SEASIDE HEALTH PLAN

Providers Manual

MEDICARE ADVANTAGE

August 12, 2013

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OVERVIEW

Seaside 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.

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

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

OVERVIEW

ADMINISTRATION

Should you have any questions, please directly contact the appropriate department at Seaside Health Plan:

ADMINISTRATIVE OFFICES

Seaside Health Plan - Corporate
2840 Long Beach Boulevard, Suite 120
Long Beach, CA 90806
Phone: (855) 367-7747
Fax: (562) 424-1486
TTY/TTD: (855) 833-7747

NON-DISCRIMINATION STATEMENT

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

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

PROVIDERS CONTRACT REQUIREMENTS THROUGH POLICIES, STANDARDS AND MANUALS

The Centers for Medicare and Medicaid Services (CMS) requires that the following requirements be included in contracts or in the procedures, standards, and/or policy manuals of all Medicare contracting entities (plans and Providers) per 42 CFR 422.

Prohibition against discrimination based on health status [422.110(a)]

Providers and health plans are prohibited from discriminating against Members based on their health status.

Pay for emergency and urgently needed care consistent with provisions [422.112(b); 422.100(b)]

Claims for Emergency and urgently needed care cannot be denied.

Pay for renal dialysis for those temporarily out of service area. [422.100(b)(1)(iii)]

Members out of area are entitled to coverage for renal dialysis for up to six months.

Direct access to mammography screening and influenza vaccinations [422.100(h)(1)]

Members are entitled to a mammography screening annually by a CMS certified mammography center
Members are entitled to annual flu shots (with no copay).

No copay for influenza and pneumococcal vaccines [422.100(h)(2)]

Members are not to be charged copays for flu shots or pneumonia vaccines.

Agreements with Providers to demonstrate "adequate" access. Network must be sufficient to provide access to covered services [422.112(a)(1)]

Plans and Providers must maintain executed, Medicare-compliant contracts with a network of Providers sufficient to cover the needed services of Members.

Direct access to in-network women's health specialist for routine and preventive services [422.112(a)(3)]

Women may self-refer within the contracted network for routine women's health visits.

Approved procedures to identify, assess and establish treatment plan for serious and complex medical conditions [422.112(a)(4)]

Plans and Providers must develop and discuss treatment plans with Members for serious and complex medical conditions.

Suspension or termination of plan-contracted Providers [422.204]

Although health plans delegate contracting and credentialing functions, CMS requires all agreements to state that the health plan is ultimately responsible and must retain the right to suspend or terminate contracted Providers.

Services available 24 hrs/day, 7 days/week [422.112(a)(8)]

Contracting Medical Groups (CMGs) are required to furnish services 24 hours a day, 7 days a week. Business hours are to be posted with information regarding where the Member can access services after hours.

Members should always reach a "live voice" when calling the CMG.

Adhere to HCFA marketing provisions [422.80(a), (b), (c)]

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

Providers must submit to the Seaside Health Plan Medical Group Compliance Manager any materials to be mailed to Members regarding the health plan or their coverage. Providers must submit the materials 75 days in advance of date the materials (letters) are to be distributed. The health plans are required to submit these materials on behalf of the Providers to CMS Region IX. CMS will respond within 45 days with approval or disapproval. If disapproved the materials may be corrected and resubmitted. No materials can be utilized until the written CMS approval is received by the health plan.

Ensure services are provided in culturally competent manner [422.112(a)(10)]

Conduct a health assessment of all new enrollees within 90 days of the effective date of enrollment 422.112(b)(5)

Document in a prominent place in medial record if individual has executed Advance Directive 422.128(b)(1)(ii)(E)

Provide covered benefits in a manner consistent with professionally-recognized standards of health care 422.502(a)(3)(iii)

Payment and incentive arrangements specified between Medicare Organization (MAO), Providers, first tier, and downstream entities be specified in all contract(s) 422.208

Subject to laws applicable to federal funds 422.502(h)(2)

Disclose to HCFA all information necessary to administer and evaluate the program and establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services 422.64(a): 422.502(a)(4): 422.502(f)(2)

Must make good faith effort to notify all affected Members of the termination of a Providers contract within 15 days of notice of termination by plan or Providers 422.111(e)

Submission of encounter data, medical records and certify completeness and truthfulness 422.502(a)(8); 422.502(1)(2) & (3)

Cooperate with quality review and improvement organization's activities pertaining to provision of services for Medicare enrollees in an MAO plan 422.154(a)

Comply with medical policy, QM and MM. MAO must develop such standards in consultation with contracting Providers 422.202(b); 422.502(a)(5)

Disclose to HCFA quality and performance indicators for plan benefits re: disenrollment rates for beneficiaries enrolled in Seaside Health Plan for the previous two years 422.502(f)(2)(iv)(A)

Disclose to HCFA quality and performance indicators for the benefits under Seaside Health Plan regarding enrollee satisfaction 422.502(f)(2)(iv)(B)

Disclose to HCFA quality and performance indicators for the benefits under Seaside Health Plan regarding health outcomes 422.502(f)(2)(iv)(C)

Notify Providers in writing of reason for denial, suspension and termination 422.204(c)(1)

Provide 60 days' notice (terminating contract without cause) 422.204(c)(4)

Comply with Civil Rights Act, ADA, Age Discrimination Act, federal funds laws 422.502(h)(1)

Prohibits MAO, first tier and downstream entities from employing or contracting with individuals excluded from participation in Medicare under section 1128 or 1128A of the SSA 422.752(a)(8)

Adhere to appeals/grievance procedures 422.562(a)

MEDICARE OVERVIEW

MEDICARE PROGRAM

The Centers for Medicare & Medicaid Services (CMS) administers Medicare, the nation's largest health insurance program, which covers nearly 40 million Americans. Medicare is a Health Insurance Program for people 65 years of age and older, some disabled people under 65 years of age, and people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant). Original Medicare is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Part A helps pay for care in a hospital, skilled nursing facility, home health care, and hospice care. Part B helps pay doctor bills, outpatient hospital care and other medical services not covered by Part A.

Part A

Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers. There is no monthly premium for Part A if the Medicare eligible or spouse has worked at least 10 years in a Medicare-covered employment, is age 65, and a citizen or permanent resident of the United States. Certain younger disabled persons and kidney dialysis and transplant patients qualify for premium free Part A.

