PROVIDER MANUAL

Welcome to CHOC Health Alliance (CHA)!

Welcome to CHOC Health Alliance (CHA) and thank you for your participation in our managed care Physician Hospital Consortium (PHC). CHA coordinates medical services for Orange County's pediatric and young adult Medi-Cal recipients. As a leading care professional in Orange County, you are essential to the provision of quality, compassionate and cost effective medical care to our Members.

This provider manual will assist you in providing care to CHA Members and discusses essential policies and procedures that are important for you to understand and comply with, while treating CHA Members. This manual is updated on a regular basis as policies and procedures change, and is located on the CHA website at www.chochealthalliance.com. Please visit the website periodically to obtain the most current version. Your review and understanding of the provider manual is essential however, should there be a discrepancy between this manual and State and/or Federal regulatory requirements, the provision of those regulatory requirements prevail.

Providers are contractually obligated to adhere to and comply with all terms CHA and the provider contract, including all requirements described in this manual in addition to all Federal and State regulations governing CHA and the Provider. CHA may or may not specifically communicate such terms in forms other than the contract and this provider manual. While this manual contains basic information about Medi-Cal, Providers are required to fully understand and apply Medi-Cal requirements when administering covered services. Please refer to www.medi-cal.ca.gov for further information on Medi-Cal. Questions and recommendations regarding this manual are encouraged and should be directed to the CHA Provider Relations Department.

Thank you for your partnership and for all that you do for the children of Orange County. Together we can make a difference in the health of our pediatric Members.

Michael Weiss, D.O., F.A.A.P.
Vice President, CHOC Health Alliance

CHOC Health Alliance Overview

CHOC Health Alliance (CHA) will emerge as the premier Pediatric Health Network, leading by example in setting the highest standards by providing access to quality health care delivery, education, prevention, community resources, and family empowerment so Members can live healthier lives. CHA is a Physician Hospital Consortium (PHC) that administers health care for its assigned membership and manages access to quality and cost-effective health care for the children and young adult population in Orange County from birth to 21 years of age. CHA partners with CHOC Children's Hospital of Orange County, a center of excellence in pediatric care. The Physician partnership of the PHC is represented by the CHOC Physicians Network (CPN), an independent organization of contracted individuals comprised of primary care physicians, specialists, ancillary providers and allied professionals. CHA's membership continuously grows and through a PHC agreement with CalOptima's Medi-Cal Program, is responsible for targeting and managing needed medical services for over 150,000 Medi-Cal beneficiaries in Southern California. At CHA, we understand that communication and collaboration with our provider offices and staff is essential in strengthening our program and ensuring our Members receive high quality and cost effective healthcare services.

CalOptima Overview

CalOptima is a County Organized Health System (COHS) that manages programs funded by the State and Federal governments but are operated independently. CalOptima is governed by a Board of Directors appointed by the Orange County Board of Supervisors comprised of Members, Providers, business leaders and local government representatives. CalOptima was created in 1995, by the Orange County Board of Supervisors to ensure the delivery of quality health care services to Orange County residents. CalOptima Members have access to a comprehensive network of specialists, primary care providers, ancillary services, facilities and pharmacies in Orange County. CalOptima's mission is simple, to provide Members with access to quality health care services delivered in a cost effective and compassionate manner.

Medi-Cal Overview

Medi-Cal is California's Medicaid program. Under the provisions of Title 22 of the California Code of Regulations, the Department of Health Care Services (DHCS) administers the Medi-Cal program and has the responsibility to formulate policy that conforms to Federal and State requirements. The objective of the Medi-Cal program is to provide essential medical care and services to preserve health, alleviate sickness and mitigate handicapping conditions for eligible beneficiaries. The covered services are generally recognized as standard medical services required in the treatment or prevention of diseases, disability, infirmity or impairment. Please refer to www.medi-cal.ca.gov for further information on Medi-Cal. The Department of Managed Health Care (DMHC) is the regulatory body that governs managed health care plans, sometimes referred to as Health Maintenance Organizations (HMOs) in California. The DMHC is part of the California Health and Human Services Agency. It was established in 2000, and is responsible for enforcing the Knox-Keene Health Care Service Plan of 1975, and other related laws and regulations. For further information, go to www.dmhc.ca.gov.

Policies and Procedures

CHA has robust and comprehensive policies and procedures in place throughout its various departments that assure all compliance and regulatory standards are met. Policies and procedures are reviewed on an annual basis and required updates are made as needed. Providers are contractually obligated to adhere to and comply with all terms of CHA and provider contract(s), including all requirements described in this manual in addition to all Federal and State regulations governing CHA and the Provider. Please refer to www.medi-cal.ca.gov for further information on Medi-Cal.

Fraud, Waste and Abuse

CHOC Health Alliance is dedicated to detecting and preventing fraud, waste, and abuse. As such, CHA is committed to educating its providers regarding best practices to avoid fraud, waste, and abuse.

Fraud is generally defined as "knowingly and willfully executing, or attempting to execute a scheme or artifice to defraud any health care benefit program, or to obtain (by false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of any health care benefit program." (18 USC § 1347)

Waste is the overutilization of services, or other practices that result in unnecessary costs to the health care system. It is not generally considered to be caused by criminal negligence, but by the misuse of resources.

Abuse includes any actions that may, directly or indirectly result in one or more of the following:

- Unnecessary costs to the healthcare system (including Medicare and Medi-Cal programs)
- Improper payment for services
- Payment for services that do not meet professionally recognized standards of care
- Providing medically unnecessary services
- Accepting payment for which there is no legal entitlement, without prior knowledge that a misrepresentation of facts or circumstances has occurred.

During an investigation, "fraud" (criminal) versus "abuse" determinations will depend on specific circumstances, such as available evidence, facts of the case, and the presence of intent. As a part of CHA's commitment to preventing fraud, waste, and abuse, CHA requires its Providers and their employees to complete Fraud, Waste & Abuse and General Compliance training, and attest that they do so each calendar year. In January of each year, Providers will receive a reminder regarding this requirement and instructions on how to access the training, and submit a signed attestation to CHA.

CHOC HEALTH ALLIANCE PROVIDER MANUAL

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CHOC HEALTH ALLIANCE CONTACT INFORMATION

Administrative Offices CHOC Health Alliance 1120 W. La Veta Avenue, Suite 450 Orange, California 92868	(714) 565-5100
Member Services Department 24 Hours A Day/ Seven Days A Week Hearing Impaired TTY / TDD	(800) 424-2462 (800) 735-2922 English (800) 855-3000 Spanish
Provider Services Department Mon-Fri, 8am - 5pm	(800) 387-1103
Provider Relations Fax	(714) 509-7015
Prior Authorization Department	(800) 387-1103, option 2
Prior Authorization Fax (urgent & routine)	(855) 867-0868
Case Management Fax	(855) 867-0868
Claims Department Address Rady Children's Hospital Attn: CHOC/CPN Claims Department 3020 Children's Way, Mail Code 5144 San Diego, CA 92123	(800) 387-1103, option 1
Appeals Department Address Rady Children's Hospital Attn: CHOC/CPN Provider Appeals 3020 Children's Way, Mail Code 5144 San Diego, CA 92123	(800) 387-1103, option 1
CHA Website	**www.chochealthalliance.com**
EZ-NET Website	**https://eznet.rchsd.org**
EZ-NET Support	**eznetsupport@rchsd.org**

OTHER USEFUL CONTACT INFORMATION

CalOptima Administrative Offices 505 City Parkway West Orange, California 92868	(714) 246-8400 members, opt 3 providers, opt 4
CalOptima Customer Service Department Monday – Friday 8:00 A.M. to 5:00 P.M.	(714) 246-8500 (888) 587-8088
CalOptima Member Eligibility Verification	(714) 246-8540
CalOptima Provider Relations Department	(714) 246-8600
CalOptima Care Coordination Department	(714) 246-8686 (888) 587-7277
CalOptima Compliance & Ethics Hotline	(877) 837-4417
CalOptima Pharmacy Management Department	(714) 246-8471
CalOptima Pharmacy Fax	(855) 452-9135
Medi-Cal Benefits	(916) 445-4771
California Children's Services (CCS)	(714) 347-0300
Denti-Cal	(800) 322-6384
Orange County Mental Health Plan	(800) 723-8641
Regional Center of Orange County (RCOC)	(714) 796-5100
Vision Services Plan (VSP)	(800) 615-1883
CalOptimaWebsite	**www.caloptima.org**

PROVIDER NETWORK DEVELOPMENT AND COORDINATION

CHOC Health Alliance is responsible for coordinating covered services for thousands of Members, and accomplishes this through a comprehensive provider network of independent practitioners and facilities. CHA's network is comprised of participating health care professionals such as primary care and specialist physicians, medical facilities, allied health professionals and ancillary service providers contracted with CHOC Health Alliance. Through its various contract agreements, CHA's network provides an integrated and coordinated health care delivery system.

