SEASIDE HEALTH PLAN
An Affiliate of MemorialCare Health System

MEMORIALCARE HEALTH SYSTEM
Excellence in Health Care

Provider Manual

Commercial & Medi-Cal

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Contents

Chapter 1: INTRODUCTION

OVERVIEW

Seaside Health Plan recognizes that timely and appropriate access to physician care, as managed through a network of skilled Primary Care Physicians (PCPs) in conjunction with a network of participating specialists and hospitals, yields both high quality and the most cost-effective care.

Seaside Health Plan's systems are designed to complement and comply with state and federal laws and the regulations of the Centers for Medicare and Medicaid Services (CMS) Medicare, Medi-Cal and our various contracted Health Plans. Seaside Health Plan provides an orientation to service and non-duplication of administrative functions between the Health Plan and Contracted Providers to control costs.

This manual is a tool to assist you in providing contracted health care services to the enrolled patients assigned to Seaside Health Plan and your practice. Since Seaside Health Plan is a health care delivery system, it is important to understand that our essential responsibility is to provide comprehensive managed care to all members. While it is true that members will look to your Providers for their health care needs, they will also seek assistance from others in the Seaside Health Plan provider network to assist them with obtaining other benefits.

This manual will provide you with direction and guidance regarding the basic operational processes of Seaside Health Plan. Contracted Providers are responsible for distributing copies of the Provider Manual to their Participating Providers.

WELCOME

Using This Manual

This manual is on the Seaside Health Plan website at www.SeasideHealthPlan.org. Links are available for sections of this manual by clicking on the topic in the Table of Contents or in the Index. Each section also may contain links to other sections, definitions, and important phone numbers or to our website or outside websites containing additional information.

Icons, bold type or boxes may draw attention to important information. Icons used are as follows:

 Link to other section or website

Blue Highlight Important Information to Remember

Seaside Health Plan may not be the Primary Plan. The Primary Plan can be determined by reviewing the Member's ID Card. The members Primary Plan will also have additional information and resources available to you on their websites:

Anthem Blue Cross
Blue Shield

Health Net
LA Care

Chapter 1: INTRODUCTION

This manual and any further updates, revisions, and amendments are part of your applicable Seaside Health Plan Participating Provider Agreement. In those instances when we determine that provisions in this manual, including any further updates, revisions and amendments, differ with provisions contained in your applicable Seaside Health Plan Participating Provider Agreement, such provisions of the applicable Seaside Health Plan Participating Provider Agreement shall govern and control over the provisions of this manual.

The California Department of Health Care Services (DHCS) and the California Department of Public Health (DPH) contract with LA Care Health Plan and Health Net in Los Angeles County. Seaside Health Plan in turn contracts with these plans for the provision of Medi-Cal coverage in Los Angeles County. Seaside Health Plan contracts with Commercial Plans regulated by the Department of Managed Health Care in order to provide access to care for these plans' covered lives.

This manual provides standards for services to members of the Medi-Cal and Commercial Plans. You are only required to follow the standards in this manual that are applicable to the program in whIch the member is currently enrolled.

There are instances throughout this manual where information is included as sample or example information. This information is intended to be for illustrative purposes only and is not intended to be used or relied upon.

There are instances throughout this manual that refer to information on different websites. Any information on a website referred to in this manual, including, but not limited to, the information on the Seaside Health Plan website, is being provided for informational purposes only and is expressly not incorporated into this manual by reference. However, as discussed in the Manual Updates section of this chapter, new materials or revisions to this version of the manual may be posted on the Seaside Health Plan website and to the extent permitted by state laws, will be considered addenda to this manual.

This manual and the Seaside Health Plan website used by the Plan may provide links and pointers to internet sites maintained by third parties (Third Party Sites). From time to time, third party materials may be provided on the Seaside Health Plan site used by the Plan. Neither the Plan nor its related, affiliated companies operate or control in any respect any information, products or services on the Third Party Sites. Third party material on the Seaside Health Plan site used by the Plan and the Third Party Sites are provided without warranties of any kind either express or implied to the fullest extent permissible pursuant to applicable law. The Plan disclaims all warranties, express or implied, including, but not limited to, implied warranties of merchantability and fitness. The Plan does not warrant or make any representations regarding the use or results of the use of the third party materials on the Third Party Sites in terms of their correctness, accuracy, timeliness, reliability or otherwise.

Please note that the member's Primary Plan Benefit Agreement governs the member's benefits, conditions, limitations and exclusions. In the event of any conflict between the terms outlined in this manual and the member's benefit agreement, the terms of the member's benefit agreement shall govern.

Chapter 1: INTRODUCTION

Manual Updates

If new material or revisions to existing material in this manual occur after this manual is published, we will provide updates through various means of distribution including, but not limited to, special mailings or newsletters, fax, or through our website at www.SeasideHealthPlan.org. As we improve our website, the content is subject to change. To the extent permitted by state laws, these updates are considered addenda to the manual.

If you have questions about the content of this manual, contact your Provider Services Representative.

This manual does not contain legal, tax or medical advice. Consult your own advisors for such advice

PRIVACY AND SECURITY STATEMENT

Seaside Health Plan's latest Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant privacy and security statements can be found on our website at www.SeasideHealthPlan.org.

Non-Discrimination Statement

Seaside Health Plan does not discriminate in the employment of staff or in the provision of health care services on the basis of race, disability, religion, gender, sexual orientation, health, ethnicity, creed, age, or national origin.

Seaside Health Plan requires its contracted Providers and their contracted or employed practitioners to adhere to these standards, as required by the agreement signed by the authorized agent of the contracted medical group. Failure to adhere to the non-discrimination provisions of the signed contract may result in termination of the contract.

Provider Contract Requirements through Policies, Standards and Manuals

Providers are prohibited from giving or accepting enrollment applications in the primary health care setting (waiting rooms, exam rooms, etc.)

The following standards apply to all of Seaside Health Plan's Primary Care Providers and Members:

Ensure services are provided in culturally competent manner.

Conduct a health assessment of all new enrollees within 60 days of the effective date of enrollment if under 18 months of age and 120 days if older than 18 months of age.

Provide covered benefits in a manner consistent with professionally-recognized standards of health care.

Submission of encounter data, medical records and certify completeness and truthfulness. Provide 60 days' notice (terminating contract without cause).

Comply with Civil Rights Act, ADA, Age Discrimination Act, federal funds laws

Adhere to appeals/grievance procedures

CHAPTER 2: IMPORTANT CONTACT INFORMATION

CONTACT INFORMATION BY INQUIRY TYPE

We offer the following important contact information for Seaside Health Plan by inquiry type:

Seaside Health Plan
2840 Long Beach Blvd., Suite 120
Long Beach, CA 90806

Hearing Impaired Services

Resource	Phone Number/Website	Hours of Availability
California Relay Service	(855) 833-7747 TDD/TTY	24 hours/ 7 days a week

Provider Contracting and Services

Resource	Phone Number/Website/Email	Hours of Availability
Seaside Health Plan Web Portal	**https://www.SeasideHealthPlan.org**	24 hours/7 days a week
Provider Contracting/Services	(855) 367-7747 SeasideProvider@Memorialcare.org	Monday thru Friday: 8am to 5pm

Claims Department

Resource	Phone Number/Website/Email	Hours of Availability
Web portal	**https://www.SeasideHealthPlan.org** SeasideClaim@Memorialcare.org	24 hours/ 7 days a week
Claims Address: PO BOX 830459 Birmingham, AL 35283	1-855-367-7747 Fax: (562) 424-1486	Monday thru Friday: 8 a.m. to 5 p.m.

CHAPTER 2: IMPORTANT CONTACT INFORMATION

Fraud and Abuse

Resource	Phone Number/Website/Email	Hours of Availability
Fraud and Abuse Department	1-888-933-9044 ethicshotline@Memorialcare.org	24-Hour Ethics Hotline

Member Services/Grievance and Appeals

Resource	Phone Number/Website/Email	Hours of Availability
Web portal	**https://www.SeasideHealthPlan.org**	24 hours/ 7 days a week
Member Eligibility	(855)367-7747 SeasideEnrollment@Memorialcare.org	Monday thru Friday: 8am to 5pm
Grievance and Appeals	(855)367-7747 **https://www.SeasideHealthPlan.org** SeasideQuality@Memorialcare.org Follow instructions under "***Grievance Form***"	24 hours/ 7 days a week

Referrals

Resource	Phone Number/Website	Hours of Availability
California Children's Service Referral	http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx	N/A

CHAPTER 2: IMPORTANT CONTACT INFORMATION

Utilization Management / Case Management

Resource	Phone Number/Website	Hours of Availability
Utilization Management Department/Prior Authorizations	Seaside Health Plan: 1-855-367-7747 www.SeasideHealthPlan.org Fax: (562) 933-1891	Monday thru Friday: 8 a.m. to 5 p.m.
Care Coordination/Case Management Department	1-855-367-7747 Fax: (562) 424-1486	Monday thru Friday: 8 a.m. to 5 p.m. Provider Portal: • Submission form available 24 hours a day • SSHP Response within 3 business days

CHAPTER 3: MEMBER ELIGIBILITY

HEALTH PLAN TO HEALTH PLAN

Eligibility Verification

Providers must verify the member's eligibility before services are provided.

Member eligibility can be verified through Seaside Health Plan provider portal or directly from the Primary Health Plan.

Providers can verify Medi-Cal eligibility by using the Automatic Eligibility Verification System (AEVS) or at 1-800-456-2387.

Member should be asked at time of appointment if insurance has changed. A copy of the card should be made if a current copy is not on file.

Confirm Member Identity

Ask to See Identification (ID) Cards

To prevent fraud and abuse, Providers should confirm the identity of the person presenting the cards. Claims submitted for services rendered to non-eligible members will not be eligible for payment.

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

INTRODUCTION AND GENERAL CLAIMS GUIDELINES

We need your help to achieve our goal of rapid and efficient claims payment. Follow these guidelines to help the process go smoothly.

Share this section with your staff, and, if applicable, with your billing service agent and electronic data processing service agent. It is important that everyone involved understand the guidelines for preparing and submitting claims for services to Plan members.

Submitting a Correct—Clean Claim

Submit claims with all fields completed as outlined in this chapter and in accordance with HIPAA requirements. Claims submitted as outlined in this chapter are called—clean. This section assists you in understanding how to submit a claim to us correctly the first time, which may help avoid delays in processing.

A Claim is considered to be a "Clean Claim," when it meets the minimum requirements:

- All attachments and supplemental information; or documentation needed to provide "reasonably relevant information" information necessary to determine payor liability and the following information:
    - Provider name and address;
    - Member name, date of birth, and social security number;
    - Date(s) of service;
    - International Classification of Diseases (ICD-10CM) codes;
    - Revenue, CPT, or HCPCS codes;
    - Billed charges for each services or item provided;
    - Place of service or UB92 Bill Type;
    - Provider tax ID number or social security number;

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

- The following fields of the CMS-1500 claim form must be completed before a claim can be considered a "clean claim:"

Field 1: Type of insurance coverage	Field 12: Information release ("signature on file" is acceptable)
Field 1a: Insured ID number	Field 13: Assignment of benefits ("signature on file" is acceptable)
Field 2: Patient's name	Field 14: Date of onset of illness or condition
Field 3: Patient's birth date and sex	Field 17: Name of referring physician (if applicable)
Field 4: Insured's name	Field 21: Diagnosis code
Field 5: Patient's address	Field 23: Prior authorization number (if any)
Field 6: Patient's relationship to insured	Field 24 I, J: Non-NPI provider information
Field 7: Insured's address (if same as patient address; can indicate "same")	Field 25: Federal tax ID number
Field 8: Patient's status (required only if patient is a dependent)	Field 28: Total charge
Field 9: Other insurance information	Field 31: Signature of provider including degrees or credentials (provider name sufficient)
Field 10: Relation of condition to: employment, auto accident or other accident;	Field 32: Address of facility where services were rendered
Field 11: Insured's policy or group	Field 32a: National Provider Identifier (NPI);
Field 11c: Insurance plan or program name	Field 33: Providers billing information and phone number
Field 11d: Other insurance indicator	Field 33a: National Provider Identifier (NPI); and

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

- The following fields of the UB-04 CMS-1450 claim form must be completed for a claim to be considered a "clean claim:"

Field 1: Servicing Providers name, address, and telephone #	Field 43: Revenue descriptions
Field 3: Patient's control or medical record number	Field 44: HCPCS/Rates/HIPPS Rate Codes
Field 4: Type of bill code	Field 45: Service/creation date (for outpatient services only)
Field 5: Providers federal tax ID number	Field 46: Service units
Field 6: Statement Covers Period From/Through	Field 47: Total charges
Field 8: Patient's name	Field 50: Payor(s) information
Field 9: Patient's address	Field 52: Information release
Field 10: Patient's birth date	Field 53: Assignment of benefits
Field 11: Patient's sex	Field 56: PI
Field 12: Date of admission	Field 58: Insured's name
Field 13: Hour of admission	Field 59: Relationship of patient to insured
Field 14: Type of admission/visit	Field 60: Insured's unique ID number
Field 15: Admission source code	Field 62: Insurance group number(s) (only if group coverage)
Field 16: Discharge hour (for maternity only)	Field 63: Prior authorization or treatment authorization number (if any)
Field 17: Patient discharge status	Field 67: Principal diagnosis code
Fields 31-36: Occurrence information (accidents only)	Field 69: Admitting diagnosis code (inpatient only)
Field 38: Responsible party's name and address (if same as patient can indicate "same")	Field 74: Principal procedure code and date (when applicable); and
Fields 39-41: Value codes and amounts	Field 76: Attending physician's name and ID (NPI)
Field 42: Revenue code	

- Emergency Services: Although emergency services or out of area urgently needed services do not require authorization, in order to be considered a "complete claim," the claim must include a diagnosis. The diagnosis must be immediately identifiable as emergent or out-of-area urgent and the medical records are required to determine medical necessity and urgency.

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

Claims submitted without the above mandatory information "non-clean claims" are not accepted and will be returned to the Provider. In those cases, Providers need to fully complete and return the corrected claim with the Return to Provider Form within 30 calendar days for processing.

Claim Forms

Generally, there are two types of forms used for submitting claims for Plan reimbursement. They are:

- The CMS-1500 Claim Form for professional services
- The CMS-1450 (UB-04) Claim Form for institutional services

A general description of how to complete each of these sample forms is available at the end of this chapter. Select the form name to link to a copy of the form and a description of each of the fields and the information required in each.

These forms are available in both electronic and hard copy/paper format.

Using the wrong form or not correctly or completely filling out the form causes the claim to be returned, resulting in processing and payment delays.

Claim Filing Limits

Only submit claims after service is rendered. Claims submitted without the above mandatory information—"non -clean claims" are not accepted and will be returned to you. You will need to fully complete and return the corrected claim with the Return to Provider Form within 30 calendar days for processing.

Submit claims as soon as possible following delivery of service to avoid delays in processing.

In accordance with Title 28, California Code of Regulations (CCR) Section 1300.71, all misdirected claims received by Seaside Health Plan from the Health Plan; or from individual provider(s) submitted in error, will be forwarded to the proper payor within ten (10) working days of receipt of the claim.

Determine filing limits as follows:

- If the Plan is primary, use the length of time between the last date of service on the claim and the Plan's receipt date.
- If the Plan is secondary, use the length of time between the other payor's notice or Remittance Advice (RA) date and the Plan's receipt date.

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

Form	Type of Service to be Billed	Time Limit to File
CMS-1500 Claim Form	Professional services (physician and other professional services). Specific ancillary services, including physical and occupational therapy, skilled nursing facilities (SNF), and speech therapy.	For services provided to members, file a clean claim within **90 days** after the date of service for contracted Providers and within **180 days** after the date of service for non-contracted.
	Ancillary services, including: Audiologists, ambulance, ambulatory surgical center, dialysis, durable medical equipment (DME), diagnostic imaging centers, hearing aid dispensers, home infusion, home health, hospice, laboratories, prosthetics and orthotics, and free-standing SNFs. Some ancillary Providers may use a CMS-1450 if they are ancillary institutional Providers. Ancillary charges by a hospital are considered facility charges.	For services provided to our HMO members, file a clean claim within **90 days** from the date of service.
CMS-1450 (UB-04) Claim Form	Hospitals and institutions	For services provided to our HMO members, file a clean claim within **90 days** from the date of service.

Other Filing Limits

	Description	Time Limit to File
Third Party Liability (TPL) or Coordination of Benefits (COB)	If the claim has COB or TPL and requires submission to a third party before submitting to us, the filing limit starts from the date on insurance payment or denial from the third party.	From the date on insurance payment or denial from the third party, follow the applicable claims filing time limits set forth above.
Checking Claim Status	Claim status may be checked any time on Seaside Health Plan Provider Web Portal (www.SeasideHealthPlan.org), the provider home page.	After **30 business days** from the Plan's receipt of a clean claim, submit a Claim Follow-up Request Form.

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

Claim Follow-Up Form or Mailback Form	To submit a corrected claim following the Plan's request for more information or correction to claim or to follow up a claim that has not been paid, denied or contested.	Provider must return requested information to the Plan within **90 calendar days** from the date of the Plan's request for correction.
Provider Dispute	Providers may request a claim reconsideration in writing with a Provider Dispute Resolution Request Form	The request for claim reconsideration must be received within **365 days** from the receipt of the Plan's RA.
Plan Response to Provider Dispute Resolution Request	The Plan's response time to investigate and make a determination based on guidelines	The Plan sends acknowledgement within **15 calendar days** of receipt of paper claim disputes and **2 working days** for Electronic Data Exchange (EDI) claim disputes. Determination made in **45 business days** from the Plan's receipt of dispute or amended dispute.

Claims Correspondence Mailing Address

Seaside Health Plan
PO Box 830459
Birmingham, AL 35283

If feasible, we will notify Providers in writing of any changes in any claims submission address at least 30 days prior to the effective date of the change. If we are unable to provide 30 days' notice, we will give Providers a 30-day extension on their claims filing deadline to ensure claims are routed to the correct processing center.

Questions about Claims

Call the Seaside Health Plan (855) 367-7747 or email SeasideClaim@MemorialCare.org with questions about claims, including completing the forms.

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

SUBMITTING A CLAIM

There are two methods for submitting a claim:

- Electronic Data Interchange (EDI)
- Paper or —hard copy

Electronic Claims

Submit claims electronically through a Plan-approved electronic billing system software vendor or clearing-house. Completion of electronic claim submission requirements can speed claim processing and prevent delays.

If you use EDI, you must include:

- Billing Provider Name
- Rendering Provider
- Legal Name
- License Number (if applicable)
- Medicare Number (if applicable)
- Federal Provider Tax ID Number
- Medi-Cal ID Number
- National Provider Identifier (NPI)

We cannot be responsible for claims never received. Providers must work with their vendors to ensure files are successfully submitted to us. Failure of a third party to submit a claim to us may risk the Providers claim being denied for untimely filing if those claims are not successfully submitted during the filing limit.

Contact our Seaside Health Plan Claims Department at (855) 367-7747 or send an e-mail to SeasideClaim@MemorialCare.org:

- To learn more about EDI and how to get connected
- For a current list of approved software vendors and clearing-houses
- To submit claims electronically if your system is compatible
- For technical assistance and support (for existing accounts, e-mail Seaside Claim@MemorialCare.org)

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

Electronic data transfers and claims must be HIPAA-compliant and meet federal requirements for EDI transactions, code sets, member confidentiality and privacy.

National Provider Identifier (NPI)

NPI is a 10-position, all-numeric identifier, issued only to Providers of medical and health services and supplies. NPI is one provision of the Administrative Simplification portion of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). NPI improves the efficiency of the health care system and reduces fraud and abuse. NPI is used in all HIPAA transactions by all covered entities.

There are several advantages to using your NPI for claims and billing, especially since it offers you the opportunity to bill with only one number. Other advantages include:

- A simplified billing process since it is no longer necessary to maintain and use legacy identifiers for each plan
- The ease of administering changes for addresses and locations

Providers have only one number for electronically transacting business with any health plan with which they affiliate.

How to Apply for Your NPI

Providers may apply for an NPI online at the National Plan and Provider Enumeration System (NPPES) website at https://nppes.cms.hhs.gov or by obtaining a paper application by calling the NPPES at 1-800-465-3203.

The Centers for Medicare and Medicaid Services (CMS) developed regulations for a batch enumeration called Electronic File Interchange, or EFI. The EFI process is available to large provider groups such as hospitals and provider practice groups. For more information on EFI, go to https://nppes.cms.hhs.gov .

Although a provider may not be currently billing to Medi-Cal or other publicly funded programs, a participating provider must still apply for an NPI with CMS. According to the NPI Final Rule, we can require the NPI on paper claims for our participating Providers.

Entity Type 1 and Entity Type 2 Providers

A health care provider who is an individual human being can apply for an Entity Type 1 NPI. This includes, but is not limited to, physicians, dentists and chiropractors. Organizations, such as hospitals, can apply for an Entity Type 2 NPI. The definition of an organization includes, but is not limited to, hospitals, residential treatment centers, laboratories and group practices.

Online Resources for NPI Information

The following websites offer additional NPI information:

Centers for Medicare and Medicaid Services NPI www.cms.hhs.gov/NationalProvidentStand/

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

National Plan and Provider Enumeration System (Enumerator) http://nppes.cms.hhs.gov/NPPES

Workgroup for Electronic Data Interchange www.wedi.org

National Uniform Claims Committee www.nucc.org

National Uniform Billing Committee www.nubc.org

Paper Claims

Paper claims are scanned for optimal processing and recording of data provided; therefore, even paper claims must be legible and provided in the appropriate format to ensure scanning capabilities. The following paper claim submission requirements can speed claim processing and prevent delays:

- Use the correct form type and be sure the form meets Centers for Medicare and Medicaid Services standards (see http://www.cms.hhs.gov/).
- Use black or blue ink; do not use red ink, as the scanner may not be able to read it.
- Use the Remarks field for messages.
- Do not stamp or write over boxes on the claim form.
- Send the original claim form to us and retain the copy for your records.
- Separate each individual claim form. Do not staple original claims together, as we would consider the second claim an—attachment and not an original claim to be processed separately.
- Information is typed within the designated area of the field:
    - Be sure the type falls completely within the text space and is properly aligned with corresponding information. If using a dot matrix printer, do not use—draft mode since the characters generally do not have enough distinction and clarity for the optical character reader to accurately determine the contents.

Attachments to Paper Claims

Some claims may require additional attachments. Be sure to include all supporting documentation when submitting your claim.

Paper Claim Submission Mailing Address

Seaside Health Plan
PO Box 830459
Birmingham, AL 35283

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

Clinical Submissions Categories

The following is a list of claims categories where we may routinely require submission of clinical information before or after payment of a claim.

- Claims involving pre-certification/prior authorization/pre-determination (or some other form of utilization review) including, but not limited to:
    - Claims pending for lack of pre-certification or prior authorization
    - Claims involving medical necessity or experimental/investigative determinations
    - Claims for pharmaceuticals requiring prior authorization
- Claims involving certain modifiers, including, but not limited to. Modifier 22
- Claims involving unlisted codes
- Claims for which we cannot determine from the face of the claim whether it involves a covered service. Thus the benefit determination cannot be made without reviewing medical records (including, but not limited to, pre-existing condition issues, emergency service-prudent layperson reviews, or specific benefit exclusions. A prudent layperson is a person who possesses an average knowledge of health and medicine.)
- Claims that we have reason to believe involve inappropriate (including fraudulent) billing
- Claims that are the subject of an audit (internal or external) including high-dollar claims
- Claims for individuals involved in case management or disease management
- Claims that have been appealed (or that are otherwise the subject of a dispute, including claims being mediated, arbitrated, or litigated
- Other situations in which clinical information might routinely be requested:
- Requests relating to underwriting (including but not limited to member or physician misrepresentation/fraud reviews and stop loss coverage issues).
    - Accreditation activities
    - Quality improvement/assurance activities
    - Credentialing
    - Coordination of benefits (COB)
    - Recovery/subrogation

Examples provided in each category are for illustrative purposes only and are not meant to represent an exhaustive list within the category.

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

Coordination of Benefits (COB)

COB claims received without these items will be mailed back to you with a request to submit to the other carrier or program first.
Following receipt of the Insurance payment or denial, the claim for the authorized service (with a copy of the Insurance Explanation of Benefit) is then processed, as the payment liability can then be determined.

The filing limit for all COB claims is 180 days for hospitals and institutions and professional services Providers and 365 days for ancillary service Providers, as described above from the date on the other carrier's or program's RA or Notice of Denial of Coverage or Reimbursement.

We encourage you to make every effort to identify and notify Seaside Health Plan of any facts that may be related to auto, worker's compensation, or third-party injury or illness; and to execute and provide documents that may reasonably be required or appropriate for the purpose of pursuing reimbursement or payment from other payors.

When submitting claims as COB, indicate other coverage in:
Boxes 9a-d of the CMS-1500 Claim Form or Boxes 58-62 of the CMS-1450 Claim Form

CLAIMS PROCESSING AND PAYMENT

Claims Processing

All claims are assigned a unique Document Control Number (DCN). The DCN identifies and tracks claims as they move through the Claims Processing System. This number contains the Julian date, which indicates the date the claim was received. It monitors timely submission of a claim.

DCNs are composed of 11 digits:

- 2-digit Plan year
- 3-digit Julian date
- 2-digit reel identification
- 4-digit sequential

Claims entering the system are processed for verification of member coverage and automatically apply the appropriate co-payments, coinsurance and deductibles. The claims processing system allows claim item pricing based on user-defined adjudication tables. Each claim is subjected to a comprehensive series of check points called ―Levels of Adjudication. The Levels of Adjudication edits verify and validate all claim information to determine if the claim should be paid, denied, or suspended for manual review.

The following claim status codes are applied to each claim invoice to track the status of a claim:

- E status (Approved Claim);
- X (Denied).

- S status (Suspended, unprocessed claim);
- A status (Updated to financial);
- P status (Processed, Finalized);

Providers are responsible for all claims submitted with their provider number, regardless of who completed the claim. Providers using billing services must ensure that their claims are handled properly.

Entities submitting claims for services rendered by a health care provider are subject to Medi-Cal suspension if they submit claims for a provider who is suspended from Medi-Cal.

