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POLICY & PROCEDURE
200.001 - Day Surgery Pre-Authorization

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Date Revised: November 15, 1991; March 19, 1997; August 23, 2000

Approved By: Date:

Policy:

Certain types of day surgeries require prior notification or approval from the contracted plan. The contracted plan will be notified within 4 working days in advance of the planned procedure when medically feasible. In an emergency, prior notification is not necessary. However, the plan will be notified by the admitting hospital within 24 hours of the procedure, or by the end of the next working day if on a weekend or holiday. Physicians failing to notify the plan prior to elective procedures will be subject to Independent Physicians Network sanction. Information including diagnosis, procedure, physician name, patient name and ID number, hospital or facility must be provided as follows:

Procedure:

1. The number given at the time of notification, only confirms notification, it does not guarantee payment. Approval for payment is based upon documentation in the medical record, medical necessity, benefit coverage and member eligibility at the time of service.

2. The contracted plan will evaluate the medical necessity and appropriateness of the principal procedure for all lines of business (Medicaid and Commercial).

3. Any questionable cases will be reviewed by the Independent Physicians Network Medical Director.

4. Approved day surgeries will be given notification and the physician's office will be contacted by the contracted plan.

5. The physician's office will be notified by the contracted plan if the request has been denied.

POLICY & PROCEDURE
200.002 - Delivery and Length of Stay

Date Issues: 10/01/84
Policy Number: 200.002

Date Revised: November 15, 1991; June 25, 1997; August 23, 2000

Policy:

Postpartum length of stay is based on the type of delivery and other services provided.

Procedure:

Medicaid
1. Postpartum discharge will be routinely assumed to occur at two days for vaginal delivery, and at four days for cesarean delivery.

2. Postpartum tubal ligations should be done within 24 hours of delivery. Total length of stay for delivery with postpartum tubal ligations should not exceed 48 hours.

Commercial
1. Postpartum discharge will be in accordance with the enrollees Plan contract.

2. Postpartum tubal ligations should be done within 24 hours of delivery. Total length of stay for delivery with postpartum tubal ligations should not exceed 48 hours.
Emergency admissions, defined as those situations in which the patient requires immediate medical intervention, do not require pre-authorization. However, the contracted plan will be notified by the admitting hospital within 24 hours following admission or by the next business day if on a weekend or holiday. Physicians failing to notify emergency admissions will be subject to Independent Physicians Network sanction policies.

Procedure:

1. The contracted plan will be notified within 24 hours of an emergency admission or by next business day by the admitting physician. Information required includes:
   a) Patient's name and member number
   b) Admitting diagnosis
   c) Treatment plan
   d) Date of Admission

2. Emergency review will be done retrospectively at the time the admission review is done by the plans Medical Services staff.

3. After review, the Medical Services staff will determine if:
   a) There is criteria compliance
   b) Criteria compliance is questionable
   c) The review gives evidence that criteria have not been met for admission

4. In cases where the criteria are met, the Medical Services staff may authorize the admission. This information is relayed by the contracted plan to the admitting physician and hospital.

5. In cases where criteria compliance is questionable or not met, the Medical Services Department contacts the admitting physician for further information. If, after speaking with the admitting physician, criteria are still not met, the case is referred to the Independent Physicians Network Medical Director who will discuss the case with the physician personally.
6. Final determination is made by the Independent Physicians Network Medical Director for Medicaid members. Final determination is also made by the Independent Physicians Network Medical Director in conjunction with the plan contract certificate of insurance for Commercial members.
Policy:

Patients admitted to a non-contracted facility will be evaluated for possible transfer to a contracted facility. Expected length of stay and continuity of patient care will be considered.

Procedure:

1. The contracted plan will alert the PCP of enrollee's admission to a non-contracted facility. The PCP is required to obtain medical information from the attending physician at the non-contracted facility, telephonically. Transfer to a contracted facility will take place if the following is met:
   a) Medical stability as identified by attending physician in discussion with PCP
   b) Inability to receive the care the enrollee needs
   c) Extensive long-term/complex type of care

2. If the PCP/Plan makes the decision to transfer the enrollee to a contracted facility, the PCP will coordinate the transfer upon the enrollee's stabilization.

3. If the decision is to have the enrollee remain in the non-contracted facility, telephonic review monitoring by the contracted plan case management nurses, and periodic consultations with admitting physician in conjunction with the PCP will occur. Upon facility discharge, office/outpatient follow up by PCP will be done.
POLICY & PROCEDURE
200.005 - Home Visit For 1 Day OB Stay

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Date Revised: June 25, 1997; August 23, 2000

Approved By: Date:

Policy:

**Medicaid**
Physicians must order a home visit for moms and babies that have been discharged in one day after an uncomplicated vaginal delivery, and will be discharged in three days after an uncomplicated cesarean section because the standards for Obstetrical care have changed.

**Commercial**
Physician may order a home visit for moms and babies that have been discharged in one day after an uncomplicated vaginal delivery, and will be discharged in three days after an uncomplicated cesarean section.

Procedure:

**Medicaid**
1. The pediatricians, family practitioners, and obstetricians must order follow-up in-home visits for baby and mom after a 1 day normal uncomplicated vaginal delivery or a 3 day uncomplicated cesarean section.

2. The home visit will consist of a maternal/child assessment of both mom and baby and education on baby care.

**Commercial**
1. Pediatricians, family practitioners, and obstetricians may order follow-up in-home visits for baby and mom after a 1 day normal uncomplicated vaginal delivery, or a 3 day uncomplicated cesarean section.

2. The home visit will consist of a maternal/child assessment of both mom and baby and education on baby care.
POLICY & PROCEDURE
200.006 - Elective & Non Emergency Admissions

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Date Revised: November 15, 1991; March 19, 1997; August 23, 2000

Approved By: Date:

Policy:

Elective and non-emergency admissions must be reviewed prior to admission. The contracted plan must be notified at least 4 working days in advance of the planned admission. Physicians failing to notify the plan prior to elective or non-emergency admission will be subject to Independent Physicians Network sanction.

Procedure:

1. The physician's office initiates pre-admission notification by telephone. This information will be reviewed by the contracted plan Medical Services staff.

2. Pre-admission review is done by the contracted plan Medical Services staff using designated criteria as determined by the plan.

3. If the indications for admission meets the criteria for appropriateness of admission, the admission is approved.

4. If indications for admission do not meet criteria for appropriateness of admission, the Medical Services staff will forward medical information to the Independent Physicians Network Medical Director for review. Additional medical information may be requested from the physician or PCP. If the request is denied, a letter of denial is mailed to the requesting physician and PCP by the contracted plan. If the request is approved, #3 above is followed.
## POLICY & PROCEDURE

### 200.007 - Prior Day Admissions

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**Date Revised:** November 15, 1991; August 23, 2000

**Approved By:**

**Policy:**

Day prior admissions for procedures are **not** a covered benefit unless the physician can document an expected **improved outcome** from the day prior admission.

**Procedure:**

1. Requests for day prior admission are evaluated on a case by case basis by the contracted plan.

2. The admitting physician must provide supporting documentation.

3. If the extra day meets designated criteria for inpatient stay, the day prior to admission will be approved.

4. If the extra day does not meet the designated criteria, the Independent Physicians Network Medical Director will review the request and make a final decision.
Policy:

All mental health and substance abuse inpatient and outpatient services for Independent Physicians Network enrollees must be provided through the plan's contracted mental health, substance abuse provider.

Procedure:

All psychiatric services for Independent Physicians Network enrollees must be provided or authorized by the contracted mental health, substance abuse provider network. This includes all mental health and substance abuse problems requiring inpatient or outpatient care.

A referral from the PCP is not needed.
POLICY & PROCEDURE
200.009 - CT, MRI Prior Authorizations

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Date Revised:

Approved By: Date:

Policy:

All non-emergent, outpatient CTs and MRIs must be performed at free standing imaging sites approved by Independent Physicians Network.

Procedure:

All non-emergent, outpatient CTs and MRIs must be ordered by a member’s assigned PCP or a specialist with a valid referral. All non-emergent, outpatient CTs and MRIs must be performed at free standing imaging sites approved by Independent Physicians Network. A completed order form shall accompany the member to the site on the date of the exam. Prior authorizations are not required for IPN approved free standing sites.

Prior authorizations are required for all non-emergent, outpatient CTs and MRIs before the CT or MRI will be permitted at a hospital or non-IPN approved imaging site. Prior authorizations may be requested from the member’s Health Plan and will only be allowed if special circumstances exist where the CT or MRI cannot be performed at an IPN approved free standing CT or MRI site.
POLICY & PROCEDURE
200.010 – Implantable contraceptives

| Category: Utilization Management | Section: Implantable contraceptives | Date Issued: 6/23/93 | Policy Number: 200.010 |

**Date Revised:** June 25, 1997; August 23, 2000

**Approved By:**

**Date:**

**Policy:**

A pre-authorization is required for all implants and removals of implantable contraceptives to be performed in a day surgery or outpatient setting. Implants or removals of implantable contraceptives to be done in a physician’s office **Do Not** require pre-authorization. Payment will be denied for services provided without Independent Physicians Network prior-authorization.

**Procedure:**

1. Upon the receipt by the Plan of a pre-authorization request for an implant or removal of a implantable contraceptive to be performed in a day surgery or outpatient setting, the Plan will inform the PCP that documentation for medical necessity is required and request that the patient's medical records be submitted to the Plan.

2. The Plan will forward this information to Independent Physicians Network for a decision by Independent Physicians Network’s Medical Director or his appointee. If the Medical Director is unable to make a determination, the request will be reviewed by Independent Physicians Network's Medical Review Committee.

3. Independent Physicians Network will notify the Plan of their decision. Only those cases approved by Independent Physicians Network will be authorized to be performed in a day surgery or outpatient setting.
POLICY & PROCEDURE
200.011 - PT, OT & ST Prior Authorizations

| Category: Utilization Management | Section: Physical Therapy, Occupational Therapy, and Speech Therapy Prior Authorizations | Date Issued: 12/18/02 | Policy Number: 200.011 |

Date Revised:

Approved By: ___________________________ Date: ___________________________

Policy:

All outpatient Physical Therapy, Occupational Therapy, and Speech Therapy must be performed at free standing therapy sites approved by Independent Physicians Network.

Procedure:

All outpatient Physical Therapy, Occupational Therapy, and Speech Therapy must be ordered by a member’s assigned PCP or a specialist with an IPN approved referral. Therapy must be performed at free standing therapy sites approved by Independent Physicians Network. A completed therapy treatment prescription shall accompany the member to the therapy site on the date of the evaluation.

Prior authorization is required for all outpatient Physical Therapy, Occupational Therapy, and Speech Therapy before therapy will be permitted at a hospital or non-IPN approved therapy site. Prior authorizations may be requested from the member’s Health Plan and will only be allowed if special circumstances exist where the therapy service cannot be performed at an IPN approved free standing therapy site.
POLICY & PROCEDURE
200.12 - Prior Authorizations

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Date Revised: February 1, 1991; December 22, 1993; June 22, 1994; September 28, 1994; August 23, 1995; May 28, 1997; August 23, 2000

Approved By: Date:

Policy:

Prior Authorization/notification is required for (Medicaid, Medicare and Commercial):

*ALL ELECTIVE AND NON-EMERGENCY HOSPITAL ADMISSION*- including obstetrical deliveries-by the 2nd trimester if feasible

THE FOLLOWING DAY SURGERY AND OUTPATIENT PROCEDURES -

- Blepharoplasty, upper lid
- Bone growth stimulators, Electromagnetic or Ultrasound
- Breast Reduction
- Breast Reconstruction
- Cochlear Implants
- Colonoscopy
- CT scan (only if not done at a free standing site)
- Potential cosmetic services
- End Stage Renal Disease Services
- Endoscopic sinus surgery
- EGD (esophagogastroduodenoscopy)
- Potential Experimental/Investigational services
- All Frenotomies (tongue clipping)
- Hernia repair over age 16
- Hysterectomy, including endometrial ablation and uterine artery embolization
- IVIG (outpatient)
- Ligaton, Vein stripping
- Mastectomy
- MRI (only if not done at a free standing site)
- Nerve Decompression
- Pain Clinic
- Plasmapheresis
- PET Scans
- Obesity surgery
- Rhinoplasty
- Sclerotherapy
- Septoplasty
Sleep study and surgeries for sleep apnea
All sterilizations performed on Medicaid members

Tonsillectomy/adenoidectomy (commercial and Medicaid only)
Transplant Services
Tubal ligation in conjunction with delivery
Tympanostomy
Drugs specified as requiring prior authorization in contracted plan drug formulary
Home health care, DME
PT, OT, speech therapy (after initial patient evaluation)

Procedure:

1. Notify contracted plan at least four working days in advance of the planned admission or procedure when medically feasible.
2. In an emergency, pre-notification is not necessary. Notify the contracted plan within 24 hours of the admission for Medicaid members and 48 hours for Commercial members or by the end of the next working day if on a weekend or holiday.
POLICY & PROCEDURE
200.013 - Reduction Mammoplasty

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Policy:

Medicaid
Prior approval from the Independent Physicians Network Medical Director and documented medical necessity is required for a reduction mammoplasty. A letter from the surgeon or PCP must be submitted to the Medical Director including documentation that the member meets all five criteria listed below. A picture must accompany the letter.

Procedure:

Medicaid
1. Physicians will submit documentation that the patient meets all five criteria:
   a) Bra shoulder strap pain
   b) Inability to fit into clothes
   c) Backache
   d) Maceration of skin
   e) That at least 300 grams of tissue will be removed from each breast

2. Pictures must accompany authorization request.

3. This information will be reviewed by the Medical Director who may make the decision or refer the case to the Medical Review Committee for a decision.

Commercial
Reduction mammoplasty is based on the member=s certificate of coverage and medical necessity.
Medicaid

Policy:
Prior authorization must be obtained from the Health Plan before a prescription will be allowed for any weight loss agent.

Procedure:
Prior authorization must be obtained from a member’s Health Plan before a prescription will be allowed for any weight loss agent.

Weight loss agents will only be authorized if all of the following criteria are met:

- If the patient’s body mass index exceeds 33 with no co-morbidity, or 30 with co-morbidity; and
- If the patient consults and follows-up with a nutritionist to develop a weight reduction plan. Patient must provide evidence that the weight reduction plan is being followed; and
- Patient must provide three months documented reduction in caloric intake with no weight reduction during that time; and
- Patient must provide three months documented weight loss exercise with no weight reduction during that time.

If a member meets all criteria listed above an authorization will be allowed for a maximum of six months. Scripts may only be written for 30 days at a time. While on weight loss agents, a member’s weight reduction and health status must be monitored monthly. In addition, the member’s medical records must document effective weight loss to continue with a weight loss agent.

Subsequent prior authorization will be required after the initial six month period if the physician recommends continuation of the weight loss agent. Continued monthly monitoring of the member’s weight reduction and health status must be documented in the member’s medical records.

Commercial
Weight Loss Agents are not a covered benefit for commercial members.
POLICY & PROCEDURE
200.015 - Chronic Pain Control

Category:  Utilization Management
Section:  Chronic Pain Control
Date Issued:  1/01/87
Policy Number:  200.015

Date Revised:  February 1, 1991; December 19, 1996; January 28, 1997; May 28, 1997

Approved By:  

Policy:
Referrals for chronic pain control must be referred to an IPN member physician that deals with pain management for evaluation and treatment, i.e. Physical Medicine and Rehabilitation Specialist.

Procedure:
1. Requests for referrals for chronic pain control must initially be made and seen by an IPN member physical medicine and rehabilitation physician.

2. If the IPN member physical medicine and rehabilitation physician is not successful, the patient may be referred to a pain management clinic for care. Requests for referrals to a pain control clinic must be submitted to the IPN Medical Director for review by IPN=s Medical Review Committee and these requests must include:
   a) A copy of all medical work ups which identifies the cause of the pain and the treatment provided
   b) A psychological evaluation

The Medical Review Committee will make the final decision.

Services previously performed by the Physical Medicine and Rehabilitation physician may not be duplicated without prior approval from the medical director; and limit every referral to an initial evaluation and three procedural visits with additional services requiring a re-evaluation by the referring PM&R physician.
POLICY & PROCEDURE
200.016 - Dermatology Referrals

Policy:

A maximum of three visits will be authorized to a dermatologist. If more visits are required, they must be approved by Independent Physicians Network's Medical Director.

Procedure:

Referrals to Independent Physicians Network providers for dermatology will be approved for a maximum of three visits.

The Independent Physicians Network Medical Director will review all requests for visits to a dermatologist that are in excess of the allowed three visits. These requests will be reviewed for medical appropriateness with determination to be made by Independent Physicians Network's Medical Director and/or the Medical Review Committee.
POLICY & PROCEDURE
200.017 - Epidural Steroid Injections

| Category: Utilization Management | Section: Epidural Steroid Injections | Date Issued: 01/01/87 | Policy Number: 200.017 |

Date Revised: February 1, 1991

Approved By: Date:

Policy:

Referrals for epidural steroid injections must be approved prior to services being provided.

Procedure:

Referrals for epidural steroid injections must be approved prior to services being provided and may be approved, if medically appropriate, for a maximum of 3 visits. If additional visits are needed, the specialist must submit medical records and a treatment plan to the Independent Physicians Network Medical Director and/or the Medical Review Committee for review and final decision.
POLICY & PROCEDURE
200.018 - HIV

Policy:

The purpose of this policy is to ensure that providers are obtaining an appropriately signed consent form, ordering the appropriate HIV lab tests, and having lab work processed prior to the issuance of the referral to an infectious disease specialist to ensure expedient quality care. The laboratory requirements are in accordance with recommendations by the Centers for Disease Control and the State of Wisconsin.

A. If the mother is HIV positive, the following tests should be ordered for the infant to confirm if the infant is HIV positive:

1. Newborn Baseline: PCP must order HIV DNA PCR, CD4 cell count and percentage, CBC and Differential, ELISA for antibody to HIV (and Western Blot if ELISA is positive), with referral to infectious disease specialist.