When all program requirements are met, Medicare Part A helps pay for medically necessary inpatient care in a hospital or a skilled nursing facility after a hospital stay. Part A also pays for home health and hospice care, and 80 percent of the approved cost for wheelchairs, hospital beds and other Durable Medical Equipment (DME) supplied under the home health benefit. Coverage is also provided for whole blood or units of packed cells, after the first three pints, when given by a hospital or skilled nursing facility during a covered stay.

Part B

Medicare Part B pays for many medical services and supplies, including coverage for doctor's bills. Medically necessary services of a doctor are covered no matter where received at home, in the doctor's office, in a clinic, in a nursing home, or in a hospital. The Medicare beneficiary pays a monthly premium for Part B coverage. The amount of premium is set annually by CMS. Part B also covers:

- Outpatient hospital services
- X-rays and laboratory tests
- Certain ambulance services
- Durable Medical Equipment
- Services of certain specially qualified Practitioners who are not Physicians
- Physical and Occupational therapy
- Speech/language pathology services
- Partial hospitalization for mental health care
- Mammograms and Pap smears
- Home Health care if a beneficiary does not have Part A

MEDICARE OVERVIEW

MEDICARE PLANS

The Balanced Budget Act of 1997 (BBA) established Medicare Part C also referred to as Medicare (MA). Prior to Jan. 1, 1999, Medicare HMO's existed as Medicare Risk or Medicare Cost plans. The Balanced Budget Act of 1997 was intended to increase the range of alternatives to the traditional fee for service program for Medicare beneficiaries. The options included Health Maintenance Organizations (HMOs) and Preferred Providers Organizations (PPOs).

MANAGED CARE PLAN ENROLLMENT

Most Medicare beneficiaries are eligible for enrollment in a managed care plan. To enroll, an individual must:

- Have Medicare Parts A & B and continue paying Part B premiums
- Live in Seaside Health Plan's service area
- Not have permanent kidney failure at the time of enrollment unless they are currently enrolled in Seaside Health Plan's commercial product.

Seaside Health Plan must enroll Medicare beneficiaries, including younger disabled Medicare beneficiaries, in the order of application, without health screening. Medicare plans are required to have an open enrollment period from November 15th through December 7th each year, with a 01/01/ plan effective date.

EFFECTIVE/TERMINATION DATE COINCIDES WITH A HOSPITAL STAY

If a Member's effective date occurs during an inpatient stay in a hospital, Seaside Health Plan is not responsible for any services under Medicare Part A during the inpatient stay. (This provision applies to acute hospital stays only, not to stays in a Skilled Nursing Facility (SNF).

Seaside Health Plan is responsible for inpatient hospital services under Part A on the day after the day of discharge from the inpatient stay. All other services, other than inpatient hospital services under Part A are covered by the Medicare plan beginning on the effective date of enrollment.

If the Member's Medicare coverage terminates while the Members is hospitalized, Seaside Health Plan is responsible for the facility charges until discharge regardless of the reason for the coverage termination.

ELIGIBILITY VERIFICATION

OVERVIEW

Primary Care Providers (PCP) should check eligibility for Medicare & Medi-Cal/Medicare Members and use the Member's assigned health plan for eligibility. Eligibility is also available on Seaside Health Plan's website but may not be as current as the health plans directly. Passwords to each website are unique to each health plan. To obtain passwords, contact each health plan.

Health plan look up by website:

Blue Shield of California	www.blueshieldca.com
Care 1st Health Plan	www.care1st.com
Health Net Health Plan	www.heatlhnet.com
LA Care Health Plan	www.lacare.org
Seaside Health Plan	www.SeasideHealthPlan.org

A Member's eligibility must be checked for each visit; especially any time extensive services are to be provided, so that appropriate benefits and coverage may be determined. It is recommended eligibility be verified prior to the Member's appointment date so those Members who do not appear on the eligibility list have the opportunity to contact Seaside Health Plan before coming to your office for their appointment.

Please direct questions regarding eligibility status or benefits to the Member's health plan.

NOTE: POSSESSION OF A MEMBERSHIP CARD DOES NOT GUARANTEE ELIGIBILITY. Always verify eligibility with the health plan.

ELIGIBILITY VERIFICATION

Seaside Health Plan's Contracted Health Plans. The Lines of Business identifies each health plan

HEALTHPLAN	LINE OF BUSINESS
Blue Shield ▪ Medicare (65) Plus	L62
Care 1st Health Plan • Medicare	L46
Health Net ▪ Medicare Benefit Program	L81
LA Care • Medicare	L70

All health plan listings of new Members assigned by Providers will be forwarded to the corresponding physician group on a monthly basis. These new Members are to be contacted right away for an appointment with their new PCP for an initial health assessment and/or health risk assessment based on their insurance plan requirements.

HEALTH PLAN BILLABLE CHARGES BY LINE OF BUSINESS

HEALTHPLAN	LOB	Billable Charges
Blue Shield Health Plan ➢ Medicare (65) Plus	L62	Bill for all vaccinations & medications
Care 1st Health Plan ➢ Medicare	L46	Bill for vaccinations & medications
Health Net Health Plan ➢ Medicare Benefit Program	L30	Bill for only Flu shots

MEMBER COPAYMENT COLLECTION

Member copayments or share of cost for medical services given is the responsibility of the Providers office to collect at the time of the visit. Always verify copayment. Copayment is the Member's obligation. You can look up the Member's insurance benefits on their assigned health plan website.

COORDINATION OF BENEFITS

If the Member has Medicare Insurance plus a commercial health plan, the commercial plan is primary and should be billed first for services provided. The secondary insurance is billed for any remaining balance. If the Member has a Third Party Liability (TPL) claim, the services are billed to the TPL party and not the Member's primary insurance.

If you have any questions regarding covered benefits, administrative procedures or general issues regarding Seaside Health Plan please contact us at (855) 367-7747.

COMPLIANCE WITH MEDICARE LAWS, AUDITS, AND RECORD RETENTION REQUIREMENTS

Medical records and other health and enrollment information of an enrollee must be handled under established procedures that:

- Safeguard the privacy of any information that identifies a particular enrollee
- Maintain such records and information in a manner that is accurate and timely
- Identify when and to whom enrollee information may be disclosed.

In addition to the obligation to safeguard the privacy of any information that identifies a particular enrollee, Seaside Health Plan including its participating Providers, is obligated to abide by all Federal and state laws regarding confidentiality and disclosure for mental health records, medical health records, and enrollee information. First tier and downstream Providers must agree to comply with Medicare laws, regulations, and CMS instructions (422.504(I)(4)(v)), and agree to inspections, evaluations and audits by CMS and/or its designees and to cooperate, assist, and provide information as requested, and maintain records a minimum of 10 years; For the purposes specified in this section, Providers agree to make available Providers premises, physical facilities and equipment, records relating to Plan's Covered Individuals, including access to Providers computer and electronic systems and any additional relevant information that CMS may require. Providers acknowledge that failure to allow HHS, the Comptroller General or their designees the right to timely access under this section can subject Providers to a fifteen thousand dollar ($15,000) penalty for each day of failure to comply.

