MemorialCare™
Select Health Plan

MemorialCare Select Provider Manual

Revision Date: 2018

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CHAPTER1: INTRODUCTION

OVERVIEW

MemorialCare Select Health Plan recognizes that timely and appropriate access to specialty 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.

MemorialCare Select Health Plan's systems are designed to complement and comply with state and federal laws and the regulations. MemorialCare Select 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 MemorialCare Select Health Plan and your practice. Since MemorialCare Select 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 MemorialCare Select 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 MemorialCare Select 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 MemorialCare Select Health Plan website at www.MemorialCareSelectHealthPlan.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

This manual and any further updates, revisions, and amendments are part of your applicable MemorialCare Select 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 MemorialCare Select Health Plan Participating Provider Agreement, such provisions of the applicable MemorialCare Select Health Plan Participating Provider Agreement shall govern and control over the provisions of this manual.

This manual provides standards for services to members of the MemorialCare Select Commercial Program.

CHAPTER1: INTRODUCTION

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 MemorialCare Select 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 MemorialCare Select Health Plan website and to the extent permitted by state laws, will be considered addenda to this manual.

This manual and the MemorialCare Select 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 MemorialCare Select 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 MemorialCare Select 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 MemorialCare Select Health 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.

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 mailing or newsletter, fax or through our website at www.MemorialCareSelectHealthPlan.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

MemorialCare Select 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.MemorialCareSelectHealthPlan.org.

CHAPTER1: INTRODUCTION

Non-Discrimination Statement

MemorialCare Select 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.

MemorialCare Select 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 MemorialCare Select 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
- Submit encounter data, claims and medical records timely, complete and accurate.
- Provide 120 days' notice (terminating contract without cause)
- Comply with Civil Rights Act, ADA, Age Discrimination Act, federal funds laws
- Adhere to appeals/grievance procedure

CHAPTER 2: IMPORTANT CONTACT INFORMATION

CONTACT INFORMATION BY INQUIRY TYPE

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

MemorialCare Select
Health Plan 17360
Brookhurst Street
Fountain Valley, CA 92708

Provider Contracting and Services

Resource	Phone Number/Website	Hours of Availability
MemorialCare Select Health Plan Web Portal	www.MemorialCareSelectHealthPlan.org	24 hours/7 days a week
Provider Contracting/Services	(855) 367-7747 MCSelectProvider@Memorialcare.org	Monday thru Friday: 8am to 5pm
Member Service/Eligibility	(844) 805-8700 MCSelectMemberServices@Memorialcare.org	Monday thru Friday: 8am to 5pm

Claims Department

Resource	Phone Number/Website	Hours of Availability
Web portal	www.MemorialCareSelectHealthPlan.org	24 hours/ 7 days a week
Claims Address: PO BOX 20900 Fountain Valley, CA 92708	1-855-367-7747 Fax: (657) 241-3960	Monday thru Friday: 8 a.m. to 5 p.m.

Fraud and Abuse

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

CHAPTER 2: IMPORTANT CONTACT INFOMRATION

Member Services/Grievance and Appeals

Resource	Phone Number/Website	Hours of Availability
Web portal	www.MemorialCareSelectHealthPlan.org	24 hours/ 7 days a week
Member Service/Eligibility	(844) 805-8700 MCSelectMemberServices@Memorialcare.org	Monday thru Friday: 8am to 5pm
Grievance and Appeals	(844) 805-8700 www.MemorialCareSelectHealthPlan.org Follow instructions under "***GRIEVANCE FORM***"	24 hours/ 7 days a week

Hearing Impaired Services

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

Pharmacy

Resource	Phone Number/Website	Hours of Availability
MedImpact PBM	(844) 513-6001 customerservice@medimpact.com	24 hours/ 7 days a week

CHAPTER 3: MEMBER ELIGIBILITY

ELIGIBILITY VERIFICATION

Member eligibility can be verified through MemorialCare Select Health Plan web portal. To obtain access, please contact your Provider Service Representative.

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

Confirm Member Identity

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.

Ask to See Identification (ID) Cards

Commercial Plans:

Providers should ask Members at time of appointment if insurance has changed. A copy of the Member ID card should be made if a current copy is not on file. Eligibility can be verified through MemorialCare Select Health Plan Provider Portal (www.MemorialCareSelectHealthPlan.org) or by calling the provider service number on the Member's ID card.

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;
    - Name and state license number of attending physician.

- 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

- 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.

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 the Participating Provider Group or MemorialCare Select 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.

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 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.
CMS-1450 (UB-04) Claim Form	Hospitals and institutions	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.

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 MemorialCare Select Health Plan Provider Web Portal (www.MemorialCare SelectHealthPlan.org), the provider home page.	After **45 working days** from the Plan's receipt of a clean claim, submit a Claim Follow-up Request Form.

Claim Follow-Up Form or Mail back 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

MemorialCare Select Health Plan
PO BOX 20900
Fountain Valley, CA 92728

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 MemorialCare Select Health Plan (855) 367-7747 with questions about claims, including completing the forms.

Provider 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
MemorialCare Select Health Plan
17360 Brookhurst Street
Fountain Valley, CA 92708

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
- 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 MemorialCare Select Health Plan Claims Department at (855) 367-7747 or send an e-mail to MemorialCare SelectClaim@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 MemorialCare Select Claim@MemorialCare.org)

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.

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

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.

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/

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

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

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

MemorialCare Select Health Plan
PO BOX 20900
Fountain Valley, CA 92728

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.

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 MemorialCare Select 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);
- S status (Suspended);
- A status (Updated to financial);
- P status (Posted);
- X (Denied).

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.

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.

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

Claims Payment

MemorialCare Select 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:

MemorialCare Select Health Plan
17360 Brookhurst Street
Fountain Valley, CA 92708

If the provider contests the notice of reimbursement of the overpayment of a claim, the provider must submit a written notice to MemorialCare Select 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

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

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

- You can check the Plan has a website that includes a provider portal designed to allow Providers to check claim status 24 hours per day, 7 days per week.

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

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.

We may also request additional information retroactively for a claim that has already been paid.

Time Frame for Returning Requested Information

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

How to Submit Requested Additional Information

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

- 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.

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 or use the IVR phone system 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 MemorialCare Select 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/UB04 Form)

Missing Codes for Required Service Categories	Current HCPCS and CPT Manuals must be used because changes are made to the codes quarterly o 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. 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 NDC number.
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 appear 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.	
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.

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

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 MemorialCare Select 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 completed Provider Dispute Resolution Request Form with all points of contention itemized and explained. You can find the form on the www.MemorialCare SelectHealthPlan.org/ca website under Forms and Tools.
- 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 MemorialCare Select Health Plan does not receive all the information necessary to make a decision, MemorialCare Select 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:

MemorialCare Select Health Plan
Attn: Grievances and Appeals
17360 Brookhurst Street
Fountain Valley, CA 92708

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.

MemorialCare Select 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.

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.

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. IC-10 Procedure Codes will be required as of 10/2/2015.

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

- 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.

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 Plan ID card number when billing, whether submitting electronically or by paper.

Physician License Number

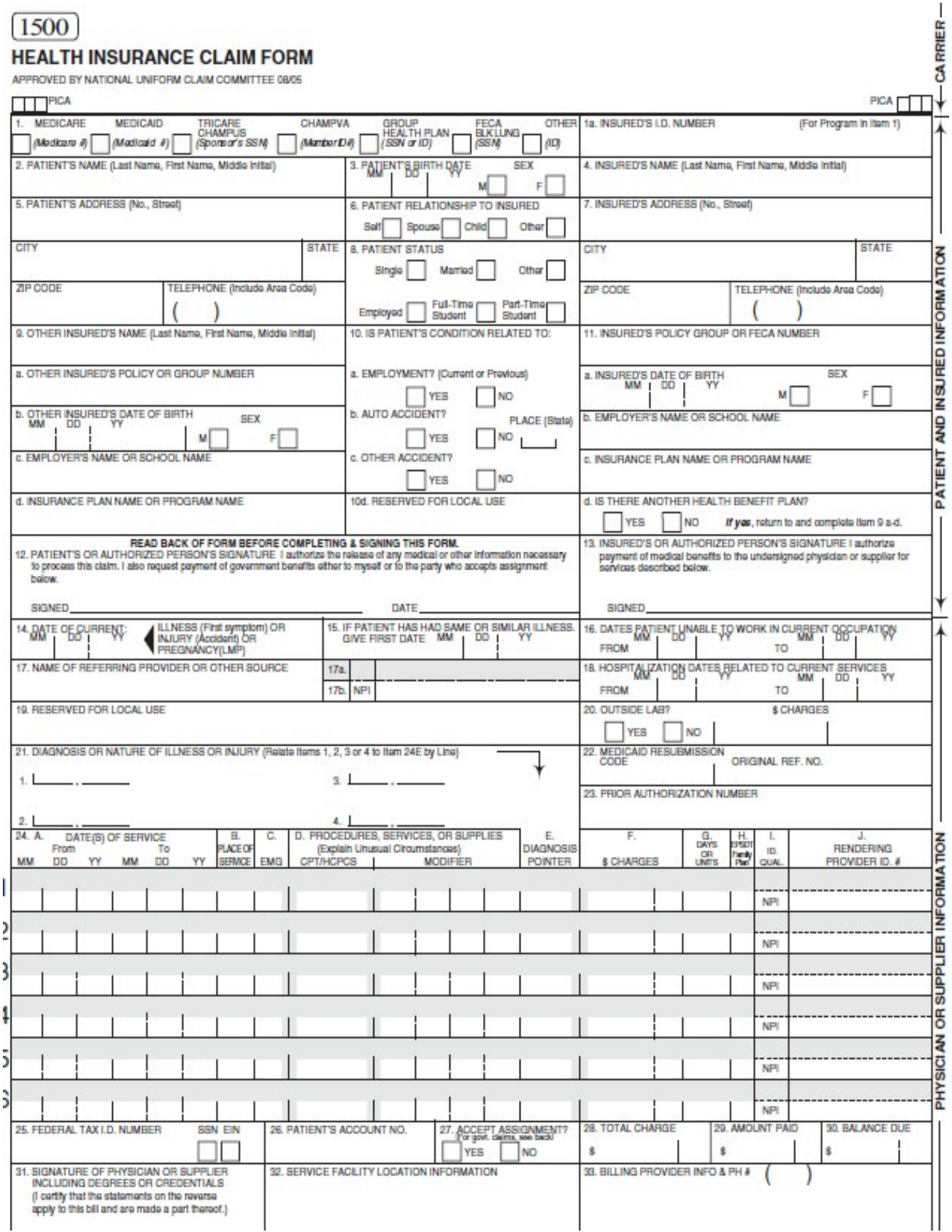
Indicate the rendering physician's state-issued license number in Box 24 of the CMS-1500 Form. Missing or invalid license numbers may result in nonpayment.

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.

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)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

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.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR 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. #
										NPI
										NPI
										NPI
										NPI
										NPI
										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.)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # ( )

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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, and 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.

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).

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.

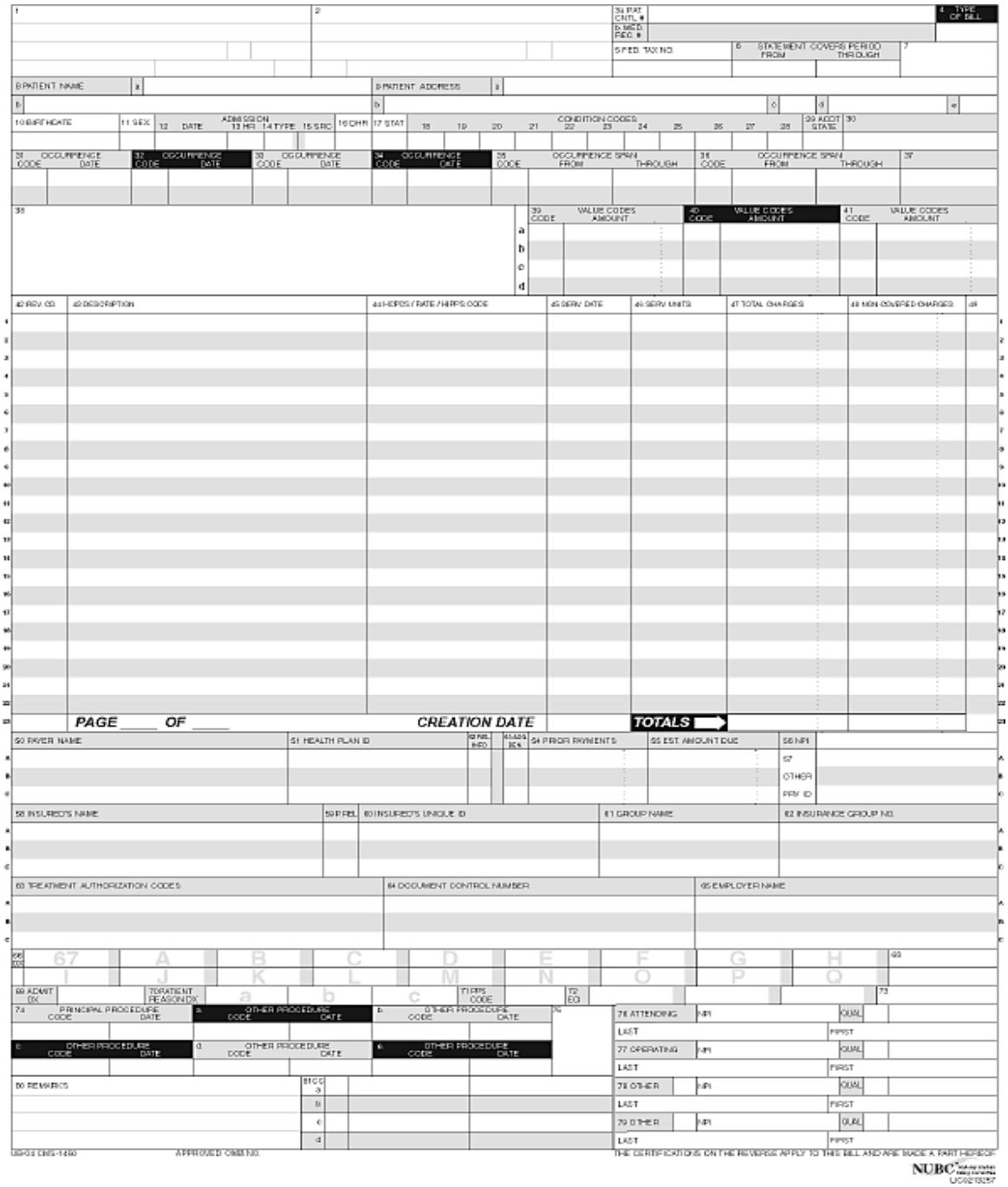
Member ID Number

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

Use the member's MemorialCare Select Health Plan Member ID 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 *Occurrence and Date*	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 payers.
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.

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

PROFESSIONAL BILLING REQUIREMENTS BY SERVICE CATEGORY

Sterilization Claims

Sterilization is any procedure/treatment performed to permanently take away the ability to reproduce.

Billing Sterilization Claims

Use the CMS-1500 Claim Form and follow appropriate coding guidelines. Attach a copy of the completed Sterilization Consent Form PM330 to the claim for either gender receiving the sterilization.

Refer to the California Code of Regulations, Title 22, Section 51305.4 for Consent Form PM330 guidelines.

Durable Medical Equipment (DME)

See *Ancillary Billing Requirements by Service Category*.

Emergency Services

Authorizations are not required for medically necessary emergency services. Emergency services are defined in the Providers contract and by State and local law.

Related professional services offered by physicians during an emergency visit are reimbursed according to the Providers contract.

For emergency services billing, indicate the Injury Date in Box 14 on the CMS-1500 Claim Form.