2. At age 1 and 4 months, the PCP must order CBC with Differential, CD4 cell count and percentage, HIV DNA PCR until positive twice or negative twice, with referral to infectious disease specialist.

3. At age 18 months, PCP must order ELISA for antibody to HIV (Western blot confirmation if ELISA is positive). If positive, repeat. If negative, report as A sero-reverter® to the Wisconsin AIDS/HIV program.

4. For PRN deterioration/acute illness, PCP must be seen first, with referral to infectious disease specialist.

B. Enrollees 18 months of age and older (1.5 to 99 years old):

1. PCP must order ELISA for antibody to HIV (Western Blot confirmation if ELISA is positive).

2. If ELISA is negative but the enrollee is participating in high risk activities such as needle
sharing (tattoo, drugs, piercing, etc) or unprotected sex, PCP must order and repeat ELISA in 1 month.

3. If ELISA is equivocal, PCP must immediately order DNA PCR and repeat ELISA.

HIV Referral Policy
Page 2

Procedure:

1. Enrollee or enrollee’s guardian must sign HIV lab consent form.

2. Order lab tests, as indicated above, at IPN’s capitated lab on a Dynacare requisition form. If enrollee will be referred to a specialist, indicate the specialist’s name on the lab requisition form. The lab will send test results to the requesting physician and the indicated specialist.

3. Referrals to HIV specialists will not be approved until lab testing and results are available.

4. Medicaid: Blood should only be drawn at capitated IPN laboratory sites.

Commercial: Blood may be drawn at Plans approved reference lab (s) unless a capitation arrangement exists for the plan.
POLICY & PROCEDURE
200.019 - Keloids

Category: Utilization Management  Section: Keloids  Date Issued: 01/01/87  Policy Number: 200.019

Date Revised: February 1, 1991; July 28, 1993; May 28, 1997

Approved By: Date:

Policy:

Referrals for treatment and/or removal of keloids for cosmetic purposes will be denied as a non-covered service. Cosmetic surgery and related services are a non-covered benefit for both Medicaid and Commercial enrollees. Medically appropriate treatment and/or removal of keloids requires prior approval from the State in the case of a Medicaid recipient.

Procedure:

1. Deny all requests for cosmetic surgery and related services, i.e. treatment and/or removal of keloids, unless medically appropriate documentation is provided for Medicaid enrollees only.

2. If medical appropriateness is provided for treatment and/or removal of a keloid, the documentation will be reviewed by Independent Physicians Network's Medical Director. If Independent Physicians Network's Medical Director determines that medical appropriateness warrants treatment and/or removal of the keloid, documentation will be forwarded to the State for consideration in the case of Medicaid recipients.
POLICY & PROCEDURE
200.020 - Psychiatric Referrals

Policy:

Referrals from the PCP for psychiatric services are not required, however, enrollees must use contracted plan providers.

Procedure:

All psychiatric referrals or services must be authorized by Independent Physicians Network approved psychiatric providers. This includes, but is not limited to, mental health, substance abuse, domestic or sexual abuse, and behavioral problems.
Policy:

All referrals must be initiated by the enrollee’s primary care physician (PCP), regardless of whether or not the specialist being referred to is within or outside of the PCP’s office, by calling the contracted plan’s referral system. An OB/GYN may refer to a geneticist or a perinatologist.

Procedure:

1. All referrals must be initiated by the enrollee’s primary care physician, regardless of whether or not the specialist being referred to is within or outside of the PCP’s office, by calling the contracted plan’s referral system.
2. Letters of approval or denial will be sent by the Plan to the PCP and the specialist.
3. The number and type of service approved will be indicated on the approved referral.
4. Additional visits may be approved by Independent Physicians Network if requested prior to the expiration of a current approved referral. All other changes require the PCP generate a new referral.
5. Post dated referrals or referrals requested after service has been provided are not allowed.

Referrals to Physicians Within Independent Physicians Network:

A. Most referrals will be approved for a maximum of six visits, not to exceed six months.
B. Dermatology, Genetics, or Perinatology referrals will be approved for a maximum of three visits with a six month maximum. If more visits are requested, a treatment plan must be submitted for review by Independent Physicians Network’s Medical Director.
C. Referrals to OB/GYNs for pregnancy may be approved for twelve visits with a one year maximum.
D. Diagnosis must be consistent with the type of specialist to whom the referral is written.
E. Dietary consultations will be approved with a PCP’s written order for five visits for a maximum of six months. If more visits are requested, a treatment plan must be submitted for review by Independent Physicians Network’s Medical Director.
Out of Network Referrals:

A. Referrals to non Independent Physicians Network physicians may be considered for approval if:

* The out of Independent Physicians Network physician performed prior medical care which necessitates that the same physician provide the follow-up care.

*There are no Independent Physicians Network member physicians that can provide the necessary service(s).

Plan Specific Referral Requirements:
Some contracted health plans may offer benefit plans that have referral requirements that differ from the Independent Physicians Network requirements. Independent Physicians Network will work with those contracted health plans to distribute the plan referral requirements to IPN physicians for any benefit plan where the requirements are different than described above.
POLICY & PROCEDURE
200.022 - Vision Referrals

Category: Utilization Management
Section: Vision Referrals
Date Issued: 10/02/91
Policy Number: 200.022

Date Revised: April 5, 1992; June 25, 1997

Approved By: Date:

Policy:

Medicaid
A referral is not required for routine eye exams performed by an Independent Physicians Network approved contracted vision provider. A referral is required for eye exams referred to an Independent Physicians Network member ophthalmologist who does not participate in the Independent Physicians Network approved contracted vision provider network. A referral is also required for all vision/ophthalmic services not included in the routine eye exam.

Commercial
A referral is not required for routine eye exams performed by the Plan's approved, contracted vision provider. A referral is required for all medically appropriate vision/ophthalmic services not included in the routine eye exam.

Procedure:

Medicaid
1. The enrollee may self refer for routine vision exams only and must use a provider within the Independent Physicians Network approved contracted vision provider network.

2. All vision services, other than for routine eye exams to the Independent Physicians Network approved vision service provider, requires a referral from the PCP, including routine eye exams from an ophthalmologist who is not a provider in the Independent Physicians Network approved vision service plan.

Commercial
1. The enrollee may self refer for routine vision exams only and must use a provider within the Plan's approved, contracted vision provider network.

2. All medically appropriate vision services other than routine eye exams to the Plan's approved, contracted vision service provider requires a referral from the PCP.
Policy:

When both a hemoglobin (85014) and hematocrit (85018) are done on the same date of service, only one of the above will be reimbursed.

Procedure:

Reimbursement will be made for only one component of the hemoglobin and hematocrit when done the same date of service.
A. In-Office lab test allowed with a **Certificate of Waiver Only**.

**Urinalysis**
- CPT 81002 - Urinalysis by dipstick or tablet reagent; without microscopy OR
- CPT 81003 - Urinalysis by dipstick or tablet reagent: automated, without microscopy
- CPT 81025 - Urine pregnancy test, by visual color comparison method

**Chemistry**
- CPT 82270 - Blood, occult; feces screening OR
- CPT 82274 - Blood occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations

**Hematology**
- CPT 85018 - Hemoglobin by single analyze instruments with self-contained or component features to perform specimen/reagent interaction, providing direct measurement and readout (Hemocue)
- CPT 85651 - Sedimentation rate, Westergren Type
- CPT 82962 - Glucose, blood by glucose monitoring device(s) clear by the FDA specifically for home use
- CPT 87880 - Infectious agent detection by immunoassay with direct optical observation; Streptococcus, Group A
- CPT 85013 - Blood count; spun microhematocrit
- CPT 85014 - Hematocrit (Wampole STAT-CRIT)
- CPT 82947 - Glucose; quantitative
- CPT 82950 - Glucose, post glucose dose (includes glucose)
B. In-Office lab tests allowed with a **Certificate for Provider Performed Microscopy**.

<table>
<thead>
<tr>
<th>Category</th>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td><strong>Chemistry</strong></td>
<td>CPT 83655</td>
<td>Lead</td>
</tr>
<tr>
<td><strong>Urinalysis</strong></td>
<td>CPT 81000</td>
<td>Urinalysis, by dip stick or tablet reagent; with microscopy</td>
</tr>
<tr>
<td></td>
<td>CPT 81015</td>
<td>Urine microscopic only</td>
</tr>
<tr>
<td><strong>Microbiology</strong></td>
<td>CPT 87210</td>
<td>Wet Mount, O &amp; P</td>
</tr>
<tr>
<td></td>
<td>CPT 87220</td>
<td>Tissue exam for fungi (KOH slide)</td>
</tr>
<tr>
<td><strong>Miscellaneous</strong></td>
<td>CPT 89190</td>
<td>Nasal smear for granulocytes (i.e. eosinophils, basophils and neutrophils)</td>
</tr>
</tbody>
</table>

C. Remaining In-Office lab tests, physician must obtain a **Certificate issued by CLIA finding the laboratory in compliance with all applicable condition level requirements**.

<table>
<thead>
<tr>
<th>Category</th>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Urinalysis</strong></td>
<td>CPT 81005</td>
<td>Urinalysis; qualitative or semiquantitative</td>
</tr>
<tr>
<td></td>
<td>CPT 82948</td>
<td>Glucose, blood, reagent strip</td>
</tr>
<tr>
<td><strong>Chemistry</strong></td>
<td>CPT 85660</td>
<td>Sickling of RBC, reduction, slide method</td>
</tr>
<tr>
<td></td>
<td>CPT 84132</td>
<td>Potassium; serum</td>
</tr>
<tr>
<td></td>
<td>CPT 87430</td>
<td>Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method, streptococcus, Group A</td>
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<tr>
<td></td>
<td>CPT 82565</td>
<td>Creatinine: Blood</td>
</tr>
<tr>
<td><strong>Hematology</strong></td>
<td>CPT 85025</td>
<td>CBC with differential (automated)</td>
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<tr>
<td></td>
<td>CPT 85048</td>
<td>WBC</td>
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</tbody>
</table>

* **CLIA Waiver certificate** qualifies physicians to perform lab in Section A only

* **CLIA Provider Performed Microscopy certificate** qualifies physicians to perform lab in Sections A and B only.

* **CLIA Compliance certificate** qualifies physicians to perform lab in Sections A, B, and C.
Policy:

Medicaid

A single or multiple lab handling fee is reimbursable when the specimen is sent out of the physician's office. A single venipuncture charge (CPT Code 36415), excluding finger sticks, is reimbursable in addition to the lab handling fee.

Procedure:

Reimbursement for single or multiple lab handling fees will be made when the specimen is collected by the physician's office and sent out of the physician's office to Independent Physicians Network's contracted lab.

The following codes must be used for proper reimbursement of lab handling fees:

- Single Specimen  99000
- Multiple Specimen  99000M

A single venipuncture charge (CPT Code 36415), excluding finger sticks, is reimbursable in addition to the lab handling fee.

Commercial

Reimburse only 99000 with a 90 modifier.
POLICY & PROCEDURE
200.026 - Laboratory Testing

<table>
<thead>
<tr>
<th>Category:</th>
<th>Section:</th>
<th>Date Issued:</th>
<th>Policy Number:</th>
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<tbody>
<tr>
<td>Utilization Management</td>
<td>Laboratory Testing</td>
<td>05/01/92</td>
<td>200.026</td>
</tr>
</tbody>
</table>

Date Revised: June 25, 1997; February 27, 2002

Approved By: Date:

Policy:

**Medicaid, Healthystart, Badgercare, and CompcareBlue**
All laboratory services must be performed by Independent Physicians Network's capitated laboratory except for those tests indicated on the Independent Physicians Network in-office lab list or as specifically excluded by other Independent Physicians Network policies.

**Commercial - Healthcare Direct and UnitedHealthcare**
Use of Independent Physicians Network’s capitated lab is preferred for all laboratory services except for those tests indicated on Independent Physicians Network’s in-office lab policy or as specifically excluded by other Independent Physicians Network policies.

Procedure:

**Medicaid, Healthystart, Badgercare, and CompcareBlue**
All laboratory testing must be ordered by the physician and performed by Independent Physicians Network’s capitated laboratory provider. Exceptions are identified in Independent Physicians Network policies (eg. in-office laboratory tests).

**Commercial - Healthcare Direct and UnitedHealthcare**
Use of Independent Physicians Network=s capitated lab is preferred for all laboratory services except for those tests indicated on Independent Physicians Network=s in office lab policy or as specifically excluded by other Independent Physicians Network policies.
Policy:

Tissue samples resulting from day surgery or outpatient surgery which require pathology laboratory testing may be performed at the facility performing the surgery. In the case of surgery performed at Froedtert and Children’s, the pathology services are covered under the Dynacare capitation and will not be paid separately by Independent Physicians Network.

Procedure:

Reimbursement for these pathology services, except for Froedtert and Children=s, will be paid in accordance with the appropriate Independent Physicians Network or State fee schedule.
POLICY & PROCEDURE
200.028 - Pediatric Lab Testing

<table>
<thead>
<tr>
<th>Category:</th>
<th>Section:</th>
<th>Date Issued:</th>
<th>Policy Number:</th>
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<tbody>
<tr>
<td>Utilization Management</td>
<td>Pediatric Lab Testing</td>
<td>3/12/90</td>
<td>200.028</td>
</tr>
</tbody>
</table>

Date Revised: May 1, 1992; March 16, 1994

Approved By: 

Policy:

In addition to reimbursement for an office visit or HealthCheck, the physician will be reimbursed for routine, in-office lab work based on frequency as specified in the pediatric standards and as allowed under the physician's CLIA lab certification.

Procedure:

In addition to an office visit or a HealthCheck exam, a physician may be reimbursed for lab work billed in the office in accordance with the following pediatric standards and if the physician has a CLIA waiver or certification which allows the lab test to be performed in the office.

1. Urinalysis performed:
   - at age 3-5 yrs with routine physical
   - at age 6-11 yrs with routine physical
   - after age 11 when diagnosis justifies testing

   Urine cultures are not included in a routine physical.

2. Hemoglobin **OR** Hematocrit performed in accordance with HealthCheck exam requirements:
   - at 9 months
   - at 2 years
   - at 2 1/2 years
   - once per year for ages 3-20
Policy & Procedure
200.029 - Routine Urine in Global OB

<table>
<thead>
<tr>
<th>Category:</th>
<th>Section: Routine Urine in Global OB</th>
<th>Date Issued: 8/16/90</th>
<th>Policy Number: 200.029</th>
</tr>
</thead>
</table>

Date Revised: May 1, 1992

Policy:
Reimbursement for routine chemical urinalysis using reagent strips (81002) is included in the global OB fee.

Procedure:
Deny claims submitted for routine urinalysis using reagent strips on prenatal patients. This is included in reimbursement for global OB.
POLICY & PROCEDURE
200.030 - Sweat Chloride Tests

<table>
<thead>
<tr>
<th>Category: Utilization Management</th>
<th>Section: Sweat Chloride Tests</th>
<th>Date Issued: 10/27/92</th>
<th>Policy Number: 200.030</th>
</tr>
</thead>
</table>

Date Revised: June 25, 1997

Approved By: Date:

Policy:

Medicaid only:
Sweat Chloride tests (89360) are performed by Children's Hospital of Wisconsin and will be reimbursed by Dynacare Laboratories.

Procedure:

The only site available for sweat chloride testing is Children's Hospital of Wisconsin. Dynacare Lab is unable to perform this testing, however, they are responsible for payment of the test. Payment will be denied by Independent Physicians Network as a capitated service. Dynacare will make direct payment to Children's.
Policy:

Infertility services are not a covered benefit under the Medical Assistance Program. Infertility services for commercial enrollees is specified in their employer plan contract. Infertility is a covered benefit for Medicare enrollees.

Procedure:

MEDICAID:

Physician and related services for infertility procedures are not a covered benefit for Medicaid enrollees, therefore request from an enrollee for infertility workup will be denied.

MEDICARE:

Reasonable and necessary services associated with treatment for infertility are covered under Medicare as described by the Health Care Financing Administration (HCFA), with the exception of the GIFT and ZIFT procedures, which are not a covered benefit for Medicare

COMMERCIAL:

Infertility is a covered benefit for Commercial enrollees and each individual employer plan contract should be referenced.
POLICY & PROCEDURE
200.032 - Norplant Pregnancy Test

| Category: | Section: Norplant Pregnancy Test | Date Issued: 5/20/92 | Policy Number: 200.032 |

Date Revised: June 17, 1992

Approved By: Date:

Policy:

A pregnancy test must be performed on the same day the Norplant is inserted to determine that, to the best of the physicians knowledge, the patient is not pregnant at the time of insertion. In addition, the manufacturer's recommendations should be used as a guideline.

Procedure:

1. For Medicaid members only a physicians claims for Norplant implants should include both a charge for Norplant insertion (11975) and a pregnancy test (81025) on the same date of service. Payment will be made for each service. Claims without pregnancy tests should be referred to the Independent Physicians Network Medical Director for quality review.

2. Norplant is a non-covered benefit for Commercial members, therefore any service performed in association with this non-covered benefit is also not covered.
POLICY & PROCEDURE
200.033 - NST & Fetal Biophysical Profiles

<table>
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<tr>
<th>Category:</th>
<th>Section:</th>
<th>Date Issued:</th>
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<tbody>
<tr>
<td>Utilization Management</td>
<td>NST &amp; Fetal Biophysical Profiles</td>
<td>6/26/91</td>
<td>200.033</td>
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</tbody>
</table>

Date Revised:

Approved By: Date:

Policy:

Fetal non-stress tests (59025) are included in a Fetal Biophysical Profile (76818) and will not be paid in addition to a Fetal Biophysical Profile performed on the same date of service.

Procedure:

Upon the receipt of an edit report from the Plan which list a claim for a non-stress test (59025) billed on the same date as a fetal biophysical profile (76818), Independent Physicians Network will deny the non-stress test as included in the fetal biophysical profile.
I. PURPOSE

The purpose of this policy is to ensure that providers are billing obstetrical charges appropriately for the services they have performed. This policy may be adapted to a review format if poor compliance is identified.