CHA's network is selectively developed to include those participating health care professionals who meet certain criteria such as credentialing, board certification, appointment availability, geographic location, specialty, acceptance of financial considerations, hospital privileges, provision of quality of care and the acceptance of managed care principles.

Contracted participating health care professionals are required by contract to coordinate Member care within the CHA provider network. All services and referrals for CHA Members, with the exception of family planning, should be directed to CHA contracted providers.

Network Development & Provider Relations Department

The Network Development & Provider Relations Department serves as a liaison between CHA and the provider community, and is responsible for training, strengthening and maintaining the provider network in accordance with regulations. In addition to identifying opportunities and challenges related to the management, satisfaction, alignment and retention of physicians, CHA's Network Development & Provider Relations staff also coordinates and monitors performance and quality improvement capacity building for network physicians.

Each CHA Provider has an assigned Provider Relations representative who can be reached by email at ProviderRelations@chochealthalliance.com or by phone at 1(800) 387-1103, option 3.

When to Contact the Provider Relations Department:

- Practice or Provider changes and updates
- Information on a Participating Network Provider
- Termination from practice
- Change in panel status
- Demographic information changes
- Tax Identification Number (TIN) changes
- Contract questions
- Electronic Data Information (EDI)

For a list of additional changes and/or updates that require communication to CHA's Provider Relations Department, please visit www.chochealthalliance.com.

General Provider Responsibilities

The following responsibilities are minimum requirements with which to comply regarding contract terms and all applicable laws. Providers are contractually obligated to adhere to and comply with all terms of the plan, the provider contract and requirements outlined in this manual. CHA may or may not specifically communicate such terms in forms other than in the contract and this provider manual. This section outlines general provider responsibilities however; additional responsibilities are included throughout the manual.

Medi-Cal Registration

Each Provider must be registered with Medi-Cal and obtain a provider identification number.

National Provider Identification (NPI) Registration

All healthcare professionals who participate with CHOC Health Alliance must register and receive a National Provider Identifier (NPI). Providers and medical groups must register their National Provider Identifier (NPI) number with the DHCS for each service location to be registered with CHOC Health Alliance. For information on registering with the DHCS, please contact the California Department of Health Care Services Provider Enrollment Division at MS 4704 PO Box 997412 Sacramento, CA 95899 or by calling (916) 323-1945. If you need assistance in acquiring an NPI, please contact the National Plan and Provider Enumerator System (NPPES) at (800) 465-3203.

Your claims must indicate your correct NPI, or they may be improperly paid or denied. If you do not know your NPI, please refer to the Centers for Medicare and Medicaid Services at http://www.cms.gov or contact CHA's Provider Relations Department.

Telephone Accessibility Standards

Providers are responsible to be available during regular business hours and have appropriate after hours coverage. Providers must have coverage 24 hours per day, seven days per week, including on call coverage, responding within 30 minutes, according to Access and Availability Standards.

Cultural Awareness / Seniors & Persons with Disabilities (SPD)

Providers are required to develop and maintain cultural competency by attending periodic training opportunities regarding cultural awareness and linguistic needs of the community. In addition, Providers are to complete an annual Seniors and Persons with Disabilities Competency & Sensitivity Training, and develop and maintain techniques to enhance provider-member interaction, such as active listening, appropriate non-verbal communication, and paraphrasing to ensure understanding of member needs.

Child Protective Services

Providers are required to report reasonable, suspected or observed instances of child abuse or neglect within 36 hours of receiving the information concerning the event. These may include cases involving a pregnant minor. Providers should report suspected or observed instances of child abuse

or neglect to the Orange County Child Abuse Registry. To report a case of suspected child abuse or neglect, call the Orange County Child Protective Services at **(714) 940-1000** or (**800) 207-4464**, 24 hours a day, seven days a week. If the case is urgent, immediately report the suspected child abuse or neglect to the local law enforcement agency and to the Orange County Child Protective Services using the 24 hour hotline noted above.

Covering Physicians

As stated in the CHA Provider contract, Provider Relations Department must be notified if a covering Provider is not contracted or affiliated with CHA. If Professional is, for any reason, from time to time unable to provide Primary Care Services when and as needed, Professional may secure the services of a qualified covering physician who shall render such Primary Care Services otherwise required of Professional; provided, however, 1) the covering physician so furnished must be qualified to practice the same specialty as Professional and must be a physician approved by CPN to provide Primary Care Services to Enrollees; and 2) the covering physician cannot provide Primary Care Services for Professional over a continuous period longer than 60 calendar days.

Professional shall be solely responsible for securing the services of such covering physician and paying said covering physician for those Primary Care Services provided to Enrollees. Professional shall ensure that the covering physician: (a) looks solely to Professional for compensation; (b) shall accept CHA's peer review procedures; (c) shall not directly bill Enrollees for Primary Care Services or Covered Services under any circumstances; (d) shall comply with CHA's utilization management program; and (e) shall comply with the terms hereof.

MEMBER SERVICES

Verifying Member Eligibility

All Providers must verify a Member's eligibility with CHA prior to the delivery of covered services. All Providers are responsible for verifying eligibility prior to rendering services. CHA will not reimburse Providers for services rendered to Members who lost eligibility or were not assigned to the Primary Care Provider's panel, unless, s/he is a physician covering for a Provider in the assigned PCP's practice.

Member eligibility may be verified through one of the following ways:

1. CalOptima website www.caloptima.org, or by calling calling CalOptima's eligibility number (714) 246-8540.

2. Medi-Cal website www.medi-cal.ca.gov, or by calling AEVS at 800-456-2387. AEVS is a service for Medi-Cal eligibility verification and is available to all registered Medi-Cal Providers.

3. CHA Provider Portal EZ-NET Website https://eznet.rchsd.org

4. CHA Telephone Verification. Until you receive an EZ-NET login you may call Provider Services at (800) 387-1103 to verify eligibility. Before any eligibility information can be released and to protect Member confidentiality, Providers will be asked to provide identifying information such as Member identification number and date of birth.

Please note: CalOptima is the best resource for the most current Member eligibility.

Primary Care Provider (PCP) Assignment

Members are given a choice of a PCP, by CalOptima, prior to enrollment with CHA. Enrollment information is sent by CalOptima to each Member, and must be returned to CalOptima. CalOptima communicates the Members' PCP choice to CHA. If the Member does not make a PCP choice, a PCP will be assigned by CHA according to CalOptima's automatic assignment policy. The assignment takes into consideration the PCP's Member capacity and if he/she is accepting new Members. Depending upon age, medical condition and geographic location of the Member, the choice of a PCP may include those practicing in a variety of areas, such as pediatrics, family practice, general practice and internal medicine. Members receive a welcome packet and a letter notifying them of the contact information for their PCP.

When a Member has been assigned to a PCP, the assignment is recorded in the CHA electronic system. Each PCP receives a capitation roster each month, indicating the Members assigned to him/her. The roster includes enrollment based on information for the month, provided to CHA. Providers may also view a list of all assigned Members, including SPD members, online at https://eznet.rchsd.org. Providers should always verify eligibility and enrollment with CHA prior to providing services.

Changes to Assigned PCP

If a Member requests to change his/her PCP during the month, the change will be made effective as follows:

- Changes requested on or prior to the tenth day of the month, will be made effective the first of that month.
- Changes requested after the tenth day of the month, will be made effective the first of the month following the request.

Changes cannot be requested by the Provider or Provider's office staff. The Member, Member's parent or legal guardian must make the PCP change request with CHA.

Dis-Enrolling Members from a PCP Practice

Should a PCP want an assigned Member dis-enrolled from his/her practice due to the Member's non-compliance or disruptive behavior in the office, the PCP can request the Member's dis-enrollment. The initial step in the process is to mail a certified letter to the Member. A written request must also be sent to the CHA Provider Relations Representative. CHA will review the request and if deemed appropriate, the Member will be notified by mail to call CHA and select a new PCP. A new PCP will be auto-assigned if the Member, Member's parent or legal guardian does not call CHA within 10 days of receiving the letter. Until the change is complete, the Provider will be responsible for urgent or emergent medical treatment that the Member requires, until a new PCP has been assigned/selected.

