BROWN & TOLAND

MEDICAL GROUP'S

FOLLOW-UP

PPO SUBMISSION

Submitted by:

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October 7, 2004

Responses to FTC Staff's Follow-Up Questions

1. Follow-Up Questions Regarding PPO Referrals

Explain how Brown & Toland PPO participating physicians make referrals to specialists.

Under a PPO system, patients generally are free to choose among doctors both within and outside of the network.

Will Brown & Toland require its PCPs to refer only to specialists within the network?

If not, does Brown & Toland have any estimate of the percentage of patients that its PCPs may refer to specialists outside the network or of patients that may ask to be referred to a specialist outside of the network?

If referrals will occur outside the network, are the processes that Brown & Toland proposes to implement to achieve the benefits of clinical integration going to have any effect to the extent such out of network referrals occur?

If yes, how will that be achieved?

1. Response to Follow-Up Questions Regarding PPO Referrals

Brown & Toland's PPO physicians refer to specialists based on the clinical needs of their patients. PPO plans do not prohibit patients from self referring to specialists outside of Brown & Toland's PPO network, and Brown & Toland cannot change this benefit design. For two reasons, however, PPO patients are likely to stay within the Brown & Toland network for specialty care. First, PPO plans provide financial incentives for patients to stay within the network, as patients must pay higher co-payments if they are treated by out of network physicians. Second, Brown & Toland primary care physicians almost always refer to specialists within the Brown & Toland network. This stems from the Brown & Toland physicians' practice patterns with regard to HMO plans.1 This referral practice will continue, in all likelihood, going forward as interdependencies among network physicians that exist with regard to Brown & Toland's HMO business continue to transition to the PPO business.2

Brown & Toland estimates that specialty referrals outside of its PPO network will be rare. For any such referrals, Brown & Toland's case managers will likely assist in

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1 The physicians participating in Brown & Toland's PPO network all participate in Brown & Toland's HMO network, and account for roughly 80 percent of HMO business. *See* PPO Submission, p. 3.

2 *See* PPO Submission p. 2 for a description of the market shift from HMO to PPO products and the corresponding effect on Brown & Toland's focus.

coordinating care with out of network physicians if the patient is enrolled in a case management program for chronic care. In addition, through Brown & Toland's electronic medical records ("EMR") program, a referring Brown & Toland physician may provide an out of network physician with a complete history of a patient's care via a fax copy, which could eliminate duplicative testing and unnecessary treatments. Long term, as national standards for data sharing are established and more physicians implement electronic medical records, an electronic record could be sent to – and clinical notes received back from – the out of network physician.

2. *Follow-Up Questions Regarding Brown & Toland's Internet-Based System*

Provide more information about how the internet-based system that is being put in place to share data among PCPs and specialists will work.

Will this system differ from any system that Brown & Toland currently offers its physicians and case managers for HMO patients?

If the answer is yes, describe those differences.

What does Brown & Toland estimate as incremental cost of putting this system into place and how many years will it take for the system to be fully operational?

What does Brown & Toland estimate to be the useful life of this system once it is fully operational?

2. *Response to Follow-Up Questions Regarding Brown & Toland's Internet-Based System*

Brown & Toland's EMR system, when operational, will support both the PPO and HMO products. Brown & Toland will invest $12 million over a ten-year period to implement and manage the EMR and other practice management systems. The system is intended to facilitate information sharing among Brown & Toland network physicians and, relatedly, to increase the quality of care and reduce costs by supporting the following operations:

- Clinical guideline adoption and use;
- Drug utilization review – i.e., reviewing drug-to-drug interactions, allergy interactions, and formulary coverage;
- Disease management programs;
- Patient education;
- Electronic prescriptions and computerized physician order entry;
- Increase preventative health care by standardizing clinical note generation.

The EMR system facilitates sharing of clinical patient information across the Brown & Toland physician network. Network physicians will no longer have to separately purchase, implement, and maintain a record-keeping system. Through the EMR system, information that has been captured in a paper medical record will be captured in electronic format.

The EMR system includes the following modules:

- *Workflow* – The workflow module facilitates communication between staff, maintains work tasks for each user, captures patient calls and routes these to the appropriate staff (such as a triage nurse), and supports physician rounding activities by providing physicians with key patient information on hand-held devices.

