POMONA VALLEY MEDICAL GROUP
HEALTH CARE HERALD

~News from ProMed Health Care Administrators & Pomona Valley Medical Group, Inc. ~
Fall 2009

President's Message

By Jeereddi A. Prasad, M.D., President

Summer is over. With health care reform activity, we are in for exciting times. Negotiations with PVHMC are almost complete. We have dedicated Hospitalist and SNFist teams in place. Dr. Kommineni has been appointed Assistant Medical Director for UM & QM review.

I am working on Care Models for elective orthopedic surgeries at this time. In the coming months I am planning on developing a High Risk Clinic to manage complex disease states post hospital discharge before the patients see their PCPs.

Our emphasis for the coming year is going to be on enhancing Pay for Performance and HCC Coding. As health care reform evolves we will be planning on developing care centers of excellence for certain chronic diseases wit provider groups.

We are planning the next Quarterly PCP meeting to be held soon.

Please take note of our new Provider's Corner article. I encourage you to submit articles of importance for inclusion in our quarterly newsletter. As always it is a pleasure to work with all of you.

Thank you all.

Chief Operating Officer's Bulletin

By Brian Werderman, COO

As we are approaching the end of 2009, I would like to extend a warm welcome to both new and existing ProMed providers in the Pomona network. As Chief Operating Officer of ProMed, I am excited about the opportunity to work with you and our dedicated management team in Ontario. We value the partnership with our providers, and will be rolling out a number of initiatives to enhance your presence and success in the Inland Empire region.

Given the dynamic state of healthcare, we want to be proactive in working with you to respond to the many challenges you will be facing in 2010 and beyond. Dr. Prasad, Rick Jacob, our Provider Relations team and I will be meeting with you on a quarterly basis to get your input on issues that impact your business, and how we can work together to find solutions to help you succeed. Among the many topics we will be discussing are Pay for Performance, HCC Coding/Risk Adjustment, patient satisfaction and maximizing the use of technology for the various aspects of your practice. I look forward to meeting all of you in the months ahead.

Business Development

By Rick Jacob, VP of Business Development

<u>Open Enrollment is Upon Us:</u>
ProMed has embarked on the development of linking our physician network to the employers and senior community that our physician network services. With that being said, ProMed has currently set up 37

Business Development *continued on page 2*

INSIDE THIS ISSUE

employers and/or senior events that will be taking place during the fall to winter season. In addition, ProMed has begun to develop a physician directory that will feature all of our contracted primary care physicians.
If you haven't gotten your picture for the directory or have interest in participating in our events, please contact Dawn Tumser at (909) 932-1045 ext. 4673.

Lost some of your patient base?
We are committed to assisting our PCP's in retaining and growing their membership. Call me to discuss strategies on how to enhance your practice base and ways ProMed can assist.
Rick Jacob (909) 758-4682

IPA Exclusivity:
Remember IPA exclusive providers have added privileges with ProMed, for more details contact Rick Jacob at (909) 758-4682.

Senior Aging In Process:
Did you know that you could be losing membership when your Commercial members "age in" or turn age 65? Many members receive so much information as they approach 65, they don't realize that they need to remain in a Senior plan that is contracted with their physician and Medical Group.
In an effort to ensure Commercial members turning age 65 retain you as their PCP, Pomona Valley Hospital Medical Center as their primary facility and Pomona Valley Medical Group, please let your members know that they should compare benefits with the following contracted health plans:

- **Inter Valley Health Plan**
- **Secure Horizon's**
- **Health Net Seniority Plus**

As long as they select a plan from any of these options, they ensure continuity of care and most importantly their personal physician. Call me to discuss a plan on how you can retain your membership as they age in.
Rick Jacob at (909) 758-4682.

Featuring our New Providers:
I would like to welcome the following new Exclusive providers to ProMed, Pomona Valley Medical Group:

- **LaVerne Medical Group: Dr. Ron Dunchok, Dr. Tung-Fan Kwong and Dr. Afshin Saadat.**
- **Chaparral Medical Group: Dr. Henry Sideropoulos**
- **Dr. Kanan Modi**

I would like to welcome the following new providers to ProMed, Pomona Valley Medical Group:

- **Dr. James Ho**
- **Dr. Duc Nguyen**

PROVIDER SERVICES

By: Dawn Tumser, Provider Relations Supervisor

PROVIDER SATISFACTION SURVEY

I want to thank those who participated in ProMed's 3rd qtr. (2009) Provider Satisfaction Survey. ProMed encourages you to participate in these quarterly surveys. ProMed will continue to listen to the concerns and recommendations of our providers and identify those areas that require further attention. Thank you again for your continued support.

PROVIDER UPDATES

New Providers
Ron Dunchok, MD – Internal Medicine
1234 Foothill Blvd., # 2
La Verne, CA 91750
(909) 596-4879

Tung-Fan Kwong, MD – Internal Medicine
1234 Foothill Blvd., # 2
La Verne, CA 91750
(909) 596-4879

Afshin Saadat, MD – Internal Medicine
1234 Foothill Blvd., # 2
La Verne, CA 91750
(909) 596-4879

Freddie Balguma, MD – Pediatric Cardiologist
630 N. 13th Avenue, # C
Upland, CA 91786
(909) 981-6635

Adam Hickerson, MD - Urologist
160 E. Artesia, Suite 220
Pomona, CA 91767
(909) 623-3428

Gowriharan Thaiyananthan, MD - Neurosurgeon
160 E. Artesia Street, Suite 360
Pomona, CA 91767

Milan Sheth, MD – Hematology/Oncology
350 Vinton Ave., Suite 101

Provider Updates *continued on page 3*

Pomona, CA 91767
(909) 620-5502

Dharmesh Mehta, MD
750 N. Archibald Ave., Suite L
Ontario, CA 91764
(909) 989-7551