Member Benefits Identification Card (BIC)

Each Medi-Cal/CalOptima eligible Member receives an identification card from the California Department of Health Services (DHS) commonly known as a Benefits Identification Card (BIC). CalOptima also sends a card to each Member, which indicates the Member's name, date of birth, CalOptima identification number, and assigned Health Network. Both cards should be presented to the Provider's office each time the Member presents for services, but services should not be denied if no card is presented. The BIC does not guarantee that the Member is eligible for the CalOptima program. Providers who have questions about a Member's eligibility may call CalOptima at (714) 246-8540 or CHA Customer Service at (800) 387-1103.

Providers are also encouraged to take the precaution of verifying the identity of the person presenting the BIC against some other form of identification, such as a driver's license or other form(s) of photo identification. This type of verification not only deters fraudulent use of the Medi-Cal / CalOptima program, but also protects the provider against performing services for which payment may be denied.

Member Rights and Responsibilities

CHA Members shall have the right to:

- Be treated with dignity and respect by all CalOptima, Health Network staff and Provider office staff
- Privacy and confidentiality of medical information
- Receive information about CalOptima, contracted Health Networks, Providers, covered services and Member rights and responsibilities.
- Choose a Primary Care Provider from within the CHA Network
- Speak openly with health care Providers about medically necessary treatment options, regardless of cost or benefit
- Help make health care decisions, including the right to say no to medical treatment
- Voice complaints or appeals, either verbally or in writing, about CHA or about the care provided or received
- Receive language interpretation services in the Member's preferred language
- Make an advance directive
- Access family planning services, Federally Qualified Health Care Centers (FQHC's), Indian Health Service Facilities, sexually transmitted disease services and emergency services outside the CHA network
- Request a state hearing, including information on the conditions under which a state hearing can be expedited
- Have access to his or her medical record, and where legally appropriate, receive copies of, update or correct the medical record
- Access minor consent services
- Receive written Member information in large size print and other formats upon request and in a timely manner
- Receive information about his or her medical condition and treatment plan options in a way that is easy to understand
- Make suggestions to CHA about Member rights and responsibilities

- Freely use these rights without negatively affecting how he or she is treated by CHA, Providers or the State

Member Responsibilities

CHA Members shall have the responsibility to:

- Follow the procedures outlined in the CHA Member Handbook to obtain services, and for questions or concerns
- Understand his or her medical needs and work with health care Providers to create a treatment plan
- Notify CalOptima and health care Providers about what they need to know about their medical condition in order to ensure care
- Schedule and attend medical appointments and inform the office when he or she must cancel an appointment
- Learn about his/her medical condition and what keeps him/her healthy
- Actively participate in health care programs that keep him/her well
- Follow the treatment plan prescribed by his/her PCP and Specialist(s)
- Schedule and keep periodic checkups for infants and children in the CHDP Program
- Prenatal Members must schedule and keep obstetrical checkups at the recommended intervals
- Members are encouraged to participate in other available prevention and wellness programs
- Notify CalOptima and the County Social Services Agency of address/phone number changes or changes in family size that affect eligibility or enrollment for example, marriage, birth, adoption, divorce, death or guardianship
- Inform CHA and the Provider if he/she is also covered by other insurance, including Medicare
- Be cooperative and courteous to those who are partners in his/her health care

COVERED SERVICES

CalOptima / Medi-Cal

As a Health Network contracted with CalOptima, CHA is required to make available a specific list of covered services to enrolled Members. The services are covered when medically necessary, must be provided by or arranged by the Member's PCP or specialist, and are subject to the prior authorization guidelines of CHA. A list of covered services and a matrix of the carved-out covered services, which denotes the financially responsible party for each type of service, is listed below. The following list is not all inclusive. The specific services to be delivered to CHA Members are described in detail on the CalOptima website. If a provider has questions as to whether a service is covered, he/she should submit a prior authorization, or contact the CHA Prior Authorization Department at (800) 387-1103, option 2.

Covered Services for all CalOptima Members

- Applied Behavior Analysis (ABA)
- Allergy Testing and Treatment
- Chemical Dependency-Detoxification
- Corrective Appliances
- Dental Services (Repair of Accident/Injury Only)
- Durable Medical Equipment (DME)
- Emergency Care Services
- Family Planning Services
- Genetic Testing/Counseling
- Health Education Programs
- Home Health Care (Including IV/Injectables)
- Hospice Services
- Hospitalization, Inpatient and Outpatient Services
- Immunizations
- Laboratory Services
- Limited Allied Health Services
- Maternity Care/Perinatal Support Services Program
- Medical Supplies/Dressings
- Nutritional Dietetic Counseling
- Outpatient Mental Health Services
- Pain Management Services
- Pediatric Preventive Services (CHDP)
- Physical Therapy
- Physician Visits
- Podiatry Services
- Prenatal Care
- Prescription Drugs
- Preventive Services (CHDP Program)
- Prosthetic and Orthotic Devices
- Radiology Services
- Reconstructive Surgery
- Rehabilitation-Short Term (PT/OT/Speech)
- Sensitive Services (HIV, AIDS, STD testing and treatment)
- Skilled Nursing Facility (Short Term Rehab/Sub-Acute-Non-Custodial)
- Skilled Therapies (physical, occupational, and speech)
- Medically Necessary Transportation Services
- Vision Services

Covered Services that are not the Responsibility of CHA (Carved out Services)

The following services are not covered by contract with CHA and CalOptima. Members should be directed to call CalOptima's Customer Service Department at (714) 246-8500 for questions regarding the following services:

- Alcohol and drug treatment services
- Home and community-based waived services
- Laboratory services provided under the State alpha feto protein testing program administered by the Genetic Disease Branch of the Department of Health Services
- Local Education Authority (LEA) and LEA assessment services
- Long term care services rendered by skilled nursing facility and intermediate care facilities (facility daily charges shall be paid through the existing Medi-Cal fee-for-service program; hospital service as defined in Title 22,CCR, Section 511180 rendered in a skilled nursing facility or intermediate care facility are not long term care services)
- Mental health services, which includes psychiatric inpatient services
- Pharmacy services (see below on how to access formulary)
- Vision services
- Dental services
- CCS eligible conditions
- Services not rendered in accordance with CalOptima policies or contractual requirements

- Health Education- CalOptima will inform the Member whether or not he or she may participate in a health education program without a referral from a practitioner. To receive information or to enroll in a class, the Member may call CalOptima's Health Education or Customer Service department.

Carved out services are not the direct financial responsibility of CHA. The matrix of financial responsibility below outlines the responsible parties for these covered services.

Service	Responsible Party
California Children's Services (CCS)	CCS Program
Child Health & Disability Prevention (CHDP)	CHDP Program
Dental Care	Denti-Cal
Mental Health	Orange County Health Care Agency, Children's Youth Services
Pharmacy Services	CalOptima
Perinatal Support Services	CalOptima
Health Education	CalOptima
Services received pending eligibility	CalOptima
Substance Abuse	Orange County Alcohol and Drug Abuse Services
Vision Services	VSP

How to Access the CalOptima Formulary
To access the CalOptima formulary log on to www.caloptima.org. Near the top of the page, click on Providers, then click on Pharmacy Information. On the left side menu, click on Access CalOptima Formularies via Epocrates and click on Access Online Formularies. You will need to set up a username and password at initial login.

120-DAY INITIAL HEALTH ASSESSMENT (IHA)

Members shall receive an Initial Health Assessment (IHA) within 120 calendar days of enrollment into the CalOptima Program, and again at defined intervals, unless the Member's Primary Care Provider (PCP) determines that the Member's medical record contains complete and current information to allow for an assessment of the Member's health status and health risk, in accordance with applicable statutory, regulatory, and contractual requirements. Providers shall review the IHA with the Member at each visit.

CHA shall inform contracted Providers of the need for timely IHA for all Members, and shall track IHAs to ensure assessments are conducted within the timeframes specified in applicable statutes and regulations. CalOptima and CHA have developed written procedures to identify Members with special health care needs and to ensure that such Members receive age appropriate and timely IHAs.

Staying Healthy Assessment forms for all age groups are available to download and print from the CHA website or the CalOptima website in English, Spanish, Vietnamese, Farsi and Korean (Chinese and Arabic, effective June 1, 2015).