- *Electronic Prescribing* – This module: (1) allows the physician and support staff to enter and update historical medication and allergy information, process medication renewal requests, view and print patient drug education to enhance patient communication regarding medications; (2) performs an automated five-step drug utilization review; and, (3) sends prescriptions directly to pharmacies. (When industry capabilities are in place, the EMR system will track patient compliance with prescriptions.)

- *Clinical Results Reporting* – This module allows for the viewing of laboratory and other diagnostic results with notification and detail of abnormal findings as well as reference ranges. Results can be reviewed by means of flowsheets and graphs, enabling the tracking of trends over time for a more comprehensive analysis of patient history.

- *Order* – This module provides immediate electronic transmission of ambulatory orders to laboratories and other ancillary departments. Personalized orders concerning a patient's specific diagnosis, medical history, clinical practice guidelines, and medical necessity checking are available at the point of ordering.

- *Charge* – This module automates the capture of office and inpatient visit charges. Diagnosis codes, units, and appropriate CPT codes are reported within this module.

- *Clinical Note* – This module allows a physician to create a complete clinical note. The clinical note is created through data entry, citation of existing clinical data, and direct dictation. Templates can be configured for specialties, for individual offices, or for individual physicians. Physicians can view current patient conditions, past medical history, past surgical history, family history, or personal history. Physicians can also quickly produce clinical correspondence to send to referring and primary care physicians.

It is also worth noting that clinical laboratory results from Brown & Toland's contracted laboratories will be loaded into the system (as part of the Clinical Results Reporting module, discussed above). These results will be available for online viewing by the ordering physician and can be shared with any physician to whom a patient is referred. After all laboratory vendors are providing results to Brown & Toland, radiology results and other ancillary test results will similarly be loaded into the system.

Brown & Toland is currently installing at its administrative offices the EMR system's hardware and software. By the end of 2004, the clinical results reporting module will be provided to PPO physicians who need ancillary test results for patient care. A base module is included with the clinical results reporting module and this allows physicians to add on the additional EMR modules listed above. Brown & Toland signed a ten-year license agreement (with ten-year renewal options) and believes that the EMR system will be useful as long as physicians use computers to track patient care.

3. *Follow-Up Questions Regarding Quality of Care.*

Provide information about how Brown & Toland's financial investment promotes a system that provides a higher quality of care and fosters interdependence among the physicians.

Does Brown & Toland have methods for measuring improvements in care? If not, is it planning to develop such measurements? Will the results of these measurements be made available to payers and patients?

3. *Response to Follow-Up Questions Regarding Quality of Care.*

Brown & Toland has invested – and continues to invest – in processes designed to improve the quality of care and foster interdependence among network physicians. This includes, for instance, developing protocols and guidelines that dictate appropriate care for specific diagnoses (see pp. 5-7, 12-13 of the PPO Submission), conducting utilization review (see pp. 7-12 of the PPO Submission), overseeing a case management program (see pp. 13-15 of the PPO Submission), managing a quality improvement program (see pp. 15-17 of the PPO Submission), and implementing the EMR system (described above).

Through these processes, data is shared among network physicians, utilization trends are tracked, patients who could benefit from case management programs are identified, a physician's delivery of care is compared to his or her peer group's, patients who frequently are admitted to a hospital or who frequently visit an emergency room are identified, children in need of immunizations are identified, and patients who could benefit from additional preventative care are identified.

Improvements in care can be measured by analyzing an individual patient's treatment. For instance, patients who visit an emergency room two times over the course

of six months will be evaluated for case management services. Brown & Toland can measure the extent to which the patient's condition has improved by tracking emergency room visits following his or her enrollment in the case management program. Health plans will be given information concerning patients who could benefit from Brown & Toland's case management programs.

4. *Follow-Up Questions Regarding PPO Cash Flow.*

Does Brown & Toland currently receive any money from the PPO operations? More broadly, provide information that will allow the FTC to understand how the money is flowing, and from where. How does the financial structure contribute to the PPO accomplishing its overarching goal of providing high quality, cost-effective medical care?