Kanan Modi, MD
1305 W. Arrow Hwy., Suite 104
San Dimas, CA 91773
(909) 394-9004

Provider Address Changes
Priti Desai, MD
315 N. 3rd Avenue, Suite 205
Covina, CA 91723
(626) 332-4543

Frederick Lauppe, MD
250 E. Bonita Ave., Suite 200
Pomona, CA 91767

Sandra Hollenberg, MD
250 E. Bonita Ave., Suite 200
Pomona, CA 91767

Pramila Agrawal, MD
250 E. Bonita Ave., Suite 200
Pomona, CA 91767

Carrie Knoll, MD
250 E. Bonita Ave., Suite 200
Pomona, CA 91767

James Warren, MD
250 E. Bonita Ave., Suite 200
Pomona, CA 91767

Ericka Hong, MD
250 E. Bonita Ave., Suite 200
Pomona, CA 91767

THE MOST VALUABLE MEDICINE

NO MEDICINE IS more valuable, none more efficacious, none better suited to the cure of all our temporal ills than a friend to whom we may turn for consolation in time of trouble, and with whom we may share our happiness in time of joy.

SAINT AILRED OF RIVAULX (1109-1166)
Historian and abbot

Provider's Corner

By Ewa Konca, M.D., Endocrinology

Obesity has reached the epidemic, here in America and worldwide. Being overweight or obese is not just an inconvenience, personal burden or factor that lowers one's self esteem.

It is a major contributor to many diseases like diabetes, hypertension, sleep apnea, osteoarthritis, cardiovascular and lipid disorders, hormonal disruptions and certain cancers. We as a population have to perceive the gravity of the situation, work on better habits, better food on our tables, better lunches at schools, better snacks in vending machines, better choices in restaurants... .

I as a physician in the field of Endocrinology and Metabolism have to voice a need for wellness.

But what is Wellness:

... "Wellness is not just an absence of illness, but is an active process of achieving an individual's full potential of physical, mental and spiritual well being through-health-producing activities... "

As we age our metabolism drops about 0.5% per year after 20.

This mostly related to a loss of muscle mass, we lose about 5 lbs of muscle in a decade (unfair? Yes, but that's the nature of things, our anabolic hormones Testosterone and Growth hormones are going down, so are the female sex hormones... Sorry Ladies!

Meanwhile, as we subject ourselves to more stress and more demands, our catabolic hormone cortical and the enzyme that loves to store the fat 11-B hydroxydehydrogenaze (HSD) works against us.

If you do not eat right, exercise more, reduce stress, work to fight against free radicals and other toxins in the environment (pollution, noise, excessive alcohol, caffeine, lots of sugar or artificial sweeteners, by products of plastics and certain cosmetics preservatives, like parabems in high concentrations, you will quickly find why at age 50 you have this extra 40 lbs. right around your belly.

You didn't do anything different, so how and why?

Unfortunate, but Stress, lack of Sleep, or poor sleep quality, inadequate nutrition, lack of exercise, and lousy state of mind will make us FAT...

Provider's Corner *continued on page 4*

Not only craving the sweets, getting more irritable is the sign of you losing the battle with cortisol, you may be assured that soon after your mind is going to be lazy and foggy and sure enough you will be reaching for more coffee or soda.

Think different...

Think balanced Macro (Protein, Complex carbs, good fats) and Micronutrients (Vitamins and Minerals). Think PHYTONUTRIENTS (4-5 cups of veggies and fruits combined a day or a good supplement can help to block HSD fat storing enzyme).

Think 15 minutes of exercise, 15 minutes of relaxation and a good night's sleep. That will bring you much closer to wellness.

Good luck on the way to a better, healthier, younger YOU!!!

Provider & Member Services Update

By Laura Jewell, Dir. of Provider & Member Services

As Rick Jacob, VP of Business Development mentioned, we are focusing on activities that market our providers, provide health education, ensure our members receive high quality of care and service, while assisting in growing your membership. We have partnered with health plans, employer groups and senior communities and are scheduled for 37 events through the end of this year (and are still scheduling). Provider Relations/Business Development would very much like your participation to help us showcase your office and services. We do the following type of events to help focus members on the benefits of being a part of our Network:

1. **Open Enrollments**, partner with employers while members are making decisions on health care options and selecting their Primary Care Physician.
2. **Health Fairs**, are great publicity and develop a name for our physicians and services offered through the group. Health Fairs draw large crowds and members can change medical groups at any time, so these platforms really can be good exposure.
3. **Senior Centers**, partner with the senior community to provide education, communicate services offered, along with awareness of our physician network.

When seniors are happy with their health plan and provider, they are very loyal members.
Our main goal is member education, health awareness and vitality among our members along with continuity of care and service. However, we want to be more competitive in the Inland Empire marketplace to help increase your membership. Kaiser is a large competitor and getting larger. They have huge provider participation at events. We realize the value in a personal physician in the local community, but we need to communicate the strengths of our providers. We feel that provider participation will assist us in this endeavor.

We need help with screenings and lectures at events. We need you and/or your office staff to be available to help us communicate a message to the local community that Pomona Valley Medical Group Primary Care Physicians are their "**Personal**" Care Physicians. We feel that personalizing our physicians within the community helps attract membership for our providers, separating our Provider network from Kaiser while building strong loyal relationships. However, we need your help.

After all, our Personal Physician Network is YOU. We would love the opportunity to assist you with continuously growing your membership.

Please contact Provider Relations/Business Development to let us know how you can participate and coordinate events that are located close to your office. Dawn Turnser, Supervisor of Provider Relations and Business Development is at extension 4673 and Lisa Lett, Provider Relations and Business Development Representative is at extension 4674.

Call us to let us know what screenings or lectures you would be available for to allow us the opportunity to show case you and your office at a local event.