Elements Included in an IHA

An IHA shall include the following elements:

1. Comprehensive History: All elements of the comprehensive history shall give a provider the ability to assess and diagnose a Member's acute and chronic conditions. The comprehensive history shall include, but is not limited to:
    - Member's history of present illness
    - Member's past medical history
    - Member's social history
    - A review of the Member's organ systems

2. Preventive Services for asymptomatic Members:

    - For Members under 21 years of age:
      The assessment shall include age-specific assessments and services as required by the Child Health and Disability Prevention Program (CHDP) and as specified by the most recent American Academy of Pediatrics (AAP) age specific guidelines and periodicity schedule. If examinations occur more frequently as specified by the AAP periodicity schedule rather than on the CHDP examination schedule, the assessment shall follow the AAP periodicity schedule.

    - For Pregnant Members/Perinatal Services:
      The assessment shall include perinatal support services in accordance with the most current guideline of the American College of Obstetrics and Gynecology (ACOG). CalOptima and CHA shall implement the Department of Health Care Services (DHCS) approved comprehensive risk assessment tool for all pregnant Members that is comparable to the ACOG standard and the Comprehensive Perinatal Services Program (CPSP) standards, including an individual care plan, in accordance with Title 22 California Code of Regulations, Section 51348.

3. Comprehensive Physical and Mental Status Exam

4. Diagnoses and Plan of Care that include follow-up activities

5. Individual Health Education Behavioral Assessment (IHEBA)

Who Can Perform an IHA

An IHA shall be performed by a Member’s assigned PCP, an OB/GYN or Perinatologist during a Member’s pregnancy, a non-physician mid-level Provider such as a Nurse Practitioner (NP) or a Physician Assistant (PA).

If a Member's IHA is performed by a Provider other than the Member's assigned PCP, the Member's PCP shall ensure that documentation of the IHA is contained in the Member's primary medical record and is completed within the required timelines.

Timeframe to Perform an IHA

Timelines for the provision of an IHA shall begin on a Member's effective date of enrollment with CalOptima.

1. Effective Date of Enrollment

    - A Member's effective date of enrollment is the first month following notification from DHCS that the Member is eligible for CalOptima and the Member is not on a hold status with DHCS.
    - If an infant is born to a Member, the effective date of enrollment shall be the infant's date of birth.
    - In the case of retroactive enrollment, the Member's effective date shall be the date that CalOptima receives notification of the Member's enrollment with CalOptima.

2. If a Member requests a change in his or her PCP or CalOptima initiates a change in a Member's PCP assignment and the Member's IHA has not been completed, the newly assigned PCP shall complete the Member's IHA within 120 calendar days from the date the Member was assigned to the new PCP.

Alternate Settings Used to Perform an IHA

An IHA may be performed in a setting other than in an ambulatory care setting if the Member is continuously enrolled for 120 days and is admitted or residing in the following setting:

- If a Member is admitted to a nursing facility or residing in a nursing facility upon becoming a Member, the nursing facility PCP assessment may provide information for the IHA. The Member's assigned PCP shall complete the IHA or ensure completion of all components of the IHA.

- If a Member is homebound, the Member's PCP may conduct parts of the IHA at a home visit provided that all components of the IHA are completed within 120 days after enrollment.

- If a Member is hospitalized at any time during the initial 120 day period, the Member's PCP may complete the IHA in the hospital during the 120 day period. Any physical findings from the hospitalization shall be rechecked and documented in a post hospital discharge outpatient visit as appropriate.

Documenting and Reporting of an IHA

- The PCP shall document the performance of an IHA or the equivalent information for example a PM160, a CMS1500, and a Staying Healthy Assessment (SHA) shall be included in a Member's medical record.

- The PCP shall document all elements of the IHA or any applicable IHA exemption in the Member's medical record.

- The PCP shall document and submit all pertinent information to CHA in accordance with the encounter data capture and reporting process requirements, and to CalOptima utilizing the PM160.

Requirements for Exemptions from an IHA

The timeline requirements for completion of a Member's IHA shall be exempt only if documented in the Member's medical record and in the following situations:

- All elements of the IHA have been completed within 12 months prior to the Member's effective date of enrollment and the Member's current PCP has reviewed and updated the Member's medical record.

- If a newly enrolled CalOptima Member chooses to remain with his or her current PCP, the PCP may incorporate relevant Member information from the Member's existing Medical Record to complete the IHA elements.

- A Member who is not continuously enrolled in CalOptima during the initial 120 calendar day period.

- A Member who loses eligibility prior to an IHA being performed.

- A Member who refuses an IHA. Provider must document the refusal on the form and file in the Member's medical record.

- A Member who misses a scheduled PCP appointment and two additional documented attempts to reschedule are unsuccessful. Documentation must include at least the following:
  - One attempt to contact the Member by telephone at telephone number on record.
  - One attempt to contact the Member by letter or postcard sent to the Member's address on record.
  - CHA or PCP has made a good faith effort to update the Member's contact information.
  - Attempts to perform the IHA at any subsequent Member's office visits even if the deadline for IHA completion has elapsed.

CHA shall send new Member education packets regarding IHAs which includes:

- The availability of the IHA for all Members

- How to arrange for an appointment within the appropriate timelines

- The importance of keeping the IHA and other appointments

- Member's rights regarding IHA, including providing the Member with IHA results

SENIORS AND PERSONS WITH DISABILITIES (SPD)

The Seniors and Persons with Disabilities (SPD) category addresses a special population of Members living with chronic illness, or developmental, physical, and/or cognitive challenges. SPD Members often have difficulties with the activities of daily living, and have an increased need for care. CalOptima uses an internally developed, proprietary risk stratification algorithm to identify all SPD Members who have higher risk and more complex health needs and those who are at lower risk. The risk stratification algorithm incorporates Member specific utilization data to identify Members with higher risk and more complex health care needs.

Based on the results of the risk stratification algorithm, Members are assessed using a Health Risk Assessment (HRA). This information is sent to CHA, and Members can be referred to either basic, care coordination (moderate) or complex case management based on risk stratification level. On an annual basis, CHA reassesses all SPD Members using the HRA for all active Members who enroll before the first of that year, or whenever there are changes to a Member's health status.

CHA uses the HRA to develop a care plan, individualized to meet the Member's medical, functional, psychosocial, social support and access to care needs. This includes reviewing the tool and process at an Interdisciplinary Care Team (ICT) structure for facilitating the collaborative process of communication and development of the Member's care plan among the Member's medical, behavioral and ancillary Providers.

The assessment also includes coordination of services provided in and out of the plan as well as the identification of Members who require referrals to home and community based services, community resources, and available services and benefits. There is an evaluation of caregiver or family availability and involvement in, and decision making about, the Member's treatment plan as well as an evaluation of the Member's mental health status, and psychosocial and cognitive functioning, to facilitate access to primary care, specialty care, and other health services to meet the physical and cognitive needs of the Member.

The Interdisciplinary Care Team (ICT) structure for facilitating the collaborative process of communication and development of the Member's care plan among the Member's medical, behavioral and ancillary Providers includes the identification and facilitation of referrals for Members who require referrals to a disease management program, health education, counseling or self-management support, coordination of Member' s care across the continuum of health, from outpatient or ambulatory to inpatient settings while ensuring a comprehensive reassessment of a Member's health status and identification of barriers.

CARE COORDINATION/CASE MANAGEMENT

CARE MANAGEMENT

The Care Management Department provides case management services to improve collaboration among Members, Providers, and health care systems. Staff is available to coordinate resources in order to meet Members' medical needs and ensure the Member receives the best possible care. The care management program is focused on assuring individualized services that are consistently administered and cost-effective. CHA focuses on different types of care management cases such as complex care coordination and perinatal cases. Members are screened to determine the appropriate care management needs.

Complex Case Management

Members enrolled in case management are assigned to a dedicated case manager who will provide regular telephone contact. Based on Member's needs, the case manager will prepare a care plan and coordinate multidisciplinary medical management resources, and coordinate requested ancillary services. Case managers may call the PCP to obtain additional information or seek assistance to best meet the Members' needs. Individualized care plans and updated progress notes are faxed to the PCP on an as needed basis. The PCP will be notified of case closure when Members' goals are met.

Providers can obtain a case management referral form from the CHA website.

