RIOS

Arizona IPA

SPECIALIST

MANUAL

RIOS
Arizona IPA

Provider Acknowledgement Form

Provider/Group Name: _____

I acknowledge that I (and/or staff) have received the Provider Manual/ Portal Training for Rios Arizona IPA

_____
Signature

_____
Print Name

_____
Title/Position

_____
Date

Please fax or email this signed form to

Fax:
Email: contracting@simplehealthcare.tod

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WELCOME TO

RIOS
Arizona IPA

Our administrative staff is available to assist you in any way to serve our patients efficiently. If you have any questions, please feel free to contact our Management Service Organization (MSO) at:

Simple HealthCare MSO, Inc.
Rios Arizona IPA
495 E. Rincon St. Suite 212
Corona, CA. 92879
Telephone: (844)220-9222

SECTION 1: CONTACT INFORMATION

Simple Health Care MSO	Toll Free: (844) 220-9222 Direct Office: (951) 566-1234
Inpatient Notification, Medical Records, Referrals and Authorization	Inpatient Notification, Medical Records, Referrals and Authorization **Fax: (866) 779-3518**
Customer Service	➢ Customer Service Phone (844) 220-9222 **Option 1** info@simplehealthcare.today
Provider Portal **Web Support**	➢ Provider Portal https://shcmso.quickcap.net support@simplehealthcare.today Phone: (844) 220-9222 **Option 2**
Claims Department **Electronic Claim Submission**	➢ **Mail Claims To:** 495 E Rincon Street Suite 212 Corona, CA. 92879 Phone: (844) 220-9222 **Option 3** ➢ **Provider Portal:** https://shcmso.quickcap.net ➢ **Clearinghouse** Office Ally Payer ID: **RIOSA**
Credentialing Department	Contracting@simplehealthcare.today Phone: (844) 220-9222 **Option 4**
Referral - Authorization Department	➢ **Provider Portal:** https://shcmso.quickcap.net Phone: (844) 220-9222 **Option 5**
Provider Relations	provider-relations@simplehealthcare.today Phone: (844) 220-9222 **Option 6**

Case Management	Phone: (844) 220-9222 **Option 7**
HCC Department	Phone: (844) 220-9222 **Option 8**
Radiology	**Simon Med Imaging** www.simonmed.com **Assure Imaging** www.assureimaging.com **Open MRI** www.openmrisolutions.com
Laboratory	**Sonora Quest Website:** www.sonoraquest.com Refer to Ancillary Roster or Website for specific location contact information
Pharmacy	Refer to Members Health Plan's Contracted Hospitals or call Customer Service
Hospitals	Refer to Members Health Plan's Contracted Hospitals or call Customer Service
Health Plans	**Bright Healthcare:** www.brighthealthcare.com **Alignment Health Plan** www.alignmenthealthplan.com

Section 1.1 Provider Portal

Please visit our website to submit claims, authorization submission, and inquiry status information. Providers can also take advantage of our on-line service to view the primary care physician and specialist provider rosters.

Please visit us at: www.riosarizonaipa.com

Our on-line features includes:

- Provider Portal Access
- Provider Rosters; Provider Search Inquiries
- References

Portal can be accessed via the following link **https://shcmso.quickcap.net/** by selecting the blue logo **Rios** Arizona IPA. Click on the First Time User button, fill out your information and submit your login request. We promptly approve portal login requests. If you have additional questions, contact us by calling (844)220-9222 Ext.2001, or send a fax to ((866) 779-3518.

The Provider Relations Department is available Monday-Friday from 8:30 a.m. – 5:00 p.m. PST. Please contact our office at (844)220-9222, or email contracting@simplehealthcare.today for any inquires.

SECTION 2: EMERGENCY/AFTER HOURS

Section 2.1 What to Do in Case of an Emergency

When a Rios Arizona IPA member calls with an emergency; first determine the type of emergency; should the member call 9-1-1, go to the nearest emergency room, after hours' convenient care center, or go to your office.

ONLY LICENSED PERSONNEL SHOULD HANDLE THE TRIAGE OF PATIENTS.

If you determine that it is a life-threatening emergency; instruct the patient to hang up the phone and dial 9-1-1 immediately.

If you determine that the patient is stable and does not need emergency medical transportation, instruct the patient to get a designated driver and go to the nearest emergency room, after hours' convenient care center, or your office to be evaluated. A patient should never be instructed to drive themselves in the event of an emergency.

SECTION 3: PATIENTS & HEALTH EDUCATION

Section 3.1 How to Greet Patients

WHEN THE PATIENT ARRIVES AT YOUR OFFICE:

1) Ask the patient to present their medical insurance identification card, verify if they have secondary insurance, and verify eligibility with the patient. Please contact the patient's contracted Health Plan(s) to verify eligibility.