Thank you.

PVMG News in Review – Qtr. 3, 2009 Memos

By Karen Harvey, Executive Assistant

The following are memos that were sent to providers regarding key issues in the past quarter. Please review to make certain you received the memos and their attachments. *(Begins page 5)*. This information is usually good to share with our staff and maintain for future reference.

If you have any questions about these memos or require

ProMed Health Care Administrators

Memorandum

Date: **July 17, 2009**

To: **ALL PMPV and UMG Local PCPS**

CC: **Managers and Supervisors:**

From: **Jeereddi A. Prasad, M.D., President/Acting CMO**

Re: Documentation and Coding

PacifiCare has contracted with a physician who is also a certified coder to provide a monthly newsletter on Documentation and Coding.

The purpose of this newsletter is to provide information that can be utilized to increase documentation and coding practices, which will facilitate a more accurate patient health status. Each month a new subject will be addressed.

Please recall, CMS (Center for Medicare and Medicaid Services) reimbursement to IPAs is based on the morbidity of Medicare enrollees. Therefore, failure to code patient medical conditions appropriately will decrease payments to IPA physicians from CMS.

It is ProMed's intention to share these newsletters monthly with our contracted IPA PCPS. Additionally, each month's topic will also be shared with our appropriate contracted specialists.

July 2009 Topic: Congestive Heart Failure

If you have any questions or suggestions on specific coding or documentation issues you may:

- Contact Bridget Harper at bridharp@ca.rr.com **OR**
- Contact Dr Jeereddi Prasad

We trust you will find this information useful to your practice.

MDQuickFax™ Helping doctors get useful information, quickly.

Zack Gerbarg, MD, CPC (certified professional coder), editor

Making the Diagnosis: Congestive Heart Failure

Congestive Heart Failure (CHF) is a common diagnosis in elderly patients that needs to be documented in a progress note and coded at least once each calendar year. For most patients, CHF is a chronic disease that can be managed but not cured. So even a patient whose CHF is well-compensated on treatment still has the underlying disease.

The most common form of CHF is left-sided heart failure with fluid overload. Some patients have combined left and right heart failure and a smaller number have only right heart failure.
Based on the rules for ICD-9 diagnosis coding, a diagnosis only exists when a physician documents it in a progress note based on a face-to-face visit.

What are the most common symptoms and signs that lead to the diagnosis of CHF?
Symptoms of CHF typically include shortness of breath, fatigue, weight gain, and nocturnal dyspnea. Physical examination may include rales in the lungs, ankle edema, and tachycardia. A chest x-ray might show an enlarged heart and signs of fluid in the lungs. An echocardiogram often reveals a decreased ejection fraction and may also show an enlarged heart.

Patients at high risk for CHF include patients with a history hypertension, myocardial infarction, or valvular heart disease.
ICD-9 code Documentation

428.0 CHF, unspecified

428.1 Left heart failure
428.20 Unspecified systolic heart failure
428.30 Unspecified diastolic heart failure
428.40 Unspecified combined systolic and diastolic heart failure
428.9 Unspecified heart failure (e.g. documentation HF)
402.91 Heart failure due to unspecified hypertensive heart disease
(also code heart failure if 428.0-428.43 apply)

Example: The correct documentation and coding for a patient with heart failure seen at least once each year might be:
- **Progress note:** CHF due to hypertensive heart disease
- **Diagnosis codes:** 402.91, 428.0

Basic principles of diagnosis coding:
Every patient should be seen at least once each year with all significant medical diagnoses reviewed and documented in the medical record which is dated and signed by a physician. **A claim or encounter for each physician visit should be submitted that includes specific codes for all diagnoses that are documented in the medical record.**
The information and examples provided above are minimal documentation to support diagnosis coding as only one part of a complete progress note. Final decisions about diagnosis coding should be based on review of standard reference materials.

ProMed Health Care Administrators

Memorandum

Date: **June 30, 2009**

To: **ALL PMPV and UMG Local PCPS**

CC: **Managers and Supervisors:**

From: **Jeereddi Prasad, M.D., President/Acting CMO**

Re: Documentation and Coding

PacifiCare has contracted with a physician who is also a certified coder to provide a monthly newsletter on Documentation and Coding.

The purpose of this newsletter is to provide information that can be utilized to increase documentation and coding practices, which will facilitate a more accurate patient health status. Each month a new subject will be addressed.

Please recall, CMS (Center for Medicare and Medicaid Services) reimbursement to IPAs is based on the morbidity of Medicare enrollees. Therefore, failure to code patient medical conditions appropriately will decrease payments to IPA physicians from CMS.

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June 2009 Topic: COPD

If you have any questions or suggestions on specific coding or documentation issues you may:

- Contact Bridget Harper at bridharp@ca.rr.com **OR**
- Contact Dr Jeereddi Prasad

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Zack Gerbarg, MD, CPC (certified professional coder), editor

Making the Diagnosis: COPD

Chronic Obstructive Pulmonary Disease (COPD) is a common diagnosis in Medicare patients that needs to be documented in a progress note and coded at least once each calendar year. **COPD is characterized by chronic airflow obstruction that is not fully reversible.** Chronic pulmonary disease presents in many forms with a common theme that there is usually a history that helps identify the etiology, symptoms consistent with the diagnosis, physical findings that may suggest the diagnosis, a supporting chest x-ray, and abnormal pulmonary function tests.

What are the most common symptoms and signs that lead to the diagnosis of COPD?

In order to make the diagnosis of chronic obstructive pulmonary disease the patient usually has a history of smoking, cough, sputum production, and exertional dyspnea. Some patients also have an asthmatic component to their COPD.