II. DEFINITIONS

A. ANTEPARTUM CARE: Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressure, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery.

B. DELIVERY SERVICES: Delivery services include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, placement of local anesthesia, IV induction of labor, artificial rupture of membranes, vaginal delivery with or without episiotomy, operative vaginal delivery with or without forceps or cesarean delivery.

C. POSTPARTUM CARE: Postpartum care includes hospital and normal postpartum office visits. ACOG considers the postpartum period to be approximately six weeks following the date of the cesarean or vaginal delivery. If the recipient fails to return for the postpartum visit, the provider must adjust the claim to reflect delivery only or the reimbursement will be recouped through audit.

III. CODING GUIDELINES
A. **GLOBAL OB CARE**
Code 59400 is for routine obstetric care and includes antepartum, vaginal delivery and postpartum care. Code 59510 is for routine obstetric care and includes antepartum, cesarean delivery and postpartum care.

B. **ANTEPARTUM CARE ONLY (DOES NOT INCLUDE DELIVERY)**
Antepartum care includes those services previously outlined under **DEFINITIONS**. When the physician or clinic providing the prenatal care is not the physician or clinic who performs the delivery, the 1st thru 3rd antepartum visits must be itemized. The physician, coverage group or clinic should code each visit separately using the appropriate office visit code. The level of service of the office visit codes submitted should be as follows:

a. **INITIAL OBSTETRICAL WORK-UP (HISTORY & PHYSICAL EXAM)**

99204 Office visit, new patient, comprehensive history; comprehensive exam; & moderate complexity medical decision making or
99205 Office visit, new patient, comprehensive history; comprehensive exam; & high complexity medical decision making or
99214 Office visit, established patient, comprehensive history; comprehensive exam; & moderate complexity medical decision making or
99215 Office visit, established patient, comprehensive history; comprehensive exam; & high complexity medical decision making

b. **SUBSEQUENT PRENATAL VISITS**

99213 Office visit, established patient, problem focused history; problem focused exam; straightforward medical decision making

c. **GLOBAL ANTEPARTUM CODES**

More than 3 office visits provided for antepartum care should be submitted as follows:

59425 Antepartum care only; 4 - 6 visits
59426 Antepartum care only; 7 or more visits

d. **LAB WORK**

Any associated lab work allowed on Independent Physicians Network=s in-office lab list may also be coded separately, with the exception of routine chemical urinalysis. All other lab work must be performed by Independent Physicians Network=s contracted lab.
e. COMMON SITUATIONS REQUIRING ITEMIZATION
1) Transfer of an OB patient from one clinic or OB group to another.
2) Change of insurance during pregnancy.
   If a member was effective with another insurance carrier prior to enrolling in Independent Physicians Network, the provider should bill the other carrier for services rendered for that patient.
3) Sporadic or late OB care.
4) Miscarriage or termination of pregnancy.

3. NON-OBSTETRICAL DIAGNOSIS
   If a patient sees her physician for an unrelated diagnosis, the physician may bill separately for these visits using the appropriate office visit code. These include: chronic hypertension, diabetes, management of cardiac, neurological, or pulmonary problems, other conditions (e.g. urinary tract infections) with a diagnosis other than complication of pregnancy.

C. DELIVERY ONLY
   Code 59409 is for vaginal delivery only and code 59410 is for vaginal delivery only, including postpartum care. Code 59514 is for caesarean delivery only and code 59515 is for a cesarean delivery only, including postpartum care. These codes are to be used when the physician, coverage group or clinic performing the delivery is not the physician providing the antepartum care. Delivery services includes those services previously outlined under DEFINITIONS.

D. POSTPARTUM CARE ONLY
   Code 59430 is for postpartum care only. It is to be used when the physician or clinic providing the postpartum care is not the physician or clinic who performs the delivery. Postpartum care includes those services previously outlined under DEFINITIONS. Code 59430 is to be claimed as a global code.

E. ASSISTANT SURGEON
   Assistant Surgeon's fees are not covered for a single or multiple birth vaginal delivery. Therefore, a claim submitted with codes 59400-80 or 59410-80 will be denied. Assistant Surgeons are allowed with cesarean deliveries except in teaching facilities where ob residents are available. The Assistant should attach the appropriate modifier to the cesarean delivery only code, 59514. The assistant surgeons reimbursement will be based on IPN=s assistant surgeons policy.

F. COMPLICATIONS OF MATERNITY SERVICES
   Any complications or unusual circumstances related to the maternity services should be identified by submitting a 22 modifier on the corresponding obstetrical code. In order to be considered for additional reimbursement, supporting
documentation must be submitted with the original claim for all complications and unusual circumstances.

1. **TWIN VAGINAL DELIVERY**
   Providers should bill one global ob (with vaginal delivery code) 59400 or 59610 plus a code for vaginal delivery only. (59409-51 or 59612-51) The vaginal delivery only code will be subject to IPN=s multiple surgery policy.

2. **COMBINATION TWIN VAGINAL AND CESAREAN DELIVERY**
   Providers should bill one global ob (with cesarean delivery code) 59510 or 59618 plus a vaginal delivery only code. (59409-51 or 59612-51) The vaginal delivery only code will be subject to IPN=s multiple surgery policy.
POLICY & PROCEDURE
200.035 - In Office OB Ultrasound Training/Experience Requirements

Category: Utilization Management
Section: In-Office OB Ultrasound Training/Experience Requirements
Date Issued: 9/24/2003
Policy Number: 200.035

Date Revised: 
Approved By: Date: 

Policy:
The purpose of this policy is to determine if a physician’s training/experience are appropriate to permit them to perform OB ultrasounds in-office.

Procedure:
1. To perform obstetrical ultrasounds in-office a physician must be:
   A. Board Certified or achieve Active Candidate status in OB/GYN; and
   B. Have completed their residency after 1981 or be accredited by the American Institute of Ultrasound in Medicine (AIUM) for OB ultrasounds or the American College of Radiology (ACR); and
   C. Have no historical quality related OB ultrasound concerns as determined by IPN.

2. If evidence exists of a historical quality related OB ultrasound concern, then a physician will only be considered to perform in-office OB ultrasounds if the physician has been reviewed by IPN’s OB Ultrasound Review Committee subsequent to the occurrence of the concern.

3. Physician’s ultrasound equipment must be compliant with the requirements of the accrediting agency. In addition, the following information must be verified and recorded at each annual site visit:
   Manufacturer and Model of ultrasound equipment
   Year Built
   Last Inspection Date
   Maintenance/Calibration Logs

4. The credentials of a technician employed by the physician to perform the ultrasound must be compliant with the requirements of the accrediting agency. In addition, the following information must be recorded at each annual site visit:
   Technician’s name
   Experience/Training
   License Number
   Certification
   Credentials
POLICY & PROCEDURE
200.036 - Authorization Review

<table>
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<tr>
<th>Category:</th>
<th>Section: Authorization Review</th>
<th>Date Issued: 9/25/04</th>
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</table>

Revised:

Policy:
The basis for granting or denying approval shall be on the basis of medical necessity according to the definition and UM standards specified by the State or Plan and NCQA and URAC accrediting bodies. ERISA standards from the Department of Labor will only apply when they are more stringent than NCQA and URAC standards for all types of authorizations.

Procedure:
Providers must supply Independent Physicians Network (IPN) specified documentation prior to treatment for certain procedures which are outlined in the Provider Office Reference Manual. Services that require prior authorization should not be started prior to the determination of coverage (approval or denial of the prior authorization) for non-emergency services. Non-emergency treatment started prior to the determination of coverage will be performed at the financial risk of the provider office. If coverage is denied, the treating Provider may be financially responsible if balance billing is disallowed by regulation.

Procedure for Emergency or Urgent Authorization
In an emergency situation, the need to prior authorize services is waived. An Emergency is defined as treatment to ameliorate pain, infection, swelling, uncontrolled hemorrhage and traumatic injury that would lead a prudent layperson to reasonably expect that the absence of immediate care would result in serious impairment or would place the person's health in serious jeopardy. These services will be reviewed retrospectively for medical necessity.

Procedure for Prior Authorization
The participating provider office submits a request for prior authorization of benefits by submitting the appropriate information that notates the medical necessity of the service. The provider can submit this information via paper or telephonically via the IVR system.

1.01 The submitted documentation will be reviewed by a nurse in the Medical Services Management Department using the criteria established by the Plan design and Provider Office Reference Manual. If the documentation claim is incomplete, the request for authorization will be denied administratively.

1.02 The nurse will approve the service as a covered benefit if the requested service and submitted documentation is consistent with the Plan benefit design and clinical guideline.

1.03 If the requested service requires the determination of medical necessity or the appropriateness of care, the request will, on the same day, be referred to one of IPN's Medical Directors for review and determination within the next one business day. All denied or reduced clinical determinations must be reviewed and signed off by a medical director.

1.04 Once a determination is made, a permanent file is set up in the Prior Authorization database. This file contains all pertinent Member and Provider information as well as the outcome of the review.
Notification Process

1.01 The outcome of the reviews will be communicated by the Plan in writing to the Provider within two (2) business days. This communication will also contain information on Provider appeal rights. The criteria used for determination of medical necessity will be clearly documented in the notification letter to the provider and member.

1.02 For any services that are denied or reduced, the Plan will send a denial letter to the Member, within two (2) business days, if specified by the Plan or regulatory agency and it will state clearly the reason for the denial and all Member appeal rights. This includes but is not limited to filing a complaint, grievance or a request for a State Fair Hearing, if applicable.

1.03 The criteria used to determine medical necessity will be published in the Provider Office Reference Manual. IPN shall provide to the Provider, upon request, a copy of the review criteria utilized in benefit determination. The plan shall provide to the member, upon request, a copy of the review criteria utilized in the benefit determination.

Time Frames for Prior Authorizations

1.0001 All determinations will be completed within two (2) business days of receipt of all documents unless specified differently by the Plan or regulation.

1.0002 The notification of the determination will be communicated by the Plan in writing to the Provider and Member within two (2) business days of the determination unless specified differently by the Plan or regulation. A description of the appeal process is included with all denial letters.

1.0003 Urgent prior authorization requests will be determined and the provider notified within one calendar day. (NCQA standard UM 4.1.4)

Urgent or Emergent Prior Authorizations, unless defined otherwise by a state or Plan are defined as those requests for services to treat situations which involve the resolution of acute pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury that a prudent layperson, possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in:

• Placing the health of the person afflicted in serious jeopardy;
• Serious impairment to such person’s bodily functions;
• Serious dysfunction of any bodily organ or part of such person, or
• Serious disfigurement of such person.

Procedure for Retrospective Review or Post Service

All urgent or emergent prior authorization will be reviewed retrospectively.

The Provider will send in the appropriate documentation marked Retrospective Review along with all necessary documents to be reviewed after treatment has been provided.

The retrospective review completed by the nurse to determine coverage and to certify that the services were urgent or emergent in nature. The clinical criteria utilized in the retrospective review are the same criteria utilized in the prior authorization process to determine medical necessity and appropriateness of care. All denied determinations are reviewed by a medical director.

Timeframes for Retrospective Review

1.01 All retrospective reviews shall be determined within thirty (30) business days from the initiation of the UM process unless a more stringent standard applies per Plan or regulation.
1.02 Provider notification of denied or reduced determinations will be made within two business days of the decision by the Plan.

**Notification Process**

1.01 The clinical criteria used to determine utilization management decisions will be published in the Provider Office Reference Manual. IPN shall supply to the Provider, upon request, a copy of the review criteria utilized in benefit determinations. The plan shall provide to the member, upon request, a copy of the review criteria utilized in the benefit determination.

1.02 The notification of the determination will be communicated in writing to the Provider and Member within two (2) business days of the determination unless specified differently by the Plan or regulation. A description of the appeal process is included with all denial letters.
Policy & Procedure
300.001 - Application - Physician

| Category: Credentialing/ Recredentialing | Section: Application - Physician | Date Issued: 6/15/93 | Policy Number: 300.001 |

**Date Revised:** October 10, 1995; July 4, 1996; July 24, 1996; February 18, 1999; March 24, 2004; October 5, 2004

**Approved By:**

**Date:**

**Policy:**

Independent Physicians Network’s (IPN’s) credentialing meets, or exceeds, the standards set by the National Committee on Quality Assurance (NCQA). Independent Physicians Network credentials physicians (as defined by the State of Wisconsin as MDs, DOs or foreign trained equivalents) who apply for membership with Independent Physicians Network.

Applications for membership in Independent Physicians Network, including new members and continuing members, are reviewed by the Credentials Committee for recommendation to the Board of Directors. Applicants are reviewed by the Board of Directors for a decision regarding membership in Independent Physicians Network. IPN will not discriminate against any applicant on the basis of race, gender, color, religion, national origin, ancestry, sexual orientation, age, veteran, marital status, or health care providers that serve high risk populations or those who specialize in the treatment of costly conditions. IPN does not delegate any credentialing/recredentialing functions.

**Procedure:**

1. **Information Required from Applicant**
   
   **New Applicant:** physicians requesting to be members of Independent Physicians Network are sent a cover letter, an Independent Physicians Network application, an IPN physician provider agreement, a list of IPN approved hospitals, a credentialing checklist and an orientation schedule.

   **Applicants to be Recredentialed:** Member Physicians are sent a notice of recredentialing, an
Independent Physicians Network application, a list of IPN approved hospitals and a recredentialing checklist.

**Required Application Information** must be provided by all applicants and returned within ten (10) days after Independent Physicians Network has sent the application.

The applicant must provide all information required by the Credentials Committee for credentialing and recredentialing including:

- Fully Completed and Signed Application
- Signed, Unamended IPN Physician Provider Agreement
- Copy of Current State License
- Copy of Current Malpractice Insurance Coverage
- Copy of Current DEA License
- Copy of Current CLIA Certificate(s)
- Copy of Current Certification/License of Staff who Perform Testing in Office
- Other information as Required by the Committee or Board from time to time

2. **Work History**
A minimum of five years of work history will be obtained from the applicant and assessed for gaps. No primary verification will be required. All gaps exceeding 6 months will be investigated. A verbal explanation will be accepted for gaps of 6 to 12 months. Gaps in excess of 12 months will require written explanation from the provider.

3. **Second Notice and Incomplete Applications**
A Second Request is sent by Independent Physicians Network if:

- the application is not received within ten (10) days after Independent Physicians Network has sent the application;
- if the application is incomplete;
- or if additional information must be provided to the Committee by the applicant.

All requested information is requested to be returned to IPN within ten (10) days of the date the applicant is sent the second notice.

4. **Final Notice**
A Final Notice is sent by certified mail, if the requested information is not received within ten (10) days from the date the second notice is sent. The Final Notice informs the applicant that their application is incomplete and that the credentialing/recredentialing process will be discontinued unless the information is received by IPN within ten (10) days of the date of the certified letter. Failure to provide required information needed to complete the credentialing/recredentialing process will result in denial of membership or termination of membership in Independent Physicians Network and termination of the physician provider agreement with Independent Physicians Network.

5. **Applicant Assistance**
All requests for information by the Independent Physicians Network credentialing staff will encourage the applicant to contact IPN with questions concerning the requirements of the credentialing process, or for assistance in completing the application and the credentialing process in a timely fashion.
6. **Application Status**  
At any time during the credentialing/recredentialing process the applicant, upon request, will be informed of the status of their credentialing/recredentialing application.

7. **Other Sources of Information**  
Independent Physicians Network requests information regarding the applicant along with a copy of the release form signed by the applicant from or accesses available information from:

- ABMS or Residency Program as applicable
- National Practitioner Data Bank
- State Mediation Panel
- State Patient Compensation Fund
- Hospital Medical Staff Office(s) (where applicant has privileges)
- Hospital Department Chiefs (if applicable)
- Wisconsin Medicaid Certification Report
- Wisconsin Department of Regulation & Licensing Monthly Disciplinary Report
- Office of the Inspector General (Lists Fraud & Abuse Claims w/Dept. of HHS)
- Other Independent Physicians Network Member Physicians for Personal Knowledge about the Applicant (upon Committee request)
- Other Sources as May be Necessary/or Requested by the Credentials Committee or the IPN Board of Directors

8. **Physicians Right to Correct Erroneous Information**  
During the application process, if the IPN Credentialing staff notes differences between the physician’s application information and the information given to IPN from any of the above sources, the physician has the right to correct the information on the application.

9. **Complete Applications are Reviewed by the Credentials Committee**  
The Credentials Committee will:

* Review each file and complete the application work sheet.

* Document Committee's concerns regarding applicant or the application, such as quality issues, physician utilization, or patient complaints.

* Document their comments regarding Professional Sanction History questions to which applicant has respond affirmatively.

* Make a recommendation to the Board regarding each applicant.

10. **Committee Recommendations are Reviewed by the Board of Directors**  
The Independent Physicians Network Board of Directors will:

* Review all applicants requesting membership in Independent Physicians Network.

* Review the Credentials Committee recommendations.
* Determine the outcome of each applicant’s request for membership.

11. **Notification of Board of Directors Decision**
Immediately (or within 60 calendar days) following the Board of Directors meeting, Independent Physicians Network will notify all credentialing/recredentialing physicians of the Board of Directors’ decision regarding their status with IPN.

12. **Appeals**
Applicants denied membership in Independent Physicians Network may appeal the decision of the Board of Directors by sending a written request for appeal within thirty (30) days of notification from the Board of the denial.
Policy & Procedure
300.002 - Physician Appeals Process/Review Action


Date Revised: January 28, 2004

Approved By

Date:

Policy:

Provides for the evaluation of quality of care and service provided by Member Physicians, defines the range of actions that may be taken to improve performance, establishes an appeal process and methods of notifying member physicians about the appeal process and establishes a reporting mechanism for serious deficiencies.