All members should be referred back to the Primary Care Provider (PCP) of record for follow-up care. Unless clinically required, follow-up care should never occur in the Emergency Department of a hospital.

Initial Health Assessments (IHA)

The PCP functions as the "medical home" or "patient advocate" and is responsible for member access to health care. Based on the member's age, the PCP provides an Initial Health Assessment (IHA) consisting of a complete history and physical within 60 to 120 days from the member's date of enrollment with us. Preventive services are to be rendered according to our Clinical Practice Guidelines.

Billing Codes for Initial Health Assessment

When billing for preventive services, use these ICD-10 diagnosis codes:

- V20.2 for children (newborn to 18 years of age)
- V70.0 for adults (19 years and older)

Refer to the *Adult Preventive Care Procedure Codes* for CPT office visit codes for IHA and Adult Preventive Care.

For details on correct billing procedures, refer to *Submitting a Claim*. You can also reference the Physician's Current Procedural Terminology (CPT) manual published by the American Medical Association (AMA).

Commercial Plans

Please contact MemorialCare Select Health Plan Utilization Management Department for coordination of the referral at (855) 367-7747.

Newborns

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

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)
- Behavioral Health Services (Mental Health) in network only

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.

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

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.

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.

Special billing instructions and requirements:

- No additional requirements
- Utilization Management approval is required for all admissions
- Include ICD-10-CM procedure codes for the delivery in form Locators 80 (principal procedure) through 81 (other procedures); applicable maternity procedure codes are 720 to 74.99, 75.50 to 75.52, 75.61 to 75.62, and 75.69; applicable Boarder Baby Revenue Codes are 0170 to 0173, 0179, unless otherwise indicated

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.

A treatment plan must accompany all sub-acute care admissions, including:

- Functional, reasonable, objective and measurable goals within a predictable time frame for each skilled discipline
- A discharge plan and options that are individually customized and identified from the admission date and carried forward from the admission date
- Required weekly summaries for each discipline; bi-weekly team conference reports

Defining Levels of Care

Level 1

Level 1 represents the most basic level of care (room and board, nursing care, ancillary services, supplies, medication equipment and so on) required by a patient who does not need general acute care, as provided in an inpatient acute care setting, but who requires documented, continuous skilled nursing care. Care must be medically necessary and the services must be authorized.

Special billing instructions and requirements include:

- Utilization Management approval is required for admission.
- A revenue code must be included for the approved sub-acute care level; the appropriate revenue code for Level 1 is 0191.

Level 2

To meet Level 2 requirements, in addition to meeting all requirements for Level 1, the patient must need one or more of the following services:

- Wound care

- Inhalation therapy by a licensed respiratory therapist, consisting of four or more treatments per day for skilled therapeutic intervention, which is not routine or a self-administered treatment or self-administered pharmaceuticals

- Rehabilitation services rendered by a registered occupational, speech or physical therapist for a documented rehabilitation diagnosis, including occupational, speech or physical therapy lasting between 90 minutes and three hours per day for five or more days per week

- Initiation of nasogastric, gastrostomy, and jejunostomy feedings and administration of continuous feeding when medically necessary; total parenteral nutrition (TPN)

- Continuous IV therapy through a peripheral or central line (other than solely for hydration) or through Heparin lock

- Colony-stimulating factors

- Ostomy care

- Tracheostomy care

- Special beds (for example, KinAir, Clinetron)

- Continuous passive motion machines

- TENS/MENS units

Special billing instructions and requirements include:

- Must have Utilization Management approval for admission

- Must include a Revenue Code for the approved sub-acute care level; the appropriate revenue code for Level 2 is 0192

Level 3

To qualify for Level 3 care, the patient must meet criteria for either C-1 or C-2, as described below:

C-1: In addition to meeting all the requirements for Level 1, the patient requires one or more of services listed below.

- Hemodialysis

- Ventilator care

- Expanded spectrum IV antibiotics for sub-acute and skilled nursing facilities

- Rehabilitation residential transitional living centers for post-acute rehabilitation services; such programs must meet the patient treatment and discharge plan requirements and must include four to six hours per day of skilled physical, occupational, speech, or neuropsychological therapy.

C-2: To qualify for Level 2 care, in addition to meeting all requirements for Level 1, the patient requires three or more services from items described in Level 2.

Special Billing Instructions and Requirements include:

- Must have Utilization Management approval for admission.
- Must include a Revenue Code for the approved sub-acute care level; the appropriate Revenue Code for Level 3 is 0193 or 0194.

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.

Special billing instructions and requirements include:

- ICD-10-CM principal diagnosis codes are required for all services provided in an Emergency Room setting.
- Each service date must be billed as a separate line item.

Refer all members back to the Primary Care Provider of record for follow-up care. Unless clinically required, follow-up care should never occur in the Emergency Department of a hospital.

Urgent Care Visits

The billing requirements for urgent care visits apply to all urgent care cases treated and discharged from the hospital Outpatient Department/Emergency Room and include 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 visit.

Urgent care refers to nonscheduled, non-emergency hospital services required to prevent serious deterioration of a patient's health status as a result of an unforeseen illness or injury. Urgent care visits do not apply to those cases that are admitted and treated for inpatient care following urgent care treatment.

Special billing instructions and requirements include:

- Required use of ICD-10-CM principle diagnosis codes for all services provided in an urgent care setting or designated facility.
- Billing each service date as a separate line item.
- Using the required Revenue Code 0456

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.

Special billing instructions and requirements include:

- Use of CPT4/HCPCS Codes for each surgical procedure in Form Locators 44 (HCPCS/RATES); Revenue Codes 036X, 0480, 0481, 0490, 070X, 071X, 075X, 076X, 079X, and 0975 are required with the appropriate CPT4/HCPCS Code. (Note: Outpatient surgery is billed with CPT4/HCPCS code according to HIPAA mandate.)

- Giving service dates (both principal and other) must accompany each procedure.

Billing instructions and requirements for outpatient care include:

- Using the required CPT4/HCPCS Codes for each service; the technical component (TC) modifier is required when appropriate. The following CPT4/ HCPCS Codes are not valid with a TC modifier:

80049–85097	93000–93018	94690
95130–87999	93040–93237	94760–94762
89050–89399	93720–93799	95851–95857
91100	93980–93990	958950

- Billing each service as a separate line item

- Using the following Revenue Codes with the appropriate CPT4/HCPCS Code:

0300–0302	0340–0341	061X
0305–0309	0349	0636
031X	035X	073X
032X	040X	074X
0330	0482	092X
0339	0483	0971–0972

- Following the billing requirements outlined in the service category when the Respiratory Therapy Department performs ECG, EEG or EKGs. Do not apply the Outpatient Therapy billing requirements.

- Entering 13X as the type of bill field entry.

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.

Special billing instructions and requirements include:

- Billing each service date as a separate line item

- Using the required Revenue Codes:

    - Physical therapy–042X or 0977
    - Occupational therapy–043X or 0978
    - Speech therapy–044X or 0979
    - Respiratory therapy–044X or 0976, or
    - Using the applicable HCPCS/CPT4 codes or Medical Local Only Codes

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.

Refer to *Home Infusion Therapy* for HIT billing instructions.

Other Services

This category is meant for those rare service types that do not reasonably fall under any other specific reimbursement rate. Other services rendered by the hospital that are not covered under the specific payment rates in the fee schedule are reimbursed at a percentage as specified in the hospital contract.

We may require medical necessity review and prior approval for these services, pursuant to the agreement between us and the hospital.

Stop Loss Claims

Stop loss is a provision only in certain MemorialCare Select Health Plan State Sponsored Business Participating Provider Agreements. Check your agreement to confirm if this section applies to you.

Submit claims eligible for stop loss payment to us according the following guidelines.

Provider Responsibility

- Identify claims that meet our stop loss criteria.
- Submit notice to us within 90 days from the date of discharge. (Provider should not wait for per-diem payment to submit stop loss claims.)

The hospital must allow us, or its authorized agent, free access to the medical records upon written request from us. Failure to provide all necessary supporting documentation may result in the hospital waiving its rights to the additional stop loss payments. Any request for additional information must be provided within 10 working days of the date requested.

Qualifications

- We must be the primary payor.
- The Plan is secondary to Medicare and the member has Part B benefits but does not qualify for Part A, or the member is eligible for Part A but the Part A benefits are exhausted.
- Entire length of stay must be approved.
- The level of care billed must be the same as the approved level of care, or changes to the covered billed charges may be reduced.

Contract Changes During Hospitalization

Determination of stop loss eligibility is based on the contract in force at the time of admission.

Submission Procedure

To qualify for stop loss consideration, the hospital must comply with all of the following procedures:

- A stop loss requires two separate submissions.
- Per diem claims should be submitted in the usual fashion (paper or electronic).

- Stop loss claims must be submitted and received within 90 days of the patient's discharge and in the format described in these guidelines.

Stop Loss Claim Submission Requirements

Submit stop loss claims as hard copy and include the following items:

- Original hard-copy Claim Form CMS-1450 Claim Form for the entire Length of Stay (LOS)
- Complete itemized bill
- Complete medical records including, but not limited to:
    - Physician orders
    - Physician progress notes
    - History and physical
    - Laboratory results
    - Diagnostic, radiological, or surgical procedure results

Stop Loss Claims Address

Mail all stop loss claims by certified mail to:

MemorialCare Select Health Plan
17360 Brookhurst Street
Fountain Valley, CA 92708

Stop Loss Payment

A Provider is paid a stop loss provision once the criteria listed in the contract are met.

Stop Loss Application

Stop loss only applies to the per-diem rates for the entire inpatient acute admission and does not apply to other rates, including, but not limited to:

- Case rates
- Negotiated rates by Case Management for specific admissions
- Per visit rates
- Global fee payments
- Percentage of charges payments

Non-covered Charges

Items not covered in the total covered billed charges include, but are not limited to:

- Member comfort items
- Technical support charges
- Take-home drugs
- UR service charges
- Incremental and other nursing charges
- Charges not meeting medical necessity
- Charges not supported by the medical records as actual charges for services that occur after the member leaves the hospital

Audits

- We perform audits on all paid claims wherever stop loss provision applies.
- We retain the right to use an authorized agent in the performance of the audit.
- Hospital agrees to provide complete medical records with the notice of stop loss and to provide access to the information relative to the claim if requested by us or a third party auditing on our behalf.
- Late charges are not eligible for the stop loss provisions if identified or submitted after 90 days of discharge.
- Undercharges and overcharges identified during an audit are not subject to the 90-calendar day filing limit.
- Charges used to determine the stop loss threshold are limited to basic room and board charges.

Stop Loss Reconsideration/Appeal

- The Provider has 365 days from the date of stop loss payment to request a reconsideration by us (see *Provider Dispute Resolution* section for more details)

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 MemorialCare Select 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 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

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.

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

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

- Manufacturer's purchase invoice, or
- Manufacturer's suggested retail price (MSRP) from a catalog dated before August 1, 2003.
    - If the item was not available before August 1, 2003, 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.
    - Providers must mark each catalog page or invoice line so it can be matched to the appropriate claim line.
- For scooters, in addition to the above, the invoice must be an amount published by the manufacturer before August 1, 2003. If the item was not available before then, Providers must list the date of availability in the Reserve for Local Use field (Box 19) of the CMS-1500 Claim Form. The catalog page that initially published the item must be attached to the claim.
- Wheelchair claims from manufacturers billing as Providers must include:
    - The suggested retail price (MSRP) from a catalog page dated before August 1, 2003. If the item was not available before August 1, 2003, the manufacturer's invoice must accompany the claim.
    - The initial date of availability must be documented in the Reserve for Local Use field (Box 19) of the CMS-1500 Claim Form.

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.

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. Clic 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 the MemorialCare Select Health Plan UM Department for authorization prior to delivery of the service.

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

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:

- 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.

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.

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.

When billing for ASC:

- 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.

CHAPTER 4: CLAIMS AND BILLING GUIDELINES

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 at least on a monthly basis.

Encounters must be sent to MemorialCare Select Health Plan as they are available, but at a minimum on a monthly basis through MemorialCare Select Health Plan's preferred clearing house (Office Ally and Emdeon).

Questions about Encounter Data Reporting

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

CPT Codes for Evaluation and Management

Office or Other Outpatient Services, New Patient

Code	Description
99201	Office or other outpatient visit for the evaluation and management of a new patient; the presenting problems are self-limited or of minor severity.
99202	Office or other outpatient visit for the evaluation and management of a new patient; the presenting problems are of low to moderate severity.
99203	Office or other outpatient visit for the evaluation and management of a new patient; the presenting problems are of moderate severity.
99204	Office or other outpatient visit for the evaluation and management of a new patient; the presenting problems are of moderate to high severity.
99205	Office or other outpatient visit for the evaluation and management of a new patient; the presenting problems are of moderate to high severity.

Office or Other Outpatient Services, Established Patient

99211	Office or other outpatient visit for the evaluation and management of an established patient; the presenting problems are of minimal severity.
99212	Office or other outpatient visit for the evaluation and management of an established patient; the presenting problems are self- limited or of minor
99213	Office or other outpatient visit for the evaluation and management of an established patient; the presenting problems are of low to moderate
99214	Office or other outpatient visit for the evaluation and management of an established patient; the presenting problems are of moderate to high
99215	Office or other outpatient visit for the evaluation and management of an established patient; the presenting problems are of moderate to high

Office or Other Outpatient Consultations, New Patient or Established Patient

99241	Office consultation for a new or established patient; the presenting problems are self-limited or of minor severity.
99242	Office consultation for a new or established patient; the presenting problems are of low to moderate severity.
99243	Office consultation for a new or established patient; the presenting problems are of moderate severity.
99244	Office consultation for a new or established patient; the presenting problems are of moderate to high severity.
99245	Office consultation for a new or established patient; the presenting problems are of moderate to high severity.

CHAPTER 5: UTILIZATION MANAGEMENT

UTILIZATION MANAGEMENT OVERVIEW

Medical Policy and Clinical Utilization Management (UM) Guidelines

Medical policy and clinical UM guidelines differ in the type of determination being made. In general, medical policy addresses the medical necessity of new technology and new applications of existing technology while clinical UM guidelines focus on detailed selection criteria, goal length of stay (GLOS), or the place of service for generally accepted technologies or services.

Medical policies serve as one of the sets of guidelines for coverage decisions. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. MemorialCare Select Health Plan members should discuss the information in the medical policies with their treating health care professionals.

Clinical UM guidelines serve as one of the sets of guidelines for coverage decisions. This may include but is not limited to decisions involving pre-certification, inpatient review, level of care, discharge planning and retrospective review.

Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and/or federal law. A Medical policy or a clinical UM guideline does not constitute plan authorization, nor is it an explanation of benefits.

Medical Policy and Clinical Utilization Management (UM) Guidelines are annually approved by the UM committee. MemorialCare Select Health Plan's UM committee uses Hayes and MCG™ guidelines (formerly known as Milliman Care Guidelines®) as our standards for determination of Medical necessity.

Delegated entities are not delegated for Medical Policy; issues that are possibly Experimental/Investigational are referred to the plan.

If you would like to request a hard copy of an individual medical policy, please call MemorialCare Select Health Plan Member Services at 844-805-8700 which is the number on the back of the member's identification card. The materials provided to you are guidelines used by this Plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract.

CHAPTER 6: CARE COORDINATION/CASE MANAGEMENT

CARE COORDINATION/CASE MANAGEMENT OVERVIEW

Basic comprehensive medical care management is provided to each member by his/her Primary Care Provider

Case Management seeks to eliminate duplication, delays, and miscommunication in services, and to create an atmosphere where the medical plan can provide optimal healthcare and outcome results in a safe and timely manner.

MemorialCare Select offers a comprehensive case management program in coordination with the Participating Provider Groups to empower members to take control of their health care needs across the care continuum by coordinating quality health care services and the optimization of benefits through a realistic, cost-effective, and timely case management plan.

