></td>
<td>• Roles of medications</td>
</tr>
<tr>
<td></td>
<td>• Skills: inhaler/spacer/holding chamber use, self-monitoring</td>
</tr>
<tr>
<td></td>
<td>• Environmental and control measures</td>
</tr>
<tr>
<td></td>
<td>• When and how to take rescue actions</td>
</tr>
<tr>
<td>Children ≥ 2 yrs old can begin learning about their asthma.</td>
<td></td>
</tr>
<tr>
<td>Allergens and Irritants</td>
<td>Counsel all patients with asthma to avoid:</td>
</tr>
<tr>
<td></td>
<td>• Exposure to allergens to which they are sensitive.</td>
</tr>
<tr>
<td></td>
<td>• Exposure to environmental tobacco smoke.</td>
</tr>
<tr>
<td></td>
<td>• Exertion when levels of air pollution are high.</td>
</tr>
<tr>
<td></td>
<td>• Use of beta-blockers.</td>
</tr>
<tr>
<td></td>
<td>• Sulfite-containing and other foods to which they are sensitive</td>
</tr>
<tr>
<td>Other factors that can contribute to asthma severity: rhinitis, sinusitis,</td>
<td>Counsel adult patients with severe persistent asthma, nasal</td>
</tr>
<tr>
<td>GERD, some medications, viral respiratory infections.</td>
<td>polyps, or a history of sensitivity to aspirin or nonsteroidal</td>
</tr>
<tr>
<td></td>
<td>anti-inflammatories regarding the risk of severe and even fatal</td>
</tr>
<tr>
<td></td>
<td>exacerbations from using these drugs.</td>
</tr>
<tr>
<td>Action Plan</td>
<td>The use of written self-management (action) plans has been shown</td>
</tr>
<tr>
<td></td>
<td>to reduce morbidity with both adults and children.</td>
</tr>
<tr>
<td></td>
<td>Develop a written Action Plan with all asthmatic patients to</td>
</tr>
<tr>
<td></td>
<td>guide:</td>
</tr>
<tr>
<td></td>
<td>• Self-management,</td>
</tr>
<tr>
<td></td>
<td>• Recognition of early signs,</td>
</tr>
<tr>
<td></td>
<td>• Appropriate intensification of therapy,</td>
</tr>
<tr>
<td></td>
<td>• Removal or allergic or irritant precipitants, and</td>
</tr>
<tr>
<td></td>
<td>• Prompt communication between patient and clinician</td>
</tr>
<tr>
<td></td>
<td>Base the written action plan on signs and symptoms and/or PEF.</td>
</tr>
<tr>
<td></td>
<td>Instruct patient how to use their plan.</td>
</tr>
<tr>
<td></td>
<td>For patient education, using the “traffic signal” Peak Flow Zone</td>
</tr>
<tr>
<td></td>
<td>system for Action Plans, with specific instructions for action in</td>
</tr>
<tr>
<td></td>
<td>each zone, may facilitate the patient’s self-management:</td>
</tr>
</tbody>
</table>
### Outpatient Management of Asthma (cont.)

| Action Plan (cont.) | • Green Zone (80-100% of personal best) = Good control  
|• Yellow Zone (e.g. 60-<80%) = Caution  
|• Red Zone (e.g. <60%) = Danger. Medical Alert  
|Caretakers of children with asthma (teachers, coaches, sitters, etc) should have a copy and understand the action plan. 
|Provide appropriate patients with a daily asthma diary  
|Smoking | Advise patients not to smoke, and to avoid smoke exposure. Tobacco smoke is a major precipitant of asthma symptoms in children and adults  
|Antibiotics | Not recommended for treatment of acute asthma exacerbations except as needed for comorbid conditions  
|Beta Blockers | Nonselective beta blockers can cause asthma symptoms in 25% of asthmatic patients who take them and thus nonselective beta blockers should be avoided with asthma patients  
|MAOI’s | Avoid sympathomimetic bronchodilators.  
|Children | **Infants and Young Children:**  
|Diagnosis in infants can be difficult.  
|• Assess difficulty breathing, changes in respiration rate, altered sleep patterns, retractions, irritability, lethargy, decreased appetite, weight loss.  
|• Consider a diagnostic trial of inhaled bronchodilators and anti-inflammatory medication  
|Consider long-term control therapy for: >3 wheezing episodes in the past yr that lasted > 1 day and affected sleep and risk factors for development of asthma present  
|• Risk factors: parental history of asthma or diagnosis of atopic dermatitis or 2 of a) diagnosed allergic rhinitis, b) wheezing apart from colds, c) peripheral blood eosinophilia  
|**School-age Children and Adolescents:**  
|Instruct parents and child in use of all medications, devices.  
|Provide a written asthma management plan for the student’s school (including action plan, long-term control medication and prevention of EIB if appropriate, and trigger factors to avoid)  
|Promote active participation in physical activities, exercise, and sports. Older children should be allowed to carry and self-administer quick relief medications (with physician and parent approval)  
|Older Adults | Due to a high prevalence of other obstructive lung diseases, a 2-3 week trial of systemic steroids will determine disease reversibility  
|• Asthma medications may have increased adverse effects in the elderly; adjust as needed  
|• Medications for other diseases may exacerbate asthma  
|Pregnancy | Adequate control is essential during pregnancy. For most drugs used to treat asthma and rhinitis, there is little to suggest an increased risk to the fetus. (except brompheniramine, epinephrine, and alpha-adrenergic compounds)  

### Managing Special Situations

**Seasonal Asthma:** Treat according to the step-wise approach for long-term management.

**Cough Variant:** Seen especially in young children. Cough is the principal symptom, occurring frequently at night. Monitor day and afternoon PEF. Therapeutic trials with ICS or bronchodilator may be helpful in diagnosis. Treat according to step-wise approach to long-term management of asthma. Prolonged night cough may also be due to allergic rhinitis, sinusitis, GERD

**Exercise-Induced Bronchospasm (EIB):** Anticipate in all asthma patients. Teachers and coaches should be notified that a child has EIB. Recommended treatment is inhaled beta2-agonists (effective with 80% of patients), cromolyn sodium or nedocromil shortly before exercise (5-15 minutes).

**Surgery:** Evaluation before surgery should include review of symptoms, medication use, and measurement of pulmonary function. Attempt to improve lung function to predicted values or personal best. If systemic corticosteroids received during past 6 months, hydrocortisone IV should be given during surgical period.

---

This guideline is intended to provide information to aid health care providers and it is not a substitute for clinical judgement in treating individual patients. It is subject to updating pending the release and review of additional data, based upon changes in scientific knowledge and technology

### References

American Psychiatric Association: Practice Guideline for the Treatment of Patients with Major Depressive Disorder (Revision). American Journal of Psychiatry 2000; 157 (April supplement)


Rachelefsky GS, Shapiro G, Bergman D, et al. Pediatric Asthma: Promoting Best Practice. 1999 Milwaukee, Wis; American Academy of Allergy, Asthma and Immunology Inc; 1999
Stepwise Approach to Managing Asthma Long Term for Adults and Children > 5 years old

Step 1
Mild Intermittent
(PEF ≥80% Predicted)
PEF variability < 20%

- Symptoms ≤2 days/week
- Nocturnal symptoms ≤ 2 nights/month
- Asymptomatic and normal PEF between exacerbations
- Exacerbations brief (from a few hours to a few days); intensity may vary

Step 2
Mild-Persistent
(PEF ≥80% Predicted)
PEF variability 20-30%

- Symptoms > 2/week but < 1x/day
- Nocturnal symptoms 3-4/ month
- Exacerbations may affect activity

Step 3
Moderate-Persistent
(PEF >60-<80% Predicted)
PEF variability >30%

- Daily symptoms
- Nocturnal symptoms > 1x/wk
- Daily use of inhaled short-acting beta2-agonist
- Exacerbations affect activity
- Exacerbations ≥ 2 times a week; may last days

