



PROVIDER SERVICE AGREEMENT

STATE OF TEXAS

COUNTY OF LUBBOCK

This provider service agreement (hereinafter referred to as "Agreement") is made by and between **HealthSmart Preferred Care, Inc.** (hereinafter referred to as HSPC), a Texas corporation, and **Southwest Medical IPA**, (hereinafter referred to as "Provider" whether one or more).

Whereas, HSPC, in the normal course of its business, has been empowered by separate Agreements (singularly a "Client Service Agreement") to negotiate, monitor and control the purchase of health care services, among other things, on behalf of its clients (singularly "Client," collectively "Clients"), who are made up of various business entities; and

Whereas, Provider, in the regular course of business, furnishes health care services to current, disabled, retired or other employees or former employees and any dependents of such persons eligible for coverage under Client's health benefit plans who are designated by Client as covered under a Client Service Agreement (hereinafter referred to as "Covered Individual"); and

Whereas, Provider desires to create inducements in the form of discounted pricing arrangements as set forth in Exhibit "B" for services rendered to HSPC's Clients and HSPC desires to promote the Provider to its Clients by making them aware of these inducements and encouraging them to utilize the Provider's services to the fullest practical extent.

Whereas, the following definitions apply in the context of this Agreement:

Client - an employer, insurance carrier, third party administrator, health care service plan, trust, any government unit or any other entity which has an obligation to provide benefits to a Covered Individual and which has entered into a Client Agreement with HSPC to participate in the HSPC provider network.

Covered Individual - any person eligible to receive health services that are covered by a Plan administered by Client.

Client Service Agreement - an agreement between HSPC and Client which set forth the terms and condition under which (i) Client will be responsible for payment of claims or Client shall cause another entity to be responsible for payment of claims (ii) providers in the HSPC network will provide medical services to Covered Individual.

Payer - Client or entity that Client has designated as having responsibility for payment of claims.

Plan - a health benefit program offered or administered by HSPC or Client.

Now therefore, in consideration of the mutual covenants and agreements contained herein, the receipt and sufficiency of which are hereby acknowledged, Provider and HSPC agree as follows:

1. **Provider Services**- This Agreement shall cover all hospital, medical, or other health care services provided by Provider to Covered Individuals.
2. **Licensure** - At all times, during the term of this Agreement, Provider and Provider's employees shall, at Provider's expense, meet all applicable federal, state and local statutory requirements relating to professional licensing and standing. Provider shall notify HSPC in writing within five (5) business days upon any change of these requirements.
3. **Liability Insurance** - At all times during the term of this Agreement, Provider shall, at Provider's sole cost and expense maintain general and professional liability insurance coverage in the amounts of two hundred thousand dollars (\$200,000.00) per occurrence and six hundred thousand dollars (\$600,000.00) aggregate, as primary coverage. Provider shall also insure that his/her employees maintain the applicable general and professional liability insurance coverage. Failure to maintain proper insurance coverage, shall be grounds to immediately terminate this Agreement.
4. **Billing** - Provider agrees to submit all claims for Covered Individuals to HSPC at their normal billing rate, unless otherwise directed by HSPC. The minimum detail required with each claim is outlined in Exhibit "A", attached hereto. Provider agrees to comply with any and all procedures reasonably established by Client or Client's Payer for billing, claims reporting and eligibility determinations.
5. **Payment** - Client or Payer(s) will use best efforts to make payment for services rendered within thirty (30) days of receipt by HSPC of a properly completed itemized bill and summary HCFA 1500/UB-92 claim form, requiring no coordination of benefits, reinsurance issues, pre-existing conditions, nor needing any additional information to process. Failure to pay such claims within forty-five (45) days shall result

in the loss of the discount set forth in Exhibit B unless Client or Client's Payer notifies Provider that the claim or a portion of the claim is being contested or denied and the specific reasons for the contesting or denying of the claim or portion thereof. It is hereby understood and agreed by the parties that Provider will not, in any event, (i) look to HSPC for payment of charges of any kind whatsoever, but that the responsibility for payment lies with the Client, Payer or the Covered Individual, as the case may be, or (ii) bill the Covered Individual for any portion of the difference between billed charges and HSPC's negotiated rate schedule except as it relates to co-payments and/or deductibles as outlined in the Covered Individual's Plan. Provider may bill and collect from the Covered Individual all co-payments, deductibles, and charges for non-covered and medically unnecessary services.