Members who are at high risk are defined as having medically complex conditions that include the following but are not limited to:

- Spinal injuries
- Transplants (with additional complex conditions)
- Cancer (with additional complex condition or metastasis)
- Serious trauma
- AIDS
- Multiple chronic illnesses
- Chronic illnesses that result in high utilization
- Complex social situations that affect the medical management of the Members' care and require extensive use of resources

Care Coordination

Care coordination is provided to Members who are at moderate risk, but have an acute or chronic medical condition that requires assessment and coordination of resources in order to maintain the Member in the least restrictive setting. Perinatal Support Services for pregnant Members and other resources are provided by a case manager, to all pregnant Members up to the postpartum period. Referrals are received from internal and external sources. Internal referrals come from Concurrent Review, Prior Authorization and Member Services. They can also be generated from internal utilization reports. External referrals are from CalOptima, PCP, Specialist and Members who self-refer if they need assistance in navigating the healthcare system. Providers may refer Members to Care Management by faxing a Case Management Referral Form to (855) 867-0868.

Members may be referred to either basic, care coordination (moderate) or complex case management, provided by CHA, in collaboration with the PCP.

Basic Case Management - CHA shall collaborate with PCP to ensure lower risk Members receive basic case management which includes an Initial Health Assessment (IHA), an Initial Health Education Behavioral Assessment (IHEBA), and the identification of appropriate Providers and facilities to meet the Member's needs. There is direct communication between the Provider and Member/family regarding education including healthy lifestyle changes, coordination of carved out and linked services, and referrals to appropriate community resources and other agencies.

Care Coordination (Moderate) - Care Coordination ensures Member centric activities and the coordination of services identified in Members' care plans to optimize their health status and

quality of life. Case management and care coordination involve a comprehensive assessment of a Members condition, determination of available benefits, resources and development and implementation of a care management plan with performance goals, monitoring and follow up.

Complex Case Management - CHA shall ensure that higher risk Members receive complex case management, which involves a comprehensive assessment of a Member's condition, determination of available benefits and resources, and development and implementation of a case management plan with performance goals, monitoring, and follow up. CHA shall ensure that complex case management processes include, coordination of care or service coordination for medical services, such as, access to primary and specialty care, Durable Medical Equipment (DME), supplies and medications while facilitating and ensuring timely access to services.

Access to Care Standards

Quality assurance standards require that Members be offered appointments within the following timeframes for consultations or other services.

Type of Service/Appointment	PCP	Specialist	OB Providers
Office Wait Time	No longer than 45 minutes	No longer than 45 minutes	No longer than 45 minutes
Urgent Appointment for Services that Require Prior Authorization	Within 96 hours of request	Within 96 hours of request	Within 96 hours of a request
Non-urgent Appointment	Within ten business days of request	Within 15 business days of a request	Within ten business days of request
Notifying CHA's Prior Authorization Department of ED Admissions	Within 24 hours, if aware of admission	Within 24 hours, if aware of admission	Within 12 hours, if aware of admission
Urgent Appointment for Services that do not Require Prior Authorization	Within 24 hours after the request	Within 24 hours after the request	Within 24 hours of the request

Identifying Barriers to Care

Understanding barriers to care is essential to helping Members receive appropriate care, including routine preventive services. Although most Members and/or caregivers understand the importance of preventive care, many confront seemingly insurmountable barriers to readily comply with preventive care guidelines. To help address this, CHOC Health Alliance trains its Member Services and Care Management staffs to identify potential obstacles to care during communications with Members, their family/caregivers, PCPs and other relevant entities and works to maintain access to services. Examples of barriers to preventive care include:

- Cultural and/or language differences
- Lack of perceived need if the Member is not sick
- Lack of understanding of the benefits of preventive services
- Competing health-related issues or other family/work priorities
- Transportation challenges
- Scheduling and other access challenges

CHA works with Providers to routinely link Members with services designed to enhance access to preventive services, including:

- Coordinating interpreter services with scheduled appointments for health care services, whenever possible. Please call (800) 387-1103, option 3 to request services.
- Locating a Provider who speaks a particular language
- Arranging transportation to medical appointments
- Connecting Members to other community based support services

THE PRIMARY CARE PHYSICIAN (PCP)

Responsibilities of the CHA PCP

Primary Care Physician responsibilities shall include, but are not limited to:

- Verifying Member eligibility prior to the delivery of services by calling CalOptima at (714) 246-8540, viewing online at https://eznet.rchsd.org or by calling the CHA Member Services Department at (800) 387-1103. Failure to verify Member eligibility and PCP assignment may result in the denial of claims.

- Providing care for the majority of health care issues presented by a CHA Member, including preventive, acute care, & chronic conditions.

- Providing risk assessment, treatment planning, coordination of medically necessary services, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.
- Providing and/or coordinating medical case management to assigned Members.

- Ensuring continuity of care and an interactive relationship between the PCP and the Member.

- Increasing Member satisfaction.

- Facilitating access to appropriate health care services.

- Reducing unnecessary referrals to specialists and emergency department utilization.

- Screening health status, monitoring and providing preventive services.

- Identifying and providing appropriate health education to improve a Members' understanding of the importance of a healthy lifestyle and disease specific interventions.

- Assuring the provision of the required scope of services to assigned Members including the implementation of the Child Health and Disability Prevention Program (CHDP).

- Assuring the provision of 24 hours a day, seven days a week access to care, including accommodations for urgent care, performance of procedures, inpatient rounds, and arrangements for emergency backup coverage in the PCP's absence.

- Maintaining staff membership and admission privileges in good standing at a contracted hospital.

- Utilizing participating medical facilities for the admission of Members unless prior authorization has been obtained from CHA or in the case of an emergency. The PCP will provide or arrange for the provision of covered services to Members while in a hospital, nursing home or other health care facility as determined medically necessary by PCP or CHA's Medical Director.

- Complying with CHA Quality Improvement and Medical Management policies and procedures.

- Obtaining prior authorization for all elective hospital admissions, outpatient surgeries and related medical procedures.

- Within five days from the time a pregnancy is identified, the Provider must fax a copy of the pregnancy notification report (PNR) to CalOptima's case management department. A copy of the form and the date of CalOptima's notification should be maintained in the Members' medical record.

- Requesting an authorization from the CHA Prior Authorization department to transfer care to an obstetrician immediately upon the identification of pregnancy.

- Recording appropriate information in the Member's medical record according to CHA's medical record requirements contained in this manual.

- Facilitating and ensuring Member quality of care by establishing procedures to contact Members when they miss an appointment which requires rescheduling for additional visits, and following up on referrals/authorization requests to Specialists.

- Making all reasonable attempts to communicate with Members in their native language.

- Preserving the dignity of the Member.

- Reporting all services provided to CHA Members in an accurate and timely manner.

- Prescribing or authorizing the substitution of generic pharmaceuticals when appropriate and agreeing to abide by the CalOptima formulary.

- Rendering services to Members who are HIV positive or diagnosed with Acquired Immune Deficiency Syndrome (AIDS) in the same manner and to the same extent as other Members and under the compensation terms set forth in the contract.

- Utilize the CalOptima grievance and appeals procedures process as set forth by CalOptima.

- Coordinate the transfer of Member medical records to another Provider upon request by the Member, CHA or CalOptima.

PREVENTIVE SERVICES

The PCP is responsible for providing appropriate preventive care for eligible Members. These preventive services include, but are not limited to age appropriate immunizations, disease risk assessment, age-appropriate physical examinations, well child visits, adolescent well care visits and Early Periodic Screening, Diagnosis and Treatment (EPSDT) visits.

CHA encourages providers to outreach to CHA Members concerning appointments for medically necessary care, preventive care and scheduled screenings and examinations. Providers are required to conduct outreach whenever a Member misses an appointment and to document this outreach in the medical record. Reasonable outreach includes three attempts to contact the Member. Attempts may include written communications, telephone calls and home visits. At least one attempt must be a follow-up telephone call. Communications with the Member should take the Member's language and literacy capabilities into consideration. Preventive health guidelines can be found on the CHOC Health Alliance website at www.chocheathalliance.com.

Early Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT is the Federal program designed to facilitate early identification of health problems through periodic well-child assessment, immunization and follow-through care to resolve any identified health problems. Early and Periodic Screening, Diagnosis, & Treatment (EPSDT) is a Medi-Cal benefit for individuals under the age of 21 who have full-scope Medi-Cal eligibility. Based upon the identified health care need and diagnosis, treatment services are provided. EPSDT services include all services covered by Medi-Cal. In addition to the regular Medi-Cal benefits, a beneficiary under the age of 21 may receive additionally medically necessary services.

