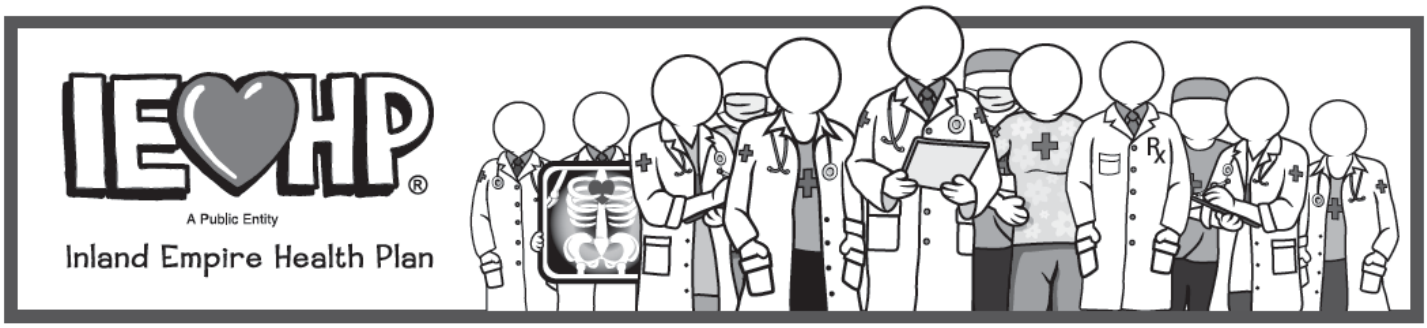

To: All PCP's

From: IEHP – Provider Relations

Date: March 20, 2018

Subject: **Updated Historical Data Form and Reporting Process**

As part of IEHP's on-going efforts to support Providers with Global Quality P4P goals, we have simplified and improved the Historical Data Form and developed a new Monthly Historical Supplemental Data Form - Provider Report.

The new Historical Data Form improves the process both for Providers and IEHP. The enhancements include:

- Clarification of required documentation
- A list of the entities that IEHP receives direct data feeds from (no need for submission by Provider office)
- Check boxes reduce the amount of manual entry required by the Provider office
- Adds new options for submission such as HbA1C point of care testing

IEHP will begin a Monthly Historical Supplemental Data Form - Provider Report which provides the following details:

- Fax Received Date
- Member ID
- Member Name
- Status Reason (Additional comments provided if case was denied)
- Member DOB
- Test Type
- Status (Indicates Approved or Denied)

The Monthly Historical Supplemental Data Provider Report will be distributed to PCP offices via fax on the 20th of the month and will capture submissions that were received the previous calendar month. (Example: April 20th report reflects submissions received by IEHP from 3/1/2018-3/31/2018). The initial report will be made available in April and will reflect information submitted year to date. Subsequent reports will reflect information received during the prior month.

The following documents are attached for your review:

- Historical Data Form-Overview of Changes
- New Historical Data Form

The **New** Historical Data Form can also be found at: https://ww3.iehp.org/en/providers/forms/historical-data-form/ and on the Provider Portal. Completed forms can be sent to fax # (909) 477-8568.

Thank you for your on-going efforts to support optimal health for our IEHP Members.

INLAND EMPIRE HEALTH PLAN

HISTORICAL DATA FORM

Summary of Changes

The Historical Data form is for submissions of visits, procedures or services to close quality gaps in care as reflected on the Preventative Care Rosters that cannot be submitted via claims or encounters (e.g. services received prior to IEHP Membership, historical surgical procedures, etc.). **Any form submitted without appropriate proof of service documentation or any form that doesn't include Member name, DOB and date of service will NOT be processed.**

Added content guidelines detailing required documentation.

Results from LabCorp, Quest, BioData, RadNet, ARMC, RUHS, and Loma Linda **do not require submission** as IEHP receives this information directly.

Added the list of entities where IEHP already receives the electronic data feeds. No additional submission needed.

Type of Historical Data:

- ☐ **PAP ONLY**
- ☐ **PAP AND HPV [co-testing]**
- ☐ **History of Total/Complete Hysterectomy [NO residual cervix]**
- ☐ **Mammogram**
- ☐ **History of Mastectomy**
- ☐ **Dilated Retinal Exam with Results**
- ☐ **Group A Streptococcus (Strep) Test – Throat**
- ☐ **HbA1c Results (for in-office Point of Care Testing)**
- ☐ **Other:**_____

Added a "Type of Historical Data" check box to reduce the amount of information the PCP or staff must manually complete.

Added new options, "Dilated Retinal Exam with Results", "HbA1c Results (for point of care testing), and an "Other" category. Revised the Immunizations column with the CAIR 2 Website resource link.

For Immunizations - Please submit through CAIR2 website: https://cair.cdph.ca.gov

Member Information

Member Name: _____

IEHP ID #: _____ DOB: _____

Repositioned the "Member Information" next to the "Provider Information".

Provider Information

Provider Name: _____

IEHP Provider #: _____ Address: _____

City: _____ State: _____ Zip: _____

Provider Phone #: _____ Provider Fax #: _____

This cover sheet MUST be accompanied with the *supporting medical record documentation*

PLEASE FAX TO: (909) 477-8568

Attn: Inland Empire Health Plan - Quality Informatics [HEDIS] Department

Additional reminder added to include the supporting medical record documentation.

INLAND EMPIRE HEALTH PLAN

HISTORICAL DATA FORM

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- ☐ **Group A Streptococcus (Strep) Test – Throat**
- ☐ **HbA1c Results (for in-office Point of Care Testing)**
- ☐ **Other:_____**

For Immunizations - Please submit through CAIR2 website: https://cair.cdph.ca.gov

Member Information
Member Name: _____
IEHP ID #: _____DOB:_____
Provider Information
Provider Name: _____
IEHP Provider #: _____ Address: _____
City: _____ State:_____ Zip:_____
Provider Phone #: _____ Provider Fax #: _____

This cover sheet MUST be accompanied with the *supporting medical record documentation*

PLEASE FAX TO: (909) 477-8568

Attn: Inland Empire Health Plan - Quality Informatics [HEDIS] Department

Last Rev: 3-09-2018