// POMONA VALLEY MEDICAL GROUP
HEALTH CARE HERALD

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

President's Message

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

The best time of the year is here! Time to get together with family and friends to share the joy.

2009 has been a year of challenge. The economy is slowly starting to recover. It looks like we may have Health Care Reform. The shape of the reform is not known yet.

We as a health care network will be facing new challenges. Our organization is working diligently to stay ahead of the curve.

I thank all of you for the support and wish you Happy and Healthy Holidays.

INSIDE THIS ISSUE

1	President's Message
1	Chief Operating Officer's Bulletin
1	Business Development
2	Provider Services
3	Provider & Member Services Update
3	2009 PAS (Patient Assessment Survey) Results
4	Provider's Corner
4	PVMG News in Review Qtr. 4, 2009
5	Medical Records Standards
6	Physician Office Access Guidelines
23	ProMed Offices Closed
23	Special Dates
23	Editorial Information

Chief Operating Officer's Bulletin

By Brian Werderman, COO

The holiday season is a time to enjoy with family and friends, and also to be thankful for the many blessings that have been bestowed upon us. It is also a time to reflect on 2009 and look ahead to 2010.

At ProMed, we are thankful for a strong year in 2009 and the partnership we have with our providers in the Inland empire. With the uncertainties looming of the impact of pending healthcare reform, our shared mission with our providers of quality patient care remains unchanged.

In 2010, ProMed will place a high priority on being a customer service organization, to help our physician partners succeed. We plan on conducting quarterly meetings to share information, and to listen and respond to the issues that are of importance and priority from your perspective.

In addition, our Provider Relations team will be visiting your offices for meetings that are more personal, targeting areas that are of specific interest and concern to you. In addition to our primary objective of quality patient care and satisfaction, we will also be focusing more attention this coming year on incentivizing our physicians for various initiatives involving Risk Adjustment, Pay for Performance and a greater emphasis on technology through our various EMR/EHR initiatives.

We thank you again for a very successful 2009, and look forward to collaborating with you in 2010.

Business Development

By Rick Jacob, VP of Business Development

This past year has been a year of transition, adjustments, and foundation building.

As ProMed has been able to expand our PCP panel of physicians and increase the number of exclusive physicians within our network. This achievement has enabled and will continue to allow us to grow our membership base (specifically on the Medicare product line) and give us the opportunity to gain new contracts in the year to come.

Business Development *continued on page 2*

In the face of a decreasing economy, ProMed has been able to position itself for future growth and I am extremely proud of the commitment by the ProMed team and the physician network that we serve.

At the end of this calendar year ProMed has participated in more than 23 senior activity events and 28 commercial events and has strengthened its hospital relationship, health plan, and broker contacts. We continually exhibit our physicians at these events to assist in increasing growth for you as well as our network.

ProMed will continue to build off the momentum that we have built and will be rolling out our age-in strategy to our providers that want to ensure that they maintain the workforce population that are turning 65. If you would like to know more about this and other ideas on how we can build each others business, please don't hesitate to contact me at (909) 758-4682.

I wish all of you the happiest Holiday Season!

PROVIDER SERVICES

By: Dawn Tumser, Provider Relations Supervisor

PROVIDER SATISFACTION SURVEY

I want to thank those who participated in ProMed's 4th 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

Ramon Fakhoury, MD – Family Practice
1780 Towne & Country Drive, Suite 103
Norco, CA 92860
(951) 270-0757

Elias Ptak, DO – Family Practice
8112 Milliken Ave., Suite 101-2
Rancho Cucamonga, CA 91730
(909) 706-3950

Pavan Nootheti, MD – Dermatology
16465 Sierra Lakes Pkwy., Suite 250
Fontana, CA 91786
(909) 770-8640

Sadiq Mandilawi, MD - Endocrinology
1234 Foothill Blvd., #2
La Verne, CA 91750
(909) 596-4879

Daniel Lee, MD – Orthopedics
1902 Royalty Drive., Suite 130
Pomona, CA 91767
(909) 629-4506

Provider Address Changes

Jeffrey Bruening, DPM
1900 Royalty Drive, Suite 230
Pomona, CA 91767
(909) 622-4501

Second Address Added

Umesh Shah, MD
1866 N. Orange Grove, Suite 104
Pomona, CA 91767
(909) 623-8628

Jeffrey Bruening, DPM
9474 Baseline Road
Alta Loma, CA 91701
(909) 987-3211

Geeta Patel, MD
2140 Grand Ave., Suite 230
Chino Hills, CA 91709
(909) 989-7551

Providers No Longer with PVMG

Lloyd Costello, MD

DURING A REHEARSAL of one of his plays, Sir James M. Barrie became increasingly irritated with the producer's young son, who was convinced he knew it all.

Repeatedly, the youth interrupted the proceedings to criticize one of the principals. After one such outburst, Barrie turned to him and said:

"My boy, you will have to be more patient with us. After all, we are not young enough to know everything."

JACOB M. BRAUDE
Braude's Treasure of Wit and Humor
Prentice-Hall, Inc.

Provider & Member Services Update

By Laura Jewell, Dir. of Provider & Member Services

Lab Corporation of America (Lab Corp)

Our contracted laboratory remains Lab Corp since February 1, 2008. We wanted to remind all of our providers that members need to be referred to Lab Corp. Quest is not contracted. We are still experiencing leakage to Quest Diagnostics for laboratory services for Pomona Valley Medical Group members.

Please make sure that all Pomona Valley Medical Group members are referred to Lab Corp for all laboratory tests.

Thank you.

PCP Meeting Follow Up Items

Many suggestions for improvement have been communicated at the PCP meetings and are in the process of being evaluated and reviewed. The following items have been decided:

IMMUNIZATIONS:

1. **Pneumococcal (Pneumovax 23) CPT code 90732 will not require prior authorization.** Immunization Authorization and Claims Guidelines have been updated.
2. **HPV (Gardasil) CPT code 90659 will not require prior authorization for female patients ages 11-26.** All male patients and female patients outside of the age range are not recommended by the CDC, except in a few circumstances. Immunization Authorization and Claims Guidelines have been updated.
3. Some PCP's requested the option of having certain higher cost immunizations delivered instead of providing and submitting for reimbursement. Our vendor, Option Care, can provide the following immunizations and you can choose to have them delivered vs. providing from your stock and billing:
   - **Zostovax (90736)**
   - **Gardasil (90649)**
   - **Verivax (90716)**
   - **Menactra (90734)**

Please follow the Immunization Authorization and Claims Guidelines to know if the immunization requires authorization and where you should bill. If Pomona Valley Medical Group is financially responsible for the immunization, you will need to submit an authorization and specify if you would like the immunization delivered. We will order from Option Care if you request it for any of the above immunizations.