For which features of the proposed PPO system might payors be willing to pay Brown & Toland separately from physician reimbursements?

4. *Response to Follow-Up Questions Regarding PPO Cash Flow.*

Brown & Toland's PPO operations are supported through overall corporate earnings. From the physicians' standpoint, this means that Brown & Toland absorbs the costs for the expansion into new products and the associated administration of those products. Brown & Toland has not asked its physicians to make direct investments other than those necessary for the physician's individual practice operations. In its current PPO environment, Brown & Toland has absorbed the investments associated with obtaining PPO contracts, managing care, collecting data, and reporting. So far, this has been done through increased operational efficiencies rather than charging fees to providers for PPO contract administration.

The financial structure of Brown & Toland's PPO operations contributes to achieving the operations' goals because investments are needed to implement and manage the clinical integration processes described in Brown & Toland's PPO Submission.

5. *Follow-Up Questions Regarding Physician Information Sharing.*

What is the benefit from sharing information between certain types of specialists (e.g., dermatology or orthopaedics) and other doctors?

More generally, explain why the participation of all specialists in the Brown & Toland network is necessary to achieving the purported benefits of clinical integration?

Will the sharing of information modify the behavior of physician specialists? If yes, how?

5. *Response to Follow-Up Questions Regarding Physician Information Sharing.*

For four reasons, it is necessary for Brown & Toland to contract with a broad range of specialists. First, Brown & Toland markets to payers a comprehensive network of physicians. This obviates the need for payers to contract separately with physicians in certain specialties. Second, Brown & Toland's clinical processes are designed to track, analyze, and improve care across a continuum: from primary care physicians to specialists. It is necessary, therefore, to have a full network of specialists so that the clinical processes apply to the treatment of patients by different specialists. Third, having a full network of physicians is convenient for patients and, relatedly, reduces out of network expenses to patients. Finally, having a full network of physicians enhances efficiency as it helps eliminate duplicative testing and diagnoses.

The sharing of information should modify behavior of physician specialists in the ways described on pp. 12-13 of the PPO Submission.

6. *Follow-Up Questions Concerning Brown & Toland's Case Managers.*

Provide more detail about the "clinical specialists."3 How will the case managers perform their duties? What sort of clinicians will serve as case managers? How will the case management program serve the purpose of the PPO?

Which patients will be assigned to case managers? What percentage of covered lives is that estimated to be?

How will the case manager system operate if a patient is referred to or chooses a specialist who is not in the Brown & Toland network?

What does Brown & Toland estimate the ratio will be of case managers to covered lives?

6. *Response to Follow-Up Questions Concerning Brown & Toland's Case Managers.*

Brown & Toland employs sixteen case and disease managers, who are experienced health care professionals.4 They include nurse practitioners, registered nurses (multispeciality), and one dietician with expertise in HIV nutritional assessments.

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3 We assume that the term "clinical specialists" refers to Brown & Toland's case managers.

4 Details of Brown & Toland's case management program, including how patients are identified to participate in the program, are provided on pp. 13-15 of the PPO Submission.

Case managers' range of services include assessment of needs, discharge planning, coordination of care across the continuum, and facilitation of social service needs. Attachment 1 to this follow-up submission includes job descriptions detailing the requirements for the case management positions. A case manager has a maximum caseload of 100 patients (this case load varies depending on the acuity of the population).

Brown & Toland case managers are trained to work with in-network or out of network physicians to coordinate care.

7. *Follow-Up Questions Concerning Brown & Toland's Claims Review Process.*

How will Brown & Toland's claims review program (described on pp. 9-11 of the materials provided to the FTC in June) work? In particular, what type of data will be available for the PPO patients and how will that data be obtained? For example, how will Brown & Toland obtain data for PPO patients related to ER utilization or hospital stays? Which of the reports listed on pp. 10-11 will go to physicians as opposed to case managers?

How will this program operate to the extent that patients seek out of network care? Will this program include information concerning lab work, pharmaceuticals, and other reimbursable services?