2) Check the membership card to see if the patient owes a co-payment. Collect the co-payment, if applicable.

3) If the patient does not have a card, recheck your eligibility list. Ask the patient if there is a secondary insurance carrier (Coordination of Benefits). In some cases, the additional insurance is the primary insurance carrier billed.

4) Ask the patient if the injury/illness is work-related. If the answer is yes, bill the patient's Workmen's Compensation Insurance Carrier.

5) If laboratory work is required, please contact our contracted laboratory service company (see page 6 for a list of contracted laboratories).

6) If a patient needs to see a specialty physician for services not provided by you, or your physicians, submit a request for authorization via the online provider portal, or fax the completed referral authorization request form (RAR) to the Utilization Management.

Bright Healthcare Health Plan	Phone: (866)255-4795 Fax: (657)400-1208
Alignment Health Plan	Phone: (323)728-7232 Fax: (323)728-8494

8) Submit all ***fee-for-service and encounter*** claims on-line, or on the CMS 1500 FORM. The claims department mailing address is **495 E. Rincon St. Suite 212, Corona, CA 92879.**

Section 3.2 Health Care Access Standards

Health care access standards established by IPA/Network ensure all members have access to health care services. We monitor performance annually for each of these standards as part of our quality improvement program. Monitoring enables us to identify areas for improvement. IPA/Network access standards are listed below in accordance with Arizona Managed Health Care Coalition, health plan, and NCQA standards.

Access Criterion	IPA/Network Standard
Preventive Care Appointment	Within 30 calendar days – 20 days for Medicare members.
Specialty Appointment	Within 15 business days
Routine Primary Care Appointment	Within 10 business days
Urgent Appointment (PCP & SPC)	Within 48 hours or Same-day appointments
Sensitive Services	Sensitive Services must be made available to members preferably within 24 hours but not exceed 48 hours of appointment request. Sensitive Services are services related to: • Sexual Assault • Drug or alcohol abuse • Pregnancy • Family Planning • Sexually Transmitted Disease • Outpatient mental health treatment and counseling. • Minors under 21 years of age may receive these services without parental consult. Confidentiality will be maintained in a manner that respects the privacy and dignity of the individual.
Emergency Care (In & Out of Area)	Immediate – Patient must go to the nearest emergency room for life-threatening emergencies.
After Hours Phone Emergency	Respond immediately and refer to 9-1-1/ER & address the needs of non-English speaking members
After Hours Phone Non-Urgent	Respond within 24 hours
Telephone Access	Live-person 24 hours

*** Providers are encouraged to accept walk-in members in case of unforeseen circumstances. Please let your patients know of your office policy for same-day appointments.**

Contact Provider Relations to verify your patient's health education program.
Provider Relations: *(844)220-9222* ***or email contracting@simplehealthcare.today***

Section 3.6 Member's Rights and Responsibilities

It is the Member's Right to:

1. Receive information about the provider group, its services, its practitioners, providers and Member's Rights and Responsibilities
2. Be free from retaliation or force of any kind when making decisions about their care.
3. Be treated with respect and recognition of their dignity and right to privacy.
4. Participate with practitioners in making decisions regarding their health care.
5. A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
6. Receive medically necessary covered services without regard to race, religion, age, gender, national origin, disability, sexual identity or orientation, family composition or size, or medical condition or stage of illness.
7. To have providers share findings of medical history and physical exams.
8. To discuss potential treatment options (including those that may be self-administered) and the risks, benefits, and consequences of treatment or non-treatment.
9. Be informed of the side effects and management of symptoms (without regard to plan coverage).
10. Receive sufficient information to provide input into the proposed treatment plan and have the final say in the course of action to take, among the clinically acceptable choices.
11. Be informed of specific health care needs which require follow-up and receive appropriate, training in self-care, and other measures they may take to promote their health.
12. To specify under what circumstances services are coordinated, and the methods for coordination.
13. To have a representative to facilitate care or treatment decisions for a Medicare Advantage member who is incapable of doing so because of physical or mental limitations.
14. Ensure that the IPA and the provider have the information required for effective patient care.
15. Ensure an appropriate exchange of information among the provider network components.
16. Receive family planning services, services at federally qualified health centers or Indian Health Centers, sexually transmitted disease (STD) services, and emergency services outside the network as stated in Federal Law.
17. Receive emergency care whenever necessary and wherever they need it.
18. Receive sensitive services, such as family planning or mental health care in, a confidential way.
19. Request an interpreter or linguistic services in their primary language.
20. To request an interpreter at no charge and not use a family member, companion, or a friend to translate for them.
21. Request any communication to be provided in their primary language.
22. Choose a primary care physician (PCP) within the network.
23. Decide about your care, including the decision to stop treatment.
24. Decide in advance how they want to be cared for in case of life-threatening illness or injury.
25. To provide a written addendum with respect to any item or statement in their medical record, if they believe the record is incomplete or incorrect.
26. Review, request corrections and receive a copy of their medical records.