HCC Update

We wanted to say thank you for all your efforts in submitting the claims identified in the HCC project. As long as you saw the member before 12/31/09, you can continue to submit the claims and health assessment forms through 3/31/10 to be eligible for the $75.00 incentive.

Looking forward to the New Year, we will be rolling out our incentive strategy early in 2010 to ensure you have much more time to see the patients and turn in the claim and health assessment forms so you can be paid the incentive.

We are striving to make the process simple, but it needs to be effective. We want to incentivize our PCP's, while ensuring we are meeting CMS guidelines. We will be communicating with you in early 2010.

Thanks again for assisting us with getting the members in for a visit before the end of the year.

2009 PAS (Patient Assessment Survey) Results

By Rosa Catalano, VP of Health Services

PVMG's trending results of the CCHRI report on Quality are as follows.

Patient Assessment Survey	2008 PVMG Score	2009 PVMG Score	CA Statewide Average
Rating of Overall health Care	85	81.9	84.5
Rating of Personal Doctor	88	86.2	87.1
Rating of Specialist	84	83.3	85.8
Coordination of Care	73	53.4	75.4
Health Promotion		53.4	55.4
Doctor-Patient Interactions	87	87.2	88.5
Office Staff Interactions	80	79.6	85.1

2009 PAS Results *continued on page 4*

 continued from page 3

Patient Access	70	70	75.0
Emergency Instructions	100	98%	96%
Physician Availability Compliant		82%	75%

Please review the above results for potential areas of improvement to meet the California Statewide Averages.

Provider's Corner

By Ewa Konca, M.D., Endocrinologist

Holidays are always a time of family gatherings, good wishes, gift giving and reflections…

On the other hand It is always a time of rush, shopping, cooking, baking and running around.

Then we realize it is 364 days to Christmas again…

This year I a got fantastic gift for Christmas.

It arrived just on time, when I was a bit frustrated caught between the patients , paperwork and the home chores . It was a gift of appreciation- a card from one of my patients who entered a" Figure 8 "program several months ago and as we were walking together every Saturday morning with our walking group supporting that program Diane became a close friend.

What a transformation!

She has lost 46 lbs, improved her diabetes, lipid profile, liver function tests (She had fatty liver with elevated liver enzymes before, that now with the use of the supplements and life style change completely normalized)
Her athletic performance has greatly improved, so is her general approach to life(not to mention her looks!)
She wrote "Thank you…for the best Christmas present,-"

The new me"-I feel better, look better and hope that I have added a few extra years of better health to my life"…
Then I have realized that my Christmas was better as well
Helping people to feel better look better and hopefully live longer, better quality lives is what my job and passion is all about .

I have been working with Arbonne products for last 10 months and have to say I am very impressed with the quality and the concepts.

It is a great tool in our hands as physicians to broaden our possibilities in helping our patients on their way to wellness.

Very high quality vegan based protein shake, that replaces one meal per day supplying a person with 20 grams of valuable protein and only 160 kcal, supporting products that help to cut the cravings for sweets and caffeine in the form of chews and energy drink plus botanically based pill taken before the main meals that help break down the fat and decrease the appetite plus stabilize blood sugar to some degree.

In our experience with Figure 8 people who are using the program report less fatigue, increased stamina and fewer cravings and consider the program very convenient and affordable.

I would love to explain more how this program can benefit you and your patients in 2010 as I am sending you the best wishes for the New Year to come

Ewa Konca,M.D.
909-969-0042
ewakonca@aol.com

PVMG News in Review – Qtr. 4, 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 7).*** 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 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.

WHAT WE HAVE DONE has barely scratched the surface. It turns out that there is, in fact, unlimited juice in that lemon. The fact is, this is not about squeezing anything at all: It is about tapping an ocean of creativity, passion, and energy, that as far as we can see, has not bottom and no shores.

JACK WELCH
CEO, General Electric

Medical Record Standards

By: LisaMarie Steffens, LVN, QI Nurse

1. Chart Organization

The record is to be maintained as follows:

1) Each member medical record must be individually trackable.
2) The record is secured to maintain confidentiality. Paper clips are not acceptable.
3) Every page in the record contains the member name or ID number.
4) All entries contain author identification and There is a section for Biographic/Personal data. There should be evidence this data is reviewed and updated every two years. Data elements contain Address, Employer to include phone number, DOB, emergency contact, including phone number, marital status.

2. Documentation Element Guidelines (Asterisk items are required for review)

1) Each page in the record contains the patient's name or ID number. Chart contents are secured.
2) There is personal biographic data that work number and marital status. This information should be updated every two (2) years. For Pediatric members, at least one parent's employer is to be documented.
3) All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, unique electronic identifier or initials. Credential is required on the progress note.
4) All entries are dated.
5) **** The record is legible to someone other than the writer.**
6) *Documentation as to patient's primary language
7) *Indication if interpreter is requested
8) * Medication allergies and adverse reactions are noted in a consistent, prominent place. If the patient has no known allergies or history of adverse reactions this is appropriately noted.
9) * Problem lists are used for members with significant illnesses and/or conditions that should be monitored. A chief complaint and diagnosis or probable diagnosis is included.
10) Information pertinent to the member's presenting complaints.
11) Laboratory and other studies are appropriately ordered.
12) There is documentation of an exam appropriate for the condition.
13) * Working diagnoses are consistent with findings.
14) * Treatment plans are consistent with diagnoses.
15) 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.
16) Three times is easily identifiable. This documentation includes serious accidents, operations, substance use, sexual activity, if applicable, and childhood illnesses. For children and adolescents (18 and younger) past medical history relates to prenatal care, birth, operations and childhood illnesses.
17) * For patients (14 years and older), there is appropriate notation concerning the use of cigarettes, alcohol and substance use and history and sexual activity, if applicable (For patients seen three or *more times, query substance, alcohol and tobacco abuse history)*
18) The history and physical records include appropriate subjective and objective* Unresolved problems from previous office visits
19) * Consultation, lab and imaging reports filed in the chart are initialed by the practitioner who ordered them to signify review. Review and signature by other professional **does not** meet this requirement. If the reports are present electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal lab and imaging results have an explicit notation in the record of follow up plans.
20) An immunization record for children is up to date or an appropriate history has been made in the medical record for the adults.
21) There is evidence that preventive screening and services are offered in accordance with guidelines and are age and gender specific.
22) All medication prescribed list name, dosage, frequency and duration.
23) * Medications given on-site list name, dosage, route as well as the site given and whether the patient had a reaction to the medication. Vaccines administered also indicate manufacturer and lot number of vial.
24) *For members over age 18, and after 3 visits, there is presence of an advance directive or evidence of education about advance directive.