7. *Response to Follow-Up Questions Concerning Brown & Toland's Claims Review Process.*

As described on pp. 7-8 of the PPO Submission, Brown & Toland physicians are required to submit to Brown & Toland copies of claims that are submitted to payers. Attachment 2 to this follow-up submission includes a copy of a claim form. In filling out this claim form, Brown & Toland physicians and hospitalists are required to reflect ER and hospital services provided to patients. The claim forms therefore provide data concerning ER utilization and hospital stays. Brown & Toland will not receive claims from any physicians who are not within its PPO network; nor will it receive data concerning services for which the hospital bills the payer separately.

Network physicians submit to Brown & Toland electronic or paper copies of PPO claims through either a direct electronic submission, ProxyMed Clearinghouse electronic submission, web-based electronic submission, or paper copy submission. (Each of these means of submission is described on p. 8 of the PPO Submission.) Lab results and prescriptions will be available through the clinical results reporting.

The reports described on pp. 10-11 of the PPO Submission will be distributed to physicians and case managers as appropriate based on the nature of the particular report. Physician aggregate reporting and support reports will be sent twice during the year. The aggregate reporting may be used to look at utilization trends, identify variances in

practice patterns, and identify PPO members who may be missing preventive care. Case managers will receive monthly reports to identify high-risk patients who may meet criteria for participation in case management or other disease management programs. Other reports will be used internally to identify variances in billing or care that may require auditing or oversite activities.

8. *Follow-Up Questions Regarding Clinical Care Guidelines and Protocols.*

How will the guidelines (protocols) work? How are the guidelines disseminated and monitored? Are they used while the care is being delivered, or for retrospective review? Provide at least one example of how the guidelines would be implemented. Discuss the extent to which the proposed protocols will affect each specialty in the network.

How are these protocols different from those generally available throughout the industry?

Describe with as much specificity as possible how Brown & Toland intends to discipline physicians who fail to follow the protocols.

8. *Response to Follow-Up Questions Regarding Clinical Care Guidelines and Protocols.*

The development of the protocols are discussed on pp. 5-7 of the PPO Submission, the monitoring of care to assess conformance with the protocols is discussed on pp. 7-12 of the PPO Submission, and enforcing adherence to the protocols is discussed on pp. 12-13 of the PPO Submission.

Protocols are available to Brown & Toland physicians on its website. In addition, Brown & Toland provides hard copies of the protocols to contracted physicians who practice in areas to which the protocols relate. Brown & Toland will work to embed these protocols in the electronic medical record application over time as opportunities for system enhancements are identified and defined. Attachment E to the PPO Submission lists the specialties to which Brown & Toland's protocols apply. Physicians within these specialties are required to adhere to – and therefore are affected by – the protocols. Physicians should consult protocols while delivering care, and Brown & Toland employees retrospectively analyze adherence to protocols. Claims data will be reviewed to identify outlier physicians (which can include those who do not adhere to protocols) as well as to prioritize remedial measures. Brown & Toland representatives visit network physicians' offices and provide training on the protocols. As to this training, priority is given to physicians who do not adhere to the protocols.

While many of the protocols adopted by Brown & Toland were developed by national organizations, Brown & Toland has internally developed roughly 100 protocols that are original to the medical group and are "proprietary." These protocols, developed

with significant input from Brown & Toland practicing physicians, conform to regional practice patterns and therefore differ from national protocols.

Guidelines concerning osteoporosis management are reflected in Attachment 3 to this follow-up submission. These guidelines were developed and implemented as follows:

The Brown and Toland Quality Improvement Committee requested that the Brown & Toland Medical Directorate form a multispecialty subcommittee of selected endocrinologists, OB/GYNs, and primary care physicians . These physicians reviewed current medical literature on osteoporosis management and data concerning network physicians' practice patterns, and recommended guidelines for adoption. These draft guidelines were then reviewed and approved by Brown & Toland's Utilization Management and Quality Improvement Committees as well as its Board of Directors. The guidelines were then communicated to the Brown & Toland physician network through the web, newsletters, and broadcast fax announcements. Furthermore, education material on prevention and treatment of osteoporosis was designed and distributed to physician offices for their patients.

Brown & Toland review of adherence to the osteoporosis management guidelines will be retrospective. PPO physicians' osteoporosis screening compliance will be identified through Brown & Toland's recredentialing office audits.