Step 4
Severe-Persistent
(PEF ≤60% Predicted)
PEF variability >30%

- Continual symptoms
- Frequent nocturnal symptoms
- Limited physical activity
- Frequent exacerbations

Therapy*
Quick Relief:
Inhaled beta2-agonist as needed (<2 times/week)**

Long Term Control:
No daily Long-term control medication needed
(Severe exacerbations may occur separated by long periods of normal lung function and no symptoms. Recommended: Course of systemic corticosteroids)

**Except when used for exacerbations due to exercise-induced bronchospasm (EIB) or viral infection

Therapy*
Quick Relief: Short-acting inhaled beta2-agonist as needed
AND Long Term Control, daily:
- Inhaled corticosteroid (low dose) (preferred)
  Alternative Therapy
  - Cromolyn sodium
  OR
  - Nedocromil
  OR
  - Leukotriene Modifier
  OR
  - Sustained release theophylline (to serum concentration of 5-15 mcg/mL)

Education*
- Teach basic facts about asthma
- Teach inhaler/spacer/holding chamber technique
- Discuss roles of medications
- Develop self-management plan
- Develop action plan for when and how to take rescue actions, especially for patients with a history of severe exacerbations
- Discuss appropriate environmental control measures to avoid exposure to known allergens and irritants

Step Down
Review treatment every 1 to 6 months; a gradual stepwise reduction in treatment may be possible.

Step Up
If control is not maintained, consider step up. First, review patient medication technique, adherence, and environmental control (avoidance of allergens or other factors that contribute to asthma severity).

* All therapy should include patient education about prevention (including environmental control where appropriate) as well as control of symptoms.

Education*
Step 1 actions plus:
- Teach self-monitoring/peak flow meter use
- Refer to group education if available, consider asthma specialist
- Review and update self-management plan

Education*
Steps 2 and 3 actions plus:
- Refer to individual education counseling, asthma specialist

March 2003 139
Attachment B
Stepwise Approach to Managing Infants and Children 0-5 years old with Acute or Chronic Asthma

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Mild Intermittent (PEFR &gt;80% Predicted)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Symptoms ≤ 2 days/week</td>
</tr>
<tr>
<td></td>
<td>• Nocturnal symptoms ≤ 2 nights/month</td>
</tr>
<tr>
<td></td>
<td>• Asymptomatic and normal PEF between</td>
</tr>
<tr>
<td></td>
<td>• Exacerbations brief (from a few</td>
</tr>
<tr>
<td></td>
<td>hours to a few days); intensity may</td>
</tr>
<tr>
<td></td>
<td>vary</td>
</tr>
</tbody>
</table>

**Step 2**
Mild-Persistent (PEFR >80% Predicted)

|        | • Symptoms > 2/week but < 1/day       |
|        | • Nocturnal symptoms 3-4 nights/month |
|        | • Exacerbations may affect activity   |

**Step 3**
Moderate-Persistent (PEFR 60-80% Predicted)
Poor symptom control with Step 2

|        | • Daily symptoms                      |
|        | • Nocturnal symptoms ≥ 1 night/week   |
|        | • Daily use of inhaled short-acting   |
|        | • Exacerbations affect activity        |

**Step 4**
Severe-Persistent (PEFR <60% Predicted)

|        | • Continual symptoms                  |
|        | • Frequent nocturnal symptoms         |
|        | • Limited physical activity           |
|        | • Frequent exacerbations              |

**Therapy**
Quick Relief: Inhaled short-acting beta2-agonist as needed (<2x/day) AND
Long Term Control, daily:
• Inhaled corticosteroid (low dose) with nebulizer or MDI with spacer/holding chamber and face mask (preferred)
  Alternative Therapy
• Cromolyn sodium (nebulizer preferred; or MDI)
• Leukotriene receptor antagonist

**Therapy**
Quick Relief: Inhaled short-acting beta2-agonist as needed (<3x/day) AND
Long Term Control, daily:
• Inhaled corticosteroid (medium dose) as monotherapy (preferred)
  OR
• Inhaled corticosteroid (low dose) AND long-acting inhaled beta2-agonist (preferred)
  Alternative Treatment
• Inhaled corticosteroids (low dose) and either leukotriene receptor antagonist or theophylline

**Education**
• Teach basic facts about asthma
• Teach inhaler/spacer/holding chamber technique
• Discuss roles of medications
• Develop self-management plan
• Develop action plan for when and how to take rescue actions, especially for patients with a history of severe exacerbations
• Discuss appropriate environmental control measures to avoid exposure to known allergens and irritants
• Consider asthma specialist referral for children < 3 yrs for Step 2 Care

**Step Down**
Review treatment every 1 to 6 months; a gradual stepwise reduction in treatment may be possible.

**Step Up**
If control is not maintained, consider step up. First, review patient medication technique, adherence, and environmental control (avoidance of allergens or other factors that contribute to asthma severity).

* All therapy should include patient/parent education about prevention (including environmental control where appropriate) as well as control of symptoms.
H. Health Management
Health Management Programs

Taking Charge of Diabetes℠

1. Overview and Goals
Taking Charge of Diabetes℠ (TCD) is a health management program that addresses both self-care and lifestyle areas. The major components of this non-clinical program are interactive member materials and provider reporting. There is no cost to members.

Program goals: Improve the care of members with diabetes by increasing diabetic members’ self-management skills and self-efficacy in managing their diabetes.

2. Program Process
Members with diabetes are identified using claims/encounter data, member health questionnaires, provider referrals and self-referrals. These members are sent the Introduction Guide, which includes basic information about diabetes and a diabetes assessment. Members with diabetes then receive two to three mailings per year. Each mailing focuses on an aspect of diabetes education and preventive care.

3. Provider Collaboration
The TCD program is a tool to provider support and can be utilized in conjunction with, or following participation in, a clinically based diabetes management program. Provider reports are available to identify patients participating in the program and patients who are delinquent with preventive exams.

4. Member Materials
Interactive materials are mailed to all members with diabetes. The following components are available:

- Introduction Guide – Includes the wallet card, diabetes assessment, self-care booklet, and resource list. The self-care booklet provides an introduction to diabetes management
- Diabetes Guides – The TCD program includes 2-3 mailings per year. Each mailing includes a reminder for a preventive exam(s) and interactive materials. Topics are rotated and may include information on nutrition, exercise, and/or diabetes self-care
- Wallet card – A handy reminder to have preventive care exams and tests done on a regular basis, with a table to record dates and results
- Glucose meter – Providers can request a free glucose meter and initial supply of test strips
- Free & Clear Stop Smoking℠ Program – For members identified as tobacco users and seeking support in quitting; a coupon that waives the program enrollment fee is available
- Spanish kits are available
Taking Charge of Your Heart Health Program℠

1. Overview and Goals:

Taking Charge of Your Heart Health℠ (TCYHH) is a self-directed intervention program that addresses both self-care and lifestyle areas. The major component of this non-clinical program is the interactive member materials to help you increase your understanding and knowledge of heart health. There is no extra cost to members.

Program Goals:
Improve the care of members with congestive heart failure or who have had a heart attack or heart-related procedure. Increase members’ self-management skills and self-efficacy in managing their heart disease.

2. Program Process

Members with congestive heart failure or who have had a heart attack or heart-related procedure are identified using claims/encounter data, member health questionnaires, provider referrals and self-referrals. These members are sent the Introduction Guide about congestive heart failure or heart disease and receive 2-3 mailings per year. Each mailing focuses on aspects of self-care and preventive care.

3. Provider Collaboration

The TCYHH program is designed to be utilized in conjunction with a clinical-based cardiovascular disease management program offered by their contracting providers. It is an enhancement to contracting provider support and clinical care.