27. Keep medical information and records confidential unless they say differently. The member has the right to amend their Protected Health Information (PHI) and obtain accounts of the disclosure of their (PHI) for treatment, payment, and health care operations or disclosures for which the member has provided authorization.
28. To authorize or deny the release of their PHI beyond uses for treatment, payment, or health care operations.
29. To view all records, materials, and documents used in making a coverage determination and are entitled to copies of their health information in electronic format from any health plan or health care provider that uses or maintains electronic health records. Medical information is released after member authorization and in accordance with applicable Federal or State law.
30. To voice grievances/complaints or appeals about the Provider Group or the care provided.
31. To Complain about their Health Plan, providers, or their care. They may appeal the Health Plan's decisions. They have the right to choose someone to represent them during the grievance process and the right for their complaints and appeals to be reviewed as quickly as possible. Medi-Cal/Medicaid members have the right to request a fair hearing.
32. Request an independent external review.
33. Disenroll from the IPA, Medical Group or Health Plan.
34. Request a second opinion about a medical condition.
35. Make recommendations regarding the IPA's rights and responsibilities.

II. Members Responsibilities:

1. Be familiar with and ask questions about their health plan coverage.
2. Follow the procedures indicated by their physician, Health Plan, and Medi-Cal program.
3. Members are responsible for treating all providers, physicians, and staff with courtesy and respect. Including being on time for visits, calling the physician for cancellations, or rescheduling an appointment.
4. Give accurate information to the Health Plan, physician, and any other provider.
5. Be a part of their health care decisions. Ask the physician questions if they do not understand.
6. Work with their physician to make plans for their health care.
7. Follow the plans and instructions for care that they have agreed on with their practitioners.
8. Supply information (to the extent possible) that the IPA/Network, practitioners and providers need to provide care.
9. Follow plans and instructions for care as agreed with their practitioners.
10. Understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
11. Immunize their children by age 2 years and always keep their immunizations up to date.
12. Call their physician when they need routine or urgent health care.
13. Care for their own health and avoid knowingly spreading disease to others.
14. Use the Health Plan's complaint process to file a complaint.
15. Report any wrongdoing or fraud to the Health Plan or the proper authorities.
16. Understand that there are risks in receiving health care and limits to what can be done medically.

SECTION 4: PROVIDER SERVICES

Section 4.1 Provider Services Department

Overview
Provider Services is committed to being accessible to all contracted physicians daily. The representatives are responsible for answering inquiries and concerns from contracted providers, and bringing them to a resolution.

Provider Services is also responsible for promoting brand awareness, maintaining a positive image, and increasing membership for the managed groups in the following channels:

- Provider Orientation
- Issues involving authorizations, claims, eligibility, capitation, contracting
- Provider Education

Section 4.2 Provider Information Updates

Within 10 business days, providers must provide the IPA with written notice of all business changes such as change of address, close of panels, and change of hours.

Section 4.3 Satisfaction Surveys

We are constantly making strides to improve satisfaction for members and providers. Our Customer Service and Provider Relations Departments are routinely assisting on the phone and in person with members and providers. In effort to evaluate our performance, we conduct an annual Member and Provider Satisfaction survey.

The survey will allow us to identify how we are doing as a health care provider and help us advance and improve our services. Our survey covers all operations areas, including utilization management, case management, claims, eligibility, customer service, marketing, provider relations, and quality management.

The Provider Relations Department is available Monday-Friday from 8:30 a.m. – 5:00 p.m.PST. Contact our office at (844)220-9222 to speak with your assigned Provider Representative.

SECTION 5: CONTRACTED PROVIDERS

Section 5.1 Urgent Cares, Hospitals, and Health Plans

Urgent Care Centers

We encourage providers to have an effective after-hours answering service for their patients. Please direct the patients to the after-hours centers for urgent, but non-life-threatening issues. A list of contracted Urgent Cares in the surrounding areas is available.

Contact Provider Relations for a current list of contracted Urgent Cares.
Provider Relations: (844)220-9222

Contracted Hospitals and Health Plans

A list of contracted Hospitals and Health Plans is available.