PHYSICIAN OFFICE ACCESS GUIDELINES

Definitions:

- **Emergency Medical Condition**

  Means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in

  (1) Serious jeopardy to the health of the individual, or, in the case of a pregnant women, the health of the woman or her unborn child or
  (2) Serious impairment of bodily functions or
  (3) Serious dysfunction of any bodily organ or part.
  (H & S code, Section 1317 1(b), Title 42 of Code of Federal Regulations)

- **Urgently Needed Services**

  Health care services needed to diagnose and/ or treat medical conditions that are of sufficient severity that care is needed within the same day, but are not emergency medical conditions.

GUIDELINES

1. PCP Physicians **must** provide access to appropriate triage personnel and emergency services 24-hous a day, seven days a week.
2. ***Medical triage during business Hours***
   All PCP sites **must** have licensed staff available for telephone or on site triage for Members during normal business hours. It is expected that all licensed triage personnel use appropriate medical judgment in determining the disposition of the patient.

- ***Members must be advised, as part of their instructions, that they should call 911 and seek emergency care if they think they are dealing with a serious acute medical emergency or go to the nearest ER or urgent care.***

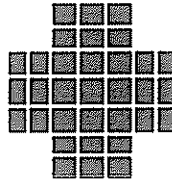
3. ***After Hours PCP Access***

- All PCPs **must** have arrangements in place for telephone access 24 hours per day, 365 days per year.
- The number listed for the PCP in the members ID card should be the 24-hour access number for that PCP and/ or IPA triage system.
- Members must be able to reach their PCP, a covering physician or a licensed triage person
- Approved licensed triage personnel include registered nurses, nurse practitioners or physician assistants.

Answering services

- Answering service personnel cannot perform triage unless they are in one of the previously mentioned categories.
- Members must be able to access their PCP or the covering personnel within 30 minutes of their initial call.

- ***Members must be advised, as part of their instructions, that they should call 911 and seek emergency care if they think they are dealing with a serious acute medical emergency or go to the nearest ER or urgent care.***



Memorandum

Date: **October 9, 2009**

To: **ALL PVMG PCPs**

CC: **Managers , Supervisors, Dr. Prasad**

From: **Jeereddi Prasad, President and Acting Medical Director**

Re: **Flu Mist will be added for 2009/10**

Flu Mist is now covered by all contracted health plans and is being added to Exhibit B of your contract. Reimbursement rate will be communicated separately. Flu Mist is recommended by the CDC for the following:

LAIV (FluMist®) is approved for use in healthy* people 2-49 years of age who are not pregnant.

Who should not be vaccinated with the nasal-spray flu vaccine LAIV (FluMist®)?

- People less than 2 years of age
- People 50 years of age and over
- People with a medical condition that places them at high risk for complications from influenza, including those with chronic heart or lung disease, such as asthma or reactive airways disease; people with medical conditions such as diabetes or kidney failure; or people with illnesses that weaken the immune system, or who take medications that can weaken the immune system.
- Children <5 years old with a history of recurrent wheezing
- Children or adolescents receiving aspirin
- People with a history of Guillain–Barré Syndrome that occurred after receiving influenza vaccine
- Pregnant women
- People who have a severe allergy to chicken eggs or who are allergic to any of the nasal spray vaccine components.

Flu Mist does NOT require prior authorization as long as the patient meets the CDC guidelines.

If you have any questions or comments, please feel free to contact Customer Service at 932-1045, press option #1.

Thank you.

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ProMed Health Care Administrators

FACSIMILE TRANSMITTAL

Date: November 10, 2009

To: PVMG & UMG PCP's

Cc: Managers, Supervisors

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

RE: HCC Incentive FAQ's — **Pages:** 1 (including cover)

Dr. Prasad recently distributed an HCC Assessment Submission Incentive memo and target patient lists for all PCP's. In reviewing multiple inquiries received from provider offices since the initial mailing, we would like to clarify the answers to the following frequently asked questions:

1. **If you have seen one of the members on your HCC report within 4-6 weeks of the date indicated on the initial communication, we will accept your HCFA 1500 along with a completed copy of the Health Assessment Form and still honor the $75.00 incentive offered. Only claims with dates of services on or after 9/1/09 will be considered.**
2. **Claims must be received manually (HCFA 1500) in order to ensure the incentive payment. Our system adjudicates claims according to your contract; therefore, if you submit claims electronically, they will be automatically capitated. There is no way for our system to pay the $75.00 incentive. Please submit manually along with the Health Assessment Form for payment to Louie Weber.**
3. **EMR's (Electronic Medical Records) will be accepted instead of the Health Assessment Form as long as the EMR has all pertinent information requested on the Health Assessment Form.**
4. **Additional supporting documentation such as labs, x-rays, and test results are not required as part of the documentation.**
5. **Claims will be accepted after 12/31/09 as long as the DOS is within the timeframe allowed. All claims must be received on or before 3/31/09 to be considered for the incentive payment.**

If you have any additional questions, please don't hesitate to call me at (909) 932-1045 ext. 4601 or Customer Service at (909) 932-1045, press option #1.

Thank you.