ATTACHMENT 1

BROWN & TOLAND PHYSICIANS SERVICE ORGANIZATION

JOB DESCRIPTION

JOB TITLE: RN CASE MANAGER

FLSA STATUS: Non-Exempt

DEPARTMENT: Case Management

DATE PREPARED: February 1-2002

REPORTS TO: Manager, Case Management

PRIMARY PURPOSE:

The RN Case Manager is responsible for care coordination and case management for a specific population of members. Specific activities and frequency of those activities will vary and be specific to the area of assignment. Activities include; conducting onsite and or telephonic assessment, coordination of an appropriate plan of care, working collaboratively with the member, member's family or significant others, health plan representatives, BTMG PCP, BTMG Physician Specialists, home health care providers, and other appropriate multidisciplinary healthcare professionals to coordinate care to meet the patient's overall care requirements. Additionally, the RN Case Manager facilitates the authorization of inpatient and outpatient services, including surgical procedures, home care services and durable medical equipment requests. The position assures that authorizations meet payer requirements, follow appropriate policies and procedures and are medically necessary, utilizing BTMG approved guidelines.

SUPERVISION:

This position assists with daily oversight of the outpatient authorization coordinator staff.

MAJOR DUTIES AND RESPONSIBILITIES:

1. Assesses, plans, implements, coordinates, monitors and evaluates the options and services which will meet the members health needs across the care continuum, and provides quality cost-effective outcomes. Identify issues, resolve problems, interpret policies, etc., and ensure interface between care team members.

2. Utilizes clinical knowledge, assessment, problem solving and decision-making skills to evaluate request for authorization. Including screening for appropriateness, verification of eligibility, interpretation of benefits and medical necessity, obtaining additional information and researching issues, as needed in order to facilitate objective medical management decisions based upon approved BTMG criteria, standards and guidelines.

3. Regular communication and interface with Physician Advisors and Medical Directors for clinical decisions regarding medical necessity, problem resolution, and all care/service denials.

4. Works collaboratively with other members of the Care Management/QI Department, the Claims Department, the Health Plans and BTMG providers to identify individuals who require case management services.

5. Gathers and reports utilization data, logs, etc., in accordance with NCQA and HMO/plan requirements and ensures utilization data and quality information is accurately documented for reporting.

6. Works with providers and health plan representatives to access and support development of any programs available within BTMG and/or the contracted Health Plans for member education, disease management programs, and health improvement as appropriate for members.

7. When indicated, oversight of non-clinical UM coordinator letter generation in compliance with governmental regulations, NCQA standards, and HMO/plan guidelines, including compilation and dissemination of accurate written notifications of noncoverage to BTMG members, MDs, health plans, etc.

8. Participate in development of interdepartmental processes and procedures to improve care management within BTMG and BTMG.

9. Assist in the development, implementation, and evaluation of standards of care, policies, procedures, medical review criteria, and protocols to improve care management throughout the delivery system and across the care continuum.

10. Provide education, orientation, and consultation to care team members as to the role of care management at BTMG.

11. Accepts and performs other duties, assignments and responsibilities as directed.

REQUIREMENTS:

EDUCATION AND/OR TRAINING: RN, BSN preferred. Current California unrestricted Nursing license.

SKILLS AND ABILITIES: Excellent verbal and written communication skills. Computer literacy w/ typing skills. Organizational skills. Ability to prioritize. Strong negotiation skills. Flexible and able to work independently. Ability to maintain a high volume workload.

EXPERIENCE: Minimum of three years recent acute clinical experience required. Managed care experience preferred, preferably in an HMO or IPA setting.

OTHER CRITERIA: Complies with company and departmental administrative policies and procedures; performs job safely with respect to others, and to property, and to individual safety; works effectively with others to encourage teamwork and productivity. Maintains strict confidence of client information, ensuring client's privacy, and does not discuss internal business with external entities.

PHYSICAL REQUIREMENTS: Requires intermittent sitting, writing and typing/data entry in a computerized Windows environment up to an average of five hours per day. May also require standing and or walking up to 6 hours a day.