Contact Provider Relations for a current list of contracted hospitals and Health Plans.
Provider Relations: (844)220-9222

SECTION 6: ELIGIBILITY

Section 6.1 Member Eligibility Verification

Member eligibility must be verified by contacting the health plan. The membership card is not necessarily valid proof of eligibility. Always check your most current eligibility list. If you are in doubt about a patient's eligibility, contact the patient's contracted Health Plan.

Each member's identification card is different, but the information is essentially the same. Most membership cards include:

- Name of Insurance Company – HMO/ IPA
- Member's Name
- Membership No.
- Group No.
- Type of Plan
- Effective Date
- Co-Payment amount varies (you **must** be checked with member's current health plan**)**
- Name of Primary Care Physician

Section 6.2 Monthly Eligibility & Capitation Report

The eligibility and capitation reports are mailed to PCPs monthly. The reports contain current membership information, retroactive additions, and terminations. The capitation rate by member is also included in your reports.

The CAPITATION REPORT shows the recalculated membership for the Capitation period indicated on the report. Capitation is run for six months to capture retroactivity and current membership.

This report contains the following information:

a) **MEMBER NAME:** Identified member first and last name.
b) **MEMBER ID NUMBER:** Identifies the health plan identification number.
c) **GENDER:** Male or Female
d) **HMO:** Identifies the capitated health plan with capitated membership.
e) **EFFECTIVE DATE:** Identifies the member's effective date with the PCP.
f) **TERM DATE:** Identifies the member's termination date with the PCP.
g) **AGE:** Member's age
h) **CAP MONTH/YR:** The capitation period by month.
i) **CAP:** The capitation paid amount for the capitation period.
j) **ADJUSTMENT COLUMN:** Shows any manual adjustments applied to your current capitation payment.
k) **MEMBER MONTHS TO DATE:** An accumulative total of member months for the capitation period.
l) **CAPITATION DOLLARS EARNED TO DATE:** The total capitation earned for the capitation period.
m) **GROSS CAPITATION DUE:** The current capitation payable for the capitation period.
n) **CAPITATION PREVIOUSLY EARNED:** The capitation previously paid for the capitation period minus the current month's payment.
o) **NET CAPITATION DUE:** The current month's capitation payment.

If you have any questions regarding the information on the capitation report, please contact our Claims Department at (844)220-9222.

SECTION 7: UTILIZATION MANAGEMENT

Section 7.1 Referral Authorization Requests Policies & Procedures

Purpose:

The Utilization Management Committee (UMC) oversees the development and implementation of an effective referral and authorization process, reviewed, and updated annually. The UM staff works in conjunction with the Medical Director and the UMC to review requests for healthcare services and approve (or deny) authorizations appropriately in compliance with health plan mandates.

- ***To obtain copies of Utilization Management Policy & Procedures or Utilization Management criteria, contact your Provider Relations Representative.***

Policy:

The UM staff will follow IPA's approved process for reviewing, authorizing, modifying, or denying requested services. The authorization/denial determinations will be based on medical necessity, benefits, and will reflect the appropriate application of the approved practice guidelines and criteria. Information will be clearly documented and available for review. Upon request, members and providers will receive written notification about the criteria used to determine the approval or denial of health services. The following notice will accompany disclosure of the criteria: *"The materials provided to you are guidelines used by this IPA to authorize, modify or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."*

Procedure:

The process involves the following cooperative efforts:

- Non-licensed personnel collect data for pre-authorization and concurrent review.
- Licensed professionals supervise the approval process.
- A designated senior physician will have substantial involvement in the referral/authorization process.
- Appropriately licensed health professionals will supervise all review decisions.

All parties will abide by IPA's approved policies and procedures.

Time Frames:

IPA/Network will meet all regulatory and contracted health plan standards for time allowed to process referral/authorization requests. IPA/Network will make utilization decisions in a timely manner and accommodate the urgency of individual situations. The decisions for UM's referral/authorization timelines are established by Simple HealthCare MSO (Based on ICE standards)

- The period that authorizations are valid is determined by the UMC (in accordance with contracted health plan requirements). The provider must always check member eligibility at the time of service.

- Treatment authorization requests may be placed on pending status until all necessary additional information is obtained for the UMC to make an appropriate determination. In this situation, the requesting provider will be contacted within five (05) business days to submit the required information. The request may be pended up to 14 calendar days.

Section 7.2 Referral Authorization Requests Policies & Procedures Con't.

Delays, Modifications, and Denials:

In accordance with the Managed Care code, when services requested on a referral authorization request (RAR) are delayed, modified, or denied, IPA/Network will disclose the criteria used in the determination to the member and provider in writing upon request. This information will be clearly noted on the written notification sent to the provider and member. Additionally, the name and phone number of the physician who made the determination will be clearly indicated on the notification to the provider.