Child Health and Disability Prevention (CHDP)

Child Health and Disability Prevention (CHDP) is a state funded preventive program that delivers periodic health assessments and services to low income children and youth in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services. Health assessments are provided by enrolled private physicians, local health departments, community clinics, managed care plans, and some local school districts.

CHA providers are expected to complete the following when providing CHDP services:

- Provide immunizations to Members in accordance with Federal and California State Standards
- Educate Members on the importance of CHDP services
- Refer Members with developmental disabilities for appropriate services
- Document each CHDP assessment in the Member's medical record (paper or electronic)
- Comply with CHA's minimum medical record standards for quality management, CHDP guidelines and other requirements under the law
- Cooperate with CHA's periodic reviews of CHDP services, which may include chart reviews to assess compliance with standards
- Report members' CHDP visits by recording the applicable current procedural terminology (CPT) preventive codes in the required claims submission form

Educating Members about CHDP Services
Primary Care Providers (PCPs) are required to educate Members and their families on the importance of CHDP services and encourage them to routinely schedule CHDP screening appointments. CHA will also educate members and their families on CHDP services including information regarding wellness promotion programs. CHA informs Members about CHDP services through a variety of communications, including:

- Member handbook
- CalOptima Member quarterly newsletters
- CalOptima's Health Education Campaign materials
- CalOptima's website at www.caloptima.org
- CHOC Health Alliance website at www.chochealthalliance.com
- Reminder postcards from CalOptima
- Care plan interventions for high risk Members enrolled in care management

Screenings

CHA requires its Primary Care Providers (PCPs) to conduct comprehensive, periodic health assessments, or screenings, from birth through age 20 years, at intervals as specified in the CHDP periodicity schedule. CHA encourages PCP's to incorporate the use of a standardized developmental screening tool for children consistent with the American Academy of Pediatrics (AAP) policy statements and clinical guidelines. AAP policy recommends routine surveillance (assessing for risk) at all well child visits, and screening using a standardized tool. Developmental screenings should be documented in the medical record using a standardized screening tool. To be considered complete, a CHDP visit must contain all services appropriate to the child's age, including:

- Complete unclothed physical examination
- Complete health history
- Developmental review; primary care providers are encouraged to use a standardized developmental screening tool for children consistent with the American Academy of Pediatrics (AAP)
- Vision, hearing and dental review
- Measurements, blood pressure and vital signs
- Nutritional review
- Health education/anticipatory guidance
- Laboratory procedures including hemoglobin/hematocrit, urinalysis, tuberculin test (for high-risk groups) and blood lead screening
- Immunizations
- Screen the Member according to the procedures outlined in the periodicity chart and bill using the standard PM160 or CMS1500 claim form with appropriate CPT codes for each encounter. These procedures are intended to provide an indication of the scope and depth of the CHDP screening component and the frequency with which these services should be performed. These procedures are minimum requirements and are not intended to restrict the physician's judgment as to the kinds of additional services required under individual circumstances. The need for additional services must be specifically documented in the Member's chart.
- Discuss screening results with the parent(s) or guardian, explaining the findings in detail along with recommendations for diagnosis and treatment. Anticipatory guidance relevant to age and risk factors should also be given.
- Submit authorization requests or referrals for follow-up care or call CHA Case Management for assistance, should the child need further diagnosis and/or treatment.

Progress notes must clearly indicate which course of action was taken. CHA covers all medically necessary services for children, which correct, ameliorate, or maintain health status. Members under the age of 21 years should be treated according to the recommended schedule of preventive health care. This information should be retained as part of the Member's medical record. The evaluation should include all age appropriate required components including the scheduling of the

next appointment if possible. It will be necessary for PCPs to submit a PM160 and/or a CMS1500 claim form for each encounter.

Immunizations

CHA's CHDP program addresses all Member preventive health screenings and immunizations from birth through age 20. CHA expects Providers to adhere to Advisory Committee on Immunization Practices (ACIP) Recommendations.

CHA monitors immunizations through its encounter/claims system and through medical record review. Data is extracted and cross referenced with each PCP's panel to ensure screenings and immunizations for children are occurring according to the CHDP periodicity schedule. CHA follows up with PCPs whose Members are not receiving immunizations as required and may assist in providing Member outreach and support.

CHA encourages all PCPs who administer childhood immunizations to enroll in the California Vaccines for Children Program (VFC), administered by the California Department of Health.

Providers must not routinely refer Medicaid Members to the local health department to receive vaccines. CHOC Health Alliance expects all network Providers to submit immunization data to the California Immunization Registry database (CAIR®).

CHA Primary Care Physicians are Required to:

- Register with Medi-Cal and maintain a contractual relationship with CHOC Health Alliance and complete and maintain all CHA credentialing and re-credentialing requirements.

- Never bill a Member for the provision of covered services in accordance with Title 22 of the California Code of Regulations, Section 51002.

- Identify any other insurance and billing the other insurance company before billing CHA.

- Have a broad education with training that is supported by demonstrated ability and experience in providing primary care, including ongoing participation in continuing medical education focused in the area of primary care.

- Assume responsibility for the provision and documentation of CHDP screening services for all assigned Members under the age of 21 years in accordance with AAP guidelines periodicity schedule and submit PM160s to CalOptima and CMS1500 encounter forms to CHA.

- Refer Members under the age of 21 years for follow-up, diagnosis and treatment as necessary, ensuring that treatment is initiated within 15 days of screening services.

- Refer Members under the age of 21 years with medically eligible and confirmed diagnosis to California Children's Services (CCS) for follow up and treatment services.

- Utilize each clinical encounter to assess the child's immunization status and the need for any CHDP screening services thus avoiding missed opportunities to update immunizations

and meet periodicity standards and maintain an office adequately designed with equipment and supplies necessary to provide CHDP services.

- Abide by CHDP health assessment standards, minimum medical record standards and strive to adapt the standards for pediatric immunization practices.

- Maintain CHDP certification for providing quality care to all CHA Members younger than 21 years of age.

- Participate in reviews to assure compliance with CHA medical record standards, pediatric standards and CHDP, which may include medical record review according to regulatory requirements.

CAPITATION PAYMENTS

CHA will pay the PCP a monthly capitation payment for the delivery of covered services during the term of his/her agreement based on the number of Members assigned to the PCP for the month. Capitation payments will be based upon specific CalOptima rate codes and contracted amounts found in the Providers' contract. Questions concerning monthly capitation payments should be directed to the CHA Provider Relations Department.

MEDICAL RECORDS

Each provider office/clinic shall designate an individual who is responsible for the medical record system by which clinical information is collected, processed, maintained, stored, retrieved and distributed. Storage may be electronic or hard copy.

All active records shall be labeled and filed in a defined system (alphabetically by last name, first, middle; or numerically using a terminal digit, serial, or other uniquely assigned numbering system) to facilitate the retrieval of the record.

Active records are to be stored in a secured area, which may include a centralized record room or decentralized areas within the office that protect records from loss, tampering, alteration or destruction. The records must be organized in a systematic filing method that allows active records to be retrieved upon demand.

Inactive records for adults shall be retained for ten years from date of last visit. For minors, the record shall also be retained for a minimum of ten years. Medical records of minors shall be kept until the minor has reached the age of 21, but in no case less than ten years.

Medical records involving litigation must be retained for a period of not less than ten years following the termination of litigation. All required records must be maintained in a legible form, and must be readily available upon request of the attending provider, clinic, or any other person authorized by law to make such request. Storage must be in a secured location, with restricted access that meets the same security requirements as active records, and shall be retrievable within five working days if necessary.

Filing of Information

All documents shall be filed chronologically within the record with the Member's name and the name of the Primary Care Provider (PCP) on each document. Reports for example, laboratory or radiology may be filed in a segregated manner in chronological order. The documents must be secured in a folder to prevent loss.

All reports shall be filed in the medical record within 48 hours of receipt including, but not limited to, laboratory, radiology, electroencephalograms (EEG) and Echocardiograms (ECG), consultation, hospital and emergency department reports.

Format and Content

An individual record shall be established for each Member and shall be updated during each visit or encounter. The record shall be in a legibly handwritten or printed format and reflect the findings of each visit or encounter including, but not limited to the date of service, chief complaint, follow up from previous visits, tests/therapies ordered, diagnosis or medical impression and any physical, psychosocial and/or educational needs identified during the encounter.