PERSONAL ERGONOMICS: Complies with policies and procedures, equipment orientation and workspace set up to ensure personal safety and well being as it relates to ergonomically sound usage, reporting immediately to management any complications or difficulties regarding appropriate usage of workplace and equipment.

APPROVALS:

_____ _____

Employee **Date**

_____ _____

Manager / Supervisor **Date**

BROWN & TOLAND PHYSICIAN SERVICES ORGANIZATION

JOB DESCRIPTION

JOB TITLE: HIV Clinical Specialist (Nutrition)

JOB CODE:

FLSA STATUS: .8FTE

REPORTS TO: Manager, Health & Quality Improvement

DATE PREPARED: April, 2003

PRIMARY PURPOSE: Responsible for implementing the nutrition and case management components of the HIV Management Program which includes, but is not limited to, one to one case management related to coordination of nutrition, social/mental, community, and healthcare services. Nutrition case management includes, but is not limited to, assessment of weight & body composition, assessment and recommendations for use of anabolic therapies, nutrition counseling to ensure adequate nutrient intake, and nutrition strategies for symptom management and treatment of metabolic problems. Communicates regularly and as needed with primary care providers, care management (inpatient and outpatient), insurance companies, clinical labs and other referral resources to ensure continuum of care. Participates in program development and outcome data collection/evaluation with Health Improvement operations staff, Medical Directors and HIV physician advisors as needed.

SUPERVISION: This position does not supervise anyone.

MAJOR DUTIES AND RESPONSIBILITIES:
(E = Essential; D = Desirable)

1. Conducts all BTMG physician consultation and one to one nutritional counseling including baseline BIA, recommending and/or initiating nutrition supplements, weight increase therapy, antidiarrheal therapy, general, mycobacterium avium complex (MAC) and cryptosporidiosis nutritional consult, etc. (E)

2. Provides clinical expertise as deemed appropriate to the position. (E)

3. Works with HI operations staff and HIV advisory team on program development, data collection and outcomes reporting. (E)

4. Prepares agenda items, presents materials, and takes minutes at HIV Advisory Board meetings.

5. Conducts program in-services education for BTMG physicians, nurses, hospital staff and other BTMG departments. (E)

6. Maintains up to date information on developments in nutritional therapy, counseling and treatment options. (E)

7. Works closely with Care Management to coordinate authorizations and referrals to community and BTMG network resources to facilitate continuity and coordination of care. Examples include referrals to home care vendors, DME vendors, etc. when medically indicated per BTMG Referrals Services policies & procedures. (E)

8. Represents BTMG HIV management program at conferences, seminars, etc. as requested. (E)

9. Accepts and performs other duties as assigned. (E)

REQUIREMENTS:

EDUCATION AND/OR TRAINING: Registered Dietitian (R.D.), M.S. Preferred. Specializing in HIV.

SKILLS AND ABILITIES: Computer literate and excellent typing skills. Excellent oral and written communication skills; individual and group. Strong analytical and problem-solving skills. Thorough knowledge of the physiological, psychosocial, and treatment aspects of HIV. Ability to maintain high volume workload with minimal supervision. Work well under pressure.

EXPERIENCE: Experience in working as an educator and/or clinician with HIV patients and physicians. Patient education experience with groups and individual.

OTHER CRITERIA: Complies with policies and procedures; performs job safely with respect to others, to property, and to individual safety; works effectively with others to encourage teamwork and productivity. Maintains strict confidence of client information ensuring client's privacy, and does not discuss internal business with external entities.

APPROVALS:

Incumbent Date

Supervisor Date

BROWN & TOLAND PHYSICIAN SERVICES ORGANIZATION

JOB DESCRIPTION

JOB TITLE: Asthma Nurse Practitioner **JOB CODE: Non-Exempt**

FLSA STATUS: .5 FTE

REPORTS TO: Manager, Health & Quality Improvement

DATE PREPARED: June 2001
DATE REVISED: January, 2003

PRIMARY PURPOSE:

Responsible for implementing the Asthma/COPD Management Program, which includes teaching education classes, one-on-one case management, and coordinating referrals to Specialists and outpatient services such as pulmonary rehabilitation. Communicates regularly with primary care providers and specialists to ensure continuum of care. Conducts in-service and education programs to B&T physicians and hospital staff. Performs regular post education follow-up to assist in outcome data collection. Participates in curriculum development with Medical Directors and Physician Advisory as needed. 20% time devoted to the implementation of the Hip & Knee Program for Case Management.