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

ProMed Health Care Administrators

FACSIMILE TRANSMITTAL

Date: November 12, 2009

To: PVMG & UMG PCP's

Cc: Managers, Supervisors

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

RE: UPDATED VERSION HCC Incentive FAQ's — **Pages:** 1 (including cover)

Dr. Prasad recently distributed an HCC Assessment Submission Incentive memo and target patient lists for all PCP's. In reviewing multiple inquiries received from provider offices since the initial mailing, we would like to clarify the answers to the following frequently asked questions:

1. **You can mail or fax your completed HCFA 1500 form along with your Health Assessment Form. If you prefer to fax, send to: (909) 949-3826.**
2. **A legal sized, laminated tool with HCC diagnosis codes highlighted in Red is being mailed to your offices today. The tool will assist with identifying the HCC related diagnosis codes by category.**
3. **If you have seen one of the members on your HCC report on or after 9/1/09, we will accept your HCFA 1500 along with a completed copy of the Health Assessment Form and still honor the $75.00 incentive offered. Only claims with dates of services on or after 9/1/09 will be considered.**
4. **Claims must be received manually (HCFA 1500) in order to ensure the incentive payment. Our system adjudicates claims according to your contract; therefore, if you submit claims electronically, they will be automatically capitated. There is no way for our system to pay the $75.00 incentive. Please mail to Louie Weber or Fax to (909) 949-3826 to receive your incentive.**
5. **EMR's (Electronic Medical Records) will be accepted instead of the Health Assessment Form as long as the EMR has all pertinent information requested on the Health Assessment Form.**
6. **Please use E&M CPT codes along with appropriate HCC diagnosis codes. E&M codes are: 99201-99205, 99211-99215. Use HCC Diagnosis Tool to assist with diagnosis codes.**
7. **Additional supporting documentation such as labs, x-rays, and test results are not required as part of the documentation.**
8. **Claims will be accepted after 12/31/09 as long as the DOS is within the timeframe allowed (9/1/09 to 12/31/09). All claims must be received on or before 3/31/09 to be considered for the incentive payment.**

If you have any additional questions, please don't hesitate to call me at (909) 932-1045 ext. 4601 or Customer Service at (909) 932-1045, press option #1.
Thank you.

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

ProMed Health Care Administrators

Memorandum

Date: October 19, 2009

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

From: Laura Jewell, Director of Provider and Member Services

CC: Rick Jacob, VP Business Development

Jeereddi Prasad, President and Acting Medical Director

Re: **Commercial Member Retention for Members Turning 65**

We are committed to assisting our PCP's in retaining and growing their membership. In an effort to ensure Commercial members turning age 65 retain their PCP, Hospital and Medical Group, we would like to start sending out the attached personalized letter to your Commercial patients who will be turning 65 within 6 months.

We feel that your involvement is critical to ensure the success of retaining these members. We will send the letters on your behalf and follow up with the members; however, we request that you use any scheduled appointment time to reinforce that the member should call us to assist them with selecting a contracted senior plan to ensure continuity of care and service. Ultimately, our goal is to retain your membership with you while they are transitioning from Commercial to Senior.

If you would like us to implement this process on your behalf, please sign below and fax back to Karen Harvey at: (909) 931-5077.

If you have any questions, please feel free to contact me at (909) 932-1045 ext. 4601.

Thank you.

Print Name	*Date*	*Signature*

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Dear ____________

As a valued patient, your Personal Care Physician, Dr. ____________, feels it's important to communicate your health plan options as you approach your 65th birthday. It's not too early to start thinking about what you should do about your health care when you turn 65. Becoming a senior has never been so good!!

Your health care coverage options will change when you become eligible for Medicare. As you approach this milestone, it can be a somewhat confusing. However, Dr. ____________ wants to make things easy and ensure there is no disruption in care or service.

You can keep your Personal Care Physician, Dr. ____________, your assigned facility: Pomona Valley Hospital Medical Center or San Antonio Community Hospital and your Medical Group while enhancing your benefits.

Here are a few of the added benefits you will receive through our assigned Medical Group:

- Affiliations with most major senior health plans, hospitals and Urgent Care locations in the Inland Empire service area.
- No cost senior wellness classes
- Coordination of transportation
- Senior Newsletters
- Dedicated Member Service line – 1-800-281-8886

Your Medical Group can help by offering you various health plan options which address your needs.

Call Customer Service at 1-800-281-8886 to discuss your options. One phone call and you can keep your doctor, hospital and medical group.

After all we want to simplify all of this for you and make this a seamless transition. Enjoy the perks and benefits of turning 65! You deserve it.

We look forward to hearing from you.

Sincerely,

Customer Service Department

Memorandum

Pomona Valley Medical Group, Inc.
D.B.A. ProMed Health Network
www.promedhealth.com

VIA FACSIMILE – 1 PAGE

Date: **November 18, 2009**

To: **PVMG PCP's, Specialists and Ancillary Providers**

Copy: **J. Prasad, M.D., B. Werderman, Managers and Supervisors**

From: **Jacqueline Caya, Contracts Manager**

RE: **Pomona Valley Medical Group – Care 1st Health Plan Medi-Cal Members**

IMMEDIATE ATTENTION REQUIRED

The purpose of this communication is to inform you that Pomona Valley Medical Group and Care 1st Health Plan will not be renewing their contract for **Care 1st Health Plan Medi-Cal members**.

Therefore, effective January 1, 2010 the Pomona Valley Medical Group contract with Care 1st Health Plan for Medi-Cal members will terminate.

Please be informed that your Care 1st Health Plan Medi-Cal patients may soon be receiving correspondence from Care 1st Health Plan notifying them of this termination. Your members may be asking how they can continue care with you. If your Care 1st Health Plan patients would like to continue under your care, they could certainly join our other Pomona Valley Medical Group contracted Medi-Cal Health Plan listed below:

Pomona Valley Medical Group Contracted Medi-Cal Health Plan
•Community Health Plan

To those Exclusive Pomona Valley Medical Group Primary Care Physicians, we are working with Community Health Plan to try and bulk transfer your Care 1st Health Plan membership to Community Health Plan. However, to ensure your Care 1st Health Plan members transition, you can ask your Care 1st Health Plan members to call the L.A. County Health Care Options office at (800) 430-4263.