Claim Return for Additional Information

Claims submitted without all necessary information "non-clean claims" are not accepted and will be returned to you. You will need to fully complete and return the corrected claim within 30 calendar days for processing with the Return to Provider Form and follow the instruction included on how to resubmit the claim.

Claim Filing with another Payor

If a provider files a claim with the wrong payor and provides documentation verifying the initial timely claims filing to us (within the applicable claims filing time limits set forth above in this chapter from the date of the other carrier's denial letter or RA Form), we process the Providers claim without denying it for failure to file within our filing time limits.

Claims Payment

Seaside Health Plan reimburses each complete claim, or portion thereof, whether in state or out of state, no later than 45 working days after the date of receipt of the complete claim for HMO lines of business and 30 working days the date of receipt of the complete claim for non-HMO lines of business (PPO and POS).

Claims Overpayment Recovery Procedure

When an overpayment is discovered, we initiate the overpayment recovery process by sending a letter to the provider requesting a refund. Return all overpayments to us upon the Providers receipt of the notice of overpayment. Mail the check and a copy of the overpayment notification to:

Seaside Health Plan
2840 Long Beach Boulevard,
Suite 120
Long Beach, CA 90806

If the provider contests the notice of reimbursement of the overpayment of a claim, the provider must submit a written notice to Seaside Health Plan within **30 working days** of the receipt of the notice stating the basis upon which the provider believes the claim was not overpaid.

If the provider does not contest the notice of reimbursement, the provider must send reimbursement within **30 working days** of receipt of the notice of overpayment of a claim.

If we do not hear from the provider or receive payment within 30 days, the overpayment amount is deducted from claims payments.

In cases when we determine that recovery is not feasible, the overpayment is referred to a collection service.

Checking Claim Status

Providers should receive a response from us within **30 business days** of receipt of a clean claim.

You can check the status of your claim by doing either of the following:

- Seaside Health Plan has a website (www.seasidehealthplan.org) that includes a provider portal designed to allow Providers to check claim status 24 hours per day, 7 days per week.

- Seaside Health Plan has a call center available Monday –Friday 8am-5pm, with staff who can answer your questions claim status.

CLAIM RETURNED FOR INFORMATION

We send a request for additional or corrected information to the provider when the claim cannot be processed due to incomplete, missing, or incorrect information in the original claim submission.

The request for information includes a form that allows the provider to return the requested information in an easy-to-follow format. This form must be returned with the requested information in order to process the claim.

We may also request additional information retroactively for a claim that has already been paid. The same form is used for Plan requests for information.

Time Frame for Returning Requested Information

Upon receipt of this request for more information, the provider must provide the additional information within **30 days** of the Plan's request for information.

How to Submit Requested Additional Information

To re-submit additional or corrected information on a claim, Providers should send:

- A copy of the form requesting more information

- Any and all supporting documentation (such as records, reports) that the physician or provider deems pertinent or that has been requested by us

- A copy of the original/corrected CMS-1500 or CMS-1450 Claim Form.

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

Common Reasons for Rejected and Returned Claims

Problem	Explanation	Resolution
Duplicate Claim Submission	Duplicate claims are submitted before the applicable processing time frame has passed. Overlapping services dates for the same services create a question about duplication.	Wait to resubmit a claim until the appropriate time frame for processing has passed. Then, look up claim status on the provider website to check claim status.
Authorization Number Missing/ Doesn't Match Services	The Authorization Number is missing or the approved services do not match with the services described in the claim.	Confirm that the Authorization Number is on the claim form (CMS-1500, Box 24 and CMS-1450, Box 63) and that the approved services match the provided services.
Missed Filing Limit	The time frame for submitting a claim for reimbursement is determined by the applicable Seaside Health Plan State Sponsored Business Participating Provider Agreement and the type of services provided (professional, ancillary or institutional).	Be sure to submit the claim within: • 90 days (contracted Providers) and 180 days (non-contracted Providers) from date of service for professionals (CMS-1500 Form) • 90 days (contracted Providers) and 180 days (non-contracted Providers) for institutions (CMS-1450 Form)
Missing Codes for Required Service Categories	Current HCPCS and CPT Manuals must be used because changes are made to the codes quarterly or annually. Manuals may be purchased at any technical book store or call the American Medical Association or the Practice Management Information Corporation to order manuals.	Make sure all services are coded with the correct codes (see lists provided). Check the code books or ask someone in your office familiar with coding.
Unlisted Code for Service	Some procedures or services do not have a code associated with them, so an unlisted procedure code is used.	We need a description of the procedure and medical records when appropriate in order to calculate reimbursement. For DME, prosthetic devices, hearing aids, or blood products, we require a manufacturer's invoice. For drugs/injections we require the
By Report Code for Service	Some procedures or services information is missing.	We need a description of the procedure and medical records when appropriate to calculate reimbursement. For DME, prosthetic devices, hearing aids or blood products, we require a manufacturer's invoice. For drugs/injections, we require the NDC number.

Unreasonable Numbers Submitted	Unreasonable numbers, such as —9999 may appea in the Service Units fields.	Be sure to check your claim for accuracy before submitting it for processing.
Submitting Batches of Claims	Stapling claims together can make the subsequent claims appear to be attachments rather than individual claims.	Make sure each individual claim is clearly identified and not stapled to another claim.
Incorrect Return of Requested Information	When we request additional information, please include a Provider Dispute Resolution Request form with the request. Provider Dispute Resolution Request form can be found by visitng www.seasidehealthplan.org	Be sure to attach records or corrected claim to the original Provider Dispute Resolution Request form. Send each Form in a separate envelope to be sure each is identified as an individual response.
Nursing Care	Nursing charges are included in the hospital and outpatient care charges. Nursing charges that are billed separately are considered unbundled charges and are not payable. In additional, we will not pay claims using different room rates for the same type of room to adjust for nursing care.	Do not submit bills for nursing charges.
Hospital Medicare ID Missing	A Medicare ID number is required to process. Hospitals claim at their appropriate contracted rates.	On the CMS-1450 Form, hospitals must enter their Medicare ID number in Box 64.

PROVIDER DISPUTE RESOLUTION

If a provider does not agree with the outcome of a claim decision, the provider can file a Provider Dispute Resolution (PDR) request with us.

Time frame for Filing a Dispute

Deadlines for filing disputes must be within 365 days after a plan's action, or 365 days after filing the claim, if no action is taken.

How to File a Dispute

Provider disputes must be submitted to Seaside Health Plan's provider appeals department in writing or on the Provider Dispute Resolution Form. The original claim number must link disputes to a claim.

Include information that may affect the outcome of the dispute, including:

- A copy of the original/corrected CMS-1500 or CMS-1450 Claim Form
- Any and all supporting documentation (such as records, reports) which the claimant deems pertinent or that we have requested

When Seaside Health Plan does not receive all the information necessary to make a decision, Seaside Health Plan will send the provider the following within thirty (30) calendar days of our receipt of the appeal request:

- Written notice of what is required;
- Date the information is due;
- A reminder that failure to send the information within the allowed thirty (30) day time frame will result in closure of the appeal with no further review.

Provider Dispute Address

Mail the Provider Dispute Resolution form and supporting documentation to:
Seaside Health Plan
2840 Long Beach Boulevard,
Suite 120
Long Beach, CA 90806-7506

Plan Response to Provider Dispute Resolution (PDR) Request

We send an acknowledgement of receipt Provider disputes in writing according to the following timeframes:

- Within 15 working days of receipt for paper claim disputes
- Within 2 working days for EDI claim disputes.

Seaside Health Plan resolves and issue written determination of disputes within 45 working days after the date of receipt of disputes or amended disputes.

CMS-1500 CLAIM FORM

Who Should Use a CMS-1500 Claim Form?

All professional Providers and vendors should bill us using the most current version of the CMS-1500 Form. Refer to the *Sample Section from the CMS-1500 (08-05) Claim Form* section for a sample.

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

Completing a CMS-1500 Claim Form

Complete all the fields for reimbursement. Refer to the *CMS-1500 (08-05) Claim Form Fields* section for complete instructions.

Coding—Professional

To be sure that claims are processed in an orderly and consistent manner, standardized code sets must be used.

The Healthcare Common Procedure Coding System (HCPCS) provides codes for billing for a variety of services. These codes are sometimes called National Codes. HCPCS consists of two principal subsystems, referred to as Level 1 and Level 2 of the HCPCS.

- Level 1 consists of Current Procedural Terminology (CPT) codes maintained by the American Medical Association (AMA). CPT codes are represented by five numeric digits.

- Level 2 consists of other codes that identify products, supplies and services not included in the CPT codes, such as ambulance and durable medical equipment (DME). These are sometimes called the alpha-numeric codes because they consist of a single alphabetical letter followed by four numeric digits.

Medi-Cal Local Codes and Modifiers

In addition to the HCPCS, the California Department of Health Care Services (DHCS) created a set of additional codes for its Medi-Cal Program, sometimes called Local Codes. These codes identify services and products specific to Medi-Cal.

Medi-Cal also provides for modifiers to HCPCS.

To ensure accurate handling and prompt payment of claims, use the following national guidelines when coding claims:

- Current Procedural Terminology Codes (CPT): Refer to the current edition of the Physicians' CPT manual, published by the American Medical Association; to order, call 1-800-621-8335.

- Healthcare Common Procedure Coding System (HCPCS): Refer to the current edition of HCPCS published by the Centers for Medicare and Medicaid Services (CMS); to order, call 1-800-633-7467.

- International Classification of Diseases, 10th Revision (ICD-10 Procedure Codes): Practice Management Information Corporation. Applicable ICD-10 procedure codes must be in Boxes 80–81 of the CMS-1450 Form when the claim indicates a procedure was performed; to order, call 1-800-633-7467.

- UB-04Manual, Uniform Billing Procedures, published by the California Healthcare Association; to order, call 1-800-494-2001.

- Medi-Cal Local Only Codes (Local Only Codes): Use Local Only Codes until the state remediates the codes; do not use Local Only Codes for dates of service after the remediation date; Local Only Codes billed after the remediation date will be denied for use of an invalid procedure code (Medi-Cal only).

- Modifier Codes: Use modifier codes when appropriate with the corresponding Local Only, HCPCS or CPT codes; for paper claims, all modifiers should be billed immediately following the procedure code in Box 24D of the CMS-1500 or in Box 44 of the CMS-1450 Claim Forms with no spaces.

Use the Additional Code Tables: Medi-Cal for commonly used codes for professional services.

On-Call Services

Insert **On-Call** for PCP in Box 23 of the CMS-1500 Claim Form when the rendering physician is not the PCP, but is ―covering for‖ or has received permission from the PCP to provide services that day.

Prior Authorization Number

Indicate the prior authorization number or other authorization information in Box 23 of the CMS-1500 Claim Form.

Member ID Number
Use the member's CIN (Client Index Number) when billing, whether submitting electronically or by paper.

Use the member's Plan ID card number, not the number on the Identification Card issued by the State.

Physician License Number

Indicate the rendering physician's state-issued license number in Box 24 of the CMS-1500 Form. Missing or invalid license numbers may result in nonpayment.

Mid-level practitioners must submit claims with their name and license number in Box 19 of the CMS-1500 and the supervising physician's license number in Box 24 of the CMS-1500 Form. The following are defined as mid-level:

- Physician Assistants

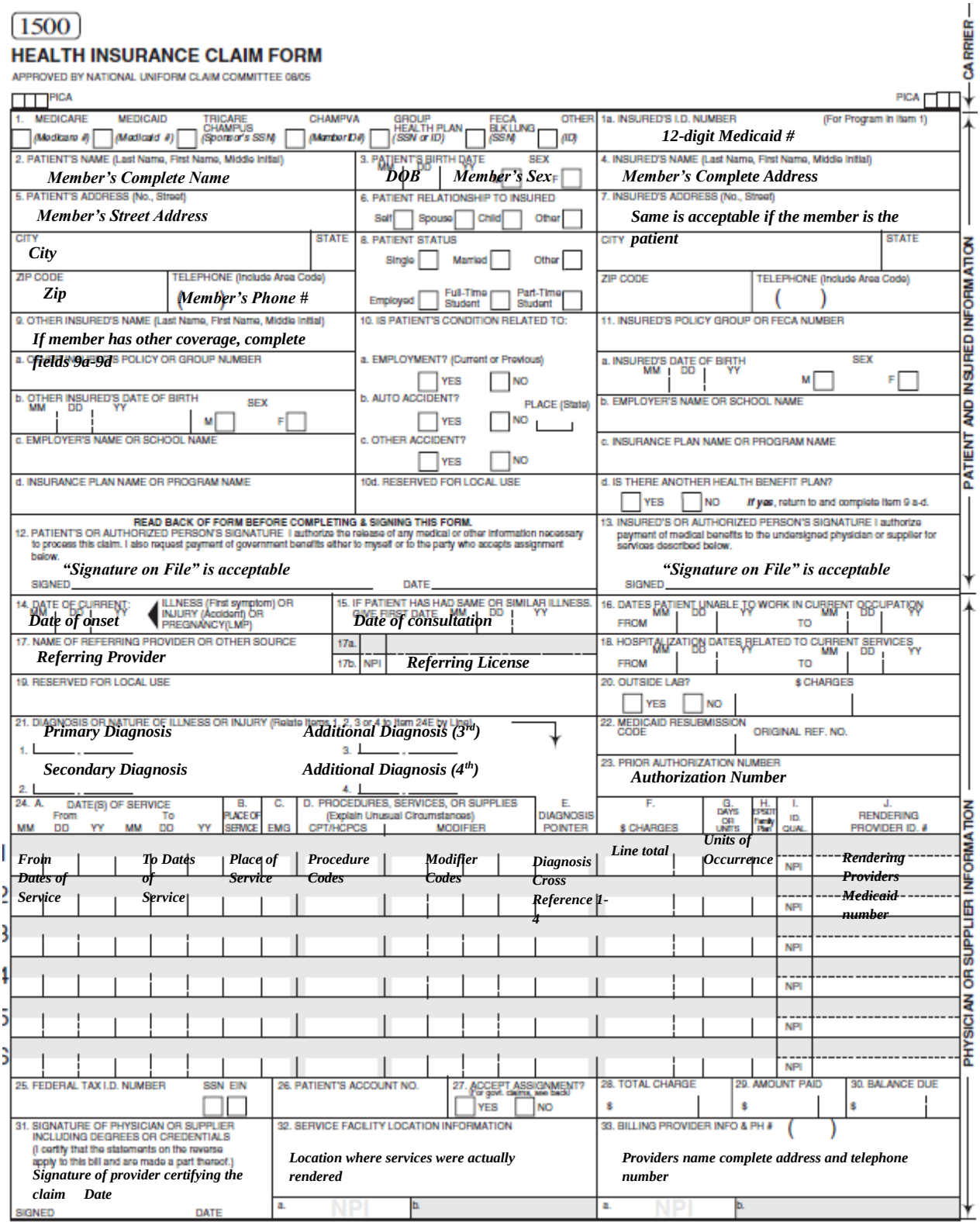
- Nurse Practitioners

- Certified Nurse Midwives

Refer to the CMS-1500 (08-05) Claim Form Fields section for sample field descriptions for the CMS-1500 (08/05) Claim Form or visit the Centers for Medicare and Medicaid Services website at www.cms.hhs.gov/forms.

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

Sample Section from the CMS-1500 (08-05) Claim Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1) — *12-digit Medicaid #*

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) — *Member's Complete Name*

3. PATIENT'S BIRTH DATE MM DD YY — *DOB* SEX M F — *Member's Sex*

4. INSURED'S NAME (Last Name, First Name, Middle Initial) — *Member's Complete Address*

5. PATIENT'S ADDRESS (No., Street) — *Member's Street Address*

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street) — *Same is acceptable if the member is the patient*

CITY — *City* STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE — *Zip* TELEPHONE (Include Area Code) — *(Member's Phone #*

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) — *If member has other coverage, complete fields 9a-9d*

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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. — *"Signature on File" is acceptable*

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. — *"Signature on File" is acceptable*

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) — *Date of onset*

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY — *Date of consultation*

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — *Referring Provider*

17a.

17b. NPI — *Referring License*

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. *Primary Diagnosis*

2. *Secondary Diagnosis*

3. *Additional Diagnosis (3rd)*

4. *Additional Diagnosis (4th)*

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER — *Authorization Number*

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From Dates of Service	*To Dates of Service*	*Place of Service*		*Procedure Codes*	*Modifier Codes*	*Diagnosis Cross Reference 1-4*	*Line total*	*Units of Occurrence*		NPI	*Rendering Providers Medicaid number*
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

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.) — *Signature of provider certifying the claim Date*

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION — *Location where services were actually rendered*

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( ) — *Providers name complete address and telephone number*

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-093-0999 FORM CMS-1500 (08/05)

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

CMS-1500 (08-05) Claim Form Fields

If the claimant does not complete these fields on the CMS-1500 Form, the claim may be delayed or returned for additional information.

Field #	Title	Explanation
Field 1	Medicaid/Medicare/Other ID	If claim is for Medi-Cal, put an X in the Medicaid box. If the member has both Medi-Cal and Medicare, put an X in both boxes. Attach a copy of the form submitted to Medicare to the claim.
Field 1a	Insured's ID Number	From the Plan member's ID Card. Make sure to use the member's CIN number from the paper ID card, not the number from the State's card.
Field 2	Patient's Name	Enter the last name first, then the first name and middle initial (if known). Do not use nicknames or full middle names.
Field 3	Patient's Birth Date	Write date of birth as MM/DD/YY (month, day, year) format. For example, write September 1, 1993 as 090193. If the full date of birth is not available, enter the year, preceded by 0101.
Field 4	Insured's Name	Same is acceptable if the insured is the patient (not required for Medi-Cal).
Field 5	Patient's Address/Telephone Number	Enter complete address. Include any unit or apartment number. Include abbreviations for road, street, avenue, boulevard, place, or other common ending to the street name. Enter patient's telephone number, including area code.
Field 6	Patient Relationship to Insured	The relationship to the member or subscriber, such as self, spouse, child or other (not required by Medi-Cal).
Field 7	Insured's Address/Telephone Number	"Same" is acceptable if the insured is the patient (not required by Medi-Cal).
Field 8	Patient Status	Check patient's status (single, married, other, employed, full-time student or part-time student). Check all that apply.
Field 9	Other Insured's Name	If there is other insurance coverage in addition to the member's coverage, enter the name of the insured.
Field 9a	Other Insured's Policy or Group Number	Name of the insurance with the group and policy number.
Field 9b	Other Insured's Date of Birth	Enter date of birth in the MM/DD/YY (month, day, year) format.
Field 9c	Employer's Name or School Name	Name of other insured employer or school.
Field 9d	Insurance Plan Name or Program Name	Name of Plan Carrier.
Field 10	Patient's Condition Related To	Include any description of injury or accident, including whether it occurred at work.

Field 10a	Related to Employment?	Y or N. If insurance is related to Workers Compensation, enter Y.
Field 10b	Related to Auto Accident/Place?	Y or N. Enter the state where the accident occurred.
Field 10c	Related to Other Accident?	Y or N.
Field 10d	Reserved for Local Use	
Field 11a-b	Insured's Policy Group or FECA Number; Date of Birth, Sex, Employer or School Name	Complete information about Insured, even if same as Patient.
Field 14	Date of Current	Injury, Illness, or Pregnancy (if applicable)
Field 21	Diagnosis or Nature of Illness or Injury	Enter the appropriate diagnosis code or nomenclature. Check the manual or with a coding expert if not sure.
Field 24a	Date(s) of Service	If dates of service cross over from one year to another, submit two separate claims (for example, one claim for services in 2006, one claim for services in 2007).
Field 24b	Place of Service	
Field 24d	Procedure, Services or Supplies	Enter the appropriate CPT codes or nomenclature. Indicate appropriate modifier when applicable. Do not use NOC Codes unless there is no specific CPT code available. If using an NOC Code, include a narrative description.
Field 24e	Diagnosis Code	Use the most specific ICD-10 code available.
Field 24f	$Charges	Charge for each single line item.
Field 24g	Days or Units	If applicable
Field 24H	EPSDT Family Plan	Enter Y for EPSDT or N for non-EPSDT.
Field 25	Federal Tax ID Number	Enter this nine-digit number.
Field 28	Total Charge	Total of line item charges
Field 31	Full Name and Title of Physician or Supplier	Actual signature or typed/printed designation is acceptable.
Field 32	Provider Servicing Address	Include any suite or office number. Include abbreviations for road, street, avenue, boulevard, place, or other common ending to the street name.
Field 33	Physician's or Supplier's Billing Name	Provider Identification Number (the number we assigned to the provider)

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

CMS-1450 (UB-04) CLAIM FORM

Who Should Use the CMS-1450 Claim Form?

All Medicare-approved facilities should bill us using the most current version of the CMS-1450 Claim Form.

Coding

To be sure that claims are processed in an orderly and consistent manner, standardized code sets must be used.

The Healthcare Common Procedure Coding System (HCPCS) provides codes for billing for a variety of services. These codes are sometimes called National Codes. HCPCS consists of two principal subsystems, referred to as Level 1 and Level 2 of the HCPCS.

- Level 1 consists of Current Procedural Terminology (CPT) codes maintained by the American Medical Association (AMA). CPT codes are represented by five numeric digits.

- Level 2 consists of other codes that identify products, supplies and services not included in the CPT codes, such as ambulance and durable medical equipment (DME). These are sometimes called the alpha-numeric codes because they consist of a single alphabetical letter followed by four numeric digits.

Medi-Cal Local Codes and Modifiers

In addition to the HCPCS, the California Department of Health Care Services (DHCS) created a set of additional codes for its Medi-Cal Program, sometimes called Local Codes. These codes identify services and products specific to Medi-Cal.

Medi-Cal also provides for Modifiers to HCPCS.

Inpatient Coding—Institutional

- CMS-1450 Revenue Codes: Code claim forms using appropriate CMS-1450 revenue codes; to order the current Billing Procedures Manual, call 1-800-494-2001.

- ICD-10 Procedure Codes: Applicable ICD-10 procedure codes must be in Boxes 70-74e on the UB-04 Form when the claim indicates a procedure was performed; to order the current Code Book, call 1-800-633-7467.

- Modifier Codes: Use modifier codes when appropriate; refer to the current edition of the Physicians' Current Procedural Terminology Manual published by the American Medical Association (AMA).

Note: Bill surgical supply charges using the appropriate procedure code for the services rendered; they must be accompanied with a ZM (without anesthesia) or ZN (with anesthesia) modifier.

Outpatient Coding—Institutional

- HCPCS Codes: Refer to the current edition of CMS Common Procedure Coding System published by the Centers for Medicare and Medicaid Services (CMS); to order, call 1-800-633-7467.

- CPT Codes: Refer to the current edition of the Physicians' Current Procedural Terminology manual published by the American Medical Association (AMA); we require that when outpatient services are billed, they must have itemized CPT/HCPC/local use codes; use of Revenue Codes only on outpatient claims will result in a delay or denial of the claim for lack of information; to order, call 1-800-621-8335.

Note: Medi-Cal Only–-Use the appropriate HCPCS or CPT codes. The use of Revenue Codes only on outpatient claims may result in a delay or denial of the claim for lack of information.

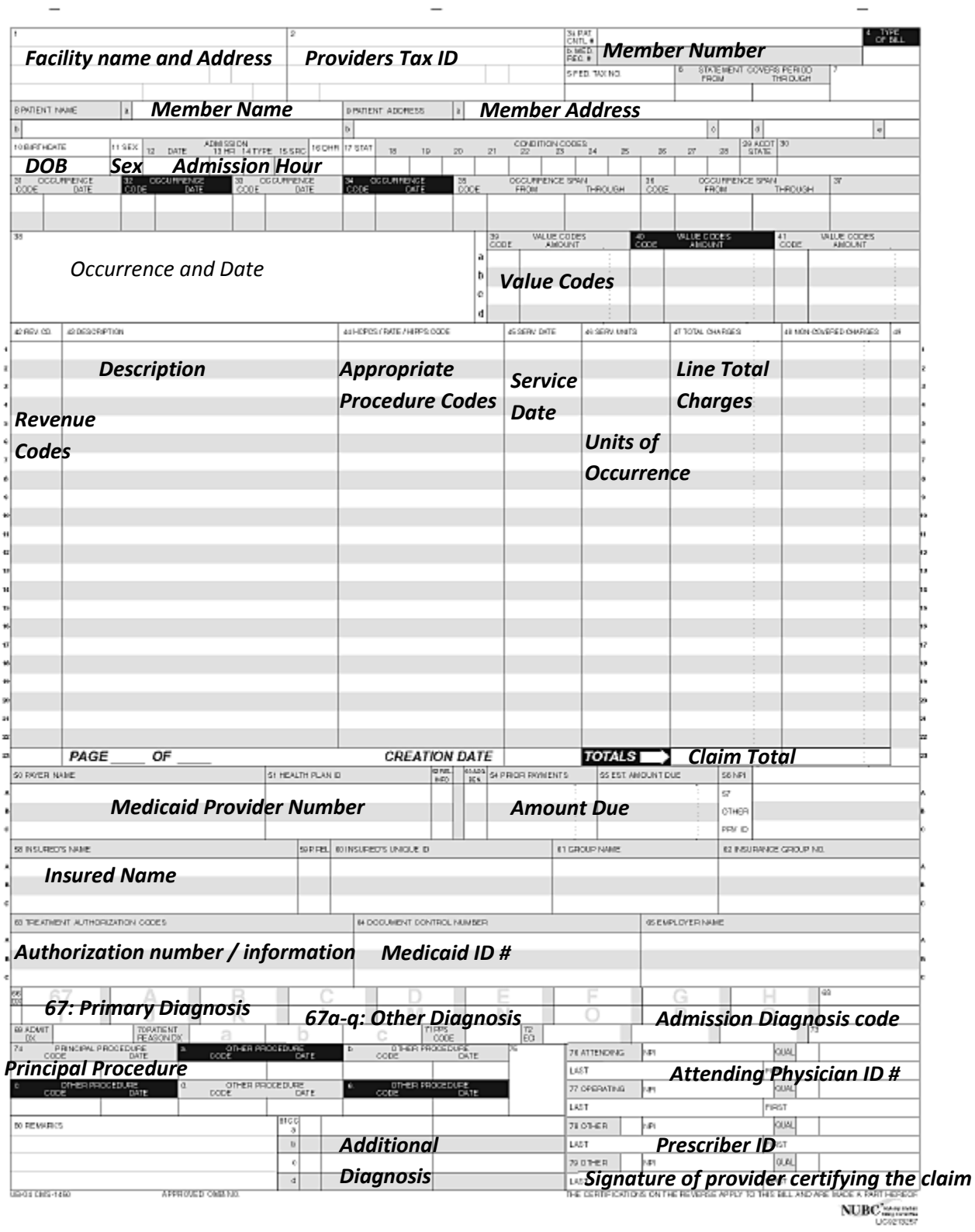
When billing Medicare/Medi-Cal claims, submit with HCPCS/CPT and corresponding Revenue Codes.