On physical exam, the patient may have an increased respiratory rate, diminished breath sounds, prolonged expiration, and may use ancillary muscles to assist in labored breathing. Chest x-ray may be read as consistent with emphysema or COPD. Pulmonary function tests (spirometry), if done correctly, can differentiate various forms of chronic lung disease. In COPD, the results show classic reduction of FEV1 and FEV1/FVC. Simple chronic bronchitis is characterized by a chronic productive cough, but does not have airflow obstruction.

Patients with severe COPD often meet the criteria for chronic respiratory failure such as $PO_2 < 60$ mmHg or $PCO_2 > 45$ mmHg and may be placed on chronic oxygen therapy.

ICD-9 code Documentation

491.0 Simple chronic bronchitis (no evidence of obstruction)
491.20 Obstructive chronic bronchitis without exacerbation
491.21 Obstructive chronic bronchitis with acute exacerbation
492.8 Emphysema
493.20 Chronic obstructive asthma, unspecified
496 COPD not classified elsewhere
518.83 Chronic respiratory failure

Example: The correct documentation and coding for a patient with COPD seen at least once each year might be:

Progress note: Emphysema on 24 hour 2L/min O_2 with underlying chronic respiratory failure
Diagnosis codes: 492.8, 518.83

Basic principles of diagnosis coding:
Every patient should be seen at least once each year with all significant medical diagnoses reviewed and documented in the medical record which is dated and signed by a physician. **A claim or encounter for each physician visit should be submitted that includes specific codes for all diagnoses that are documented in the medical record.**
The information and examples provided above are minimal documentation to support diagnosis coding as only one part of a complete progress note. Final decisions about diagnosis coding should be based on review of standard reference materials.

ProMed Health Care Administrators

Memorandum

Date: **August 3, 2009**

To: **ALL PMPV and UMG Local PCPS**

CC: **Managers and Supervisors:**

From: **Jeereddi A. Prasad, M.D., President/Acting CMO**

Re: **Documentation and Coding**

PacifiCare has contracted with a physician who is also a certified coder to provide a monthly newsletter on Documentation and Coding.

The purpose of this newsletter is to provide information that can be utilized to increase documentation and coding practices, which will facilitate a more accurate patient health status. Each month a new subject will be addressed.

Please recall, CMS (Center for Medicare and Medicaid Services) reimbursement to IPAs is based on the morbidity of Medicare enrollees. Therefore, failure to code patient medical conditions appropriately will decrease payments to IPA physicians from CMS.

It is ProMed's intention to share these newsletters monthly with our contracted IPA PCPS. Additionally, each month's topic will also be shared with our appropriate contracted specialists.

July 2009 Topic: The Residual Effects of Stroke

If you have any questions or suggestions on specific coding or documentation issues you may:

- Contact Bridget Harper at bridharp@ca.rr.com **OR**
- Contact Dr Jeereddi Prasad

We trust you will find this information useful to your practice.

MDQuickFax™ Helping doctors get useful information, quickly.

Zack Gerbarg, MD, CPC (certified professional coder), editor

The Residual Effects of Stroke: Documentation and Coding

Example: Progress note: History of embolic stroke with no residual effects
Diagnosis code: V12.54

The diagnosis of stroke of any kind (thrombotic, ischemic, hemorrhagic, or non-specific) is an acute diagnosis that should only be used if the patient is being treated in the hospital for a stroke or if the patient is having a stroke at the time of the visit. Depending on the specific diagnosis, the ICD-9 code range is between 430 and 434.

Examples: 430 Subarachnoid hemorrhage
433.11 Occlusion and stenosis of carotid artery with cerebral infarct

Note: The ICD-9 diagnosis code **436 is no longer the correct code for an unspecified acute stroke or CVA** and has been replaced by code 434.91.

If the patient has had a stroke but has no residual effects, the correct diagnosis is "history of stroke" or "S/P stroke" or similar documentation. However, if the patient has had a stroke and has residual effects from the stroke, then the residual effects should be documented and coded.

Documentation and ICD-9 coding for stroke and its late or residual effects include:

ICD-9 Physician Documentation
V12.54 Personal history of TIA or cerebral infarct without residual effects

438.11 aphasia due to cerebrovascular disease
438.20 hemiplegia affecting unspecified side due to cerebrovascular disease
438.30 monoplegia of upper limb affecting unspec side due to cerebrovasc disease
438.40 monoplegia of lower limb affecting unspec side due to cerebrovasc disease

Example: The correct documentation and coding for a residual effect of stroke might be:
Progress note: S/P CVA resulting in right arm paralysis
Diagnosis codes: 438.30

Basic principles of diagnosis coding:
Every patient should be seen at least once each year with all significant medical diagnoses reviewed and documented in the medical record which is dated and signed by a physician. A claim or encounter for each physician visit should be submitted that includes specific codes for all diagnoses that are documented in the medical record.
The information and examples provided above are minimal documentation to support diagnosis coding as only one part of a complete progress note. Final decisions about diagnosis coding should be based on review of standard reference materials.

ProMed Health Care Administrators

Memorandum

Date: **August 11, 2009**

To: **ALL PMPV and UMG Local PCPS**

CC: **Managers and Supervisors:**

From: **Jeereddi A. Prasad, M.D., President/Acting CMO**

Re: **Documentation and Coding**

PacifiCare has contracted with a physician who is also a certified coder to provide a monthly newsletter on Documentation and Coding.

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Please recall, CMS (Center for Medicare and Medicaid Services) reimbursement to IPAs is based on the morbidity of Medicare enrollees. Therefore, failure to code patient medical conditions appropriately will decrease payments to IPA physicians from CMS.

It is ProMed's intention to share these newsletters monthly with our contracted IPA PCPS. Additionally, each month's topic will also be shared with our appropriate contracted specialists.