4. Member Materials

Interactive materials will be mailed to the members with congestive heart failure or who have had a heart attack or heart-related procedure. The following components are available:

- Introduction Guide – Includes the wallet card, self-care and preventive care information and resource list. The information on self-care and preventive care includes nutrition, exercise, stress management, medication compliance and important preventive tests
- Heart Disease Guide – TCYHH program includes 2-3 mailings per year. Each mailing includes a reminder for a preventive exam and interactive materials. Topics are rotated and may include information on nutrition, exercise, preventive care, stress management or medication compliance
- Wallet Card – A handy reminder to have preventive care exams and tests done on a regular basis, with a table to record dates and results
- Free & Clear StopSmoking℠ Program – For members identified as tobacco users and seeking support in quitting; a coupon that waives the program enrollment fee is available
Taking Charge of Depression℠ Program

1. Overview and Goals

The Taking Charge of Depression (TCDep) program has been designed to complement the treatment members receive from their contracting primary care physician and offers education and lifestyle support to assist them in managing their depression. This program promotes the appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care and evaluation of the appropriate use of psychopharmacological medications.

2. Program eligibility:
   - Have been diagnosed with depression
   - Have been prescribed anti-depressant medication by their physician or nurse practitioner
   - Have been referred to the TCDep program by their contracting provider.
   - Have consented to participate in the program.

3. Member Materials

After enrolling in the TCDep program, a member will receive a tool kit that includes the following reference materials:

Program Booklet that covers the following topics
   - Feeling better about yourself
   - You and your doctor: Partners in health
   - Q&A about antidepressant medications
   - Understanding your prescription drug benefit
   - Lifestyle choices and your mood
   - Self-Care Resource Guide that contains a list of books, audiotapes, brochures websites and other helpful resources
   - Convenient pill dispenser
   - Workbook that provides structured exercises to guide you in identifying depression symptoms and changing your thought patterns
   - An audiotape that complements the workbook information

4. Telephonic Support

Telephonic support focuses on supporting compliance with treatment and building a partnership with your contracting physician.
End Stage Renal Disease (ESRD)

The Renal Case Management program serves the ESRD members in the continuity and coordination of their complex, high cost, medical management needs. The program provides an opportunity for continuous quality improvement for members, acute care institutions, dialysis centers, nephrology and primary care services. Data collected from medical records, administrative data and member surveys provides the opportunity to actively intervene to assist members and their practitioners in managing ESRD, and to measure the effectiveness of the program.

There were 1936 ESRD members at the end of September. Albumin and Hematocrit monitors both meet performance goals. Targeted mailings are sent to newly identified members with ESRD that includes the dialysis cookbook and educational materials. Contact PCC for any newly identified ESRD members.

Free and Clear StopSmoking℠

1. Overview and Goals

The Free & Clear StopSmoking℠ (SS) program is a highly effective, self-paced smoking cessation program designed to meet individual needs. The major components of this program are telephonic support and interactive member materials. Smoking cessation aids can also be used. In addition, the program is integrated with our other Health Improvement and Disease Management programs. Program length is one year. This is a component of all health management programs. PCC contracts with Group Health Cooperative of Puget Sound to provide this program.

2. Program Process

Members enroll in the program by calling the 800 enrollment number (800-292-2336) provided to them by their physician, employer, or directly from PCC. Program fees are collected from the participant at the time of enrollment. An enrollment fee of $20.00 may apply.

3. Member Materials

- A kit is mailed to the participant that includes:
  - Introductory letter
  - Your Guide to Quitting Tobacco
  - Your Allies’ Guide: Helping Someone Quit Tobacco
  - Tool kit – Items to help with the quitting process
  - Program available in English & Spanish

4. Smoking Cessation Aids

Smoking cessation aids may be available to members who participate in the program. The products covered are nicotine patches or Zyban™, A non-nicotine therapy. Participants must be enrolled in the Free & Clear StopSmoking℠ program and obtain a prescription from their physician for one of the products. The specialists will review use of the smoking cessation aid with participants, and if appropriate, provide them with instructions on how to obtain the products.
5. Telephonic Support

Participants are assigned to an SS specialist for a one-year period. After receipt of the Quit Kit, the support calls begin. Each participant receives five phone calls over the course of one year. The time and frequency of calls are tailored to the participant’s needs and readiness to quit.

6. Physician Collaboration

A letter may be sent to the participants’ physician, after the participant has been assessed for use of NRT or Zyban™. Physicians are encouraged to include the letter in the patient’s medical chart as a reminder to discuss his/her progress toward smoking cessation goals. Physicians and the health care team can most effectively help members accomplish the goal of smoking cessation by communicating its importance. Summary reports of patients’ status in the program are available for Medical Groups.
I. Required Report Submissions
PacifiCare conducts ongoing monitoring and evaluation of delegated PMG/IPAs delivery systems and performance metrics to ensure compliance with PacifiCare’s standards for delegation.

The attached GRID identifies the minimum reporting requirements to be submitted to PacifiCare by Provider organizations. Frequency and detail of reporting will vary based on contractual relationships between PacifiCare and the PMG/IPA. These reports are to be submitted to PacifiCare according to the 2003 report requirement schedule. The schedule indicates to whom the reports are to be submitted.

Clinical Management Program Monitoring and Reporting
Annual, quarterly or more frequent reporting to PacifiCare is required of all PMG/IPAs. Reporting requirements are updated each year dependent upon changes in regulatory requirements and accreditation standards, delegation agreements, and issues brought forward in PacifiCare’s QI Program outcome analysis. The following reports should be submitted to PacifiCare quarterly.

Authorization and Denial Logs
PacifiCare requires weekly submission of authorization and service denial logs including hospital, skilled nursing facility and out patient surgery. Facility logs must include the level of care authorized each day. Denial letters for all institutional services should be attached as well as denials for all services PacifiCare pays for.

QM Workplan
PacifiCare requires the submission of a written quarterly report detailing the progress with the current PMG/IPA QM Workplan. QM activity information may include progress in the areas of audits and studies, member and practitioner satisfaction activities, member complaints, credentialing activities, and other QM activities. Statistical data should be incorporated whenever possible.

Complaint Report/Log
PacifiCare requires submission of a quarterly Complaint Report/Log. The Complaint Report contains PacifiCare and Secure Horizons member identification, status of each complaint (open/closed), PacifiCare Severity Level, (Refer to Section F, Member Complaints) and a brief description of the actions taken.

UM Statistics
PacifiCare requires select UM statistical reporting. This self-reported data will be incorporated with various other internally available data to prepare a snapshot review of potential under- and/or over-utilization of various services at the provider group level.

Quarterly Credentialing Report This information will be utilized to ensure consistency with review as compared to our practitioner database.
**Purpose:** To identify the minimum reporting requirements to be submitted to PacifiCare by Provider Organizations. Frequency and detail of reporting will vary based on contractual relationships between PacifiCare and Provider Organizations. *(Excludes POS services)* Not intended for Direct Contract Network.