Member ID Number

Use the member's CIN (Client Index Number) when billing, whether submitting electronically or by paper.

Go to Recommended Fields for CMS-1450 for field descriptions or visit the Centers for Medicare and Medicaid Services website at www.cms.hhs.gov/forms.

Sample Section from the CMS-1450 Form with Instructions



CHAPTER 4: CLAIMS AND BILLING GUIDELINES

Recommended Fields for CMS-1450

The following guidelines will assist in completing the CMS-1450 Form (—R‖ indicates a required field).

The "PAGE___OF__" and "CREATION DATE" fields on Line 23 should be reported on all pages of a multiple-page form.

Field	#	Box Title	Description
1	R	Blank	Facility name, address, and telephone number.
2		Blank	
3a		PAT. CNTL #	Member's account number.
3b		MED. REC #	Member's record number, which can be up to 20 characters long.
4	R	TYPE OF BILL	Enter the Type of Bill (TOB) Code.
5		FED. TAX NO.	Enter the Providers Federal Tax ID number
6	R	STATEMENT COVERS PERIOD	"FROM" and "THROUGH" date(s) covered by the claim being submitted
7		Blank	Leave blank.
8a–b	R	PATIENT NAME	Member's name.
9a–e	R	PATIENT ADDRESS	Complete address (number, street, city, state, zip code, telephone number).
10	R	BIRTHDATE	Member's date of birth in MM/DD/YY (month, day, year) format.
11	R	SEX	Member's gender.
12	R	ADMISSION DATE	Member's admission date to the facility in MM/DD/YY (month, day, year) format.
13	R	ADMISSION HR	Member's admission hour to the facility in military time (00 to 23) format.
14	R	ADMISSION TYPE	Type of admission.
15	R	ADMISSION SRC	Source of admission.
16	R	DHR	Member's discharge hour from the facility in military time (00 to 23) format.
17	R	STAT	Patient status.
18–28		CONDITION CODES	Enter Condition Code (81) X0 – X9.
29		ACDT STATE	Accident State. Leave blank.
30		Blank	
31–34		OCCURRENCE CODE OCCURRENCE DATE	Occurrence Code (42) and date, if applicable.

35–36		OCCURRENCE SPAN (CODE, FROM, AND THROUGH)	Enter dates in MM/DD/YY (month, day, year) format.
37		Blank	Leave blank.
38		Blank	Enter the responsible party name and address, if applicable.
39–41		VALUE CODES (CODE AND AMOUNT)	Enter Value Codes.
42	R	REV. CD.	Revenue Code. Revenue Codes are required for all institutional claims.
43	R	DESCRIPTION	Description of services rendered
44	R	HCPCS/RATE/HIPPS CODE	Enter the accommodation rate per day for inpatient services or HCPCS/CPT code for outpatient services.
45	R	SERV. DATE	Date of services rendered.
46	R	SERV. UNITS	Number/units of occurrence for each line or service being billed.
47	R	TOTAL CHARGES	Total charge for each line of service being billed
48		NON-COVERED CHARGES	Enter any non-covered charges.
49		Blank	Leave blank.
50		PAYOR NAME	Payor Identification. Enter any third party payors.
51	R	HEALTH PLAN ID	Medicare Provider ID Number/unique Provider ID Number. The billing provider number is required.
52		REL. INFO	Release of information certification indicator.
53		ASG BEN.	Assignment of benefits certification indicator.
54		PRIOR PAYMENTS	Prior payments.
55	R	EST. AMOUNT DUE	Estimated amount due.
56	R	NPI	Enter the NPI Number.
57		OTHER PRIV ID	Enter the other provider ID, if applicable.
58	R	INSURED'S NAME	Member's Name.
59		P. REL	Patient's relationship to insured (N/A: Member is the insured).
60	R	INSURED'S UNIQUE ID	Insured's ID Number — Certificate number on the member's ID card.
61		GROUP NAME	Insured Group Name — enter the name of any other health
62	R	INSURANCE GROUP NO.	Enter the Policy Number of any other health plan.
63		TREATMENT AUTHORIZATION CODES	Authorization Number or authorization information must be entered on this field.
64		DOCUMENT CONTROL NUMBER	The Control Number assigned to the original bill.
65		EMPLOYER NAME	Name of organization from which the insured obtained the other policy.

66	R	DX	Enter the diagnosis and procedure code qualifier (ICD version indicator).
67	R	Blank	Principal Diagnosis Code. Enter the ICD-10 diagnostic
67a–q	R	Blank	Other Diagnosis Codes. Enter the ICD-10 diagnostic codes, if applicable.
68		Blank	Leave blank.
69		ADMIT DX	Admission Diagnosis Code — enter the ICD-10 code.
70a–c		PATIENT REASON DX	Enter the member's reason for this visit, if applicable.
71		PPS CODE	Prospective Payment System (PPS) Code. Leave blank.
72		ECI	External Cause of Injury Code.
73		Blank	Leave blank.
74	R	PRINCIPAL PROCEDURE (CODE/DATE)	ICD-10 principal procedure code and dates, if applicable.
74a–e	R	OTHER PROCEDURE (CODE/DATE)	Other Procedure Codes.
75		Blank	Leave blank.
76	R	ATTENDING	Enter the attending physician's ID Number.
77	R	OPERATING	Enter the Provider Number if you use a surgical procedure on this form.
78–79	R	OTHER	Enter any other Provider Numbers, if applicable.
80		REMARKS	Use this field to explain special situations.
81a–c		CC	Enter additional or external codes, if applicable.

PROFESSIONAL BILLING REQUIREMENTS BY SERVICE CATEGORY

Billing Codes for CHDP

Only CHDP-certified Providers will be reimbursed for services rendered. Providers must use the CMS-1500 claim form or electronic submission to bill for services rendered.

Whether you use the proper claim submission or the electronic submission for your CHDP claims, you must mail the PM-160 Informational Only forms to:

Seaside Health Plan
2840 Long Beach Boulevard,
Suite 120
Long Beach, CA 90806-7506

School-based clinics can bill us electronically. For questions regarding electronic billing, contact Electronic Data Interchange (EDI) at 1-800-227-3983.

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

PM-160 Form Completion

Complete the CHDP PM-160 Information Only form and submit copies to:

- Seaside/Primary Plan with each claim for service
- The local county CHDP office
- Member or parent of member
- The member's medical record

Make sure to include the Providers original signature and the correct county-specific Prepaid Project Code on the PM-160 Form. The Prepaid Project Code prevents incorrect reporting of encounter data.

For a Copy of the PM-160 Form, contact the claimant's local CHDP office. They will sent the PM-160 form pre-printed with Provider of Service information.

By using the appropriate CHDP services codes, Seaside Health Plan can capture accurate claims data which will make the HEDIS review process less intrusive for Providers. Seaside Health Plan follows AAP Prevention Care Guidelines.

Mental Health

For Medi-Cal members only, certain Mental Health Services are carved out to the State.

The PCP is expected to treat members with situational mental health problems, the most common of which are depression and anxiety disorders. For those Medi-Cal members whose mental health problems do not respond to treatment in a primary care setting, referrals must be made to the local county mental health system for assessment and ongoing services as indicated.

Commercial Plans
For commercial plans all Mental Health Services are covered by the Primary Health Plan. Please contact Seaside Health Plan Utilization Management Department for coordination of the referral at (855) 367-7747.

Newborns

Newborns of Medi-Cal members are covered under the mother, using the mother's CIN (Client Index Number), for the month of birth and the following month or until such time as the Department of Health Care Services issues a CIN for the newborn. Services rendered before the CIN is issued to the newborn should be billed using the CIN of the mother, and the name, date of birth, and other information about the newborn. Encourage Medi-Cal members to contact their social worker immediately and fill out all required paperwork to accurately enroll the newborn and prevent any lapse in coverage.

Commercial Plans

Newborns are typically covered through the mother's coverage from her Primary Health Plan for the first 30 days. It is the responsibility of the parents to contact the Primary Health Plan to enroll the newborn within the time period.

Self-Referable Services

Medi-Cal
Members may access the following self-referable services at any time without pre-service review requirements if their benefits allow.

- Diagnosis and treatment of Sexually Transmitted Diseases (STD)
- Testing for the Human Immunodeficiency Virus (HIV)
- Family Planning Services–services to prevent or delay pregnancy
- Abortions (in-network only)
- Annual Well Woman exam (ICD-10 Diagnosis V72.3) (in-network only)
- Prenatal services (in-network only)— obstetric care

Self-referable services may (unless limited by state or federal regulation) be rendered by a willing provider, even those without a contract. We reimburse contracted Providers according to the Providers contract; we reimburse reasonable and customary rates for non-contracted Providers.

Commercial Plan:

- Diagnosis and treatment of Sexually Transmitted Diseases (STD)
- Testing for the Human Immunodeficiency Virus (HIV)
- Family Planning Services–services to prevent or delay pregnancy
- Abortions (in-network only)
- Annual Well Woman exam (ICD-10 Diagnosis V72.3) (in-network only)
- Prenatal services (in-network only)— obstetric care
- Mammograms (in-network only)

Member must use a provider contracted with the primary plan. Refer to Primary Plan.

Sensitive Services

Medi-Cal
Sensitive services are provided for family planning, including contraceptive management, sexually transmitted diseases, including AIDS/HIV, and other sensitive services, including abortion and alcohol/drug treatment for minors over age 12.

PM330 See Susan, Get P&Ps from Apple

Authorization requirements are waived when these services are billed. Members may receive these services from either in-network Providers or out-of-network Providers. Sterilization claims for either gender must include an attachment of the DHCS PM 330 consent form. Sterilization claims submitted without a DHCS PM330 consent form with the appropriate dates and patient signatures will be denied.

Vision Services (Routine)

Refer to the Primary Plan for covered vision services.

Additional Billing Resources

This Provider Operations Manual and information from the following references, provide detailed instructions on uniform billing requirements.

- Current Procedural Terminology (CPT) 2006, American Medical Association. To order, call 1-800-621-8335.
- CMS Common Procedure Coding System (HCPCS), National Level II (current year). To order, call 1-800-633-7467.
- ICD-10 CM (current edition), Volumes 1, 2, 3 (current year) Practice Management Information Corporation. To order, call 1-800-633-7467.

HOSPITAL AND INSTITUTIONAL BILLING REQUIREMENTS BY SERVICE CATEGORY

This section provides special billing requirements applicable to each service listed below. The member's benefits may not cover some of the services listed, so it is important to confirm benefit coverage.

Maternity and Boarder Baby Care

The billing requirements for maternity care apply to all live and still birth deliveries and include payment for all associated services, including, but not limited to, room and board for mother (including all nursing care), nursery for baby (including all nursing care), delivery room/surgery suites, equipment, laboratory, radiology, pharmaceuticals and other services incidental to admission.

The maternity rate does not apply to newborns who are admitted to an intensive care unit or who remain in the hospital as boarder babies after the mother is discharged.

CCS Referrals

Medi-Cal members who have a CCS-eligible condition must be referred to CCS in a timely manner and as directed by the local CCS field office or our Utilization Management Department.

Do not assume because the professional services are authorized by CCS that the facility component will automatically be granted authorization. Facilities must ensure they are paneled and approved

for the procedure or service they are rendering on a CCS-eligible condition to ensure compensation for services rendered.

Therapeutic abortions are excluded for payment under this rate, as well as treatment for ectopic and molar pregnancies or similar conditions.

The maternity care rate covers the entire admission except for admissions that are approved for extension beyond what is contractually indicated on the continuous inpatient days. In such cases, the inpatient acute care requirements apply for each approved and medically necessary service day for the entire admission unless otherwise indicated.

The Boarder Baby requirements are specific only to the days that the baby remains in the hospital nursery after the mother is discharged but do not apply to accommodations in the Neonatal Intensive Care Unit. Prior authorization is required for this extended boarder baby service period. A separate billing must be submitted for the period after the mother is discharged.

Inpatient Acute Care

The billing requirements for inpatient acute care apply to each approved and medically necessary service day in a licensed bed (not covered under another category in this section) and include, but are not limited to, room and board (including all nursing care), emergency room (if connected with admission), urgent care (if connected with admission), surgery and recovery suites, equipment, supplies, laboratory, radiology, pharmaceuticals and other services incidental to the admission. Utilization Management approval is required for all admissions

Inpatient Sub-Acute Care

The billing requirements for inpatient sub-acute care include each approved and medically necessary service day in a duly licensed and accredited facility at the appropriate level of care. Each inpatient sub-acute care admission is considered a separate admission from any preceding or subsequent acute care admission and should be billed separately. Covered services rendered during an admission include, but are not limited to, room and board (including all nursing care), equipment use, supplies, laboratory, radiology, pharmaceuticals and other services incidental to the admission.

Sub-acute care includes levels of inpatient care less intensive than those required in an inpatient acute care setting.
All admissions and levels of care require prior approval.

Emergency Visits

The billing requirements for an Emergency Room visit apply to all emergency cases treated in the hospital Emergency Room (for patients who do not remain overnight) and cover all diagnostic and therapeutic services provided, including, but not limited to, facility use (including all nursing care), equipment, laboratory, radiology, supplies, pharmaceuticals and other services incidental to the Emergency Room visit. Reimbursement for Emergency Room services relates to the emergency diagnosis and can be based on urgent care rates, depending on the diagnosis. Emergency services are services provided in connection with the initial treatment of a medical or psychiatric emergency. ED must notify

Seaside of a member within 30 minutes once stabilized. **Outpatient Laboratory, Radiology and Diagnostic Services**

The billing requirements for outpatient laboratory, radiology and diagnostic services (not included elsewhere) refer to services that include, but are not limited to, clinical laboratory, pathology, radiology and other diagnostic tests. These billing requirements include services rendered in relation to an outpatient visit for laboratory, radiology or other diagnostic services, including, but not limited to, facility use, nursing care (including incremental nursing), equipment, professional services (if applicable), specified supplies and all other services incidental to the outpatient visit. See the fee schedule to view outpatient laboratory, radiology, and other diagnostic services fee schedules (technical component only).

Outpatient radiation therapy is excluded from this service category and should be billed under the requirements of the Other Services category.

Outpatient Surgical Services

The billing requirements for outpatient surgical services apply to each outpatient hospital visit for outpatient surgery services, including, but not limited to, facility use (includes nursing care), equipment, supplies, pharmaceuticals, blood, laboratory, radiology, imaging services, implantable prostheses and all other services incidental to the outpatient surgery visit.

Even though a service is classified by the hospital as an outpatient service, if the member is receiving that service in the hospital as of 12 a.m., the hospital is reimbursed at the inpatient per diem rate.

Billing requirements are based on the highest grouping submitted. See the fee schedule for details. For surgery services that are not defined in the surgery grouping, medical records might be requested by us for review and determination of surgery grouping.

Outpatient Therapies

Outpatient therapy services include physical therapy, occupational therapy, speech therapy, and respiratory therapy. An outpatient therapy visit means a single service date. Outpatient therapy visits include, but are not limited to, facility use (includes all nursing care), therapist/professional services, supplies, equipment, pharmaceuticals and other services incidental to the outpatient therapy visit.

Outpatient Infusion Therapy Visit and Pharmaceuticals

The outpatient infusion therapy visit billing requirements apply to each outpatient hospital visit for infusion therapy services, including, but not limited to, facility use (including all nursing care), equipment, professional services, laboratory, radiology, supplies (for example, syringes, tubing, line insertion kits and so on), intravenous solutions (excluding pharmaceuticals), kinetic dosing and other services incidental to the outpatient infusion therapy visit. An outpatient infusion therapy visit means a single service date.

The outpatient infusion therapy pharmaceuticals billing requirements apply to the drugs (for example, chemotherapy, hydration and antibiotics) used during each outpatient visit for infusion therapy services, except for blood and blood products, which are considered other services.

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

ANCILLARY BILLING REQUIREMENTS BY SERVICE CATEGORY

This section provides special billing requirements applicable to each service listed below. The member's benefits may not cover some of the services listed. Be sure to confirm benefit coverage. Also, consult your Seaside Health Plan State Sponsored Business Participating Provider Agreement for specifics regarding billing for any of these or other services.

The majority of Ancillary claims submitted are for:

- Laboratory and Diagnostic Imaging on a CMS-1500 Form
- Durable Medical Equipment on a CMS-1500 Form

Other types of services are also described.

Laboratory and Diagnostic Imaging

Note: To submit Laboratory and Diagnostic Imaging claims, refer to the guidelines below. (Use the CMS-1500 Form.)

- Billing requirements per contract: Our billing requirements apply to all member claims, except some services administered through Medi-Cal and other state contract programs.
- System edits: Edits are in place for both electronic and paper claims; therefore, claims not submitted in accordance with requirements cannot be readily processed and most likely will be returned.
- Valid coding: For claims submitted to us, valid HCPCS, CPT or Revenue Codes are required for all line items billed, whether sent on paper or electronically. Refer to the specific service category for special coding requirements.
- Split-year claims: For example, for services that begin before December 2012 but extend beyond December 2013, split claims at calendar-year end. This is necessary to accurately track calendar-year deductibles and co-payment maximums.
- Contract change during course of treatment: When a Providers reimbursement is affected by a contract change during a course of treatment, the Provider is required to split the dates of service in order to be reimbursed at the new rate.
- Itemization: Itemization of services is required when the from and through service date is the same.
- Medical records: Medical records for certain procedures might be requested for determination of medical necessity.
- Modifiers: Use modifiers in accordance with your specific billing instructions.

- Unlisted procedures: Services or procedures may be performed by physicians that are not found in CPT; therefore, specific code numbers for reporting unlisted procedures have been designated. When an unlisted procedure code is used, we need a description of the service to calculate the appropriate reimbursement and may request medical records.

  If it is determined a valid Local or National Code exists for an unlisted code, then the claim will not be paid.

- CPT Code 99070: This code (supplies and materials provided by the Provider over and above those usually included with the office visit or other services) is not accepted by us. Health care professionals are to use HCPCS Level II codes, which give a detailed description of the service provided. We will pay for surgical trays only for specific surgical procedures. Surgical trays billed with all other services will be considered incidental and will not be payable separately.

Disposable and Incontinence Medical Supplies

The Department of Health Care Services (DHCS) has implemented Health Insurance Portability and Accountability Act (HIPAA)-mandated changes to Medi-Cal Managed Care billing requirements for disposable and incontinence medical supplies. Below is a reminder of billing criteria required for these claims:

You are required to bill disposable incontinence and medical supplies with HCPCS Level II Codes for contracted items using either ASC X12N 4010A1P electronic format or CMS-1500 Form for paper claims.

You may not use Local ―99‖ Codes for disposable incontinence and medical supplies.

The state requires the use of the Universal Product Number (UPN) information for contracted incontinence and medical supplies; however, we do not require the use of UPN information at this time.

Durable Medical Equipment

Durable Medical Equipment (DME) is covered when prescribed to preserve bodily functions or prevent disability.

DME Pre-service Review

All custom-made DME requires pre-service review; also, some other DME services may require pre-service review.

Prior to dispensing, contact our Utilization Management (UM) Department to determine if the DME services require pre-service review. Services that require pre-service review will be denied if approval is not obtained from UM. The UM Department reviews for medical necessity for all requested services requiring pre-service review. The presence of a HCPCS code does not necessarily indicate benefit coverage or payment for a particular service. Some DME codes may be ―By Report‖ and therefore require additional information for pre-service review as well as for processing at point of claim.

DME Billing

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

DME Providers should bill with the appropriate modifier to identify rentals versus purchases (new or used). Claims that lack the appropriate modifier will be reimbursed at rental price or rejected for corrected billing.

NU is the modifier to designate New; UE is the modifier to designate Used.; RR is the modifier to designate Rental.

Follow these general guidelines for DME billing:

- Use Local or HCPCS Codes for DME or supplies.
- Use miscellaneous codes (such as E1399) when a HCPCS Code does not exist for that particular item of equipment; use of an unlisted code like E1399 cannot be used to describe an expensive or difficult to order item when an adequate code exists for that item; E1399 is By Report.
- Attach the manufacturer's invoice to the claim if using a miscellaneous or unlisted code (such as E1399).
- The invoice must be from the manufacturer, not the office making a purchase.
- Unlisted codes will not be accepted if valid HCPCS Codes exist for the DME and supplies being billed. Catalog pages are not acceptable as manufacturer's invoices.
- Procedure Code L9999 is obsolete.
- Many Local Codes have been remediated and are no longer acceptable for submission.

The correct way to bill for sales tax for DME/supplies is to

- Bill the code for the service with the appropriate modifier for rental or purchased for the amount charged, less the sales tax.
- Bill the S9999 code on a different line with charges only for the sales tax.

For example:

Procedure	Modifier	Amount
E0570	Applicable modifier code to designate a rental is RR.	100.00
S9999	Sales tax will be paid as billed	8.00

DME Rental

Medical documentation from the prescribing doctor is required for DME rentals. Most DME is dispensed on a rental basis only, such as oxygen tanks or concentrators. Rented items remain the property of the DME Provider until the purchase price is reached.

- DME Providers may use normal equipment collection guidelines. We are not responsible for equipment not returned by members.
- Charges for rentals exceeding the reasonable charge for a purchase will be rejected, and rental extensions may be obtained only on approved items.

DME Purchase

DME may be reimbursed on a rent-to-purchase basis over a period of ten months unless specified otherwise at the time of review by our UM Department.

Wheelchairs/Scooters

Medi-Cal wheelchair claims are examined by claims examiners. The examiners follow Medi-Cal guidelines when calculating payments for By Report (customized) wheelchair claims.

By report claims on CMS-1500 Claim Forms must be accompanied by either:

- Manufacturer's purchase invoice, or
- Manufacturer's suggested retail price (MSRP) from a current catalog.
    - If the item was not available on a current catalog, claims must be submitted with a manufacturer's purchase invoice, the catalog page that initially published the item, and the MSRP. The initial date of availability must be documented in the Reserved for Local Use field (Box 19) of the claim.
    - Documentation must include:
        - Item Description
        - Manufacturer Name
        - Model Number
        - Catalog Number
        - Completion of the Reserved for Local Use field (Box 19) on the CMS-1500 Claim Form with the total MSRP of the wheelchair, including all wheelchair accessories, modifications, or replacement parts and the name of the employed Rehabilitation and Assistive Technology of America (RESNA)-certified technician.

Modifiers

For a listing of DME Modifier Codes, see Appendix 1 of the HCPCS 2006 publication available from the American Medical Association (AMA) or log onto the AMA web site (www.ama-assn.org/) for online access.

Other Service Types

Ambulance

Ambulance services, including those for municipalities, should use a CMS-1500 Form to bill for ambulance services. A Transportation Authorization Request (TAR) is required for all non-emergency ground transportation.

- Use appropriate modifiers that describe the “to” and “from” locations.
- In the code fields for Medi-Cal, use the Medi-Cal Local Codes.

More information about Medi-Cal requirements for Ambulance services can be found in the DHCS Operations Manual “Medical Transportation -- Ground Billing Codes and Reimbursement Rates” section. Click
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part2/m ctrangndcd_a05.doc

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

Dialysis

All Dialysis care must be preauthorized (except where Medicare is primary payor). Contact our UM Department for authorization prior to delivery of the service.

Dialysis centers and other entities which perform dialysis may use the CMS-1450 Form or the CMS-1500 Form to bill for dialysis services.

When billing for dialysis, use Medi-Cal Local Codes.

More information about Medi-Call requirements for Dialysis services can be found in the DHCS Operations Manual "Dialysis Examples: UB-04" section. Click http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part2/di alexub_o03o04.doc

Home Health

All Home Health care must be preauthorized. Contact our UM Department. for authorization prior to delivery of the service.

When billing for a Home Health visit, Use a CMS-1450 Form.

When billing for Home Health use Medi-Cal Local Codes.
(See the *Durable Medical Equipment (DME)* for billing for supplies and equipment; See *Home Infusion Therapy* below for billing guidelines for injections given or home infusion therapy.)

Home Infusion Therapy

All Home Infusion Therapy (HIT) claims are priced by an outside vendor, Ancillary Care Management (ACM). ACM prices all the services billed and converts NDC codes appropriate to the infusion codes. ACM then forwards the pricing information to us by daily EDI submission. If a claim is submitted prior to 9 p.m., it is transmitted overnight to us and appears in our system the following business afternoon.

Contracted HIT Providers should submit all HIT claims directly to ACM by logging onto ACM's website at www.acmcentral.com. Providers can call the ACM Help Desk at 1-800-957-9693 to get a User ID issued to access the website. The ACM User Manual is posted on the ACM website.

Coding:

- Provider should enter the appropriate HIT Codes provided by Medi-Cal Local Codes provided to ACM or Per Diem Code in the ―Item ID‖ field and also enter the National Drug Code (NDC) Number with quantity to be billed.
- For Total Parenteral Nutrition (TPN), bill by entering the appropriate ―Per Diem Codes and the B Codes.
- For compounded drugs, bill by entering the appropriate NDC Number.
- Bill by using the appropriate NDC Number and quantity of each unit or per vial.

Synagis

- Providers should submit CPT-4 Code 90378 and the appropriate number of units; 1 unit of 90378 is equivalent to 50 mg.

- Providers should always submit the patient's weight for the date of service being billed.

Hospice

All hospice care must be preauthorized. Contact our Utilization Management (UM) Department for authorization prior to hospice admission.

Hospices should bill for hospice services on the CMS-1450 Form.