Procedures:

1. If at any time Independent Physicians Network, Inc. (IPN) obtains information regarding a Member Physician’s professional competence or conduct, which affects or could be detrimental to patient safety or to the delivery of quality patient care, the Credentials Committee will perform a professional review and make a recommendation to the Board of Directors. Any action taken, which does not relate to the competence or professional conduct of a Member Physician is not a professional review action within the meaning of this policy.

2. Professional review actions which Independent Physicians Network may impose on Member Physicians include but are not limited to the following:

   a. Requirement for participation by member physician in educational programs to improve performance;

   b. Requirement for prior approval of specific procedures or treatments;

   c. Requirement for concurrent monitoring;

   d. Limitation of specific clinical privileges; or

   e. Termination of participation as a member physician with IPN.
The Credentials Committee will recommend to the Board of Directors if any of the actions should be taken based on the competence or professional conduct of an IPN Member Physician. The Member Physician is entitled to the appeals process set forth within this policy.

However, the action shall not be viewed as a professional review action if it is taken as the result of the following:

a. Loss of valid and unrestricted license to practice medicine in the State of Wisconsin;
b. Failure to obtain or maintain adequate malpractice and general liability insurance;
c. Revocation, suspension, limitation, or restriction of the Member Physician’s privileges by any hospital for any reasons related to the quality of patient care or the Member Physician’s conduct in relation to patients and/or staff;
d. Failure to maintain hospital privileges in at least one IPN approved hospital or failure to obtain a formal inpatient coverage arrangement with another IPN member physician of the same specialty;
e. Exclusion from participation in Medicare, Medicaid or all Federal Health Care Programs;
f. Failure to maintain a valid and unlimited DEA registration;
g. Termination of contract and membership agreement with Independent Physicians Network.

Appeals Procedure:

1. If the IPN Board of Directors impose a professional review action with respect to a Member Physician, the Member Physician will be notified in writing, by certified mail, of the action and why the action is recommended. The Member Physician must appeal the decision in writing, within 30 days after receipt of notice. Included in the appeal must be any additional information regarding the area of concern. Provider has the right to be represented by an attorney.

2. If the physician appeals the Board’s decision, the Board of Directors will review their decision after receipt of the additional information. The Board of Directors once again have the right to require a professional review action if they feel that appropriate corrective measures have not been made in the area of concern. The physician will be notified of the decision by certified mail.

Reporting:

If a professional review action is taken by the IPN Board of Directors based on the member physician’s professional conduct or competence, Independent Physicians Network will notify all health plans that currently hold contracts with IPN, of the Board of Directors decision.
Policy & Procedure
300.003 - Physician’s Hospital Privileges

<table>
<thead>
<tr>
<th>Category: Credentialing</th>
<th>Section: Physician’s Hospital Privileges</th>
<th>Date Issued: October 19, 1999</th>
<th>Policy Number: 300.003</th>
</tr>
</thead>
</table>

Date Revised: November 26, 2003

Approved By: Date:

Policy:

All applicants must have admitting privileges or a formal inpatient coverage arrangement with an Independent Physicians Network member physician, who has admitting privileges at an IPN approved hospital. The member physician or contracted provider agreeing to cover must be of the same specialty as the applicant. Hospital inpatient coverage must be at a hospital contracted by each plan.

Procedure:

Information Required from Applicant

1. **New Applicant** physicians requesting membership in Independent Physicians Network are sent a list of Independent Physicians Network approved hospitals along with all other credentialing materials. Primary source verification of hospital privileges is required by NCQA.

   **Recredentialing** members are sent a list of Independent Physicians Network approved hospitals along with all other recredentialing materials. Primary verification of hospital privileges is required by NCQA.

2. **Applicants who do not have hospital privileges** will be requested to provide:

   - Information regarding termination, suspension, pending or denial of hospital privileges; and
   - A reason as to why they do not have hospital privileges; and
   - A formal inpatient coverage arrangement.

   Covering physicians must be member physicians or contracted providers with Independent Physicians Network in good standing; and

   Covering physicians must be of the same specialty as the applicant; and

   Covering physicians must have privileges at a hospital contracted by each plan; and

   Covering physicians must submit a letter attesting to the formal coverage arrangement.

3. **Applicants denied hospital privileges** will be reviewed by the Credentials Committee and a recommendation made to the Board on a case by case basis. The applicant will be notified of the Board of Director’s decision.
Policy & Procedure
300.004 - Interim Review Procedures - Physician

| Category: Credentialing/Recredentialing | Section: Interim Review Procedures - Physician | Issued: 01/28/04 | Policy Number: 300.004 |

Date Revised: March 24, 2004

Approved By: Date:

Policy:

Provides for the consistent evaluation of Member Physicians on an ongoing basis in compliance with NCQA and Independent Physicians Network’s credentialing guidelines.

Procedures:

1. In the month received, the Member Physician must forward a copy of:
   a. The current State of Wisconsin License
   b. The current DEA License
   c. The current Malpractice Insurance face sheet

2. Member Physicians must immediately notify Independent Physicians Network of:
   a. Any limitation or suspension of hospital privileges.
   b. Any action take by the Wisconsin Department of Regulation and Licensing.
   c. Any knowledge received by the Member Physician or notification to the Member Physician that adverse information has been reported to the National Practitioner Data Bank.
   d. Any health condition that might impair or affect the Member Physician’s ability to
practice medicine that would have an adverse effect on the safety of the patient or the delivery of quality patient care.

e. Any potential litigation regarding the Member Physician’s practice of medicine.

3. Monthly the Independent Physicians Network credentials staff will review the following:

a. The State of Wisconsin Disciplinary Action Report for sanctions or actions affecting a Member Physician.


Any discrepancies or disciplinary concerns are brought to the attention of the Board of Directors for appropriate action.
Policy & Procedure
300.005 - Medical Director/Assistant Medical Director Utilization Review Visit - Physician

Date Revised: November 26, 2003

Policy:

Independent Physicians Network’s Medical Director/Assistant Medical Director will perform structured data sharing visits annually with all primary care physicians, all OB/GYNs and high volume specialists. The Medical Director(s) will visit all other specialists/contracted providers every other year.

Purpose:

The purpose of the Medical Director’s visit is to:

I. Provide physician support regarding Independent Physicians Network member physicians’ inquiries and compliance issues as they relate to State or Federal guidelines or regulations.

II. Promote positive relations with enrollees, physicians, provider staff and employees of Independent Physicians Network.

III. Review Independent Physicians Network’s policies and procedures and standards for quality medical care.

IV. Provide support regarding compliance with Independent Physicians Network Policy & Procedures and offer assistance & education as needed for physicians to meet compliance requirements.

V. Review utilization and medical outcomes information, provided to IPN by the health plans.

VI. Educate member physicians on current standards for medically managing care; including cost effective quality improvement initiatives such as use of capitated lab services, free standing imaging centers and referrals to Independent Physicians Network member physicians as medically appropriate.

VII. Inform physicians about the opportunities available to contribute to or be involved in Independent
Physicians Network, such as committees or special projects.

VIII. Other issues as directed by the Board or as deemed necessary by the Medical Director and/or member physicians.

Procedure:

Upon completion of the Independent Physicians Network’s nurse’s site visit/chart review:

1. Administrative staff will schedule the utilization and medical outcomes review visit with one of the IPN Medical Directors and the member physician.

2. Administrative staff will provide the Medical Director/Assistant Medical Director with utilization and medical outcomes data as they relate to the member physician.

3. Medical Services staff will provide written documentation relating to the most recent site visit and/or medical record keeping review within seven (7) days of the visit.

4. Medical Director/Assistant Medical Director will conduct the utilization and medical outcomes review visit with the member physician. The member physician will be asked to complete and sign the Physician Office Visit-Discussion Topics Checklist.
Policy: All new applicants must attend a scheduled orientation meeting at the Independent Physicians Network’s Administrative office. The orientation is designed to help the applicant better understand Independent Physicians Network and the benefit and expectations of membership in Independent Physicians Network.

Procedures to follow in scheduling the orientation:

1. The IPN administrative staff will send an orientation schedule with an application package.
2. If the applicant has not scheduled an orientation, the IPN administrative staff will call the applicant to schedule an orientation meeting during the time their application is in process.
3. If the applicant fails to schedule an orientation, the IPN administrative staff will provide the Medical Director or Assistant Medical Director the applicant’s name to contact.
4. If the applicant still fails to schedule an orientation, the IPN administrative staff will send the applicant a letter with a deadline and orientation schedule asking applicant to contact IPN to schedule an orientation.
5. If all efforts fail, the IPN administrative staff will send a letter and withdraw the applicant from the credentialing process due to failure to attend an orientation meeting.
Policy & Procedure
300.007 – Physician’s Right to Review

| Category: Credentialing/ Recredentialing | Section: Physician’s Right to Review | Date Issued: 1/28/2004 | Policy Number: 300.007 |

Date Revised: 

Approved By: 

Date: 

Policy:

All applicants have the right to review certain information obtained by Independent Physicians Network during the credentialing/recredentialing process. This includes information obtained from certain outside primary sources such as the National Practitioner Data Bank, malpractice insurance carriers and the Wisconsin Department of Regulation and Licensing - Medical Examining Board. This does not include review of references, personal recommendations or personal knowledge disclosed by IPN Committee members and/or the IPN Board of Directors.

Procedure:

1. All applicants are notified of their right to review information obtained by Independent Physicians Network via the IPN Orientation Packet and the IPN Provider Manual distributed to each physician’s main office.

2. Information obtained from certain outside primary sources as indicated above will be available to be reviewed by the physician only after a written and signed request has been submitted to:

   Independent Physicians Network, Inc.
   Attn: Credentialing Department
   6767 West Greenfield Avenue, Suite 300
   Milwaukee, WI 53214

3. Information may be reviewed by the physician at the Independent Physicians Network administrative office, during normal business hours, in the presence of an IPN staff member. If the Credentialing Department is unsure of the type of information that can be released, the Director of Administrative Services will be notified. The Director of Administrative Services will discuss with the Executive Director and/or Board President whether information may be released. The Executive Director and/or the Board President reserve the right to discuss whether information should be released with legal counsel.

This document contains proprietary and confidential information and may not be disclosed to others without written permission.
Policy & Procedure
300.008 - Site Visit/Medical Record Review - Physician

| Category: Credentialing/ Recredentialing | Section: Site Visit/Medical Record Review-Physician | Date Issued: 10/17/1995 | Policy Number: 300.008 |

Date Revised: February 18, 1999; February 20, 2000; February 2004; October 05, 2004; May 25, 2005

Approved By: Date:

Policy:

Independent Physicians Network requires documentation of a structured site visit and review of medical record keeping for all primary care physicians, all OB/GYN, and high-volume specialists, annually. Site visits and medical record reviews are conducted for all other member physicians during initial credentialing and recredentialing. A site visit will also be conducted when a member physician relocates or opens an additional office. The site visit review form and medical record review letter must be part of the completed physician file for review by the Credentials Committee, for recommendation to the Board of Directors.

Procedure:

1. **PHYSICAL SITE:**
   
   **Accessibility:**
   
   The exterior of the building is assessed as follows; available parking, handicapped parking, handicap access, first floor office, if not, is there a working elevator, automatic opening for main entrances. (See office standards attached)

   **Adequacy:**
   
   The following is assessed in the waiting area; handicap accessible bathroom, seating capacity, physical appearance, designated office area for privacy, exit signs, fire extinguishers visible and properly charged. (See office standards attached)

   The following is assessed in the exam rooms; privacy, patient gown/drape provided, comfortable temperature, harmful equipment not patient accessible, appropriate disposable equipment used, clean table paper, hazardous waste disposed of appropriately, physical appearance, sharps container available. (See office standards attached)

2. **EQUIPMENT:**
Independent Physicians Network is interested in knowing what equipment is used in the physician's office (i.e. x-ray, lab, EKG, etc), and depending on the procedures done, does the physician have the appropriate staff (i.e. lab tech, x-ray techs, etc.) performing these procedures.

3. **CLIA CERTIFICATE:**
   A copy of the CLIA certificate is obtained for the physician's credentials file. Independent Physicians Network also verifies that the physician is billing appropriate lab according to the CLIA certificate he/she was issued.

4. **VISUAL INSPECTION OF DEA:**
   The DEA is examined verifying that the copy in the physician's file at Independent Physicians Network’s administrative office is valid.

5. **EVALUATION OF PATIENT'S MEDICAL RECORDS:**
   The medical record area is assessed for confidentiality, security and privacy. For physicians in the initial credentialing process their records are reviewed when there is adequate utilization and at a minimum a mock medical record is reviewed for organization and filing of information in the medical record. Physicians that are in the recredentialing process have the actual record review done the same day as the site visit or within two weeks of the site visit. Independent Physicians Network requires an overall score of 80% of criteria met to be in compliance. (See office standards attached)

6. **STAFF INSERVICE:**
   Independent Physicians Network's Medical Services representative educates the office staff on the use of Independent Physicians Network providers, a capitated laboratory (Dynacare), and contracted imaging centers and discusses issues such as claim problems, (the use of the voice response referral line, and how to access the eligibility line.)

7. **NO SHOW POLICY:**
   The no show policy is documented and becomes part of the Independent Physicians Network physician's file. The staff is reminded that "no shows" must be documented in the patient record.

8. **COVERING PHYSICIANS:**
   Documentation is made of the covering physicians and becomes part of the Independent Physicians Network physician's file, and the physician is reminded that the covering physicians must be Independent Physicians Network physicians.

9. **HEALTHCHECK:**
   HealthCheck is a comprehensive preventive screening of Medicaid enrollees ages 0-20. Independent Physicians Network addresses that all PCP's must perform HealthChecks and instructs the office on the proper billing procedure and makes sure that the physician is aware that there are pre-printed age appropriate guideline forms to assist the physician in performing a HealthCheck. If HealthCheck is not being performed the issue is referred to the Medical Director.

10. **AVAILABILITY OF APPOINTMENTS:**
    Independent Physicians Network's Medical Services representative discusses with the office staff how many days it takes to schedule a new patient visit (average 30 days), how many days it takes to schedule a routine/well check appointment (average 2 weeks), how long
does the patient have to wait to schedule an emergent/urgent appointment (average 24 hours). If a physician does not fall within the average appointment times, the physician is requested to send an explanation for this occurrence and what corrective action will be taken to ensure this practice will not continue. Independent Physicians Network's Medical Services representative and Medical Director are available to assist with the corrective action. (See office standards attached)

11. **WAITING TIME:**
   Independent Physicians Network's Medical Services representative discusses with the office staff the amount of time the patient must wait before being seen (average 10-15 minutes). If the physician does not fall within the average waiting time, the physician is requested to send an explanation for this occurrence and what corrective action will be taken to ensure this practice will not continue. Independent Physicians Network's Medical Services representative and Medical Director are available to assist with the corrective action. (See office standards attached)

12. **AVAILABILITY OF DOCTOR AFTER HOURS:**
   Independent Physicians Network's Medical Services representative addresses with the office staff if an Independent Physicians Network physician's patients are educated on how to access the physician after hours and the way in which this is conveyed to the patients. Again, if problems arise the physician is requested to send an explanation for this occurrence and what corrective action will be taken to ensure this practice will not continue. Independent Physicians Network's Medical Services representative and Medical Director are available to assist with the corrective action. (See office standards attached)

13. **REVIEWER'S SIGNATURE:**
   When the site visit is complete the Independent Physicians Network designated reviewer will sign the completed form.
   Based on the composite site visit and/or medical record audit score(s), various quality issues or documentation problems may be presented to the Independent Physicians Network Medical Director for review. Decisions are as follows:

   **Site Visit Thresholds**

   80% or > of standards met = **Pass**
   A letter will be sent identifying deficiencies, if any or a letter congratulating physician on deficiency free status. Follow up in six months to ensure compliance; unless at the discretion of the Medical Director/Medical Review Committee, intervention requires more frequent follow-up or monitoring.

   79% or < of standards met = **Corrective Action Plan Required**
   A letter identifying deficiencies and a plan of corrective action will be provided to the physician. Follow up visit at least every six months until the site visit performance standard threshold of 80% or > is met; unless at the discretion of the Medical Director/Medical Review Committee, intervention requires more frequent follow up or monitoring. Revisiting the site will consist of reviewing only those items that are not in compliance. Failure of a physician to comply with a plan of corrective action will be addressed by the Medical Review Committee to determine
further action, if necessary.

**Medical Record Review Thresholds**

> 2/3 of charts are free of deficiencies = Pass  
Letter- identifying deficiencies if any or  
letter congratulating physician on deficiency free status  
Follow up in one year to ensure compliance; unless at the discretion of the  
Medical Director/Medical Review Committee intervention requires monitoring or  
more frequent follow-up

> or =  to 1/3 of charts are deficient = Corrective Action Plan Required  
Letter identifying deficiencies  
Follow up visit may or may not be required, depending upon the items requiring  
 improvement; unless at the discretion of the Medical Director/Medical Review  
Committee intervention requires monitoring or more frequent follow up. If the same  
criteria is deficient for 3 years or more, the reviewer will notify the Medical Director  
and the Director-Medical Services to assist with the corrective action.

Independent Physicians Network's Medical Director will make a decision on the issues or  
documentation presented or may direct further review by the Medical Review Committee for their  
decision or recommendation to the Board of Directors. The results of the decision will be  
documented in writing and communicated to the physician(s).

The results of the site visit and medical record documentation are shared with every member  
physician. Independent Physicians Network pro-actively educates Independent Physicians  
Network’s member physicians regarding the quality of care requirements and documentation needed  
to meet Managed Care and medical record standards.