To those Non- Exclusive Pomona Valley Medical Group Primary Care Physicians, if you do not want your Care 1st Health Plan members to transition to another Medical Group, you can ask your Care 1st Health Plan members to call the L.A. County Health Care Options office at (800) 430-4263.

Please inform your Pomona Valley Medical Group Care 1st Health Plan Medi-Cal members that they can receive continuity of care from you even after termination, if they meet continuity of care criteria. Please note that prior authorization from Care 1st Health Plan is required for elective and urgent services. In special circumstances, services may be authorized for up to a year from the date of the contract termination.

Beginning January 1, 2010 you will need to bill Care 1st Health Plan directly for continuity of care services rendered to Care 1st Health Plan Medi-Cal members. You will receive reimbursement directly from Care 1st Health Plan on a Fee for Service basis. Please submit your Care 1st Health Plan Medi-Cal claims to the following address:

Care 1st Health Plan
Claims Department
601 Potrero Grande Drive
Monterey Park, CA 91755

If you or your Care 1st Health Plan Medi-Cal patients have any questions, they are invited to call our Customer Service Department at (909) 932-1045, press Option #1. We appreciate your assistance in this matter. Thank you!

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

Memorandum

Pomona Valley Medical Group, Inc.
D.B.A. ProMed Health Network
www.promedhealth.com

Date: **December 10, 2009**

To: **All PVMG PCPs and Specialists**

CC: **Managers and Supervisors**

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

Re: **Outpatient Procedures**

In compliance with the exclusive contract we have signed with PVHMC, effective November 2, 2009 you will be required to perform all outpatient procedures for Pomona Valley Medical Group members except Blue Cross HMO members at the PVHMC.

All Blue Cross HMO outpatient procedures will continue to be performed at Four Seasons Surgery Center.

Please alert your office staff to this change in authorization requirements.

Thank you.

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4150 E. Concours St., Suite 100, Ontario, CA 91764 909.932.1045 800.281.8886 Fax: 909.932.1065

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.

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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October 2009 Topic: Diabetes Mellitus

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.

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1

December 10, 2009

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

Diabetes Mellitus: Documentation and Coding:

Example: Progress note: adult diabetes complicated with diabetic peripheral vascular disease
Diagnosis codes: 250.70, 443.81

The most common mistake physicians make in documenting and coding for diabetes is to leave out important and common complications and manifestations of this disease. CMS (The Centers for Medicare and Medicaid Services) is now measuring patient severity and requiring physicians to be more accurate and complete in their diagnosis documentation and coding. Diagnosis codes for diabetes require 5 digits and may require a second code for the diabetic complication.

Don't miss these important diagnoses and be sure to document diabetic complications:
ICD-9 Physician documentation in the medical record
250.0x diabetes, uncomplicated
250.4x diabetic nephropathy (also **538.81** nephropathy)
250.5x diabetic retinopathy
(also **362.02** proliferative retinopathy; 362.01 background retinopathy does not impact severity)

250.6x diabetic neuropathy (also polyneuropathy **357.2**)
250.7x diabetic peripheral vascular disease (also peripheral angiopathy **443.81**)
250.8x other manifestations due to diabetes, e.g. diabetic hypoglycemia

Where x is the fifth digit, selected from one of the following:
x=0 adult diabetes, not stated as uncontrolled;
x=1 juvenile diabetes, not stated as uncontrolled
x=2 adult diabetes, uncontrolled
x=3 juvenile diabetes, uncontrolled

Example: The documentation and coding for a diabetic patient might be:
Progress note: uncontrolled adult diabetes with diabetic nephropathy
Diagnosis codes: 250.42, 583.81

Note: If the documentation is "diabetes with microalbuminuria or proteinuria" then a coder cannot assume diabetic nephropathy – the physician has to document "diabetic nephropathy."

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.

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2

ProMed Health Care Administrators

Memorandum

Date: **September 18, 2009**

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October 2009 Topic: Angina and Myocardial Infarction

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

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December 10, 2009

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

Making the Diagnosis: Angina and Myocardial Infarction

Coronary Artery Disease is a non-specific diagnosis that should only be used when a more specific diagnosis cannot be reached. Examples of more specific diagnoses include angina or myocardial infarction. Cardiac diagnoses should be documented in a progress note and coded at least once each calendar year.

A patient with angina that is stable on medication still has the diagnosis of angina. But, if a patient no longer has angina after bypass surgery or a stent, they no longer have angina as a diagnosis.

A myocardial infarction is considered "acute" for 8 weeks. After that, it should be documented and coded as an old MI or as history of MI. It is important to remember to document in a progress note and code for an old MI at least once each year even if the MI occurred many years ago.

What are the most common symptoms and signs that lead to the diagnosis of angina or myocardial infarct (MI)?
Symptoms of angina include chest pain consistent with cardiac pain that usually gets worse with exertion and better with rest or nitrates. Patients may also experience shortness of breath. Angina that occurs at rest is unstable angina. An EKG may show transient changes with angina but cardiac enzymes are not elevated and there is no evidence of permanent heart muscle damage.

With a myocardial infarction, the patient has chest pain and documented EKG changes with elevation in cardiac enzymes. On further cardiac studies, after an MI there are signs of permanent cardiac wall damage. An MI may be complicated by arrhythmia and CHF.
Risk factors for angina and MI include smoking, diabetes, hypertension, and hyperlipidemia.

ICD-9 Physician Documentation

410.90 acute myocardial infarct or acute MI (within 8 weeks of acute MI, then use old MI)

411.1 intermediate coronary syndrome or unstable angina
412 old myocardial infarct or history of MI
413.9 angina pectoris
414.00 coronary artery disease (CAD), ASHD - only select if not angina or MI
428.0 congestive heart failure

Example: Progress note: history of MI with stable CHF
Diagnosis codes: 412, 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.

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Memorandum

Date: November 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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November 2009 Topic: Common Rheumatologic Diagnoses

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

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

Common Rheumatologic Diagnoses: Documentation and Coding

Example: Progress note: systemic sclerosis involving the lungs

Diagnosis codes: 710.1, 517.2

There are several common Rheumatologic or Connective Tissue diseases that are important to diagnose, document in a progress note, and then code in a claim or encounter at least once each calendar year. When a disease such as rheumatoid arthritis results in complications that impact other organ systems, you should document the causal relationship in your note and submit diagnosis codes for the underlying disease plus codes for the affected organ system.