<table>
<thead>
<tr>
<th>Report Requirement</th>
<th>Frequency of Report to PacifiCare</th>
<th>PROVIDER TYPE/DELEGATED STATUS</th>
<th>Reports sent to PacifiCare contact:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. QUALITY MANAGEMENT:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. QM Program Evaluation of Prior year</td>
<td>2/15/03</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>2. QM Workplan for current year</td>
<td>2/15/03</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>3. QM Program Description</td>
<td>2/15/03</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>4. QM Coalition Quarterly Report</td>
<td>2/15/03, 5/15/03, 8/15/03, 11/15/03</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>5. Member Complaint Report</td>
<td>2/15/03, 5/15/03, 8/15/03, 11/15/03</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>B. CREDENTIALING:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Credentialing Plan</td>
<td>2/15/03</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>2. Credentialing Quarterly Progress Report</td>
<td>2/15/03, 5/15/03, 8/15/03, 11/15/03</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>C. UM PROGRAMS:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UM Program Evaluation of Prior Year</td>
<td>2/15/03</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>UM Program Description</td>
<td>2/15/03</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>UM Workplan for Current Year</td>
<td>2/15/03</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>UM Coalition Quarterly Report</td>
<td>2/15/03, 5/15/03, 8/15/03, 11/15/03</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>SH &amp; CO Quarterly Pre-Service Denial Letters <em>(submit 2 completed letters of each)</em></td>
<td>2/15/03, 5/15/03, 8/15/03, 11/15/03</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Expedited Initial Organizational determinations Log <em>(Medicare only)</em></td>
<td>Monthly</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Report Requirement</td>
<td>Frequency of Report to PacifiCare</td>
<td>Partial Risk Delegated</td>
<td>Shared Risk Delegated</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
<td>------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td><strong>PMG/IPA Bed Day formula; definition; inclusions/exclusions of services.</strong></td>
<td>Annually or upon change</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Group self-reported PCC Bed Days:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Acute Bed Days/1000</td>
<td>SNF Bed Days/1000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Acute Admits/1000</td>
<td>SNF Admits/1000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Acute ALOS</td>
<td>SNF ALOS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Acute LOC</td>
<td>SNF LOC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Acute LOC</td>
<td>OP Surgery/1000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Variance Bed Day Reports/Trends (Hospital &amp; SNF)</strong></td>
<td>No less than monthly</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Institutional Log</strong></td>
<td>Monthly</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>PMG/IPA Authorization Logs/Service Denial Logs</strong></td>
<td>Weekly</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>▪ Hospital w/ LOC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ SNF w/ LOC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ OP Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Denial letters for all institutional denials and denials associated with services PacifiCare pays claims for</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Admission Notification</strong></td>
<td>Immediate 24/7</td>
<td>✓</td>
<td>(Supplied by Hospital)</td>
</tr>
<tr>
<td><strong>Hospital daily census or hospital face sheet</strong></td>
<td>Daily</td>
<td>✓</td>
<td>(Supplied by hospital)</td>
</tr>
<tr>
<td><strong>Case Management logs (Includes Catastrophic, Chronic, Transplants, ER high utilizers) and Hospice logs</strong></td>
<td>Monthly</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report Requirement</td>
<td>Frequency of Report to PacifiCare</td>
<td>Partial Risk Delegated</td>
<td>Shared Risk Delegated</td>
</tr>
<tr>
<td>--------------------------------------------------------------</td>
<td>----------------------------------</td>
<td>------------------------</td>
<td>-----------------------</td>
</tr>
</tbody>
</table>
| ESRD Log                                                    | Monthly                          | ✓                      | ✓                     | ✓                                      | ESRD Unit in PCC’s Case Mgmt Department  
Network Mgmt. Contact  
5757 Plaza Drive  
Mail Stop CY44-116  
Cypress, CA 90630  
FAX: 714/226-8801 |
| Professional Services Encounter Data Submission             | Monthly                          | ✓                      | ✓                     | ✓                                      | Network Mgmt. Contact  
5757 Plaza Drive  
Mail Stop CY44-116  
Cypress, CA 90630  
FAX: 714/226-8801 |
| Institutional Services Encounter Data Submission            | Monthly                          | ✓                      | ✓                     |                                        |                                    |
| Member Routine appeals (Forward immediately to PacifiCare)  | Not delegated                    | N/A                    | N/A                   | N/A                                    | PacifiCare Appeals Dept.  
PO Box 6006 (CO)  
PO Box 489 (SH)  
Mail Stop CY44-157  
FAX: 714-226-8804  
FAX: 800-346-0930 (expedited) |
| Member Expedited appeals (Forward immediately to PacifiCare)| Not Delegated                    | N/A                    | N/A                   | N/A                                    | Med. Mgmt Dept.  
5757 Plaza Drive  
Mail Stop CY44-164  
Cypress, CA 90630  
FAX: 800-537-3992 |
| Experimental/investigational services, Clinical Trials (Forward immediately to PacifiCare) | Not Delegated                    | N/A                    | N/A                   | N/A                                    | PCC Quality Mgmt. Dept  
FAX: 714/226-6885  
5757 Plaza Drive  
Mail Stop CY44-142  
Cypress, CA 90630 |
| Member Grievances (Forward immediately to PacifiCare)       | Not Delegated                    | N/A                    | N/A                   | N/A                                    |                                    |
### Sample Log

**PACIFICARE / SECURE HORIZONS**

**QUARTERLY MEMBER COMPLAINT / GRIEVANCE LOG**

<table>
<thead>
<tr>
<th>PMG/IPA Name:</th>
<th>Date Submitted:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member ID#</strong></td>
<td><strong>Date received</strong></td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

March 2003 152
J. Delegation
Delegation
Delegation occurs when PacifiCare gives a PMG/IPA the authority to carry out a function that PacifiCare would otherwise perform. This authority includes the right to decide what to do and how to do it, within the parameters specified in the mutually agreed upon delegation document. The clinical functions that PacifiCare currently considers for delegation are Credentialing, Medical Records and Utilization Management. Delegation determinations are based on pre-delegation and annual assessments against NCQA standards and regulatory and contractual requirements.

The sample delegation amendment grid included in this section reflects the clear expectation PacifiCare holds of its delegated provider network. (The Delegation Grid is customized for each Provider contract.) The delegation agreement supports the PMG/IPA relationship with PacifiCare. The PMG/IPA must implement a similar process for any sub-delegation it implements, and must include PacifiCare in the approval of this relationship. The grid will be updated on an as needed basis as regulatory or business requirements demand. In addition, the threshold scoring required for delegation will increase year to year until optimal performance throughout the network is achieved.

Delegation Categories

- Delegation
- Delegation with a corrective action plan
- Undelegation (Dedelegation)

Delegation Decisions & Thresholds

- Credentialing - 85% or higher full delegation, plus critical elements
- Medical Records - 85% or higher full delegation, plus critical elements
- Utilization Management - 85% or higher full delegation, plus critical elements

Any performance below these thresholds, where the PMG/IPA shows a willingness to implement required improvements, and in the judgement of the PacifiCare clinical staff the changes can be implemented in 90 days or less, may be recommended for delegation with a CAP.

For UM, a PMG/IPA may perform well on the clinical annual assessment, yet experience sub-optimal outcomes in performance indicators such as inpatient bed days. In addition to assessments against NCQA standards and regulatory requirements, PMG/IPA outcomes are measured against several parameters. Based on the results and evaluation for causes and potential improvement, PacifiCare may negotiate an alteration in delegation of the specific elements in the delegation grid under UM. Such an alteration may also be determined based on a change in the financial responsibilities of the contract participants.

Protected Health Information (PHI).

- Medical Group may use Protected Health Information as it directly relates to information required to make credentialing and recredentialing determinations.
- Medical Group must ensure that PHI is not used inappropriately and ensure that it is not subject to further disclosure when used in the credentialing and recredentialing process.
Such safeguards include securing files from access by the public or by personnel not directly involved in the credentialing and recredentialing process.

- If the Medical Group subdelegates any credentialing functions, the Medical Group will ensure that the subdelegate has safeguards in place to protect the information from inappropriate use or further disclosure.
- Medical Group will provide members access to their information.
- Medical Group will inform PacifiCare if any inappropriate use of protected health information occurs.
- Medical Group will protect, return, or destroy protected health information if the delegation agreement ends.
Delegation Grids
**Attachment 1**