August 2009 Topic: Common Pulmonary Diseases

If you have any questions or suggestions on specific coding or documentation issues you may:

- Contact Julie Boo at Julie.boo@ingenix.com **OR**
- Contact Dr Jeereddi Prasad

We trust you will find this information useful to your practice.

MDQuickFax™ Helping doctors get useful information, quickly.

Zack Gerbarg, MD, CPC (certified professional coder), editor

Common Pulmonary Diseases: Documentation and Coding

Example: Progress note: COPD with chronic respiratory failure
Diagnosis code: 496, 518.83

The Centers for Medicare and Medicaid (CMS) are requiring physicians to accurately document and code pulmonary diseases in order to evaluate patient severity.

Even for patients with long-standing chronic pulmonary disease (chronic bronchitis, emphysema, or COPD), it is important at least once each calendar year for physicians to document in their medical records and submit in their claims the correct ICD-9 diagnosis codes. Common pulmonary diseases that impact Medicare severity adjustment include:

ICD-9 code Documentation
481 pneumococcal pneumonia
491.20 obstructive chronic bronchitis, without exacerbation
491.21 obstructive chronic bronchitis, with acute exacerbation
491.9 chronic bronchitis
492.8 emphysema
493.20 chronic obstructive asthma, unspecified
496 COPD
V44.0 tracheostomy
518.83 chronic respiratory failure

162.9 primary lung cancer

(note: **198.3** metastatic to brain; **198.5** metastatic to bone; **196.9** metastatic to lymph node)
197.0 secondary lung cancer (metastatic to lung from other source)

Example: The correct documentation and coding for a patient with pulmonary disease seen at least once each year might be:

Progress note: patient with emphysema, tracheostomy functioning well
Diagnosis codes: 492.8, V44.0

Progress note: lung cancer with metastases to brain, undergoing treatment
Diagnosis codes: 162.9, 198.3

Basic principles of diagnosis coding:
Every patient should be seen at least once each year with all significant medical diagnoses reviewed and documented in the medical record which is dated and signed by a physician. **A claim or encounter for each physician visit should be submitted that includes specific codes for all diagnoses that are documented in the medical record.**

The information and examples provided above are minimal documentation to support diagnosis coding as only one part of a complete progress note. Final decisions about diagnosis coding should be based on review of standard reference materials

ProMed Health Care Administrators

FACSIMILE TRANSMITTAL

Date: *August 18, 2009*

To: *PVMG PCP's & Specialist's*
*UMG PCP's * Specialist's*

Cc: *Managers, Supervisors*

From: *Laura Jewell* ***Phone #:*** *909.932.1045, x4601*
Director of Provider and Member Services

RE: *Language Assistance Programs* ***Pages: 3*** *(including cover)*

Attached please find a tool to assist you in providing language assistance to your limited English speaking members. We realize most of your offices will use office personnel who are bilingual to provide interpretive services. However, if there isn't anyone available to interpret a particular language, please call the appropriate health plan number on the attached document.

Please remember to document the member's preferred language in the patients chart. Additionally, if the member refuses language assistance or insists on using a family member, you must document this information as well.

Face to face interpreters must be arranged in advance of your appointment. Please call the appropriate health plan number at least 5-7 days in advance of the scheduled appointment. If the appointment is cancelled, please provide a 48-hour advance notice.

If you have any additional questions, please don't hesitate to call Customer Service at (909) 932-1045, press option #1.

Thank you.

4150 E. Concours St., Suite 100, Ontario, CA 91764

LANGUAGE ASSISTANCE PROGRAMS BY HEALTH PLAN

(C&L and LAP)
Updated 7/09

Language Assistance Program for Commercial Members:

The Language Assistance Program (LAP) requires the health plan provide interpretation services(over-the-phone and in-person) at no cost for threshold languages determined based on the language preferences of the largest number of Commercial plan enrollee only. ***If the member speaks a different language other than one identified as a threshold language by the health plan, please contact the health plan for assistance.***

Health Plan	Phone Number	Threshold Languages
Aetna Com/POS	1-877-287-0117 Sign Language (CA Relay): 1-888-877-5379	*Spanish*
Anthem Blue Cross Comm/POS	1-888-254-2721 Sign Language (CA Relay): 1-888-877-5379	*Spanish* Chinese Vietnamese Korean Tagalog
Blue Shield Com/POS/HF	1-866-346-7198 Sign Language (CA Relay): 1-888-877-5379	*Spanish* Chinese Vietnamese
Cigna Com/POS	1-800-244-6224 Sign Language (CA Relay): 1-888-877-5379	*Spanish* Chinese
Great West	1-800-663-8081 Sign Language (CA Relay): 1-888-877-5379	*Spanish*
Health Net Com/ POS/HF	1-800-522-0088 Sign Language (CA Relay): 1-888-877-5379	*Spanish* Chinese
PacifiCare Com/POS	1-800-624-8822 Sign Language (CA Relay): 1-888-877-5379	*Spanish* Chinese

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4150 E. Concours St., Suite 100, Ontario, CA 91764

LANGUAGE ASSISTANCE PROGRAMS BY HEALTH PLAN

(C&L and LAP)

Updated 7/09

Cultural & Linguistics Program for Medi-Cal Members:

In accordance with regulatory requirements, free interpretations services must be available 24-hours/day 7-days/week for Limited English speaking and hearing impaired Medi-Cal members.

Health Plan	Phone Number	Guidelines
Care First Medi-Cal	Spoken Languages: 1-800-605-2556 Sign Language (CA Relay): 1-888-877-5379	In-person interpretation requires a 5-7day advance request. Cancelations or to reschedule require 48-hour advance notice.
CHP Medi-Cal	Spoken Languages: 1-800-475-5550 Sign Language (CHP TTD): 1-800-353-7988 Sign Language (CA Relay): 1-888-877-5379	In-person interpretation requires a 7-10 day advance request. Cancelations or to reschedule require 48-hour advance notice.