QUALITY MANAGEMENT

In coordination with the Primary Medicare Advantage Plan, Seaside Health Plan Quality Management Program provides activities that encompass the following: clinical studies and interventions, Member and Providers health education, preventive care, participation in disease management programs, HEDIS® data collection and improvement activities, access and availability monitoring, Member and Providers satisfaction, credentialing of Practitioners and Providers, peer review, patient safety initiatives and continuity and coordination of care.

BOOKING LEAD TIME REPORTS

Seaside Health Plan will monitor the number of days to appointments for each specialty and Providers by producing and reviewing "Booking Lead Time Reports".

- Booking Lead-Time Reports are generated on a weekly basis.
- This report is calculated by finding the next three available appointments dates by specialty and Providers, and determining the number of days that appointment date is from the day the report is prepared. This number is averaged to provide the "booking lead time".
- These reports are forwarded to the medical operations team for review on a weekly basis.
- Reports are reviewed according to the established standards, with corrective action made by appropriate staff Members.

90 DAY HEALTH ASSESSMENT

Seaside Health Plan Providers are educated on the 90 day initial health assessment requirement, as specified in the Providers Manual.

An initial health assessment is performed on Medicare Members within 90 days of the date of enrollment

The Primary Health Plan processes the enrollment of new Members.

- The post-enrollment packet, which is sent to all new Members, includes information regarding the importance of scheduling an initial health assessment and instructions on how the Member can schedule appointments.
- The PCP should conduct the initial health assessment at the first appropriate health care contact and document the assessment in the medical records.

EDUCATION AND TRAINING

Providers are responsible for reinforcing the importance of accessing preventive health services at every patient encounter.

- The medical record reflects diagnostic, treatment and follow-up services for symptomatic findings or risk factors identified in the IHA within 60 days following discovery
- The medical record reflects TB screening for Members identified as high risk
- The medical record reflects a dental screening/oral assessment and dental referral starting at age 3 or earlier, if warranted
- The medical record includes documented age-appropriate immunizations
- If the IHA has not been completed due to missed appointments, the medical record reflects documented missed appointments and attempts for follow-up, as appropriate.

HEALTH ASSESSMENT SERVICES

The guidelines specified in the Primary Plan's Adult and Pediatric Preventive Care Standards define the initial health assessment. They are derived from accepted national sources such as the U.S. Preventive Services Taskforce and the American Academy of Pediatrics. Current approved preventive health guidelines are posted to Primary Plan's intranet site as well as Seaside Health Plan's site (www.SeasideHealthPlan.org), which is available to Members and Providers.

The Member's health history and the presence of risk factors determine the scope of preventive services required and the interval of subsequent visits. The PCP arranges and coordinates appropriate referrals, based on exam/assessment results.

The initial health assessment includes the administration of the Individual Health Education Behavioral Assessment or "Staying Healthy Tool".

Health assessments for Members 21 years and older must include, at minimum:

- History and physical examination
- Blood Pressure
- Cholesterol screening
- Clinical breast exam for women over 40 years of age

- Mammogram for women over 40 years of age
- Pap smear for women beginning at the age of first sexual intercourse
- Tuberculosis screening or immunizations for adults as required
- Health education and anticipatory guidance appropriate to age and health status
- Screening for prostate cancer in men, starting at 45 years of age with high risk factors and 50-70 years of age with average risk

Health assessments for Members under 21 years of age, the initial assessment and ongoing assessments must follow the requirements of the CHDP Program. For Members under 21 years of age, the initial assessment includes:

- Health and developmental history
- Unclothed physical examination, including assessment of physical growth
- Inspection of ears, nose, mouth, throat, teeth and gum
- Assessment of nutritional status
- Hearing and Vision screening, appropriate to age
- Immunizations and Tuberculosis testing appropriate to age and health history necessary to make status current
- Lab tests appropriate to age and sex, including anemia, diabetes, lead levels, sickle cell trait and urinary tract infections
- Documented testing for lead poisoning in IHA. (if appropriate) (lead level checks at ages 12 mo., 24 mo., or 72 mos.) Lead level range-above 15 should be referred to Los Angeles Lead Program.
- Follow-up lead re-checks done on lead levels 10 to 14 in 3 months and follow-up on lead confirmatory (venous) re-check is performed on lead levels 15 to 19 within 1-2 months.
- Health education and anticipatory guidance appropriate to age and health status
- Identification, treatment and follow-up on obese Members
- HPV immunization was offered to age appropriate females (11-26)

PCP COORDINATION OF CARE

Treatment for medical conditions or abnormal findings identified at the time of the exam/assessment must be initiated within ninety (90) days. Justification for any delay(s) beyond this period must be documented in the Member's medical record. The PCP coordinates necessary specialty referrals, utilizing the authorization and referral process.

During the initial and subsequent exam/assessment, the PCP reinforces the need for regularly scheduled preventive care visits. PCPs are advised to schedule future appointments at the conclusion of the encounter. The PCP coordinates all appropriate referrals to dental Providers and to the county Women Infant and Children Program (WIC) Program.

ENCOUNTER DATA FOR RISK ADJUSTMENT PURPOSES

Risk Adjustment and Data Submission:

Risk adjustment is the process used by CMS to adjust the payment made to Seaside Health Plan based on the health status of Seaside Health Plan's Medicare Members. Risk adjustment was implemented to pay Medicare Plans more accurately for the predicted health cost expenditures of Members by adjusting payments based on demographics (age and gender) as well as health status. As a Medicare organization, diagnosis data collected from

encounter and claim data is required to be submitted to CMS for purposes of risk adjustment. Because CMS requires that Plans submit "all ICD9 codes for each beneficiary", Seaside Health Plan also collects diagnosis data from the Members' medical records created and maintained by the Providers.

Under the CMS risk adjustment model, Seaside Health Plan is permitted to submit diagnosis data from inpatient hospital, outpatient hospital and physician encounters only.