Since complex care management is considered an opt-out program, all eligible members have the right to participate or decline participation.

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 in one of two ways: 1) by calling the Care Management Department at 562-933-0950; and 2) by faxing a completed Care Management Referral Form to 562-933-1891. A case manager will respond to the person who submitted the faxed request within three business days.

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
- 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

CHAPTER 6: CARE COORDINATION/CASE MANAGEMENT

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.

CHAPTER 7: PROVIDER GREIVANCE AND APPEALS

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. MemorialCare Select Health Plan has a formal process for reviewing member grievances and appeals. Please call (562) 933-0950 or visit our website at www.MemorialCare Selecthealthplan.org 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
MemorialCare Select Health Plan
17360 Brookhurst Street
Fountain Valley, CA 92708

Providers can also submit a grievance by fax to (562) 424-1486.

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

Attn: Grievances and Appeals
MemorialCare Select Health Plan
17360 Brookhurst Street
Fountain Valley, CA 92708

Providers also may fax appeal requests to (562) 424-1486.

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

CHAPTER 7: PROVIDER GREIVANCE AND APPEALS

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 MemorialCare Select 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 or their designee for MemorialCare Select Health Plan. The grievance will be reviewed and referred to the appropriate department for response and recommendation. The resolution will be communicated as outlined by the plan program within the appropriate timeframe.

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.

CHAPTER 7: PROVIDER GREIVANCE AND APPEALS

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 MemorialCare Select Health Plan's determinations should consult your Provider Contract for details of Arbitration in accordance with the MemorialCare Select Health Plan Participating Provider Agreement.

Contact Information

MemorialCare Select Health Plan	(855) 367-7747
Utilization Management:	
TDD:	(562) 426-3106

CHAPTER 8: PROVIDER ROLES AND RESPONSIBILITIES

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, we assign 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

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

The PCP is responsible for providing members with routine medical care and serves as the key evaluator of needed care within each managed care system. Referrals are made when services are medically necessary, outside the PCP's scope of practice, or when members are unresponsive to treatments, develop complications, or specialty services are needed. The PCP is responsible for making referrals and coordinating all medically necessary services required by the member. Pertinent summaries of the member's record should be transferred to the specialist by the PCP.

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.

Where Applicable PCPs:

- Are expected to refer members to specialists or specialty care behavioral health care services, other carved-out services, health education classes, and community resource agencies when appropriate
- 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

Outpatient Referrals and Specialty Referral Tracking

If the PCP determines that a member requires specialty services or examinations outside of the standard primary care, the provider must request for these services to be performed by appropriate contracted Providers. The provider must ensure the following steps in coordinating such referrals:

- Submit a referral request to MemorialCare Select to obtain authorization for those services.
- After obtaining the authorization(s):
    - PCP/MemorialCare Select is responsible for notifying and referring the member to the appropriate specialist or facility.
    - PCP, office staff, or member may arrange the referral appointment.
    - PCP office notes the referral in the member's medical record and attaches any authorization paperwork.

- PCP discusses the case with the member and the referral provider.
- PCP 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.)
- PCP Discuss the results of the referral, any plan for further treatment, and care coordination with the member, if needed.

Referrals are tracked by the PCP's office and MemorialCare Select for follow-up through a tickler file, log or computerized tracking system. 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 PCP is responsible in ensuring timely receipt of the specialist's report (e.g., use of tickler file). Reports for specialty consultations or procedures should be in the member's chart within two (2) weeks.

If the PCP has not received the specialist's report within the determined timeframe, the PCP contacts the specialist to obtain the report.

For urgent and emergent cases, the specialist should initiate a telephone report to the PCP as soon as possible, and a written report should be received within two (2) weeks.

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.

CHAPTER 8: PROVIDER ROLES AND RESPONSIBILITIES

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 a contracted network specialist is referred 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.

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 section of this manual 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.

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. Refer to *Important Contact Information* for phone numbers.

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.

CHAPTER 8: PROVIDER ROLES AND RESPONSIBILITIES

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.

Interpreter Services

Providers must notify members of the availability of free 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*.

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

I. A well-organized medical record keeping system supports effective patient care, information confidentiality and quality review processes.

Criteria	Guidelines
A. An individual medical record is established for each member.	Practitioners are able to readily identify each individual treated. A medical record is started upon the initial visit. "Family charts" are not acceptable.
B. Member identification is on each page.	Member identification includes first and last name, and/or a unique identifier established for use on clinical site. Electronically maintained records and printed records from electronic systems must contain member identification.
C. Individual personal biographical information is documented.	Personal biographical information includes date of birth, current address, home/work phone numbers, and name of parent(s) /legal guardian if member is a minor. If member refused to provide information, "refused" is documented in the medical record. Member may refuse to provide all personal information requested.
D. Emergency "contact" is identified.	The name and phone number of an "emergency contact" person is identified for all members. Listed emergency contacts may include a spouse, relative or friend, and must include at least one of the following: home, work, pager, cellular or message phone number. If the member is a minor, the primary (first) emergency contact person must be a parent or legal guardian and then other persons may be listed as additional emergency contacts. Adults and emancipated minors may list anyone of their choosing. If a member refuses to provide an emergency contact, "refused" is noted in the record.
E. Medical records are consistently organized.	Contents and format of printed and/or electronic records within the practice site are uniformly organized.
F. Chart contents are securely fastened.	Printed chart contents are securely fastened, attached or bound to prevent medical record loss. Electronic medical record information is readily available.
G. Member's assigned primary care physician (PCP) is identified.	The assigned PCP is ***always*** identified when there is more than one PCP on site and/or when the member has selected health care from a non-physician medical practitioner.
H. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing-impaired persons are prominently noted.	The primary language and *requests* for language and/or interpretation services by a non-or limited-English proficient member are documented. Member refusal of interpreter services is documented. The PCP and/or appropriate clinic staff member who speak the member's language fluently can be considered a qualified interpreter. Family or friends should not be used as interpreters, unless specifically requested by the member. Language documentation is not necessary "N/A," if English is the primary language, however, if "English" *is documented,* the point may be given.

ll. Well-documented records facilitate communication and coordination, and promote efficiency and effectiveness of treatment.

Criteria	Guidelines
A. Allergies are prominently noted.	Allergies and adverse reactions are listed in a prominent, easily identified and consistent location in the medical record. If member has no allergies or adverse reactions, "No Known Allergies" (NKA), "No known Drug Allergies" (NKDA), or □□is documented.
B. Chronic problems and/or significant conditions are listed.	Documentation may be on a separate "problem list," or a clearly identifiable problem list in the progress notes. All chronic or significant problems are considered current if no "end date" is documented. **Note:** Chronic conditions are current long-term, on-going conditions with slow or little progress.
C. Current *continuous* medications are listed.	Documentation may be on a separate "medication list," or a clearly identifiable medication list in the progress notes. List of current, on-going medications identifies the medication name, strength, dosage, route (if other than oral), and frequency. Discontinued medications are noted on the medication list or in progress notes.
D. Signed Informed Consents are present when any invasive procedure is performed.	Adults, parents/legal guardians of a minor or emancipated minors may sign consent forms for operative and invasive procedures.* Persons under 18 years of age are emancipated if they have entered into a valid marriage, are on military active duty, or have received a court declaration of emancipation under the CA Family Code, Section 7122. Note: Human sterilization requires DHCS Consent Form PM 330. * An invasive procedure is a medical procedure that invades (enters) the body, usually by cutting or puncturing the skin or by inserting instruments into the body. Very minor procedures such as drawing blood testing, umbilical cord blood donations and a few other very specific tests are not considered invasive and do not require a consent. Consent is implied by entering the provider's office or lab and allowing blood to be drawn. Ref: National Institutes of Health; American Cancer Society. Note: Written consent for HIV testing is no longer required (AB 682) 2007.
E. Advance Health Care Directive information is offered. (Adults 18 years or age or older; Emancipated minors)	Adult medical records include documentation of whether the member has been offered information or has executed an Advance Health Care Directive (California Probate Code, Sections 4701).
F. All entries are signed, dated and legible.	**Signature:** includes the first initial, last name and title of health care personnel providing care, including Medical Assistants. Initials may be used only if signatures are specifically identified elsewhere in the medical record (e.g. signature page). Stamped signatures are acceptable, but must be authenticated, meaning the stamped signature can be verified, validated, confirmed, and is countersigned or initialed. Note: In electronic records (EMR), methods to document signatures (and/or authenticate initials) will vary, and must be individually evaluated. Reviewers should assess the log-in process and may need to request print-outs of entries. **Date:** includes the month/day/year. Only standard abbreviations are used. Entries are in reasonably consecutive order by date. Handwritten documentation does not contain skipped lines or empty spaces where information can be added. Entries are not backdated or inserted into spaces above previous entries. Omissions are charted as a new entry. Late entries are explained in the medical record, signed and dated. **Legibility:** means the record entry is readable by a person other than the writer. Handwritten documentation, signatures and initials are entered in ink that can be readily/clearly copied.
G. Errors are corrected according to legal medical documentation standards.	The person that makes the documentation error corrects the error. One correction method is (single line drawn through the error, with the writer's initial and date written above or near the lined-through entry). Similar variations such as (single line and initial) are also used. The corrected information is written as a separate entry and includes date of the entry, signature (or initials), and title. There are no unexplained cross-outs, erased entries or use of correction fluid. Both the original entry and corrected entry are clearly preserved. Note: EMR methods are on a case by case basis. There should be a documented the log-in process and whether the EMR allows for corrections to be made after entries are made.

CHAPTER 8: PROVIDER ROLES AND RESPONSIBILITIES

III. Medical records support coordination and continuity-of-care with documentation of past and present health status, medical treatment and future plans of care.

Criteria	Guidelines
A. History of present illness is documented.	Each focused visit (e.g., primary care, urgent care, acute care, etc.) includes a documented history of present illness.
B. Working diagnoses are consistent with findings.	Each visit has a documented "working" diagnosis/impression derived from a physical exam, and/or "Subjective" information such as chief complaint or reason for the visit as stated by member/parent. The documented "Objective" information (such as assessment, findings and conclusion) relate to the working diagnoses.
C. Treatment plans are consistent	A plan of treatment, care and/or education related to the stated diagnosis is documented for each diagnosis.
D. Instruction for follow-up care is documented.	Specific follow-up instructions and a definite time for return visit or other follow-up care is documented. Time period for return visits or other follow-up care is definitively stated in number of days, weeks, months, or PRN (as needed).
E. Unresolved and/or continuing problems are addressed in subsequent visit(s).	Previous complaints and unresolved or chronic problems are addressed in subsequent notes until problems are resolved or a diagnosis is made. Each problem need not be addressed at every visit. Documentation demonstrates that the practitioner follows up with members about treatment regimens, recommendations, and counseling.
F. There is evidence of practitioner *review* of consult/referral reports and diagnostic test results.	There is documented evidence of practitioner review of records such as diagnostic studies, lab tests, X-ray reports, consultation summaries, inpatient/discharge records, emergency and urgent care reports, and all abnormal and/or "STAT" reports. Evidence of review may include the practitioner's initials or signature on the report, notation in the progress notes, or other site-specific method of documenting practitioner review. Note: Electronically maintained medical reports must also show evidence of practitioner review, and may differ from site to site.
G. There is evidence of *follow-up* of specialty referrals made, and results/reports of diagnostic tests, when appropriate.	Consultation reports and diagnostic test results are documented for ordered requests. Abnormal test results/diagnostic reports have explicit notation in the medical record, including attempts to contact the member/guardian, follow-up treatment, instructions, return office visits, referrals and/or other pertinent information. Missed/broken appointments for diagnostic procedures, lab tests, specialty appointments and/or other referrals are noted, and include attempts to contact the member/parent and results of follow-up actions.
H. Missed primary care appointments and outreach	Documentation includes incidents of missed/broken appointments, cancellations or "No shows" with the PCP office. Attempts to contact the member or parent/guardian and the results of follow-up actions are documented.

IV. As applicable, Pediatric preventive services are provided in accordance with current AAP periodicity, and include CHDP assessments.

Criteria	Guidelines
A. Initial Health Assessment (IHA) **IHA includes H&P and IHEBA**	The IHA (H&P and IHEBA) enables the PCP to assess current acute, chronic and preventive needs *and* to identify those Members whose health needs require coordinated services with appropriate community resources/other agencies not covered by the Plan.
1. History and physical (H&P)	**New members**: An H&P is completed within 120 days of the effective date of enrollment into the Plan, or documented within the 12 months prior to Plan enrollment. The H&P is sufficiently comprehensive to assess and diagnose acute and chronic conditions, which may include: history of present illness, past medical and social history, and review of organ systems. If an H&P is not found in the medical record, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to reschedule are documented.
2. Individual Health Education Behavioral Assessment (IHEBA)	**New members**: An age-appropriate IHEBA ("Staying Healthy" or other DHCS-approved tool) is completed by the member or parent/guardian within 120 days of the effective date of enrollment into the Plan, or within the 12 months prior to Plan enrollment. Staff may assist. The IHEBA has evidence of practitioner review such as signature/initials, and dates and intervention codes, which may be documented on the IHEBA form, in progress notes, or other areas of the paper or electronic medical record system. If an initial IHEBA is not found in the medical record, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to reschedule are documented.
B. Subsequent Periodic IHEBA	An age-appropriate IHEBA is re-administered when the member has reached the next specific age interval designated by MMCD. Documentation requirements are the same as the initial IHEBA.
C. Well-Child Visit	
1. Well-child exam completed at age appropriate frequency	Health assessments containing CHDP age-appropriate content requirements are provided according to the most recent AAP periodicity schedule for pediatric preventive health care. Assessments and identified problems recorded on the PM160 form are documented in the progress notes. Follow-up care or referral is provided for identified physical health problems as appropriate. **Note**: Where the AAP periodicity exam schedule is more frequent than the CHDP periodicity examination schedule, the AAP scheduled visit must include all assessment components required by the CHDP program for the lower age nearest to the current age of the child.
2. Anthropometric measurements	Height and weight are documented at each well-child exam. Include head circumference for infants up to 24 months.
3. BMI Percentile	BMI percentile is plotted on an appropriate CDC growth chart for each well-child exam ages 2-20 years. Note: The BMI percentile calculation is based on the CDC's BMI-for-age- growth charts, which indicates the relative position of the patient's BMI number among others of the same sex and age. Ref: www.cdc.gov/nccdphp/dnpa/bmi/index.htm
4. Developmental screening	Developmental surveillance at each visit and screening for developmental disorders at the 9^{th}, 18^{th} and 30^{th} month visits. Children identified with potential delays require further assessment and/or referral. (Ref: AAP and CHDP periodicity schedules)
5. Anticipatory guidance	Includes age appropriate counseling/health education provided to parent or pediatric member.
6. STI screening on all sexually active adolescents, incl. chlamydia for females	All sexually active adolescents should be screened for sexually transmitted infections (STIs), including chlamydia for females.
D. Vision Screening	Age-appropriate visual screening occurs at each health assessment visit, with referral to optometrist/ophthalmologist as appropriate. **Note:** Although specific screening details are not generally documented in the medical record, screening for infants and children (birth to 3 years) may consist of evaluations such as external eye inspection, ophthalmoscopic red reflex examination, or corneal penlight evaluation. Visual acuity screening usually begins at age 3 years.