14. **ANNUAL REVIEW SUMMARY:**

Independent Physicians Network Medical Review staff will review annually a summary of site visits  
and chart audit outcomes for the previous calendar year and submit summary data to the Medical  
Review Committee. The Medical Review Committee will review the data to assess Independent  
Physicians Network’s compliance with established standards and goals as they relate to credentialing  
and medical records. As a result of the audit, the Medical Review Committee at its discretion may  
offer recommendations for improvement. Recommendations will be communicated to member  
physicians.
## Policy & Procedure
### 300.009 - Confidentiality

<table>
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<tr>
<th>Category:</th>
<th>Credentialing/Recredentialing</th>
<th>Section:</th>
<th>Confidentiality</th>
<th>Date Issued:</th>
<th>8/25/2004</th>
<th>Policy Number:</th>
<th>300.009</th>
</tr>
</thead>
</table>

**Date Revised:**

**Approved By:**

| Date: |

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### Purpose:
IPN guides its internal operations by a policy on confidentiality, whose purpose it is to ensure that each IPN Provider’s and IPN Enrollee’s right to protection of information is respected while allowing Quality Improvement and Care Management efforts to go forward.

In addition, IPN has an interest and responsibility in protecting employee information in compliance with state and federal employment laws.

### Policy:
The following policy outlines the basic principles for maintaining confidentiality, and serves as the policy governing exchange of information between IPN Providers, IPN Enrollees and IPN.

General principles that may apply to the maintenance of confidentiality include: access to information on a “need-to-know” basis; and, seeking only that information that is necessary to make a decision regarding the addressed concern or quality of care. Furthermore, all patient-specific information obtained during the process of utilization review will be kept confidential in accordance with HIPAA standards and applicable state and federal laws.

It is IPN’s policy to respect the right to confidentiality of privileged information for IPN Providers and Enrollees, and to not release or make available to any parties (internal and external) privileged information to which consent to release has not been given.

For the purposes of this policy, the documents that are deemed protected under the right to confidentiality are the Enrollee’s Record, the Provider Record and Employees’ personnel and medical files.

These are defined as:

**Enrollee Record** - The Enrollee Record is kept in the Provider's office, and is also known as the Enrollee’s chart. It includes, but is not limited to: a registration form, medical history, and all x-rays, treatment plans and progress notes, as well as any other...
documentation, such as consent forms, letters from specialists, etc.

Provider Record - The Provider Record consists of, but is not limited to: an extensive application form, listing licensing, DEA registration, practice location, employment information, education information, sanctions to include Medicaid as well as a questionnaire addressing any judgments, limitations, revocations, reprimands, suspensions, criminal convictions, drug or alcohol issues, and mental or physical impairments that could limit ability to provide high quality, professional services. Primary verification of the above information, as well as liability insurance information and a report from National Practitioners Data Bank (NPDB).

Employee Record - The Employee Record is retained in the Human Resources Department. It includes, but is not limited to: job application form, medical history, employment information, education, performance reviews as well as any other documentation subject to applicable state and federal regulations.

Procedure:

IPN Providers’ or IPN Employees’ Consent to Release (Provider) Information

All collection of IPN Provider or IPN Employee information will be conducted on a “need to know” basis and shall comply with IPN’s Confidentiality Policy. Information subject to this policy includes, but is not limited to: license registration, professional training and schooling, Drug Enforcement Agency registration, proof of liability insurance, disciplinary actions, lawsuits and sanctions and other state-specific license requirements.

Every provider office is expected to cooperate fully with any request for information necessary for the credentialing or recredentialing process. Every employee is expected to cooperate fully with any request for information necessary in accordance with applicable state and federal laws.

Enrollees’ Consent to Release Information

IPN is aware that Enrollees may sign a consent to release information with their respective Plans, and that this consent may include IPN in its purview.

The contracts that IPN makes with Providers shall explicitly state the expectations about the confidentiality of Enrollee information and records. IPN’s Providers shall assure that they will comply with all state and federal laws pertaining to confidentiality; they also shall assure that they have obtained proper consent from Enrollees to disclose confidential information in appropriate circumstances as determined by IPN.

All IPN Providers shall maintain a written policy on confidentiality for their own internal operations. This policy shall ensure the confidentiality of Enrollee information used for any purpose. All IPN Providers shall provide each Enrollee with a statement paraphrasing the provisions of this policy.

IPN Providers may not intentionally falsify an Enrollee health care record, conceal or
withhold a Enrollee health care record with intent to prevent its release to the Enrollee or to his/her authorized guardian. IPN Providers may not intentionally destroy or damage records in order to prevent or obstruct an investigation or prosecution.

All IPN Provider facilities shall display a Patient Rights and Responsibilities Statement in an area visible to patients.

**Requesting Enrollee Records**

Requests for Enrollee Records are made only by employees authorized to do so by the IPN Board of Directors or a designate, and then only when it is necessary to assure the Enrollee’s right to proper payment or to review the quality, appropriateness or necessity of services received from an IPN Provider. When requests for information are made, the scope of the request should be limited to that information which is absolutely necessary to complete the particular function, and if at all possible, should not include the whole Enrollee Record. Information obtained for one purpose may be used for other purposes within the utilization management program. Note that written permission of the Enrollee is not required for purposes of coverage determination or quality improvement as supported in State statutes and the IPN Provider contract. Nor is written permission required for use in any public entity investigation or enforcement of health care fraud.

All Enrollee records and data requested by IPN may be duplicated. IPN reserves the right to request the original records, if duplicated records are not adequate. If a quality issue is identified, it is referred to Medical Review for further review.

**Access to Confidential Information**

No IPN employee shall be given access to IPN Provider or Enrollee Records unless specifically authorized according to current company policy. Access to information should be limited to a "need-to-know" basis; that is, an IPN employee shall only seek (and be provided) that information which is necessary to thoroughly accomplish the job. Records are to be handled in a manner which assures the strictest confidence, without the possibility of accidental exposure. All IPN employees shall keep in mind their commitments to confidentiality while communicating via e-mail and telephone, using printers and copy machines, and disposing of waste materials by shredding when appropriate.

All authorized persons who obtain information from IPN Providers either by telephone, written correspondence or in person, have been trained to provide their IPN identification by means of their name and title and present a business card when applicable.

Confidential information shall be entered into IPN’s secured information systems only by authorized personnel. These additions or changes should be date stamped, the person entering the information should be identified in the record, and those individuals who will be informed about the additions or changes should be listed. These additions or changes shall then be disseminated to all users of the information.
Storage of Confidential Information

**IPN Provider Records**

All Provider Records shall be kept in a locked location, with access according to Company policy. When an authorized employee needs to see a Provider Record, s/he shall follow appropriate processes. Any Provider information stored electronically shall be secured by system administrators.

Minutes of the Credentialing Committee will be held in the strictest of confidence, and accessible only to the appropriate parties at IPN and Plans.

**IPN Enrollee Records**

When Enrollee Records arrive from IPN Providers, they shall be to the attention of IPN’s Medical Director or a designate. While on the premises, these records are kept in locked locations. They shall be viewed only by the necessary and authorized personnel.

Any Enrollee information stored electronically shall be secured by system administrators. IPN shall provide a back-up system whereby all information is safeguarded in the event of an electronic failure, flood, or other emergencies.

Records will be maintained in the paper form for a minimum of 1 year.

The purging from the computerized database of archaic or inaccurate data shall take place in a timely manner. Upon termination of an IPN Provider, those computer files that have been maintained shall be retained for historical purposes.

If an onsite visit is required for a utilization review of an IPN Provider, all activities will be coordinated with the contact person designated by the IPN Provider and at least one day advance notice is required.

**Release of Confidential Information**

Since each Enrollee signs a consent to release confidential information with the Plan, and IPN is, in effect, a sub-contractor of the Plan, IPN respects the conditions of the respective Plans.

Information will only be released to those individuals or agencies with a bona fide use for it, as determined by IPN. All other requests will be referred to the original IPN Provider (this includes requests by employer groups and Plans).

**Research**
No consent to release information is necessary when non-identifiable Enrollee information is being requested for the purposes of research.

In the event of identifiable Enrollee information being requested for the purposes of research, the Quality Improvement Utilization Management Committee will convene to:

- Ensure that the intended research has had appropriate reviews for, and contains necessary controls to protect the confidentiality of the Enrollee;
- Verify that the identifiable information is used only for the purposes that are specified in the research consent form that needs to be signed by the Enrollee.

**Communicating Confidentiality Policies and Practices to Prospective Enrollees**

Information regarding access to Enrollee healthcare records will be available through Plan brochures, Enrollee handbooks and the posted Statement of Enrollees’ Rights and Responsibilities.

**Communicating Policies on Obtaining Consents to Enrollees and Providers**

- **Providers** - Information regarding access to Enrollee healthcare records will be available through State statutes and administrative rules, Provider contracts, Plan brochures, and office reference manuals.

- **Enrollees** - Information regarding access to Enrollee healthcare records will be available through Enrollee handbooks, the Plans customer service department and the posted Statement of Enrollees’ Rights and Responsibilities.

**Electronic Privacy Policy**

**Patient identifiable information that is or has been electronically transmitted or maintained by IPN is subject to the following rules:**

Any disclosure of protected health information is restricted to that which is necessary to accomplish the relevant purpose such as treatment, payment and healthcare operations, including quality assurance, credentialing, utilization review and other similar activities.

IPN has designated the Executive Director as its privacy officer. This officer or designee in conjunction with Human Resources is responsible for all employee privacy training to ensure safeguards to prevent intentional or accidental misuse of information systems.

The protected health information of a deceased IPN Provider or Enrollee will continue to be protected according to all applicable state and federal regulations.

A mechanism is in place at IPN to handle privacy complaints. Sanctions or terminations may be employed by IPN for violators of IPN’s privacy policies.
**Record Destruction**

Personally identifiable data for IPN Providers and Enrollees will be destroyed according to all applicable federal and state laws. The disposal methods may include paper shredding, erasure or modification of the record to ensure that records are not readable prior to disposal methods and destruction.

Only authorized personnel will have access to the personal information contained in the record for the period between the record’s disposal and record’s destruction.

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**Internal Review**

As a condition of employment, IPN’s employees are required to read and comply with the IPN Confidentiality Agreement. Employees should understand and comply with the Statement of Confidentiality before signing. The signed agreement is maintained in the employee’s personnel file, and a copy is given to the employee.

Once per year, an Educational Awareness Program will be conducted to update employees on the importance of maintaining Enrollee and IPN Provider confidentiality, and to solicit ideas about how to expand and improve in this regard.

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**Medical Review Committee**

IPN shall maintain a Medical Review Committee composed of the Medical Director, the Assistant Medical Director, and IPN member physicians.

This committee shall meet once per month to:

- Assess policies and practices;
- Oversee Quality Improvement Program, associated work plans and evaluations as well as identified program initiatives and development of performance measures.
- Oversee mechanisms to apply policies;
- Review levels of authorized user access to data across the delivery system, including IPN Providers, their staffs and IPN’s administrative staff, such as the Credentialing and Medical Services departments.
- Review the effectiveness of the Educational Awareness Program and the need for additions or corrections to it.
- Address issues such as information systems effectiveness, ease of ability to conduct day-to-day business, and ways to improve efficiency while at the same time protecting IPN Provider and Enrollee confidentiality.
- Monitor and track Enrollee complaints and will respond to any issues presented.
The Medical Review Committee, which reports to the IPN Board of Directors, reviews providers that receive 3 or more complaints within a 6-month period or complaints of significant quality of care issues.
Policy & Procedure
300.010 – Complaints By Enrollees

| Category: Credentialing/ Recredentialing | Section: Complaints by Enrollees | Date Issued: 10/05/04 | Policy Number: 300.010 |

Date Revised: November 16, 2004

Approved By: Date:

Policy:
To ensure that member complaints are responded to verbally and with written notification to the member within 48 hours of Independent Physicians Network’s (IPN’s) receipt of written complaint.

In addition, IPN will monitor complaints received and IPN’s Credentialing Committee will review the complaint log for appropriate action as necessary.

Procedure:
1. Upon receipt of written complaint from member, IPN will acknowledge receipt of complaint to member by phone or U.S. mail.
2. Complaint information and copy of complaint will then be forwarded to IPN contracted entity via fax or U.S. mail.
3. Response will be requested from IPN contracted entity within 10 days of receipt of complaint.
4. When response is received from the IPN contracted entity, the information will be forwarded to IPN’s Medical Director for determination.
5. Member will then be notified, within 30 days, of resolution of complaint by certified mail.
6. IPN’s Medical Services staff will keep a log of all enrollee complaints received at IPN.
7. IPN’s Credentials Committee will review the log every six months for all IPN providers’ history of complaints and recommends to the IPN Board of Directors appropriate action against any IPN provider when occurrences of poor quality are identified.
POLICY & PROCEDURE
400.001 – Quality Improvement Program Description

<table>
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<tr>
<th>Category: Quality Improvement</th>
<th>Section: Quality Improvement Program Description</th>
<th>Date Issued: 08/11/04</th>
<th>Policy Number: 400.001</th>
</tr>
</thead>
</table>

Date Revised:  
Approved By: Date:

Purpose:

IPN has established a Quality Improvement Program to provide a mechanism to measure performance of its Quality Improvement activities, to ensure Plan enrollees receive quality care and to ensure network Providers meet all professional standards of the delivery of care to enrollees in the most cost-efficient manner.

IPN strives to assure Plan enrollees accessible, quality, cost effective medical services. The Program will operate within the guidelines of federal and state regulatory agencies, as well as the guidelines of the National Committee for Quality Assurance (NCQA).

The objective of the Quality Improvement Program remains consistent with the IPN’s goals to provide accessible, quality, cost effective health care services and reflects IPN’s commitment to continuous quality improvement.

1.01 The objectives of IPN’s Quality Improvement Program are:

1.01 To develop and institute protocols for utilization review and management of enrollee’s health care;

1.02 To support the credentialing and recredentialing process for all Providers and clinics in the IPN network;

1.03 To monitor the quality of care delivered to enrollees through systematic and consistent evaluation of Providers’ performance;

1.04 To monitor the provider offices for accessibility to enrollees, and consistency of health care services;
The IPN Quality Improvement Program is a systematic and multidisciplinary program requiring planned and continuous change in response to IPN’s mission of providing quality care for enrollees.

1.02 Quality assessment is the measurement phase of quality improvement and includes:

2.01 Establishing criteria for quality health care and making these characteristics of quality care the standard for review. Two types of criteria are involved in developing standards. One type of criteria is explicit in nature and is delineated in the written form of patient treatment protocol and utilization guidelines. The second type of criteria is implicit in nature and based on health care procedures and practices which are “commonly understood” to be acceptable and consistent with the provision of good quality care.

2.02 Comparing the care that has actually been rendered with the criteria.

2.03 Making a peer review judgment on quality based on the results of the comparison.

1.03 Quality Improvement goes beyond measurement and involves the implementation of any necessary changes to maintain and improve the quality of care being delivered including:

3.01 Acting on the result of the evaluation by taking corrective action, and/or educating the Provider on any deficiencies noted.

3.02 Assuring that the actions have favorable impact by raising the standards for the health care delivered.

1.04 The purpose of the Quality Improvement Program is to evaluate the quality of health care delivered to IPN enrollees. The goals of the program are to:

4.01 Support the delivery of the highest quality of medical care by the IPN Provider. The primary objective is the Member’s health and welfare.

4.02 Identify any areas of the practice that needs improvement and implement any necessary changes.

4.03 Provide ongoing feedback to the Provider.

4.04 Analyze statistical data to assure efficient utilization.

The Quality Improvement Program will utilize accepted standards, guidelines and protocols that have been developed by the American Medical Association and other specialty organizations.

1.05 Areas of Review and Commitment
5.01 Member Accessibility to health care Services;
5.02 Network Credentialing / Recredentialing;
5.03 Eligibility Information;
5.04 Utilization Review;
5.05 Continuous Quality Improvement
5.06 Site and medical record reviews

1.06 Committee Protocol

6.01 The Medical Director, or designee, will chair the Medical Review committee which is responsible for oversight of the QI Program;
6.02 The Committee will meet on a monthly basis;
6.03 The Committee shall maintain minutes for all meetings and record attendance.
6.04 The Committee shall provide an annual report of quality improvement activities to the Board of Directors.
1.07 Administration

The Board President shall assure that the Quality Improvement Program receives adequate resources and reasonable support to facilitate the effective operation of the Program. The Medical Director with the support of the Assistant Medical Director, the Executive Director and the Director of Medical Services are responsible for Quality Improvement Program implementation and support services.

IPN is required to operate within the context of the contracted Plans’ Quality Assurance/Quality Improvement Programs. IPN will adhere to appropriate accreditation standards of the Plans. In most instances, IPN will receive approval of network credentialing/recredentialing, policies and procedures, standards and corrective action from the contracted Plans. IPN will use its best efforts to incorporate Plan specific criteria within the Program as respectively requested.
POLICY & PROCEDURE
400.002 – Quality Committees

Date Revised:

Approved By: Date:

Purpose:
The organization and processes utilized by IPN ensure proper communication and a checks and balances process to meet the goals of the organization. Several standing committees have been established to meet the primary objectives of IPN; these include but are not limited to the Board of Directors, the Medical Review Committee and the Credentialing Committee.

Policy
1.01 Medical Review Committee

The committee members include: Medical Director, Vice President of Medical Affairs and 9 additional IPN physicians representing various specialties. Areas of responsibility include the establishment of quality indicators and performance goals, monitoring reports of quality improvement activities, identifying performance that does not meet goal and developing corrective actions as necessary. The committee also performs an annual review of QI program, QI policies, procedures, clinical guidelines, and the QI work plan. It is also responsible for the development of new policies and procedures, the review of Plan audit reports and corrective action plans and the integration and coordination of quality improvement activities. The committee is also responsible for provider appeal reviews, reviewing providers with multiple enrollee complaints or complaints regarding significant quality of care issues, reviewing all claims appeals, reviewing potential fraud issues, reviewing clinical policies and procedures, and review of unusual practice patterns. The Medical Review Committee reports to the Board.