- For Medi-Cal, use the appropriate "Z" codes, the range is Z7100 through Z7106. These claims are paid according to DHCS Medi-Cal Hospice rates.

For Medi-Cal members, the Hospice Care section of the Department of HealthCare Services Provider Manual provides detailed billing instructions. Click http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part2/ho spic_m01i00o03o08.doc

Physical Therapy

All physical therapy must be preauthorized. Contact our Utilization Management (UM) Department for authorization prior to delivery of services.

- Physical therapists bill on a CMS-1500 Form. Rehabilitation centers bill on a CMS-1450 or CMS-1500 Form.

- Physical therapy is coded using national HCPCS Codes. When entering modifiers, do not include hyphens.

For Medi-Cal claims, if the requested information does not fit neatly in the Reserved For Local Use field (Box 19) of the claim, type requested information on an 8½ x 11-inch sheet of paper and attach it to the claim.

Skilled Nursing Facilities (SNFs)

All Skilled Nursing Facility care must be preauthorized. Contact our Utilization Management (UM) Department for authorization prior to SNF admission. SNF care is billed using a CMS-1450 Form.

Ambulatory Surgical Centers (ASC)

Most outpatient surgery delivered in an Ambulatory Surgical Center requires preauthorization. Ambulatory Surgical Centers bill on a CMS-1450 Form.

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

When billing for ASC:

- Medi-Cal--Use the Medi-Cal Local Code for room charges.
- Indicate bill type 830X.
- Itemize all claims.

Additional Billing Resources

The following references provide detailed instructions on uniform billing requirements:

- Current Procedural Terminology (CPT), American Medical Association; to order call 1-800-621-8335.
- CMS Common Procedure Coding System (HCPCS), National Level II (current year); to order, call 1-800-633-7467.
- ICD-10 CM (current edition), Volumes 1, 2, 3 (current year) Practice Management Information Corporation; to order, call 1-800-633-7467.
- CMS-1450 Manual, Uniform Billing Procedures, published by the California Healthcare Association; to order, call 1-800-494-2001.

Encounter Data Reporting

Because data regarding an encounter is obtained by us through claims data mining, those groups delegated for claims processing must submit encounter data to us as prescribed below:

Capitated Providers must submit all encounter data electronically to us on a monthly basis.

Encounters must be reported by the tenth (10th) of the month for all encounters for the preceding 90 days. For example, encounter data being submitted on July 10 should reflect encounters from April 1 through July 1. It is a DHCS requirement to submit encounter data on time.

Encounter Data File Format

Provide encounter data to us in a proprietary format, except in the instance of L.A. Care Health Plan members.

Submit encounter data for L.A. Care members to Seaside Health Plan in the latest X12N37 HIPAA-compliant format.

Questions about Encounter Data Reporting

For questions about encounter data reporting, contact us at (855) 367-7747.

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

The attached codes are a representative sample of the codes most frequently utilized by Providers . Professional judgment should always be used in billing the most appropriate code for the service rendered. The most current version of the CPT Manual should be used for full descriptions of the codes.

CPT codes are routinely updated for both additions and deletions. This list represents our best efforts to accurately reflect currently approved CPT Codes as of the date of publication of this Provider Manual. Refer to the most current edition of the CPT Manual for the most current codes.

Global billing is not accepted. All charges must be itemized.

CHAPTER 5: UTILIZATION MANAGEMENT

OVERVIEW

Our Utilization Management (UM) Program is a collaboration with Providers to promote and document the appropriate use of health care resources.

The UM Department takes a multi-disciplinary approach to help provide access to health care services in the setting best suited for the medical and psychosocial needs of the member based on benefit coverage, established criteria, and the community standards of care.

Role of Utilization Management

In conjunction with Providers, UM assists in providing access to the right care to the right member at the right time in the appropriate setting.

Service Reviews

The UM Department provides pre-service, concurrent and post-service reviews using clinical criteria based on sound clinical evidence. These criteria are available to members, physicians, and other health care Providers upon request by contacting the UM Department at (855) 367-7747 Seaside Health Plan

Availability of UM Staff

We ensure availability of UM staff at least eight hours a day on normal business days to answer UM-related calls. Member or provider UM-related calls received through the Member Services are triaged to, and handled by, UM staff.

The Utilization Management Department can be reached at the following numbers: (855) 367-7747
TDD: (855) 833-7747

After business hours and weekend, calls to the toll-free Member Services list number related to UM issues are triaged as follows:

- Request for urgent UM issues are triaged to UM staff 24 hours a day 7 days a week.
- Member or Providers/practitioners requesting non-urgent or routine UM service requests may leave a message for follow- up during normal business hours.

Decision-Making

We make UM decisions periodically in a fair, consistent, and timely manner. We do not reward practitioners and other individuals conducting utilization review for issuing denials of coverage or care. There are no financial incentives for UM decision-makers that encourage decisions that result in under-utilization.

The Utilization Management Committee (UMC) meets at least every month and supports the Quality Council in the provision of appropriate medical services and provides recommendations for UM activities.

CHAPTER 5: UTILIZATION MANAGEMENT

Decision and Screening Criteria

Seaside Health Plan ensures that UM decision and screening processes for review and approval, modification, delay or denial of services and medical necessity denials are consistently applied and will not interfere with or cause delay in service, or preclude delivery of services. Decision and screening criteria are developed for the purpose of determining the medical necessity of an outpatient procedure, service, supply, medical device/equipment, or inpatient hospital admission/continued stay. Seaside Health Plan clinical guidelines and medical policies are available on our website. Seaside Health Plan uses Milliman for inpatient reviews. Providers may request a copy of our guidelines by calling our Member Services. Out patient review utilizes a specific hierarchy

UM criteria application hierarchy is as follows:

1. Federal or State Mandate;
2. Primary Health Plan Medical Policy or Clinical Guideline;
3. Standardized Criteria (Milliman or InterQual);
4. Standardized Behavioral Health Criteria (Milliman Care Guidelines, APA & ASAM);
5. Provider Group Criteria or Guideline;
6. Community Resources (peer reviewed journals or published resources);
7. If none apply, professional judgment is used.

The decision criteria used by the clinical reviewers are evidence-based and consensus-driven. We update periodically criteria as standards of practice and technology change. We also involve actively practicing physicians in the development and adoption of the review criteria.

These criteria are available to members, physicians and other health care Providers upon request by contacting the UM Department or Member Services.

PRESERVICE REVIEW

Providers are responsible for verifying eligibility and in ensuring that our UM Department has conducted pre-service reviews for elective non-emergency and scheduled services before rendering the services. Pre-service review is required for elective inpatient admissions, outpatient surgeries, and diagnostic tests or treatments. Pre-service review ensures that services are based on medical necessity, are a covered benefit, and are provided by the appropriate Providers. It is the provider's responsibility to submit all documentation needed for pre-service referral requests.

Emergency services and sensitive services never require pre-service review or authorization from Seaside Health Plan.

Services requiring pre-service review include, but are not limited to:

- Elective Inpatient hospital care
- Selected surgical procedures (performed in an outpatient or ambulatory surgical center)
- Selected durable medical equipment (DME)
- Formula
- Home health care
- Speech therapy
- Sensory integration therapy
- All infusion therapies
- Selected MRIs and CT scans
- Reconstructive procedure
- Cardiac and pulmonary rehabilitation
- Transplants
- Hospice
- Skilled nursing facilities
- Out-of-network specialist referrals
- Out-of-network services
- For a more detailed list (by CPT and HCPCS codes) of services requiring pre-service review contact Seaside Health Plan Provider Services at (855) 367-7747.

If you do not have a User ID, click and follow the instructions to request an online account. Once approved, you will receive an e-mail confirmation of your approval. If a ProviderAccess account is not approved, you will be notified by mail.

What to Have Ready When Calling UM

To request pre-service review and report medical admission, call the UM Department at (855) 367-7747, Fax: (562) 933 – 1891 or visit www.SeasideHealthPlan.org Provider Web Portal.

To help the process be as quick as possible, have the following information ready when calling:

- Member Name and ID Number
- Diagnosis with the ICD-10 Code
- Procedure with the CPT Code
- Date of injury/date of hospital admission and third-party liability information (if applicable)
- Facility Name (if applicable)
- Primary Care Physician (PCP) Name
- Specialist or attending Physician Name
- Clinical justification for the request
- Level of care
- Results of lab tests, radiology and pathology results
- Medications
- Treatment plan with time frames
- Prognosis
- Psychosocial status
- Exceptional or special needs issues
- Ability to perform activities of daily living
- Discharge plans

Physicians, hospitals and ancillary Providers are required to provide information and documentation to the UM Department. Physicians are also encouraged to review their utilization and referral patterns.

Pre-service Review Time frame

For routine non-urgent requests, the UM Department will complete pre-service review within five business days from receipt of information reasonably necessary to make a decision. We will send requests that do not meet medical policy guidelines to our physician or medical director for review. We will notify

Providers within one business day of the UM decision (notification may be oral and/or electronic) and will send the member and requesting provider a written notification by mail within two business days from the decision.

For urgent requests, the UM Department completes pre-service review within 72 hours from receipt of the clinical information necessary to render a decision.

Requests with Insufficient Clinical Information

For pre-service requests with insufficient clinical information, we contact the provider with a request for the clinical information reasonably necessary to determine medical necessity. We make one or two attempts to contact the requesting provider to obtain the additional necessary clinical information. If we do not obtain a response within this time frame, we will send a deferral letter within five business days of receipt of the request.

This deferral letter includes specific information that we need to make a decision. If we do not receive the information, decision will be made within 5calendar days from the date on the deferral letter.

Generally speaking, the provider is responsible for contacting us to request pre-service review for both professional and institutional services. However, the Hospital or Ancillary provider should always contact us to verify pre-service review status on all non-urgent services before rendering services.

Emergency Medical Conditions and Services

We do not require authorization for treatment of emergency medical conditions. In the event of an emergency, members can access emergency services 24 hours a day, 7 days a week.

Members who call their primary care physician's office reporting a medical emergency (whether during or after office hours) should be directed to dial 911 or go directly to the nearest hospital emergency department. All non-emergent conditions should be triaged by the PCP or treating physician with appropriate care instructions given to the member.

Stabilization and Post-Stabilization

Emergency admissions do not require authorization. The Emergency Department's treating physician determines the services necessary to stabilize the member's emergency medical condition. After the member's medical condition is stabilized, the Emergency Department's treating physician must contact the member's PCP or covering physician for authorization of further services. If the PCP does not respond within 30 minutes, the needed services will be considered authorized. The member's PCP is noted on the back of the ID card.

Seaside Health Plan requires prior authorization for post-stabilization care. All continued inpatient stays are reviewed to determine whether the stay is medically necessary. The transfer process for out-of-network admissions requiring transfer to a Seaside Health Plan-contracted facility or to a higher level of care includes the following:

- The attending physician determines the member is stable for transfer to a contracted facility.

- The attending physician is to discuss the potential transfer with the PCP/Hospitalist
- To facilitate the transfer (that is, inform the caller of the in-network Hospital for transfer, identify the contracted specialist, and admit the member), the PCP is required to contact the treating physician within 30 minutes of the call.
- The attending physician must document and sign orders stating the member are stable for transfer.
- Transfers of children require the signed permission of the parents, except in cases of transfers to a higher level of care.

The Emergency Department should send a copy of the Emergency Room record to the PCP's office within 24 hours. The PCP should file the chart copy in the member's permanent medical record. The PCP should review the Emergency Room chart, contact the member, and schedule a follow-up office visit or a specialist referral, if appropriate.

All providers who are involved in the treatment of a member share responsibility in communicating clinical findings, treatment plans, prognosis, and the psychosocial condition of such member with the member's PCP to ensure effective coordination of care.

Referrals to Specialists

The UM Department is available to assist providers in identifying a network specialist or arranging for specialist care. Here are some other items to keep in mind when referring members:

Automatic Authorization: Benefited services that do not require authorization from Seaside for payment. These include the following:

Allergy - Blue Cross	Involuntary Psychiatric Inpatient Admission
Dermatology –Blue Cross	OB-GYN/Basic Prenatal Care in-network
Emergency Services	Sexually Transmitted Disease Services
Ear/Nose/Throat –Blue Cross	HIV Testing/Counseling
Family Planning Services including outpatient abortions through any family planning provider	Sensitive and confidential service and treatment
Preventive Services (including immunizations)	Outpatient mental health counseling and treatment
Services related to sexual assault	Drug and alcohol abuse

Urgent Care sought outside of the service area	Urgent Care under unusual or extraordinary circumstances provided in the service area when the contracted medical provider is unavailable or inaccessible

Direct Referral Authorization: In-network Primary Care Provider refers member directly for benefited service using the Direct Referral Authorization Form. Direct Referral Authorization is for 1 visit. These include the following:

Allergy & Immunology	Ophthalmology
Cardiology	Otolaryngology
Dermatology –Blue Cross	Pulmonary Disease
Ear/Nose/Throat –Blue Cross	Podiatry
Endocrinology	Rheumatology
Gastroenterology	Surgery, Cardiovascular
Hematology -Blue Cross	Surgery, General
Infectious Disease	Surgery, Hand
Laboratory Tests	Surgery, Plastic
Nephrology	Surgery, Orthopedic
Neurology	Surgery, Thoracic
Nuclear Medicine	Surgery, Vascular
OB/GYN	Urology
Oncology -Blue Cross	Radiology (Ultrasounds, MRI, MRA, CT Scan, Nuclear Med Studies, Mammography (to include breast imaging or image guided biopsy) and x-ray procedures that are not done in the staff model clinics
Orthopedic	Family Planning

CHAPTER 5: UTILIZATION MANAGEMENT

Prior Authorization: Benefited services that must be authorized prior to provision of the service. These include the following:

Allergy & Immunology	Home health
Ambulance	Inpatient medical and mental health admissions
Bariatric related services	Occupational/speech therapy
Behavioral health and substance abuse outpatient services	Prosthetics
Cardiology	Pain Management
Clinical trials	Self –Injectables
Durable Medical Equipment	Specialty care referrals
Dermatology services	Surgical Procedures
Endocrinology	Transplant Related Services
Experimental/investigational services and new technologies	Direct Referral Specialty Care Beyond (1) One Visit

Standing Referrals: Authorization request for specialized care over a prolonged period for a life-threatening, degenerative or disabling condition.

After obtaining the authorization(s):

- Provider/Seaside is responsible for notifying and referring the member to the appropriate specialist or facility.
- Provider, office staff, or member may arrange the referral appointment.
- Provider office notes the referral in the member's medical record and attaches any authorization paperwork.
- Provider discusses the case with the member and the referral provider.
- Provider receives reports and feedback from the referral provider regarding the consultation and treatment. (A written report must be sent to the PCP by the referral provider, or facility the member was referred to.)

- Provider discuss the results of the referral, any plan for further treatment, and care coordination with the member, if needed.
- Provider serves as the medical case manager within each managed care system.
- Referrals are tracked by the Provider's office for follow-up. The log or tracking mechanism notes, at a minimum, the following for each referral:

    - Member name and identification number
    - Diagnosis
    - Date of authorization request
    - Date of authorization
    - Date of appointment
    - Date consult report received

- The Provider is responsible in ensuring timely receipt of the specialist's report. Reports for specialty consultations or procedures should be in the member's chart within 10 days.
- If the Provider has not received the specialist's report within the determined timeframe, the Provider contacts the specialist to obtain the report.
- For urgent and emergent cases, the specialist should initiate a telephone report to the Provider as soon as possible, and a written report should be received within 10 days.

CHAPTER 5: UTILIZATION MANAGEMENT

CONCURRENT REVIEW

Admission and Continued Stay Reviews

Providers are to notify Seaside Health Plan and provide a clinical review within 24 hours of admission or the next business day if the member is admitted on a weekend or holiday. Seaside Health Plan will contact hospitals and request clinical reviews within 24 hours of notification of admissions. All inpatient stays beyond the approved number of days require concurrent review. Providers are to submit ongoing reviews as requested by Seaside Health Plan.

Seaside Health Plan performs continued stay reviews to assure the medical care rendered is medically necessary and provided at the appropriate facility and level of care. The clinical information for continued stay reviews may be provided by the Hospital or the attending physician and may be called or faxed to Seaside Health Plan.

When a continued inpatient stay or treatment is expected to exceed the number of days authorized during pre-service review or when the inpatient stay or treatment did not have pre-service review, the Hospital or provider must contact us for concurrent review in order to determine if the inpatient stay or treatment is medically necessary. In such case, we require clinical review of the inpatient stay or treatment for all members upon admission and during the course of the member's hospitalization. We perform the review, based on clinical information provided to us by the Hospital or attending physician, to assess that the medical care rendered is medically necessary and that the facility and level of care are appropriate. We identify members admitted to the inpatient setting by:

- Facilities reporting admissions
- Providers reporting admissions
- Members or their representatives reporting admissions
- Claims submissions for services rendered without authorization
- Pre-service authorization requests for inpatient care

The UM Department completes concurrent inpatient reviews within 24 hours of receipt of clinical information or sooner, consistent with the member's medical condition. Review coordinators request clinical information from the Hospital on the same day they are notified of the member's admission/continued stay. If the information provided meets medical necessity review criteria, we will approve the request within 24 hours from the time the information is received. We will send requests that do not meet medical policy guidelines to the physician advisor or medical director for review.

We will notify Providers within 24 hours of the decision. We will send a written notification to the member and requesting provider within two business days of any denial decision.

CHAPTER 5: UTILIZATION MANAGEMENT

Inpatient Admission Notification

We identify members admitted to the impatient setting (acute care hospital, acute rehabilitation hospital, intermediate facility, or skilled nursing facility) by:

- Facilities reporting admissions within 24 hours of admission or the first business day after a weekend
- Providers reporting admissions
- Member or their representatives reporting admissions
- Pre-service authorization requests for impatient care for elective admissions

Utilization Management: (855) 367-7747

Evidence-based criteria are used in medical necessity and appropriate level of care determinations.

Clinical Information

Facilities are required to provide clinical information within 24 hours of the admission notification in order to facilitate concurrent review, certify approved impatient days, expedite discharge planning and authorizations, and ensure proper claims payment. Decisions are made within 24 hours of the receipt of the clinical information needed to make these decisions.

The review coordinator performs ongoing follow-up concurrent reviews in collaboration with Hospital UM staff and provides assistance with discharge planning, as needed, to facilitate and coordinate the timely transition of care when medically indicated.

Denial of Service

Only a medical or behavioral health physician who possesses an active State of California professional license or certification can deny an outpatient procedure, service, durable medical equipment (DME), inpatient hospital admission, or continued inpatient hospital stay for lack of medical necessity or of medical information..

The UM Department has available of physician reviewers to discuss by telephone adverse determinations based on medical necessity. Providers may contact the physician clinical reviewers to discuss any UM decision by calling the UM Department at (855) 367-7747.

Post-Service/Retrospective Review

Post-service/retrospective reviews determine the medical necessity or level of care for inpatient services or treatments that were rendered without obtaining pre-service or concurrent review, and, therefore, no inpatient days or treatments were certified. For inpatient admissions or treatments where no pre-service or concurrent notification was received, a copy of the medical record is required with the claim.

CHAPTER 5: UTILIZATION MANAGEMENT

Elective non-emergent services performed without the required pre-service review will be denied since this is not a covered benefit.

SELF-REFERRAL

Medi-Cal:

Members may self-refer for sensitive services, such as:

- Family planning services, including:
    - Health education and counseling
    - Limited history and physical examinations
    - Laboratory tests
    - Diagnosis and treatment of sexually transmitted diseases if medically indicated
    - HIV testing and counseling
    - Contraceptive pills, devices/supplies
    - Sterilization
    - Pregnancy testing and counseling
- Annual examination with a network OB/GYN

Commercial:

- Annual examination with a network OB/GYN
- Mammogram
- HIV
- Family Planning
- STD
- Consult Primary Plan for further self-referral services (possible direct access for commercial plan)

SECOND OPINIONS

A second opinion must be given by an appropriately qualified health care professional. When the request is regarding care from a specialist, a provider of the same specialty must give the second opinion. This specialist must be within the network and may be selected by the member.

For cases in which there is no provider within the network who meets the specified qualification, we may authorize a second opinion by a qualified provider outside of the network upon request by the member.

ADDITIONAL SERVICES

The provider continues to cover and ensure the provision of primary care and other services unrelated to the additional services and coordinate services between the primary care providers and these.

California Children's Services

California Children's Services (CCS) is a state and county-funded program that serves children under the age of 21 who have acute and chronic conditions that may benefit from specialty medical care and case management. State statutes and contracts require that CCS Program services be carved out of our Medi-Cal. As a result, upon suspicion or identification of a CCS-eligible condition, please refer the child to the local CCS Program or contact us to assist with the referral

Mental Health Services

Mental health services are covered by the Primary Plan or the Los Angeles County Department of Mental Health for Medi-Cal members. We, however, cover outpatient mental health services that are within the scope of practice of the primary care physician.

Commercial Members usually have a Mental Health Service carve out please consult with you Primary Care Plan website.

For a list of the covered mental health services and benefit limitations, review the benefit matrixes found in the Medical Benefits subsection under Covered and Non-covered Services.

If you have questions or need assistance, call the CCC at the following numbers:

Medi-Cal (Los Angeles County only): 1-888-285-7801
TDD: 1-888-757-6034

Authorizing Mental Health Services

Medi-Cal Members

Contact the member's Primary Plan to report and obtain authorization for any inpatient admission to a participating Hospital pertaining to a mental health diagnosis.

Commercial Insurance
Members and Providers please consult the Primary Plan.

Vision Care:

CHAPTER 5: UTILIZATION MANAGEMENT

For LA Care: VSP coordinates L.A. Care's Medi-Cal members' vision care benefits. To access Medi-Cal vision care and lenses benefits, call VSP at the toll free number 1-800-877-7195.

For all other Managed Medi-Cal plans, contact the plan for benefits.

To find out more about Medi-Cal eye exams or vision care coverage, L.A. Care MCLA members can also call L.A. Care Member Services at the toll free number 1-888-839- 9909

Commercial: Contact primary plan for benefits

CHAPTER 6: CARE COORDINATION/CASE MANAGEMENT

CARE COORDINATION/CASE MANAGEMENT OVERVIEW

The Care Management Program affords both members and Providers expert assistance in coordinating complex health care needs for members. We encourage our Providers to make use of this effective program.

Care Management is a collaborative process that assesses, develops, implements, coordinates, monitors, and evaluates care plans designed to optimize members' health care benefits and promote quality outcomes. The case manager, through interaction with the member, member representative or Providers, collects and analyzes data and information about the actual and potential care needs for the purpose of developing a care plan. Cases may be identified by disease state or condition or high utilization of services.

Referral Process

Providers, nurses, social workers and members or their representatives may refer members to Care Management by calling the Provider Services of the member's Primary Plan.

Provider Responsibility

It is the Providers responsibility to participate in the care management process through information sharing (such as medical records) and facilitation of the care management process by:

- Referring members who could benefit from care management
- Sharing information as soon as possible (for example, during the Initial Health Assessment the Primary Care Physician [PCP] identifies care management needs)
- Collaborating with care management staff on an ongoing basis
- Monitoring and updating the care plan to promote goal achievement
- Providing medical information
- Calling Care Management if members are referred to county or state-linked services

Additional Potential Referrals

Additional referrals might be for:

- Potential transplants
- Complex or multiple-care needs such as multiple trauma or cancer
- Chronic illness such as asthma, diabetes, heart failure, or end-stage renal disease
- High-risk pregnancies and pre-term births
- HIV/AIDS
- Frequent hospitalizations or Emergency Room utilization
- Members who are aged, blind, or disabled

- Hemophilia, sickle cell anemia, cystic fibrosis, or cerebral palsy
- Children or adults with special health care needs requiring coordination of care and "carved-out" services such as certain mental health services
- Persons with developmental disabilities
- Individuals who may need or are receiving services from out-of-network Providers or programs

ROLE OF THE CASE MANAGER

Case managers develop a care plan and:

- Facilitate communication and coordination between all members of the health care team, involving the member and family in the decision-making process in order to minimize fragmentation in the health care delivery system

- Educate the member and all Providers of the health care delivery team about care management, community resources, benefits, cost factors and all related topics so that informed decisions can be made

- Encourage appropriate use of medical facilities and services, improving the quality of care and maintaining cost-effectiveness on a case-by-case basis

Procedures

Upon identification and referral of a potential member for care management, the case manager contacts the referring Provider and member and completes an initial assessment.

The case manager develops an individualized care plan based on information from the assessment and with the involvement of the member, the member's representative, and the referring Provider.

The case manager periodically re-assesses the care plan to monitor the following: progress toward goals, any necessary revisions, and any new issues to ensure that the member receives support and teaching to achieve care plan goals. Once goals are met or the case can no longer be impacted by care management, the case manager closes the member's case. Communication between Case Manager and the Provider is ongoing.

Accessing Specialists: Access to Care Unit

Case managers are available to assist PCPs with accessing specialists when needed. For assistance locating a specialist, call the Seaside Health Plan.

CHAPTER 8: PROVIDER ROLES AND RESPONSIBILITIES

PROVIDER GRIEVANCES AND APPEALS

We provide a process for Providers to file a written grievance with us that is related to dissatisfaction or concern about another Provider, the Plan or a Member. We also assure the Providers' right to file an appeal with us for denial, deferral or modification of a post-service request.

Providers can also request an appeal on behalf of a member for denial, deferral, or modification of a prior authorization or request for concurrent review. These appeals are treated as member appeals and follow the member appeal process. The member's Primary Plan has a formal process for reviewing member grievances and appeals. Please refer to the member's ID card for information on how to file member grievance and appeals.

Providers can also submit a claims dispute to us. For additional information on claims disputes, see Chapter 4, ***Claims and Billing Guidelines***, in this manual.

How Providers File a Provider Specific Grievance or Appeal

Providers may file a grievance in writing to the Grievances and Appeals (G&A) Department and submit to:

Attn: Grievances and Appeals
Seaside Health Plan
2840 Long Beach Blvd. Suite 120
Long Beach, CA 90806-7506

Providers can also submit a grievance by fax to (562) 933-1891.