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Criteria	Guidelines
E. Hearing Screening	Non-audiometric screening for infants/children (2 months to 3 years) includes family and medical history, physical exam and age-appropriate screening. Audiometric screening for children and young adults (3 -20) is done at each health assessment visit and includes follow-up care as appropriate. A failed audiometric screening is followed up with a repeat screening at least two weeks and no later than 6 weeks after the initial screening. If the second screening also fails, there is a referral to a specialist.
F. Nutrition Assessment	Screening includes: 1) height and weight, 2) hematocrit or hemoglobin to screen for anemia starting at 9-12 months, and 3) breastfeeding and infant feeding status, food/nutrient intake and eating habits (including evaluation of problems/conditions/needs of the breastfeeding mother). Based on problems/conditions identified, nutritionally at-risk children under 5 years of age are referred to the Women, Infants and Children (WIC) Supplemental Nutrition Program for medical nutrition therapy or other in-depth nutritional assessment.
G. Dental Assessment	Inspection of the mouth, teeth and gums is performed at every health assessment visit. Children are referred to a dentist ***at any age*** if a dental problem is detected or suspected. Beginning at 3 years of age, all children are referred annually to a dentist regardless of whether a dental problem is detected or suspected.
H. Blood Lead Screening Test	Children receiving health services through Medi-Cal Managed Care Plans must have blood lead level (BLL) testing as follows: 1. at 12 month *and* 24 months of age, 2. between 12 months and 24 months of age *if* there is no documented evidence of BLL testing at 12 months or thereafter, *and* 3. between 24 months and 72 months of age *if* there is no documented evidence of BLL testing at 24 months or thereafter. Elevated BLL of 10 □g/dL or greater require additional BLL and follow-up in accordance with current DHCS policy or as follows: • 10-14 □g/dL: Confirm with venous sample within 3 months of original test; • 15-19 □g/dL: Confirm with venous sample within 2 months of original test, then retest 2 months following the confirmatory testing; • 20-44 □g/dL: Confirm with venous sample in 1 week to 1 month, depending on severity of BLL; • 45-59 □g/dL: Retest with venous sample within 48 hour; • 60-69 □g/dL: Retest with venous sample within 24 hours; • □□70 □g/dL: EMERGENCY. Retest immediately with venous sample. Children with elevated BLLs are referred to the local Childhood Lead Poisoning Prevention Branch or, if none, to the local health department. All children with confirmed (venous) BLLs of □□20 □g/dL must be referred to CCS.
I. Tuberculosis Screening	All children are assessed for risk of exposure to tuberculosis (TB) at each health assessment. The Mantoux skin test, or other approved TB infection screening test,* is administered to children *identified at risk,* if there has not been a test in the previous year. The Mantoux is not given if a previously positive Mantoux is documented. Documentation of a positive test includes follow-up care (e.g. further medical evaluation, chest x-ray, diagnostic laboratory studies and/or referral to specialist). Practitioners are required to follow current CDC and American Thoracic Society guidelines for TB diagnosis and treatment. *Per June 25, 2010 CDC MMWR, FDA approved IGRA serum TB tests, i.e., QuantiFERON®-TB Gold (QFT-G and QFT-GIT) and T-SPOT®.TB (T-Spot). The Mantoux is preferred over IGRA for children under 5 years of age. Ref: www.cdc.gov/tb/publications/factsheets/testingIGRA.htm
J. Childhood Immunizations	
1. Given according to ACIP guidelines	Immunization status is assessed at each health assessment visit. Practitioners are required to ensure the provision of immunizations according to CDC's most recent Advisory Committee on Immunization Practices (ACIP) guidelines, unless medically contraindicated or refused by the parent.
2. Vaccine administration documentation	The name, manufacturer, and lot number of each vaccine given is recorded in the medical/electronic record or on medication logs, including immunization registries.
3. Vaccine Information Statement (VIS) documentation	The date the VIS was given (or presented and offered) *and* the VIS publication date are documented in the medical record.

V. As applicable, Current Guide to Clinical Preventive Services, U.S. Preventive Services Task Force (USPSTF) Report is the minimum standard for adult preventive health services.

Criteria	Guidelines
A. Initial Health Assessment (IHA) Includes H&P and IHEBA	The IHA (H&P and IHEBA) enables the PCP to assess current acute, chronic and preventive needs *and* identify those Members whose health needs require coordinated services with appropriate community resources/other agencies not covered by the Plan.
1. History and physical (H&P)	**New members**: An H&P is completed within 120 days of the effective date of enrollment into the Plan, or documented within the 12 months prior to Plan enrollment. The H&P is sufficiently comprehensive to assess and diagnose acute and chronic conditions, which may include: history of present illness, past medical and social history, and review of organ systems. If an H&P is not found in the medical record, the reasons (e.g., member's refusal, missed appointment) and contact attempts to reschedule are documented.
2. Individual Health Education Behavioral Assessment (IHEBA)	**New members**: An age-appropriate IHEBA ("Staying Healthy" or other DHCS-approved tool) is completed by the member within 120 days of the effective date of enrollment into the Plan, or within the 12 months prior to Plan enrollment. The IHEBA has evidence of practitioner review such as signature/initials, and dates and intervention codes, which may be documented on the IHEBA form, in progress notes, or other areas of the paper or electronic medical record system. If an initial IHEBA is not found in the medical record, the reasons (e.g., member's refusal, missed appointment) and contact attempts to reschedule are documented.
B. Subsequent Periodic IHEBA	An age-appropriate IHEBA is re-administered when the member has reached the next specific age interval designated by MMCD. Documentation requirements are the same as the initial IHEBA.
C. Periodic Health Evaluation according to most recent USPSTF Guidelines.	Periodic health evaluations occur in accordance with the frequency that is appropriate for individual risk factors. The type, quantity and frequency of preventive services will depend on the most recent USPSTF recommendations. In addition to USPSTF recommendations, periodic health evaluations are scheduled as indicated by the member's needs and according to the clinical judgment of the practitioner. Example: A patient with elevated cholesterol levels and other risk factors for coronary heart disease (CHD) may be evaluated more frequently than other persons of the same age without similar risk factors.
D. High Blood Pressure Screening	All adults 18 years and older including those without known hypertension are screened. A blood pressure (B/P) measurement for the normotensive adult is documented at least once every 2 years if the last systolic reading was below 120 mmHg and the diastolic reading was below 80 mmHg. B/P is measured annually if the last systolic reading was 120 to 139 mmHg and the diastolic reading was 80 to 89 mmHg. USPSTF link for high blood pressure screening: http://www.uspreventiveservicestaskforce.org/uspstf07/hbp/hbprs.htm
E. Obesity Screening	Includes weight and body mass index (BMI).
F. Lipid DiSorders Screening	All men (ages 35 years and older) are screened. Women (ages 45 years and older) are screened if at increased risk for coronary heart disease. Screening includes measurement of total cholesterol (TC) and high-density lipoprotein cholesterol (HDL-C). **Note:** Men under 35 years and women under 45 year may also be screened for lipid disorders if at increased risk for coronary artery disease. USPSTF link for lipid disorder screening: http://www.uspreventiveservicestaskforce.org/uspstf/uspschol.htm

VI. As applicable, Perinatal assessments are provided according to the current American College of Obstetrics and Gynecologists (ACOG) standards

Criteria	Guidelines
A. Initial Comprehensive Assessment (ICA)	**Note: Item A.1 assesses the timeframe of a completed ICA. Items A2-9 assess the individual components of the ICA, and can receive a "yes" score - *apart from the timeframe*.**
1. ICA completed within 4 weeks of entry to prenatal care	The ICA was completed within 4 weeks of entry to prenatal care.
2. Obstetrical and Medical History	Obstetric/medical: Health and obstetrical history (past/current), LMP, EDD.
3. Physical Exam	Physical exam: includes breast and pelvic exam.
4. Lab tests	Lab tests: hemoglobin/hematocrit, urinalysis, urine culture, ABO blood group, Rh type, rubella antibody titer, STI screen.
5. Nutrition	Nutrition: Anthropometric (height/weight), dietary evaluation, prenatal vitamin/mineral supplementation.
6. Psychosocial	Psychosocial: Social and mental health history (past/current), substance use/abuse, support systems/resources.
7. Health Education	Health education: Language and education needs.
8. Screening for Hepatitis B Virus	All pregnant women are screened for Hepatitis B during their first trimester or prenatal visit, whichever comes first.
9. Screening for Chlamydia Infection	All pregnant women ages 25 and younger, and older pregnant women who are at increased risk, are screened for chlamydia during their first prenatal visit.
B. Second Trimester Comprehensive Re-assessment	Subsequent comprehensive prenatal re-assessments include Obstetric/medical, Nutrition, Psychosocial and Health Education re- assessments are completed during the 2nd trimester.
C. Third Trimester Comprehensive Reassessment	Subsequent comprehensive prenatal re-assessments include Obstetric/medical, Nutrition, Psychosocial and Health Education re- assessments are completed during the 3rd trimester.
1. Screening for Strep B	All pregnant women are screened for Group B Streptococcus between their 35th and 37th week of pregnancy.
D. Prenatal care visit periodicity according to most recent ACOG standards	ACOG's *Guidelines for Perinatal Care* recommend the following prenatal schedule for a 40-week uncomplicated pregnancy: • First visit by 6-8th week • Approximately every 4 weeks for the first 28 weeks of pregnancy • Every 2-3 weeks until 36 weeks gestation • Weekly thereafter until delivery • Postpartum visit within 4-8 weeks after delivery If the recommended ACOG schedule is not met, documentation shows missed appointments, attempts to contact member and/or outreach activities.
E. Individualized Care Plan (ICP	ICP documentation includes specific obstetric, nutrition, psychosocial and health education risk problems/conditions, interventions, and referrals.

F. Referral to WIC and assessment of Infant Feeding status	Pregnant and breastfeeding Plan members must be referred to WIC (Public Law 103-448, Section 203(e)). Referral to WIC is documented in the medical record (Title 42, CFR 431.635). Infant feeding plans are documented during the prenatal period, and infant feeding/breastfeeding status is documented during the postpartum period (MMCD Policy Letter 98-10)
G. HIV-related services *offered*	The ***offering*** of prenatal HIV information, counseling and HIV antibody testing is documented (CA Health & Safety Code, Section 125107). Practitioners are ***not required*** to document that the HIV test was given or disclose (except to the member) the results (positive or negative) of an HIV test. Offering a prenatal HIV test is not required if a positive HIV test is already documented in the patient's record or if the patient has AIDS diagnosed by a physician. **Note:** Member's participation is voluntary. Practitioner may provide HIV test or refer to other testing program/site. Documentation or disclosure of HIV related information must be in accordance with confidentiality and informed consent regulations.
H. AFP/Genetic Screening *offered*	The ***offering*** of blood screening tests prior to 20 weeks gestation counting from the first day of the last normal menstrual period is documented (CCR, Title 17, Sections 6521-6532). Genetic screening documentation includes: 1) family history, 2) Triple marker screening tests: Alpha Fetoprotein (AF), unconjugated estriol (UE), human chorionic gonadotropin (HCG), 3) member's consent or refusal to participate. **Note:** Member's participation is voluntary. Testing occurs through CDPH Expanded AFP Program, and only laboratories designated by CDPH may be used for testing.
I. Domestic Violence/Abuse Screening	Provision of a Domestic Violence Screening is documented. Assessment checklists, body diagrams and/or documentation in progress notes are acceptable. Domestic violence screening includes medical screening, documentation of physical injuries or illnesses attributable to spousal/partner abuse, and referral to appropriate community service agencies (CA Health & Safety Code, Section 1233.5).
J. Family Planning Evaluation	Family Planning counseling, referral or provision of services is documented (MMCD Policy Letter 98-11).
K. Postpartum Comprehensive Assessment	Comprehensive postpartum reassessment includes the 4 components: medical exam, nutrition (mother and infant), psychosocial, health education are completed within 4-8 weeks postpartum (MMCD Policy Letter 96-01). If the postpartum assessment visit is not documented, medical record documents missed appointments, attempts to contact member and/or outreach activities. Infant feeding/breastfeeding status is documented during the postpartum period (MMCD Policy Letter 98-10).

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 ensure that the member's primary written and spoken languages are recorded in their medical record as well as the use of 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.

CHAPTER 8: PROVIDER ROLES AND RESPONSIBILITIES

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 it's 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.

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.MemorialCare Select 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 Providers availability at each site.

CHAPTER 8: PROVIDER ROLES AND RESPONSIBILITIES

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.

MemorialCare Select 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 Providers 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 MemorialCare Select Health Plan Provider Agreement for responsibilities and time frames as these relate to provider termination from the Plan.

MemorialCare Select 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.

CHAPTER 8: PROVIDER ROLES AND RESPONSIBILITIES

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352

(See reverse for public burden disclosure.)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** year _____ quarter _____ date of last report _ -

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is a Subawardee, Enter Name and Address of Prime:
☐ Prime ☐ Subawardee Tier _____, *if known*: Congressional District, *if known*: 4c	Congressional District, *if known*:
6. Federal Department/Agency:	7. Federal Program Name/Description: CFDA Number, *if applicable*: _____
8. Federal Action Number, *if known*:	9. Award Amount, *if known*: $
10. a. Name and Address of Lobbying Registrant (*if individual, last name, first name, MI*):	b. Individuals Performing Services (*including address if different from No. 10a*) (*last name, first name, MI*):
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____
Federal Use Only:	Authorized for Local Reproduction Standard Form LLL (Rev. 7-97)

PRINT

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether sub awardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing,

pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influence and officer employee of any agency, a Member of Congress, an officer or employee of Congress, Member of Congress in connection with a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, State and zip code of their porting entity. Include Congressional District, if known. Check the appropriate classification of their porting entity that designates if it is, or expects to be, a prime or sub award recipient. Identify the tier of the sub awardee, e.g., the first sub awardee of the prime is the 1st tier. Sub awards include but are not limited to subcontracts, sub grants and contract awards under grants.

5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001."

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, State and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.

(b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).

11. The certifying official shall sign and date the form; print his/her name, title, and telephone number.

CHAPTER 8: PROVIDER ROLES AND RESPONSIBILITIES

CHAPTER 9: PREVENTATIVE HEALTH CARE GUIDLINES

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.

MemorialCare Select Health Plan adopts the 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:

- MemorialCare Select Health 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) 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: BEHAVIORAL HEALTH CARE

BEHAVIORAL HEALTH CARE

When a Member Needs to Access Behavioral Health Services

MemorialCare Select Health Plan's Behavioral Health Network through *Windstone* includes psychiatrists and other licensed behavioral health care professionals in which members have direct access through these professional services. Members who would like assistance locating a MemorialCare Select Health Plan Behavioral Health Network Provider may call *Windstone* at the toll-free number (800) 577-4701 located on their identification card.

Members do not need an authorization from a PCP or from the medical group or IPA. They may simply call a MemorialCare Select Health Plan Behavioral Health Network psychiatrist, or other licensed behavioral health care professional through *Windstone* and make an appointment for outpatient professional services.

Behavioral Health Utilization Review Program

The utilization review and authorization process begins when the member, provider or facility calls or submit a request to MemorialCare Select Health Plan for authorization via our authorization request portal. All aspects of behavioral health treatment for MemorialCare Select Health Plan are authorized by the Utilization Management (UM) department. This includes emergency care, as well as care that must be provided by non-network Providers due to the network's inability to provide the care in-network.

The UM Department works with facilities, providers and members to ensure the highest standard of care is given and treatment is managed appropriately. Authorization and concurrent review is coordinated between the requesting provider and the MemorialCare Select Health Plan UM staff.

Utilization review evaluates medical necessity and appropriateness of care and the setting in which care is provided. Member and their physician are advised of all utilization review determinations in compliance with regulatory policy and timeliness standards

There are three stages of utilization review:

1. Pre-service review determines the medical necessity and appropriateness of treatment for non-urgent outpatient and urgent higher levels of care.

2. Concurrent review determines whether services are medically necessary and appropriate when pre-service review is not required or when MemorialCare Select Health Plan is notified while the service is ongoing; for example, an emergency admission to the hospital for psychiatric or chemical dependency treatment.