Provider notification of modification or denial:

If the requested service is denied or modified, the provider will receive written/electronic notification within 24 hours of the decision for all request types (must include expedited appeal language). Care shall not be discontinued until the member's treating provider has been notified of the decision and a care plan has been agreed upon by the treating provider that is appropriate for the patient's medical needs. The provider will receive a notifications for all retrospective cases within 30 calendar days.

Retro Request:

Suppose the requested service is to be considered as Retro. In that case, the provider must notify IPA with written/electronic notification within 5 calendar days of the decision along with attachments of Medical Records.

Referral to Non-contracted practitioner/provider:

The member must be referred to a contracted/credentialed practitioner/provider through IPA/Network. In the event that a contracted/credentialed practitioner/provider cannot be located for a particular health service, the referring physician must contact the UM Department for further guidance.

"To ensure all members and providers receive quality care,* IPA/Network *does not offer any financial incentives to anyone for decision making. All decisions are made based on medical necessity."

Section 7.3 Referral Authorization Request (RAR) Form Guidelines

The following are guidelines to use in completing the RAR form:

Turnaround Time for Referral Approvals:

Routine Referrals (5 calendar days): Check this box if the request falls into the routine category.

Expedited Pre-Service (72 hours): Check this box if you refer a member for any service that needs to be completed within 72 hours. Please follow up with a phone call.

Contact our Customer Service Department for assistance in expediting any urgent requests that need to be processed in an expedited manner.

Retroactive: Turnaround time (30 calendar days): Check this box if you have already given medically necessary services without specific authorization for the patient's convenience. (Must have UMC approval and be submitted within 60 days of the date of service).

Patient Information and Service Information: To be filled out completely with appropriate codes. *Please use the highest CPT codes, if applicable.*

Diagnosis or Reason for Request: To be filled out completely with appropriate codes – This is meant to help the referring specialist to know what care has been given by the PCP. The more completed information, the easier it will be for the specialist to assist the PCP in the care of the member. *Please use the highest CPT codes, if applicable.*

Section 7.4 Referral Authorization Request (RAR) Submission

All referrals for IPA/Network must be submitted in one of the following forms.

1. **Online Web Portal:** https://shcmso.quickcap.net/ (Click proper State-CA/AZ)
2. **Fax:** ((866) 779-3518 (Your Provider Relations Representative will provide you with a RAR Form)

**** Preferred submission through online portal***

Section 7.5 Medical Record Standards

PURPOSE: To ensure timely, consistent, and complete medical record documentation that is detailed, organized, allows effective patient care, quality review, appropriate health management, and follows NCQA Standards.

POLICY:

1. The provider practice site will comply with the physician network-approved medical record standards.

2. Each provider practice site maintains a medical record for every member seen.

   2.1 A chart is first prepared when a member presents the first time for treatment or the physician receives reports relating to the individuals' treatment elsewhere.

   2.2 The individual record includes appropriate documentation of the care provided, all ancillary services/diagnostic tests ordered by physicians, and all referred diagnostic and therapeutic services.

   2.3 The medical record incorporates information from subsequent contacts between the member and the participating physician group.

3. The medical record is a source for member-specific data and information to:

   - Facilitate member care
   - Serve as a support document, as well as a financial and legal record
   - Support quality assessment and improvement analysis

4. The physician network providers are required to maintain a centralized area.

   4.1 Medical Records are easily accessible to office personnel who need the information and to government reviewers, peer review organizations, external quality review organizations, or other authorized entities to assess the quality of care or investigate member grievances or complaints.

5. Detailed mental health, substance abuse, and HIV test results records may be filed separately to maintain confidentiality.

6. Providers must maintain policies and procedures that address confidentiality and the release of member information to any internal or external person. All disclosures to any third party for any purpose other than treatment, payment, or health care operations shall be recorded on a log and kept in the patient's medical record.

7. The member's medical record is maintained in a current, detailed, organized manner, reflecting effective care of the member and facilitating the quality review.

7.1 All entries in the record will be factual and accurately reflect the services provided to the member and the member's condition.

8. Documentation standards and goals of medical record maintenance are distributed to practice sites.

9. Provider practice site medical record policies and procedures include organization of the medical record, which specifies the appropriate charting, and filing of information in the medical record.

10. Medical records of scheduled patients are pre-pulled before their scheduled appointments and are available to the provider practice site at each patient encounter.

11. The physician network provider offices have organized systems that ensure accurate filing, tracking and availability of the medical records.