### UTILIZATION MANAGEMENT DELEGATION GRID

<table>
<thead>
<tr>
<th>Function</th>
<th>Delegation Status</th>
<th>Provider Group Responsibility/ Performance Measure</th>
<th>Reporting Frequency</th>
<th>PacifiCare Oversight</th>
</tr>
</thead>
<tbody>
<tr>
<td>UM Program Structure and Process</td>
<td>Delegated</td>
<td>Provider Group (PG) will meet all regulatory, NCQA, and PacifiCare Standards. Development and documentation of program structure and accountability, including:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
|                               | Not delegated     | 1. Goals & Objectives, including behavioral health care aspects  
|                               |                   | 2. Cmte responsibilities;  
|                               |                   | a) Membership  
|                               |                   | b) Minutes  
|                               |                   | c) Dissemination of information  
|                               |                   | d) Education of staff & providers  
|                               |                   | 3. UM Director & senior physician’s and designated behavioral health care practitioner roles  
|                               |                   | 4. UM Dept interfaces with other depts.  
|                               |                   | 5. Program is evaluated & approved annually  
|                               |                   | For each UM function delegated there must be documentation of:  
|                               |                   | 1. Staff & Physician responsibilities related to each UM function.  
|                               |                   | 2. Appropriate and Adequate professional and non-professional staffing mix and decision-making responsibilities  
|                               |                   | 3. Regular and after-hours UM process and communication services defined  
|                               |                   | 4. Interface with PacifiCare appropriately  
|                               |                   | 5. Data elements as required  
|                               |                   | 6. Reporting capability  
|                               |                   | Implementation of corrective action plan for elements of non-compliance.  |
| Pre-Service Authorization Professional: | Delegated        | For pre-service authorization the Provider Group (PG) must:  
| Institutional                  | Not delegated     | - Comply with PacifiCare’s Turn Around Times and notification requirements, consistent gathering of appropriate information, and assisting in transition of care when benefits end  
|                               |                   | - Follow nationally recognized medical necessity criteria or criteria based on sound clinical evidence  
|                               |                   | - Develop and document program to perform pre-service authorization function of outpatient care meeting all regulatory and PacifiCare standards  |
|                               |                   | - Weekly submission of authorization/denial logs  
|                               |                   | - Monthly submission of encounter data  
|                               |                   | - Participation in census verification process  |
|                               |                   | - Pre-delegation onsite assessment to determine ability to perform function  
|                               |                   | - Annual onsite assessment to determine ability to perform function  |

---

March 2003  
157
## Utilization Management Delegation Grid

<table>
<thead>
<tr>
<th>Function</th>
<th>Delegation Status</th>
<th>Provider Group Responsibility/ Performance Measure</th>
<th>Reporting Frequency</th>
<th>PacifiCare Oversight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concurrent Review</td>
<td>Delegated</td>
<td>For concurrent review PG must:</td>
<td>- Daily submission of patient census by admission and discharge and Level of Care - Monthly submission of Bed Days per thousand members per year</td>
<td>- Pre-delegation onsite assessment to determine ability to perform function - Annual onsite assessment to determine ability to perform function</td>
</tr>
<tr>
<td></td>
<td>Not delegated</td>
<td>- Comply with PacifiCare’s Turn Around Times and notification requirements. - Follow nationally recognized medical necessity criteria or criteria based on sound clinical evidence - Develop and document programs to perform concurrent review of acute and Skilled Nursing Facility inpatients meeting all regulatory and PacifiCare standards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge Planning</td>
<td>Delegated</td>
<td>Develop and document program to perform discharge planning functions for Acute and Skilled Nursing Facility meeting all regulatory and PacifiCare standards</td>
<td>Reviewed during annual assessment.</td>
<td>- Pre-delegation onsite assessment to determine ability to perform function - Annual onsite assessment to determine ability to perform function</td>
</tr>
<tr>
<td></td>
<td>Not delegated</td>
<td>Issue timely and appropriate acute facility notice of noncoverage. Issue timely and appropriate Skilled Nursing Facility Notice of Non-coverage.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out Of Area (OOA)</td>
<td>Delegated</td>
<td>If not delegated, report any OOA notifications received by group.</td>
<td></td>
<td>- Pre-delegation onsite assessment to determine ability to perform function - Annual onsite assessment to determine ability to perform function</td>
</tr>
<tr>
<td></td>
<td>Not delegated</td>
<td>If delegated, develop and document program to perform OOA concurrent review meeting all regulatory and PacifiCare standards.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
<td>Delegated</td>
<td>Develop and document program to perform Case Management function meeting all regulatory and PacifiCare standards</td>
<td>Monthly submission of Case Management Log • ESRD • Transplants • Catastrophic</td>
<td>- Pre-delegation onsite assessment to determine ability to perform function - Annual onsite assessment to determine ability to perform function</td>
</tr>
<tr>
<td></td>
<td>Not delegated</td>
<td>IF NOT delegated, responsible to share coordination of care with PacifiCare Case Managers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transplants</td>
<td>Delegated</td>
<td>Develop and document Policies and Procedures to support notification to PacifiCare of potential transplant candidates. Responsible to provide PacifiCare with all necessary information to make medical determination and manage the case.</td>
<td>Report cases immediately.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not delegated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Technology</td>
<td>Delegated</td>
<td>Develop and document Policies and Procedures to support notification to PacifiCare of requests for new technology and coordination of making determinations.</td>
<td>Ad Hoc</td>
<td>N/A</td>
</tr>
<tr>
<td>Function</td>
<td>Delegation Status</td>
<td>Provider Group Responsibility/ Performance Measure</td>
<td>Reporting Frequency</td>
<td>PacifiCare Oversight</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Retrospective-Review</td>
<td></td>
<td>For Retrospective-review of services PG must:</td>
<td></td>
<td>- Pre-delegation onsite assessment to determine ability to perform function</td>
</tr>
<tr>
<td>Professional</td>
<td>Delegated Not delegated</td>
<td>- Comply with PacifiCare’s Turn Around Times and notification requirements.</td>
<td>Weekly submission of authorization/denial logs.</td>
<td>- Annual onsite assessment to determine ability to perform function</td>
</tr>
<tr>
<td>Institutional</td>
<td>Delegated Not delegated</td>
<td>- Follow nationally accepted medical necessity criteria or criteria based on sound clinical evidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denials</td>
<td>Delegated Not delegated</td>
<td>- Develop and document program to perform retrospective review function.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>Delegated Not delegated</td>
<td>For Denials of services PG must:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Institutional</td>
<td>Delegated Not delegated</td>
<td>- Comply with PacifiCare’s Turn Around Times and notification requirements.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Interpretations</td>
<td>Delegated Not delegated</td>
<td>- Follow nationally recognized medical necessity criteria or criteria based on sound clinical evidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Develop and document program to perform denial function, meeting all regulatory and PacifiCare standards.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>For Benefit Interpretations PG must:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Comply with PacifiCare’s Turn Around Times and notification requirements.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Request PacifiCare interpretation when unable to make clear determination based on resources provided by PacifiCare (e.g., Benefits Manual)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Request PacifiCare determination regarding medical necessity when requested service appears to be of an experimental or investigational nature for a member who has a “life-threatening” or “seriously debilitating” condition as defined in the California Health &amp; Safety Code (see note below)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>N/A</td>
<td></td>
<td>- Pre-delegation onsite assessment to determine ability to perform function</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Pre-delegation onsite assessment to determine ability to perform function.</td>
<td></td>
<td>- Annual onsite assessment to determine ability to perform function</td>
</tr>
<tr>
<td>Appeals</td>
<td>Delegated Not delegated</td>
<td>- Develop and document program to support cooperation with PacifiCare in handling appeals.</td>
<td>PacifiCare will provide the PG a quarterly report to show number of appeals and overturn rate for specific PG.</td>
<td>- Pre-delegation onsite assessment to determine ability to perform function</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Notify PacifiCare of all member and provider appeals coming through PG.</td>
<td></td>
<td>- Annual onsite assessment to determine ability to perform function</td>
</tr>
<tr>
<td>Satisfaction with UM</td>
<td>Delegated Not delegated</td>
<td>PG will meet all regulatory, NCQA, and PacifiCare Standards.</td>
<td></td>
<td>- Pre-delegation onsite assessment to determine ability to perform function</td>
</tr>
<tr>
<td>Process</td>
<td></td>
<td>PG will annually gather and evaluate information about member and practitioner satisfaction with the UM process and address opportunities for improvement.</td>
<td></td>
<td>- Annual onsite assessment to determine ability to perform function</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>Delegated Not delegated</td>
<td>PG will meet all regulatory, NCQA, and PacifiCare Standards.</td>
<td></td>
<td>- Pre-delegation onsite assessment to determine ability to perform function</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emergency policies and procedures require:</td>
<td></td>
<td>- Annual onsite assessment to determine ability to perform function</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Coverage of emergency services to screen and stabilize the member without prior approval where a prudent layperson, acting reasonably, would have believed that an emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Function</td>
<td>Delegation Status</td>
<td>Provider Group Responsibility/ Performance Measure</td>
<td>Reporting Frequency</td>
<td>PacifiCare Oversight</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------</td>
<td>----------------------------------------------------</td>
<td>---------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coverage of emergency services if an authorized representative, acting for PBHC, authorized the provision of emergency services. A behavioral healthcare practitioner or physician reviews presenting symptoms as well as the discharge diagnosis for potential denial of emergency services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensuring Appropriate Utilization</td>
<td>Delegated ☑</td>
<td>PG will meet all regulatory, NCQA, and PacifiCare Standards. PG at least annually monitors and analyzes relevant data and takes action to correct any patterns of potential or actual inappropriate under- or over-utilization, using quantitative and qualitative data analysis.</td>
<td></td>
<td>- Pre-delegation onsite assessment to determine ability to perform function. - Annual onsite assessment to determine ability to perform function.</td>
</tr>
</tbody>
</table>
| Subdelegation of Utilization Management | Delegated ☑     | If PG subdelegates UM, PG will:  
- Develop detailed documentation of mutually agreed upon delegation agreement identifying:  
  - Listing of responsibilities of delegate (PG) & sub-delegate;  
  - Specific delegated activities;  
  - Process for evaluating sub-delegate’s performance, and  
  - Remedies if sub-delegate does not perform  
- Retain right to approve/ disapprove new providers and to discipline providers  
- Conduct pre-delegation evaluation  
- Conduct annual evaluation, including file review, according to NCQA’s methodology  
- If sub-del agreement includes the use of PHI, the sub-del document includes:  
  - List of allowed uses of PHI  
  - Description of sub-delegate safeguards to protect the information from inappropriate use or further disclosure  
  - Stipulation that the delegate will ensure that subdelegates have similar safeguards  
  - Stipulation that the subdelegate will provide individuals with access to their PHI  
  - Stipulation that the subdelegate will inform the organization if |                     | Submit copies of subdelegation agreements to PacifiCare prior to subdelegation and on an annual basis | - Annual assessment of sub-delegation process, including agreements, polices and procedures, and ongoing evaluation of performance, according to NCQA standards & methodology - Implementation of Corrective Action Plan(s) for elements of non-compliance |
<table>
<thead>
<tr>
<th>Function</th>
<th>Delegation Status</th>
<th>Provider Group Responsibility/ Performance Measure</th>
<th>Reporting Frequency</th>
<th>PacifiCare Oversight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>inappropriate uses of the information occur</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stipulation that the subdelegate will ensure PHI is returned, destroyed or protected if the delegation agreement ends</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PacifiCare’s responsibilities relating to Medical Management and those responsibilities, which PacifiCare has delegated to the Provider Group, are outlined above.