RADV AUDITS

As part of the risk adjustment process, CMS will perform a risk adjustment data validation (RADV) audit in order to validate the Medicare Members' diagnosis data that was previously submitted by Plans. These audits are typically performed once a year. If Seaside Health Plan is selected by CMS to participate in a RADV audit, Seaside Health Plan and the Providers that treated the Medicare Members included in the audit will be required to submit medical records to validate the diagnosis data previously submitted.

ICD-9 CM CODES

CMS requires that Physicians currently use the ICD-9 CM Codes (ICD-9 Codes) and coding practices for Medicare business. In all cases, the medical record documentation must support the ICD-9 Codes selected and substantiate that proper coding guidelines were followed by the Providers. For example, in accordance with the guidelines, it is important for Physicians to code all conditions that co-exist at the time of an encounter and that require or affect patient care or treatment. In addition, coding guidelines require that the Providers code to the highest level of specificity which includes fully documenting the patient's diagnosis.

USE OF SEASIDE HEALTH PLAN TRADEMARK WITHIN COMMUNICATIONS

Our Provider contracts stipulate that any printed materials, including but not limited to letters to Seaside Health Plan Members, brochures, advertisements, telemarketing scripts, packaging prepared or produced by Providers or any of his/her/its subcontractors pursuant to this Agreement must be submitted to Seaside Health Plan to assure compliance with Federal and State guidelines. Seaside Health Plan agrees its approval will not be unreasonably withheld or delayed. In order to make this easier on you the Providers, we have simplified the submission of the document(s) to Seaside Health Plan for review.

To submit a document for review, please send the copy to us. Although Seaside Health Plan's legal team will be reviewing the copy, it is your responsibility to comply, and to require any of your subcontractors to comply, with all applicable Federal and State laws, regulations, CMS instructions, and marketing activities under this Agreement, including but not limited to, the National Marketing Guide for Medicare Managed Care Plans, and any requirements for CMS prior approval of materials. We again welcome you to use our name and logo when you send out communications to you patients in an effort to provide information to your patients.

PROVIDERS CREDENTIALING

CREDENTIALING SCOPE

Seaside Health Plan ensures that its medical Providers, ancillary Providers, and pharmacies meet the credentialing and re-credentialing performance standards for participation on practitioner panel. Seaside Health Plan evaluates and selects licensed independent Practitioners to provide care to its Members.

The Seaside Health Plan credentials the following contracted health care Practitioners: medical doctors, doctors of osteopathic medicine, doctors of podiatry, chiropractors, and optometrists providing services covered under the medical benefits plan and Doctors of Dentistry providing services covered under the medical benefits plan including oral maxillofacial surgeons.

Seaside Health Plan, where applicable, 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 Providers listed in Seaside Health Plan's network directory will be credentialed.

Seaside Health Plan credentials the following contracted Health Delivery Organizations (HDOs): Hospitals; Home Health Agencies; Skilled Nursing Facilities; (Nursing Homes); Free-Standing Surgical Centers; Lithotripsy Centers treating kidney stones and free standing Cardiac Catheterization labs if applicable to certain regions and Behavioral Health Facilities providing mental health and/or substance abuse treatment in an inpatient, residential or ambulatory setting.

CREDENTIALS COMMITTEE

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

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

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

INITIAL CREDENTIALING PROCESS

Each Practitioner or Providers needs to complete a standard application form. The application form may be required by the state or it may be a standard form that Seaside Health Plan either created or accepted. Seaside Health Plan uses the California Participating Physician Application (CPPA) form for Practitioners.

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

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

RE-CREDENTIALING PROCESS FOR PROVIDERS

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

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

HEALTH DELIVERY ORGANIZATIONS (HDO)

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

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

APPEALS PROCESS

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

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

NONDISCRIMINATION POLICY

Seaside Health Plan will not discriminate against any applicant for participation in its programs or networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Seaside 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 re-credentialing process. Determinations as to which Practitioners and Providers require additional individual review by the Credentials Committee are made according to predetermined criteria related to professional conduct and competence as outlined in Plan Credentialing Program Standards. Credentials Committee decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process.

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

ACCESS TO CARE AND SERVICES

Seaside Health Plan ensures that all covered services, including additional or supplemental services contracted for by the Medicare enrollee, are accessible under Seaside Health Plan. Medically necessary services are available 24 hours a day, seven days a week.

Organizations and Providers who contract with Seaside Health Plan's Medicare network are required to establish and implement appropriate treatment plans for a Member with complex and serious medical conditions. Accordingly, an established treatment plan must include an adequate number of direct access visits to relevant specialty Providers. Treatment plans must be time-specific and updated by the PCP.

ACCESS GUIDELINES

Seaside Health Plan Providers should 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**: 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	$\leq$ 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

MONITORING AND QUALITY IMPROVEMENT

Seaside Health Plan has established performance measures to assist in developing and maintaining adequate Providers and Practitioners in all our Medicare networks. Performance is monitored at least annually and strategies are developed as needed to overcome deficiencies in the networks. Other pertinent sources of information for reviewing network adequacy include appeals and complaints regarding access and availability. Out-of-network referrals are approved for Seaside Health Plan Members when in-network Providers and Practitioners are not available or accessible in the Members' geographic locations. In certain circumstances, the Member may only be responsible for the in-network cost sharing.

Seaside Health Plan monitors access and availability as part of the Quality Management Program and as communicated by the Providers Manual using but not limited to the following:

- Verification of the Advanced Access Programs
- Documentation of Member calls
- Member complaint's regarding Providers access;
- Physician office complaints regarding Providers access;
- Feedback from Seaside Health Plan UM Department regarding access to Providers;

Seaside Health Plan monitors the provision of preventive services by medical Providers, ancillary Providers on a Plan-wide basis through:

- Regular measurement of the level of preventive care provided to Members against its established guidelines;
- Critical evaluation of the results of preventive care monitoring.

When Seaside Health Plan identifies problems, actions are taken to ensure appointment availability and monitors to assure improvements are maintained.

If necessary, a Corrective Action Plan (CAP) is initiated that includes, at a minimum: the date opened; the target completion date; the actual completion date (or space for it to be added upon completion); the deliverable / task to be completed; the responsible party; and a column for the "current status" enabling the responsible party to report barriers, progress, and any noteworthy changes.

The Providers is required to respond to areas of deficiency per CAP requirements and in a maximum of 30 days. Seaside Health Plan will work with and offer support to the Providers to ensure the timely resolution of CAP requirements. Failure to provide the requested information or to implement the CAP may result in further action including revocation as specified in the Providers Agreement.