6. **Non-Discrimination** - Provider will not discriminate against any Covered Individual represented by HSPC based on the source of payment, race, color, sex, age, religion, national origin, handicap or health status.

7. **Staff Privileges** - Participating Provider warrants that he/she has active staff privileges at one or more participating hospitals. Participating Provider agrees to maintain all necessary qualifications and standings for such privileges.

8. **Referrals** - Provider shall refer Covered Individuals to HSPC in-network providers except in the case of an emergency or as otherwise required by law. If Covered Individual expressly requests that services be from a provider who is non-participating, Provider will make best effort to inform HSPC so that HSPC may inform Covered Individual the their benefits may change. Provider shall admit Covered Individuals only to participating hospitals except in the case of an emergency or as otherwise required by law. If Covered Individual expressly requests that services be from a provider who is non-participating, Provider will make best effort to inform HSPC so that HSPC may inform Covered Individual the their benefits may change.

9. **Relationship of the Parties** - Provider and HSPC are independent contractors. This Agreement is not intended to create an employer-employee relationship, partnership or joint venture between the Provider and HSPC. Furthermore, this Agreement shall not be deemed to create any rights or remedies in persons who are not parties to this Agreement.

10. **Term** - The initial term of this Agreement will be for one year. The Agreement will be automatically renewed after the initial term for one (1) year terms (hereinafter referred to as renewal terms) unless either party gives written notice of termination at least ninety (90) days prior to the initial term expiration date or an anniversary date of the initial term expiration date or an anniversary date of the initial term (collectively the initial term and any renewal terms will be referred to herein as the term of the Agreement).

11. **Termination Without Cause** - Either party to this Agreement may terminate the Agreement at any time without cause by giving the other party ninety (90) days written notice of such termination.

12. **Immediate Termination** - Either party may terminate this Agreement upon a material breach by the other party. Material breach shall include but is not limited to Provider's loss, suspension, or revocation of his/her license to practice medicine, medical staff privileges, or professional liability insurance. Provider shall notify HSPC in writing within five (5) days of the occurrence of any event described in this Section 12.

13. **Obligations Surviving Termination** - In the event that this Agreement is terminated under the terms herein, Provider agrees that the rates in Exhibit B shall apply to all charges for services provided to a Covered Individual prior to the effective date of termination.

14. **Non-Exclusive** - This Agreement will not be construed to be an exclusive agreement between HSPC and Provider nor shall it be deemed to be an agreement committing HSPC, its Clients or providers to refer any minimum number of individuals to Provider for services.

15. **Fee Schedule** - Provider agrees to furnish professional health care services under this Agreement according to the fee schedule, attached hereto as Exhibit "B". It is understood that all modifiers billed by Provider shall be paid in accordance to the Medicare Program Fee Schedule guidelines. The initial rate period for Exhibit "B" shall be for a period of time coinciding with the initial term. All subsequent rate periods for Exhibit "B" shall be one (1) year increments of time and shall coincide with the renewal terms. Requested changes to Exhibit "B" shall be sent to Provider by certified mail, return receipt requested. Fee Schedule shall be updated to current RBRVS effective January 1st of each year, no other changes to Exhibit "B" shall be made without written authorization of both parties.

16. **Utilization Management Program** - HSPC, Client or Client's Payer shall establish or contract for Utilization Management which will seek to assure that covered services compensated under a Client Service Agreement are Medically Necessary. "Medically Necessary" shall mean services or supplies which under the provisions of this Agreement, are determined by HSPC, Client or Client's Payer to be (i) appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition; (ii) provided for diagnosis or direct care and treatment of the medical condition; (iii) within standards of good medical practice within the organized medical community' and (iv) not primarily for the convenience of the Covered Individual or Provider. Except as otherwise provided in a Client Services Agreement, covered services must be Medically Necessary. Provider agrees to use best efforts to comply with all administrative and utilization review, peer review and quality assurance programs of HSPC and HSPC's Client or Client's Payer, and, upon request by HSPC, to serve on related program

committees. If Provider is engaged, or is about to be engaged in any proceeding or other matter of HSPC, in which Provider has, or may have, a conflict of interest (such as the person under consideration has a business arrangement with, or is related to, or otherwise is affiliated with the Provider), the Provider agrees to disclose such immediately and will abstain from any discussion or voting on the matter being discussed or acted upon. Utilization management program guidelines of HSPC may change from time to time. Provider shall be notified thirty (30) days prior to implementation of such changes. Provider may terminate Agreement with ninety (90) days notice to HSPC should Provider not wish to participate under such changes to utilization management program. Provider agrees to notify Client or Client's Payer prior to the non-emergency admission of any Covered Individual. In the event of an emergency admission, Provider shall notify Client or Client's Payer the next business day after admission. Nothing in this Agreement requires Provider to release records pertaining to Covered Individuals without prior written authorization of Covered Individuals.