The provider may submit the provider appeal request in writing to:

Attn: Grievances and Appeals
Seaside Health Plan
2840 Long Beach Blvd. Suite 120
Long Beach, CA 90806-7506

When to File a Grievance or Appeal

- A grievance may be filed up to 180 days after the date of the incident that gave rise to the grievance.
- A Provider appeal may be filed up to 365 days after the date of the Notice of Action letter from the Plan advising the Provider of the adverse determination.

For claims disputes, see Chapter 4, ***Claims and Billing Guidelines***, in this manual.

Receipt and Acknowledgement of a Grievance or Appeal

We send a written acknowledgement to the provider within five calendar days of receiving a grievance, non-physician provider appeal. For acknowledgement time frames for claims dispute, refer to Chapter 4, ***Claims and Billing Guidelines***, in this manual.

Requesting More Information

We may request, by telephone or by fax, with a signed and dated letter, medical records or a Provider explanation of the issues raised in the grievance or appeal received by the Plan.

For grievances or appeals, Providers are expected to comply with our request for information within 10 days of our request.

Refer to Chapter 1, ***Introduction and General Claims Guidelines***, in this manual for the time frames applicable to claims disputes.

Grievance & Appeal Investigation Responsibilities

Clinical Grievances (Quality of Care)

Quality of care issues should be reported to Seaside Health Plan Quality Department at (855) 367-7747. The Quality Manager will launch an investigation and if upon review, a clinically urgent situation is identified, the grievance is processed as quickly as the medical condition warrants until a satisfactory resolution is reached. The Chief Medical Officer makes recommendations for further actions when necessary. This may include forwarding the case to the Quality Council for peer review.

Administrative Grievances (Quality of Service)

For administrative grievances, please contact the Senior Vice President for Seaside Health Plan or their designate. The grievance will be reviewed and referred to the appropriate department for response. The Chief Operating Office or designate will communicate the response to the Provider.

Appeal

When a Provider wishes to appeal a medical necessity denial, the Provider may contact the reviewing physician by phone that made the initial determination for an informal reconsideration. If the Provider is still not satisfied he/she should follow the appeals procedure noted in the formal notice of denial.

When to Expect Resolution

For grievances, we send a written resolution letter to the provider within 30 calendar days from the receipt of the grievance. The resolution letter also provides details on the Providers additional grievance rights. For claims disputes, refer to Chapter4, Claims Disputes, in this manual.

According to state laws, we may not be able to disclose to Providers the final disposition of certain grievances. In cases where we have investigated a provider or in cases related to quality of care, we notify the Provider that the grievance was received and investigated and inform the Provider that the final disposition of the grievance cannot be disclosed due to peer review confidentiality laws.

Provider Dissatisfaction with Resolution

Providers who are still dissatisfied with the outcome of the Seaside Health Plan's determinations should contact the Primary Plan.

Please consult your Provider Contract for details of Arbitration in accordance with the Seaside Health Plan Participating Provider Agreement.

Contact Information

Seaside Health Plan
Claims: (855) 367-7747
TDD: (855) 833-7747

PRIMARY CARE PHYSICIANS SCOPE OF RESPONSIBILITIES

Plan members select a contracted Primary Care Physician (PCP) as their main provider of health care services within the established time period of the effective date of enrollment. If, after the established time period of the effective date of enrollment, the member has not selected a PCP, Seaside Helath Plan assigns the member to a PCP.

The PCP's scope of practice includes the development and oversight of the member's treatment and care plan, which includes availability to health care 24 hours a day, 7 days a week. The PCP serves as the primary provider of a member's health care services. We furnish each PCP with a current list of enrolled members assigned to the PCP.

The PCP provides routine, preventive, and urgent services and ensures that the member receives appropriate specialty, ancillary, emergency, and hospital care as well as access to health care services 24 hours a day, 7 days a week. The PCP provides information to the member or legal representative of the member about the illness, the course of treatment, and prospects for recovery in terms he or she can understand.

PCP responsibilities include providing or arranging for:

- Routine and preventive health care services
- Emergency care services
- Hospital services
- Ancillary services

- Specialty referrals
- Interpreter services
- EPSDT/CHDP screening services for children and adolescents
- Coordination with care coordinators to ensure continuity of care for members
- CCS

PCPs coordinate care with clinic services, such as therapeutic, rehabilitative, or palliative services for outpatients. With the exception of nurse-midwife services, the physician furnishes clinic services. PCPs must cooperate with any court-ordered services.

CHAPTER 8: PROVIDER ROLES AND RESPONSIBILITIES

Referrals

PCPs coordinate and make referrals to appropriate specialists, ancillary providers, or community services. They monitor and track all services and provide health education information, materials, and referrals. Members have the right to select an OB/GYN without referrals from their PCPs.

All PCPs:

- Are expected to refer members to specialists or specialty care, including the Child Health and Disability Prevention (CHDP) Program, California Children's Services (CCS), behavioral health care services, other carved-out services, health education classes, and community resource agencies when appropriate
- Must coordinate with the Women, Infants and Children (WIC) Special Supplemental Nutrition Program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit, or hemoglobin
- Must coordinate with the local tuberculosis (TB) control program to ensure that all members with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy (DOT)
- Are responsible for screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders
- Must document referrals, including referrals to carved-out services
- Are expected to help members in scheduling appointments with other providers and health education programs
- Are expected to track and document appointments, clinical findings, treatment plans and care received by members referred to specialists, other health care providers, or agencies regarding continuity of care

Specialty referrals to in-network providers do not require prior authorization. See ***Chapter 6: Utilization Management, Referral to Specialist*** in this manual.

Initial Health Assessment

PCPs should review their monthly eligibility list provided by us and proactively contact their assigned membership to make an appointment for the member's initial health assessment within 60 days of enrollment for members younger than 18 months and within 120 days of enrollment for members 18 months and older. The PCP's office is responsible for making and documenting all attempts to contact assigned members. Member medical records must reflect the reason for any delays in performing the Initial Health Assessment (IHA), including any refusals by the member to the exam. For more information, refer to Initial Health Assessment in ***Chapter 13, Access Standards & Access to Care*, or *Chapter 16, Health Services and Programs***, in this manual.

CHAPTER 8: PROVIDER ROLES AND RESPONSIBILITIES

Transitioning Members between Facilities or to Home

Subject to benefit limits, PCPs initiate or help with the discharge or transfer of:

- Members at an inpatient facility to the appropriate level of care of facility (skilled nursing facility, intermediate rehabilitation facility) when medically indicated or home

- Members hospitalized in an out-of-network facility to an in-network facility (or to home with home health care assistance when medically indicated). The coordination of member transfers from non-contracted out-of-network facilities to contracted in-network facilities is a priority that may require the immediate attention of the PCP. Contact our review coordinator to assist in this process.

Comprehensive Perinatal Services Program for Medi-Cal (PCPs and OB/GYNs only)

Seaside Health Plan providers must complete a comprehensive risk assessment tool for all pregnant female Members that is comparable to the American College of Obstetrics and Gynecology standard and Comprehensive Perinatal Services Program (CPSP) standards.

The results of this assessment shall be maintained as part of the obstetrical records and shall include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components.

The risk assessment tools shall be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit. Risks identified shall be followed up on by appropriate interventions, which must be documented in the medical record.

Program standards, requirements and forms can be located via:

- Medi-Cal Provider Manual website;
- Primary Plan's website;
    - Anthem Blue Cross
    - HealthNet
    - LA Care

DHS approved CPSP tools and protocols are located via:

- LA County Public Health Maternal, Child & Adolescent Health website

Standard Obstetrical Record Elements-CPSP

Standard Obstetrical record elements shall be included in the obstetric, nutritional, psychosocial and educational examination of pregnant members in compliance with DHS and the most current guidelines of the American College of Obstetrics and Gynecology (ACOG), CPSP, and Title 22. Obstetrical records include the CPSP Patient Records -Comprehensive Perinatal Services Program Documentation Forms and/or any obstetric record that applies with the CPSP standards for documentation.

CHAPTER 8: PROVIDER ROLES AND RESPONSIBILITIES

Referral to Specialists-CPSP

Seaside Health Plan providers are responsible for ensuring that appropriate hospitals are available within the provider network to provide necessary high-risk pregnancy services.
Pregnant women that are at high risk of a poor pregnancy outcome are referred to appropriate specialists including primatologists and have access to genetic screening with appropriate referrals.

Specialists may include, but are not limited to:

- Cardiologists
- Psychiatrists
- Internists
- Infectious Disease
- Geneticists
- Specialty High-Risk Obstetricians
- Oncologists
- Endocrinologists

Examples of these referral types and protocols may include, but are not limited to:

- Diabetes
- Hypertension
- Hepatitis
- HIV+
- Genetic Problems
- Epilepsy or Neurological Disorder
- Renal Disease
- Alcohol or Drug Abuse
- Maternal Cardiac Disorders
- Thyroid or Other Endocrine Disorders
- Epilepsy or Neurological Disorder

Common Pregnancy Conditions/Issues Requiring Multidisciplinary Management

Pregnant members exhibiting any of the following representative conditions/ issues will have interventions and referrals developed utilizing the Nutrition (N), Psychosocial (PS), or Health Education (HE) protocols:

- Unintended or unwanted pregnancy (PS)
- Teenage pregnancy (PS)
- Fear of physicians, hospitals, and medical personnel (HE)
- Language barriers (HE)
- Lack of basic reproductive awareness (HE)
- Housing and transportation problems (PS)
- Domestic violence (PS)
- No previous contact with health care systems (HE)
- Multiple gestation (HE), (PS), (N)
- Need for bed rest during pregnancy (PS), (HE)
- Previous receipt of unfriendly health care services (HE)
- Personal and religious beliefs at odds with optimal prenatal care (HE)

Common Postpartum Conditions/Issues Requiring Multidisciplinary Management:

- Postpartum blues, postpartum depression (PS)
- Housing, food, transportation problems (PS)
- Lack of basic parenting skills and role models (HE)
- Breastfeeding difficulties (HE)
- Sexual pain/difficulties (HE)
- Severe anemia (N)

Comprehensive Perinatal Services Personnel

The primary component of quality multidisciplinary management of comprehensive perinatal care is personnel. Participating obstetrical providers must ensure that health education, nutrition, psychosocial assessment, re-assessment and intervention are administered by qualified personnel. Training of Comprehensive Perinatal Services personnel will be provided by L.A. Care with technical assistance from the County of Los Angeles Comprehensive Perinatal Service Program.

Comprehensive Perinatal practitioners may include any of the following:

- General Practice physician
- Family Practice physician
- Pediatrician
- Obstetrician-Gynecologist
- Certified Nurse Mid-Wife
- Registered Nurse
- Nurse Practitioner
- Physician's Assistant
- Social Worker
- Health Educator
- Childbirth Educator
- Registered Dietitian
- Comprehensive Perinatal Health Worker

Ancillary Services/staff who may provide services within specific components of Comprehensive Perinatal services or services available within Linked/Carved out Services include, but are not limited to:

- Geneticists
- Other medical specialists
- Public Health Services
- Family Planning Services
- Substance Abuse Prevention Service
- Community-Based Organizations
- Community Outreach Services
- Agencies providing transportation
- Domestic Violence Units
- Child Protective Services
- Local Diabetes and Pregnancy Programs
- Dental Services
- Specialty Mental Health Services

- Translation Services
- Women's Center
- Respite Care Services

Other Referrals include, but are not limited to:

- WIC Supplemental Nutritional Program

Seaside Health Plan providers shall ensure that all pregnant, breastfeeding and postpartum women, and infants and children who are eligible for WIC supplemental food services will be assessed, and if appropriate, referred to the Los Angeles County Public Health Services WIC Program.

Family planning referral protocols may include assistance with birth control issues, STD information or control, procedure or counseling.

A referral may be done, but is not required for this service, as members can self refer to Family Planning Services. For instance,

Social Work referrals due to:

- Family Abuse/Domestic Violence
- Financial Problems
- Other identified social needs

PCPs must follow all Provider responsibilities as outlined in this manual.

SPECIALIST SCOPE OF RESPONSIBILITIES

Specialist physicians are those who are licensed with additional training and expertise in a specific field of medicine. Specialist physicians treat Plan members to supplement the care given by PCPs. Access to contracted network specialists is through the member's PCP. In limited cases, such as family planning and evaluation, diagnosis, treatment and follow-up of sexually transmitted diseases (STDs) the member can self-refer.

PCPs refer members to Plan-contracted network specialist physicians for conditions beyond the PCP's scope of practice that are medically necessary. Specialists diagnose and treat conditions specific to their area of expertise. Specialist care is limited to Plan benefits.

Specialists must follow all Provider responsibilities as outlined in this manual.

Members with disabling conditions or chronic illnesses or children with special health care needs may request that their PCPs be specialists. Specialist physicians acting as PCPs must follow all responsibilities of a PCP.

HOSPITAL SCOPE OF RESPONSIBILITIES

PCPs refer members to Plan-contracted network hospitals for conditions beyond the PCP's scope of practice that are medically necessary. Hospital care is limited to Plan benefits.

CHAPTER 8: PROVIDER ROLES AND RESPONSIBILITIES

Hospital professionals diagnose and treat conditions specific to their area of expertise. Hospital professionals must follow the processes of all providers unless specified otherwise.

Hospital providers must provide members with an adequate supply of medications upon discharge from the Emergency Room or the inpatient setting to allow reasonable time for the member to access a pharmacy to have prescriptions filled.

Notification of Admission and Services

The Hospital must notify us or the review organization of an admission or service at the time the member is admitted or service is rendered. If a member is admitted or a service is rendered on a day other than a business day, the Hospital must notify us of the admission or service during the morning of the next business day following the admission or service.

Notification of Decision

If the Hospital has not received notice of pre-service review determination at the time of a scheduled admission or service, as required by the Utilization Management (UM) Guidelines and the Hospital Agreement, the Hospital should contact us and request the determination status.

Any admission or service that requires pre-service review, as discussed in the Utilization Management Guidelines and the Hospital Agreement, and has not received the appropriate review, may be subject to post-service review denial. Generally, the physician is required to perform all pre-service review functions with us. However, the Hospital must ensure, before services are rendered, that these have been performed or risk post-service denial. Refer to Utilization Management for pre-service review time frames

Hospitals must follow all Provider responsibilities as outlined in this manual.

ANCILLARY SCOPE OF RESPONSIBILITIES

We have a network of various participating health care professionals and facilities. Health care professionals provide medically necessary services when a licensed physician or licensed health care professional orders the services and are in accordance with the applicable benefit agreement and ancillary agreement. All services provided by the health care professional, and for which the health care professional is responsible, are listed in the ancillary agreement.

PCPs refer members to Plan-contracted network ancillary professionals for conditions beyond the PCP's scope of practice that are medically necessary. Ancillary professionals diagnose and treat conditions specific to their area of expertise. Ancillary care is limited to Plan benefits.

Ancillaries must follow all Provider responsibilities as outlined in this manual.

CHAPTER 8: PROVIDER ROLES AND RESPONSIBILITIES

RESPONSIBILITIES APPLICABLE TO ALL PROVIDERS

Eligibility Verification

All Providers must verify member eligibility immediately before providing services, supplies, or equipment. Eligibility may change monthly, so a member eligible on the last day of the month may not be eligible on the first of the following month. We are not responsible for charges incurred by ineligible persons. Verify eligibility by using POS, Provider Access website or call the Customer Care Center. Refer to ***Important Contact Information*** for numbers for each respective program.

Pre-service Reviews

- Providers must obtain pre-service reviews for:
- Elective surgery in an ambulatory surgical center or outpatient hospital setting
- Nonemergency hospital admissions, including surgery
- Out-of-network specialist referrals
- Custom-made medical equipment
- Additional treatments or procedures listed under preservice review as outlined in
- Utilization Management

Providers submit pre-service review requests directly to our Utilization Management Department.

An emergency medical service to triage and stabilize a member does not require pre-service review.

Collaboration

The Provider shares the responsibility of giving considerate and respectful care and working collaboratively with Plan members and their families, specialist physicians, hospitals, ancillary providers, and others for the goal of providing timely, medically necessary and quality health care services. Providers must permit members to participate actively in decisions regarding medical care, except as limited by law. The Provider also facilitates interpreter services and provides information about the Comprehensive Perinatal Services Program for Medi-Cal (PCPs and OB/GYNs only).

Interpreter Services

Providers must notify members of the availability of free health plan interpreter services and strongly discourage the use of minors, friends, and family to act as interpreters. Refer to ***Interpreter Services and Services*** for the Hard of Hearing in this manual for provider responsibilities for signage, notification of interpreter services, refusal forms for interpreter services, after-hours linguistic access, and updating language capabilities with us. Providers can reach the California Relay System and Interpreter Services at the numbers listed in ***Important Contact Information.***

CHAPTER 8: PROVIDER ROLES AND RESPONSIBILITIES

Communication for Continuity of Care

The PCP maintains frequent communication with the specialist physician, hospital, or ancillary provider regarding continuity of care. We encourage physicians, hospitals, and providers to maintain open communication with their patients regarding appropriate treatment alternatives, regardless of their benefit coverage limitations. We do not penalize physicians, non-physician practitioners, or other health care providers for discussing medically necessary or appropriate patient care.

We established comprehensive and consistent mechanisms to provide continued access to care for members when physicians terminate from the Plan. Under specified circumstances, members may finish a course of treatment with the terminating provider. For more information, refer to ***Continued Access to Care/Continuity of Care*** in this manual.

Confidentiality

PCPs must ensure that their members' medical and behavioral health and personal information are kept confidential as required by state and federal laws. They must prepare and maintain all appropriate records in a system that permits prompt retrieval of information on members receiving covered services from the PCPs.

Obtaining Signed Consent

The PCPs obtain required signed consent before providing care. Consent for treatment must be given at the initial office visit by member, parent or guardian by signing a "Consent to Treat" patient form. This form must be maintained in the patient's medical record. Before performing a human sterilization procedure, consent forms must meet the stipulations for informed consent and for waiting time frames.

Medical Records Documentation & Access to Medical Records

Providers are responsible for ensuring that member medical records are organized and complete and include documentation from specialists, hospitals, ancillary providers, carved-out services, and community services when applicable. The Provider must record the use of any and all interpreter services, including interpreter services delivered by office staff. Documentation must be signed, dated, legible, and completed in a timely manner. Medical records must be stored in a secured location.

Providers must provide us with prompt access, upon demand, to medical records or information for quality management or other purposes, including utilization review, audits, reviews of complaints or appeals, Health Employer Data and Information Set (HEDIS®), and other studies.

Providers must provide us, its regulatory agencies or its contracted External Quality Review Organization (EQRO) with access to office sites for facility or medical records reviews upon our request. Mandated time limitations for the completion of reviews and studies require the cooperation of the provider to provide medical records expediently. Providers must have procedures in place to provide timely access to medical records in their absence.

For public health communicable disease reporting, providers must provide all medical records or information as requested and within the time frame established by state and federal laws.

CHAPTER 8: PROVIDER ROLES AND RESPONSIBILITIES

Reporting

Health care professionals agree to provide to us, on request, periodic reports that include:

- Patient identification
- Service date and type of service
- Diagnosis
- Referring physician and other related information

Mandatory Reporting of Abuse

Providers ensure that office personnel have specific knowledge of local reporting requirements, agencies and procedures to make telephone and written reports of known or suspected cases of abuse. All health care professionals must immediately report actual or suspected child abuse, elder abuse, and domestic violence to the local law enforcement agency by telephone.

Providers must submit a follow-up written report to the local law enforcement agency within the time frame required by law. The Quality Management staff explains how to document the reporting of child, adult, elder, and domestic violence abuse. The Facility Site Review is required to examine this documentation. Providers can obtain additional copies of the Safety Training Modules tool by calling a local Community Resource Coordinator.

Notifying the Plan of Changes

Providers must notify us of any:

- Change in professional business ownership
- Change in business address or the location where services are provided
- Legal or governmental action initiated against a health care professional, including, but not limited to, an action for professional negligence, for violation of the law, or against any license or accreditation, which, if successful, would impair the ability of the health care professional to carry out the duties and obligations under the Provider Agreement
- Other problem or situation that impairs the ability of the health care professional to carry out the duties and obligations under the Provider Agreement care review and grievance resolution procedures

Use the Provider Change Form to notify us of changes. You can find the form on the www.seaside healthplan.com website under Forms and Tools.

In the event we determine that the quality of care or services provided by a health care professional is not satisfactory, as may be evidenced by or in member satisfaction surveys, member complaints or

grievances, Utilization Management data, complaints, or lawsuits alleging professional negligence, or any other quality of care indicators, we may terminate the Provider Agreement.

Health care professionals agree to be bound by and comply with Plan policies, procedures and rules.

Members' Rights and Responsibilities

All Plan PCPs actively support the Members' Rights and Responsibilities Statement as written in Members Rights and Responsibilities section of this manual.

Oversight of Non-Physician Practitioners

All providers using non-physician providers must provide supervision and oversight of such non-physician providers consistent with state and federal laws. The supervising physician and the non-physician practitioner must have written guidelines for adequate supervision. All supervising providers must follow state licensing and certification requirements.

Non-physician practitioners are advanced registered nurse practitioners (including certified nurse midwives) and physician assistants. These non-physician practitioners are licensed by the state and working under the supervision of a licensed physician as mandated by state and federal regulations.

Office Hours

To maintain continuity of care, all Providers must be available to provide services for a minimum of 24 hours each week. The Provider must be available 24 hours a day by telephone or have an on-call physician take calls. Office hours must be conspicuously posted. For specific hours of operation and after-hours requirements, refer to ***Chapter 10, Access Standards & Access to Care.***

The provider must inform members of the Provider's availability at each site.

Licenses and Certifications

Providers must maintain all licenses, certifications, permits, accreditations, or other prerequisites required by us and federal, state, and local laws to provide medical services. Copies of the licenses, certifications, permits, evidence of accreditations or other prerequisites are in the respective Provider Agreements.

Seaside Health Plan recommends the use of Agency for Healthcare and Research Quality (AHRQ) website at http://effectivehealthcare.ahrq.gov/index.cfm/tools-and-resources/?PC=EHCITall for CE/CME Modules, Faculty Slides, Webcasts, and Other Resources.

Prohibited Activities

All providers are prohibited from:

- Billing eligible members for covered services
- Segregating members in any way from other persons receiving similar services, supplies, or equipment

- Discriminating against Plan members

Open Clinical Dialogue/Affirmative Statement

Nothing within the Provider's participating Provider Agreement or this Provider Manual should be construed as encouraging providers to restrict medically necessary covered services or to limit clinical dialogue between the providers and their patients.

Providers can communicate freely with members regarding the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

Provider Terminations

When a participating provider or a participating physician group notifies the Plan that he or she intends to terminate his or her contract with the Plan's provider network, the Plan notifies all members assigned to the terminating provider or physician group that the provider is terminating and will no longer be available to the member as a physician participating in the provider network. The Plan makes every effort to notify members at least 60 days prior to the termination. Providers should refer to their Seaside Health Plan Provider Agreement for responsibilities and time frames as these relate to provider termination from the Plan.

Seaside Health Plan acts in accordance with California Health and Safety Code Sections 1373.65, 1373.95 and 1373.96 (SB 244), California law regarding continuity of care when either a physician or a physician's group OR the contract is terminated. A physician or group may choose to complete a member's regimen of care following contract termination provided the physician or group accepts the previous rate of payment until the member's treatment is completed (such as pregnancy chemotherapy or surgeries). Refer to the ***Continued Access to Care/Continuity of Care*** for more information.

FINANCIAL REQUIREMENTS FOR PARTICIPATING MEDICAL GROUPS

It is the policy of Seaside Health Plan to take appropriate action to limit its exposure to unwarranted financial risks from its business relationships with its delegated Participating Medical Groups (PMGs). This responsibility begins with a screening analysis of the PMG by appropriate Seaside Health Plan units and includes the conduct of a financial review by Health Management Organization (HMO) Finance. The review involves tracking the financial performance of the PMG, particularly those experiencing adverse financial trends.

State Regulations

State regulations require that health plans monitor the financial position of its capitated PMG or delegated risk-bearing organizations (RBOs) to ascertain that they demonstrate compliance with the financial solvency requirements mandated in Title 28, Section 1300.75.4 of the California Code of Regulations (CCR). The PMGs also must meet, at all times, the financial performance standards or covenants hereunder listed, which are mandated by the Medical Services Agreement. We engage in financial monitoring in order to protect Seaside Health Plan members from Provider group insolvency that may result in the interruption

of the delivery of health care services. The PMG must furnish the quarterly and annual financial information to Seaside Health Plan and other data as may be required by law and Seaside Health Plan as stated under Financial Audit Requirements – Access to Financial Data.

Pursuant to Seaside Health Plan' Medical Services Agreement, each PMG is required to submit audited financial statements to Seaside Health Plan no later than 150 calendar days (five months) following the end of its fiscal year. The annual financial statements shall be attested by an independent certified public account (CPA). The PMG also may be required, if necessary, to submit tax returns, along with the internally prepared financial statements and other related reports.

In addition to the fiscal year-end financial statements, the PMG also agrees to provide Seaside Health Plan with quarterly financial statements within 45 days after the close of each fiscal quarter, or as often as deemed necessary by Seaside Health Plan to ensure appropriate monitoring. The financial data enables Seaside Health Plan to assess the financial status of the PMG and/or its capacity to fulfill its financial obligations under the Medical Services Agreement.

CHAPTER 9: PREVENTIVE HEALTH CARE GUIDELINES

PREVENTIVE HEALTH CARE GUIDELINES

Good health begins with good lifestyle habits and regular exams. Preventive health care guidelines help Providers keep members on track with necessary screenings and exams based on age and gender.

Seaside Health Plan adopts the Primary Plan's Preventive Health Care Guidelines and/or U.S. Preventive Services Task Force.

Providers can access the most up-to-date preventive healthcare guidelines through the Internet by going to the following links and scrolling through age-related sections for more specific information:

- Primary Plan's website
- US Preventive Services Task Force http://www.uspreventiveservicestaskforce.org/tools.htm

If you do not have Internet access, you can request a hard copy of the Preventive Health Care Guidelines by calling our Member Services at (855) FOR-SSHP or (855) 367-7747.

Our recommendation of these guidelines is not an authorization, certification, explanation of benefits, or a contract. Benefits and eligibility are determined in accordance with the requirements set forth by the State of California.