3. Post-service review is performed to review services that have already been provided. Post-service review applies in cases when pre-service or concurrent review was not used. Post-service review may also be performed for services that continued longer than originally authorized.

Members can access care for mental health and substance abuse disorders in any of the following ways:

1. Members may call MemorialCare Select Health Plan Member Services at the toll-free number (844) 805-8700 located on their identification card for instructions and help on how to access care.

2. Members may directly access care from a participating psychiatrist or other licensed behavioral health care professional who is part of the MemorialCare Select Health Plan Behavioral Health Network through Windstone.

3. Members may request a recommendation from their PCP for any MemorialCare Select Health Plan Behavioral Health Network provider, hospital or facility, but authorization from the PCP is not required.

4. Prior authorization is required for facility-based services, unless it is an emergency. To obtain information regarding prior authorization for facility-based services, Members should call Member Services at the telephone number (844) 805-8700 located on their ID card.

Coordination of Care

Communication between all professionals and PCPs who are involved in the provision of care to MemorialCare Select Health Plan members is strongly encouraged. Our philosophy is that a dialogue between the therapist, PCP and/or psychiatrist is essential to completing a comprehensive clinical assessment and to effectively coordinate care. Toward that end, we ask that you discuss the importance of this communication with each member and make every reasonable attempt to elicit his or her permission to coordinate care.

A PCP may receive a copy of the Patient Consent to Exchange Information form from a MemorialCare Select Health Plan psychiatrist or other licensed behavioral health care professional. The form is being sent to the PCP in an effort to share clinical information for comprehensive treatment and continuity of care. It is important that all physicians providing care to a member be aware of possible coexisting medical conditions and all current medications, as there may be adverse interactions or duplicate prescribing.

CHAPTER 11: 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 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.

Access Guidelines

MemorialCare Select 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 5 calendar days 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.

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.

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, when they are new enrollee or their provider terminates.

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)

CHAPTER 11: ACCESS STANDARDS & ACCESS TO CARE

Physician Contract Termination

A terminated physician or Provider or Provider group who actively treats members must continue to treat members until their date of termination.

After we receive a physician's/Providers or physician's group notice to terminate a contract, MemorialCare Select Health Plan notifies members impacted by the termination of a Physician/Provider or Provider group. We send a letter to inform the affected members of the termination. Every effort is made to notify members at least 60 days prior to the termination.

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.

CHAPTER 12: PROVIDER QUALITY IMPROVEMENT

QUALITY MANAGEMENT (QM) PROGRAM STRUCTURE

Quality Improvement Overview

We believe in Continuous Improvement

Commitment to our Members' health and their satisfaction with the care and services they receive is the basis for MemorialCare Select Health Plan Quality Improvement (QI) Program. MemorialCare Select Health Plan's QI Program is an ongoing and comprehensive process that ensures our organization's goals and objectives are identified, grouped and coordinated into an operational framework. MemorialCare Select Health Plan's goal is to maintain a well- integrated system that continuously identifies and acts upon opportunities for improved quality. MemorialCare Select strives to support the patient-Provider relationship, which ultimately drives all quality improvement. MemorialCare Select Health Plan is evolving and building upon our culture with a focus on continuous improvement. Continuous improvement is our ongoing effort to be better at what we do.

Annually, MemorialCare Select Health Plan prepares a Quality Improvement Plan that outlines clinical and service quality initiatives. An annual evaluation is also developed highlighting the outcomes of these initiatives.

Goals and Objectives

The following goals and objectives have been adopted to support MemorialCare Select Health Plan's mission and to promote continuous improvement in quality care, patient safety, and quality of service to our Members and Providers.

As part of the QI Program, initiatives in these major areas include, but are not limited to:

Quality and Safety of Clinical Care

- *Chronic Disease and Prevention*: MemorialCare Select Health Plan focuses on Member and/or Provider outreach for chronic conditions like asthma, heart disease, diabetes and COPD and for preventive health services such as immunizations and cancer screenings. Improvements in these areas result in improved clinical measures such as HEDIS® (Healthcare Effectiveness Data and Information Set).

- *Behavioral Health Programs*: MemorialCare Select Health Plan focuses on improving the coordination between medical and behavioral health care, specifically addressing conditions such as alcohol and other drug use, depression, attention deficit hyperactivity disorder, and bipolar disorder.

- *Patient Safety*: MemorialCare Select Health Plan works with physicians, hospitals, and other health care Providers to help reduce adverse health care-related events and unnecessary cost of care, as well as to develop innovative programs to encourage improvements in quality and safety. Priority areas include medication safety, radiation safety, surgical safety, infection control, patient protection, patient empowerment, care management and payment innovation.

- *Continuity and Coordination of Care*: MemorialCare Select Health Plan's goal is to help improve continuity and coordination of care across physicians and other health care professionals through interventions that promote timely and accurate communication.

- *Service Quality*: MemorialCare Select Health Plan periodically surveys its Members and uses other tools to assess the quality of care and service provided by our network Providers and practitioners. We also strive to provide excellent service to our Members and Providers. MemorialCare Select Health Plan

analyzes trends to identify service opportunities and recommends appropriate activities to address root causes.

CHAPTER 12: PROVIDER QUALITY IMPROVEMENT

Access and Availability of Care

MemorialCare Select Health Plan monitors appropriate Member access to care through a variety of different mechanisms, which includes, but is not limited to:

- Monitor & track access and availability of care-related Member grievances and appeals at the plan level.
- Conduct an annual telephonic survey to assess physician office's compliance with the after-hours care standards. In surveying after-hours care, physician offices are called after business hours to determine whether the telephone call was answered, or not answered, by a person or a recording; had emergency instructions; had a means by which the caller could speak to a physician after hours; and an expectation as to when a return call can be expected.
- Use Member responses to the annual Member satisfaction survey.
- Assess the ratio of physicians and specialists per California ZIP code to determine compliance with the MemorialCare Select Health Plan availability standards.

Emergency Access Standards

California law requires health plans to follow a "prudent layperson" standard in providing directions for emergency care, and prohibits plans from denying payment for emergency services, even if the situation was discovered not to be emergent, if any "prudent layperson" would have considered the situation to be an emergency. A "prudent layperson" is a person who is without medical training, and who draws on his or her practical experience when making a decision regarding whether emergency medical treatment is necessary.

Consistent with our established policy on emergency access, MemorialCare Select Health Plan expects every MemorialCare Select Health Plan physician to instruct his or her office and after-hours answering service staff regarding emergencies. If the caller believes he or she is experiencing an emergency, the caller should be instructed to dial **911**, or to go directly to the emergency room. Answering machine instructions must also direct the Member to call **911** or go to the emergency room, if the caller believes he or she is experiencing an emergency. If emergency service is authorized by the answering service, this authorization is considered binding and cannot be retracted at a later date.

Access Standards for Medical Professionals

Physicians are required to comply with MemorialCare Select Health Plan Access Standards:

Open or Closed Practice

MemorialCare Select Health Plan has the ability to maintain and manage open or closed practice information. Open or closed practice refers to a participating practitioner's ability or inability to accept new Members (patients). This information is useful to Members and clinical staff when trying to schedule appointments with available practitioners.

As a reminder, all participating practitioners agree to render medical services to any and all Members until the participating practitioner closes their practice and are no longer accepting new Members (patients) from any of their contracted health plans and the participating practitioner believes, in their reasonable professional judgment, that accepting additional Members would endanger a Member's (patient's) access to or continuity of care. To best serve Members and Providers, participating practitioners shall give MemorialCare Select Health Plan prompt written notice of such practice closure.

Patient Safety

CHAPTER 12: PROVIDER QUALITY IMPROVEMENT

Patient safety is critical to the delivery of quality health care. Our goal is to work with physicians, Hospitals and other health care Providers to promote and encourage patient safety and to help reduce medical errors through the use of guidelines and outcomes-based medicine and promotion of the use of processes and systems aimed at reducing errors. Specifically, support will be provided for the medical and behavioral health care of our Covered Individuals through collaborative efforts within MemorialCare Select Health Plan network. Improving patient safety is dependent upon not only patient needs, but also upon informed patients and the global health care community's demand for respect and attention to clinical outcomes-based practices.

Member's Rights and Responsibilities

As a MemorialCare Select Health Plan member, you have the ***right to…***

Respectful and courteous treatment. You have the right to be treated with respect, dignity & courtesy from your health plan's providers & staff. You have the right to be free from retaliation or force of any kind when making decisions about your care.

Privacy and confidentiality. You have the right to have private relationship with your provider and to have your medical record confidential. You also have the right to receive copy of, amend and request corrections to your medical record. If you are a minor, you have the right to certain services that do not need your parents' okay.

Choice and involvement in your care. You have the right to receive information about your health plan; it's the services, its doctors, and other providers. You have the right to choose your primary care provider (PCP) from the doctors & the clinics listed in your health plan's provider directory. You also have the right to get appointments within a reasonable amount of time. You have the right to talk with your doctor about any care your doctor provides or recommends, discuss all treatment options, and participate in making decisions about your care. You have the right to a second opinion. You have the right to talk candidly to your doctor about appropriate or medically necessary treatment options for your condition, regardless of the cost or what your benefits are. You have the right to decline treatment. You have a right to decide in advance how you want to be cared for in case you get a life threatening illness or injury.

Receive timely customer service. You have the right to wait no more than 10 minutes to speak to a customer service representative during MemorialCare Select Health Plan's normal business hours.

Voice your concerns. You have the right to complain about MemorialCare Select Health Plan, the health plans and providers we work with, or the care you get without fear of losing your benefits. MemorialCare Select Health Plan will help you with the process. If you don't agree with a decision, you have the right to appeal, which is to ask for a review of the decision. You have the right to disenroll from your health plan whenever you want.

Service outside of your health plan's provider network. You have the right to receive emergent or urgent services as well as family planning and sexually transmitted disease services outside of your health plan's network. You have the right to receive emergency treatment whenever and wherever you need it.

Service and information in your language. You have the right to request an interpreter at no charge instead of using a family member or friend to interpret for you. You should not use children to interpret for you. You have the right to get the Member Handbook and other information in another language or format (such as audio, large print or Braille).

CHAPTER 12: PROVIDER QUALITY IMPROVEMENT

Know your rights. You have the right to receive information about your rights and responsibilities. You have the right to make recommendations about these rights and responsibilities.

As a MemorialCare Select Health Plan member, you have the ***responsibility to…***

Act courteously and respectfully. You are responsible for treating your doctor and all providers and staff with courtesy and respect. You are responsible for being on time for your visits or calling your doctor's office at least 24 hours before your visit to cancel or reschedule.

Give up-to-date, accurate and complete information. You are responsible for giving correct information and as much information as you can to all of your providers and to MemorialCare Select Health Plan. You are responsible for getting regular check-ups and telling your doctor about health problems before they become serious.

Follow your doctor's advice and take part in your care. You are responsible for taking over your health care needs with your doctor, developing and agreeing on goals, doing your best to understand your health problems, and following the treatment plans and instructions you both agree on.

Use the Emergency Room only in an emergency. You are responsible for using emergency room in cases of an emergency or as directed by your doctor.

Report wrong-doing. You are responsible for reporting health care fraud or wrong doing to MemorialCare Select Health Plan. You can do this without giving your name by calling the 24- hour Ethics line at (888) 933-9044 and leaving a message or sending an email to ethicshotline@memorialcare.org.

Continuity and Coordination of Care

MemorialCare Select Health Plan encourages communication among all physicians, including PCPs and medical specialists, as well as other health care professionals who are involved in providing care to MemorialCare Select Health Plan Covered Individuals. Please discuss the importance of this communication with each Covered Individual and make every reasonable attempt to elicit his or her permission to coordinate care at the time treatment begins. Health Insurance Portability and Accountability Act (HIPAA) allows the exchange of information between Covered Entities (e.g., health care Providers) for the purposes of Treatment, Payment and Health Care Operations.

The MemorialCare Select Health Plan QI Program is an ongoing and integrative program, improvement activities designed to help ensure the continuity and coordination of care across physician and other health care professional sites, and to enhance the quality, safety, and appropriateness of medical and behavioral health care services offered by network Providers.

MEDICAL RECORD REFIEW STANDARDS

CHAPTER 12: PROVIDER QUALITY IMPROVEMENT

MemorialCare Select Health Plan has medical record standards that require Providers to maintain medical records in a manner that is current, organized, and facilitates effective and confidential Member care and quality review. MemorialCare Select Health Plan performs medical record reviews to assess network PCPs in relation to current medical record standards. MemorialCare Select Health Plan recognizes the importance of medical record documentation in the delivery and coordination of quality care and requires Providers to comply with MemorialCare Select Health Plan's standards for medical record documentation.

Medical record audits/reviews are performed annually on a percentage of randomly chosen PCPs contracted. For purposes of medical record audits/reviews, a PCP is defined as family medicine, general medicine, internal medicine, pediatrics and obstetrics/gynecology (when acting as a PCP).

In order to pass the audits/reviews, an office must attain an overall score of 80 percent or greater on the medical record audit. If a Provider fails to meet MemorialCare Select Health Plan's standard of 80 percent, CAP will be issued and a re-review is conducted within six months. Should the Provider continue to score less than 80 percent on the medical record review, the Provider will be put on corrective action that could result in termination from the network.

Medical Record Criteria

The medical record will be evaluated for the following criteria:

1. Every page in the record contains the patient name or ID number.

2. Allergies/NKDA (no known drug allergies) and adverse reactions are prominently displayed in a consistent location.
3. All presenting symptom entries are legible, signed, and dated, including phone entries. Dictated notes should be initialed to signify review. Signature sheet for initials are noted.

4. A problem list is maintained and updated for significant illnesses and medical conditions.
5. A medication list or reasonable substitute is maintained and updated for chronic and ongoing medications.

6. History and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting symptoms, and treatment plan is consistent with findings.

7. Laboratory tests and other studies are ordered, as appropriate, with results noted in the medical record. (The clinical reviewer should see evidence of documentation of appropriate follow-up recommendations and/or non-compliance to care plan).

8. Documentation of advance directive/Living Will/Power of Attorney discussion in a prominent part of the medical record for adult patients who are MA Members; and documentation on whether or not the patient has executed an advance directive with a copy to be included in the medical record. (We also encourage Providers to maintain documentation of advance directive discussions and copies of executed advance directives in patients' files for other, non-MA Members).

9. Continuity and coordination of care between the PCP, specialty physician (including BH specialty) and/or Facilities if there is reference to referral or care provided elsewhere. The clinical reviewer will look for a summary of findings or discharge summary in the medical record. Examples include progress notes/reports from consultants, discharge summary following inpatient care or outpatient surgery, physical therapy reports, and home health nursing Provider reports.

10. Age appropriate routine preventive services/risk screenings are consistently noted, i.e., childhood immunizations, adult immunizations, mammograms, pap tests, etc., or the refusal by the patient, parent or legal guardian of such screenings/immunizations in the medical record.

CHAPTER 13: CLINICAL PRACTICE GUIDLINES

CLINICAL PRACTICE GUIDELINES

MemorialCare Select Health Plan considers clinical practice guidelines to be an important component of health care. MemorialCare Select Health Plan adopts nationally recognized clinical practice guidelines, and encourages physicians to utilize these guidelines to improve the health of our Covered Individuals. Several national organizations produce guidelines for asthma, diabetes, hypertension, and other conditions. We review the guidelines at least every two years or when changes are made to national guidelines for content accuracy, current primary sources, new technological advances and recent medical research.

Providers can access the up-to-date listing of the medical, preventive and behavioral health guidelines through our website @ www.MemorialCareSelecthealthplan.org.

With respect to the issue of coverage, each Covered Individual should review his/her evidence of coverage for details concerning benefits, procedures and exclusions prior to receiving treatment. The evidence of coverage supersedes the clinical practice guidelines.