17. **Responsible Parties** - Each party will use reasonable care and due diligence in performing this Agreement. Each party shall be responsible for any claims, actions, liabilities or damages arising under this Agreement out of their acts or omissions of the other party or the acts or omissions of such other party's officers, employees, agents or representatives arising under this Agreement. Neither party shall be liable or assumes any responsibility for defending, or the expense of defending, the other party: its officers, employees, agents or representatives against any claim or legal action, or in any dispute resolution, administrative or regulatory proceeding arising under this Agreement out of such party's acts or omissions.

18. **Confidentiality** - Until the termination of this Agreement, all information provided by a party to the other party, and not otherwise expressly stated by the party in writing to be available for public distribution, will be deemed to be proprietary to that party and of a highly confidential nature including, but not limited to, information concerning any provider networks, other systems, fee schedules, programs, processes and methods used by the party (collectively referred to as the "Information"), all of which it is agreed have substantial value to the party.

The parties shall not, while this Agreement is in effect, utilize for their own benefit (other than the use as specifically provided for this Agreement), in whole or in part or reformulated in any other type of report or filing, any of the Information which a party may obtain, directly or indirectly from the other party.

Payer shall be responsible for obtaining written releases by Covered Individuals authorizing the release of medical information by Provider, and shall, notwithstanding any other provisions in this Agreement, indemnify and hold harmless Provider for any liability in connection with the requested release. Payer agrees to reimburse reasonable copy and shipping charges Provider incurs to furnish information the Payer requests.

19. **Governing Law** - This Agreement will be controlled, construed and enforced in accordance with the laws of the State of Texas.

20. **Counterparts** - This Agreement may be executed simultaneously in one or more counterparts with the same effect as if the signatories executing the several counterparts had executed one counterpart.

21. **Assignment/Subcontracting** - Neither party may assign this Agreement without the written permission of the other parties. Nothing in this Agreement prevents HSPC from contracting with groups, insurers, Payers, employers or individual Clients for access to Participating Provider under the terms of this Agreement.

22. **Negotiation of Payer Agreements** - In the event this Agreement is entered into with or through a marketing agent the following will apply: At all times during the term of this Agreement, HSPC shall use its best efforts to identify potential Payers, to market all Participating Providers to such Payer, and to negotiate in good faith with such Payers. If, after reviewing a proposal for a Payer Agreement, HSPC elects not to enter into that Payer Agreement, Provider may enter into a contract or contracts with any or all such Payers.

23. **Severability** - If any part of any provision of this Agreement is held to be invalid or unenforceable under applicable law, said part or provision shall be ineffective to the extent of such invalidity or unenforceability, without in any way affecting the remaining parts of the Agreement, which shall be construed and enforced as if such invalid or unenforceable part or provision had not been inserted.

24. **Entire Agreement** - This is the entire Agreement along with all Exhibits. This Agreement supersedes any prior agreement between the parties. Any prior agreements, promises, negotiations or representations, be they written or oral, not set forth in this Agreement, are of no force and effect.

25. **Force Majeure Clause** - In the event that the performance by either party hereto of any of its obligations or undertakings hereunder shall be interrupted or delayed by any occurrence and not occasioned by the conduct of either party hereto, whether such occurrence be an act of God or the common enemy or the result of war, riot, civil commotion, sovereign conduct or the act or conduct of any person or persons not a party or privy hereto, then it shall be excused from such performance for such period of time as it is reasonably necessary after such occurrence to remedy the effects thereof.

26. **Copayment, Coinsurance, and Deductibles** - Provider agrees to comply with HSPC's Client's health plan requirements in regards to copayments, coinsurance, and deductibles, and will collect the appropriate copayment, coinsurance, or deductible from the Covered Individual. Provider shall collect the copayment, if any, required by HSPC's Client's health plan at the time services are rendered to the Covered Individual.