CHAPTER 10: ACCESS STANDARDS & ACCESS TO CARE

APPOINTMENT STANDARDS

We base standards for appointment scheduling on guidelines published by the American College of Obstetricians and Gynecologists (ACOG), National Committee for Quality Assurance (NCQA); as well as L.A. Care, Department of Health Care Services (DHCS) and California Department of Managed Health Care (DMHC) contractual requirements.

Primary care physicians (PCPs) and specialists must meet standards for appointment scheduling to ensure that members have timely access to medical care and services. We monitor provider compliance with appointment access on a regular basis. Failure to comply with outlined standards may result in corrective action.

Initial Health Assessments

PCPs are required to perform an Initial Health Assessment (IHA), which, depending on the member's age, includes a complex medical history, a head-to-toe physical examination and an assessment of health behaviors within 60 (for members younger than 18 months) to 120 days (for members 18 months and older) of the new members' assignment to the practice.

Access Guidelines

Seaside Health Plan providers comply with the following access guidelines or the current DMHC guidelines:

Service	Definition	Availability Standard
Emergency Services	**Emergency:** Services for a potentially life threatening medical and mental health condition requiring immediate intervention to avoid disability or serious detriment to health	Immediate, 24 hours a day, 7 days per week
Urgent Care	**Urgent Care:** Services for a non-life threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner	Within 48 hours of request when no prior authorization is required
		Within 96 hours of request when a prior authorization is required
Interpreter Services	**Interpreter Services** Provided either in-person, over the phone or by video in the language preference of the member	Coordinated and scheduled at the time of the appointment

PCP	**Preventive Care**: Well Child Exams, Physical Exams, Routine Wellness Appointments	Within 30 business days of request
	EPSDT/CHDP	10 business days of request, not to exceed 30 calendar days
	Routine Primary Care (non-urgent): Services for a patient who is symptomatic but does not require immediate diagnosis and/or treatment	Within 10 business days of request
	Office Waiting Room Time: The time a patient with a scheduled medical appointment is waiting to see a practitioner once in the office	≤ 45 minutes
	Speed of Telephone Answer (Practitioner's Office): The maximum length of time for practitioner office staff to answer the phone	30 seconds
Specialty Care Providers	**Routine Specialty Care (non-urgent)** Services for a patient who is symptomatic but does not require immediate diagnosis and/or treatment	Within 15 business days of request
	First Prenatal Visit	Within 14 calendar days of request
		Within 7 calendar days of request of request
Ancillary	**Routine Ancillary Services (non-urgent)**	Within 15 business days of request
Behavioral Health and Autism Diagnosis and Treatment	**Routine Behavioral Health Care (non-urgent)**	Within 10 business days of request
	Non-life-threatening emergency	Within 6 hours of hours
	Behavioral Health Telephone Responsiveness • Quarterly average speed of answer for screening and triage calls. • Quarterly average abandonment rate for screening and triage calls.	≤ 30 seconds ≤ 5%

Access to After-Hours Medical and Mental Health Care	**Member Services, answering services, automated systems must:** • Provide emergency instructions • Offer a reasonable process to contact the covering physician or other "live" party • If process does not enable the caller to contact the covering physician directly, the "live" party must have access to a practitioner for both urgent and non-urgent calls • Professional exchange staff must have access to practitioner for both urgent and non-urgent calls	Available 24 hours a day
	Call Return Time The maximum length of time for PCP or on-call physician to return a call after hours	30 minutes
Dental, if Applicable	**Dental Services** Urgent Care	Within 72 hours of the request
	Routine Dental Services (non-urgent)	Within 36 business days of the request
	Preventive Dental Care	Within 40 business days of the request

Missed Appointment Tracking

When members miss appointments, providers must document the missed appointment in the members' medical record. Providers must make at least three attempts to contact the member to determine the reason for the missed appointment.

The medical record must reflect the reason for any delays in performing an examination, including any refusals by the member. Documentation of the attempts to schedule an Initial Health Assessment must be available to us or state reviewers upon request.

Med-Cal Beneficiary Health Care Rights

To ensure compliance with Medi-Cal Beneficiary Health Care Rights (CA 42 CFR Section 438.100), Seaside Health Plan members enrolled in the Medi-Cal Program are allowed to obtain health care from Federally Qualified Health Centers (FQHCs) and Indian Health Centers. Independent Practice Associations (IPAs) are encouraged to contract with and support the traditional safety net providers. If an IPA is not contracted with an FQHC or Indian Health Center, the IPA must still allow any member assigned to one of its contracted providers to have access to these safety net clinics.

CHAPTER 10: ACCESS STANDARDS & ACCESS TO CARE

The Seaside Health Plan policy, which supports the Medi-Cal Beneficiary Health Care Rights, is that if a member assigned to an IPA-contracted provider receives covered health care services during a visit to an FQHC or Indian Health Center, then that clinic will bill the IPA at the prevailing Medi-Cal fee-for-service rate for that visit. The IPA must pay the claim as an out-of-network provider. In this way, compliance with regulations will be maintained, and these safety net providers will be kept financially whole.

AFTER-HOURS SERVICES

Members have access to quality, comprehensive health care services 24 hours a day, 7 days a week. Members can call their PCP with a request for medical assessment after PCP normal office hours. The PCP must have an after-hours system in place to ensure that the member can reach his or her PCP or an on-call physician with medical concerns or questions. An answering service or after-hours personnel must instruct the member that the length of wait for the Provider to contact the member (within 30 minutes for urgent situations) or forward member calls directly to the PCP or on-call physician.

The answering service or after-hours personnel must ask the member if the call is an emergency. In the event of an urgent situation, after-hours personnel immediately connect the member to the PCP or an on-call physician. In an emergency, after-hours personnel direct the member to dial 911 or to proceed directly to the nearest hospital emergency room.

We prefer that the PCP use a Plan-contracted in-network physician for on-call services. When that is not possible, the PCP must use best efforts to ensure that the covering, non-contracted, on-call physician abides by the terms of the Provider contract.

We monitor PCP compliance with after-hours access standards on a regular basis. Failure to comply with after-hours access standards may result in corrective action.

Members can also call the health plan's 24-hour 24/7 Nurse Advice Line information line to speak to a registered nurse. The health plan's 24/7 Nurse Advice Line nurses provide health information regarding illness and options for accessing care, including emergency services, if appropriate.

Non-English speaking members who call their Provider after hours can expect to receive language appropriate messages with appropriate care instructions. These instructions direct the member to dial 911 or to proceed directly to the nearest hospital emergency room in the event of an emergency or provide instructions on how to call the on-call provider in a nonemergency. If an answering service is used, the person at the answering service should know where to contact a telephone interpreter for the member.

CONTINUED ACCESS TO CARE/CONTINUITY OF CARE

In compliance with California Health and Safety Code Sections 1373.65, 1373.95 and 1373.96 (SB244) California law regarding continuity of care, we ensure continued access to care for members with qualifying conditions.

Qualifying conditions are medical conditions that may qualify a member for continued access to care/continuity of care, such as, but not limited to:

- An acute condition
- A serious chronic condition
- Pregnancy, regardless of trimester, through immediate postpartum care
- Terminal illness
- Care of a newborn child between the ages of birth and 36 months
- Surgery or other procedure authorized by us that is scheduled to occur within 180 days of the contract's termination or within 180 days of the effective date of coverage for a newly covered enrollee
- Degenerative and disabling conditions (a condition or disease caused by a congenital or acquired injury or illness that requires a specialized rehabilitation program or a high level of care, service, resources, or continued coordination of care in the community)

Continuity of Care Process

Care management nurses review member and Provider requests for continuity of care. If continuity of care is appropriate, facilitate continuation with the current physician until short-term regimen of care is completed or the member transitions to a new practitioner.

Only a Plan physician can deny continuity of care services. Decisions are communicated in writing and mailed to the member and to the physician within two business days of the decision. Members and physicians can appeal the decision by following the procedures in ***Chapter 9, Member Grievances and Appeals.***

Examples of reasons for continuity of care denials include, but are not limited to:

- The condition is not a qualifying condition.
- The treating physician is currently contracted with us.
- The request is for change of PCP only and not for continued access to care.
- The member is ineligible for coverage.
- The course of treatment is complete.
- Services rendered are covered under a global fee.
- The services requested are not a covered benefit.

- Continuity of care is not available with the terminating Provider.

Emergency Department Protocol Reporting Process

Seaside does not require prior authorization of emergency services and care to a patient with medical/psychiatric emergency.

Seaside provides 24hr access for patients and providers including non- contracted hospitals to obtain timely authorizations for medically necessary post-stabilization Care through the 24 hr toll-free member services line.

If post-stabilization requests are denied, the decision is communicated within 30 mins of the request.

CHAPTER 11: PROVIDER QUALITY IMPROVEMENT

QUALITY MANAGEMENT (QM) PROGRAM STRUCTURE

As required by federal and state guidelines, Seaside Health Plan's QM Program provides an ongoing monitoring and improvement of the accessibility, availability, continuity, and quality of clinical care and service delivered to plan members to ensure that appropriate care provided by each contracting provider group is consistent with professionally recognized standards of practice and not withheld or delayed for any reason, including a potential financial gain and/or incentive to the Plan Providers, and/or others.

Quality Management (QM) Program Scope

QM Program activities of problem identification, evaluation, corrective action and follow-up are designed to measure the quality of services that the members receive. Seaside Health Plan staff accomplishes these activities with input from the various committees, focusing on effectiveness, accessibility, availability, appropriateness and continuity of care.

The scope of clinical services review includes, but is not limited to; services provided all contracted provider entities such as Physicians, hospitals, ambulatory care and outpatient surgery centers.

If after evaluation of a monitored process indicator or audit reveals that inappropriate or sub-standard services have been provided or that services have not been provided, actions for improvement are instituted according to the various quality committee recommendations, and through the appropriate department(s). These actions may include education, system and/or process changes, or disciplinary action, as necessary.

In addition to the internal quality of care review system, Seaside Health Plan's QM program designs and implements reasonable procedures for continuously reviewing the performance of health care personnel, utilization of services, facilities, and cost.

Seaside Health Plan tracks and trends the quality of care provided by individual Providers/provider groups through provider-specific rates, investigation of complaints regarding specific cases and site visits to ensure that care provided meets professionally recognized standards of practice.

Quality Management (QM) Program Work Plan and Annual Evaluation

Seaside Health Plan implements a QM Work Plan for corrective actions or QM Programs to address identified quality issues by incorporating input from appropriate professionals into the design of the QM Work Plan.

The QM Program and QM Work Plan are reviewed, evaluated and revised on an annual basis to assess the effectiveness of its corrective actions or QM Programs. Results of the evaluation are used to formulate corrective action to the next year's program, and are the basis of the next year's QM Program QM Work Plan. The annual evaluation, revised QM Program, and QM Work Plan activities are submitted to the Board of Directors for review, input, and final approval. The QM Work Plan is reviewed quarterly by the Plan Quality Council which includes monitoring the effectiveness of the programs and tracks how the QM Work Plan is incrementally performing.

CHAPTER 11: PROVIDER QUALITY IMPROVEMENT

What Providers Can Do to Support the Plan's Quality Management (QM) Program

Providers support the activities of the Quality Management (QM) Program by:

- Providing access to medical records for quality improvement projects and studies
- Participating in the facility and medical record audit process
- Completing corrective action plans when applicable
- Responding in a timely manner to requests for written information and documentation if a quality of care or grievance issue has been filed
- Utilizing preventive health and clinical practice guidelines in member care

HEDIS Activities

We ask Providers to support and contribute to our efforts to improve HEDIS measures rates.

Seaside Health Plan provides assistance for medical office staff regarding HEDIS activities. Additionally, Providers can request information which includes:

- Information about the year's selected HEDIS measures
- Guidelines on how data for those measures will be collected
- Codes associated with each measure for administrative data
- Tips for smooth coordination of medical record data collection

Access to Medical Records for HEDIS Reviews

The Quality Management staff will contact the Provider's office to arrange for a review or to copy any medical records required for QM studies.

Office staff must give access to medical records for review and copying.

Satisfaction Surveys

Member Satisfaction Surveys

We participate in the Consumer Assessment of Healthcare Providers and Systems (CAHPS), an annual survey of members to measure satisfaction with the service and care provided by us and our Providers.

CHAPTER 11: PROVIDER QUALITY IMPROVEMENT

The survey measures access to care, member satisfaction with the Plan, and satisfaction with provider communication and office staff performance.

Provider Satisfaction Surveys

We may conduct Provider surveys to monitor and measure Provider satisfaction with our services and access to care and to identify areas for improvement. We inform Providers of results and plans for improvement through Provider bulletins, newsletters, and meetings, or training.

Provider participation in the survey process is highly encouraged. Provider feedback is very important to us to help address areas needing improvements.

CHAPTER 11: PROVIDER QUALITY IMPROVEMENT

MEDICAL RECORD AND FACILITY SITE REVIEWS

We may conduct medical record reviews and Facility Site Reviews to:

- Determine the Provider office's ongoing compliance with standards for providing and documenting health care services and with processes that maintain safety standards and practices
- Confirm Provider involvement in the continuity and coordination of care for the members

DHCS and the Plan have the right to enter into the premises of Providers to inspect, monitor, audit, or otherwise evaluate the work performed. We will perform all inspections and evaluations in such a manner as not to unduly delay work (in accordance with the Provider contract).

Facility Site Review

As required by California statute, all primary care physician sites participating in the Medi-Cal Managed Care Program statute must undergo an initial site inspection (Facility Site Review) and subsequent periodic site inspections, regardless of the status of other accreditation or certification. A Facility Site Review is completed as part of the initial credentialing process for new Providers if that site has not been previously reviewed and accepted as part of the Plan's credentialing process.

The Plan conducts a Facility Site Review of each PCP every three years in accordance with Plan standards.

Obstetrics/Gynecology (OB/GYN) specialty sites participating in the Medi-Cal Managed Care Program (and not serving as PCPs) must undergo an initial site inspection.

Site Review Collaboration

We collaborate with other health plans within each Medi-Cal Managed Care county to establish systems and implement procedures for coordinating and consolidating site audits for mutually shared primary care physicians. The collaboration provides a system-wide process to minimize site review duplication and to support consistency in PCP site reviewers.

Facility Site Review Scoring

We will notify Providers of the Facility Site Review score, all cited deficiencies, and corrective action requirements at the time of a non-passed survey.

Provider office sites will complete a critical element deficiency corrective action plan within 10 days of the Facility Site Review.

CHAPTER 11: PROVIDER QUALITY IMPROVEMENT

Provider Support of the Facility Site Review Process

The Provider and office staff will:

- Provide an appointment time for the Facility Site Review
- Be available to answer questions and to participate in the exit interview
- Schedule a time for follow-up Facility Site Reviews, if applicable
- Correct critical element deficiencies within 10 days following the Facility Site Review
- Complete a corrective action plan within 30 days
- Sign an attestation statement (a section of the facility application) that corrective actions are complete
- Submit a completed corrective action plan, supporting documents, and signed attestation statement to our Quality Management Analyst

MEDICAL RECORD DOCUMENTATION STANDARDS

We established medical record standards that require Providers to maintain medical records in a manner that is current and organized and permits effective and confidential member care and quality review. We perform medical record reviews upon signing of a contract and, at a minimum, every three years thereafter to assure that network Providers are in compliance with the standards.

Medical records are stored and retrieved in a manner that protects patient information according to the Confidentiality of Medical Information Act. This act prohibits a provider of health care from disclosing any individually identifiable information regarding a patient's medical history, mental, and physical condition or treatment without the patient's or legal representative's consent or specific legal authority. Records required through a legal instrument may be released without patient or patient representative consent. Providers must be familiar with the security requirements of the Health Insurance Portability and Accountability Act (HIPAA) and be in compliance.

Providers must keep, maintain and have readily retrievable medical records as are necessary to disclose fully the type and extent of services provided to a member in compliance with state and federal laws. Documentation must be signed, dated, legible and completed at or near the time at which services are rendered.

CHAPTER 11: PROVIDER QUALITY IMPROVEMENT

Providers must ensure that an individual is delegated the responsibility of securing and maintaining medical records at each site.

Providers shall prepare and maintain all appropriate records in a system that permits prompt retrieval of information.

Providers must protect patient confidentiality and shall make member's information, including but not limited to, medical records available in accordance with applicable state and federal law so not to cause undue delay or disruption in care.

Medical Record Documentation Standards

Every medical record, at a minimum, is to include:

- The patient's name or ID Number on each page in the record
- Personal biographical data, including home address, employer, emergency contact name and telephone number, home and work telephone numbers, and marital status
- All entries dated with month, day, and year
- All entries contain the author's identification (for example, handwritten signature, unique electronic identifier or initials) and title
- Identification of all providers participating in the member's care and information on services furnished by these providers
- A problem list, including significant illnesses and medical and psychological conditions
- Presenting complaints, diagnoses and treatment plans, including the services to be delivered
- Physical findings relevant to the visit including vital signs, normal and abnormal findings, and appropriate subjective and objective information
- Information on allergies and adverse reactions (or a notation that the patient has no known allergies or history of adverse reactions)
- Information on advance directives
- Past medical history, including serious accidents, operations, illnesses, and, for patients 14 years old and older, substance abuse. For children and adolescents past medical history relates to prenatal care, birth, operations, and childhood illnesses.

- Physical examinations, treatments necessary, and possible risk factors for the member relevant to the particular treatment
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- For patients 14 years and older, appropriate notation concerning the use of cigarettes, alcohol, and substance abuse (including anticipatory guidance and health education)
- Information on the individuals to be instructed in assisting the patient
- Medical records, which must be legible, dated and signed by the physician, physician assistant, nurse practitioner, or nurse midwife providing patient care
- An immunization record for children that is up-to-date or an appropriate history is in the medical record for adults.
- Provider communication regarding diagnosis, treatment plan and health education provided to the patient;
- Referrals and coordination of care activities to fully demonstrate continuity of care needs are addressed;
- Screening and timely identification and referral of members diagnosed with co-existing medical and mental health conditions.

CHAPTER 11: PROVIDER QUALITY IMPROVEMENT

ADVANCE DIRECTIVES

Advance Directives are written instructions, such as living wills or durable powers of attorney for health care, recognized under state law and signed by a patient, that explain the patient's wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known.

Seaside Health Plan requires documentation of advance directives/Living Will/Power of Attorney discussion in a prominent part of the medical record for adult patients and documentation on whether or not the patient has executed an advance directive with a copy to be included in the medical record.

Seaside Health Plan adopts and implements the Primary Plan's policies and procedures on advance directives for its members allowing a member's representative to facilitate care or treatment decisions for a member who is unable to do so.

Five Wishes Training Video for staff training is available to you through Seaside or the Five Wishes website.

CHAPTER 12: CLINICAL PRACTICE GUIDELINES

CLINICAL PRACTICE GUIDELINES

Seaside Health Plan supports physicians in following nationally-accepted clinical practice guidelines to improve the health of the members. Several national organizations produce guidelines for asthma, diabetes, hypertension, and other conditions. We have reviewed and recommend these clinical practice guidelines.

Providers can access the most up-to-date clinical practice guidelines from nationally recognized sources through the Internet by going to the following links:

- Enter www.SeasideHealthPlan.org

If you do not have Internet access, you can request a hard copy of the Clinical Practice Guidelines by calling our Member Services at 1-855-367-7747.

Our recommendation of these guidelines is not an authorization, certification, explanation of benefits, or a contract. Benefits and eligibility are determined in accordance with the requirements set forth by the State of California.

CHAPTER 13: HEALTH SERVICES AND PROGRAMS

INITIAL HEALTH ASSESSMENT

Primary care physicians (PCPs) must perform an Initial Health Assessment (IHA) with new members. The IHA consists of:

- A history and physical examination
- A developmental assessment
- A health education behavioral assessment that enables the provider to comprehensively assess the member's current acute, chronic, and preventive health needs

For new members over the age of 18 months, providers must complete an IHA within 120 days of enrollment. For members under the age of 18 months, providers must complete an IHA within 60 days following the date of enrollment or within the periodicity schedule established by the American Academy of Pediatrics for children ages two and younger, whichever is less.

The provider or staff member must contact a new member to schedule an appointment for an initial health examination. Providers have access to an eligibility report online under our secure provider website, ProviderAccess. Providers who are unable to access the website can request a hard copy of the monthly new member eligibility report by calling our Member Services.

An IHA is not necessary if the member is new to the Plan but is an existing patient of the PCP group and has a documented IHA within the past 12 months prior to the member's enrollment. Follow-up is not required if there is an established medical record that shows a baseline health status. This record must include sufficient information for the PCP to understand the member's health history and to provide treatment recommendations, as needed. Transferred medical records can meet the requirements for an IHA if a completed health history is included.

For children under 21 years of age, providers must complete:

- A physical examination
- A developmental history
- An assessment of nutritional status
- A dental evaluation
- A vision screening
- A hearing screening

We monitor PCP provision of IHAs through different methods, such as quality management studies, medical record reviews, and facility audits.

CHAPTER 13: HEALTH SERVICES AND PROGRAMS

The translated forms are available for printing at www.SeasideHealthPlan.org in the Forms and Tools Library section. You also may contact our Member Services.

STAYING HEALTHY ASSESSMENT TOOL

Providers must use the Staying Healthy Assessment Tool (SHAT), also known as the Individual Health Education Behavioral Assessment (IHEBA), with all new Medi- Cal members. The Office of Clinical Preventive Medicine (OCPM), the Medi-Cal Managed Care Division (MMCD), and Medi-Cal Managed Care Health Plans developed this assessment over the past several years to:

- Identify health risk behaviors
- Provide health education counseling
- Assist in prioritizing individual health education needs related to lifestyle, behavior, environment and cultural linguistic background
- Assist in initiating and documenting focused health education interventions, referrals and follow-up

The Staying Healthy Assessment Tool is a set of five age-specific questionnaires that address 11 different patient behavioral risk factors, such as alcohol use, smoking, and nutrition. Providers can find these questionnaires online at www.dhs.ca.gov/ps/ocpm/html/staying%20healthy.htm.

Our Health Promotion Consultants (HPCs) or other designated Community Outreach Specialist (COS) can provide the necessary training and materials needed to implement the SHAT in the PCP offices.

New Medi-Cal Members

All new Medi-Cal members need to complete the SHAT within 120 calendar days of enrollment or within 60 days for children less than 18 months of age as part of the Initial Health Assessment.

Existing Medi-Cal Members

All existing members need to complete the assessment at their next non-acute care visit but no later than the next scheduled health screening exam.

PCP Responsibilities

This text is adapted from the Department of Health Care Services' website.

To meet administrative timelines, the PCP must review the completed form with the member initially, review it again annually, and re-administer it to:

- Children when they start in a new age group (such as 0–3, 4–8 and 9–11 years)

- Adolescents age group 12–17 years (administer the form annually)
- Adults 18 years and older (review the form annually; re-administer the form every 5 years)

The PCP must document health education interventions and referrals using Intervention Codes listed on the bottom of each tool and initial and date all interventions.

Members can complete the SHAT questionnaires, or office staff can provide assistance utilizing age appropriate forms for each age group. Counseling points are available on the California Department of Health Care Services website to discuss important behavior risk factors for which patients may need additional health education and counseling.

We monitor PCP provision of the SHAT through different methods such as quality management studies, medical record reviews and facility audits.

HEALTH EDUCATION MATERIALS AND REFERRALS

Seaside Health Education (HE) Program is committed to improving and maintaining the health and wellness of the members through health promotion and disease management offered in a culturally sensitive and linguistically appropriate manner.

Seaside adopts the member's Primary Plan health education materials and make available for PCP and members through our website at www.SEASIDEHEALTHPLAN.org and in hard copies upon request. Please call the Seaside Member Services to request hard copies of health education materials.

The following are available for HE materials:

- Age Specific Anticipatory Guidance
- Asthma
- Breastfeeding
- Childhood Obesity *
- Diabetes
- Exercise/Physical Activity
- Family Planning
- HIV/STD Prevention
- Hypertension
- Immunizations
- Injury Prevention (intentional & unintentional)
- Lead Poisoning*
- Nutrition
- Obesity
- Parenting
- Perinatal
- Substance Abuse
- Tobacco Prevention and Cessation
- Well Child *

* Additional health topic requirements for Healthy Families Members.

How to Schedule Health Education Classes

The Utilization Management (UM) Department handles referrals for HE classes and/or other interventions. You may refer their patients for HE by completing and submitting the Health Education Referral Form or the Treatment Authorization Request Form and faxed Seaside UM Department. Once received, UM will locate a health education class in collaboration with the Primary Plan.

CHAPTER 14: CREDENTIALING AND RECREDENTIALING

CREDENTIALING POLICIES

Seaside Health Plan ensures that its IPAs/Medical Groups, medical providers, ancillary providers, and pharmacies meet the credentialing and re-credentialing performance standards for participation on practitioner panel. Seaside Health Plan evaluates and selects licensed independent practitioners to provide care to its members.

The types of practitioners credentialed and re-credentialed include Medical Practitioners, Psychiatrists, Addiction Medicine Specialists, DCs, DDSs/DMDs (Oral Surgeons), DOs, DPMs, PAs and APNs Master's level CCNSs, CPNPs, CNPs, and CNMs.

We also credentials contracted Health Delivery Organizations (HDOs) for participation in our network:

- Acute care hospitals;
- Home health agencies;
- Skilled nursing facilities;
- Nursing homes;
- Free-standing surgical centers;
- Behavioral health facilities providing mental health and/or substance abuse treatment in an inpatient, residential or ambulatory setting.

Primary or NCQA accredited/certified verification sources are used to ensure that credential decisions are based on the most accurate, current and complete information available. Verification sources must not be more than 180 calendar days of the credentialing committee decision.

Seaside Health Plan Credentialing Committee

Seaside Health Plan's Credentialing Committee (CC) is a peer review body that decides to accept, keep, deny or end a practitioner's participation in Seaside Health Plan's programs or networks.

Our verification of credentials is ongoing and up-to-date, and the re-credentialing process is implemented every three years. The CC, which meets on a predetermined basis, may have additional meetings called by the Chair of the CC on an as-needed basis.