1.02 Credentialing Committee

The committee members include the Medical Director and seven additional IPN physicians. The committee is responsible for providing a professional and qualified group of practitioners for our various
networks using the approved standards. The committee thoroughly investigates all provider credentials, approves providers to participate in the plan and completes a re-credentialing process every two years. The Credentialing Committee reports to the Board.
POLICY & PROCEDURE
400.003 – Position of Administrative and Operational Functions

| Category: Quality Improvement | Section: Position of Administrative and Operational Functions | Date Issued: 08/11/04 | Policy Number: 400.003 |

Date Revised:

Approved By: Date:

Purpose:

A Plan may delegate authority to IPN to perform functions for the Plan; however, the Plan must maintain responsibility for ensuring that the functions are being performed according to its expectations and NCQA standards. IPN’s delegation agreements with Plan will vary depending on the functions to be transferred. Depending on the delegation agreement, services include but are not limited to quality improvement and utilization management, credentialing, and medical record and site reviews.

Policy:

Delegation agreements between IPN and Plans must stipulate the extent of delegation functions. Because IPN works with multiple Plans, consistency in the use of the same Quality Improvement/Utilization Management criteria is essential. IPN applies, at a minimum, NCQA standards to every criterion that is applicable to managed care. The Plan should ensure that the Quality Improvement/Utilization Management criteria selected by them, at a minimum, are based on sound clinical evidence, updated periodically and applied consistently.

Unless otherwise noted specifically by the Plan, all applicable credentialing standards of NCQA will be applied. If there are additional criteria by the Plan, these must be communicated clearly through written documentation or attached to the delegation document to IPN. These additional criteria must be substantively different from NCQA and offer significant rationale to be considered by IPN for implementation.

IPN does not subdelegate Quality Improvement or Utilization Management functions to another entity.
POLICY & PROCEDURE
400.004 – Position of the Quality Improvement Department Personnel

Date Revised:

Approved By: Date:

Purpose:
To assure that the Quality Improvement Program has sufficient representation of practitioners and appropriate clinical staff, the Quality Improvement Department includes professional and administrative staff. Coordination of all functions is considered essential in meeting the quality improvement requirements.

Policy:
The Medical Director is responsible for the oversight and coordination of the Quality Improvement Program and the functional areas of Provider Credentialing, Utilization Management and Peer Review. The preferred personnel resources for these areas include:

<table>
<thead>
<tr>
<th>Title of Position</th>
<th>Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Director</td>
<td>Should be a licensed physician. Should possess a minimum of 2-3 years past involvement in a managed care or insurance environment, preferably in a management position. Experience with NCQA, governmental agencies and health plan issues.</td>
</tr>
<tr>
<td>Assistant Medical Director</td>
<td>Should be a licensed physician. Possess 5 years of clinical experience. Experience with a managed care or insurance company.</td>
</tr>
<tr>
<td>Medical Review Committee Member</td>
<td>Should be an IPN member physician. Possess 5 years of clinical experience and currently practicing. Experience with a Peer Review process.</td>
</tr>
<tr>
<td>Credentialing Committee Member</td>
<td>Should be an IPN member physician. Experience with HMO credentialing processes and NCQA standards.</td>
</tr>
<tr>
<td>Director of Medical Services</td>
<td>Possess a minimum of 5 years clinical medical practice. Should possess a minimum of 2-3 years experience in a managed care or insurance environment. Masters prepared in business administration or health care administration preferred. Professional licensure preferred. Experience with NCQA standards.</td>
</tr>
</tbody>
</table>
Purpose:
Each calendar year, IPN develops a schedule of Quality Improvement activities it intends to execute known as the Quality Improvement Work Plan. The Quality Improvement Work Plan is integrated as part of the overall Quality Improvement Plan. This allows IPN to measure its performance and accomplish its objectives in a timely fashion.

Policy:
Following are some of the quality mechanisms that are in place to assess and measure performances and expectations of Providers.

1.01 Site Audits
Random medical records of care and site visits are performed prior to network participation for compliance with NCQA and external regulatory agency requirements. Medical record reviews and site visits are again completed at the time of recredentialing.

1.02 Items Requiring Corrective Action
If necessary, the Provider will be presented a plan of corrective action specifying the plan of correction and an estimated length of time needed for said correction. A re-audit will be completed within six months to ensure implementation of the corrective action plan. The Medical Review Committee monitors all corrective action plans.

During the follow-up audit, the Provider must demonstrate that the recommended actions were, in fact, adequately addressed or implemented.

In those instances where the provider office fails to comply with its corrective action, the Medical Review Committee will determine further actions after full review. Failure to
implement the corrective action plan may result in termination.

1.03 Non-Compliant Offices

Provider offices deemed non-compliant with respect to issues raised by the Medical Director’s review or the Medical Review Committee’s review may be subject to a sanction:

The following penalties could be imposed:

3.01 Restriction of enrollment

3.02 Suspension or cancellation of Provider contract

The Quality Improvement Work Plan/Quality Improvement Program Description is a lengthy document, which details the specifics of the above and other components. It is reviewed and revised annually as IPN continuously strives to improve the care and services it offers. A copy of the Quality Improvement Work Plan/Program Description can be reviewed by any Provider upon request. All items listed in the Quality Improvement Program/Work Plan are reviewed and measured on a quarterly basis. Each item is tracked and documented using NCQA’s Quality Improvement Activity Form.
### POLICY & PROCEDURE
400.006 – Practice Guidelines

<table>
<thead>
<tr>
<th>Category: Quality Improvement</th>
<th>Section: Practice Guidelines</th>
<th>Date Issued: 08/11/04</th>
<th>Policy Number: 400.006</th>
</tr>
</thead>
</table>

**Policy:**

It is expected that many provider practices will have their own organized quality improvement systems in operation which incorporate such standards and protocols.

**Policy:**

It is expected, as a minimum, that the following areas will be assessed for quality and appropriateness:

1.01 Patient Care

1.01 Patient Evaluation

A. Health History

B. Current medications and drug allergies

C. Baseline health status

D. Family history and social history, including use of cigarettes, alcohol and drug abuse (Pediatrics only)

E. Immunization history

1.02 Appropriate Care Planning must reflect proper:

2.01 Sequencing and timing of care for needs of patient

2.02 Alternative plans if possible

1.03 Preventive protocols must be innovative and reflect:
3.01 Assessment of health status
   A. Significant illnesses and medical conditions – problem list
   B. Documentation of healthcheck indicators (for enrollees under 21)

3.02 Individualized patient education programs

3.03 Patient compliance

1.04 Patient management procedures include:

4.01 Medical emergencies
   A. Certification of office personnel
   B. Appropriate established procedures
   C. Equipment and medicaments

4.02 Medically compromised patient guidelines
   A. Appropriate consultant mechanisms

1.05 Environmental Safety:

5.01 Infection control and sterilization
   A. Appropriate handling of all equipment/instruments/surfaces
   B. Operational protocols for handling of infectious patients
   C. CLIA Certification (if applicable)
   D. Monitoring systems
   E. Use of disposables, barrier techniques, and personal protective equipment (PPE)

5.02 Physical Site
   A. Accessibility
   B. Adequacy

5.03 Radiation Safety (if applicable)
A. Monitoring system
B. Operational protocols for minimizing radiation
C. Compliance with state regulations
D. Patient/operator shielding

1.06 Patient Records must contain adequate documentation of:

6.01 Registration information

6.02 Health history and subsequent update at follow up examinations

6.03 Medical alerts

6.04 Initial clinical examination

6.05 Periodic/follow up examination
6.06 Clinical problems/diagnosis
6.07 Treatment Plan
6.08 Medical referrals
6.09 Treatment rendered (progress notes)
6.10 Specialty care

The purpose of all measurements is to provide feedback to be utilized for continued improvement of care.
POLICY & PROCEDURE
400.007 – Assessment Guidelines

Category: Quality Improvement
Section: Assessment Guidelines
Date Issued: 08/11/04
Policy Number: 400.007

Date Revised:

Approved By: Date:

Purpose:
The Quality Improvement Program will utilize the following mechanisms to ensure proper utilization of services and systems for Providers.

Policy:
The following mechanisms are utilized in the Quality Improvement Program which incorporates the Best Practice Guidelines.

1.01 Self Assessment
Provider compliance with Best Practice Protocols and Utilization Guidelines on a daily basis.

1.02 On-site Review

201.1 Procedural Audit
A. A record maintenance type of review which is used to assure compliance with Best Practice Protocols (Patient Record) and completeness of documentation.
B. Will be performed per Provider by an IPN representative.

201.2 Analytical Audit
A. A general review used to analyze the overall process of patient care as reflected in the patient record.
B. Will be performed per Provider. This information is compiled by the Director of Medical Services and analyzed by IPN.

201.3 Clinical Audit
A. A selective review, clinical evaluation, initiated because of a particular problem or finding from a procedural or analytical audit.
B. Will be performed by IPN per Provider.

201.4 Computer Utilization Reports

A. Statistical analysis of treatment patterns and utilization based on data derived from treatment histories and utilization review reports.

B. Professional Peer Review
**POLICY & PROCEDURE**
400.008 – Corrective Action Plan

<table>
<thead>
<tr>
<th>Category:</th>
<th>Quality Improvement</th>
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<tr>
<td>Section:</td>
<td>Corrective Action Plan</td>
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<tr>
<td>Date Issued:</td>
<td>08/11/04</td>
</tr>
<tr>
<td>Policy Number :</td>
<td>400.008</td>
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</tbody>
</table>

Date Revised:

Approved By: Date:

**Purpose:**

Whenever a Provider fails to meet the Best Practice Guidelines established in the Quality Improvement Program, Providers are given the opportunity to accept a Corrective Action Plan. Compliance with the Best Practice Guidelines is the goal of a Corrective Action Plan.

**Policy:**

Upon completion of the procedural audit, any problems or omissions identified will be relayed to the Provider by IPN. Feedback will be documented on the appropriate form and given back to the Provider for corrective action. The Provider makes the appropriate corrections in the record and indicates on the audit that the corrections have been completed. IPN will maintain documentation of all audit procedures.

Upon completion of an analytical and official audit, any discrepancies or questions concerning the appropriateness of care will be discussed between an IPN Medical Director and the Provider.
**POLICY & PROCEDURE**
500.001 - After Hours/Special Services Codes

<table>
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<tr>
<th>Category:</th>
<th>Section:</th>
<th>Date Issued:</th>
<th>Policy Number:</th>
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<tr>
<td>Reimbursement</td>
<td>After Hours/Special Service Codes</td>
<td>02/27/02</td>
<td>500.001</td>
</tr>
</tbody>
</table>

**Date Revised:**

**Approved By:**

**Date:**

**Policy:**

Independent Physicians Network will allow additional reimbursement for services in an office setting provided outside of scheduled office hours.

**Procedure:**

Independent Physicians Network will additionally reimburse providers for after hours care in addition to the appropriate office visit CPT code when an office visit is provided outside of scheduled office hours in an office setting as follows:

- CPT4 code 99050 service requested after office hours; or
- CPT4 code 99054 service requested on Sundays and holidays

After hours care is defined as care provided by a physician at times other than their scheduled hours to treat only patients with an urgent illness or condition.

Only one of the above CPT4 codes can be billed in addition to the appropriate office visit code.
**Policy:**

Independent Physicians Network encourages physicians to perform antepartum tests in their office versus the more costly hospital setting.

**Procedure:**

1. The reimbursement for a non-stress test is as follows:
   
   a. When a non-stress test is done in the hospital, the hospital will be reimbursed the Independent Physicians Network fee max for CPT # 59025 (technical component only).*

   b. The physician interpreting the non-stress test done in the hospital will be reimbursed for CPT # 59025-26 (professional component only).*

   c. A physician doing a non-stress test in the office will be reimbursed the combined fee for CPT # 59025. (both technical & professional components).*

   *If a non-stress test is done on the same date of service as a fetal biophysical profile, the non-stress test will be denied. (see below)

2. The reimbursement for a Fetal Biophysical Profile is as follows:
   
   a. When a fetal biophysical profile is done in the hospital, the hospital is reimbursed for CPT # 76818 (technical component) and the physician interpreting the test will be reimbursed for 76818-26 (professional component).

   b. If the physician performs the entire fetal biophysical profile in the office (including non-stress test) the combined fee for CPT # 76818 will be paid (technical and professional components).

   c. When a fetal biophysical profile is done in the physician's office and the non-stress test is done in the hospital, the hospital is reimbursed for CPT #59025 technical component only. The physician is paid the combined fee for CPT # 76818 minus the amount paid to the hospital for the
d. When a fetal non-stress test is done on the same date of service as a fetal biophysical profile, the non-stress test is considered a component of the fetal biophysical profile and will not be reimbursed.
POLICY & PROCEDURE
500.003 - Assistant Surgeon

<table>
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<tr>
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<th>Section:</th>
<th>Date Issued:</th>
<th>Policy Number:</th>
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<tr>
<td>Reimbursements</td>
<td>Assistant Surgeon</td>
<td>2/1/91</td>
<td>500.003</td>
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</tbody>
</table>

Date Revised: November 15, 1991; July 28, 1993; January 26, 1994

Approved By: Date:

Policy:

Surgical procedures that allow assistant surgeons is attached. Any surgical procedures not on the list must be reviewed by Independent Physicians Network for determination of reimbursement. Assistant surgeons will only be considered if the hospital where the procedure is performed does not have back-up house staff (eg. employed, teaching, residents, etc.) to provide coverage.

Procedure:

1. Surgical procedures on the allowable assistant surgeon list are eligible for assistant surgeon reimbursement as follows:

   **CPT Modifiers and Reimbursement Levels**

   $\S\ 80$ Assistant Surgeon: Surgical assisting services are provided by a surgeon and may be identified by adding the modifiers "80" to the usual procedure number. Reimbursement will be at 20% of the fee maximum.

   $\S\ 81$ Minimum Assistant Surgeon: Minimum surgical assistant services are provided by a physician assistant and are identified by adding the modifier "81" to the usual procedure number. Reimbursement will be at 10% of the fee maximum.

   $\S\ 82$ Assistant Surgeon: (when qualified resident surgeon not available): The unavailability of a qualified resident surgeon is a prerequisite for use of modifier "82" appended to the usual procedure code number. Reimbursement will be at 20% of the fee maximum.

2. If medical circumstances warrant the use of an assistant surgeon for a procedure that is not on the eligible procedure list, the claim may be submitted for individual consideration. The appropriate modifier should be used and supporting documentation attached. Approved circumstances will be paid at the same reimbursement level outlined above for eligible claims.
### Approved Assistant Surgeon Procedures

<table>
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<th>Description</th>
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<td>Open treatment of frontal sinus fracture</td>
</tr>
<tr>
<td>21348</td>
<td>Open treatment of nasomaxillary complex fracture with bone grafting</td>
</tr>
<tr>
<td>21356</td>
<td>Open treatment of depressed zygomatic arch fracture</td>
</tr>
<tr>
<td>21366</td>
<td>Open treatment of complicated fracture of molar area with bone grafting</td>
</tr>
<tr>
<td>21408</td>
<td>Open treatment of fracture of orbit, except &quot;blowout&quot;; without implant, with bone graft</td>
</tr>
<tr>
<td>21423</td>
<td>Open treatment of palatal or maxillary fracture complicated, multiple approaches</td>
</tr>
<tr>
<td>21436</td>
<td>Open treatment of craniofacial separation complicated, multiple surgical approaches, internal fixation, with bone grafting</td>
</tr>
<tr>
<td>23616</td>
<td>Open treatment of proximal humeral fracture with proximal humeral prosthetic replacement</td>
</tr>
<tr>
<td>24516</td>
<td>Open treatment of humeral shaft fracture, with insertion of intramedullary implant, with or without cerclage and/or locking screws</td>
</tr>
<tr>
<td>24546</td>
<td>Open treatment of humeral supracondylar or transcondylar fracture, with or without internal or external fixation, with intercondylar extension</td>
</tr>
<tr>
<td>27226</td>
<td>Open treatment of posterior or anterior acetabular wall fracture, with internal fixation</td>
</tr>
<tr>
<td>27227</td>
<td>Open treatment of acetabular fracture involving anterior or posterior column, or a fracture running transversely across the acetabulum, with internal fixation</td>
</tr>
<tr>
<td>27228</td>
<td>Open treatment of acetabular fracture involving anterior and posterior columns, includes T-fracture and both column fracture with complete articular detachment, or a single column or transverse fracture with associated acetabular wall fracture; with internal fixation</td>
</tr>
<tr>
<td>27245</td>
<td>Open treatment of intertrochanteric, per trochanteric, or subtrochanteric femoral fracture, with intramedullary implant, with or without interlocking screws and/or cerclage</td>
</tr>
<tr>
<td>27507</td>
<td>Open treatment of femoral shaft fracture with plates/screws, with or without cerclage</td>
</tr>
<tr>
<td>27511</td>
<td>Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, with or without internal or external fixation</td>
</tr>
<tr>
<td>27513</td>
<td>Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, with or without internal or external fixation</td>
</tr>
<tr>
<td>27535</td>
<td>Open treatment of tibial fracture, proximal, unicondylar, with or without internal or external fixation</td>
</tr>
<tr>
<td>27558</td>
<td>Disarticulation of knee</td>
</tr>
<tr>
<td>27759</td>
<td>Open treatment of tibial shaft fracture by intramedullary implant, with or without interlocking screws and/or cerclage</td>
</tr>
<tr>
<td>27826</td>
<td>Open treatment of fracture of weight bearing articular surface/portion of distal tibia with internal or external fixation; of fibula only</td>
</tr>
<tr>
<td>27827</td>
<td>Open treatment of fracture of weight bearing articular surface/portion of distal tibia with internal or external fixation; of tibia only</td>
</tr>
<tr>
<td>27828</td>
<td>Open treatment of fracture of weight bearing articular surface/portion of distal tibia with internal or external; of both tibia and fibula</td>
</tr>
<tr>
<td>33501</td>
<td>Repair of coronary arteriovenous or arteriocardiacoarticular chamber fistula without cardio-pulmonary bypass</td>
</tr>
<tr>
<td>33517</td>
<td>Coronary artery bypass, using venous graft and arterial graft, single vein graft</td>
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<tr>
<td>33518</td>
<td>Coronary artery bypass, using venous graft and arterial graft, two venous grafts</td>
</tr>
<tr>
<td>33519</td>
<td>Coronary artery bypass, using venous graft and arterial graft, three venous grafts</td>
</tr>
<tr>
<td>33521</td>
<td>Coronary artery bypass, using venous graft and arterial graft, four venous grafts</td>
</tr>
<tr>
<td>33522</td>
<td>Coronary artery bypass, using venous graft and arterial graft, five venous grafts</td>
</tr>
<tr>
<td>33523</td>
<td>Coronary artery bypass, using venous graft and arterial graft, six or more venous grafts</td>
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</tbody>
</table>
33533 - Coronary artery bypass, using arterial graft, single arterial graft
33534 - Coronary artery bypass, using arterial graft, two coronary arterial grafts
33535 - Coronary artery bypass, using arterial graft, three coronary arterial grafts
33536 - Coronary artery bypass, using arterial graft, four or more coronary arterial grafts
33800 - Aortic suspension for tracheal decompression
35480 - Transluminal peripheral atherectomy, open; renal or other visceral artery
35481 - Transluminal peripheral atherectomy, open; aortic artery
35482 - Transluminal peripheral atherectomy, open; iliac artery
35483 - Transluminal peripheral atherectomy, open; femoral-popliteal artery
35484 - Transluminal peripheral atherectomy, open; brachiocephalic artery
35485 - Transluminal peripheral atherectomy, open; tibioperoneal trunk and branches
43842 - Gastroplasty, vertical - banded, for morbid obesity
43843 - Gastroplasty, other than vertical - banded, for morbid obesity
49315 - Laparoscopy, surgical; appendectomy
49905 - Omental flaps
50727 - Revision of urinary-cutaneous anastomosis
50728 - Revision of urinary-cutaneous anastomosis with repair of fascial defect and hernia
50782 - Ureteroneocystostomy; anastomosis of duplicated ureter to bladder
50783 - Ureteroneocystostomy; with extensive ureteral tailoring
56307 - Laparoscopy; with removal of adnexal structures
56308 - Laparoscopy; with vaginal hysterectomy with or without removal of tubes, with or without removal of ovaries
56309 - Laparoscopy; with removal of leiomyomata, subserosal
56354 - Hysteroscopy; with removal of leiomyomata
56631 - Vulvectomy, radical, partial; with unilateral inguinal-femoral lymphadenectomy
56633 - Vulvectomy; radical, complete
56634 - Vulvectomy; radical, complete; with unilateral inguinal-femoral lymphadenectomy
56637 - Vulvectomy; radical, complete; with bilateral inguinal-femoral lymphadenectomy
58262 - Vaginal hysterectomy; with removal of tube(s) and/or ovary(s)
58263 - Vaginal hysterectomy; with removal of tube(s) and/or ovary(s), with repair of enterocele
61531 - Subdural implantation of strip electrodes through one or more burr or trephine hole(s) for long term seizure monitoring
61760 - Stereotactic implantation of depth electrodes into the cerebrum for long term seizure monitoring
POLICY & PROCEDURE
500.004 - ASC Enhanced Direct Patient Care Rate