Coinsurance and deductibles are the responsibility of the Covered Individuals and shall be collected directly from the Covered Individual by the Provider. Further, Provider agrees not to discriminate against the Covered Individual due to the requirement or non-requirement of a copayment by the HSPC's Client's health plan.

If the Payer is a secondary Payer for a Medicare beneficiary, nothing in this agreement will be operate or be otherwise construed to prohibit a Provider from collecting co-payments or deductible amounts regardless whether the secondary Payer is required to make any payment on a claim.

27. **Arbitration** - Any dispute under this Agreement shall be submitted to binding arbitration in Lubbock County, Texas under the rules then prevailing of the American Arbitration Association, and judgment upon the award rendered may be entered and enforced in any court of competent jurisdiction. Arbitration will be administered by the South Plains Dispute Resolution Center - South Plains Association of Governments in Lubbock, Texas. HSPC and Provider, before entering into arbitration, shall each appoint an arbitrator, and these two arbitrators shall select a third arbitrator to be a member of the panel. Should the two arbitrators not be able to agree on a choice of the third, then the South Plains Dispute Resolution Center - South Plains Association of Governments shall make the appointment of a person who is neutral to the parties in controversy. None of the arbitrators shall be officers or employees of the parties to this Agreement. Each arbitrator shall be a recognized expert in the health law field. The written decision of the majority of the three arbitrators shall be binding on both HSPC and Provider. The cost of arbitration, including fees per arbitrator, shall be borne equally by the parties.

28. **Dispute Resolution** - Provider and HSPC agree to exercise good faith in the informal resolution of disputes arising under this Agreement. Provider and HSPC agree to cooperate in good faith with the dispute resolution and grievance procedures. Provider and HSPC agree to make a good faith attempt to mediate and resolve any dispute between the between the parties before either party pursues other available remedies as set forth in Section 27. A meeting will be held as soon as possible after notification to either party that a dispute exists which has been unable to be resolved through routine procedures. Provider and HSPC will be present or represented by individuals who may make decisions about the matters in dispute.

29. **Notice** - All notices and communications required under this Agreement shall be in writing and shall be sent certified mail, return receipt requested:

If to HSPC: HealthSmart Preferred Care, Inc.
Attention: Mark Blakemore
Vice President of Network Development
3223 S. Loop 289, Suite 145
Lubbock, Texas 79453
(806) 473-2500

If to Provider: Southwest Medical IPA
3610 24th St
Lubbock, Tx 79410

30. **Amendments** - HSPC may modify this Agreement upon thirty (30) days prior written notice to Provider. Rejection of such modifications will be assumed if Provider fails to respond to such modifications, in writing, within the thirty (30) day time period. Any amendments or modifications required by state or federal law may be implemented immediately by HSPC.

31. **Waiver of Breach or Default** - Waiver by either party of any breach or default of the other, or failure of either party to enforce at any time any of the provisions hereof, shall not be deemed a waiver by such party of any other breach or default or the right of such party thereafter to enforce any provision of this Agreement.

32. **Identification** - HSPC or HSPC through Client shall be responsible, at its sole expense, for establishing and maintaining identification and verification procedures which Provider shall use in verifying Covered Individuals' eligibility for Plan coverage. HSPC will insure by contract provision that Payers provide such plans. Payer shall furnish each Covered Individual with an identification card, setting forth, at a minimum, Payor's name, any applicable co-payment, coinsurance or deductible; a toll-free telephone number for eligibility and coverage questions; and the address for submitting provider's claims. Payer shall instruct its Covered Individuals to present this identification card when obtaining services from Provider. The ID card itself does not guarantee eligibility. Provider shall verify benefit eligibility of Covered Individual by calling the phone number indicated on the ID card. Prior to providing non-emergency services to Covered Individual, Provider shall verify that the Covered Individual is eligible to receive such services. Provider agrees to obtain prior authorization from HSPC or HSPC's Client or Client's Payer for specified non-emergent inpatient and outpatient covered services. Provider agrees to allow HSPC's Clients or Client's Payers to deduct from the compensation for his/her services an amount equal to the total cost of any covered service for which the Provider failed to obtain prior authorization, if there is a pattern of non authorized services. If Payer fails to furnish an identification card complying with this paragraph, Payer shall be obligated to pay

Provider's usual and customary charges for any services rendered to Covered Individuals. If Covered Individual does not present ID card at time services are provided, Payer or Covered Individual shall be obligated to pay Provider's usual and customary charges for services. Provider has the right to rely on membership cards, member lists and telephone authorization to verify coverage and benefits for Covered Individuals.