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

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

APPLICATION OF CLINICAL CRITERIA GUIDELINES

Seaside Health Plan uses Medicare coverage guidelines, nationally recognized clinical guidelines, and internally developed guidelines for medical appropriateness review. Actively practicing Physicians and other relevant Practitioners are involved in the development and adoption of the criteria. Medical necessity decision making includes assessing the needs of the individual patient and characteristics of the local delivery system.

UM criteria application hierarchy is as follows:

- Federal or State Mandate;
- Health Plan Medical Policy or Clinical Guideline;
- Standardized Criteria (Milliman or InterQual,);
- Standardized Behavioral Health Criteria (Milliman Care Guidelines, APA & ASAM);
- Providers Group Criteria or Guideline;
- Community Resources (peer reviewed journals or published resources);
- If none apply, professional judgment is used.

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

These criteria are available to Members, Physicians and other health care Providers upon request by contacting the UM Department or Member Services at (855) 347-7747.

CLINICAL PRACTICE GUIDELINES SOURCE MATRIX

Condition	Clinical Practice Guideline	Source
General Guidelines	A public resource for evidence-based clinical practice guidelines. NGC is an initiative of the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, http://ww.ahrq.gov	National Guideline Clearinghouse www.guideline.gov Clinical Practice Guidelines http://www.ahrq.gov/clinic/cpgsix.htm
Angina	2007 Chronic Angina Focused Update of the ACC/AHA 2002 Guideline for the Management of Patients with Chronic Stable Angina	American Heart Association www.americanheart.org 2007 Chronic Angina Focused Update of the ACC/AHA 2002 Guidelines for the Management of Patients with Chronic Stable Angina http://circ.ahajournals.org/cgi/reprint/CIRCULATIONAHA.107.187930 American College of Cardiology www.acc.org
Anxiety Disorder	Practice Parameter for the Assessment and Treatment of Children and Adolescents with Anxiety Disorders 2007	American Academy of Child and Adolescent Psychiatry www.aacap.org
Attention Deficit Hyperactivity Disorder (ADHD)	Diagnosis and Evaluation of the Child with ADHD 2000 Treatment of the School Aged Child with ADHD 2001	American Academy of Pediatrics www.aap.org Diagnosis and Evaluation http://aappolicy.aappublications.org/cgi/reprint/pediatrics:105/5/1158 Treatment http://aappolicy.aapublications.org/cgi/reprint/pediatrics:108/4/1033
Asthma	NAEPP Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma – 2007	National Institutes of Health/National Heart, Lung and Blood Institute www.nhlbi.nih.gov
Chlamydia	Sexually transmitted diseases Treatment Guidelines	Centers for Disease Control and Prevention http://www.cdc.gov Department of Public Health http:/publichealth.lacounty.gov

Chronic Obstructive Pulmonary Disease (COPD)	Diagnosis and management of Stable Chronic Obstructive Pulmonary Disease: A Clinical Practice Guideline from the American College of Physicians – 2007 Screening for Chronic Obstructive Pulmonary Disease Using Spirometry	National Guideline Clearinghouse www.guideline.gov American College of Physicians http://www.acponline.org/clinical_information/guidelines/guidelines/ U.S. Preventive Services Task Force (USPSTF) http://www.uspreventiveservicestaskforce.org
Chronic Pain	Assessment and Management of Chronic Pain - 2009	Institute for Clinical systems Improvement www.ICSI.org
Congestive Heart Failure (CHF)	Diagnosis and Management of Congestive Heart Failure – 2009	American Heart Association www.americanheart.org American College of Cardiology www.acc.org
Major Depressive Disorder - Adult	Treating Major depressive Disorder 2010	American Psychiatric Association www.psych.org
Depressive Disorders – Adolescents and Children	Practice parameters for the Assessment and Treatment of Children and Adolescents with Depressive Disorders 2007	American Academy of Child and Adolescent Psychiatry www.aacap.org
Diabetes	2011 Standards of Medical Care in Diabetes	American Diabetes Association www.diabetes.org
High Blood Cholesterol in Adults	Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults – 2004	National Institutes of Health/National Heart, Lung and Blood Institute www.nhlbi.nih.gov
HIV	Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States 2010 Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents 2010	U.S. Department of Health and Human Services, AIDS info www.AIDSinfo.nih.gov U.S. Department of Health and Human Services, AIDS info www.AIDSinfo.nih.gov
Hypertension	The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure 2003	National Institutes of Health/National Heart, Lung and Blood Institute www.nhlbi.nih.gov

Low Back Pain	Diagnosis and Treatment 2007 Diagnostic Imaging 2010 Adult Low Back Pain 2010	American College of Physicians http://www/acponline.org/clinical_information/guidelines/guidelines/ American College of Physicians http://www.annals.org/serch?fulltext=diagnostic+imaging+for+low+back+pain&submit=yes Institute for Clinical Systems Improvement www.ICSI.org
Myocardial Infarction (MI)	Management of Patients with ST-elevation Myocardial Infarction 2009	American Heart Association www.americanheart.org American College of Cardiology www.acc.org
Otitis Media	Otitis Media With Effusion 2004 Diagnosis and Management of Acute Otitis Media 2004	American Academy of Family Physicians http://www.aafp.org/online/en/home/clincalrecs/guidelines.html
Obesity in Adults	Clinical Guidelines on Identification, Evaluation, and Treatment of Overweight and Obesity in Adults 1998	National Institute of health/National Heart, Lung and Blood Institute www.nhlbi.nih.gov
Obesity in Childhood	Assessment, Prevention, and treatment of child and Adolescent Overweight and Obesity 2005	Expert Committee American Medical Association www.ama-assn.org/
Perinatal Care	Guidelines for Perinatal Care 6th Edition 2007	American College of Obstetricians and Gynecologists www.acog.org American Academy of Pediatrics www.aap.org
Pharyngitis	Respiratory Illness in Children and Adults, Diagnosis and Treatment 2011	Institute for Clinical Systems Improvement www.ICSI.org
Smoking Cessation	Treating Tobacco Use and Dependence: 2008	U.S. Department of health and Human Services Consortium/Agency for Healthcare Research and Quality www.ahcpr.gov http://ww.ahrq.gov/clinic/cpgsix.htm

REGULATORY COMPLIANCE REGARDING FINANCIAL INCENTIVE AND UTILIZATION MANAGEMENT DECISIONS

Seaside Health Plan 's Utilization Management requires that all medical decisions regarding the nature and level of care provided or services rendered to a Seaside Health Plan Member must be made by a qualified medical Practitioners, unhindered by fiscal or administrative concerns. (A practitioner is defined as; Primary Care Practitioner (PCP), specialist (SCP), or psychologist for behavioral health requests, and applies to either in-network or out-of-network Practitioners.) All medical necessity Utilization Management decisions are made by staff licensed in the state of California, and are based solely on medical necessity and medical appropriateness, and not on the cost of the service to Seaside Health Plan. Seaside Health Plan may direct the service to be provided at the most cost effective setting once medical appropriateness is established. Non-contracted Providers may be used if the service requested is not available within the Seaside Health Plan's network. As such, requests for authorization will not be denied based solely on costs associated with the provision of services.