We notify providers that they have the right to review information that supports their credentialing applications. If we can't verify the credentialing information or if a discrepancy is found, Seaside Health Plan asks practitioner within 30 calendar days of notice to correct wrong information. We also provide details about the issue in question, how to submit more information and where to send it.

CHAPTER 14: CREDENTIALING AND RECREDENTIALING

Initial Credentialing Process

Each practitioner or provider needs to complete a standard application form. The application form may be required by the state or it may be a standard form that Seaside Health Plan either created or accepted. Seaside Health Plan uses the Council for Affordable Quality Healthcare (CAQH) form for practitioners.

During the credentialing process, we verify an applicant's legal authority to practice, relevant training, experience and competency from original sources. All verifications need to be current and take place within the 180-day period before the credentialing committee makes its recommendation or verifications need to follow other usual accreditation standards.

Practitioner will be notified of the initial credentialing decision (approvals/denials) and re-credentialing denials within 60 calendar days of the CC's decision.

Re-credentialing Process for Providers

Seaside Health Plan's re-credentialing process re-verifies and identifies changes in provider's license, sanctions, certification, health status and/or performance information. This includes, but is not limited to, malpractice experience, hospital privileges or other activities that may reflect on provider's professional conduct and competence. Seaside Health Plan reviews this information to assess whether the Plan's network practitioners and Health Delivery Organizations continue to meet Seaside Health Plan's credentialing standards.

Seaside Health Plan must re-credential all practitioners and Health Delivery Organization in network and in the Plan's credentialing program every three (3) years unless contract or state regulations require more frequent re-verification.

Health Delivery Organizations (HDO)

To determine whether participating network Health Delivery Organizations (HDO) meet appropriate standards of professional conduct and competence, they are subject to credentialing and re-credentialing within the scope of Seaside Health Plan credentialing program. Seaside Health Plan's re-credentials HDOs every 3 years unless regulatory or accrediting bodies require more frequent re-credentialing. Each HDO that applies for continuing participation in the Plan's programs or networks needs to complete and submit a re-credentialing application along with all the required supporting documentation.

New HDO applicants need to submit a standardized application to Seaside Health Plan for review. If applicants meet the screening criteria, Seaside Health Plan starts the credentialing process. In addition to meeting Seaside Health Plan's licensing and other eligibility criteria for participating HDOs, new HDO applicants are required to maintain accreditation by an appropriate, recognized accrediting body. If there is no accreditation, Seaside Health Plan may evaluate the most recent site survey by Medicare or the appropriate state oversight agency for that HDO.

CHAPTER 14: CREDENTIALING AND RECREDENTIALING

Appeals Process

If the information reviewed during the credentialing or re-credentialing process shows that providers are not meeting professional conduct and competence standards, Seaside Health Plan may not approve or may end their participation in the programs or network. It is Seaside Health Plan's goal to treat participating and applying providers fairly, and provide them with a process to appeal rulings that end their participation for professional competence and conduct reasons. They may also appeal rulings that would result in a report to the National Practitioner Data Bank (NPDB). If providers, including HDOs, have been refused initial participation in our networks, they have the opportunity to correct any errors or omissions which may have led to the refusal.

Seaside Health Plan gives practitioners the opportunity to appeal if they've been denied and/or terminated from participating our networks or programs. This includes denials of requests for initial participation that Seaside Health Plan reported to the NPDB based on professional competence and conduct considerations. If a practitioner's license is suspended or lost, if there is a criminal conviction or if we determine that the practitioner may pose a risk of harm to members, we may end the practitioner's participation immediately. A practitioner whose license has been suspended or revoked does not have a right to informal review/reconsideration or formal appeal.

More information about credentialing and recredentialing can be found on the Seaside Health Plan's website at www.SeasideHealthPlan.org

CHAPTER 15: ENROLLMENT AND MARKETING RULES

PHYSICIAN MARKETING

Limitations on the Medi-Cal Program

Because physicians are in a unique position of trust to influence patients on the selection of a health plan, the Department of Health Care Services (DHCS) has created policies for marketing practices by Providers for state programs.

Policies prohibit network Providers from making false and misleading claims that:

- The Primary Care Physician (PCP) office staffs are employees or representatives of the state, county, or federal government.
- The Plan is recommended or endorsed by any state agency, county agency, or any other organization.
- The state or county recommends that a prospective member enroll with a specific health plan.
- A prospective member or medical recipient will lose benefits under the Medi-Cal Program or other welfare benefits if the prospective member does not enroll with a specific health plan.

Policies **prohibit** network Providers from:

- Offering or giving away any form of compensation, reward, or loan to a prospective member to induce or procure a Seaside Health Plan member enrollment in a specific health plan
- Using any list of members for enrollment purposes obtained originally from confidential state or county data sources or from data sources of other contractors
- Using any list of Seaside Health Plan members for enrollment purposes obtained originally from confidential state or county data sources or from the data sources of other contractors
- Marketing practices that discriminate against medical recipients based on marital status, age, religion, sex, national origin, language, sexual orientation, ancestry, pre-existing psychiatric problem, or medical condition (such as pregnancy, disability or acquired immune deficiency syndrome) other than those specifically excluded from coverage under our contract
- Reproducing or signing an enrollment application for the member
- Engaging in any marketing activity on state or county premises on behalf of Seaside Health Plan or its affiliates or any other location not authorized in Seaside Health Plan's Marketing Plan (event locations include, but are not limited to, health fairs and festivals, athletic organizations and events, recreational activities, and Plan-sponsored events (including grand openings and luncheons, school-based enrollment events, Back to School Nights, conferences, safety fairs, Chambers of Commerce, small businesses and other locations approved by DHCS)

Providers and both members and prospective members may:

- Help the member preliminarily find out what program he or she may qualify.

- If a qualified prospect expresses interest in us during a medical visit, Providers may direct him or her to call Seaside Health Plan (855) 367-7747.

- Direct individuals who are eligible for Medi-Cal to call our Outreach Call Center (OCC) at (855) 367-7747to contact a Community Outreach Specialist (COS).

- File a complaint with us if you or a member objects to any member marketing either by other physicians or our representatives; refer to Chapter 9, Member Grievances and Appeals, for more information on the complaint process

How Prospective Members Find Out About Us

The Plan and its contracted network Providers may not market directly to individuals and families. Any information prospective members receive about our Plan comes from the State, from the Plan upon a specific prospective member request, from the Plan's Community Resource Coordinators (for Medi-Cal members), or from marketing activities approved by DHCS. The State must also approve any marketing materials we create.

PHYSICIANS' ROLE IN MEDI-CAL MARKETING AND ENROLLMENT

As a provider caring for Medi-Cal and other State Sponsored Business members, you are required to obtain approvals prior to using patient-focused marketing materials that you create. Before distributing materials to your Medi-Cal patients, submit your materials to us. We will review and seek approval from the following agencies, as appropriate:

- Primary Health Plan: Health Net, LA Care Health Plan, Anthem Blue Cross
- Department of Health Care Services (DHCS),
- Department of Managed Health Care (DMHC),
- Other stakeholders, as required.

We are not responsible for obtaining approvals from other health plans with which you may participate as a provider of services. Seaside Health Plan may obtain separate legal review from in-house counsel for any materials submitted for approval. Please contact your local COS when you have materials for review. Please keep in mind as you are planning your materials that the review period can vary for a complete review and response to the provider office. Your local COS will let you know the time line, depending on the request.

CHAPTER 15: ENROLLMENT AND MARKETING RULES

PROGRAM ENROLLMENT PROCESS

Medi-Cal

Enrollment in our Medi-Cal Program occurs through L.A. Care for Los Angeles County members or through Health Care Options (HCO) for mainstream counties. These DHCS-contracted enrollment companies present health plan options to individuals and families eligible for Medi-Cal or other programs. These individuals and families then enroll into the managed care plan of their choice. The enrollment company informs us of any new member enrollment and notifies us after enrollment of any changes in member eligibility, status, or member information (such as change of address).

Medi-Cal recipients receive a pre-enrollment packet that includes a Medi-Cal Enrollment Form and the Plan's provider directory. If not assigned to a Managed Medi-Cal Plan, Medi-Cal recipients must complete and return the signed Enrollment Form to HCO within 45 days. This includes the selection of a health plan and a Primary Care Provider (PCP). If the member does not choose a plan or a PCP within that time frame, the State assigns the member to a Managed Medi-Cal plan and then submits the member information to the Plan. The Plan then assigns a PCP for the member.

For more enrollment information, use the following resources:

DHCS Medi-Cal Website:	www.medi-cal.ca.gov
L.A. Care (Los Angeles County):	1-888-452-2273
HCO (all counties except Los Angeles County):	1-800-430-4263

MEDI-CAL – CALIFORNIA'S MEDICAID PROGRAM

What Is Medi-Cal?

Seaside Health Plan provides Medi-Cal services for the California Department of Health Care Services and the Department of Public Health in Alameda/Contra Costa, Fresno, Los Angeles (as a Plan partner with L.A. Care Health Plan), Sacramento, San Francisco, San Joaquin, Santa Clara, Stanislaus and Tulare Counties. We enhance access, emphasize prevention, improve quality of care, educate members and providers and provide first-class customer service.

Medi-Cal (California's Medicaid Program)

Medi-Cal:

- Is the second largest source of health care coverage in California, surpassed only by employer-based coverage.
- Provides health care coverage for low-income people who lack health insurance.

- Is a complex network of public and private health care providers who serve California's most vulnerable citizens.

Who Is Eligible for Medi-Cal?

While Medi-Cal is for low-income Californians, not everyone who is poor is eligible. There are 165 categories, or ―aid codes, under which an individual or a family may be eligible. Generally speaking, Medi-Cal covers:

- Low-income children and their parents.
- Aged, blind or disabled persons.
- Low-income pregnant women.
- Individuals with refugee status.
- Qualified low-income Medicare recipients.
- People in special treatment programs (for example, tuberculosis and dialysis).

In Los Angeles County, we are subcontractors for the Medi-Cal Program for L.A. Care Health Plan.

See *Medi-Cal Managed Care Benefits Summary* for Medi-Cal benefits information.

Program Contacts

Medi-Cal Customer Care Center:	1-800-407-4627Blue cross
Medi-Cal, Health Care Options (HCO):	1-800-430-4263
L.A. Care Customer Care Center:	1-800-285-7801
Medi-Cal, L.A. Care (Los Angeles County):	1-888-452-2273

DENTAL SERVICES BENIFITS

Proper dental care is essential to the overall health of the members. Lack of dental care and resulting oral diseases are among the most prevalent health problems in the United States. Lack of attention to dental issues can contribute to existing medical problems, reflect nutritional status, and create psychosocial problems.

Our PCPs perform dental screening as part of the initial health assessments (IHA) for adults and children. This inspection follows guidelines established under the Child Health and Disability Prevention (CHDP), the Comprehensive Perinatal Services Program (CPSP) and the U.S. Preventive Task Force Guidelines.

Dental services are not available for Medi-Cal members over age 21.

Screening for Dental Problems

PCPs conduct an inspection of the teeth, gums and mouth as part of an initial health assessment and make referrals to a dentist if appropriate.

Dental Referral Procedures

If needed, referrals to a dentist occur at a minimum during the initial health assessment and following each subsequent preventive care assessment. Members who have medical conditions or who are taking medication that affect the condition of the mouth or teeth are referred on an as-needed basis (for example, members who are immuno-compromised due to HIV or chemotherapy are at risk for developing mouth lesions that will require immediate care).

The referral of children is a priority. An oral assessment is conducted during CHDP screenings; Medi-Cal eligible children over the age of three need to be linked to a dentist for preventive dental care, diagnosis, and treatment of existing problems. Parents needing assistance with scheduling a dentist appointment or obtaining transportation to the dentist are referred to the local CHDP office.

Medi-Cal members can also call the toll-free Denti-Cal Dental Plan number at 1-800-423-0507 for dental plan information, referral to a dentist, or for information related to the member's designated dental plan (if applicable).

MENTAL HEALTH SERVICES

Non-Emergency Mental Health Services

PCPs shall treat members with situational mental health, the most common of which are depression and anxiety disorders. For members whose mental health does not respond to treatment in a primary care setting, call the following numbers for referral and authorization information regarding assessment and ongoing services:

- Medi-Cal: Call your local county mental health department.

Emergency Mental Health Services

PCPs refer any member in crisis, or who is a threat to himself, herself, or others, immediately for emergency care. An emergency referral for mental health services does not require a pre-service review by us; however, PCP-initiated referrals allow for better coordination of care for the member.

The Mental Health Parity Law Protects Members with Certain Conditions

A health plan must cover the same or equal benefits for certain mental health conditions that it covers for other medical conditions. This is called "mental health parity." It is a law in California.

The Mental Health Parity Law (MHPAEA) ensures the same medical care coverage for the following mental health conditions:

- Major depression
- Bipolar (manic-depressive) disorder
- Panic disorder
- Anorexia
- Bulimia
- Obsessive-compulsive disorder
- Autism or Pervasive Developmental Disorder
- Schizophrenia
- Schizoaffective disorder
- Children's severe emotional disturbances

VISION SERVICES

Medi-Cal members access basic vision care services through Vision Service Plan (VSP) providers. VSP is an independent entity not affiliated with us or our affiliates.

Providers can contact the VSP Provider Service Support Line at 1-800-615-1883 for questions or visit the VSP website at www.vsp.com.

COUNTY AND STATE-LINKED SERVICES

To ensure continuity and coordination of care for members, we enter into agreements with locally based public health programs. Providers are responsible for notifying the Care Coordination/Case Management Department when a referral is made to one of the agencies listed below.

Care Coordination/Case Management Contact Numbers:

Telephone: 1-855/367-7747

Fax: 1-562/933-1891

This notification ensures that case manager nurses and social workers can follow up with members to coordinate their care and that members receive all necessary services while keeping the provider informed.

Sample of Available State Services and Programs

Content in the following list is a sample of State services; current information can be accessed on each respective program website.

- **California Early Start**

  A statewide inter-agency system of coordinated early intervention services for infants and toddlers with disabilities and their families.
  Website: Department of Developmental Services www.dds.cahwnet.gov

- Provides early intervention and related services
- Based on the assessed need of the child
- Delivered within the child's everyday routines, activities and places
- For infants and toddlers from birth to 36 months
- For children with significant developmental delays
- For children at high risk of having a substantial developmental disability

- **Child Health and Disability Prevention (CHDP) Program**

  The CHDP Program is a preventive health program serving California's children and youth. CHDP makes early health care available to children and youth with health problems as well as to those who seem well.

  To be reimbursed, providers must be certified
  Website: Department of Health Care Services, www.dhcs.ca.gov

  - A full range of health assessment services
  - Referrals for diagnosis and treatment of suspected problems
  - Coordination of care to assist families with medical appointment scheduling, transportation and access to diagnostic and treatment services
  - Periodic health services to non-Medi-Cal eligible children and youth (from birth to 19 years of age)
  - Health assessments for children enrolled in Head Start and State Preschool
  - Referral candidates: California Med-Cal recipients from birth to 21 years

- **Local Mental Health Plans**
  County mental health service system to provide community-based, integrated mental health services.

  Website: Department of Mental Health www.dmh.ca.gov

  - Pre-crisis and crisis services
  - Rehabilitation and support services
  - Comprehensive evaluation and assessment
  - Vocational rehabilitation
  - Residential services
  - Medication education and management
  - Services for homeless persons
  - Case management
  - Group services
  - 24-hour treatment services
  - Wraparound services

- **Family Planning Services**

  Health education and certain medical services provided through community-based programs, including private nonprofit agencies and county health departments.

Website: Department of Public Health http://www.cdph.ca.gov/programs/OFP/Pages/default.aspx

- Comprehensive medical knowledge, assistance and services relating to family planning community resources
- Contraception
- Referral candidates: Those seeking information about methods for planning family size, deciding when to have children and preventing unwanted pregnancies

- **Confidential HIV Counseling and Testing**

  A program that integrates prevention counseling with HIV testing.

  Website: Department of Health Care Services www.dhs.ca.gov/AIDS

  - Confidential HIV testing, counseling
  - Early intervention services
  - HIV/AIDS resources
  - Referral candidates: Individuals who may have engaged in behavior that places them at risk for contracting HIV

- **Immunization Services**

  Local immunizations coalitions and registries.

  Website: Department of Health Care Services, Immunizations Branch www.dhs.ca.gov
  - Educate the community about childhood immunization
  - Recruit physicians to participate in the state's immunization registry system
  - Make referrals to provider for ongoing care and immunizations
  - Maintain regional immunizations registries

- **Directly Observed Therapy (DOT) for Treatment of Tuberculosis**

  Support service to prevent further transmission of infection and to prevent development of disease resistance.

  Website: Department of Health Care Services www.dhs.ca.gov

  - Provides or arranges for management of patients, including children and adolescents:
    - At risk for noncompliance with treatment of tuberculosis
    - On intermittent therapy or when treatment has failed
    - Who have relapsed after completing prior regimens
    - With demonstrated drug resistance to Isoniazid or Rifampin
    - Coordination of care with provider
  - Referral candidates: Those at risk for noncompliance with medical treatment for tuberculosis

- **Women, Infants and Children Program (WIC)**

A supplemental nutrition program that helps pregnant women, new mothers and young children eat well and stay healthy.

Website: Department of Health Care Services, WIC Branch www.wicworks.ca.gov

- Supplemental food services, including special vouchers to buy healthy foods such as milk, juice, eggs, cheese, cereal, dry beans and peas and peanut butter.
- WIC foods support both the American Academy of Pediatrics feeding guidelines and Dietary Guidelines for Americans. A greater variety of foods, more incentives for breastfeeding women, and medical supervision for participants with medical conditions are featured. Fruits and vegetables will be available to WIC participants. Infants 6 to 11 months old will receive less formula and more baby food items. Infants will no longer receive juice. Allowances for milk, eggs, and juice have been reduced. Soy-based beverages and tofu can be substituted for milk and cheese.
- Information about nutrition and health to help women and their families eat well and be healthy
- Support and information about breastfeeding such as incentives for breastfeeding including reducing the formula allowance for partially breastfed infants and expanding the amount of food for nursing mothers
- Help in finding health care and other community services. Use the revised WIC Referral Form to document both the type and amount of WIC foods to infants and children with special needs. A qualifying condition is required for children to receive soy milk or tofu from WIC.
- Referral candidates:
    - Eligible pregnant women and breastfeeding mothers
    - Children under 5 years old (including foster children)
    - Families with a low to medium income; working families may qualify

- **Population-Based Prevention Program**

  Community-based prevention programs

- **Refugee Health Services**

  For arriving refugees: medical screening and initial medical treatment until enrolled in a health plan

- **Sexually Transmitted Disease (STD) Services**

  Local clinics provide STD screening, counseling, diagnosis and treatment services

- **Childhood Lead Screening**

  Local programs provide educational programs

- **Local Maternal, Child and Adolescent Health (MCAH) Programs**

  - Comprehensive Perinatal Services Program (CPSP)
  - Black Infant Health

- Adolescent Family Life Program
- Cal Learn
- Maternal, Child and Adolescent (MCAH) Outreach
- Sickle Cell Program
- Perinatal Substance Abuse Program
- Sweet Success California
- Diabetes and Pregnancy Program
- Infant Morbidity and Mortality Health Status Review

- **Genetic Testing and Counseling**

  - Evaluation of amniotic fluid for genetic evaluation
  - Genetic counseling

- **School-Based Clinic (SBC) Agreements**

  - Provision of preventive care services
  - SBCs coordinate care with member/dependents provider, including notifying provider if child requires follow-up care
  -

Directly Observed Therapy (DOT) for Tuberculosis

Tuberculosis (TB) has reemerged as an important public health problem, and drug resistance continues to increase. Poor compliance with medical regimens is a major reason for development of resistance. In Directly Observed Therapy (DOT), the patient is assisted in taking medications prescribed to treat TB.

Members with TB with poor compliance are referred to the Local Health Department (LHD) for DOT services.

Early Start Program

California's Early Start Program is for infants and toddlers up to 36 months with developmental disabilities. Federal and state laws mandate early intervention services to eligible children and families. In California, the Department of Developmental Services (DDS) administers and coordinates Early Start. Early intervention services are coordinated at a regional center or local education agency.

What Children Are Served by Early Start Programs?

Infants and toddlers from birth to 36 months may be eligible for Early Start if they:

- Have significant developmental delays in one or more of these areas:
  - Cognitive development
  - Physical and motor development, including vision and hearing
  - Emotional-social development

  - Adaptive development (for example, feeding difficulties)

- Have established risk conditions of known etiology or those conditions are expected to result in significant developmental problems

- Are at high risk of having a substantial developmental disability due to a combination of risk factors

Regional Centers: A Single Point of Entry

Eligible children may receive services through one of California's many community-based regional centers.

These Regional Centers provide a single point of entry into the system that will:

- Provide intake, evaluation and assessment
- Determine eligibility and service needs

- Provide service coordination

What Can the Family Expect from Early Start?

The list of services is quite extensive and includes:

- Assistive technology devices audiology services

- Family training and support

- Counseling and home visits

- Health services

- Medical services for diagnostic or evaluation purposes

- Nursing services

- Nutrition services

- Occupational services

- Physical therapy services

- Psychological services

- Social work services

- Special instruction

- Speech-language pathology services

- Transportation and related costs

- Vision services

CHAPTER 16: COVERED AND NON-COVERED SERVICES

CALIFORNIA CHILDREN'S SERVICES

General Information

The California Children's Services (CCS) program is a state and county-funded program that serves children under the age of 21 who have acute and chronic conditions such as cancer, congenital anomalies and other serious medical conditions that benefit from specialty medical care and case management.

State statutes and contracts require that CCS program services be carved out of Medi-Cal. As a result, upon identification of a CCS-eligible condition, Providers must refer a child to the local CCS program or contact us to assist with the referral to CCS.

The CCS program requires prior authorization through CCS for all services to be funded through CCS, per the California Code of Regulations. Services are generally authorized starting from the date of referral, with specific criteria for urgent and emergency referrals. A full description of the CCS program is available at http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx

Sample Services and Benefits

CCS provides funding for diagnosis, treatment and medical benefits (including medication and supplies) for eligible children. Care is delivered by CCS-paneled Providers, CCS-approved facilities, Special Care Centers and other outpatient clinics. Additional services may be authorized by CCS based on a child's unique needs. This may include such necessary items as transportation to physician appointments, travel and lodging arrangements, special equipment and shift care.

The state CCS program assesses the qualifications of each provider on its panel and maintains a list of specialists and hospitals that have been reviewed and found to meet CCS program standards. CCS also provides comprehensive medical case management services to all children enrolled in the program.

Medical Therapy Program (MTP)

Medical Therapy Program (MTP) provides physical and occupational therapy and comprehensive team services to children with specific physical disabilities, such as cerebral palsy, that require rehabilitation. The team physicians are specialists experienced in the treatment of chronically handicapped children. The team performs examinations and prescribes physical therapy (PT), occupational therapy (OT), durable medical equipment (DME) and other interventions to treat the child's eligible condition.

Special Care Centers

Children who need multi-disciplinary, multi-specialty care are required by CCS to receive their care at an approved special care center. Examples of conditions that benefit from treatment at special care centers are:

- Craniofacial anomalies
- Complex congenital heart disease
- Chronic renal failure, including dialysis and transplant

- Sickle cell, hemophilia and other hemoglobinopathies
- Malignant neoplasms
- Certain endocrine disorders, including diabetes
- Inherited metabolic disorders
- Spina bifida
- Chronic lung disease
- HIV infection
- Cystic fibrosis
- Seriously ill neonates requiring hospitalization in the Neonatal Intensive Care Unit (NICU)

High-Risk Infant Follow-Up Program (HRIP)
HRIP provides follow-up to infants up to three years of age who are discharged from an NICU without a CCS-eligible condition but who are at risk for developing a CCS-eligible condition such as cerebral palsy. Follow-up services include developmental assessment, neurology, ophthalmology and audiology evaluations.

Program Eligibility

To meet CCS program eligibility, children must:

- Be under 21 years of age
- Have a CCS-eligible medical condition (refer to CCS Medical Eligibility at http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx)
- Meet certain other criteria (such as residential)
- Be cared for by CCS-paneled Providers. Requirements for participation on the CCS Provider Panel for specialists are listed on the back of the Panel Application, which may be obtained by contacting CCS. Anesthetists, assistant surgeons, certain other specialists and family practitioners who are not on the CCS panel may provide services as requested by a paneled physician.

Contact your local CCS office if you want to become a CCS-paneled provider

For an application and requirements for CCS paneling go to
http://www.dhcs.ca.gov/services/ccs/Pages/apply.aspx

Find the telephone number and addresses for the local CCS offices at
http://www.dhcs.ca.gov/Pages/Contacts.aspx

CHAPTER 16: COVERED AND NON-COVERED SERVICES

Children who have Medi-Cal are financially eligible for the CCS program. For other criteria such as residential requirements, we can assist with this information.

CCS Medical Eligibility

This brief summary document has been developed solely for the convenience and use in understanding the general medical eligibility criteria of the CCS program. It is not an authoritative statement of, and may not be cited as authority, for any decisions, determinations, or interpretations under the CCS program.

Please refer to the California Code of Regulations, Title 22, Division 2, Part 2, Subdivision 7, CCS, Chapter 4, Medical Eligibility, Sections 41800-41872 for full description. The applicable medical eligibility section is noted with each category below.

A. Infectious Diseases (ICD-9-CM 001-139 & ICD-10 A00-B99) (Section 41811)

In general, these conditions are eligible when they:

- involve the central nervous system and produce disabilities requiring surgical and/or rehabilitation services;
- involve bone;
- involve eyes leads to blindness;
- are congenitally acquired and for which postnatal treatment is required and appropriate.

B. Neoplasms (ICD-9-CM 140-239 & ICD-10 C00-D49) (Section 41815)

All malignant neoplasms, including those of the blood and lymph systems.

Benign neoplasms when they constitute a significant disability, visible deformity, or significantly interfere with function.

C. Endocrine, Nutritional, and Metabolic Diseases, and Immune Disorders (ICD-9-CM 240-279 & ICD-10 E00-E89) (Section 41819)

In general, these conditions are eligible. Examples of eligible conditions include diseases of the pituitary, thyroid, parathyroid, adrenal, pancreas, ovaries and testes; growth hormone deficiency, diabetes mellitus, diseases due to congenital or acquired immunologic deficiency manifested by life-threatening complications, various inborn errors of metabolism; cystic fibrosis.