33. **Coordination of Benefits and Subrogation** - Each Plan will specify which party is responsible for coordination of benefits. Provider will assist and cooperate with Payers in coordinating benefits for covered services with responsible Payers. Regardless, the Provider is entitled to collect reimbursement from all sources without limitation up to the usual and customary amount of charges. If Payer elects to exercise rights under subrogation, Payer must make payment to Provider in accordance with the Agreement while pursuing those rights.

34. **Explanation of Benefits Forms** - EOB or similar statements must identify membership in HSPC to obtain discounted fees. Payer will provide an EOB or similar statement for each Covered Individual clearly identifying charges, reimbursement amounts and adjustments for each payment. HSPC will require the same or similar contract provision with agreements with various Payers.

No offsets or deductions without permission. In no event shall Payer offset overpayments against, or deduct overpayments from, any other payments it owes to Provider.

If HSPC or Payer arbitrarily downcodes a service and pays the lesser amount on the EOB, HSPC will use best efforts to ensure a note shall be added to the EOB notifying the Provider of the downcode and the reduced payment and the reason therefore.

35. **Plan Design** - This Agreement only applies to managed care benefit programs and is not intended to apply to indemnity products or any other products offered by HSPC, Client or Client's Payer. Notwithstanding; any other statements in this Agreement to the contrary, if HSPC, Client or Client's Payer permits access to Provider by non-Covered Individual at the discounted rate, Client or Client's Payer shall be required to pay Provider's normal billed charges.

36. **Use of Name** - HSPC shall have the right to use Provider's name in any list of participating providers that it may provide to existing or prospective clients.

37. **Provider Access** - Provider agrees to serve new managed care patients who have chosen provider under a plan which uses HSPC as its' preferred provider network unless Provider notifies HSPC ninety (90) days in advance that his/her practice is full. Furthermore, Provider agrees to provide or to have made arrangements for the provision of Medical Services to Covered Individuals twenty four(24) hours a day, seven days a week.

38. **Silent PPOs** - Neither HSPC nor any individual Payer or associated network will be permitted to sell or otherwise provide access to Provider through the use of "bundling", "wrap-around PPO's", "shadow PPO's", "silent PPO's", or similar arrangements. In the event such a practice is discovered, the Provider may terminate the agreement with the particular Payer or Network.

39. **Credentialing** - Participation as HSPC Provider shall be conditioned on the credentialing procedures of the Provider. Credentialing standards and criteria shall adhere to NCQA guidelines and shall include without limitation, the requirement that participating physicians be appropriately licensed and certified and in good standing under all applicable laws and regulations of the State of Texas. Provider will provide HSPC with a description of the credentialing standards and criteria upon HSPC's request.

EXHIBIT "A"

The following information items are required for each claim submitted to HSPC by Provider:

- (a) Patient name
- (b) Covered Individual's name
- (c) Covered Individual's SS #
- (d) Employer
- (e) Group #
- (f) Dates of service
- (g) Provider's name & tax ID #
- (h) Billing address
- (i) ICD9 diagnosis (if applicable)
- (j) CPT4 codes and accompanying charges for each procedure billed

EXHIBIT "B"
REIMBURSEMENT SCHEDULE

Southwest Medical IPA

By execution of this Agreement, Provider hereby accepts and agrees to be bound by all terms and conditions of Provider Service Agreement between HSPC and Provider, subject to the specifications, modifications and additions set forth below.

Specifications, Modifications, and Additions:

A. HealthSmart Health Benefit Network:

Cost Reduction Mechanism(s):

Discount: For MDs and DOs:

- (1) Codes ranging from 99201 – 99400:
135% of Current RBRVS, locality 99
- (2) All other codes:
185% of Current RBRVS, locality 99
- (3) Any code not listed in the fee schedule, see Exhibit "C", or codes with a zero value will revert to 20% off Provider's billed charges.
- (4) Anesthesia services shall be reimbursed based on procedure base value from CPT Anesthesia Code, a time unit based on 15 minute intervals multiplied by a per unit conversion factor of \$52.00.