Cultural & Linguistics Program for Senior Members:

Health Net Seniors	Spoken Languages: 909-932-1045 Sign Language (CA Relay): 1-888-877-5379	Submit Authorization Request to PVMG/UMG
IVHP Senior	Spoken Languages: 909-932-1045 Sign Language (CA Relay): 1-888-877-5379	Submit Authorization Request to PVMG/UMG
Secure Horizons Senior	Spoken Languages: 909-932-1045 Sign Language (CA Relay): 1-888-877-5379	Submit Authorization Request to PVMG/UMG

ProMed Health Care Administrators

Memorandum

Date: **September 3, 2009**

To: **ALL PMPV and UMG Local PCPS**

CC: **Managers and Supervisors:**

From: **Jeereddi A. Prasad, M.D., President/Acting CMO**

Re: Documentation and Coding

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Please recall, CMS (Center for Medicare and Medicaid Services) reimbursement to IPAs is based on the morbidity of Medicare enrollees. Therefore, failure to code patient medical conditions appropriately will decrease payments to IPA physicians from CMS.

It is ProMed's intention to share these newsletters monthly with our contracted IPA PCPS. Additionally, each month's topic will also be shared with our appropriate contracted specialists.

September 2009 Topic: Common Vascular Diseases

If you have any questions or suggestions on specific coding or documentation issues you may:

- Contact Sasha Evans @ sasha.evans@ingenix.com. **OR**
- Contact Dr Jeereddi Prasad

We trust you will find this information useful to your practice.

MD QuickFax™ Helping doctors get useful information, quickly.

Zack Gerbarg, MD, CPC (certified professional coder), editor

Common Vascular Diseases: Documentation and Coding

Example: Progress note: abdominal aortic aneurysm, peripheral vascular disease
Diagnosis codes: 441.4, 443.9

Vascular diseases are common in older patients and can often occur as a manifestation of diabetes. Remember to document in your progress notes and then submit all the appropriate ICD-9 diagnosis codes with your claims for your patients who have vascular diseases.

Documentation and ICD-9 coding for common vascular diseases include:

ICD-9 Physician Documentation
440.0 atherosclerosis of the aorta
440.1 atherosclerosis of the renal artery
440.21 atherosclerosis of the extremities with intermittent claudication
440.23 atherosclerosis of the extremities with ulceration
(also code **707.10** ulcer of lower limb, except decubitus)

441.2 thoracic aneurysm, without mention of rupture
441.4 abdominal aortic aneurysm (AAA), without mention of rupture
443.81 peripheral vascular disease due to diabetes
(also code first: **250.70** diabetes with peripheral vascular manifestations)
443.9 peripheral vascular disease

451.11 phlebitis and thrombophlebitis of the femoral vein
451.19 phlebitis and thrombophlebitis of other deep vessels of lower extremities
(Note: 451.0 phlebitis of superficial vessels does not impact severity adjustment)

Example: The correct documentation and coding for a patient with vascular disease seen at least once each year might be:
Progress note: peripheral vascular disease with improving skin ulcer on left leg
Diagnosis codes: 440.23, 707.10

Basic principles of diagnosis coding:
Every patient should be seen at least once each year with all significant medical diagnoses reviewed and documented in the medical record which is dated and signed by a physician. **A claim or encounter for each physician visit should be submitted that includes specific codes for all diagnoses that are documented in the medical record.**
The information and examples provided above are minimal documentation to support diagnosis coding as only one part of a complete progress note. Final decisions about diagnosis coding should be based on review of standard reference materials.

ProMed Health Care Administrators

Urgent Memorandum

Via FACSIMILE – 3 Pages

Date: **September 9, 2009**
To: **PVMG & UMG PCP's, Specialists, and Urgent Care Centers**
Copy: **J. Prasad, M.D., Managers, Supervisors, Case Managers, Customer Service**
From: **Jacqueline Caya, Contracts Manager**
RE: **Pandemic Influenza H1N1 Vaccination Planning**

Dear Providers:

Attached please find two (2) Informational Documents regarding the Pandemic Influenza H1N1 Vaccine (*aka Novel Influenza A (H1N1) Vaccine*). Please note, the H1N1 Vaccine is not intended to replace the seasonal flu vaccine, it is intended to be used along-side the seasonal flu vaccine.

These documents will provide information and instructions on the following topics:

1) Who should be vaccinated
2) When will the vaccine be available
3) How many Manufacturers are producing the vaccine
4) How can Providers order the H1N1 Vaccine
5) Pre-Registering and Ordering the vaccine
6) Receiving vaccine information and updates
7) Reporting your H1N1 Vaccine usage

The H1N1 Vaccine will be furnished at no cost to all Providers.

ProMed Health Care Administrators is currently researching vaccine administration reimbursement as it relates to the Pandemic Influenza H1N1 Vaccine with our Contracted Health Plans. Further information on this subject will be forwarded to you soon.

If you administer vaccines, please follow the attached instructions to Pre-Register and Order this vaccine for our PVMG and UMG members as soon as possible.

If you have any questions, please contact our Customer Service Department at (909) 932-1045, Press Option 1.

Thank you.

4150 E. Concours Street, #100, Ontario, CA 91764-4989
Phone (909) 932-1045 Fax (909) 932-1065

Pandemic Influenza H1N1 Vaccine is coming soon!

Who should be vaccinated?

On August 21, 2009, the CDC Advisory Committee of Immunization Practices (ACIP) published recommendations for "Use of Influenza A (H1N1) 2009 Monovalent Vaccine".