11.1 These medical record systems are appropriate to the practice site of the provider.

11.2 The maintenance of the medical record is the responsibility of the individual provider's office.

11.3 A patient's medical record should be easily retrievable at the time of the patient's encounter and for administrative purposes.

11.3.1 There should be a mechanism for tracking the record.

11.3.2 Records should be stored in one central location inaccessible to unauthorized persons.

12. The medical record is a legal document, and its contents are confidential.

12.1 The medical record should be secure and inaccessible to unauthorized access to prevent loss, tampering, and disclosure of protected health information (PHI) alteration or destruction of the record.

12.2 Original entries in a medical record are not to be altered, destroyed, or removed from the entry.

12.2.1 If an entry needs to be corrected, one line will be drawn through the incorrect entry, and the correct entry written directly above the original entry.

12.2.1.1 White-out or other products will not be used to cover the entry.

12.2.1.2 The incorrect entry will not be completely blacked-out.

12.3 The medical record may be amended, corrected, reconstructed or late entries may be documented.

12.3.1 To amend a medical record is to:

12.3.1.1 Provide facts not available at the time the original entry was made.

12.3.1.2 Provide evidence that the information originally documented in the health record was in error or incorrectly represented the fact(s); or

12.3.1.3 Explain or clarify missing or incomplete entries.

12.3.1.4 Upon receiving noitce from any covered entity, amend any portion of an individual's personal health information.

12.3.2 To correct or complete documentation in a medical record is to:

12.3.2.1 Add signature(s), title(s), and/or date of entry that was not documented at the time the original entry was made by the original author.

12.3.2.2 Add a late entry (when adding an entry later, clearly identify the date of the entry as well as the date of the occurrence).

12.3.2.2.1 Example: 11/05/17 late entry for 10/31/17 (including time if applicable)

12.3.2.3 Add a required report of missing assessment using the current date (cannot be postdated); or

12.3.2.4 Transcribe information, with the date of transcription, recorded elsewhere in the medical record.

12.3.3 To reconstruct or rebuild a medical record, use as much as possible of the contents from the original record to form a secondary medical record (any record that is inadvertently destroyed or lost should be reconstructed).

12.3.3.1 A reconstructed record must contain an explanation of the circumstances of the destruction or loss of the original medical record, the date the medical record was reconstructed, and the name and title of the person making the entry.

13. The physician network will conduct audits on medical record standard compliance, and the provider offices will implement physician network recommended corrective actions for performance improvement.

14. Follow-up evaluations will be conducted, when necessary, for the provider offices that have implemented corrective actions to resolve non-compliance issues.

15. The physician network member medical records are made available to authorized reviewers (i.e., CMG, Health Plans, etc.)

16. The medical records will be kept in compliance with the current CMG/regulatory requirements according to the following standards:

16.1 **Organization**: The record is to be organized as follows:

16.1.1 Each member's medical record must be individually trackable.

16.1.2 The record is secured to maintain confidentiality.

16.1.2.1 Each form or other document must be securely placed in the appropriate section of the chart using fasteners.

16.1.2.1.1 No loose papers or removable self-stick notes are to be in the chart.

16.1.2.1.2 Information on these items must be transferred to a progress sheet or other form.

16.1.2.1.3 Reports or other documents that are not on a standard size paper must be stapled or taped to an 8 ½ X 11 sheet and then placed in the chart.

16.1.3 There is a section for patient identification, including name, age, employer, occupation, work and home telephone number, address, insurance information, and marital status.

16.1.4 Every page in the record contains the member's name, including date of birth or ID number.

16.1.5 All entries contain author identification and are legible to someone other than the author and dated.

16.1.5.1 Signatures must include the first initial, full last name, and title.

16.1.5.2 Initials are acceptable if the author can be identified in some other manner (i.e., signature card)

16.1.5.3 All providers participating in the member's care are identified, along with services furnished by these providers.

16.1.6 All consent forms must be filled out completely, including the date, time, and signatures.

16.1.6.1 If the consent is completed by someone other than the patient (i.e., parent of a minor child) the relationship must be noted.

16.1.6.2 The provider or staff must witness all consent forms.

16.2 **Documentation**: The following information is documented:

16.2.1 Medication allergies and adverse reactions are noted consistently in prominent places.

16.2.1.1 Otherwise, “No known allergies” or “No history of adverse reactions” is noted.

16.2.2 Past medical history for patients seen more than three times is easily identifiable.

16.2.2.1 This documentation includes serious accidents, operations, and childhood illnesses.

16.2.3 For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.

16.2.4 Documentation includes the use of cigarettes, alcohol, and substance abuse for members aged 14 and older.

16.2.4.1 Substance abuse is queried for members seen three or more times.

16.2.5 Problem lists are used for members with significant illnesses and/or conditions that should be monitored.

16.2.5.1 A chief complaint and diagnosis or probable diagnosis are included.

16.2.6 The history and physical records include appropriate subjective and objective information pertinent to the member’s presenting complaints.