The total reimbursement will be based on total base units, plus total time units, plus any risk factors, physical status modifiers times the conversion factor, plus line placements.

75-2620457
Tax Identification Number

Mailing Address:

Southwest Medical IPA
3610 - 24th
Lubbock Tex 79410

B. HealthSmart Network for Workers' Compensation/ Occupational Injuries

Cost Reduction Mechanism(s): The Lesser Of:

- (a) The provider's billed charges; or
- (b) 90% of the Texas Worker's Compensation Fee Schedule

If you choose to opt out of the HealthSmart Workers' Compensation/ Occupational Network, please indicate by initialing the appropriate location below.

Initial _____

The information contained within this document is confidential and proprietary. It is intended for the use of the recipient for the purpose of review and is not to be disclosed in either a direct or indirect manner.

BY:

8-15-01

Southwest Medical IPA

Tax ID

UTILIZATION MANAGEMENT

DEFINITION:

Utilization Management refers to the process of evaluating proposed hospital admissions and medical services to identify patterns of treatment for quality and appropriateness. This is accomplished through pre-admission certification, concurrent review, retrospective review, discharge planning and Case Management.

PURPOSE:

The purpose of a Utilization Management system is to establish a systematic approach to monitor the appropriateness of care to be provided and determine whether proposed medical services or services provided comply with nationally recognized standards. When feasible, alternate methods of care are recommended at the same level of quality, but at lower costs.

OBJECTIVES:

1. Carefully coordinate with physicians to maintain quality health care services which are medically appropriate while controlling costs;
2. Establishing a Utilization Management process that causes minimal disruption to the health care system;
3. Encourage consistency in the procedure for interaction between the Utilization Management Organization and providers, payors, and consumers of health care.

INTENT:

1. Reduction of admissions for procedures which can safely and effectively be performed in an outpatient setting;
2. Reduction of inappropriate admissions or procedures or inappropriate care by specific practitioner or hospital;
3. The selection and use of lower cost alternative setting at the earliest possible point, in lieu of continued use of a higher cost setting;
4. The appropriate use of preventive and early detection to reduce the necessity for more intensive and expensive services later;
5. The appropriate selection of use of an equal quality alternative for diagnostic, ancillary and rehabilitative services.

Selection of a lower cost alternative should not adversely affect accessibility and continuity of services to Covered Individuals. It is important to assure that controls on services are medically appropriate and not just for controlling costs.

PROCESS:

A. Notification of Hospital Admissions:

Each non-emergency hospital admission is pre-certified for a length of stay based upon diagnosis, the procedure, and the judgement of the attending physician. If a Covered Individual is to be hospitalized, the provider must notify the Utilization Management Department as soon as the admission has been scheduled. For elective admissions, notification should take place at least seven days prior to the admission, or as soon as the admission has been scheduled.

The Utilization Management Department does not require pre-certification of emergency admissions. However, notification is required within 48 hours of the emergency admission to the hospital.

Failure to notify the Utilization Management Department of any hospital admission may result in a reduction of benefits. A toll-free telephone access is provided 24 hours a day, seven days a week. Normal business hours are Monday to Friday, 8:00 am to 5:00 pm. At other times a message can be left on the tape recorder or with a staff person.

B. Pre-certification of Hospital Admissions:

Each non-emergency hospital admission is pre-certified for a length of stay based upon the diagnosis, plan of treatment, procedure to be performed, and any other pertinent information which is obtained from the admitting physician. All such calls will be handled by the Utilization Management Department personnel.

All medical information is checked against established medical criteria to confirm the need for in-hospital care and to determine the average length of stay for the particular diagnosis, procedure and treatment. Such factors as age and multiple problems are included in this process. The Utilization Management Department checks for weekend admissions and necessity of some procedures that may be done on an outpatient basis and pre-admission testing.

If the proposed hospital admission does not meet the medical criteria for inpatient hospitalization, the Utilization Management Department will refer the case to the physician consultant for review. The physician consultant will be of the same specialty or knowledgeable in the treatment of the case in question.

The physician consultant will either approve the pre-certification of the hospital admission or ask for further information to be supplied, or the attending physician to call the physician advisor for clarification. If the physician consultant continues to disagree with the attending physician on the need for hospitalization, there will be notification of such recommendations.

Within one working day the attending physician will be notified by telephone and a written notification will be sent to the hospital, attending physician, Covered Individual, and the payor. The written notification should include the principle reason for the determination and the way to initiate an appeal of determination.