SUPERVISION:

Position does not supervise anyone.

MAJOR DUTIES AND RESPONSIBILITIES:

(E = Essential; D = Desirable)

1. Works with Physician Directors and Advisors on development of the education group series and materials for asthma website. (E)
2. Provides clinical expertise as deemed appropriate to the position. (E)
3. Conducts asthma education groups and 1:1 education. (E)
4. Responsible for one-on-one patient case management. (E)
5. Communicates regularly with primary care providers and specialists to ensure continuum of care. (E)
6. Participates in education programs and other activities that promote the Asthma Management Program to B&T physicians, nurses, and hospital staff. (E)

7. Assists with the development of asthma/COPD guidelines and care maps for disease management. (E)

8. Analyzes effective asthma/COPD care approaches. (E)

9. Assists with research-related activities when applicable, including asthma studies. (E)

10. Accepts and performs other related duties and responsibilities as assigned. (E)

11. Implements the pre-surgery case management for the Hip & Knee Program. (E).

REQUIREMENTS:

EDUCATION AND/OR TRAINING: R.N.,N.P., M.S. preferred. Specializing in Pulmonology preferred.

SKILLS AND ABILITIES: Outstanding communication and group skills. Thorough knowledge of the physiological, psychosocial, and treatment aspects of asthma. Experience in working as an educator and/or clinician with asthmatic adults.

EXPERIENCE: Experience with community based programs or individual patient education. Ability to communicate effectively with physicians, staff and outside agency personnel.

OTHER CRITERIA: Complies with policies and procedures; performs job safely with respect to others, to property, and to individual safety; works effectively with others to encourage teamwork and productivity. Maintains strict confidence of client information ensuring client's privacy, and does not discuss internal business with external entities.

APPROVALS:

Incumbent **Date**

Supervisor **Date**

ATTACHMENT 2

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REA

Attachment 2

HEALTH INSURANCE CLAIM FORM

PICA

PICA
MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE MM DD YY SEX M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)
CITY STATE
8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student
ZIP CODE TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO
a. OTHER INSURED'S POLICY OR GROUP NUMBER
b. AUTO ACCIDENT? YES NO PLACE (State)
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F
c. OTHER ACCIDENT? YES NO
c. EMPLOYER'S NAME OR SCHOOL NAME
10d. RESERVED FOR LOCAL USE
d. INSURANCE PLAN NAME OR PROGRAM NAME
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. EMPLOYER'S NAME OR SCHOOL NAME
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 3.
2. 4.
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
22. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $
29. AMOUNT PAID $
30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED DATE
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
PIN# GRP#

PATIENT AND INSURED INFORMATION

CARRIER

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAM

ECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY
PPLICABLE PROGRAMS.

OTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may e guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process ne claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature uthorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health nsurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

ATTACHMENT 3

Attachment 3

BROWN & TOLAND
MEDICAL GROUP

Quick Reference: Osteoporosis Management Guidelines

This is a tool designed to assist clinicians to incorporate the management and prevention of osteoporosis into practice. This was developed by the Brown & Toland Osteoporosis Advisory Group, with an expert review of advances since the 1997 Guidelines from the National Osteoporosis Foundation. For complete information, refer to the BTMG Guidelines for the Management of Osteoporosis.

Risk Assessment

- Counsel all post menopausal women on the risk factors for osteoporosis, evaluate for risk for fracture, and determine the need for testing.

In general, the more risk factors a woman has the greater her risk of fracture. If one or more risk factors are present, bone mineral density (BMD) testing may be indicated to determine whether therapy is appropriate.

Note: Black women are at lower risk for osteoporosis.

Bone Mineral Density Testing for Untreated Women Considering Drug Therapy

Measurements of bone mineral density can predict fracture risk. A variety of densitometers are in clinical use, however a **HIP DXA scan** is BTMG's preferred test since it is the best predictor of hip fractures and it predicts fractures at other sites. The only exception to this is for patients on current corticosteroid treatment where ordering a SPINE DXA scan is recommended.