ICD-9 code Documentation

710.0 systemic lupus erythematosus (SLE)
710.1 systemic sclerosis
(also add 359.6 if complicated by systemic inflammatory myopathy)
(also add 517.2 if lung involvement in systemic sclerosis)

710.2 sicca syndrome (including Sjögren's syndrome)
710.3 dermatomyositis
710.4 polymyositis

714.0 Rheumatoid Arthritis (RA)
(also add 357.1 if complicated by polyneuropathy)
(also add 359.6 if complicated by systemic inflammatory myopathy)

720.0 ankylosing spondilitis
720.2 sacroiliitis, not elsewhere classified

725 polymyalgia rheumatica

Examples: The correct documentation and coding for a patient with a connective tissue disease seen at least once each year might be:

- **Progress note:** polymyalgia rheumatica responding well to treatment
- **Diagnosis code:** 725

- **Progress note:** polyneuropathy due to long-standing rheumatoid arthritis
- **Diagnosis codes:** 714.0, 357.1

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.
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ProMed Health Care Administrators

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November 2009 Topic: Lower Limb Amputations

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.

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

Lower Limb Amputations: Documentation and Coding

Example: Progress note: diabetic peripheral angiopathy with right foot amputation
Diagnosis codes: 250.70, 443.81, V49.73

Lower limb amputations often result from long-standing vascular disease or from trauma. To capture the severity of patients who have had amputations, it is important to document this condition at least once each year in a progress note and submit the appropriate diagnosis codes with your claim. Remember that even for an amputation that occurred years ago, you should document it each year in a progress note based on a patient visit.

The correct diagnosis codes for an amputation include the code(s) for the underlying condition first and then the V code for the amputation. For a patient with underlying peripheral vascular disease due to diabetes, code the diabetic manifestation (250.70), the secondary peripheral vascular disease (443.81), and then the amputation (appropriate V code). 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 amputations.

Documentation and ICD-9 coding for lower limb amputations include:

ICD-9	Physician Documentation
V49.70	lower limb amputation, unspecified level
V49.71	lower limb amputation, great toe
V49.72	lower limb amputation, other toe(s)
V49.73	lower limb amputation, foot
V49.74	lower limb amputation, ankle
V49.75	lower limb amputation, below knee
V49.76	lower limb amputation, above knee

Example: The correct documentation and coding for a patient with an amputation seen at least once each year might be:
Progress note: peripheral vascular disease with history of BKA left leg
Diagnosis codes: 443.9, V49.75

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ProMed Health Care Administrators

Memorandum

Date: **December 10, 2009**

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

CC: **Managers and Supervisors:**

From: **Kit Thapar, MD, Chief Medical Officer**

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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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. I have also attached a copy of the Coding class held at the Corona Regional Medical Center, August 14, 2007 from 9-1.

November 2008 Topic: Making the Diagnoses: Cancer vs. "History of cancer"

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 Kit Thapar.

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

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December 10, 2009

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

Making the Diagnosis: Cancer vs. "History of cancer"

1) A common error that physicians make in documentation and coding is that they are not clear about the correct way to handle the diagnosis of cancer.

If a patient has an **active primary cancer, active metastases, or is on active treatment**, then the correct documentation and coding is cancer. For example:

- **Progress note:** 84 yr woman s/p mastectomy for breast cancer, on tamoxifen
- **Diagnosis code:** 174.9 (breast cancer)

However, if a patient no longer has active disease or metastases and is no longer on active treatment, then the correct documentation and coding is "history of cancer." For example:

- **Progress note:** history of Dukes A colon cancer, no recurrence, no current treatment
- **Diagnosis codes:** V10.05 (personal history of colon cancer)

Here are the most common solid tumor cancers:

ICD-9 Documentation "History of..." and ICD-9 code
153.9 malignant neoplasm of colon (history of colon cancer = V10.05)
162.9 malignant neoplasm of lung (history of lung cancer = V10.11)
174.9 malignant neoplasm of female breast (history of breast cancer = V10.3) **185** malignant neoplasm of prostate (history of prostate cancer = V10.46)
188.9 malignant neoplasm of bladder (history of bladder cancer = V10.51)

Increased surveillance or testing for cancer by itself does not lead to the diagnosis of active cancer. If the patient above with a history of colon cancer is getting annual screening colonoscopy, but has no evidence of active cancer, the documentation and coding is still "history of colon cancer".

2) A second common error is to omit documentation and coding for metastatic cancer. Here are the most common sites for metastases that should be documented and coded if present:

197.7 metastatic cancer to liver metastatic cancer)
196.9 metastatic cancer to lymph node (note: there are no "history of" codes for
198.3 metastatic cancer to brain
198.5 metastatic cancer to bone

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The information provided here is for general advice for appropriate documentation and coding. Final decisions should be based on review of standard reference materials.

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November 2007 Topic: Ruling Out Diagnoses

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

- Contact Angelice Wilson at angelice.Wilson@phs.com OR
- Contact Dr Kit Thapar or myself at ProMed.

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Diagnosis Documentation and Coding: Ruling Out Diagnoses

Physicians face the common problem of not always being able to make a definitive diagnosis. How should you approach diagnosis documentation and coding in this situation?

When you suspect a diagnosis or are in the process of evaluating a patient, there are several things you can do to document and code this in your progress note:

- Document the patient's symptoms and signs and select diagnosis codes that correspond to them, typically ICD-9 codes in the range from 780 to 799. Some examples include:

ICD-9 code	Documentation
780.4 786.05	Dizziness, light-headedness, or vertigo
786.50 790.4	Shortness of breath
	Chest pain
	Non-specific elevation of transaminase levels

- For example, if a patient presents with intermittent chest pain, document the symptom as "intermittent chest pain" or "chest pain, rule out angina" and use the ICD-9 code for unspecified chest pain (786.50).
- If you then do a stress test which is abnormal, you can document the more definitive diagnosis of angina (ICD-9 code 413.9), but if you rule out angina, then the diagnosis stays as the symptom of chest pain.
- Once you make a definitive diagnosis, you should not submit the ICD-9 code for a symptom that relates to that diagnosis. In the example above, a patient with angina who has chest pain would only have the ICD-9 code for angina submitted with the claim.