Nutritional disorders such as failure to thrive and exogenous obesity are not eligible.

D. Diseases of Blood and Blood-Forming Organs (ICD-9-CM 280-289 & ICD-10 D50-D89) (Section 41823)

In general, these conditions are eligible. Common examples of eligible conditions are: sickle cell anemia, hemophilia, and aplastic anemia. Iron or vitamin deficiency anemias are only eligible when there are life-threatening complications.

E. Mental Disorders and Mental Retardation (ICD-9-CM 290-319 & ICD-10 F01-F99) (Section 41827)

Conditions of this nature are not eligible except when the disorder is associated with or complicates an existing CCS-eligible condition.

F. Diseases of the Nervous System (ICD-9-CM 320-389 & ICD-10 G00-G99) (Section 41831)

Diseases of the nervous system are, in general, eligible when they produce physical disability (e.g., paresis, paralysis, ataxia) that significantly impair daily function.

Idiopathic epilepsy is eligible when the seizures are uncontrolled, as per regulations. Treatment of seizures due to underlying organic disease (e.g., brain tumor, cerebral palsy, inborn errors of metabolism) is based on the eligibility of the underlying disease.

Specific conditions not eligible are those which are self-limiting and include acute neuritis and neuralgia; and meningitis that does not produce sequelae or physical disability. Learning disabilities are not eligible.

G. Diseases of the Eye (ICD-9-CM 360-379 & ICD-10 H00-H59) (Section 41835)

Strabismus is eligible when surgery is required.

Chronic infections or diseases of the eye are eligible when they may produce visual impairment and/or require complex management or surgery.

H. Diseases of the Ear and Mastoid (ICD-9-CM 380-389 & ICD-10 H60-H95) (Section 41839)

- Hearing loss, as defined per regulations;
- Perforation of the tympanic membrane requiring tympanoplasty;
- Mastoiditis;
- Cholesteatoma.

Diseases of the Circulatory System (ICD-9-CM 390-459 & ICD-10 I00-I99) (Section 41844)

- Conditions involving the heart, blood vessels, and lymphatic system are, in general, eligible.

J. Diseases of the Respiratory System (ICD-9-CM 460-519 & ICD-10 J00-J99) (Section 41848)

Lower respiratory tract conditions are eligible if they are chronic, cause significant disability, and respiratory obstruction; or complicate the management of a CCS-eligible condition.

Lungs: chronic lung disease of infancy is eligible; chronic lung disease of immunologic origin is eligible, as per regulations.

K. Diseases of the Digestive System (ICD-9-CM 520-579 & ICD-10 K00-K95) (Section 41852)

Diseases of the liver, chronic inflammatory disease of the gastrointestinal (GI) tract and most congenital abnormalities of the GI system are eligible; and gastroesophageal reflux, as per regulations.

Malocclusion is eligible when there is severe impairment of occlusal function and is subject to CCS screening and acceptance for care.

L. Diseases of the Genitourinary System (ICD-9-CM 580-629 & ICD-10 N00-N99) (Section 41856)

Chronic genitourinary conditions and renal failure are eligible. Acute conditions are eligible when complications are present.

M. Diseases of the Skin and Subcutaneous Tissues (ICD-9-CM 680-709 & ICD-10 L00-L99) (Section 41864)

These conditions are eligible if they are disfiguring, disabling, and require plastic or reconstructive surgery and/or prolonged and frequent multidisciplinary management.

N. Diseases of the Musculoskeletal System and Connective Tissue (ICD-9-CM 710-739 & ICD-10 M00-M99) (Section 41866)

Chronic diseases of the musculoskeletal system and connective tissue are eligible. Minor orthopedic conditions such as toeing-in, knock knee, and flat feet are not eligible. However, these conditions may be eligible if expensive bracing, multiple casting, and/or surgery is required. See Q. below for acute injuries.

O. Congenital Anomalies (IDC-9-CM 740-759 & ICD-10 Q00-Q99) (Section 41868)

Congenital anomalies of the various systems are eligible if the condition limits a body function, is disabling or disfiguring, amenable to cure, correction, or amelioration, as per regulations.

P. Perinatal Morbidity and Mortality (ICD-9-CM 760-779 & ICD-10 P00-P96)

Neonates who have a CCS-eligible condition and require care in a CCS-approved neonatal intensive care unit (NICU) because of the eligible condition.

Critically ill neonates who do not have an identified CCS-eligible condition but who require one or more of the following services in a CCS-approved NICU:

Invasive or non-invasive positive ventilatory assistance.

Supplemental oxygen concentration by hood of greater than or equal to 40 percent.

Maintenance of an umbilical artery (UA) or peripheral arterial catheter (PAC) for medically necessary indications, such as monitoring blood pressure or blood gases.

Maintenance of an umbilical venous catheter or other central venous catheter for medically necessary indications, such as pressure monitoring or cardiovascular drug infusion.

Maintenance of a peripheral line for intravenous pharmacological support of the cardiovascular system.

Central or peripheral hyperalimentation.

Chest tube.

Neonates and infants who do not have an identified CCS-eligible condition but who require two or more of the following services in a CCS-approved NICU:

Supplemental inspired oxygen.

Maintenance of a peripheral intravenous line for administration of intravenous fluids, blood, blood products or medications other than those used in support of the cardiovascular system.

Pharmacological treatment for apnea and/or bradycardia episodes.

Tube feedings.

Q. Accidents, Poisonings, Violence, and Immunization Reactions (ICD-9-CM 800-999 & ICD-10 S00-T88) (Section 41872)

Injuries of the central or peripheral nervous and vital organs may be eligible if they can result in permanent disability or death. Fractures of the skull, spine, pelvis, or femur which when untreated would result in permanent loss of function or death. Burns, foreign bodies, ingestion of drugs or poisons, lead poisoning, and snake bites may be eligible, as per regulations.

Medical Eligibility for Specific Conditions

The CCS program requires sufficient medical documentation at the time of referral, and, in some cases, very specific documentation to provide evidence of strong suspicion that a CCS-eligible condition exists.

- Cerebral Palsy: Detailed medical reports document the physical findings with a complete musculoskeletal and neurological exam.
- Congenital Heart Disease: If a heart murmur is detected on a routine physical exam, refer the child after the primary care provider (PCP) confirms the murmur requires ongoing medical management.
- Hearing Loss: Refer after two separate audiometric evaluations, performed at least six weeks apart, document hearing loss, if the child fails the Newborn Infant Hearing Screening Program or has documentation of risk factors associated with a sensor neural or conductive hearing loss.

- HIV Infection: If a positive PCR antigen or virus isolation results, refer children with risk factors for HIV, including those less than 18 months of age with only a positive HIV antibody test to CCS for monitoring and follow-up.
- Lead Poisoning: A single blood level of 20 ug/dl or greater than if symptomatic. Otherwise, two blood levels of 20 ug/dl or one of 45 ug/dl or greater than, even if asymptomatic.
- Malocclusion: Refer clients with a craniofacial anomaly to a paneled Craniofacial Center for orthodontic treatment.
- Scoliosis: X-ray reports show a curvature of the spine greater than 20 degrees.
- Strabismus: Determination by an ophthalmologist that surgery is required to correct the condition or that the strabismus is related to another CCS-eligible condition.

REFERRAL PROCESS

We can assist Providers in making referrals to CCS. General guidelines follow for making referrals, including information that CCS requires to authorize services.

The CCS program accepts referrals from any source such as health care Providers, parents, legal guardians, school nurses, regional center counselors, health plans or other interested parties. Referrals to CCS may be made verbally or in writing. To consider a request, CCS requires the following information:

- Date of referral
- Insurance information
- First and last name of child
- Home address of child
- Home and work numbers of parent/legal guardian
- Name and address of individual or agency requesting services
- Date of birth
- Client index number (CIN)
- Diagnosis
- Services requested (include current procedural terminology [CPT] or healthcare common procedure coding system [HCPCS] codes as appropriate)

CCS also requires medical records that support the CCS-eligible diagnosis; if a Plan representative is assisting you in completing a referral to CCS, we may request medical records from your office to facilitate this process.

For CCS Referral Forms when making a referral to CCS, go online to the following website for established client or new client referrals: http://www.dhcs.ca.gov/formsandpubs/Pages/default.aspx

Emergency Referrals

For an emergent hospital admission or treatment, notify CCS within one business day. Follow up urgent and emergency referrals with all relevant medical reports to determine CCS medical eligibility. Notify us immediately for assistance in making an urgent or emergency referral to CCS.

Outpatient Services

CCS requires preauthorization for elective procedures and treatment. CCS requires information regarding the planned procedure or treatment. We can assist you in making a request or referral to CCS for outpatient services.

Inpatient Referrals

For elective hospital admissions, submit written requests to CCS before the scheduled date of admission. Include the following information with the referral/request for service:

- Attending physician
- Name of hospital
- Admitting diagnosis
- Operative or diagnostic procedure (include CPT codes as appropriate)
- Estimated length of stay (LOS)

We can help you in making a request or referral to CCS for inpatient services.

CCS Referral Procedures/Care Management

Our staff works closely with the local CCS offices. The following procedures represent an overview of our referral and care management procedures for the Plan's Medi-Cal Managed Care members who are eligible for CCS.

- Through intake requests for preauthorization, the Member Services or Utilization Management identifies members who have a CCS-eligible condition.
- Utilization Management uses CCS eligibility criteria to determine if a referral to CCS is needed and also advises the provider to refer to CCS if appropriate.

- Utilization Management refers the child to the Pediatric Care Management Unit for CCS referral and continuity of care.
- Our Care Management associates create a referral to CCS and obtain medical records and additional information CCS requires to determine eligibility.
- Our Care Management nursing staff work collaboratively with the local CCS office to assure timely authorization of services and to coordinate care.
- The PCP continues to provide care unrelated to the CCS-eligible condition.
- Once CCS authorizes services, the PCP office is notified in writing of the CCS authorization for the member's records.
- Our claims associates assist with billing questions for children who have services authorized by CCS.

Provider Paneling

Requirements for participation on the CCS provider panel for specialists are listed with the paneling application. Contact CCS or download the form online from the CCS website http://www.dhcs.ca.gov/formsandpubs/Pages/default.aspx

Anesthetists, assistant surgeons and certain other specialists who are not on the CCS panel may provide services as requested by a paneled physician. Contact your local CCS office if you are interested in becoming a CCS-paneled provider. Find the telephone number and addresses for local CCS offices online at http://www.dhcs.ca.gov/ProvGovPart/Pages/Directories.aspx

PHARMACY BENEFITS

Members who are enrolled in Medi-Cal have pharmacy benefits. These benefits cover outpatient prescription drugs obtained through a retail pharmacy or mail order pharmacy, based on medical necessity and type of coverage. Licensed Providers can prescribe medically necessary medication for a member.

Member's Primary Plan is the administrator of pharmacy benefits. The member's Primary Plan contact information is on the member's ID card.

Copayments

Plan members are responsible for pharmacy copayments.

Formulary

The member's Primary Plan has a formulary and, in most cases, an administrator of pharmacy benefits. The member's Primary Plan contact information is on the member's ID card.

CHAPTER 16: COVERED AND NON-COVERED SERVICES

The goal of the formulary is to ensure that members receive therapeutically appropriate and cost-effective drug therapy. Since the formulary promotes rational, scientific care based on consideration of published clinical studies, Food and Drug Administration (FDA) data, community standards and cost-benefit evaluations, the formulary serves as a primary reference in the selection of medications for members.

Certain formulary medications and non-formulary medications may require a Prior Authorization of Benefits (PAB) depending on the member's pharmacy benefit plan. Refer to the member's Primary Plan for details.

Over-the-Counter (OTC) Medications

The pharmacy benefit through the member's primary health plan may cover the following over-the-counter (OTC) medications when prescribed by a licensed practitioner for the treatment and monitoring of diabetes. Please refer to the primary plan for more information.

Injectables

For self-injectable medications under the pharmacy benefit, refer to the Primary Plan for coverage information. The member's Primary Plan contact information is on the member's ID card.

Office-based injectables, including vaccines, are covered under the medical benefit.

Carve-Outs for Medi-Cal Members Only

For Medi-Cal members only, select drugs and drug classes maybe carved out of the Primary Plan's pharmacy benefit and reimbursed by Fee For Service (FFS) Medi-Cal. The Department of Health Care Services (DHCS) carve-outs for HIV, anti-psychotic medications, erectile dysfunction and heroin detox apply specifically to Medi-Cal and are reimbursable through Electronic Data Systems (EDS). Other therapeutic classes might be eligible for coverage under California Children's Services (CCS) for Medi-Cal. For CCS carve-outs, refer to the *California Children's Services* section in this chapter for more information.

Medical Devices

The pharmacy benefit for members provides coverage for diabetic supplies, spacers and peak flow meters. All other medical devices, such as nebulizers or insulin pumps, are covered under the medical benefit.

Phenylketonuria (PKU)

Enteral supplements are not a pharmacy-covered benefit with the exception of enteral supplements for PKU. Obtain all other supplements through the medical benefit when medically necessary.

Contraceptives

The pharmacy benefit covers oral contraceptives, contraceptive devices and OTC contraceptives; however, injectable contraceptives and implantable devices, such as Norplant, are available through the medical benefit only.

Screening for Dental Problems

PCPs conduct an inspection of the teeth, gums and mouth as part of an initial health assessment and make referrals to a dentist if appropriate.

Dental Referral Procedures

If needed, referrals to a dentist occur at a minimum during the initial health assessment and following each subsequent preventive care assessment. Members who have medical conditions or who are taking medication that affect the condition of the mouth or teeth are referred on an as-needed basis (for example, members who are immuno-compromised due to HIV or chemotherapy are at risk for developing mouth lesions that will require immediate care).

The referral of children is a priority. An oral assessment is conducted during CHDP screenings; Medi-Cal eligible children over the age of three need to be linked to a dentist for preventive dental care, diagnosis, and treatment of existing problems. Parents needing assistance with scheduling a dentist appointment or obtaining transportation to the dentist are referred to the local CHDP office.

Medi-Cal members can also call the toll-free Denti-Cal Dental Plan number at 1-800-423-0507 for dental plan information, referral to a dentist, or for information related to the member's designated dental plan (if applicable).

Commercial Benefit Plans: Please check with the Primary Plan as variations in covered benefits do exist

CHAPTER 17: MEMBER RIGHTS AND RESPONSABILITIES

MEMBER RIGHTS AND RESPONSIBILITIES

The Primary Health Plan communicates member rights and responsibilities in the new member packets we issue to members and in Provider Manuals we issue to Providers. We are proud to collaborate with you to ensure access to quality health care for the members and thank you for your continued efforts in pursuit of this goal.

Member Rights for all Seaside members:

Seaside Health Plan commits to treating members in a manner that respects their rights. These rights are:

- To be treated with respect and recognition of your dignity and need for privacy.
- To be provided with information about Seaside Health Plan, its services, its practitioners and Providers and your rights and responsibilities.
- To voice grievances or appeals about Seaside Health Plan
- To have a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- To make recommendations regarding Seaside Health Plan Members' rights and responsibilities policies.
- To choose a Primary Care Physician who has primary responsibility for coordinating your medical care.
- To receive as much information about any proposed treatment or procedure, as you need in order to give or withhold informed consent.
- To participate actively in decisions regarding your medical care.
- To full consideration of privacy concerning your medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly.
- To confidential treatment of all communications and records pertaining to your care. Your (or your parent's, legal guardian's or authorized caretaker relative's) written authorization will be obtained before medical records can be made available to anyone not directly concerned with your medical care, except as permitted or required by law.
- To receive reasonable responses to any reasonable requests you may make for service.
- To reasonable continuity of care and to know in advance the time and location of an appointment as well as the Physician or other Contracting Provider providing the care.
- To be advised if a Physician proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such experimentation.

- To be informed of continuing health care requirements.
- To know the rules and policies that apply to obtaining benefits/Covered Services.

- To exercise the foregoing rights without regard to age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status or the source of payment or utilization of services.

Member Responsibilities for All Our Members

Members have the following responsibilities as health care consumers:

- Participate actively with practitioners in decision-making regarding your medical care.

- Follow plans and instructions for care that you have agreed on with your practitioner

- Provide, to the extent possible, information needed by Seaside Health Plan's professional staff, Contracting Medical Groups, Primary Care Physicians, and other practitioners to care for you.

- Participate in understanding your health problems and developing mutually agreed upon treatment goals.

- Know and understand the terms, conditions and provisions of this Health Plan and abiding by them.

- Inform the Plan regarding any change in residence and any circumstance, which may affect your entitlement to coverage or eligibility.

- Learn about your medical condition and its significance to your overall well-being.

- Follow preventive health guidelines, prescribed treatment plans and guidelines given by those providing medical care.

- Schedule or reschedule appointments and informing the Contracting Medical Group or Primary Care Physician when it is necessary to cancel an appointment.

- Be considerate and respectful to the medical staff and other Members.

- Express grievances through the Primary Health Plan Grievance and Appeals Procedure.

CHAPTER 18: FRAUD AND ABUSE

FRAUD AND ABUSE

We are committed to protecting the integrity of the programs we offer and the efficiency of our operations by preventing, detecting, and investigating fraud and abuse.

Understanding Fraud and Abuse

Combating fraud, abuse, and waste begins with knowledge and awareness.

Fraud includes, but is not limited to, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit and/or fraudulent use of medical insurance information. The attempt itself is fraud, regardless of whether or not it is successful.

Abuse is any practice that is inconsistent with sound fiscal, business, or medical practices and results in an unnecessary cost to the program.

Examples of Provider Fraud or Abuse

These are typical examples of provider fraud and abuse:

- Billing for services not provided
- Billing for medically unnecessary tests
- Unbundling/upcoding
- Misrepresentation of diagnosis or services
- Underutilization and overutilization
- Soliciting, offering, or receiving kickbacks or bribes
- Billing professional services performed by untrained personnel
- Altering medical records

Examples of Member Fraud and Abuse

These are examples of member fraud and abuse:

- Making frequent emergency room visits with non-emergent diagnoses
- Obtaining controlled substances from multiple Providers
- Violating pain management contract
- Using more than one physician to obtain similar treatments or medications
- Using Providers not approved by the Primary Care Physician (PCP)

- Forgoing or selling prescriptions
- Loaning insurance ID cards
- Disruptive/threatening behavior
- Relocating out-of-service area

Reporting Fraud and Abuse

There are two ways for a Provider to report allegations of fraud and abuse:

- Contact our 24-Hour Ethics Hotline at (888) 933-9044 or send an e-mail to ethicshotline@memorialcare.org
- Complete the Suspected Fraud, Waste and Abuse Report

Although you may remain anonymous, we encourage you to provide as much detailed information as possible, including:

- Your name and business and telephone numbers
- Name, address, and license or insurance ID of the provider or member
- Allegation
- Date of incident or incidents
- Supporting documentation

The more information you provide, the better chance we have of successfully reviewing and resolving the issue.

Role of the Compliance Committee

We do not tolerate acts that adversely affect our Providers or members. We investigate all reports of fraud and abuse. Allegations and investigative findings are reported to the California Department of Health Care Services (DHCS) and regulatory and law enforcement agencies. In addition to reporting, we take corrective action, by implementing a Corrective Action Plan (CAP) for resolution

False Claims Act

We are committed to complying with all applicable federal and state laws including the Federal False Claims Act (FCA).

CHAPTER 18: FRAUD AND ABUSE

The FCA is a federal law that provides the federal government with the means to recover money stolen through fraud by government contractors. Under the FCA, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages, or loss, to the government plus civil penalties of $5,500 to $11,000 per false claim.

The FCA also contains Qui Tam or “Whistleblower” provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.

PROVIDER ACCESS WEBSITE

Provider Access is your online connection to real-time eligibility, benefits, claims status, and other valuable resources. As we improve our website, the content is subject to change. We are working to reduce administrative issues and make it easier for you to help your patients. Using this website, you can:

Verify member eligibility

Obtain status on claims and claim reporting

Obtain eligibility reports and file downloads

Obtain fee schedule information

Access the Provider Operations Manual (POM)

Obtain program news and information

Provider Access requires that you request and use a Personal Identification Number (PIN) and requires that your Internet Service Provider (ISP) provides a secure e-mail domain. Accounts such as Yahoo, Hotmail, Netscape, and Lycos are not acceptable domains.

Log in to Provider Access

- Go to www.SeasideHealthPlan.org Give full link to take to provider portal
- Refer to the Login box, select Medical from the drop-down list, then click Login

If you do not have a User ID, select Register for Provider Access in the dialog text to request an account and follow the instructions to request an online account.

Once approved for an online account, you will receive an e-mail confirmation of your account approval. If for some reason we cannot approve a Provider Access account for you, we will notify you by mail.

INTERPRETER SERVICES AND SERVICES FOR THE HARD OF HEARING

We appreciate the need for good communication between providers, patients, and the Plan and offer the linguistic tools needed for satisfying and effective medical encounters. Following is a list of interpreter services.

Members should have the opportunity to declare their linguistic preferences at all points of medical/clinical and non-medical/administrative contact where it may be including but not limited to:

- Enrollment – information maintained in the enrollment file by the Primary Plan
- Making an appointment;
- Initial health assessment;

- The exam room;
- Contact with Member Services.

Providers and clinic staff ensure that the member's primary written and spoken languages are recorded in their medical chart.

Services – All Services are Available through the Primary Health Plan

- Telephone Interpreters: Available 24 hours a day, 7 days a week by calling the Member Services during business hours and 24/7 NurseLine after-hours
- Services for the Hard of Hearing: Sign language interpreters may be scheduled in advance for use at key points of medical contact by calling the Customer Care Center. We request 24 business hours to cancel an interpreter service; TTY and California Relay Services are available 24 hours a day, 7 days a week.
- Assistance for the Visually Impaired: Visually-impaired members can request verbal assistance or alternative formats for assistance with printed materials.
- Face-to-Face Interpreters: Interpreters may be used at key points of medical contact by calling the Customer Care Center 72 business hours in advance to schedule an interpreter. We request 24 business hours to cancel an interpreter service.

Provider Responsibilities

Providers who have delegated responsibilities, such as Utilization Management, should Seaside Health Plan's Language Assistance Program Notice with benefit-related communications to members.
The notice is available on the Seaside Health Plan provider website in the Forms and Tools Library at http://www.SeasideHealthPlan.org

- Signage: The Plan has a sign in English and in threshold languages informing members of their right to request free interpretation services are visibly posted at each provider office in the following location but not limited to: Waiting room; Reception area; and Exam room.
- Notification: Providers must notify members of the availability of health plan interpreter services and strongly discourage that minors, friends, and family act as interpreters.
- Documentation of Notification: If the member chooses to use a friend, family member or minor as an interpreter after being notified of the availability of free interpreter services, the Provider must document this choice in a prominent place in the member's medical record.
- Request/Refusal Forms for Interpretive Services: Electronic PDF copies of these forms are available on the www.SeasideHealthPlan.org.
- After-Hours Linguistic Access: We encourage Providers to accommodate non-English proficient members by having multi-lingual messages on answering machines and training their answering services and on-call personnel on how to access interpreter services.

- Provider Directory Updates: Providers are required to maintain a system to monitor the language capability listed in the Provider Directory - the language which they and their staff speak. Providers are required to notify us of changes in the language capability of medical and administrative staff. The website Provider Directory is updated as changes are received; printed copies of the Directory are updated twice a year.

Providers must document a process for assessing interpreter capabilities of staff who speak the language, as listed in the directory. Key points include:

- Language skills self-assessment, upon hire, as changes occur in their language capability and annually thereafter.

- Documentation and demonstration of proficiency in English and other language, fundamental knowledge in declared languages of health care terminology and delivery system by:

    - Bilingual provider and staff providing interpreting services to members must maintain a language capability form (e.g., ICE approved language self – assessment form, certification of language proficiency or interpreter training) on file;

    - Bilingual staff providing medical interpreting services are required to take a language proficiency test provided by a qualified agency to determine if candidate is qualified for medical interpreting;

Interpreting and translation staff are certified by a qualified agency such as Cyracom, Berlitz, Pacific Interpreters or Pals for Health for language proficiency and translation skills.

Providers must supply Seaside Health Plan with documentation of assessment upon request

Resources Available on Our Website

To find a list of resources on our website go to www.SeasideHealthPlan.org

CULTURAL COMPETENCY AND HEALTH AND READING LITERACY

We acknowledge the diversity of our membership and Provider network. We appreciate the challenges Providers may encounter integrating appropriate culturally diverse behaviors, values, norms, practices, attitudes and beliefs about the causes of disease, prevention, and treatment in the delivery of health care. In addition, consideration of members' health and reading literacy levels also may add to the complexity of cultural competence.

Although medical advances and increased efforts regarding preventive medicine have contributed to increased life expectancies and improved general health for many Americans, health disparities are still very evident in the African American, Hispanic, Asian/Pacific Islander, and American Indian/Alaskan Native, and other populations.

We are eager to assist your office with increasing your cultural competence and decreasing health disparities. We also recognize that such competence is a process that evolves over time and that you and your office staff may be at various levels of awareness, knowledge and skills. We encourage you to increase your cultural sensitivity by using the cultural and linguistics resources included on our website. Go online to www.SeasideHealthPlan.org and select Health Education for more information.

As you know, it is important to assess the individual health beliefs and practices of your members and to consider the role of culture and ethnicity. In doing so, your assessment efforts should uncover a member's certain cultural health beliefs, attitudes and traditions. Although some beliefs may be associated with various groups of people, there may be a great deal of diversity within cultural groups. Categorizing groups of people according to their cultural or ethnic backgrounds when addressing their health care needs may lead to misunderstandings and possible transfer of misinformation.

Low Literacy and Its Impact on the Health Professional

Accurately assessing members' reading and health literacy helps to improve communication between Providers and members. As a health professional, you need to make sure members understand their medical conditions and health instructions. Tips to assist you in determining a member's health and reading literacy levels and successfully educating your members may be found online by going to www.SeasideHealthPlan.org.

The above information about cultural competency assists Providers in complying with the requirements of Title VI of the Civil Rights Act of 1964 and the California Department of Health Care Services policies for delivery of culturally competent health care.