Preventive Health Guidelines

MemorialCare Select Health Plan considers preventive health guidelines to be an important component of health care. MemorialCare Select Health Plan adopts preventive health guidelines in accordance with recommendations made by nationally recognized organizations and societies such as the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the Advisory Committee on Immunizations Practices (ACIP), the American College of Obstetrics and Gynecology (ACOG) and the United States Preventive Services Task Force (USPSTF). The above organizations make recommendations based on reasonable medical evidence. We review the guidelines annually for content accuracy, current primary sources, new technological advances and recent medical research and make appropriate changes based on this review of the recommendations and/or preventive health mandates. We encourage physicians to utilize these guidelines to improve the health of our Covered Individuals.

The current guidelines are available on our website @ www.MemorialCareSelecthealthplan.org.

With respect to the issue of coverage, each Covered Individual should review his/her evidence of coverage for details concerning benefits, procedures and exclusions prior to receiving treatment. The evidence of coverage supersedes the clinical practice guidelines.

Cultural Diversity & Linguistic Services

Language barriers and lack of cultural awareness can sometimes make communication difficult. MemorialCare Select Health Plan wants to remind all our providers that services are available to assist in communicating with your MemorialCare Select Health Plan patients no matter what language they are most comfortable speaking.

Providers must ensure to all members have access to health care providers and services in their language of choice.

When members are hard-of-hearing or deaf and need assistance, they can call California Relay Service at 711.

CHAPTER 13: CLINICAL PRACTICE GUIDLINES

When providers and staff need to communicate with the hard-of-hearing or deaf members, please call California Relay Service at 1-888-877-5379 (English) & 1-888-877-5381 (Spanish). There is no cost for this service that is available 24 hours day, 365 days a year.

Provider Friendly Tips:

- Notify members of the availability of free health plan interpreter services.
- Always document the patient's preferred language in their medical record.
- Post the translated signs indicating Free Interpreting Services including American Sign Languages at medical and nonmedical sites.
- Provide After Hours Exchange Services with instructions on how to connect a member to an interpreter over the phone if needed.

A variety of brochures and handouts specific to the member's cultural and linguistic needs are available to Providers at no cost.

Please visit us at www.MemorialCareSelecthealthplan.org to download these materials or call our Member services to request hard copies.

For any questions or concerns please feel free to call 1-855-367-7747.

CHAPTER 14: HEALTH SERVICES AND PROGRAMS

HEALTH EDUCATION MATERIALS AND REFERRALS

MemorialCare Select 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.

MemorialCare Select adopts OHCS health education materials and make available for PCP and members through our website at www.MEMORIALCARE SELECTHEALTHPLAN.org and in hard copies upon request.

Members and providers may obtain more information about these programs and services by calling the Member Services.

Health Education Classes
The Utilization Management (UM) Department handles referrals for HE classes and/or other interventions. MemorialCare Select providers may refer their patients by completing and submitting the Health Education Referral Form and faxed to MemorialCare Select UM Department. Once the referral is received, UM will assist in locating the health education classes needed.

Community Outreach
MemorialCare Select participates in health fairs and community events to provide and distribute brochures and information in order to promote personal health awareness and appropriate health behavior change among MemorialCare Select Members and other Members of the community.

Health Education Materials
A variety of brochures and handouts are made available to providers at no cost. All materials selected are culturally sensitive and linguistically appropriate (refer to Section XVII Cultural and Linguistic Appropriate Services for definitions), and do not exceed the 6th grade reading level as required by the CA Department of Health CA Services (CA DHCS).

How to Get Health Education Materials for Your Office

A variety of brochures and handouts specific to the members' cultural and linguistic needs are available to Providers at no cost. Go to www.MemorialCareSelectHealthPlan.org to download these materials or call our Member Services to request for hard copies.

MemorialCare Select will provide education materials including alternative formats (Braille, large size print, video or audio, accessible materials online or on CD, and/or other appropriate technologies and methods). MemorialCare Select will provide these services upon requests.

Health Education State Requirements for Providers

Please review the following Department of Health Care Services (DHCS) requirements for health education. If you need clarification on any of the requirements, please call our Quality Management Department.

CHAPTER 14: HEALTH SERVICES AND PROGRAMS

Health Education Services
Please document referrals to health education services in your patient's medical record. Health education services include classes, individual counseling and support groups.

Patient Education Materials
All health education materials you provide to your patients need to be medically accurate, culturally sensitive and linguistically appropriate. The materials we have available for you have been reviewed and meet these requirements.

County Threshold Languages

	English	Armenia	Arabic	Chinese	Farsi	Khmer	Korean	Russian	Spanish	Tagalog	Vietnam
Los Angeles	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
OC	✓								✓		✓

CHAPTER 15: CREDENTIALING AND RECREDENTIALING

Credentialing Scope

MemorialCare Select Health Plan credentials the following health care practitioners: medical doctors, doctors of osteopathic medicine, doctors of podiatry, chiropractors, optometrists, and doctors of dentistry, including oral surgeon, providing Health Services covered under the Health Benefits Plan.

MemorialCare Select Health Plan also credentials behavioral health practitioners, including psychiatrists and physicians who are certified or trained in addiction psychiatry, child and adolescent psychiatry, and geriatric psychiatry; doctoral and clinical psychologists who are state licensed; master's level clinical social workers who are state licensed; master's level clinical nurse specialists or psychiatric nurse practitioners who are nationally and state certified and state licensed; and other behavioral health care specialists who are licensed, certified or registered by the state to practice independently. In addition, other individual health care practitioners listed in MemorialCare Select Health Plan's Network directory will becredentialed.

MemorialCare Select Health Plan credentials the following Health Delivery Organizations (HDOs): Hospitals; home health agencies (HHAs); skilled nursing facilities (SNFs); (nursing homes); free-standing surgical centers; as well as behavioral health facilities providing mental health and/or substance abuse treatment in an inpatient, residential or ambulatory setting.

Credentials Committee

The decision to accept, retain, deny or terminate a practitioner's participation in a Network or Plan Program is conducted by a peer review body, known as the Credentials Committee (CC).

The CC will meet at least once every quarter. The presence of a majority of voting CC members constitutes a quorum. The Chief Medical Officer chairs the CC and serves as a voting member (the Chair of the CC). The CC will include at least two participating practitioners, including one who practices in the specialty type that most frequently provides services to MemorialCare Select Health Plan members and who falls within the scope of the credentialing program, having no other role in MemorialCare Select Health Plan Network management. The Chair of the CC may appoint additional Network practitioners of such specialty type, as deemed appropriate for the efficient functioning of the CC.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation, or terminate a practitioner from participation require a majority vote of the voting members of the CC in attendance, the majority of who are MemorialCare Select Health Plan Network Providers.

During the credentialing process, all information that is obtained is highly confidential. All CC meeting minutes and practitioner files are securely electronically stored, can only be seen by appropriate Credentialing staff, medical directors, and CC members. Documents in these files may not be reproduced or distributed, except for confidential peer review and credentialing purposes.

Practitioners are notified that they have the right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a

discrepancy in the credentialing information obtained, the Credentialing staff will contact the practitioner within thirty (30) calendar days of the identification of the issue. This communication will specifically notify the practitioner of his or her right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the specific process for submission of this additional information, including where it should be sent. Depending on the nature of the issue in question, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue(s) in question, including copies of the correspondence or a detailed record of phone calls, will be clearly documented in the practitioner's credentials file. The practitioner will be given no less than fourteen (14) calendar days in which to provide additional information.

MemorialCare Select Health Plan may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

Nondiscrimination Policy

MemorialCare Select Health Plan will not discriminate against any applicant for participation in its Networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, marital status or any unlawful basis not specifically mentioned herein. Additionally, MemorialCare Select Health Plan will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities that are provided to the Members to meet their needs and preferences, this information is not required in the credentialing and recredentialing process. Determinations as to which Providers require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence as outlined in MemorialCare Select Health Plan Credentialing Program Standards. CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process.

Practitioner Rights

Right to review information

MemorialCare Select Health Plan acknowledges the provider/practitioner's right to review information it has obtained to evaluate their credentialing application, attestation or CV.

Right to correct erroneous information

If MemorialCare Select Health Plan can't verify the credentialing information or if a discrepancy is found, MemorialCare Select Health Plan asks practitioner in writing within 30 calendar days of notice to correct wrong information. See Attachment A. MemorialCare Select Health Plan also provides details about:

- The issue in question;
- How to submit more information;
- Where to send more information;
- The person to whom corrections must be submitted.

MemorialCare Select Health Plan documents the receipt of the corrections in the practitioner's file as well all communication that happens between the Plan and the practitioner about the issue in question.

Right to be informed of application status
Practitioners may submit a written request or call MemorialCare Select Health Plan's toll-free phone number to inquire about the status of their credentialing application. MemorialCare Select Health Plan will respond in the same manner the request was submitted. This request will be documented in the practitioner's credentialing file with the date and name of the MemorialCare Select Health Plan credentialing staff that provided the information.

Practitioners are provided with contact telephone number and email to inquire as to the status of their application.

Practitioner will be notified of the initial credentialing decision (approvals/denials) and re-credentialing denials within 60 calendar days of the committee's decision through appropriate avenues for notification such as:

- Application;
- Contract;
- Provider manual;
- Web site;
- Letter to practitioners;
- Other information distributed to practitioners.

Right to be informed of Appeals Process
MemorialCare Select Health Plan notifies practitioners through the credentialing application, provider contract, provider manual, Plan website, letters to practitioners and/or other information distributed to practitioners of their rights to review information that supports their credentialing applications. They are informed of their right to appeal the decision of the credentialing committee.

Initial Credentialing

Each practitioner or HDO must complete a standard application form when applying for initial participation in MemorialCare Select Health Plan Provider Network. This application form may be the required form by the state of CA or it may be a standard form that MemorialCare Select Health Plan either created or adopted.

CHAPTER 15: CREDENTIALING AND RECREDENTIALING

MemorialCare Select Health Plan will verify those elements related to an applicants' legal authority to practice,

relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the one-hundred-eighty-(180) day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, MemorialCare Select Health Plan will review verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

Verification Element
License to practice in the state of California
DEA License
Education, Training and Board Certification
Work history
Malpractice insurance
Malpractice claims history
Medical Board Sanctions/State sanctions and restrictions on licensure and limitations on scope of practice
Hospital admitting privileges in good standing at a Network Hospital
Medicare Sanction
MediCal Sanctions
Medicare Opt-Out

B. HDOs

Verification Element
Accreditation, if applicable
Appropriate California State License to practice
Malpractice insurance
Medicare certification, if applicable
Medicare Health Inspection rating of 3 stars or higher
Department of Health/CMS Survey results or recognized accrediting organization certification—if none, MemorialCare Select Health Plan conducts an onsite quality assessment
License sanctions or limitations, if applicable
Any Medicare and Medicaid Sanctions

Recredentialing

The recredentialing process incorporates re-verification and the identification of changes in the Participating Provider's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, Hospital privilege or other actions) that may reflect on the Participating Provider's professional conduct and competence. This information is reviewed in order to assess whether the Participating Providers continue to meet MemorialCare Select Health Plan credentialing standards.

During the recredentialing process, MemorialCare Select Health Plan will review verification of the credentialing data as described in the tables under Initial Credentialing unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

All applicable practitioners and HDOs in the Network within the scope of MemorialCare Select Health Plan Credentialing Program are required to be recredentialed every three (3) years unless otherwise required by contract or state regulations.

Health Delivery Organizations (HDOs)

New HDO applicants will submit a standardized application to MemorialCare Select Health Plan for review. If the candidate meets MemorialCare Select Health Plan screening criteria, the credentialing process will commence. To assess whether participating MemorialCare Select Health Plan Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and recredentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail in MemorialCare Select Health Plan Credentialing Program Standards, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, MemorialCare Select Health Plan may evaluate the most recent site survey by Medicare or the appropriate state oversight agency for that HDO.

Recredentialing of HDOs occur every three (3) years unless otherwise required by regulatory or accrediting bodies. Each HDO applying for continuing participation in MemorialCare Select Health Plan networks must submit all required supporting documentation.

On request, HDOs will be provided with the status of their credentialing application. MemorialCare Select Health Plan may request, and will accept, additional information from the HDO to correct incomplete, inaccurate or conflicting credentialing information. The CC will review this information and the rationale behind it, as presented by the HDO, and determine if a material omission has occurred or if other credentialing criteria are met.

Ongoing Sanction Monitoring

To support certain credentialing standards between the recredentialing cycles, MemorialCare Select Health Plan has established an ongoing monitoring program. Credentialing performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listings/reports within thirty (30) days of the time they are made available from the various sources including, but not limited to, the following:

1. Office of the Inspector General (OIG)
2. Medicare and MediCal Reports
3. State licensing Boards/Agencies
4. Clinical Quality Management Dept. (including data regarding complaints of both a clinical and non- clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
5. Other internal MemorialCare Select Health Plan Departments
6. Any other verified information received from appropriate sources

When a Network/Participating Provider has been identified by these sources, criteria will be used to assess the appropriate response including, but not limited to: review by the Chair of MemorialCare Select Health Plan CC, review by the MemorialCare Select Health Plan Chief Medical Officer, referral to the CC, suspension or termination. MemorialCare Select Health Plan credentialing departments will report Providers to the appropriate authorities as required by law.

Appeals Process

MemorialCare Select Health Plan has established policies for monitoring and recredentialing Participating Providers who seek continued participation in one or more of MemorialCare Select Health Plan's Plan Network. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and MemorialCare Select Health Plan may wish to terminate Providers. MemorialCare Select Health Plan also seeks to treat Participating Providers and applying Providers fairly, and thus provides Participating Providers with a process to appeal determinations terminating participation in MemorialCare Select Health Plan's Networks for professional competence and conduct reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB). Additionally, MemorialCare Select Health Plan will permit Providers (including HDOs) who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial. Immediate terminations may be imposed due to the Provider's suspension or loss of licensure, criminal conviction or MemorialCare Select Health Plan's determination that the Provider's continued participation poses an imminent risk of harm to Members. A Provider whose license has been suspended or revoked has no right to informal review/reconsideration or formal appeal.

CHAPTER 15: CREDENTIALING AND RECREDENTIALING

Reporting Requirements

When MemorialCare Select Health Plan takes a professional review action with respect to a Provider's participation in one or more Plan Programs or Networks, MemorialCare Select Health Plan may have an obligation to report such to the NPDB and/or Healthcare Integrity and Protection Data Bank (HIPDB). Once MemorialCare Select Health Plan receives a verification of the NPDB report, the verification report will be sent to the state licensing board. The credentialing staff will comply with all state and federal regulations in regard to the reporting of adverse determinations relating to professional conduct and competence. These reports will be made to the appropriate, legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook and the HIPDB Guidebook, the process set forth in the NPDB Guidebook and the HIPDB Guidebook will govern.

MemorialCare Select Health Plan Credentialing Program Standards

I. Eligibility Criteria

Health care practitioners:

Initial applicants must meet the following criteria in order to be considered for participation:

A. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he/she provides services to Members;

B. Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) license for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Members;

C. Must not be currently debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP.

D. For MDs, DOs, DPMs, and oral and maxillofacial surgeons, the applicant must have current, in force board certification in the clinical discipline for which they are applying.

The period of board eligibility is defined by the respective board. If there is no definition by the board, eligibility will be defined as seven years from the successful completion of an accredited training program. For physicians that are neither board certified nor board eligible, the CC, at its discretion, may decide to waive the requirement of board certification/board eligibility if there is a recognized network need for the physician to participate in the MemorialCare Select physician network.

E. Hospital admitting privileges in -good standing at a Network Hospital. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may, at its discretion, deem Hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to Hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Participating Provider to provide inpatient care.

F. Additional Criteria:

1. Quality Improvement Activities and Member Complaint history.
2. For Mid-level Practitioners: evidence of Agreement and Delineation of Services.