After the admission has been certified and a length of stay assigned, a letter of confirmation will be sent to the Covered Individual, the physician, the hospital and the payor. This notification will take place within two working days of the determination.

C. Concurrent Review:

After the admission, the Utilization Management Department will monitor services on a concurrent basis. If the Covered Individual is not discharged within the number of days initially approved, the Utilization Review personnel will contact the attending physician for additional medical information. Both care and services for each case are monitored. Further certification will depend upon the establishment of medical necessity.

Concurrent review should also be performed for those services which continue over time, such as hospital stays, nursing home stays and repeated specialist visits. Concurrent review is executed by a nurse and when needed, physicians who follow each hospital stay from admission through discharge.

Prior to or on the scheduled date of discharge, a nurse will call the attending physician to confirm the Covered Individual's discharge status or conduct an on site review. If additional days are requested the nurse will need reasons for extension; including clinical information sufficient for support of appropriateness of level or service proposed, diagnosis if the same or changed, and the number of additional days, services, or procedures proposed. If a continuation of stay is needed due to complications or other medical conditions, the stay will be recertified based upon discussion with the attending physician.

The medical information is checked against the established medical criteria to confirm the need for further hospital care. The case will be referred to a physician consultant if medical care criteria are not met. In those cases where hospitalization may still be questioned, the physician consultant may contact the attending physician for additional information. If the physician consultant disagrees with the attending physician on the need for hospitalization, there will be notification of any alternative recommendations.

Within one working day the attending physician will be notified by telephone and written notification will be sent to the hospital, attending physician, Covered Individual, and the payor. The written notification should include the principle reason for determination and the way to initiate an appeal of the determination.

If continued need for hospitalization is established, notification will be provided promptly either by telephone or in writing to the attending physician. The notification will be sent in writing to the hospital, attending physician, Covered Individual, and payor within two days of the determination.

This review is not intended as a censorship review of medical decisions. It serves as a review for length of stay, confirmation of diagnosis, and establishes uniformity and standards in the health care industry. In addition, concurrent review also assists the physician and the Covered Individual by providing discharge planning, resulting in lower costs with high quality care in non-hospital settings.

If the Covered Individual or provider will not release the necessary information to determine medical necessity of the proposed treatment, the case will fail to certify, and subsequently will be closed without assignment of days.

D. Discharge Planning:

Discharge planning is the process that assesses a Covered Individual's needs for treatment after hospitalization in order to help arrange for the necessary services and resources to effect an appropriate and timely discharge from the hospital. Discharge planning is also designed to identify those Covered Individuals who will need care after discharge from the hospital. This care may include home health services, extended care facilities or home I.V. therapy. Early identification will ensure timely discharge thus providing less expensive yet quality care.

The discharge planning process is initiated at the time that the hospital admission is certified. The Utilization Review Nurse may identify a particular diagnosis or procedure that may have the potential need for discharge planning. Contact will then be made with the attending physician, the hospital discharge planning staff, and the family in order to evaluate possible alternatives to hospitalization.

Recommendations will be made to the physician and family. Upon securing the physician's permission for the alternate care proposed, the Case Management Nurse will ensure that all discharge and home health treatment plans are appropriate for the Covered Individual's condition and home setting. The Case Management Nurse will also make sure that continuity of care is not being interrupted. Prior to the implementation of any discharge plan, all parties are advised of and are in agreement with the proposed plan of treatment.

E. Case Management:

Case Management is a service designed to identify Covered Individuals that can benefit from close review and management due to length, severity, complexity and/or cost of health care services. Case Managers locate and assess medically appropriate settings for the Covered Individuals, and manage their health care benefits as cost effectively as possible.

The goals of Case Management are to ensure that care is provided in the most appropriate setting at least costly price. Quality of care should not be compromised. The Case Manager will work closely with the hospital, the physician, the family and ancillary providers to coordinate provision of services to meet the specific needs of the Covered Individual.

Since early identification is essential to proactive Case Management, the Utilization Management Department provides referral of Covered Individuals through the precertification and concurrent review process. An identified list of illnesses, injuries and other medical treatments with high potential for case management is used to aid in this process. This list does not limit application of the program to Covered Individuals who may be in need of Case Management services.