The Provider Group agrees to be accountable for all responsibilities delegated by PacifiCare and will not further delegate any such responsibilities without the prior written approval by PacifiCare.

PacifiCare will perform audits annually and as needed to evaluate the group’s delegated status. In the event there are deficiencies PacifiCare will perform audits annually and as needed to evaluate the group’s delegated status. In the event there are deficiencies identified in the audit, PacifiCare will provide a specific corrective action plan. If the group is not able to comply with the corrective action plan within the specified time frame, PacifiCare may revoke the group’s delegated status.

* California Health and Safety Code Section 1370.4(a)(1)(B)(i) and (ii) and Section 1370.4(a)(1)(C) defines the following terms: “Life-threatening” means either or both of the following: (i) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted. (ii) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival. “Seriously debilitating,” means diseases or conditions that cause major irreversible morbidity.
# Credentialing Delegation Grid

<table>
<thead>
<tr>
<th>Function</th>
<th>Delegation Status</th>
<th>Provider Group Responsibility/ Performance Measure</th>
<th>Reporting Frequency</th>
<th>PacifiCare Oversight</th>
</tr>
</thead>
</table>
| Credentialing Program description and/or Policies and Procedures (P&Ps) | ☐ Delegated ☐ Not delegated | Full Compliance with NCQA Standards:  
- Define the scope of practitioner network to be cred/recr, i.e. MD, DO, DPM, DDS, DC, and behavioral health and other licensed independent practitioners.  
- Define criteria and verification sources used to meet criteria  
- Describe the process to delegate credentialing/recredentialing  
- Describe process used to ensure that credentialing and recredentialing are conducted in a non-discriminatory manner  
- Ensure confidentiality.  
- Describe decision making process,  
- Specify practitioner rights, notification process and time frames. | Submit Credentialing Program annually.  
- Revised credentialing policies and procedures submitted at least annually. | ☐ Initial onsite assessment  
- Annual oversight assessment  
- Evaluate and approve written Credentialing Program  
- Implementation of Corrective Action Plan(s) for elements of non-compliance |
| Credentialing Committee                           | ☐ Delegated ☐ Not delegated | Full Compliance with NCQA Standards:  
- The Provider Group (PG) designates a credentialing committee, including a range of participating practitioners of different specialties, that makes recommendations regarding credentialing decisions using a peer review process.  
- The PG documents committee’s opportunity to review credentials of all practitioners and advice in all credentialing/recredentialing decisions. | Annual credentialing program to include committee structure. | ☐ Initial onsite assessment  
- Annual oversight assessment  
- Annual Review of Committee minutes  
- Annual review of membership  
- Frequency of meetings  
- Implementation of Corrective Action Plan(s) for elements of non-compliance |
| Primary source verification of credentialing information | ☐ Delegated ☐ Not delegated | Full compliance with NCQA Standards regarding verification of information within 180 days prior to Committee approval date.  
- Meet 100% of NCQA & regulatory body standards related to primary source verification of the following:  
  - License  
  - Education & Training  
  - Board certification  
  - Professional liability claims for past 5 years  
- Meet 100% of NCQA & regulatory body standards related to data collection of the following:  
  - DEA/CDS  
  - Work History  
  - Hospital Admitting privileges, if applicable | Submit current list of practitioners credentialed and date approved with quarterly report. | ☐ Initial onsite assessment  
- Annual oversight assessment  
- Implementation of Corrective Action Plan(s) for elements of non-compliance  
- Annual audit conducted of provider’s practitioners’ credentialing files according to NCQA methodology. |
| Application/ Attestation                          | ☐ Delegated ☐ Not delegated | Full compliance with NCQA Standards.  
- The PG application must include a statement regarding:  
  - Reasons for any inability to | Immediate submission of any changes to application. | ☐ Initial onsite assessment  
- Annual oversight assessment  
- Annual audit |
<table>
<thead>
<tr>
<th>Function</th>
<th>Delegation Status</th>
<th>Provider Group Responsibility/ Performance Measure</th>
<th>Reporting Frequency</th>
<th>PacifiCare Oversight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>perform.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Lack of present illegal drug use.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- History of loss of license or felony conviction.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- History of loss or limitation of privileges or disciplinary activity.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Current malpractice insurance coverage, including dates &amp; coverage amount</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Attestation by applicant of the correctness and completeness of the application.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Signed within 180 days prior to Committee approval date.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Sanction Information</td>
<td>Delegated</td>
<td>Full compliance with NCQA Standards regarding verification of information within 180 days prior to Committee Approval date.</td>
<td>None</td>
<td>Initial onsite assessment</td>
</tr>
<tr>
<td></td>
<td>Not delegated</td>
<td></td>
<td></td>
<td>Annual oversight assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Sanction or Limitations information on licensure, as appropriate, must cover the most recent 5 year period available through the data source:</td>
<td></td>
<td>Annual audit conducted of provider’s practitioners credentialing files according to NCQA methodology.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- MD, DOs: NPDB, State Board of Medical Examiners, or Federation of State Medical Boards</td>
<td></td>
<td>Implementation of Corrective Action Plan(s) for elements of non-compliance.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- DCs: State Board of Chiropractic Examiners or the Federation of Chiropractic Licensing Boards</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- DDSs: NPDB or State Board of Dental Examiners</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- DPMs: State Board of Podiatric Examiners or Federation of Podiatric Medical Boards</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Nonphysician behavioral health &amp; other independently licensed practitioners: Appropriate state agency or State Board of Licensure or Certification</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• For all practitioners (except DDS): review of Medicare/ Medicaid sanctions, must cover the most recent 3-year period available through the data source:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- NPDB</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- FSMB</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Cumulative Sanctions Report</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Medicare and Medicaid Sanctions and Reinstatement Report</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Federal Employees Health Benefits Program department record</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- State Medicaid agency or intermediary and the Medicare intermediary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial office site visit and medical record keeping practice review of all PCPs, OB/GYNs, and High Volume Behavioral Healthcare practitioners (applicable to HMO products only)</td>
<td>Delegated</td>
<td>Full compliance with NCQA Standards regarding Initial site visit/medical record keeping review prior to the Committee approval date.</td>
<td>On an annual basis, include list of all site reviews subsequent to the initial site visit.</td>
<td>Initial onsite assessment</td>
</tr>
<tr>
<td></td>
<td>Not delegated</td>
<td></td>
<td></td>
<td>Annual oversight assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Set standards for office sites and establish thresholds for acceptable performance.</td>
<td></td>
<td>Annual review of audit tool</td>
</tr>
</tbody>
</table>
# CREDENTIALING DELEGATION GRID