II. Criteria for Selecting Practitioners

A. New Applicants (Credentialing)

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations;
2. Application attestation signed and dated within one-hundred-eighty (180) days of the date of submission to the CC for a vote;
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;
4. Current, valid, unrestricted CA license to practice;
5. No current license action;
6. No history of licensing board action in any state;
7. No current federal sanction and no history of federal sanctions (per OIG and OPM report nor on NPDB report);
8. Possess a current, valid, and unrestricted DEA license for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Members. Initial applicants who have NO DEA license will be viewed as not meeting criteria and the credentialing process will not proceed.
9. No current Hospital membership or privilege restrictions and no history of Hospital membership or privileges restrictions;
10. No history of, or current use of, illegal drugs or history of, or current, alcoholism;
11. No impairment or other condition, which would negatively impact the ability to perform the essential functions in their professional field.
12. No gap in work history greater than six (6) months in the past five (5) years. Gaps in work history of six to twenty- four (6 to 24) months will be reviewed by the CC for concerns of future substandard professional conduct and competence.
13. No history of criminal/felony convictions or a plea of no contest;
14. A minimum of the past five (5) years of malpractice case history is reviewed.
15. Meets Credentialing Standards for education/training for specialty(ies) in which practitioner wants to be listed in a MemorialCare Select Health Plan Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs and oral and maxillofacial surgeons;
16. No involuntary terminations from an HMO or PPO;
17. No "yes" answers to attestation/disclosure questions on the application form
18. For Mid-level Practitioners: evidence of Agreement and Delineation of Services.

Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

Practitioners who meet all participation criteria for initial or continued participation and whose credentials have been satisfactorily verified by the

Credentialing department may be approved by the Chair of the CC after review of the applicable credentialing or recredentialing information. This information may be in summary form and must include, at a minimum, practitioner's name and specialty.

B. Currently Participating Applicants (Recredentialing)

1. Submission of complete recredentialing application and required attachments that must not contain intentional misrepresentations;
2. Recredentialing application signed and dated within one-hundred-eighty (180) days of the date of submission to the CC for a vote;
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;
4. Current, valid, unrestricted CA license to practice;
5. No current license probation;
6. License is unencumbered;
7. No new history of licensing board reprimand since prior credentialing review;
8. No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per OIG and OPM Reports or on NPDB report);
9. Possess a current, valid, and unrestricted DEA license for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Members. Initial applicants who have NO DEA license will be viewed as not meeting criteria and the credentialing process will not proceed.
10. No current Hospital membership or privilege restrictions and no new (since prior credentialing review) history of Hospital membership or privilege restrictions;
11. No new (since previous credentialing review) history of, or current use of, illegal drugs or alcoholism;
12. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
13. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
14. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five (5) years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
15. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
16. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions
17. No QI data or other performance data including complaints above the set threshold.
18. Recredentialed at least every three (3) years to assess the practitioner's

continued compliance with MemorialCare Select Health Plan standards.

Note: the CC will individually review any Participating Provider that does not meet one or more of the criteria for recredentialing.

C. Additional Participation Criteria and Exceptions for Behavioral Health Practitioners (Non Physician) Credentialing.

Practitioners must have a minimum of two (2) years experience post-licensure in the field in which they are applying beyond the training program or practice in a group setting where there is opportunity for oversight and consultation with a behavioral health practitioner with at least two (2) years of post-licensure experience.

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type:
    a. Master or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education (CSWE) or the Canadian Association on Social Work Education (CASWE).
    b. Program must have been accredited within three (3) years of the time the practitioner graduated.
    c. Full accreditation is required, candidacy programs will not be considered.
    d. If master's level degree does not meet criteria and practitioner obtained PhD training as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet the criteria, the doctoral program must be accredited by the APA or be regionally accredited by the Council for Higher Education (CHEA). In addition, a doctor of social work from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.
2. Licensed professional counselor (LPC) and marriage and family therapist (MFT) or other master level license type:
    a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
    b. Master or doctoral degrees in divinity do not meet criteria as a related field of study.
    c. Graduate school must be accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, Council for Accreditation of Counseling and Related Educational Programs (CACREP), or Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) listings. The institution must have been accredited within three (3) years of the time the practitioner graduated.

d. If master's level degree does not meet criteria and practitioner obtained PhD training as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet criteria, this doctoral program must either be accredited by the APA or be regionally accredited by the CHEA. In addition, a doctoral degree in one of the fields of study noted above from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.

3. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
   a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing. Graduate school must be accredited from an institution accredited by one of the Regional Institutional Accrediting Bodies within three (3) years of the time of the practitioner's graduation.
   b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
   c. Certification by the American Nurses Association (ANA) in psychiatric nursing. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner.
   d. Valid, current, unrestricted DEA Certificate, where applicable with appropriate supervision/consultation by a Network/Participating Provider (Professional) as applicable by the state licensing board. For those who possess a DEA Certificate, the appropriate CDS Certificate if required. The DEA/CDS must be valid in the state(s) in which the Provider will be treating Members.
4. Clinical Psychologists:
   a. Valid state clinical psychologist license.
   b. Doctoral degree in clinical or counseling, psychology or other applicable field of study from an institution accredited by the APA within three (3) years of the time of the Provider's graduation.
   c. Education/training considered as eligible for an exception is a practitioner whose doctoral degree is not from an APA accredited institution but who is listed in the National Register of Health Service Providers in Psychology or is a Diplomat of the American Board of Professional Psychology.
   d. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.
5. Clinical Neuropsychologist:
   a. Must meet all the criteria for a clinical psychologist listed in C.4 above and be board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical

Neuropsychology (ABCN).

b. A practitioner credentialed by the National Register of Health Service Providers in Psychology with an area of expertise in neuropsychology may be considered.

c. Clinical neuropsychologists who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:

   i Transcript of applicable pre-doctoral training; OR

   ii Documentation of applicable formal one- (1-) year post-doctoral training (participation in CEU training alone would not be considered adequate); OR

   iii Letters from supervisors in clinical neuropsychology (including number of hours per week); OR

   iv Minimum of five (5) years experience practicing neuropsychology at least ten (10) hours per week

III. Behavioral Health Practitioners (Non Physician) Re-credentialing.

MemorialCare Select Health Plan will follow the same re-credentialing process of re-verifying and identifying changes in the practitioner's credentials. Please refer to the *Re-credentialing* section of this chapter for detailed information.

IV. (HDO) Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation; MemorialCare Select Health Plan may evaluate the most recent site survey by Medicare or the appropriate state oversight agency. Non-accredited HDOs are subject to individual review by the CC and will be considered for Covered Individual access need only when the CC review indicates compliance with MemorialCare Select Health Plan standards and there are no deficiencies noted on the Medicare or state oversight review, which would adversely affect quality, care or patient safety. HDOs are recredentialed at least every three (3) years to assess the HDO's continued compliance with MemorialCare Select Health Plan standards.

A. General Criteria for HDOs:

1. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Members. The license must be in good standing with no sanctions.
2. Valid and current Medicare certification.
3. Must not be currently debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP.
4. Liability insurance acceptable to MemorialCare Select Health Plan.
5. If not appropriately accredited, HDO must submit a copy of its CMS or state site survey for review by the CC to determine if MemorialCare Select Health Plan's quality and certification criteria standards have been met.

B. Additional Participation Criteria for HDO by Provider Type:

Medical Facilities

Facility Type	Acceptable Accrediting Agencies
Acute Care Hospital	TJC, HFAP, NIAHO
Ambulatory Surgical Centers	TJC, HFAP, AAPSF, AAAHC, AAAASF, IMQ
Free Standing Cardiac Catheterization Facilities	TJC, HFAP (may be covered under parent institution)
Lithotripsy Centers (Kidney stones)	TJC
Home Health Care Agencies	TJC, CHAP, ACHC
Skilled Nursing Facilities	TJC, CARF
Nursing Homes	TJC

Behavioral Health Facility:

Facility Type (BEHAVIORAL HEALTH CARE)	Acceptable Accrediting Agencies
Acute Care Hospital – Psychiatric Disorders	TJC, HFAP, NIAHO
Residential Care – Psychiatric Disorders	TJC, HFAP, NIAHO, CARF
Partial Hospitalization/Day Treatment – Psychiatric Disorders	TJC, HFAP, NIAHO, CARF for programs associated with an acute care Facility or Residential Treatment Facilities
Intensive Structured Outpatient Program – Psychiatric Disorders	TJC, HFAP, NIAHO for programs affiliated with an acute care Hospital or health care organization that provides psychiatric services to adults or adolescents CARF if program is a residential treatment center providing psychiatric services
Acute Inpatient Hospital – Chemical Dependency/Detoxification and Rehabilitation	TJC, HFAP, NIAHO
Acute Inpatient Hospital – Detoxification Only Facilities	TJC, HFAP, NIAHO
Residential Care – Chemical Dependency	TJC, HFAP, NIAHO, CARF

Partial Hospitalization/Day Treatment – Chemical Dependency	TJC, NIAHO for programs affiliated with a Hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents; CHAMPUS or CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents
Intensive Structured Outpatient Program – Chemical Dependency	TJC, NIAHO for programs affiliated with a Hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents; CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents.

CHAPTER 16: COVERED AND NON-COVERED SERVICES

Summary of Benefits and Coverage:

MemorialCare Select Health Plan (MCSHP) is committed to arranging high quality care for you in order to meet your health care needs. A combined Evidence of Coverage and Disclosure Form (EOC) is provided to our members which acts as a roadmap to describe how, when and where they can access covered health care services.

In addition to describing the benefits available under MCSHP and how to access them, the EOC also describes the costs associated with receiving covered health care services, the limitations and exclusions provided for under the plan, how to file a grievance or expedited grievance with the plan as well as other important features about the plan.

A Special Note About Behavioral Health: MCSHP has contracted with Windstone Behavioral Health Inc. (a specialty Independent Practice Association) to provide our members with Behavioral Health Care Services, including Mental Health and Substance Use Disorder Treatment Services. The EOC explains how to access Behavioral Health Care services.

A Special Note about Chiropractic and Acupuncture Services: MCSHP has contracted with American Specialty Health Plans of California, Inc., ("ASH Plans") to provide our members with a supplemental chiropractic and acupuncture benefit.

If you have questions about the information provided in the MCSHP EOC or need assistance to access an MCSHP member's benefits, you can contact Member Services at (844) 805-8700 or on line at www.MemorialCareSelecthealthplan.org.

CHAPTER 16: COVERED AND NON-COVERED SERVICES

CHAPTER 17: PHARMACY PROGRAM AND GUIDELINES

Pharmacy Program and Guidelines

Prescription Drug Formulation

MemorialCare Select Health Plan provides physicians with quarterly updates of the medications that are included on the Formulary via the web. For an abbreviated list of medications on the Formulary, members can call Member Services at the toll-free telephone number listed on their identification card or access the website at www.MemorialCare Selecthealthplan.com.

For quality assurance and pharmacotherapy advancements, the Formulary is updated quarterly by the Pharmacy and Therapeutics (P&T) Committee. Formulary revision is based on objective evaluation of the efficacy, safety and value of reviewed medications.

Generic Medications

A generic-equivalent medication is the pharmaceutical equivalent of a brand-name medication for which the brand-name medication's patent has expired. The Food and Drug Administration (FDA) must approve the generic medication as meeting the same standards of safety, purity, strength, and effectiveness as the brand-name medication.

If a generic product cannot be used due to medical necessity, a prescriber may:

- Clearly indicate on the prescription "do not substitute" (DNS) or "dispense as written" (DAW). The pharmacist must make the indication on the prescription claim, and the member is charged the higher brand-name copayment, or
- Request prior authorization for the brand-name medication documenting failure or clinically significant adverse effects to the generic equivalent.

Access to Non-Formulary Medication

When the prescribing physician denotes DNS or DAW on the prescription, the pharmacist transmits the claim using the appropriate code to allow adjudication of that claim. Select non-Formulary medications are channeled through prior authorization process through which an internal review is required prior to being dispensed.

CHAPTER 17: PHARMACY PROGRAM AND GUIDELINES

Prior Authorization of Pharmacy Benefits Process

Prior authorization is needed for prescription medication when:

- A medication is listed on the MemorialCare Select Health Plan Recommended Drug List (RDL) as needing prior authorization
- If a medication is not listed on the RDL

Prior authorization requests must be electronically submitted to MemorialCare Select Health Plan's delegated PBM, MedImpact. Faxes are accepted 24 hours a day and each request is tracked to ensure efficient handling of inquiries from physicians and members. Requests are processed within two business days (not exceeding 72 hours for urgent requests).

Timeframes

- Decisions to approve, modify, or deny requests by providers in a timely fashion, not to exceed five (5) business days after the receipt of the information reasonably necessary to make the determination.
- Urgent referrals decision to approve, modify, or deny requests by providers is done in a timely fashion, not to exceed 72 hours after the receipt of the information reasonably necessary and requested to make the determination
- If additional information is required or the information submitted does not meet the approval criteria, a final decision will be made within five (5) business days of the receipt of the request (72 hours for urgent requests).
- If necessary information to make a decision is missing, the prescribing physician may be asked to provide additional medical information in order to proceed with the review within 45 days.
    - No decision will be made until additional information is received or the 45-day time period has expired.
    - If the requested information is not provided in the required timeframe, a determination will be made based on the information available.

Prescribing physicians are notified of the decisions to approve, deny, delay, or modify initially by telephone, facsimile or electronic mail and then in writing within 24 hours of making the decision.

Members are notified of the decisions to approve, deny, delay, or modify in writing within 2 business days.

In emergency cases, or life-threatening situations, a 72-hour supply of medication may be dispensed.

Specialty Pharmacy Benefit

For specialty medications covered under the member's outpatient prescription drug benefit, MemorialCare Select Health Plan applies utilization edits to specialty pharmacy drugs to minimize wastage and promote patient compliance. Members can either pick up these medications at their local retail pharmacy or they can be delivered to their home or physician's office from our preferred specialty pharmacy. Members may be required to use MemorialCare Select Health Plan's preferred specialty pharmacy vendor to obtain their specialty medications per the EOC guidelines.

Oncology adjunct drugs given as part of a chemotherapy regimen do not have to be obtained through MemorialCare Select Health Plan's preferred specialty pharmacy. These drugs may be subject to pharmacy prior authorization requirements.

MemorialCare Select Health Plan's specialty pharmacy benefit focuses on managing the total health care needs of the members. MemorialCare Select Health Plan optimizes adherence and appropriateness of care, supports the physician/patient relationship and plan of care, reduces waste and total health care costs, includes comprehensive care management plan, utilization management (UM) and case management (CM), to ensure the member is treated in the appropriate setting – outpatient Hospital, clinic, doctor's office or at home.

Off-Label Medication Use

A medication prescribed for a use that is not stated in the indications and usage information published by the manufacturer is covered only if the medication is:

- Approved by the Food and Drug Administration (FDA)
- On the Recommended Drug List (RDL) and prescribed or administered by a participating licensed health care professional for the treatment of:
    - A life-threatening condition
    - A chronic and seriously debilitating condition for which the medication is determined to be medically necessary to treat such condition
- Recognized for treatment of life-threatening or chronic and seriously debilitating condition by one of the following:
    - The American Hospital Formulary Service (AHFS) Drug Information
    - One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services (CMS) as part of an anticancer therapeutic regimen:
        - Elsevier Gold Standard's Clinical Pharmacology.
        - National Comprehensive Cancer Network Drug and Biologics Compendium.
        - Thomson Micromedex DrugDex.
- Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal

The following definitions apply to the terms mentioned in this provision only.

CHAPTER 17: PHARMACY PROGRAM AND GUIDELINES

Pain Management for Terminally Ill Members

Requests by providers for authorization of coverage for members who has been determined to be terminally ill are approved or denied within 72 hours of the receipt of the information requested to make the decision.