16.2.7 There is documentation of an examination appropriate for the condition.

16.2.8 All medication prescribed list name, dosage, frequency, duration, date of the prescription and the number of refills.

16.2.8.1 Medications given on-site list name, dosage, route, site given, whether the patient had a reaction to the medication, and the initials of the person who gave the medication.

16.2.9 Laboratory and other studies are appropriately ordered.

16.2.10 Treatments, procedures, tests, and results are documented.

16.2.11 Working diagnoses are consistent with findings.

16.2.12 Treatment plans are consistent with diagnoses.

16.2.13 Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits.

16.2.14 The specific time to return to clinic is noted in weeks, months, or as needed.

16.2.15 Unresolved problems from previous office visits are addressed in subsequent visits.

16.2.16 Member education, recommendation, and instructions given are included.

16.2.17 Pediatric members' (age 14 and under) records have a completed immunization record or notation of immunizations up to date.

16.2.18 An immunization history has been noted for adults.

16.2.19 Preventive screening and services are offered and documented in accordance with current medical guidelines.

16.2.20 Under-and over-utilization of consultants are evaluated.

16.2.21 Consultant notes are present, as applicable.

16.2.22 Consultation, lab, x-ray (etc.) reports are initialed by the physician upon review.

16.2.23 Abnormal results include notation of follow-up plans.

16.2.24 There is no evidence that the member is placed at inappropriate risk by a diagnostic or therapeutic problem.

16.2.25 For adults over 18 years, documentation of Advance Directives.

16.3 **Completeness:** The following is done in a timely manner:

16.3.1 The medical record is checked to assure that all ordered procedures, referrals, and notes are returned and filed in the chart within ten (10) days of the visit/procedure.

16.3.2 All reports received should be filed in the appropriate section of the record within 72 hours of receipt.

16.3.3 The provider reviews and initials all test results and consultations and documents follow-up treatment for abnormal results.

16.4 **Archiving**: Medical Records are archived according to the following guidelines:

- Adult patient charts – 10 years
- Minor patient charts (<18 years of age) – 1 year after 18th birthday but not less than 10 years.
- Pregnant patient charts – 19 years after discharge
- X-Rays – 10 years
- Sign-in Sheets – 10 years

16.4.1 Patient medical records may be converted to microfilm or computer disks for longer-term storage.

16.4.2 Medical Records must be destroyed in accordance with State and Federal requirements.

16.4.3 Every provider of health care services who creates, maintains, preserves, stores, abandons, or destroys medical records shall do so in a manner that preserves the confidentiality of the information contained therein.

SECTION 8: LABORATORIES

Section 8.1 Laboratory Policies & Procedures

POLICY:

All laboratory procedures must be ordered through the IPA's contracted laboratory.

PROCEDURE:

When ordering routine laboratory procedures, please use the appropriate requisition request form provided by the laboratory.

NON-ROUTINE:

For any other complex laboratory procedure, please fax the Referral Authorization Request Form (RAR) to **(866)473-0159**

NOTE:

Your Office will be held liable for all charges if a non-contracted laboratory of Rios Arizona IPA is used and/or for services referred to a laboratory that requires prior authorization.

Section 8.2 Contracted Laboratories

Rios Arizona IPA has specifically contracted laboratories. Providers are responsible for referring patients to the IPA's contracted laboratories. **Providers who send patients to a non-contracted laboratory will be held responsible for the charges incurred.**

Contact Provider Services for a current list of contracted laboratories.

Provider Services: (844)220-9222

Section 8.3 Laboratory Procedures

Rios Arizona IPA would like to inform all providers that the following tests will require a "Pre-Authorization" along with the appropriate diagnosis for the lab to process the specimen.

Lab Test Name	CPT Codes
All Genetics Codes	**All Genetics Codes** *** Pre-Authorization Required**
***As recommended by the American Cancer Society, tests within this table are intended to monitor patients during or after cancer treatment.** ****Please call if the patient's clinical picture and/or condition require an intervention outside the guidelines noted.**	

SECTION 9: CLAIMS

Section 9.1 Claims Submission

All claims for Rios Arizona IPA including, Fee for Service, Encounters, and Capitated Services, must be submitted in one of the following forms(s).