Information to be included in Member's Chart

Demographic information including, but not limited to:

- Name, address, telephone number, age, sex and birth date
- Emergency contact person and closest relative and telephone number(s) for each
- Plan identification and Medi-Cal Number, if applicable
- Preferred language, and the request or refusal of language assistance services

Clinical Data

- Record of diagnoses, treatment and prescription orders
- Vital signs and signature/title of person performing these measurements, including height, weight, temperature, pulse, respiration rate and blood pressure (if over the age of three years old)
- Allergies and adverse reactions must be recorded on the front of the member's chart or in a standardized location in the record
- List of medications, with current updates, including name, dosage and frequency
- Ancillary services

- Medical and surgical histories including relevant family history for significant health problems, reactions to drugs, and personal habits for example, alcohol, drugs, exercise and diet

- Physical examination by body systems with findings and treatment plan when medically indicated

- All records related to all hospitalizations, such as, history and physical (H&P), discharge summary, operative reports and pathology reports

- Office laboratory and/or surgical/invasive procedures including anesthetics used, and specimens collected for pathological examination

- Emergency department encounter visit record reflecting assessment, treatment, discharge instructions and recommended follow-up

- Initial Health Assessment (IHA)

- Initial Health Education Behavioral Assessment (IHEBA)

- If a Member is 18 years or older, documentation of whether the Member has been informed and has executed an advance directive

- Signed consent form or statement for any invasive procedure

- Referral / Treatment Authorization Requests (TARs)

- Significant telephone advice, documented with date, time and signature

- Consultation reports

- Preventive care and Member education, including information on periodic exams, stool guiac, pelvic/pap smear, mammogram, instructions on breast self-exam, nutrition and accident prevention

- Immunizations must be recorded including the lot number and expiration date

Authentication of Medical Record Entries

Medical record entries must be dated and signed by each staff person or health care provider at each encounter. The signature shall consist of the first initial, last name, and title of the person making the entry.

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Member Follow-Up For No Shows

The PCP shall have a system in place to identify, monitor and follow up on any Member who does not keep his/her appointment. All attempts to contact a Member and instructions given to the Member advising him/her of the need to obtain medically necessary care must be documented.

The PCP shall document and maintain on file in the record:

- All attempts to reach the Member
- Instructions given to the Member when contact is made advising the Member of the need to obtain medically necessary care, and the possible consequence(s) of not keeping appointments
- If the PCP cannot reach the Member by telephone, the PCP shall send a letter to the Member advising the Member of the need to obtain care and the possible consequences of not getting treatment
- If a Member exhibits a habitual pattern of missing appointments, the PCP may refer to CHA's Case Management department, for assistance in managing the Member's noncompliance

CONFIDENTIALITY OF RECORDS

All Member records and Member related information shall be handled with strict confidentiality. The medical records department manager or office manager shall be responsible for maintaining, monitoring and enforcing staff compliance in keeping Member information confidential. The release of Member information when requested by the Member or under other conditions of release as identified below, and is also the responsibility of the medical records department manager or office manager.

Each employee shall be advised of the importance of strict confidentiality and receive a written copy of the confidentiality requirements. Employees shall also be responsible for reading and providing his/her signature to the statement indicating his/her understanding and willingness to abide by the requirements.

Release of any part of the medical record must be authorized in writing by the Member or Member's legal guardian/parent if the Member is a minor, except under the following conditions:

1. Mandatory Disclosure

- By a court order
- By a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority
- By subpoena, subpoena duces tecum, notices to appear served related to the Code of Civil Procedure, Section 1987, or any provision authorizing discovery in a proceeding before a court or administrative agency

- By a board, commission, or administrative agency pursuant to an investigative subpoena issued under the California Code of Regulations, Title 2, Division 2, Par 1, Chapter 2, Article 2 (Section 1180)
- By an arbitrator or arbitration panel, when arbitration is lawfully requested by either party, pursuant to a subpoena duces tecum issued under the Code of Civil Procedure, Sections 1282.6, or any other provision authorizing discovery in a proceeding before an arbitrator or arbitration panel
- By search warrant lawfully issued to a governmental law enforcement agency

2. Discretionary Disclosure

In an emergency situation, information may be disclosed between emergency medical personnel at the scene of an emergency or in an emergency medical transport vehicle, emergency medical personnel at a licensed hospital who are communicating by radio with the personnel who are at the scene, and a provider of health care may disclose medical information as follows:

- To other health care providers, provided the information is disclosed for purposes of diagnosis or treatment of the Member, or to assist another provider in obtaining payment for health care services rendered by that provider to the Member, however such disclosure is limited to that information which is necessary to accomplish this purpose.

- To an insurer, employer, health care service plan, hospital service plan, employee benefit plan, governmental authority, or any other person or entity that is or may be responsible for paying for health care services rendered to the Member, provided that the information is disclosed only to the extent necessary to determine responsibility for payment and to secure payment.

- To organized committees and agents of professional societies, medical staff of licensed hospitals, licensed health care service plans, professional standards review organizations, utilization and quality control peer review organizations as established by Congress in 42 U.S.C. Section 1320q *et seq.*; or to persons ensuring, responsibility for, or defending professional liability a provider may incur, provided such entities or persona are engaged in reviewing the competence or qualifications of health care professionals or reviewing health care services with respect to medical necessity, level of care, quality of care, or justification of charges.

- To the county coroner in the course of an investigation by the coroner's office.

- To specified researchers for bona fide research purposes. Researchers who may receive information are limited to clinical investigators, or researchers affiliated with public agencies, health care institutions, or health care research organizations accredited to perform public or private non-profit education. Researchers may not further disclose information in any way which would permit identification of the Member unless it is necessary for continuing medical care and is being released to another physician participating in the Member's care, or is required by third party insurers or state/federal representatives as part of payment and/or quality review processes.

SPECIALIST PROVIDERS

Responsibilities of the CHA Specialist

- Verify Member eligibility prior to the delivery of services by calling CalOptima at (714) 246-8540, viewing online at https://eznet.rchsd.org, or by calling the CHA Member Services Department at (800) 387-1103. Failure to verify Member eligibility and PCP assignment may result in the denial of claims.

- Check the Member's identification card each time the Member presents for services and verify against photo identification.

- Providers are responsible for identifying any other insurance and billing the other insurance company before billing CHA.

- Bill all services provided to a CHA Member electronically or on a CMS1500 claim form.

- Provide authorized services within your scope of practice.

- Refer all Members under the age of 21 years of age with CCS eligible conditions to the local CCS office and obtain prior authorization from CCS when appropriate. Failure to obtain prior authorization from CCS may result in the denial of claims.

- Prescribe or authorize the substitution of generic pharmaceuticals when appropriate, and agree to abide by the CalOptima formulary.

- Agree to render services to Members who are HIV positive or diagnosed with Acquired Immune Deficiency Syndrome (AIDS) in the same manner and to the same extent as other Members and under the compensation terms set forth in contract.

- After examination and/or provision of authorized treatment, advise PCP of findings and recommended treatment plan and/or follow up care and provide a written report of findings and recommendations to the PCP within ten working days of service being rendered to the Member.

- Communicate with the PCP and/or CHA for additional tests or diagnostic studies necessary to complete the evaluation of the Member.

- Refrain from directing Members to hospital emergency departments for non-emergent medical services at any time during the term of your agreement with CHA.

- Educate and instruct Members about the proper utilization of the physician’s office and urgent care facilities in lieu of hospital emergency departments.

- Share each Member’s relevant medical information with the Member’s assigned Primary Care Provider (PCP).

- Utilize CHA contracted hospitals, specialists, and ancillary providers and obtain prior authorization for all elective hospital admissions (inpatient and outpatient).

- Comply with CHA and CalOptima quality improvement and medical management policies and procedures.

OBSTETRIC PROVIDERS

Responsibilities of the CHA Obstetrician

- Verify Member eligibility prior to the delivery of services by calling CalOptima at (714) 246-8540, viewing online at https://eznet.rchsd.org, or by calling the CHA Member Services Department at (800) 387-1103. Failure to verify Member eligibility and PCP assignment may result in the denial of claims.

- Provide office visits to Members during regular office hours and home visits or other appropriate visits during non-office hours as determined medically necessary.

- Schedule time-specific medically necessary appointments for enrolled pregnant Members to obtain prenatal care that is within the following timeframes:

    - First trimester - within seven days of a request for an appointment
    - Second trimester - within seven days of a request for an appointment
    - Third trimester - within three days of a request for an appointment

- Initiate high risk prenatal care within three working days of identification or immediately, if an emergency exists.

- Complete a Pregnancy Notification Report (PNR) on each pregnant Member at the initiation of pregnancy related services.