ACCREDITATION AND REGULATORY COMPLIANCE FOR UTILIZATION MANAGEMENT

Seaside Health Plan ensures compliance with accreditation standards and State and Federal regulations within its own utilization management program. The requirements, standards, and regulations are established by the Centers for Medicare and Medicaid Services (CMS), Department of Managed Healthcare (DMHC) and the National Committee for Quality Assurance (NCQA).

REQUESTING AN AUTHORIZATION/REFERRAL

Request for authorization can be made through

- Seaside Health Plan Web Portal
- Via telephone: (855) 347-7747 or Fax: (562) 933-1891
- Service Authorization Request form (attachment 1); it must be completed in entirety, in order to avoid a delay in the provision of a requested service.

The following services require prior authorization (services must be authorized prior to provision of a service):

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

DIRECT REFERRAL PROCESS

It is the policy of Seaside Health Plan to provide PCP(s) with automatic referral access to a limited panel of specialists when the following conditions are met:

- The request is for initial consultation only
- The PCP is contracted with Seaside Health Plan

The Member must visit his/her PCP first; the PCP may refer the Member to a specialist listed on the referral form for the initial consultation only, without prior authorization or approval from Seaside Health Plan.

The PCP should use all available resources (i.e., other Providers within the medical group or second opinions within a scope of practice of other Providers within the medical group).

- The referral must be to one of the Providers listed on the Direct Referral Form (attachment 2). The form is updated periodically in order to ensure accuracy of the Providers. The direct referral form or Seaside Health Plan Web Portal.

Printout and any pertinent medical records must be given to the patient prior to the patient leaving the PCP(s) office. Additional copies must be given to the following:

- Fax a copy to the specialists
- One copy sent to Seaside Health Plan UM Department if the Form is used instead of Seaside Health Plan Web Portal
- One copy placed in the patient's medical chart

The Member must be eligible on the date of service. Follow-up visits requested by the Specialists must be sent to the Members PCP(s). The PCP must determine medical necessity of the request for follow up. If the PCP deems that it is medically necessary then the PCP shall forward the request to the UM Department for authorization referral.

The following services are considered to be Direct Referral (In-network Primary Care Providers refers Member directly for benefited service using the Direct Referral Authorization Form. Direct Referral Authorization is for 1 visit).

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

PRIMARY CARE PROVIDERS SCOPE OF CARE SERVICES

Milliman Care Guidelines 'Primary Care Services' Criteria (all specialties) are Seaside Health Plan's preferred Guidelines to determine what services are within the scope of the Primary Care physician (PCP).

TIMELINESS OF UM DECISIONS

Decision-making timeliness is monitored on an on-going basis to ensure compliance standards. Seaside Health Plan standards are compliant to Medicare regulations. Turn-around time reports are presented at least quarterly to the UM Committee

SPECIALIST FOLLOW-UP VISITS

The Member's PCP will be asked to determine when a follow-up visit can be provided by the PCP or required for follow-up by the specialist. The specialist is expected to timely provide a report to the PCP after visit.

UTILIZATION MANAGEMENT

CONCURRENT REVIEW

Concurrent reviews are reviews for extension of a previously approved course of treatment over a period of time or number of treatments. This includes services such as inpatient care, ongoing home health, durable medical equipment needs, pharmacy needs. Inpatient concurrent review for continued stay is considered urgent. SB 59: Care shall not be discontinued until the enrollee's treating Providers has been notified of Seaside Health Plan's or Medical Group's decision, and a care plan has been agreed upon by the treating Providers that is appropriate for the medical needs of that patient.

PATIENT FOLLOW-UP AFTER DISCHARGE

Seaside Health Plan's UM Department maintains a log of current inpatient admissions. Upon discharge, the concurrent review assistant schedules a follow-up appointment within seven (7) days of discharge. Follow-up needs to include medication reconciliation.

EMERGENCY ROOM VISIT FOLLOW-UP

Hospitals are required to call Seaside Health Plan for all Emergency Room visits of Seaside Health Plan Members. Seaside Health Plan will notify PCP of any emergency room visit as soon as possible. The PCP should follow-up with the patient in a timely manner for best practices and good continuity of care.

If a Member goes to an emergency room, the emergency room does not have to call Seaside Health Plan or the PCP until the patient is stable.

Seaside Health Plan has a 24 hour answering system for Members. The answering service is instructed to direct patient advice calls first to the patient's assigned health plan Nurse Advice. If the health plan doesn't have a Nurse Advice Program, Seaside Health Plan will provide the service with our contracted vendor and send the notes of the interaction to the patient's assigned PCP.

If the patient is in need of hospitalization Seaside Health Plan's Utilization Department will assist the patient to a contracted medical institution including any transfer of care or transportation needed to appropriate hospitalization based on contracted agreements of the Member's assigned health plan. Seaside Health Plan Utilization Department is run 24 hours a day/ 7 days a week to assist in all processes needing additional admissions and/or specialty services needing assistance.

In the event the PCP directs a Member to an Emergency Room for Services, PCP shall notify Seaside Health Plan as soon as possible, but no later than the next business day by contacting Seaside Health Plan Utilization Management Department at (855) 347-7747.

The appropriate co-payment for the emergency room treatment is to be collected by the hospital at the time of treatment unless the emergency room evaluation results in a hospital admission, in which case the emergency room co-payment is waived (in most cases) and the in-patient co-payment/deductible applies.

Members must be directed back to their PCP for all follow-up care after an emergency room visit or hospital admission.

Transportation Services by Health Plan:

Health Plan	Transportation Service
• Anthem Blue Cross • Blue Shield • Care 1st Health Plan	Contact Primary Plan or Seaside Health Plan Utilization Management Department.
• Health Net • LA Care Health Plan	LogistiCare (866) 290-9662 Telephone (800) 762-1777 Fax

Whenever there is a concern of proper transportation needed for a Member assigned to Seaside Health Plan, refer to the Utilization Management Department for clarification.