<table>
<thead>
<tr>
<th>Function</th>
<th>Delegation Status</th>
<th>Provider Group Responsibility/Performance Measure</th>
<th>Reporting Frequency</th>
<th>PacifiCare Oversight</th>
</tr>
</thead>
</table>
| Structured review that evaluates the office site against standards in the following areas:  
  - Physical accessibility  
  - Physical appearance  
  - Adequacy of waiting room and exam room space  
  - Availability of appointments  
  - Documentation of an evaluation of medical record keeping practices for conformity with standards  
  Specify methodology for identification of potential high volume behavioral health practitioners.  
  Institute actions for improvement with sites not meeting thresholds.  
  Evaluate effectiveness of actions at least every 6 months until sites with deficiencies meet thresholds.  
  Follows same procedure for an initial site visit when a PCP, OB/GYN, or high volume behavioral health practitioner relocates or opens a new site.  
  Procedures for detecting deficiencies subsequent to the initial site visit, at least every six months. Reevaluates site of new deficiencies and institutes actions for improvement.  
  Incorporation of this information into the credentialing process. | ☐ Delegated ☐ Not delegated | Full compliance with NCQA Recredentialing Standards regarding verification of information within 180 days prior to Committee approval date.  
  Recredentialing must be completed within 36 months of prior credentialing or recredentialing activity.  
  Meet 100% of NCQA and regulatory body standards related to obtaining from practitioner:  
  - Signed Attestation regarding  
    - Reasons for any inability to perform,  
    - lack of present illegal drug use,  
    - History of loss or limitation of privileges or disciplinary activity, and  
    - Current malpractice insurance coverage, including dates & amount, and  
    - correctness and | Include list of all practitioners recredentialed, including approval dates, on a quarterly basis (with quarterly report) | ☐ Initial onsite assessment  
  • Annual audit conducted of provider’s practitioners’ credentialing files according to NCQA methodology.  
  • Implementation of Corrective Action Plan(s) for elements of non-compliance. |
## CREDENTIALING DELEGATION GRID

<table>
<thead>
<tr>
<th>Function</th>
<th>Delegation Status</th>
<th>Provider Group Responsibility/Performance Measure</th>
<th>Reporting Frequency</th>
<th>PacifiCare Oversight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>completeness of application</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Meet 100% of NCQA and regulatory body standards related to primary source verification of the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− License</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Board certification (if expired or new since initial credentialing)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Professional liability claims</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Meet 100% of NCQA and regulatory body standards related to data collection of the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− DEA/CDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Hospital Admitting privileges, if applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Recredentialing Sanction information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Delegated</td>
<td>Full compliance with NCQA Recredentialing Standards regarding verification of information within 180 days prior to Committee approval date.</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>□</td>
<td>Not delegated</td>
<td>Recredentialing must be completed within 36 months of prior credentialing or recredentialing activity (as required by CMS &amp; DMHC).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Recredentialing information found in credentialing files includes the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Sanction or Limitations information on licensure, as appropriate, must cover the last 3-year period available through the data source (data that may not have come to the attention of the provider previously):</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− MD, DOs: NPDB, State Board of Medical Examiners, or Federation of State Medical Boards</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− DCs: State Board of Chiropractic Examiners or the Federation of Chiropractic Licensing Boards</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− DDSs: NPDB or State Board of Dental Examiners</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− DPMs: State Board of Podiatric Examiners or Federation of Podiatric Medical Boards</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Nonphysician behavioral health &amp; other independently licensed practitioners: Appropriate state agency or State Board of Licensure or Certification</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• For all practitioners (except DDS): review of Medicare/ Medicaid sanctions, must cover the last 3-year period available through the data source (data that may not have come to the attention of the provider previously):</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− NPDB</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− FSMB</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Cumulative Sanctions Report</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Initial onsite assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Annual oversight assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Annual audit conducted of provider’s practitioners’ recredentialing files according to NCQA methodology.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Implementation of Corrective Action Plan(s) for elements of non-compliance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Function</td>
<td>Delegation Status</td>
<td>Provider Group Responsibility/ Performance Measure</td>
<td>Reporting Frequency</td>
<td>PacifiCare Oversight</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>CREDENTIALING DELEGATION GRID</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Medicare and Medicaid Sanctions and Reinstatement Report</td>
<td></td>
<td>• Initial onsite assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Federal Employees Health Benefits Program department record</td>
<td></td>
<td>• Annual oversight assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>− State Medicaid agency or intermediary and the Medicare intermediary</td>
<td></td>
<td>• Annual audit conducted of provider’s practitioners’ credentialing files according to NCQA methodology.</td>
</tr>
<tr>
<td>Performance Monitoring:</td>
<td>❑ Delegated</td>
<td>Full compliance with NCQA Recredentialing Standards.</td>
<td>List of all credentialing decisions completed on an annual basis</td>
<td>• Implementation of Corrective Action Plan(s) for elements of non-compliance</td>
</tr>
<tr>
<td></td>
<td>❑ Not delegated</td>
<td>Specify criteria/methodology for identification of potential high volume behavioral health practitioners.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Incorporate the following information into the credentialing decision making process for PCPs and high volume behavioral health practitioners:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Member complaints (as received from plan)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Information from quality improvement activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ongoing monitoring of Sanctions and Complaints</td>
<td>❑ Delegated</td>
<td>Full compliance with NCQA standards. P&amp;Ps for ongoing monitoring of sanctions and complaints include addressing the following sources:</td>
<td>New P&amp;Ps submitted at least annually Notification to PacifiCare of any actions reported on a practitioner immediately.</td>
<td>• Initial onsite assessment</td>
</tr>
<tr>
<td></td>
<td>❑ Not delegated</td>
<td>− Medicare and Medicaid Sanctions</td>
<td></td>
<td>• Annual oversight assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>− State Sanctions or limitations on licensure</td>
<td></td>
<td>• Implementation of Corrective Action Plan(s) for elements of non-compliance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Complaints (as received from Plan)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Evidence the PG collects and reviews information from the above-referenced sources.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>PG takes action on instances of poor quality.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notification to Authorities and Practitioner Appeal Rights</td>
<td>❑ Delegated</td>
<td>Full compliance with NCQA Standards. P&amp;Ps for altering the conditions of the practitioner’s participation with PacifiCare based on quality of care of service:</td>
<td>New P&amp;Ps submitted at least annually Notification to PacifiCare of any actions reported on a practitioner immediately.</td>
<td>• Initial onsite assessment</td>
</tr>
<tr>
<td></td>
<td>❑ Not delegated</td>
<td>P&amp;Ps for reporting of quality deficiencies to appropriate authorities.</td>
<td></td>
<td>• Annual oversight assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P&amp;Ps for range of actions to be taken to improve performance prior to termination.</td>
<td></td>
<td>• Implementation of Corrective Action Plan(s) for elements of non-compliance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P&amp;Ps to describe appeals process &amp; process of notifying practitioners of appeal rights.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment of Organizational Providers )</td>
<td>❑ Delegated</td>
<td>For all contracted acute care hospitals, home health agencies, SNFs, free-standing surgical centers, and facilities providing mental health or substance abuse services in an inpatient, residential</td>
<td>Submit list of contracted organizational providers on an annual basis</td>
<td>• Initial onsite assessment</td>
</tr>
<tr>
<td></td>
<td>❑ Not delegated</td>
<td></td>
<td></td>
<td>• Annual assessment including P&amp;Ps and</td>
</tr>
</tbody>
</table>