Medicaid, HealthyStart, and BadgerCare Only

Policy:

Due to the increase in physician time for direct patient care required at ambulatory surgery centers, the physician fee for all primary surgical procedures performed at approved, contracted ambulatory surgery centers will be reimbursed at a rate enhanced by $200.00 in consideration for this additional direct patient care time.

Procedure:

Any primary surgical procedure performed in an approved, contracted ambulatory surgery center will be reimbursed at a rate enhanced by $200.00 in consideration for this additional direct patient care time.
POLICY & PROCEDURE
500.005 - Bilateral Procedures

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<th>Category:</th>
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<tbody>
<tr>
<td>Reimbursement</td>
<td>Bilateral Procedures</td>
<td>12/01/88</td>
<td>500.005</td>
</tr>
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</table>

Date Revised: April 1, 1992; February 16, 1994; July 22, 2004

Approved By: Date:

Policy:

Bilateral procedures done at the same time by the same provider will be paid at reduced percentages.

Procedure:

When bilateral procedures are billed, a "50" modifier is added to the CPT code.

a) One side is paid 100% of fee max and the contra lateral side is paid 50% of fee max.

b) One service line should be billed with a 50 modifier. Reimbursement will be 150% of fee max.

c) Bilateral procedures will be paid as above unless the provider's contract specifies differently.
Policy:

Blood gas analysis is included in the global anesthesia fee and will not be reimbursed in addition to anesthesia procedures.

Procedure:

Claims from anesthesiologist for blood gas analysis will be denied as included in the global anesthesia fee in accordance with CPT guidelines.
Policy:

Independent Physicians Network will reimburse physicians an additional $50 for performing circumcisions, CPT codes 54150-54161, in the physician's office.

Procedure:

Providers bill the CPT code applicable to the service provided. The system will identify the above listed codes with a service location code of physician's office. Claim is to be repriced as indicated above.

A referral is required unless the physician performing the circumcision is the mother's OB provider or newborn's PCP.
POLICY & PROCEDURE
500.008 - Claims Appeals

Category: Reimbursement
Section: Claims Appeals
Date Issued: 03/01/90
Policy Number: 500.008

Date Revised: November 15, 1991

Approved By: Date: 

Policy:
Claims may be appealed within 60 days of the date of the remittance advice on which a claim has been denied or paid.

Procedure:
1. To appeal a claim, copies of the following must be sent to the contracted plan claims services department within 60 days of the date of the remittance advice.
   - Remittance advice showing the denied or paid claim
   - Copy of original claim
   - Letter/note explaining the reason for the appeal
   - Operative report if applicable

2. Stamp the envelope "APPEAL".
Policy:

Providers must submit all claims to contracted plan.

Procedure:

1. To be considered for payment, claims must be submitted and received by the contracted plan within 60 days of the date of service or date of a written rejection or partial payment from another carrier.

2. Other insurance, if applicable, must be listed on the claim.

3. If the service required pre-admission notification, the notification number should be included on the claim form.

4. If the service required a referral, the referral number should be included on the claim form.

5. Charges for a different month should be submitted on a separate claim form.

6. All decisions regarding reimbursement are made by Independent Physicians Network.
Policy:

Claims not listed on a remittance advice within 30 days of **date of service** should be re-submitted to the contracted plan's claims service department.

Procedure:

1. If a claim is not listed on the paid, pend, or denied sections of the remittance advice within 30 days of **date of service** send a copy of the original claim marked "**TRACER**" to the contracted plan. Tracer claims submitted and received by the contracted plan within 60 days of the date of service will prevent untimely filing of claims.

2. Also stamp the envelope "**TRACER**".
POLICY & PROCEDURE
500.011 - Diaphragm Fitting

<table>
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<tr>
<th>Category:</th>
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<td>Diaphragm Fitting</td>
<td>9/01/98</td>
<td>500.011</td>
</tr>
</tbody>
</table>

Date Revised: February 1, 1991; June 25, 1997

Approved By: Date:

Policy:

**Medicaid**
Providers may be reimbursed for both diaphragm fitting, (57170) as well as a comprehensive office visit, (99215). This reflects the amount of time spent on patient teaching.

**Commercial**
Only diaphragm fitting, (57170) will be reimbursed.

Procedure:

**Medicaid**
When a provider bills for both diaphragm fitting, and a comprehensive office visit, both will be reimbursed.

**Commercial**
When a provider bills for both diaphragm fitting and a comprehensive office visit, only diaphragm fitting will be reimbursed.
POLICY & PROCEDURE
500.012 - Echocardiography

<table>
<thead>
<tr>
<th>Category:</th>
<th>Reimbursement</th>
<th>Section:</th>
<th>Echocardiography</th>
<th>Date Issued:</th>
<th>6/23/93</th>
<th>Policy Number:</th>
<th>500.012</th>
</tr>
</thead>
</table>

Policy:

The professional and technical components are reimbursable to certified radiologists and Independent Physicians Network cardiologists for echocardiograms performed in the office (CPT codes 93307-93350).

Procedure:

Only certified radiologists and Independent Physicians Network cardiologists may bill and be paid for both the technical and professional component of echocardiograms performed in their office by billing without a modifier.

Independent Physicians Network cardiologist's equipment must be approved by Independent Physicians Network.
Emergency Room (ER) Physician Services will be reimbursed according to the ER visit and the type of services provided.

Procedure:

1. Claims for ER visits (99281 - 99285) will be denied when billed with one of the following:
   - Laceration Repair
   - Dressing and Debridement
   - Foreign Body Removal
   - Incision and Drainage
   - Ear Wax Removal
   The procedure is paid and includes the visit.

2. The following ER Physician services are denied as included in the visit charge (99281 - 99285):
   - Venipuncture
   - Catheterization
   - Screening feces for occult blood
   - Blood Administration
   - Pulse Oximetry
   - Aerosol or vapor inhalation treatments

3. ER physician claims are denied for the following:
   - Interpretation of EKG
   - Interpretation of Lab work
   - Interpretation of X-ray
   Reimbursement for these services is made to the cardiologist, pathologist, radiologist, etc. who performs the interpretation and reporting.

4. ER physician claims for (36600) arterial puncture are allowed.

5. ER physician claims for an ER visit (99281 - 99285) and for the treatment of a fracture or cast application, the ER visit will be allowed in addition to the procedure.

Commercial
(*) Will reimburse in addition to ER visit to non-par providers.
POLICY & PROCEDURE
500.014 - Hearing & Visual Field

Date Revised: February 1, 1991; July 28, 1993; June 22, 1994; June 25, 1997

Approved By: Date:

Policy:

Medicaid (State Requirement)

If the Primary Care Physician bills for any or all of the following codes, payment will be denied. Payment for these services are included in the reimbursement for an office or HealthCheck exam:

- 92551 Screening test, pure tone, air only
- 92552 Pure tone audiometry; air only
- 92560 Bekesy Audiometry Screening
- 92567 Tympanometry
- 92568 Acoustic reflex testing

Specialists billing for the above listed codes may be reimbursed.

Procedure:

1. Upon the receipt of a claim from a Primary Care Physician for the above listed tests, the claim will be denied as "included in office visit".

2. Upon the receipt of a claim from a Specialist with an approved referral for the above listed tests, the claim will be paid.

Commercial
Reimbursement will be made for above noted services which are allowed in addition to office or preventative medicine codes.
POLICY & PROCEDURE
500.015 - IUDs

Policy:

Physicians will be reimbursed for the intrauterine devices (IUDs) and IUD insertion and removal separately, but not for an office visit in addition to the insertion fee unless some other service is performed.

Procedure:

1. Physicians will be reimbursed for insertion (58300) and removal (58301) of and IUD.
2. Physicians will be reimbursed for the intrauterine devices (IUDs),
3. Complex IUD removal will be reviewed on an individual basis for appropriate reimbursement.
4. Physicians will not be reimbursed for an office visit on the same date of service as insertion of an IUD unless some other service is performed.
POLICY & PROCEDURE
500.016 - Manipulation

Date Revised: March 16, 1994

Approved By: Date:

Policy:
Manipulations billed under CPT code 97140 by an M.D. or D.O. having the appropriate medical training are allowed and will be paid.

Procedure:
Upon the receipt of an edit report from the Plan which lists a claim for manipulation under CPT code 97140 Independent Physician Network will pay the claim in addition to an office visit.
Policy:

Independent Physician Network does not reimburse for miscellaneous (XXX99) or unlisted CPT codes.

Procedure:

1. When a claim is submitted with a miscellaneous code or unlisted CPT, it will be reviewed for a description of service or NDC code for an unlisted drug.

2. Based on this review, the claim will be paid or denied for a complete description or a No NDC code submitted.
POLICY & PROCEDURE
500.018 - Miscellaneous Supplies

<table>
<thead>
<tr>
<th>Category:</th>
<th>Section:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Reimbursement</td>
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</tr>
<tr>
<td></td>
<td>Supplies</td>
<td></td>
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</tbody>
</table>

Date Revised:

Approved By: Date:

Policy:

Supplies billed with the CPT code 99070 will be denied. Appeals may be made to Independent Physicians Network's Medical Director for supplies with appropriate documentation.

Procedure:

1. Upon the receipt of an edit report from the Plan which lists a claim for supplies under CPT code 99070, Independent Physicians Network will deny the claim.

2. A provider whose claim has been denied, may appeal the decision by providing Independent Physicians Network's Medical Director with the reason for use of the supply and an invoice documenting the cost of the supply used.

3. Supplies appropriately billed and documented will be paid at cost.
POLICY & PROCEDURE
500.019 - Modifier 22 Unusual Services

<table>
<thead>
<tr>
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<td>Modifier 22 Unusual Services</td>
<td>02/01/91</td>
<td>500.019</td>
</tr>
</tbody>
</table>

Date Revised:

Approved By: Date:

Policy:

Independent Physicians Network does not allow additional reimbursement for claims submitted with modifier 22 - unusual services.

Procedure:

1. Claims submitted with modifier 22 - unusual services, will be paid at the Independent Physicians Network fee for the CPT code billed without the modifier.

2. Providers requesting addition payment due to unusual services may submit their request for review by the Independent Physicians Network Medical Review Committee for consideration.
POLICY & PROCEDURE
500.020 - Multiple Procedures

| Category: Reimbursement | Sections: Multiple Procedures | Date Issued: 12/01/88 | Policy Number: 500.020 |

Date Revised: April 1, 1992; February 16, 1994; June 25, 1997; April 28, 1999; April 23, 2003

Approved By: Date:

Policy:

Multiple procedures done at the same time by the same provider will be paid at reduced percentages.

Procedure:

Medicaid

Multiple procedures billed, with a "51" modifier added to the CPT code will be reimbursed as follows except laparoscopy, laparotomy and peritoneoscopy will be reimbursed as indicated separately below.

1. The primary procedure or most complicated is paid 100% of fee max.

2. The first procedure after the primary procedure is paid 50% of fee max.

3. The second procedure after the primary procedure is paid 25% of fee max.

4. The third, and any remaining procedures, after the primary procedure are paid at 13% of fee max.

Laparoscopy, laparotomy or peritoneoscopy performed as part of a multiple procedure will be reimbursed at reduced percentages as follows:

1. When a laparoscopy 49320 is performed with another GYN surgical procedure, the GYN surgical procedure is reimbursed 100% of fee max and the laparoscopy is reimbursed 50% of fee max.

2. If only a laparoscopy 49320 is done, reimbursement will be 100% of fee max.
3. When an exploratory laparotomy (49000) is done with another surgical procedure, the surgical procedure will be reimbursed 100% of fee max and the exploratory laparotomy denied.

4. If only an exploratory laparotomy (49000) is done, reimbursement will be 100% of fee max.

5. If a peritoneoscopy determines that an abdominal cholecystectomy is required, the abdominal cholecystectomy (47480) should be paid at 100% and peritoneoscopy be paid at 50% of fee max.

Commercial

1. The primary procedure or most complicated is paid 100% of fee max.

2. The first through fourth procedure after the primary is paid 50% of fee max.

3. Procedures in excess of five will be reviewed before additional reimbursement will be made.
POLICY & PROCEDURE
500.021 - Neurology Nerve Conduction w/EMG

| Category: Reimbursement | Section: Neurology Nerve Conduction w/EMG | Date Issued: 4/28/93 | Policy Number: 500.021 |

Date Revised: June 25, 1997

Approved By: Date:

Policy:

Professional and technical components of EMG with nerve conduction study is reimbursable to Independent Physicians Network Neurologists and Physical Medicine & Rehabilitation physicians.

Procedure:

Independent Physicians Network Neurologists and Physical Medicine & Rehabilitation physicians performing and reading an EMG with nerve conduction study will be paid for both the technical and professional components at a rate in accordance with Independent Physicians Network and State fee schedules for codes 95860, 95869, 95900, 95904, 95933, 95903, 95934, and 95936.
POLICY & PROCEDURE
500.022 - Neuropsych Testing

<table>
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<tr>
<th>Category:</th>
<th>Section:</th>
<th>Date Issued:</th>
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<tr>
<td>Reimbursement</td>
<td>Neuropsych Testing</td>
<td>06/23/93</td>
<td>500.022</td>
</tr>
</tbody>
</table>

Date Revised: April 28, 1999

Approved By: Date:

Policy:

Neuropsychologic Testing billed under CPT code 96117 for enrollees with a medically appropriate diagnosis will be paid from Independent Physicians Network's physician service fund.

Procedure:

Upon the receipt of an edit report from the Plan which lists a claim for neuropsychologic testing under CPT code 96117 Independent Physicians Network will pay the claim.
Policy:

Reimbursement for newborns is paid with a global fee to pediatricians or family practice doctors unless documentation of significant other medical problems is provided.

Procedure:

1. Newborn In-Hospital exam (CPT 99431) is a global fee for the first 48 hours including initiation of diagnostic and treatment programs and preparation of hospital records. Subsequent day exams will be reimbursable after the first 48 hours.

2. Newborn resuscitation: care of the high risk newborn at delivery (CPT 99440) includes reimbursement for newborn exam (CPT 99431) when the pediatrician attends a C-section.
POLICY & PROCEDURE
500.024 - Office and Hospital Visit Same Day

<table>
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<tr>
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<td>Reimbursement</td>
<td>Office and Hospital Visit Same Day</td>
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<td>500.024</td>
</tr>
</tbody>
</table>

Date Revised: November 15, 1991; June 25, 1997

Approved By: Name:

Policy:

Medicaid

Office visits and hospital visits that are billed for the same date of service will both be paid if documentation indicates that the member was seen by the physician at the office and at the hospital.

Procedure:

1. When a physician bills for both an office visit (99201 - 99215) and a hospital visit (99221 - 99233) on the same date of service, both will be paid if documentation indicates that the physician saw the member at the hospital and at the office.

2. If the physician does not see the member in the hospital that day, the physician will be reimbursed for an office visit only.