Also reference "Morbidity and Mortality Weekly Report (MMWR) Recommendations and Reports" (8/28/09) via internet website: www.cdc.gov/mmwr

Initial Target Groups recommended to receive the H1N1 Influenza Vaccine include:

1. Pregnant women
2. People who live with or care for children younger than 6 months of age
3. Healthcare and emergency medical services personnel
4. Persons between the ages of 6 months through 24 years of age
5. People from 25-64 years of age who have health conditions associated with higher risk of medical complications from influenza.

Once the demand for vaccine for the prioritized groups has been met at the local level, Providers should also begin vaccinating everyone from the ages of 25 through 64 years.

Current studies indicate that the risk for infection among persons age 65 or older is less than the risk for younger age groups. However, once vaccine demand among younger age groups has been met, programs and providers should offer vaccination to people 65 or older.

When will the Vaccine be available?

Vaccine is in production and currently expected to first be available by mid-October.

How many manufacturers are producing vaccine?

Five (5) manufacturers are producing vaccine for the U.S: Sanofi Pasteur, Novartis, GSK, MedImmune, and CSL.

How can providers order the H1N1 Vaccine?

Starting **September 1, 2009**, via internet website, go to www.CalPanFlu.org to Pre-Register for Vaccine, Order Vaccine, and receive information and updates.

For more information, and updates on the H1N1 Vaccine, please visit the Centers for Disease Control and Prevention internet website at:

http://www.cdc.gov/h1n1flu/vaccination/statelocal/qa.htm

CalPanFlu.org

Pandemic Influenza H1N1 Vaccine is coming soon!

The California Department of Public Health and California's local health departments are calling all parties interested in providing this vaccine...

- Clinics, public and private
- Community Health Centers
- Community vaccinators
- Employee health programs
- Health plans
- Hospitals
- Pharmacies, chain and Independent Physicians
- Other vaccinators

Starting by September 1, 2009, go to **www.CalPanFlu.org**

1. Pre-register for vaccine

Sign up to receive H1N1 vaccine as it becomes available.
Pre-registration:

- is not a binding commitment to provide vaccine
- can *only* be done by (or in conjunction with) a physician licensed to practice medicine in California
- lets California Vaccines for Children (VFC) providers use their PIN number for fast track identification

2. Order vaccine

Vaccine is in production and currently expected to first be available by mid-October.
Vaccine and basic supplies will be delivered at **no cost to you.** Providers may bill public and private insurers for vaccine administration fees.

- **HOW:** Pre-register and order early to minimize delays. (*Note: Pre-registration and ordering do not guarantee receipt of vaccine*)
- **WHEN:** Timing and amount of vaccine deliveries will depend on available inventory.
  First deliveries are expected by mid-October or later.
- **WHO:** Initial orders will go to vaccinators serving at-risk population groups. Other requests will be filled in turn, as supply permits.

3. Receive vaccine information and updates

- vaccine availability
- storage and handling
- training on vaccination
- the pandemic in California

4. Report your H1N1 vaccine usage

- Instructions are available to complete a simple weekly report on H1N1 vaccine at your medical practice

Additional information will soon be available at **www.CalPanFlu.org**
Thank you for your interest in protecting California from pandemic influenza!

CDPH Immunization Branch Aug 2009

ProMed Health Care Administrators

Memorandum

Date: **September 18, 2009**

To: **ALL PMPV and UMG Local PCPS**

CC: **Managers and Supervisors:**

From: **Jeereddi A. Prasad, M.D., President/Acting CMO**

Re: **Documentation and Coding**

PacifiCare has contracted with a physician who is also a certified coder to provide a monthly newsletter on Documentation and Coding.

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September 2009 Topic: Peripheral Vascular Disease

If you have any questions or suggestions on specific coding or documentation issues you may:

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Making the Diagnosis: Peripheral Vascular Disease

Peripheral Vascular Disease (PVD) and atherosclerosis of the extremities are common diagnoses in elderly patients that need to be documented in a progress note and coded at least once each calendar year.

The first step for the clinician is to make the diagnosis and to clearly document it. Based on the rules for ICD-9 diagnosis coding, a diagnosis only exists when a physician notes it in a progress note based on a face-to-face visit.

What are the most common symptoms and signs that lead to the diagnosis of PVD?
Symptoms of arterial insufficiency include intermittent claudication, muscle or limb weakness with use, resting limb pain or paresthesia, and poor healing of sores or ulceration. Physical examination of an affected limb often reveals decreased pulses, decreased capillary refilling, increased venous filling time, atrophic changes, loss of hair, discoloration of skin, decreased warmth, and vascular bruits. Tests for PVD might include ankle-brachial index (comparing lower and upper extremity blood pressure), angiography, or other studies.

Patients at high risk for PVD and atherosclerosis of the extremities include patients with diabetes, history of smoking, hyperlipidemia, or other evidence of vascular disease.
ICD-9 code Documentation

443.9 unspecified peripheral vascular disease

443.81 PVD in diseases classified elsewhere – also code first the underlying disease (e.g. diabetic angiopathy – code first 250.70 or 250.72)

440.21 Atherosclerosis of the native arteries of extremities with intermittent claudication
440.22 Atherosclerosis of the native arteries of extremities with rest pain
440.23 Atherosclerosis of the native arteries of extremities with ulceration (also code ulceration 707.10 – 707.9)

440.24 Atherosclerosis of the native arteries of extremities with gangrene (also code ulceration 707.10 – 707.9)

440.30 Atherosclerosis of unspecified bypass graft of extremities
Example: The correct documentation and coding for a patient with peripheral vascular disease seen at least once each year might be:
Progress note: PVD due to uncontrolled adult onset diabetes
Diagnosis codes: 250.72, 443.81

Basic principles of diagnosis coding:
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PROVIDER SATISFACTION SURVEY
POMONA VALLEY MEDICAL GROUP 2009

