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| Referral Audit Corrective Action Plan |

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| Referral tracking process | | | | | |
| Health Plan verification and date | CRITERIA | **Deficiency Cited/Reviewer Comments** | Corrective Action | CORRECTION DATE  AND /OR  PRACTITIONERS COMMENTS. | Responsible MD or Designee at Site |
|  | RT  1 | All referrals are not being tracked from the date the patient is seen in the office to when the referral is completed and submitted to the IPA/Medical Group. | All referrals are to be completed and submitted to the IPA/Medical Group within two (2) working days or less.   * Copy of the completed referral log/ or tracking process is attached. |  |  |
|  | RT 2 | All referrals do not include ICD-10 codes | Copy of three (3) completed referrals including the ICD-10 codes will serve as evidence the new process has been implemented.   * **Copies of referrals attached.** |  |  |
|  | RT 3 | All referrals do not include CPT codes | Copy of three (3) completed referrals including the CPT codes will service as evidence the new process has been implemented.   * Copies of referrals attached. |  |  |
|  | RT 4 | All referrals do not include the physician/provider signature or identifier. | Copy of three (3) completed referrals including the physician/provider signature or identifier as evidence the new process has been implemented   * Copies of referrals attached. |  |  |
|  | RT 5 | The office is not tracking when referrals are returned from the IPA/Medical Group with referral decisions. | All referral decisions will be made within five (5) working days or less.   * **Copy of the completed referral log/ or tracking process is attached**. |  |  |

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|  | RT 6 | There is no tracking system noted or documentation when consult reports are received or attempts to obtain outside reports. | Documentation (date) when consult reports are received or attempts to obtain outside reports.  Consult reports are received within ninety (90) days of the patient’s appointment.  OR  Attempts to obtain reports will occur within thirty (30) days of the date of the referral.   * **Copy of the completed referral log/ or tracking process is attached.** |  |  |

CAP COMPLETION SIGNATURE PAGE.

I have completed the corrective action plan for the Referral Audit performed on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I affirm each

(Enter Date of Review)

Corrective action has been implemented as indicated on the attached Corrective Action Plan.

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Physician/Designee Signature Printed Name and Title Date

Please Return Completed CAP

And this signature sheet. via U.S. Mail or FAX to: Inland Empire Health Plan

Quality Management Department

Attention: QM Coordinator

P.O. Box 1800, Rancho Cucamonga, CA 91729-1800

Fax: (909) 890-5746