One of the few situations when you can add an addendum to your progress note in the medical record is when you get the results from a test that confirms a diagnosis. This typically should be within several weeks of the patient visit.

- In this situation, you can write an addendum to the existing progress note – state the date, the test result, the definitive diagnosis, and the follow up plan and then sign your name. You can resubmit your claim with the new diagnosis information.

Do not use a definitive diagnosis code until a diagnosis is confirmed. As one example, we have seen a number of cases where a diagnosis code for HIV infection (ICD-9 code 042) has been submitted with a claim when the physician is ordering a screening test to rule out the diagnosis. It is all right to document "rule out HIV" in the progress note, but you should also document any symptoms or signs and submit the appropriate diagnosis codes.

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December 2009 Topic: Common Cancers

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- Contact Dr Jeereddi Prasad

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Common Cancers: Documentation and Coding

To document and code solid tumors, use the following steps:

1. Identify the site of the tumor
2. Is the tumor primary or secondary? (be sure to code all metastatic cancers)
3. Is the tumor malignant, benign, uncertain, or unspecified?
4. If the primary tumor has been removed or the patient is cured and is not receiving treatment, document "history of ..." and use the appropriate V code

Documentation and coding for common cancers include:

ICD-9 Documentation	"History of..." and ICD-9 code
153.9 malignant neoplasm of colon	(history of colon cancer = V10.05)
162.9 malignant neoplasm of lung	(history of lung cancer = V10.11)
174.9 malignant neoplasm of female breast	(history of breast cancer = V10.3)
185 malignant neoplasm of prostate	(history of prostate cancer = V10.46)
188.9 malignant neoplasm of bladder	(history of bladder cancer = V10.51)
196.9 metastatic cancer to lymph node	(there are no "history of" codes for metastatic cancer)
197.7 metastatic cancer to liver	
198.3 metastatic cancer to brain	
198.5 metastatic cancer to bone	

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

- **Progress note:** lung cancer with metastases to the brain and bone
- **Diagnosis codes:** 162.9, 198.3, 198.5

- **Progress note:** 84 yr woman s/p mastectomy for breast cancer, on tamoxifen
- **Diagnosis code:** 174.9

- **Progress note:** history of Dukes A colon cancer, no recurrence, no current treatment
- **Diagnosis codes:** V10.05

Basic principles of diagnosis coding:
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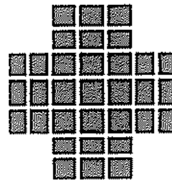

Pomona Valley Medical Group, Inc.
D.B.A. ProMed Health Network
www.promedhealth.com

Memorandum

Date: **December 11, 2009**

To: **ALL PVMG PCPs**

CC: **Managers, Supervisors, Dr. Prasad**

From: **Laura Jewell, Director of Provider and Member Relations**

Re: **H1N1 Administration Reimbursement UPDATE**

Below please find the most updated information on financial responsibility for the administration fees for H1N1. Most of the health plans will be reimbursing for the administration fees; however, there are a few exceptions that will be payable by Pomona Valley Medical Group.

You will provide the vaccine supplied to your office by the Department of Public Health and then bill the appropriate entity below with the proper administration code.

Health Plan	Bill Administration Fee To:
Aetna	Health Plan
Anthem Blue Cross	Health Plan
Blue Shield of CA	IPA
Cigna	Health Plan
Great West	Health Plan
Health Net	IPA
PacifiCare/Secure Horizon's	Health Plan
InterValley Health Plan	IPA
Community Health Plan	Health Plan
Care 1st	Health Plan

If you have any questions or comments, please feel free to contact Customer Service at 932-1045, press option #1.

Thank you.

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Date: December 10, 2009

To: All PVMG and UMG PCPs & Specialists

CC: J. Prasad, M.D., Managers & Supervisors

From: Rosa Catalano, VP of Health Care Services

Re: Speech Therapy

It has been brought to our attention that there is some confusion pertaining to Speech Therapy coverage. Please review the below information.

Description:
Speech therapy is the treatment of communication impairment and swallowing disorder related to a specifically diagnosable disease, injury, or congenital defect. Speech therapy services facilitate the development of human communication and swallowing through assessment, diagnosis, and rehabilitation.

Is Prior Authorization Recommended?

Yes – clinical Evidence to support medical necessity must be provided and used for determination (see below). Prior authorization requests must be submitted with appropriate procedure codes.

Documentation Required for Clinical Review

Initial authorization of speech therapy requires:

- Evaluation by the pediatrician and a hearing test prior to submitting request for speech therapy
- Physician request for speech services with includes a diagnosed medical condition for which services are being requested
- Standardized Test assessment ranking
- Treatment plan with the following
  - Specific treatment techniques and/or activities to be used in treatment sessions; and
  - Frequency and duration of treatment plan (e.g. 2 times per week x 6 months); and
  - Functional, measurable, objective, and time bound long-term and short-term goals, based on evaluation and current baseline functioning

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December 10, 2009

Authorization for continuation of speech therapy requires:

- Progress report after 6 months of therapy demonstrating progress made towards established goals; or
- Standardized test reassessment rank after one year of therapy, and progress made towards established goals; and
- New or revised treatment plan
- Daily progress notes for the last 3 months of therapy

Policy

Speech therapy is considered **medically necessary** when all of the following criteria are met:

- Speech therapy services are used in the treatment of communication impairment or swallowing disorders resulting from illness, injury, surgery, or congenital abnormality of any of the following:
  - Nervous System
  - Vocal Organs
  - Swallowing Organs
  - Auditory Organs; and
- Evaluation by Pediatrician and a Hearing Test must be performed prior to submitting a request for speech therapy.
- A referral from a physician documenting a diagnosed and identifiable medical condition; and
- Standardized test evaluation at or below the 7th percentile in the initial speech assessment; and
- An approved treatment plan; and
- Services are delivered by a licensed speech therapist/pathologist that holds the Certificate of Clinical Competence (CCC) granted by the American Speech-Language-Hearing Association (ASHA), and performs within the scope of licensure

Speech therapy is considered **not medically necessary** when:

- Policy criteria for medical necessity ceases to be met; or
- Standardized test reassessments after one year of continued services, (or after 6 months if >9years old); or
- Indicates no significant improvement in percentile ranking; or
- The treating or reviewing Speech Therapist concludes that the patient has reached a therapeutic "plateau"; or
- Speech therapy services duplicate other therapies authorized, particularly occupational therapy.