POST-STABILIZATION

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

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

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

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

SKILLED NURSING FACILITY

Seaside Health Plan will coordinate Skilled Nursing Facility (SNF) benefits for our Medicare Members. Inpatient SNF coverage is limited to 100 days each benefit period based on medical necessity. Seaside Health Plan Medicare plans waive the Original Medicare requirement for the 3- day inpatient hospital stay for skilled coverage. Thus, the physician may directly admit a Member into a SNF from various sites, including the office, home or from an observation stay.

Care in a SNF is covered if ALL of the following three factors are met:

- The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel.
- The patient requires these skilled services on a daily basis.
- The skilled services can be provided only on an inpatient basis in a SNF.

If any one of these three factors is not met, a stay in a SNF, even though it might include the delivery of some skilled services, may NOT be covered. If a stay in a SNF is not covered, Medicare Part B services may still be obtained and Members will be assessed the applicable copays. A benefit period is used to determine coverage under Seaside Health Plan's Medicare plans in the same manner as Original Medicare. A benefit period starts with the first day of a Medicare covered inpatient hospital or SNF stay and ends when the Member has been out of the hospital or SNF for 60 consecutive days.

Inpatient stays solely to provide custodial care are not covered under Seaside Health Plan Medicare plans. Custodial care is defined as care furnished for the purpose of meeting non-medically necessary personal needs that could be provided by persons without professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Seaside Health Plan Medicare plan or Original Medicare does not cover custodial care unless provided in conjunction with daily skilled nursing care and/or skilled rehabilitation services.

The obligation on the Providers to follow coverage limits for Original Medicare benefits (as provided in 42 CFR 422.100) must be met whenever a Providers furnishes Original Medicare, SNF and inpatient hospital services to enrollees of Medicare organizations. This obligation applies to all SNFs and applies to both teaching and non-teaching hospitals. This obligation can be implemented by Providers submitting to Medicare Administrative Contractors (MACs) no-pay claims (with condition code, 04). It is also the Providers obligation to keep an audit trail on these claims.

HOME HEALTH SERVICES

For a Member to qualify for home health benefits, the Member must be confined to the home, be under a plan of treatment reviewed and approved by a physician, and require a medically necessary qualifying skilled service. Under Seaside Health Plan's Medicare plan, the Member does not have to be bedridden to be considered confined to home. The condition of the Member should be such that there exists a normal inability to leave the home and, consequently, leaving the home would require considerable and taxing effort. If the Member leaves the home, the Member is still considered homebound if the absences from the home are infrequent, for periods of relatively short duration or to receive medical treatment. Home Care includes the following services:

- Part-time or intermittent skilled nursing and home health aide services
- Physical, occupational, and speech therapy
- Medical social services
- Medical supplies
- Durable Medical Equipment
- Portable x-rays and EKGs
- Laboratory tests.

UNDER AND OVER UTILIZATION

UTILIZATION MANAGEMENT

Seaside Health Plan has established measures to detect potential under and over utilization of services. Inpatient, outpatient, and ambulatory care utilization reports are monitored regularly against targets. Actions are implemented as needed.

Seaside Health Plan does not compensate, reward or give incentives, financially or otherwise, to its employees, consultants, or agents for inappropriate restrictions of care. Utilization review decision-making for Seaside Health Plan's Medicare is based solely on appropriateness of care and service and in accordance with applicable Medicare coverage criteria and guidelines.

DISTINGUISHING BETWEEN MEMBER APPEALS AND MEMBER GRIEVANCES

There are two procedures for resolving Medicare Members concerns: the Member appeals process and Member grievance process. All Member concerns are resolved through one of these mechanisms. The Member's specific concern dictates which process is used. Thus, it is important for the physician to be aware of the difference between appeals and grievances.

MEDICARE MEMBERS APPEALS

Member disputes or concerns about initial determinations are considered appeals and are resolved only through the appeals process. These are primarily concerns related to denial of services or payment for services. Examples of appeals include:

- Denials of services or supplies that the Member believes should be covered.
- Denials of payment for emergency or out-of-area urgently needed services.
- Discontinuation or reduction of services in a SNF, HHA, or CORF.

MEDICARE MEMBERS GRIEVANCES

All other Member concerns that do not involve an initial determination are considered grievances and are addressed through the grievance process (see "Medicare Members Grievances" section of this manual). Examples of grievances include complaints or issues raised about:

- Accessibility/timeliness of appointments
- Quality of services
- Seaside Health Plan staff
- Seaside Health Plan Medicare Physicians and their staff
- Seaside Health Plan's decision not to expedite an appeal

HOW MEMBERS FILE A GRIEVANCE OR APPEAL

Members can file a grievance or appeal through their Primary Health Plan. Their Primary Health Plan has a formal process for reviewing Member grievances and appeals. This process provides a uniform and equitable treatment of your grievance and appeal and a prompt response.

Member ID Card has the Primary Health Plan information including where to file appeals and grievances.

Seaside Health Plan and its Providers help ensure a grievance or appeal is given the attention it deserves even when we are not your Primary Health Plan by forwarding all grievances and appeals to your Primary Health Plan within 24 hours of receipt.

When Seaside Health Plan receives a request from your Primary Health Plan, Seaside forwards the request for information to the Providers within 1 business day. Seaside monitors to ensure we receive the response within 7 calendar days. Then forwards information we received to the Primary Health Plan within 24 hours of receipt.

The Member's Primary Health Plan is responsible for the correspondence, resolution and forwarding your case to Independent Medical Review if needed.

CONFIDENTIALITY AND DISCRIMINATION

All grievances and appeals are handled in a confidential manner. We do not discriminate against a Member for filing a grievance or appeal or for requesting a state fair hearing. We also notify Members of the opportunity to receive information about their primary plan's grievance and appeal process. Members may request a translated version of the process in a threshold language other than English.

PROVIDERS PAYMENT DISPUTES

Notice is provided to the Providers about the availability of the Providers Dispute Resolution (PDR) mechanism with every adjusted or denied claim. Notice includes:

- Procedures for obtaining forms;
- Instructions for filing a dispute;
- The mailing address.

Deadlines for filing disputes must not be later than 365 days after a plan's action, or 365 days after filing the claim, if no action is taken. Providers' disputes must be submitted to Seaside Health Plan's Providers appeals department in writing or on the Providers Dispute Resolution Form. Providers have one year from the date of the original EOB or RA, to dispute a claims adjudication action. The original claim number must link disputes to a claim.

Providers disputes are acknowledged in writing according to the following timeframes: within 15 working days of receipt for paper claim disputes, and 2 working days for EDI claim disputes. Seaside Health Plan will make written determination of the dispute within 45 working days.