F. Maternity Admissions:

The Covered Individual should contact the Utilization Management Department early in the pregnancy with the expected date of delivery. The Utilization Review personnel will work closely with the physician to monitor the pregnancy for potential high risk. If the pregnancy is determined to be high risk, the case should be referred to a Case Management Nurse for potential intervention. The Utilization Management Department should be notified when the Covered Individual is admitted for labor and delivery. Any other admissions prior to delivery, such as complications of pregnancy, require separate notification. The Utilization Management Department should also be notified if the baby is not going to be discharged with the mother.

G. Emergency Admissions:

Notification of Emergency Admission must take place within 48 hours of the admission.

H. Pre-Admission Testing:

The Utilization Management Department may suggest that pre-admission testing be done whenever hospitalization is necessary. Pre-admission testing allows the patient to have routine tests such as x-rays, lab tests, EKGs, etc. done on an outpatient basis prior to the hospital confinement, which usually results in saving one night's stay in the hospital. During precertification, the attending physician will be asked to determine if testing may be performed on an out-patient basis.

I. Outpatient Surgery:

The Utilization Management Department will review selected procedures for recommendation of outpatient surgical setting. When a call is received to pre-certify a surgical procedure and hospital stay, the Utilization Management Department checks all medical information against established medical criteria to determine whether the procedure may be done safely on an outpatient basis. The Utilization Management Department personnel will then discuss the possibility of using an outpatient facility with the Covered Individual's physician.

J. Retrospective Review:

The Utilization Management Department recognizes that there will be Covered Individuals who will not have precertification and concurrent review performed. These cases will be reviewed retrospectively focusing on day of admission and continued hospital stay.

The Utilization Management Department personnel will contact the hospital or attending physician to obtain all necessary information. Using established medical criteria, the Utilization Management Department personnel will determine the medical necessity of the hospitalization. If the criteria are met, the hospital admission will be certified. If the medical criteria are not met, the denial and appeal procedures for precertification and concurrent review will be followed.

K. Appeals:

When a determination is made not to approve or certify a health care service, written notification is sent to the attending physician, hospital, Covered Individual and payor. The notification will include the reason for the non-certification and a mechanism for the physician and Covered Individual to appeal.

The appeal may be initiated by phone but the follow up must be in writing and must be received within 60 days from the date of the original determination. There are no specific documents required to initiate an appeal; however, the Covered Individual may be requested to complete a release of information form if medical records are needed.

Upon return of this form, the Utilization Management Department will request the medical records from the appropriate provider(s). Upon receipt of an appeal, the Utilization Management Department personnel will obtain all information necessary for the appeal and record the process. The information will then be forwarded to a physician consultant of the same or similar specialty as the attending physician. The review will be conducted by a physician who has not previously reviewed the case.

If requested, an expedited appeal for emergency care non-certification, and non-certification of continued stay of hospital, for Covered Individuals will be completed within one working day following appeal request and receipt of all information necessary to complete the appeal. If the appeal is requested after discharge or services are provided, the appeals process will be completed with written notification of the outcome. This will be sent no later than 30 days from the receipt for the appeal request and necessary documentation needed to complete the appeal process. The physician, Covered Individual, hospital, and payor will be notified within one working day of decision to either uphold the non-certification or approve the requested admission, procedure, service or continued stay.

L. Medical Criteria:

The Utilization Management Department personnel use clearly established, nationally recognized criteria for determining the appropriateness of medical services provided or to be provided. The criteria are reviewed at least annually and revised as indicated.

The criteria may contain length of stay parameters based upon expected outcomes of care. National norms such as the PAS length of stay guidelines may also be used to assist in determining appropriate use of medical services.

M. Confidentiality:

Information about a Covered Individual's hospitalization will be released only to persons authorized to receive such information. This information is to be used solely for the purposes of Utilization Management. All access to Covered Individuals' data files and correspondence is only by employees providing Utilization Management services.

Confidentiality of Covered Individuals' records and information will be maintained by adhering to all state and federal laws. This information will be shared only with those agencies who have authority to receive such information. Summary data shall not be considered confidential as long as it does not provide sufficient information to identify the Covered Individual.

N. Review Guidelines:

Review will be conducted in accordance with the following National Data Base:

1. HCIA Length of Stay by Diagnosis and Operation, Southern Geographic Region, Annualized Volume, HCIA, Inc.
2. Inter-Qual, Inc. Healthcare Screening Criteria for Utilization Management, Geographic Annualized Volume.