March 2003
<table>
<thead>
<tr>
<th>Function</th>
<th>Delegation Status</th>
<th>Provider Group Responsibility/ Performance Measure</th>
<th>Reporting Frequency</th>
<th>PacifiCare Oversight</th>
</tr>
</thead>
</table>
| Sub-Delegation of Credentialing | ☐ Delegated ☐ Not delegated | If PG sub-delegates Credentialing to a CVO, Hospital, IPA, Behavioral Health, etc: | Submit copies of sub-delegation agreements to PacifiCare prior to subdelegation and on an annual basis | - Initial onsite assessment  
- Annual assessment of sub-delegation process, including agreements, polices and procedures, and ongoing evaluation of performance, according to NCQA standards & methodology  
- Implementation of Corrective Action Plan(s) for elements of non-compliance |

or ambulatory setting where the contract is held by the PG.

1. Confirms good standing with State and Federal regulatory bodies (including if providing services to Medicare enrollees, PG must confirm provider’s participation in Medicare); and
2. Confirms accreditation; or
4. Conducts an on-site quality assessment, if there is no accreditation status;
   • If a free-standing surgical center is not accredited, the PG must confirm Medicare certification (Calif. Health & Safety Code)
5. And initially & at least every three years, confirms continued good standing of regulatory bodies, and if applicable, accreditation

- PG retains right to approve/
**CREDENTIALING DELEGATION GRID**

<table>
<thead>
<tr>
<th>Function</th>
<th>Delegation Status</th>
<th>Provider Group Responsibility/ Performance Measure</th>
<th>Reporting Frequency</th>
<th>PacifiCare Oversight</th>
</tr>
</thead>
<tbody>
<tr>
<td>disapprove new providers and to discipline providers</td>
<td></td>
<td>Pre-delegation evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pre-delegation evaluation</td>
<td></td>
<td>Annual evaluation, including file review, according to NCQA’s methodology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• If deficiencies found, evidence of PG &amp; sub-delegate follow up for opportunities for improvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accessibility to Credentialing Files</td>
<td>☐ Delegated</td>
<td>Should any of the following provider events occur, PacifiCare shall have access to PG’s credentialing files to ensure practitioners are properly credentialed for continuity and coordination of care for members:</td>
<td>Immediately notify PacifiCare of any such provider event.</td>
<td>• Access PG credentialing/recredentialing files should any of the referenced provider events occur.</td>
</tr>
<tr>
<td></td>
<td>☐ Not delegated</td>
<td>− Bankruptcy</td>
<td>As needed, provide PacifiCare access to PG credentialing/recredentialing files should any of the referenced provider events occur.</td>
<td>• Collection of copies of selected credentialing/recredentialing files from PG for regulatory and accreditation audits, as applicable.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Termination of contract</td>
<td>Comply with requests for selected credentialing files for regulatory &amp;/or accreditation audits.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− De-delegation of credentialing activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Credentialing files must be available, including making appropriate copies, for regulatory &amp; accreditation audits.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Provider Group agrees to be accountable for all responsibilities delegated by PacifiCare and will not further delegate any such responsibilities without the prior approval by PacifiCare. PacifiCare’s responsibilities relating to Credentialing and those responsibilities, which PacifiCare has delegated to the Provider Group, are outlined above.

PacifiCare will perform audits prior to delegation, annually, and as needed to evaluate the group’s delegated status. In the event there are deficiencies identified in the audit, PacifiCare will provide a specific corrective action plan. If the group is not able to comply with the corrective action plan within the specified time frame, PacifiCare may revoke the group’s delegated status.

PacifiCare retains the right to approve, suspend and terminate individual practitioners, providers and sites.
## MEDICAL RECORDS DELEGATION GRID

<table>
<thead>
<tr>
<th>Function</th>
<th>Delegation Status</th>
<th>Provider Group Responsibility/ Performance Measure</th>
<th>Reporting Frequency</th>
<th>PacifiCare Oversight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systematic Review of Medical</td>
<td>☐ Delegated</td>
<td>- Set documentation standards and distribute to practice sites. Documentation audit tool to include all elements required by NCQA and PacifiCare.</td>
<td>Annual</td>
<td>- Audit Provider Group’s policies and processes on an annual basis to ensure conformance to standards and note deficiencies identified. Facilitate and monitor Provider Group’s compliance with work plan and corrective action plans.</td>
</tr>
<tr>
<td>Records</td>
<td>☐ Not delegated</td>
<td>- At least annually, audit medical records from a sample of primary care practitioners.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Conduct focused follow-up to improve documentation by PCPs who perform poorly against standards.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub-Delegation of Medical</td>
<td>☐ Delegated</td>
<td>If PG sub-delegates Medical Records to any entity, PG will have:</td>
<td>Submit copies of sub-delegation agreements to PacifiCare prior to subdelegation and on an annual basis</td>
<td>• Initial onsite assessment</td>
</tr>
<tr>
<td>Records</td>
<td>☐ Not delegated</td>
<td>- Detailed documentation of mutually agreed upon delegation agreement identifying:</td>
<td></td>
<td>• Annual assessment of sub-delegation process, including agreements, polices and procedures, and ongoing evaluation of performance, according to NCQA standards &amp; methodology</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Listing of responsibilities of delegate (PG) &amp; sub-delegate;</td>
<td></td>
<td>• Implementation of Corrective Action Plan(s) for elements of non-compliance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Specific delegated activities;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Process for evaluating sub-delegate’s performance, and</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Remedies if sub-delegate does not perform</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- If sub-delegation includes the use of PHI, the sub-delegation document includes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- List of allowed uses of PHI</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Description of sub-delegate safeguards to protect the information from inappropriate use or further disclosure</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Stipulation that the delegate will ensure that subdelegates have similar safeguards</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Stipulation that the subdelegate will provide individuals with access to their PHI</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Stipulation that the subdelegate will inform the organization if inappropriate uses of the information occur</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Stipulation that the subdelegate will ensure PHI is returned, destroyed or protected if the delegation agreement ends</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- PG retains right to approve/ disapprove new providers and to</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PacifiCare’s responsibilities relating to Medical Records and those responsibilities, which PacifiCare has delegated to the Provider Group, are outlined above.

The Provider Group agrees to be accountable for all responsibilities delegated by PacifiCare and will not further delegate any such responsibilities without the prior approval by PacifiCare.

PacifiCare will perform audits annually and as needed to evaluate the group’s delegated status. In the event there are deficiencies identified in the audit, PacifiCare will provide a specific corrective action plan. If the group is not able to comply with the corrective action plan within the specified time frame, PacifiCare may revoke the group’s delegated status.
Utilization Management
Annual Assessment
Questions
Credentialing
Annual Assessment
Questions
Credentialing
Provider File Review
Questions
Medical Records
Annual Assessment Questions
Medical Record
File Review
K. Quality Networking Sessions
Quality Networking Session

Quality Network Workshops are conducted three times a year. Workshops provide an opportunity for PacifiCare of California to share up-to-date information important to your business practice. If you are unable to attend, a packet of information will be sent to you.