Seaside Health Plan does not make requests to resubmit previously submitted documentation, unless the materials have been returned to the Providers.

A non-contracted Providers dispute over the calculation of the usual and customary value for health care services rendered is regarded as a Providers dispute.

Disputes may be returned if they do not clearly identify the disputed item or give an explanation of the basis for the Providers dispute. Returned disputes must clearly identify the missing information needed to resolve the dispute. Providers have 30 days from receipt of a returned dispute to submit an amended dispute.

When Seaside Health Plan does not receive all the information necessary to make a decision, Seaside Health Plan will send the Providers 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.

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

Routine Providers inquiries that Seaside Health Plan resolves in a timely fashion through existing informal processes (i.e., through customer service) are exempted from the above.

DISENROLLMENT

MEMBER DISENROLLMENTS

Seaside Health Plan will notify PCP's of terminated Members. Both the PCP and Seaside Health Plan will work cooperatively to follow-up on terminated Members.

Seaside Health Plan will also work with Primary Plans to obtain information regarding the dates eligible Members are going through redetermination of their eligibility for their respective program plan. Seaside Health Plan and PCP will work together to assist Members during redetermination so the Member may maintain their health care coverage and continue with their chosen PCP.

CLAIMS SUBMISSION

A. Claim Submission and Deadlines

A. Claims can be submitted electronically, via paper, or other agreed upon method. The attachments or supplemental information/documentation needed varies by provider type and service, but must provide the minimum information to properly adjudicate the claim and determine payer liability.

B. A Claim is considered to be a “clean claim,” when it meets the minimum requirements:

1. All attachments and supplemental information; or documentation needed to provide "reasonably relevant information" information necessary to determine payer liability and the following information:

    a. Provider name and address;

    b. Member name, date of birth, and social security number;

    c. Date(s) of service;

    d. International Classification of Diseases (ICD-9CM) codes;

    e. Revenue, CPT, or HCPCS codes;

    f. Billed charges for each services or item provided;

    g. Place of service or UB92 Bill Type;

    h. Provider tax ID number or social security number;

    i. Name and state license number of attending physician.

C. If a provider feels that submitting claims electronically is not a viable alternative, then the providers must submit paper claims on a CMS-1500 claim form for professional and other non-facility services, and on an UB-04 CMS-1450 claim form for services provided in a facility. To be considered a clean claim, the following information is mandatory, as defined by applicable law, for each claim:

1. 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: Provider’s billing information and phone number
Field 11d: Other insurance indicator	Field 33a: National Provider Identifier (NPI); and

2. 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 provider's name, address, and telephone number	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: Provider's 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: Payer(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	

D. 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.

E. Providers must bill with current CPT-IV or HCPCS codes. Codes that have been deleted from CPT-IV or HCPCS are not recognized. When a miscellaneous procedure code is billed or a code is used for a service not described in CPT-IV or HCPCS, supportive documentation must be submitted with the claim.

F. 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 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.

G. In order for a claim to be accepted and adjudicated, the claim must be received by Seaside Health Plan within contractual timeframes which cannot be less than 90 days after the date of service for contracted providers and within 180 days after the date of service for non-contracted providers. Medicare claim filing deadline is 365 days from date services were rendered.

H. If Seaside Health Plan is NOT the primary payer under coordination of benefits, then the claim must be received within 90 days from the date of payment or date of contest, denial or notice from the primary payer.

I. If Seaside Health Plan receives a claim that is the responsibility of the capitated provider to adjudicate, then Seaside Health Plan forwards the claim to the appropriate provider within 10 working days from the date of receipt of claim.

J. If a claim is denied because it was filed beyond the filing deadline, then the provider may utilize the Provider Dispute Resolution (PDR) to reconsider the claim if the provider demonstrates good cause for the delay.

    1. Appeals for claims denied because of failing to meet timely filing requirements must be submitted to Anthem in writing only and not over the phone.

B. Misdirected Claims

A. In accordance with Title 28, California Code of Regulations (CCR) Section 1300.71, all misdirected claims received by Seaside Health Plan from the Health Plan or Contracted Medical Group (CMG); 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.

    1. To comply with this standard, Seaside Health Plan forwards all misdirected claims daily (as received), in hardcopy form. The hardcopy misdirected claims are forwarded to the financially responsible medical group or health plan, for proper adjudication.

B. To help ensure timely claims adjudication, Seaside Health Plan requests that its contracted Medical Groups and Health Plans that are delegated for claims payment, continuously educate

their contracted providers regarding the correct billing address for proper direct billing of the Medical Group and/or Health Plan.

C. Acknowledgement of Claim

A. All claims (clean or not) received and verified by Seaside Health Plan are identified and the date of receipt is recorded regardless of the method of claim submission (electronic or paper).

B. The provider may readily confirm the receipt of the claim as well as the recorded date of receipt utilizing the agreed upon method of notification (via telephone inquiry or website) within the following time frames:

1. Within two working days of the date of receipt of the claim for electronic claims; or

2. Within 15 working days of the date of receipt of the claim for paper claims.

D. Claims Inquiry

A. Seaside Health Plan has a call center available Monday –Friday 8am-5pm, with staff who can answer questions from providers regarding claim status. In addition, 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.

E. Claims Process and Turnaround Time Standards

A. Seaside Health Plan has established the following standards of turnaround times of processing claims to ensure compliance with current regulatory requirements:

1. **"Clean" claims from contract providers:**

Medicare Risk	95% of clean claims in 60 calendar days
HMO (including POS)	95% of clean claims in 45 working or 64 calendar days
HMO ERISA	30 calendar days
Medi-Cal	90% of clean claims in 30 calendar days; 95% in 45 calendar days.

2. **"Clean" claims from non-contracted providers:**

Medicare Risk	95% of clean claims in 30 calendar days
HMO (including POS)	95% of clean claims in 45 working or 64 calendar days
HMO ERISA	30 calendar days

Medi-Cal	90% of clean claims in 30 calendar days; 95% in 45 calendar days.

3. **"Non-Clean" claims from contracted and non-contracted providers:**

Medicare Risk	100% in 60 calendar days
HMO (including POS)	95% in 45 working or 64 calendar days
HMO ERISA	45 calendar days and letter is sent to member
Medi-Cal	95% in 45 calendar days.

The turnaround time of a claim is based on the date of receipt of each claim and is displayed on the daily aging report. Claim examiners are assigned portions of the aging report each morning and are instructed to work the oldest claims first.