Approval rate = agree + strongly agree

BENCHMARK GOAL- 85% IN EACH AREA

	2006 YTD	2007 YTD	2008 YTD	2009 QRT 1	2009 QRT 2	2009 QTR 3	2009 YTD
SURVEYS SENT	451	397	419	124	127	127	378
RESPONSES	168	169	149	37	43	43	123
RESPONSE RATE	37.25%	42.57%	35.56%	29.84%	33.86%	33.86%	32.54%

	Questions:	APPROVAL RATE	APPROVAL RATE	APPROVAL RATE	APPROVAL RATE	APPROVAL RATE	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Ttl replies	REPLY RATE	TTL APPR	APPROVAL RATE	APPROVAL RATE
CUSTOMER SERVICES																
1	IPA staff returns your phone calls promptly	95.2%	86.7%	77.9%	83.8%	86.0%	0	0	4	15	24	43	33.9%	39	90.7%	86.8%
2	IPA staff answers your questions to your satisfaction	95.8%	90.1%	85.3%	81.1%	90.7%	0	0	4	20	19	43	33.9%	39	90.7%	87.5%
3	IPA staff is courteous when you call	98.8%	85.9%	89.1%	89.2%	93.0%	0	0	4	18	21	43	33.9%	39	90.7%	91.0%
4	IPA staff is helpful when you call	96.4%	89.1%	86.4%	89.2%	93.0%	0	0	4	18	21	43	33.9%	39	90.7%	91.0%
CUSTOMER SERVICES		96.6%	88.0%	84.7%	85.8%	90.7%						172		156	90.7%	89.1%
CLAIMS																
5	Your claims are processed in a timely fashion	88.7%	87.1%	82.3%	78.4%	81.4%	0	0	3	28	12	43	33.9%	40	93.0%	84.3%
6	Questions regarding claims are handled quickly	86.9%	82.9%	77.8%	78.4%	79.1%	0	0	5	24	14	43	33.9%	38	88.4%	81.9%
7	Questions regarding claims are handled qppropriately	84.4%	80.8%	80.3%	78.4%	79.1%	0	1	3	26	13	43	33.9%	39	90.7%	82.7%
CLAIMS		86.7%	83.6%	80.1%	78.4%	79.8%						129		117	90.7%	83.0%
AUTHORIZATIONS																
8	Referrals are returned to you in a timely fashion	95.2%	85.9%	78.8%	78.4%	79.1%	0	1	3	20	19	43	33.9%	39	90.7%	82.7%
9	IPA referral forms are user friendly	95.9%	93.6%	94.1%	86.5%	93.0%	0	0	2	19	22	43	33.9%	41	95.3%	91.6%
10	Questions regarding referrals are handled quickly	95.3%	89.1%	82.1%	78.4%	86.0%	0	0	2	20	21	43	33.9%	41	95.3%	86.6%
11	Questions regarding referrals are handled appropriately	89.4%	82.2%	83.0%	70.3%	86.0%	0	0	3	19	21	43	33.9%	40	93.0%	83.1%
AUTHORIZATIONS		94.0%	87.7%	84.5%	78.4%	86.0%						172		161	93.6%	86.0%
ANCILLARY PROVIDERS																
12	**Contracted ancillary providers render adequate services as listed below:**															
12a	Lab	55.1%	58.3%	62.6%	54.1%	69.8%	0	1	22	11	9	43	33.9%	20	46.5%	56.8%
12b	Radiology	76.5%	76.4%	70.4%	73.0%	86.0%	0	0	8	23	12	43	33.9%	35	81.4%	80.1%
12c	Home Health	64.6%	55.4%	61.6%	67.6%	72.1%	0	0	19	17	6	42	33.1%	23	54.8%	64.8%
12d	DME	64.5%	50.9%	60.0%	64.9%	74.4%	0	0	12	15	16	43	33.9%	31	72.1%	70.5%

Comments:

continued from page4

copies of the forms, please contact either the writer of the memo or Karen Harvey, Executive Assistant at (909) 932-1045, ext. 4402. Thank you.

ProMed Offices Closed

By Karen Harvey, Executive Assistant

ProMed health Care Administrator's offices including the corporate offices of Pomona Valley Medical Group and Upland Medical Group will be closed on the following dates:

- Thursday, November 26th & Friday, November 27th, 2009 for the Thanksgiving Day Holiday
- ½ day Thursday December 24th & all day Friday, December 25th, 2009 for the Christmas Holiday
- ½ day Thursday, December 31st, 2009 & all day Friday, January 1, 2010 for the New Year's Day Holiday

As always, an on-call Case Manager (nurse) is available. The on-call nurse can be reached by calling the regular office number (909) 932-1045 and following the prompts to speak with the on-call nurse. If you have any questions about ProMed's Holiday schedule please call Karen Harvey at (909) 932-1045, ext. 4402.

Special Dates

COLUMBUS DAY

MONDAY, OCTOBER 12, 2009

NATIONAL BOSSES DAY

MONDAY, NOVEMBER 16, 2009

NATIONAL BOSSES DAY

MONDAY, OCTOBER16, 2009

HALLOWEEN

SATURDAY, OCTOBER 31, 2009

DAYLIGHT SAVINGS TIME ENDS

SUNDAY, NOVEMBER 1, 2009

ELECTION DAY

TUESDAY, NOVEMBER 3, 2009

VETERAN'S DAY

WEDNESDAY, NOVEMBER 11, 2009

THANKSGIVING DAY

THURSDAY, NOVEMBER 26, 2009

PEARL HARBOR REMEMBRANCE DAY

MONDAY, DECEMBER 7, 2009

HANUKKAH

SATURDAY, DECEMBER 12, 2009

WINTER BEGINS

MONDAY, DECEMBER 21, 2009

CHRISTMAS DAY

FRIDAY, DECEMBER 25, 2009

KWANZAA BEGINS

SATURDAY, DECEMBER 26, 2009

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