Many benefit plans include a maximum allowable therapy benefit, either in duration of treatment or in number of visits. When the maximum allowable benefit is exhausted, coverage will no longer be provided even if the medical necessity criteria described above are met.

Source:Milliman Criteria

This Policy relates only to the services or supplies described herein. Benefits may vary according to benefit design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement Policy.

Code Type	Number	Description
CPT	92506	Evaluationof speech, language, voice, communication , and/or auditory

		processing
	92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
	92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals

ProMed Health Care Administrators

Memorandum

Date: December 10, 2009

To: PVMG and UMG PCPs and Rheumatologists

CC: Managers and Supervisors

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

Re: Screening Spirometries

It has recently come to my attention that there is some confusion regarding Spirometries.

Pre and Post Spirometries **do not** require prior authorization.
Complete PFTs **do** require prior authorization.

Please educate your staff on these requirements.

Thank you for your assistance in providing quality care for our members.

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4150 E. Concours St., Suite 100, Ontario, CA 91764 909.932.1045 800.281.8886 Fax: 909.932.1065

ProMed Health Care Administrators

Memorandum

Date: **December 14, 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.

December 2009 Topic: Common Cancers

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.

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1

December 16, 2009

MD QuickFax™ Helping doctors get useful information, quickly.

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

Common Cancers: Documentation and Coding

To document and code solid tumors, use the following steps:

1. Identify the site of the tumor
2. Is the tumor primary or secondary? (be sure to code all metastatic cancers)
3. Is the tumor malignant, benign, uncertain, or unspecified?
4. If the primary tumor has been removed or the patient is cured and is not receiving treatment, document "history of …" and use the appropriate V code

Documentation and coding for common cancers include:

ICD-9 Documentation	"History of…" and ICD-9 code
153.9 malignant neoplasm of colon	(history of colon cancer = V10.05)
162.9 malignant neoplasm of lung	(history of lung cancer = V10.11)
174.9 malignant neoplasm of female breast	(history of breast cancer = V10.3)
185 malignant neoplasm of prostate	(history of prostate cancer = V10.46)
188.9 malignant neoplasm of bladder	(history of bladder cancer = V10.51)
196.9 metastatic cancer to lymph node	(there are no "history of" codes for metastatic cancer)
197.7 metastatic cancer to liver	
198.3 metastatic cancer to brain	
198.5 metastatic cancer to bone	

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

- **Progress note:** lung cancer with metastases to the brain and bone
- **Diagnosis codes:** 162.9, 198.3, 198.5

- **Progress note:** 84 yr woman s/p mastectomy for breast cancer, on tamoxifen
- **Diagnosis code:** 174.9

- **Progress note:** history of Dukes A colon cancer, no recurrence, no current treatment
- **Diagnosis codes:** V10.05

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.

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2

ProMed Health Care Administrators

Memorandum

Date: **December 15, 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.

December 2009 Topic: Cancer vs. History of Cancer

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.

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

Making the Diagnosis: Cancer vs. "History of cancer"

1) A common error that physicians make in documentation and coding is that they are not clear about the correct way to handle the diagnosis of cancer.

If a patient has an **active primary cancer, active metastases, or is on active treatment** (not prophylaxis), then the correct documentation and coding is cancer. For example:

- **Progress note:** 84 yr woman s/p mastectomy for breast cancer, on tamoxifen
- **Diagnosis code:** 174.9 (breast cancer)

However, if a patient no longer has active disease or metastases and is no longer on active treatment, then the correct documentation and coding is "history of cancer." For example:

- **Progress note:** history of Dukes A colon cancer, no recurrence, no current treatment
- **Diagnosis codes:** V10.05 (personal history of colon cancer)

Here are the most common solid tumor cancers:

ICD-9	Documentation	"History of..." and ICD-9 code
153.9	malignant neoplasm of colon	(history of colon cancer = V10.05)
162.9	malignant neoplasm of lung	(history of lung cancer = V10.11)
174.9	malignant neoplasm of female breast	(history of breast cancer = V10.3)
185	malignant neoplasm of prostate	(history of prostate cancer = V10.46)
188.9	malignant neoplasm of bladder	(history of bladder cancer = V10.51)

Increased surveillance or testing for cancer by itself does not lead to the diagnosis of active cancer. If the patient above with a history of colon cancer is getting annual screening colonoscopy, but has no evidence of active cancer, the documentation and coding is still "history of colon cancer".

2) A second common error is to omit documentation and coding for metastatic cancer. Be sure to also document and code the primary cancer. Here are the most common sites for metastases that should be documented and coded if present:

196.9	metastatic cancer to lymph node	(note: there are no "history of" codes for
197.7	metastatic cancer to liver	metastatic cancer)
198.3	metastatic cancer to brain	
198.5	metastatic cancer to bone	

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.

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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:

- Friday, January 1, 2010 for the New Year's Day Holiday
- Monday, February, 15, 2010 for the President'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

NEW YEAR'S DAY

FRIDAY, JANUARY 1, 2010

MARTIN LUTHER KING, JR. DAY

MONDAY JANUARY 18, 2010

LINCOLN'S BIRTHDAY

FRIDAY, FEBRUARY 12, 2010

CHINESE NEW YEAR

SUNDAY, FEBRUARY 14, 2010

VALENTINE'S DAY

SUNDAY, FEBRUARY 14, 2010

PRESIDENT'S DAY

MONDAY, FEBRUARY 15, 2010

WASHINGTON'S BIRTHDAY

MONDAY, FEBRUARY 22, 2010

DAYLIGHT SAVING TIME BEGINS

SUNDAY, MARCH 14, 2010

ST. PATRICK'S DAY

WEDNESDAY, MARCH 17, 2010

PALM SUNDAY

SUNDAY, MARCH 28, 2010

PASSOVER

TUESDAY, MARCH 30, 2010

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