If the request is denied, or if additional information is required, the requesting provider is contacted within one (1) working day of the determinations, with an explanation of the determination, and the reason for the denial or the need for additional information.

Approval or denial of requests by providers for authorization of coverage for a member who has been determined to be terminally ill is made within 72 hours of the receipt of the information requested by the Plan to make the decision.

If additional information is required, the requesting provider is contacted within one (1) working day of the determination, with an explanation of the determination, and the reason for the need for additional information.

If the request is denied, the requesting provider is contacted within one (1) working day of the determination, with an explanation of the determination, and the reason for the denial.

Quantity Supply Limits

MemorialCare Select Health Plan's pharmacy benefit allows up to a 30-day supply of maintenance medication with an out-of-pocket expense (e.g., copayment or coinsurance) unless the member uses the mail-order program in which case a 90-day supply of maintenance medication may be provided. This quantity limit is based on FDA dosing recommendations. If a medical condition warrants a greater supply than what is recommended, then MemorialCare Select Health Plan will ensure access to a medically appropriate quantity. Prior to being dispensed, medications in this program require an internal review.

Prescription Mail-Order Program

A prescription mail-order program is available to MemorialCare Select Health Plan members. Members are required to pay their mail-order copayments for up to a 90-day supply of medication. The member copayment applies to a 90-consecutive-calendar-day supply of maintenance medications (prescription medications used to manage chronic or long-term conditions when members respond positively to medication treatment and dosage adjustments are either no longer required or made infrequently) and each refill allowed by that order was prescribed by a MemorialCare Select Health Plan participating physician or an authorized specialist. The 90-day- supply maximum is subject to the physician's judgment and the Food and Drug Administration (FDA) recommendations for use. In cases where a 90-day supply is not recommended by the FDA, the prescriber, MemorialCare Select Health Plan or its delegated PBM dispenses the correct quantity. Prescriptions filled through the mail-order program should be written for a 90-day supply whenever possible.

New prescription medication requests may be mailed to MedImpact by the member or faxed by the prescriber. The member's MemorialCare Select Health Plan identification number, date of birth, telephone number including area code should appear on the prescription request to ensure it is processed efficiently. If available, a generic equivalent medication is automatically substituted unless the prescriber indicates DAW (dispense as written) or DNS (do not substitute). Members will be charged the higher brand name copayment.

CHAPTER 17: PHARMACY PROGRAM AND GUIDELINES

Dose Optimization

The dose optimization or dose consolidation is an extension of the quantity supply limit policy and helps increase patient adherence to drug therapies. This works with the member, the member's physician or health care Provider, and the pharmacist to replace multiple doses of lower-strength medications, where clinically appropriate, with a single dose of a higher-strength medication (only with the prescribing physician's approval).

Medical Benefit Coverage

Specialty drugs covered under the Covered Individual's pharmacy benefit can be obtained through the specialty providers or physicians network.

When benefits are provided for specialty drugs under the member's medical benefits, they will not be provided under the member's prescription drug benefit. Conversely, if benefits are provided for specialty drugs under the member's prescription drug benefit, they will not be provided under the member's medical benefit.

Direct Member Reimbursement

To process a Direct Member Reimbursement for a covered prescription drug, a Commercial Prescription Drug Claim Form must be completed according to the instructions indicated on the claim form. The claim form is located on the MedImpact website (www.medimpact.com> Member>Helpdesk>DMR reimbursement form) or below in this section.

The completed claim form and receipt(s) can be sent to:

MedImpact Healthcare System

PO Box 509098

San Diego, CA 92150-9098

Fax: 858-549-1569

E-mail: Claims@Medimpact.com

CHAPTER 17: PHARMACY PROGRAM AND GUIDELINES

COMMERCIAL PRESCRIPTION DRUG CLAIM FORM

CLAIM FORM INSTRUCTIONS

Please read carefully before completing this form. **Claim forms without the required information cannot be processed and will be returned to sender.**

Part 1: Member Information (to be completed by the member)

1. Complete all information under Part 1. The member/cardholder ID Number is located on your insurance card.
2. Submit claims within the filing period specified by your health plan. For questions about your filing period, please call the number on the back of your insurance card.
3. Please submit a separate claim form for each patient and pharmacy from which you purchase medications.
4. **IMPORTANT NOTE: Payment and related correspondence will be sent to the primary subscriber unless you provide us with an Alternate Address in Part 1.**

Part 2: Receipt Information

1. Submit prescription receipts/labels that contain the requested information (shown below) or have your pharmacist complete Part 2 and Part 3. If you do not receive a receipt for your prescription(s), pharmacist signature is required.
2. Include all original pharmacy receipt(s). Tape receipts to a separate page to be submitted with the claim form. Note: Please do not staple receipts or other documentation to the claim form.
3. For multiple claims, please submit a separate Part 2 for each medication or use the multiple prescription alternative form.

PRESCRIPTION/PHARMACY INFORMATION

Prescription Label Example: Please use this example as a guide to locate the required information.

Note: Each pharmacy may have a unique label format.

Anytime Pharmacy #1234 (509)555-1234
123 Any Street **Store NPI: 1234567890**
Home Town, US 12345-6789

RX 1234567 **Date Filled: 1/1/2009**

DOE, JANE
DOB: 01/01/1900
456 Home Road (509)555-5678
Home Town, US 12345

Amoxicillin 500 mg capsules (Teva) **DAW: 0**
00000-1111-22 **QTY: 45** **Days Supply: 30**

A. SMITH, MD
NPI: 4567890123

U&C: 200.00 **COPAY: 20.00**

1. Date Filled*
2. RX Number
3. Quantity*
4. Day Supply*
5. National Drug Code (NDC)*
6. Medication Name and Strength*
7. Physician Name
8. Physician National Provider ID (NPI)
9. DAW
10. Usual and Customary Price (U&C)/RX Price*
11. Copay*
12. Pharmacy National Provider ID (NPI)

**REQUIRED INFORMATION - CLAIM WILL BE RETURNED IF THIS INFORMATION IS NOT SUPPLIED.*

Part 3: Pharmacy Information (To be completed by the pharmacy)

1. If required information is not available on the receipt, ask your Pharmacist to complete Part 2 and Part 3.
2. Remember to keep a copy of the completed claim form and receipt(s) for your records.
3. Send the completed form and receipt(s) to: MedImpact Healthcare Systems, Inc.
   PO Box 509098
   San Diego, CA 92150-9098
   Fax: 858-549-1569
   E-mail: Claims@Medimpact.com

CHAPTER 17: PHARMACY PROGRAM AND GUIDELINES

COMMERCIAL PRESCRIPTION DRUG CLAIM FORM

PART 1 ***Indicates required information**

Primary Member/Cardholder ID Number*	Group Number	
Name of Health Plan/Insurance	Primary Subscriber Name*	DOB: (mm/dd/yyyy)*
Patient Name: (First, Middle, Last)*	Date of Birth: (mm/dd/yyyy)* / /	Relationship to Primary Subscriber Self 0 Spouse 0 Dependent 0
Primary Subscriber Address: (Street, City, State, Zip code)		
Alternate Address: (Street, City, State, Zip code)		
***If no alternate address is specified, correspondence and/or payment will be forwarded to the primary subscriber address on file with your health plan/insurance.**		
Member Signature*	Telephone Number ( )	Date

Indicate reason for manually filing these claims (select one):

- ❍ Coordination of Benefits — Claims must be submitted with pharmacy receipt(s) identifying copays paid ***and*** an Explanation of Benefits from the primary carrier (or prescription history from the pharmacy showing primary insurance payment)
- ❍ Discount Card was used
- ❍ Health plan/insurance information or insurance card not available at the time of purchase
- ❍ Pharmacy not participating in network
- ❍ Pharmacy unable to process claim electronically
- ❍ Emergency — If Emergency, describe emergency below

Manual submission of claims does not guarantee reimbursement.

Describe Emergency: _____

PART 2

RX Number	Date Filled* / /	New 0 Refill 0 (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit*
Medication Name and Strength*			Physician Name & NPI Number Name: NPI:		RX Price* $ / Co-Pay* $

Compound? 0 Yes 0 No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

RX Number	Date Filled* / /	New 0 Refill 0 (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)*
Medication Name and Strength*			Physician Name & NPI Number Name: NPI:		RX Price* $ / Co-Pay* $

Compound? 0 Yes 0 No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

PART 3

Affix Pharmacy Label Here or Enter the Required Information:

Pharmacy Name*			Pharmacy Telephone Number	
Street Address			NPI*	
City	State	Zip	Pharmacist Signature*	Date*

CHAPTER 17: PHARMACY PROGRAM AND GUIDELINES

MedImpact
Delivering · Flexible · Choice

COMMERCIAL PRESCRIPTION DRUG CLAIM FORM

IMPORTANT CLAIM NOTICE

AL, AK, AZ, CT, DE, GA, ID, IL, IN, IA, KS, KY, LA, MA, MI, MN, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OR, RI, SC, SD, VT, WI, WY Residents: WARNING — For your protection, state law requires the following statement to appear on this form. Any person who knowingly with intent to, or assist with intent to, injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information may be prosecuted under state law and subject to civil fines and criminal penalties. **Additionally, DE, ID, MN, NM, OH Residents:** Anyone who commits the above act is guilty of a crime/felony and may also be subject to fines and/or criminal penalties.

AR, CA, DC, FL, HI, MD, ME, OK, TN, TX, UT, VA, WA, WV Residents: WARNING — For your protection, state law requires the following statement to appear on this form. Any person who knowingly with intent to, or assist with intent to, injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information is guilty of a crime and may be subject to imprisonment, fines, and/or denial of insurance benefits. **Additionally, AR, CA, FL, MD, OK, TX, UT, WV Residents:** Anyone who commits the above act is guilty of a crime/felony and may also be subject to fines and/or confinement in prison.

CO Residents: WARNING — For your protection, state law requires the following statement to appear on this form. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department or regulatory agencies.

NY Residents: WARNING — For your protection, state law requires the following statement to appear on this form. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PA Residents: WARNING — For your protection, state law requires the following statement to appear on this form. Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to $15,000.

Puerto Rico Residents: WARNING — For your protection, we are required to print the following. Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefits, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollar ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Exclusions and Limitations

These are benefit plan specific and are defined in the plan's evidence of coverage.
All benefit plans adhere to the mental health parity rules.

CHAPTER 18: MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS AND RESPONSIBILITIES

The MemorialCare Select 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 MemorialCare Select members:

MemorialCare Select 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 MemorialCare Select Health Plan, its services, its practitioners and Providers and your rights and responsibilities.
- To voice grievances or appeals about MemorialCare Select Health Plan or care provided by its Contracting Providers
- 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 MemorialCare Select 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 MemorialCare Select 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 MemorialCare Select Health Plan Grievance and Appeals Procedure.

CHAPTER 19: 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 is 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

CHAPTER 19: FRAUD AND ABUSE

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).

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.

CHAPTER 20: PROVIDER RESOURCES

PROVIDER ACCESS WEBSITE

The MemorialCare Select Health Plan Website 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, www.cerecons.com , 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 Manual
- Obtain program news and information

The MemorialCare Select Health Plan Website 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.

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 MemorialCare Select Health 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 Available through the MemorialCare Select Health Plan

- Telephone Interpreters: Available 24 hours a day, 7 days a week by calling the Member Services during business hours and 24/7 Nurse Line 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.

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 staffs 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 MemorialCare Select Health Plan with documentation of assessment upon request

Resources Available on Our Website

To find a list resources on our website go to www.MemorialCare SelectHealthPlan.org.

CHAPTER 21: ACRONYMS

ACRONYMS

Acronym	Definition
EDS	**Electronic Data Systems**
EOB	**Explanation of Benefits**
EOC	**Evidence of Coverage**
EPO	**Exclusive Provider Organization**
EPSDT	**Early and Periodic Screening Diagnostic and Treatment Services**
ER	**Emergency Room**
ERA	**Electronic Remittance Advice**
FDA	**Food and Drug Administration**
FFS	**Fee For Service**
FTE	**Full-Time Equivalent**
HCBS	**Home and Community-Based Services**
HCO	**Health Care Options**
HCPCS	**Healthcare Common Procedure Coding System**
HEDIS®	**Health Employer Data and Information Set**
HIPAA	**Health Insurance Portability and Accountability Act of 1996**
HIV	**Human Immunodeficiency Virus**
HMO	**Health Maintenance Organization**
HPS	**Health Promotion Specialists**
ICD-10	**International Classification of Diseases, 10th Revision**
ID	**Identification**
IHA	**Initial Health Assessment**
IHEBA	**Individual Health Education Behavioral Assessment**
IHMC	**In-Home Medicare Waiver Program**
IHSS	**In-Home Supportive Services**
IMR	**Independent Medical Review**
ISP	**Internet Service Provider**
IVR	**Interactive Voice Response**
KICK	**Kids in Charge of Kalories**
LAP	**Language Assistance Program**
LCSW	**Licensed Clinical Social Worker**
LEP	**Limited English Proficient**
LHD	**Local Health Department**
LMP	**Last Menstrual Period**
LOS	**Length of Stay**
MCAH	**Maternal, Child and Adolescent Health**
MCH	**Maternal and Child Health**
MCWP	**Medi-Cal Waiver Program**
MMCD	**Medi-Cal Managed Care Division**
MOU	**Memorandum of Understanding**
MRI	**Magnetic Resonance Imaging**
MRMIB	**Managed Risk Medical Insurance Board**
MRMIP	**Major Risk Medical Insurance Program**
MSSP	**Multipurpose Senior Service Program**
NCQA	**National Committee for Quality Assurance**

CHAPTER 21: ACRONYMS

Acronyms	Definition
NDC	**National Drug Code**
NHLBI	**National Heart, Lung and Blood Institute**
NIH	**National Institute of Health**
NRT	**Nicotine Replacement Therapy**
OB	**Obstetrician**
OB/GYN	**Obstetrics/Gynecology**
OCC	**Outreach Call Center**
OCPM	**Office of Clinical Preventive Medicine**
OS	**Outreach Specialist**
OTC	**Over the Counter**
PAB	**Prior Authorization of Benefits**
PCP	**Primary Care Physician or Primary Care Provider**
PCR	**Physician Clinical Review**
PDP	**Prescription Drug Plan**
PDR	**Provider Dispute Resolution**
PIN	**Personal Identification Number**
PMG	**Provider Medical Group**
PNR	**Pregnancy Notification Report**
POS	**Point of Service**
PPI	**Proton Pump Inhibitor**
PPO	**Preferred Provider Organization**
PQRC	**Physician Quality Review Committee**
QI	**Quality Improvement**
QIC	**Quality Improvement Committee**
QIP	**Quality Improvement Program**
QM	**Quality Management**
QMA	**Quality Management Analyst**
QMRN	**Quality Management Registered Nurse**
QMS	**Quality Management Specialist**
RA	**Remittance Advice**
RTIE	**Real Time Internet Eligibility**
SBC	**School-Based Clinic**
SED	**Serious Emotional Disturbance**
SHAT	**Staying Healthy Assessment Tool**
SNF	**Skilled Nursing Facility**
SSB	**State Sponsored Business**
STD	**Sexually Transmitted Disease**
TB	**Tuberculosis**
TIPS	**CDC's Tobacco Information and Prevention Source**
TLC	**—The Last Cigarette‖**
TPL	**Third Party Liability**
TPN	**Total Parenteral Nutrition**
TDD	**Telecommunication Device for the Deaf**
TTY	**Text Telephone (Teletype)**
UM	**Utilization Management**
VFC	**Vaccines for Children**
VSP	**Vision Service Plan**

CHAPTER 21: ACRONYMS

Acronyms	Definitions
WIC	**Women, Infants and Children Program**
WPM	**WellPoint Pharmacy Management**