Commercial

1. When a physician bills for both an office visit (99201 - 99215) and a hospital visit (99221 - 99233) on the same date of service, only the hospital visit will be reimbursed.
POLICY & PROCEDURE
500.025 - Out of Plan Services

| Category:  | Reimbursement | Section: | Out of Plan Services | Date Issued: | 02/01/91 | Policy Number: | 500.025 |

Date Revised:

Approved By: Date:

Policy:

Claims for services provided by out-of-Independent Physicians Network providers will be reimbursed at State Medicaid, Federal Medicare or reasonable and customary fees as applicable.

Procedure:

1. Out-of-Independent Physicians Network claims for Wisconsin Medicaid recipients will be paid at State Medicaid rates if billed with CPT codes; at the State outpatient rate per visit for outpatient services billed on a UB-92; and at the State's Hospital DRG rate for in-patient services.

2. Out-of-Independent Physicians Network claims for Commercial enrollees will be paid at Independent Physicians Network commercial rates or the previously negotiated rate. If additional payment is requested through an appeal, payment may be adjusted to reasonable and customary rates in accordance with the employer plan contracts. All plan benefits are limited to a maximum of reasonable and customary fees. Balances are the responsibility of the enrollee.
POLICY & PROCEDURE
500.026 - Pathology Non-Anatomical

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<tr>
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<tr>
<td>Reimbursement</td>
<td>Pathology Non-Anatomical</td>
<td>2/01/91</td>
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</tr>
</tbody>
</table>

Date Revised:

Approved By:  

Policy:

Reimbursement for the professional component of non-anatomical pathology is included in the reimbursement paid for the visit by the attending physician. Pathologists are not reimbursed for non-anatomical pathology since they do not perform a "hands on service" related to non-anatomical pathology since the interpretation and report are computer produced.

Procedure:

Claims submitted for the professional component for non-anatomical pathology will be denied. This includes claims submitted by a pathologist.
Policy:

Independent Physicians Network podiatrists will be reimbursed in three separate categories according to podiatry education and in accordance with Independent Physicians Network, State, and Plan fee schedules for Medicaid and Commercial enrollees. Podiatry services for commercial enrollees is specified in their employer plan contract.

Medicare Coverage:
Podiatrists are allowed to only perform routine foot care for Medicare enrollees. The following CPT codes are the only E&M and procedures covered for the Medicare benefit:

<table>
<thead>
<tr>
<th>CPT Code 1</th>
<th>CPT Code 2</th>
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<tbody>
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<td>11732</td>
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</table>

* Any medically necessary CPT procedures or services not listed above must be referred to an in-plan orthopedic physician.

Category I:
Category I Podiatry privileges must have completion of instruction leading to the degree of Doctor of Podiatric Medicine (DPM) which is usually four years of post graduate education (divided between
basic and clinical sciences) from a podiatric college accredited by the council on Podiatric Medical Education. The following services will be allowed:

1. Application of Orthotic foot cast using CPT codes 29405, 29425, 29450, 29515, 29540, 29550, 29580, 29730, 29740 and 29750.

Podiatry Policy

2. Avulsion of toenail under local anesthesia using CPT codes 11730, 11732.
3. Cutting toenails using CPT codes 11720 and 11721.
4. Hypercation, curettage and excision of verruca under local anesthesia using CPT codes 11055, 11056, and 11057.
5. Incision and drainage or debridement of superficial abscess and ulceration under local anesthesia using CPT codes 10060, 10120, 10140, and 10160.
6. Incision and drainage off infected ingrown toenail under local anesthesia using CPT codes 11750 and 11765.
7. Onychoplasty under local anesthesia using CPT code 11750
8. Palliative trimming of corns, calluses, and superficial lesions using CPT codes 11040, 11100, 11101, 11305, 11306, 11307 and 11740.

CATEGORY II:

Category II criteria for foot surgery (includes all forefoot and some minor rearfoot under local or general anesthesia) must be certified in foot surgery, either Board Certified or Board Qualified, by the American Board of Podiatric Surgery.

Clinical experience: Four years of postdoctoral clinical experience in an accredited health care facility before taking the certification exam.

Hospital privileges: Verification of active surgical privileges at the time cases were done listing the level or list of privileges granted.

Postdoctoral education: Must have documentation of postdoctoral education from one of the following categories:

Completion of an approved podiatric surgical residency (PSR) by the Council on Podiatric Medical Education (CME)

OR

Alternative Method (available through 1996 examination year)

Successful completion of a preceptorship (Submit a letter from the doctor or institution sponsoring the preceptorship).

Military or Federal Service (submit photocopy of records showing military or federal service).

Continuing education credits - completion of 200 hours of continuing education earned since February 1, 1989. (submit certificates or letters from state associations listing credits earned).
Podiatry Policy
Category II

With the above criteria under category II the following services will be allowed:

1. Arthroplasty - digital using CPT codes 26535, 26536
2. Arthroscopy using CPT codes 28020, 28022, 28024, 28050, 28052, 28054
3. Bunion correction using CPT code 28290
4. Bunionectomy - capsulo-tendon balance using CPT code 28290
5. Bunionectomy with arthrodesis using CPT codes 28750, 28755
6. Bunionectomy with base/neck osteotomy using CPT code 28296
7. Bunionectomy with prosthesis using CPT code 28293
8. Bunionectomy with joint resection using CPT code 28292
9. Capsulotomy - forefoot using CPT codes 28260, 28261, 28262, 28264, 28270, 28272
10. Digital fusion using CPT code 28750
11. Excision of accessory ossicle - forefoot using CPT code 28315
12. Excision of benign skin lesion - forefoot using CPT codes 28104, 28106, 28107, 28108
13. Excision of cutaneous lesions - forefoot using CPT codes 28060, 28062
14. Excision of digital or forefoot ganglion using CPT codes 28090 and 28092.
15. Excision of neuromas - forefoot using CPT code 28080
16. Excision of plantar fibroma - rearfoot using CPT codes 28100, 28102, 28103
17. Exostectomy - digit using CPT codes 28288, 28290
18. Exostectomy - Metatarsal using CPT codes 28288, 28290
19. Exostectomy - tarsal bones using CPT codes 28288, 28290
20. Fracture reduction - digital (open or closed) using CPT codes 28490, 28495, 28505, 28510, 28515, 28525
21. Fracture reduction - forefoot (open or closed) using CPT codes 28470, 28485
22. Fracture reduction - metatarsal (open or closed) using CT codes 28470, 28475, 28485
23. Haglund's disease - rearfoot using CPT codes 28100, 28120
24. Hammertoe surgery using CPT codes 28285, 28286
25. heal spurs - rearfoot (lumps and bumps) using CPT code 28119
26. Implants - metatarsophalangeal using CPT code 26531
27. Laser use - using CPT codes 17100, 17003, 17004, 17000, 11420, 11421, 11422, 11423
28. Osteotomy - forefoot using CPT codes 28306, 28307, 28308, 28309
29. Osteotomy - lesser metatarsals using CPT codes 28304, 28305
30. Planter Fasciotomy - rearfoot using CPT code 28008
31. Planter fasciotomy/heel spur resection - rearfoot using CPT code 28008
32. Reduction of digital fractures under local anesthesia using CPT codes 28510, 28515, 28525
33. Removal of foreign body using CPT codes 28190, 28192, 28193
34. Syndactylization of digits using CPT code 28345
35. Tenotomy of digit using CPT codes 28010, 28011
36. Tenotomy/capsulotomy digit using CPT codes 28230, 28232, 28234
37. Tenotomy/capsulotomy - metatarsophalangeal using CPT codes 28270, 28272
38. Injection, tendon sheath, ligament, trigger points or ganglion cyst code 20550

CATEGORY III:
Category III privileges for reconstructive rearfoot/ankle surgery must be Board certified or Qualified in reconstructive rearfoot/ankle surgery by the American Board of Podiatric Surgery. Four years of postdoctoral clinical experience in an accredited health care facility before taking certification examination. Completion of a surgical residency approved by the Council on Podiatric Medical Education (CPME) in the years (s) of the candidate's residency. Verification off active hospital surgical privileges at the time cases were done listing the level or list of privileges granted. Meeting this criteria the following services will be allowed:

1. Arthroscopy using CPT codes 29894, 29895, 29897, 29898
2. Excision off accessory ossicle - rearfoot using CPT code 28100
3. Excision of accessory ossicle - tarsal bones using CPT code 28104
4. Excision of benign skin lesions - rearfoot using CPT codes 28100, 28102, 28103
5. Excision of cutaneous lesions - rearfoot using CPT codes 11420, 11421, 11422, 11423
6. Excision of neuromas - rearfoot using CPT code 28080
7. Excision off ossicles, exostosis proximal to tarsal-metatarsal joints using CPT codes 28104, 28106, 28107.
8. Excision of soft lesions proximal to tarsal-metatarsal joints, i.e., ganglions, lipomas using CPT code 20600
9. Fracture reduction - rearfoot (open or closed) using CPT codes 28400, 28405, 28415, 28420
10. Osteotomy - rearfoot,calcaneus using CPT code 28300
11. Osteotomy -tarsal using CPT codes 28304, 28305

* Category III qualifies Podiatrist to perform the procedures in category I, II & III
* Category II qualifies Podiatrist to perform the procedures in category I & II
* Routine foot care and toe nail clipping/trimming are not a covered benefit for commercial enrollees.

Reimbursement - Podiatry Services 941212-Revised 970529 500.027-1
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POLICY & PROCEDURE
500.28 - Procedure Supplies

Policy:

Supplies billed in conjunction with a procedure will be denied as covered in the payment of the procedure. Appeals may be made to Independent Physicians Network's Medical Director for supplies provided in unusual circumstances.

Procedure:

1. Upon the receipt of an edit report from the Plan which list a claim for a procedure which includes supplies, Independent Physicians Network will deny the supply charges as included in the payment for the procedure.

2. A provider whose supply charges have been denied, may appeal the decision by providing Independent Physicians Network's Medical Director with the unusual circumstances for use of additional supplies and an invoice documenting the cost of the supplies used.

3. Supplies appropriately billed and documented and approved by Independent Physicians Network's Medical Director or Independent Physicians Network's Medical Review Committee will be paid at cost.
Policy:

Payment for a professional fee of pulse oximetry billed under CPT codes 94760, 94761 and 94762 will be denied. Payment for the service is included in the reimbursement for an office exam.

Procedure:

Upon receipt of an edit report from the Plan which lists a claim for pulse oximetry under CPT code 94760, 94761 and 94762, Independent Physicians Network will deny the professional fee as "included in office visit".

Upon receipt of an edit report from the Plan which lists a claim from an emergency physician for pulse oximetry under CPT code 94760, 94761 and 94762, Independent Physicians Network will deny the professional and technical fee as "included in emergency visit".
Policy:

Radiology professional components are reimbursable to certified radiologist; orthopedists performing, interpreting and reporting on orthopedic related films in their office; OB/GYNs performing, interpreting and reporting on ultrasounds in their offices; neurologists performing, interpreting and reporting on EMG's in their offices; podiatrists performing, interpreting and reporting on podiatry related films; and other specialists as addressed by the Medical Review Committee.

Procedure:

Radiologists may bill for their professional services of interpreting and reporting of radiological exams by billing with modifier 26.

Physicians providing radiology services in their office must bill with modifier TC and will be reimbursed the technical component only, unless there is a certified radiologist on staff in the office interpreting and preparing a report for the service provided.

Independent Physicians Network orthopedists and podiatrists may bill and be paid for both the technical and professional component for orthopedic and podiatry related radiology performed in their office by billing without a modifier. The procedures allowed must be specified in their contracts.

Independent Physicians Network OB/GYNs may bill and be paid for both the technical and professional component for ultrasounds performed in their office by billing without a modifier if their equipment and reports have been reviewed and approved by Independent Physicians Network.

Neurologists may bill and be paid for both the technical and professional component for EMGs performed in their office by billing without a modifier if their equipment and reports have been reviewed and approved by Independent Physicians Network.
Policy:

Independent Physicians Network will reimburse physicians an extra $25.00 for performing any scoping procedures including a colposcopy in the office.

Procedure:

1. When a scoping procedure is performed in the physician's office, location code 03, an additional $25.00 will be reimbursed to the physician.

2. When colposcopy with biopsy, # (57454), or colposcopy without biopsy, (57452), is performed in the physician's office, location code 03, an additional $25.00 will be reimbursed to the physician.

3. If the physician also bills for an endocervical curettage, (57505), it will be denied. This is included in reimbursement for colposcopy.
POLICY & PROCEDURE
500.032 - Surgical Tray Charge

| Category: Reimbursement | Section: Surgical Tray Charge | Date Issued: 04/28/93 | Policy Number: 500.032 |

Date Revised: March 28, 1996

Approved By: Name:

Policy:

1. The following codes will be paid the greater of $50 or 50% of the code fee in addition to the code fee if the location of service is in the physician's office:

   Repair (Closure)

   12001 - 12021 Simple
   12031 - 12057 Intermediate
   13100 - 13160 Complex

   Tympanotomy (requiring insertion of ventilating tube), local or topical anesthesia

   69433

2. The following code(s) will be paid an additional $50.00 if the location of service is the physicians office.

   Ultrasonic-guided breast biopsies

   19101

Procedure:

Providers bill the CPT code applicable to the service provided. The system will identify the above listed codes with a service location code of physician's office. Claim is to be repriced as indicated above.
Reimbursement - Tubal Done During C-Section

POLICY & PROCEDURE
500.033 - Tubal Done During C-Section

<table>
<thead>
<tr>
<th>Category:</th>
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<th>Section:</th>
<th>Tubal Done During C-Section</th>
<th>Date Issued:</th>
<th>8/01/90</th>
<th>Policy Number:</th>
<th>500.033</th>
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Date Revised: August 19, 1992

Approved By: Date:

Policy:

Physicians will be reimbursed for tubal ligation done at the time of C-Section. A sterilization consent form must have been completed for the tubal ligation as required by the State for Medicaid recipients.

Procedure:

1. Fee max will be paid for performing the C-Section. (Primary procedure)

2. Tubal ligation done at the time of C-Section, will only be paid under code #58611 (Tubal Ligation Performed at time of C-Section).

3. As required by the State, payment will not be allowed if the sterilization consent form has not been appropriately completed by Medicaid recipients.
Policy:

Independent Physicians Network Primary Care Physicians must perform Health Checks on enrollees less than 21 years of age.

Procedure:

1. Primary care physicians not performing Health Checks on enrollees less than 21 years of age that are assigned to that PCP, will not be allowed to have new enrollees assigned to them. The physician will be notified that he/she is non-compliant with this policy.

2. If the PCP continues to be non-compliant after 6 months of the notice, the physician will be terminated. Non-compliance will be determined by the Medical Review Committee (MRC) and/or Board of Directors on a case by case basis.
Policy:

Inpatients not meeting appropriate criteria for continued hospitalization will be referred to the Independent Physicians Network Medical Director.

Procedure:

The Independent Physicians Network medical director will review each case on an individual basis and appropriate action, as determined by the Independent Physicians Network medical director, will be taken.
POLICY & PROCEDURE
600.003 - Medical Record Documentation

Policy:

All Independent Physicians Network member physician medical record documentation must meet Federal, State and National requirements, guidelines and protocol.

Procedure:

The first medical record review will result in an educational follow-up letter to the physician indicating the deficiencies with medical record documentation that must be corrected.

The second medical record review failure for not following medical record guidelines will result in a visit from the Medical Director and/or Medical Director's designee to educate the physician about proper guidelines and protocol for medical record documentation. A follow-up medical record review ninety (90) days after the Medical Director and/or designee's visit will be conducted to verify compliance.

A third medical record review failure at the ninety day review or at subsequent reviews will result in an immediate $50.00 penalty and a case by case review by the Peer Review Committee for recommendation regarding continued membership in Independent Physicians Network.
POLICY & PROCEDURE
600.004 - Non-Par Lab

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<th>Date Issued: 06/23/93</th>
<th>Policy Number: 600.004</th>
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Date Revised: February 16, 1994; August 23, 2000

Approved By: Date:

Policy:
Lab work not listed on approved in-office lab sheet must be sent to Independent Physicians Network contracted lab.

Procedure:
The first failure to follow the protocol will result in an educational sanction letter to the physician indicating the error. The Independent Physicians Network health services staff will contact the physician's office staff to educate them about proper lab use. The letter must be sent certified mail.

A second failure to follow the protocol after notice of the first failure will result in a call from the Medical Director and/or a visit to the physician's office by the IPN Health Services staff to educate the physician and their staff about proper policy. The physician will be informed of the third sanction protocol.

A third failure to follow the protocol after notice of the second failure will result in recoupment of money from the physicians claim payments for claims paid by Independent Physicians Network to non-contracted laboratories.
Policy & Procedure
600.005 - Vaccine Immunization Form

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<td>Sanctions</td>
<td>Vaccine Immunization Form</td>
<td>6/25/97</td>
<td>600.005</td>
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</table>

Date Revised: 

Approved By: 

Policy: All Independent Physicians Network member physicians are required to use the Immunization Consent Form or an equivalent consent form in their Independent Physicians Network enrollee charts.

Procedure: 1. The Immunization Consent Form or an equivalent consent form must be completed and maintained in each Independent Physicians Network enrollee chart.

2. The Health Service staff will monitor the use of this consent form as part of their annual chart review.
POLICY & PROCEDURE
700.001 - PCP Termination of Care of Enrollee

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<td>Miscellaneous</td>
<td>PCP Termination of Care of Enrollee</td>
<td>06/19/91</td>
<td>700.001</td>
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Policy:
Independent Physicians Network Primary Care Physicians (PCPs) may terminate care of an enrollee if appropriate procedures are followed.

Procedure:
1. The PCP must provide the enrollee and the HMO a 30 day notice in writing of PCP’s intent to discontinue care of the enrollee. PCP must be available to provide urgent and emergency care for the enrollee during the 30 day notice period.
2. If the PCP wishes to terminate care prior to the end of the 30 day notice period, the PCP must personally make arrangements with another Independent Physicians Network PCP to care for the enrollee during that period.