1. **Via mail: 495 E. Rincon St. Suite 212**
   Corona CA 92879

   Office Ally:
   Payor ID: RIOSA

Reminders for claims submissions

- Providers need to submit encounter data including, services provided for capitated member visits.
- If applicable, claims should always be billed using the highest level of specification, 4th or 5th digit diagnosis code.

Section 9.2 Claims Submission Instructions

The following billing procedure is intended to provide a comprehensive source of instruction for billing personnel. The Health Insurance Claim Form or (CMS 1500 Form) answers the needs of many health insurers. It is a basic form prescribed by CMS for insurance claims from physicians and suppliers, except for ambulance services. Our goal is to provide quality service to all our patients. You can help accomplish this goal by following our billing instructions. Payment is dependent on sufficient/ insufficient documents submitted (i.e., Operative Report, Patient Progress Report, notes and/or any other information on medical services or supplies). If information is insufficient, your claim may result in non-payment.

To ensure proper payment, please refer to the following instructions when completing the CMS 1500 Form:

Items 1 – 12
Patient's and Insured's Information:

Box #	Instruction
1a.	Type the patient's ID Number or Social Security Number.
2.	Type the patient's Last Name, First Name, and Middle Initial (as shown on the patient's ID card).
3.	Type the patient's Date of Birth and Sex.
4.	Type Primary Insured's Name.
5.	Type the patient's mailing address and telephone number.
6.	Patient relationship to insured (i.e., self, spouse, child, other)
9a.	Type another insured's policy or group number.
9d.	Type complete insurance plan and product. (i.e., Medicare, Medi-Cal).
11.	Type insured's policy or group number.
11c.	Type complete insurance plan and product (i.e., Medicare, Medi-Cal)
12.	Patient or authorized representative must sign and date this item unless the signature is on file.
17.	Type or print the name of the referring or ordering physician (if applicable).
21.	Type or print the patient's diagnosis/condition. Please use the appropriate ICD10 code number. ***Please use the highest 5-digit code applicable.***
23.	Type prior authorizations numbers for those procedures requiring professional review organization (PRO), prior approval, or attach Treatment Authorization Request (TAR).
24a.	Type the month, day, and year for each procedure service or supplies.
24b.	Type the appropriate place of service code number. Identify the location by either where the item is used, or the service is performed.

Section 9.3 Claims Submission Instructions Cont.

24c. Type the procedure, service, or supply code number by using the CMS Common Procedure Coding System (HCPCS). If applicable, show the HCPCS modifier with the HCPCS code. However, include a narrative description if you use an unlisted procedure code.

24d. Type the diagnostic code by referring to the code number shown on item 21 to relate the date of service and the procedure performed to the appropriate diagnosis. Please remember to use the highest specialty code applicable.

24g. Type the charge for each service listed.

24f. Type the number of days or units. This item is most used for multiple visits.

25. Type the physician's/supplier's federal tax ID number.

26. Type the patient's account number assigned by the physician/supplier.

27. Check the appropriate block to indicate whether the physician/supplier accepts assignment.

28. Type the total amount of charges for the services.

29. Type the total amount that the patient paid on the submitted charges.

30. Type the balance due.

31. Type the physician/supplier, or his/her representative must sign and date this item.

32. Type the name and address of the facility if the services were performed in a hospital, clinic, laboratory, etc. If the name and address of the facility are the same as the biller's name and address shown on item 33, enter the word: "SAME".

33. Type the name and address of the facility if the services were performed in a hospital, clinic, laboratory, etc.

SECTION 10: Grievances and Appeal Process

Section 10.1 Grievances and Appeal Process

Rios Arizona IPA's policy is to refer all member grievances and appeals to the appropriate Health Plan, to ensure members are provided proper medical care of the highest possible quality.

If a member requests to file a grievance, please have the member contact the health plan or Rios Arizona IPA for tracking and/or reporting purposes.

If an authorization request has been denied and you would like to submit an appeal or grievance, contact the member's Health Plan directly. Members may also call their Health Plan directly to submit an appeal or grievance. Rios Arizona IPA does not process appeals or grievances.

Section 11:
ADA Services Decline Release Form

Dear [Name],

Our Medical Group offers free interpreting services to you and/or your companion. By signing below, you acknowledge that we have offered these services to you, and you are declining.

These Interpreters have been trained to protect your privacy, understand your language, and are considered Medical Translation Professionals.

Per our office protocol, we are to offer these trained professionals at no cost; these services are available to you at any time.

If you would like to accept these services in the future, please let us know, and we will be happy to assign an interpreter to you.

Patient Name: _____

Patient Signature: _____Date: _____

- Please place in patient's medical record.