Initial Testing

- Consider Bone Mineral Density (BMD) testing for women with one or more of the following risk factors:
    - all white and Asian women age 65 and older
    - all white and Asian women age 50 - 64 where principal risk factors include:
        - postmenopausal women who have fractures
        - oral glucocorticoid therapy for more than 3 months
        - parental history of hip or confirmed spine fracture or family history of osteoporosis
        - weight less than 127 lbs. or BMI < 22
        - current cigarette smoking
        - and/or chronic diseases known to be associated with osteoporosis

Although data is lacking, consider bone density for nonwhite women and men, aged 50 and older, who have 2 or more of the above risk factors.

RE-TESTING

- Optional testing every 2 years for those patients on current pharmacologic treatment for Osteoporosis.
- Patients who on BMD testing do not demonstrate the need for pharmacologic treatment should be re-evaluated at the following intervals based on T-scores:

T-score	Interval to Re-Test
-1.5 to -2.5*	2 years*
-1.0 to –1.5*	4 years*
>-1.0	5-10 years*

*Test sooner (1-2 years) if another condition or drug that causes osteoporosis develops in interim.

BTMG's Osteoporosis Management Guidelines (continued)

General:

- Advise all patients to obtain an adequate intake of dietary calcium (at least 1200mg/day, including supplements as necessary).
- Vitamin D 400 to 800 IU/day is recommended for all patients, including those with osteoporosis and at risk for vitamin D deficiency.
- Lifelong regular weight-bearing and muscle strengthening exercises to reduce the risk of falls and fractures.
- Advise and assist patients to quit smoking.
- Recognize and treat alcoholism.
- Provide patient education materials on good nutrition, exercise and facts on bone density testing.
- Screen for high risk of fractures on your patient's screening checklist*.

Pharmacologic:

- Recommend pharmacologic treatment for any individual with a hip or vertebral fracture or osteoporosis by BMD testing with a T score of <-2.5 at the femoral neck or lumbar spine.
- Consider offering treatment to individuals with T score of <-2.0 and who have had at least one of the following risk factors:
  - a fracture
  - long-term oral corticosteroid use
  - chronic disease(s) known to be associated with osteoporosis

FDA Approved Osteoporosis Medications:

Current Food and Drug Administration (FDA) approved pharmacologic options for osteoporosis prevention and/or treatment are hormone replacement (HRT), bisphosphonates (alendronate, risedronate), calcitonin and raloxifene.

Practice Tips:

- Select an appropriate pharmacologic intervention for your patient when necessary tailored to the patient's age, fracture history and risk for other diseases affected by the medication.

- There is no current evidence that combination drug therapy reduces the risk of fracture significantly more than using an effective single drug. Fractures may continue with effective treatment and a fracture that occurs during treatment is not an indication for changing therapy.

- Drug adherence is important to monitor and to consider when a patient appears to have lost bone density during monitoring. It is important to counsel and ask about compliance especially during the first three months of therapy.

There are no long-term studies for the use of these agents beyond 5 years. The decision to continue therapy beyond 5 years should be based on the patient's age, fracture history and long term benefit versus safety issues. It is further recommended that clinicians review treatment plans with their patients annually, especially as new data and treatment concepts are elucidated.

* Add "Prevention of Fractures" to Your Patient's Screening Checklist

Cut here and make copies for patient's chart

Patient's Name: _____ Date of Visit: _____

Checklist for Osteoporosis

Check all that apply:

_____ Caucasian and Asian Women > age 65 years

Postmenopausal Woman and

_____ Past fracture?
_____ Parental history of hip or spine fracture?
_____ Smoker?
_____ Weighs < 127 lbs.? Or BMI < 22?

_____ Taking oral corticosteroids > 3 months a year?
_____ Has rheumatoid arthritis, inflammatory bowel disease, malabsorption/sprue, Parkinson's or disease that increases fracture risk

If any are checked, order a HIP DXA scan.

Approval Dates:
6/02 - Osteoporosis Advisory Group
8/02 - BTMG QI Committee
3/04- BTMG QI Committee