- Encourage Members to participate in the Comprehensive Perinatal Support Services Program (CPSP) and refer Members as necessary.

- Refer the Member back to the Member's PCP or to the appropriate specialist for medical services that are outside the scope of the OB's practice.

- Schedule time-specific office visits during a routine pregnancy based upon the following recommended standards of the American College of Obstetrics and Gynecology (ACOG): Every four weeks for the first 28 weeks of pregnancy, every two weeks until 36 weeks of gestation and weekly thereafter.

- Maintain responsibility for care until the first day of the month following the 42nd day after delivery. A minimum of one postpartum visit should be completed at approximately six weeks postpartum. Members at high risk shall have a return visit scheduled appropriate to their individual needs.

- Refer Members to CHA participating health care providers. Members may obtain family planning services including sterilization, from in and out of network providers, without a referral/authorization.

- Initiate referrals to specialists on the same day for emergency care, within two days for urgent care and within 30 days for routine care.

- Notify CHA within 7 calendar days if an OB determines a Member is carrying multiple fetuses.

- Refer Members when appropriate to a CHA participating perinatologist for consultation and/or continued obstetrical care upon approval by the CHA Prior Authorization Department.

- Maintain hospital staff membership and admission privileges in good standing.

- Provide covered services to Members while in a hospital as determined medically necessary by the OB or CHA's Medical Director.

- Obtain prior authorization for all elective hospital admissions and outpatient surgeries except sterilization and related medical procedures.

- Maintain a current DEA number and prescribe and abide by the CalOptima drug formulary and authorize the substitution of generic pharmaceuticals.

- Render services to Members who are HIV positive or diagnosed with Acquired Immune Deficiency Syndrome (AIDS) in the same manner and to the same extent as other Members and under the compensation terms set forth in the contract.

- Provider shall not exclude any Member from participation in or, deny benefits, or otherwise discriminate against any Member in the delivery of covered services based on the Member's status as a participant in a publicly financed health benefits program, if diagnosed as having an HIV positive status, AIDS or, having a disability, age, race, color, religion, sex, national origin or any other classification protected by applicable law.

- Notify CHA when a Member meeting the CDC guidelines for the diagnosis of having HIV positive status or AIDS is identified, (maintaining patient confidentiality) or for assistance in referral if the management of such Members exceeds the OB's scope of practice.

- Make a concerted effort to educate and instruct Members about the proper utilization of the OB's office in lieu of hospital emergency departments. The OB shall not refer or direct Members to hospital emergency departments for non-emergent medical services at any time.

- Initiate and follow through on appropriate referrals to California Children's Services (CCS) for all Members up to the age of 21 years who have been diagnosed with medically eligible CCS conditions.

Documentation of Prenatal Care

The following guidelines for the provision of prenatal care should be followed and documented in the Member's medical record:

First Prenatal Visit

- Medication: allergies and adverse reactions must be listed if present. List no known allergies (NKA) if applicable.

- History: genetic and obstetric, dietary intake, tobacco/alcohol/drug use, risk factors for intrauterine growth retardation and low birth weight and prior genital herpetic lesions.

- Laboratory/diagnostic procedures: blood pressure, hemoglobin and hematocrit, ABO/Rh typing, Rh (D) and other antibody screen, VDRL/RPR, hepatitis b surface antigen, urinalysis microscopic or culture, rubella antibody titer, TB testing (optional) and GC/chlamydia RNA/DNA testing.

- Counseling: nutrition, tobacco, alcohol and drug use and car seat safety.

- High risk group factors defined by ACOG include, but are not limited to:

    - Insulin dependent Diabetes
    - Chronic renal disease or renal insufficiency
    - Epilepsy requiring medication
    - Chronic hypertension requiring medication
    - A history of delivering two or more infants at 32 weeks or less
    - A malignancy
    - A current diagnosis of highly probable intrauterine growth retardation (IUGR)
    - Premature rupture of membranes (before 32 weeks)
    - Pregnant with triplets or more
    - Potential need for cerclage procedure
    - Diagnosis of lupus erythematosus
    - Twin pregnancy with diagnosis of discordant growth
    - HIV positive mother
    - Polyhydramnios or oligohydramnios
    - Pregnancy induced hypertension

Follow-up Prenatal Visits

The following information should be documented in the medical record at each prenatal visit: Patient complaint, interval history, signs and symptoms, weight, blood pressure, fundal height, edema, fetal size and position, fetal heart tones, check urine for glucose and proteins and nutrition.

Specific screening tests and counseling are recommended at the following gestational ages:

Gestational Age	Recommended Screening
0-14 Weeks	Diabetes Mellitus (DM) Screen – at risk patients 1st Trimester California Prenatal Screening (CPS) Cystic Fibrosis Carrier Screening Tobacco use Alcohol and other drug use Gonorrhea/Chlamydia testing VDRL/RPR HbSAg Counseling and testing for HIV testing
15-20 Weeks	2nd Trimester CPS Ultrasound and cephalometry
22-24 Weeks	Fetal Echocardiogram, if indicated
24-28 Weeks	DM Screen Rh (d) antibody
36 Weeks	Ultrasound examination

Other Office Visits

The following information should be documented in the medical record for each office visit and as appropriate:

- The Member's chief complaint and/or reason for appointment shall be obtained and noted at each visit.

- Documentation of an examination and/or objective physical findings and information appropriate for the condition shall be obtained and noted at each visit.

- For all Pregnant Members, medical record must indicate vaccination for tetanus/diphtheria/whooping cough (Tdap) optimally between 27-36 weeks. Medical records must indicate the Member's immunization status for influenza vaccine, and the provider should vaccinate if indicated.

- Assessment/working diagnosis must be consistent with findings (physician's medical impression).

- Documentation of plan of action and treatment must be consistent with diagnoses.

- Documentation of appropriate Member education concerning the diagnosis, follow up care, and need for return to the physician's office.

- All medications prescribed must list name, dosage, frequency, and duration.

- All health screening procedures must be documented. All screenings performed by other physicians should also be documented in the medical record.

- Lifestyle management and preventive health information is documented to include, but not limited to family planning and sexually transmitted disease education, cancer prevention, and injury prevention for example, vehicle safety belts, occupational hazards, or home safety such as smoke detector.

- Consults/x-ray/lab/imaging reports/referrals/records-reports are filed in the medical record and initialed by physician thereby signifying review. Consultation and/or abnormal laboratory imaging study results should have an explicit notation in the medical record of follow-up plans. Referrals, past medical records, hospital records, operative and pathology reports, admission and discharge summaries, consultations and ED reports should also be filed in the medical record.

- Unresolved problems from previous visits should be addressed and documented at subsequent visits.

- If any potential quality issues are identified, the provider must refer to CHA's Medical Director for further review.

PERINATAL SUPPORT SERVICES (PSS) PROGRAM

CalOptima offers a Comprehensive Perinatal Support Services Program (CPSP) for eligible Members. These services range from preconception counseling to postpartum care and include perinatal case management for high risk Members, and outreach and family planning services whenever appropriate.

CalOptima's program facilitates the delivery of services through a multi-disciplinary approach, involving member services, provider relations, medical management, prevention and wellness departments as well as the Medical Director. Services are provided by a diverse network of participating primary care physicians, obstetricians, perinatologists, neonatologists, pediatricians and ancillary service providers dedicated to maternity services.

The purpose of the Perinatal Support Services Program is to improve fetal and maternal care during pregnancy and during the postpartum period. Basic to the program is the belief that pregnancy and birth outcomes improve when routine obstetrical care is enhanced with specific nutritional, maternity-related education, outreach activities, case management and associated interventions and family planning services. For the pregnant Member with health complications or complex social issues, the program has a comprehensive set of case management interventions that support the mother in the delivery of a healthy newborn.

CalOptima's Perinatal Support Services Program is designed to provide enhanced obstetrical services to all enrolled pregnant and postpartum women. The services are Member centered and based on the results of a screening and/or risk assessment. CalOptima coordinates and directs the care of pregnant Members through the Medical Management Department, under the leadership of the plan's Chief Medical Officer.

CalOptima's services go beyond the successful delivery of a healthy baby. CalOptima utilizes case management to assist pregnant Members with complex clinical and social issues such as substance abuse, spousal/partner abuse and emotional or mental health concerns, family planning issues, and referrals to appropriate community resources. Case managers assist in resolving these issues and work to ensure delivery of a healthy newborn without any adverse maternal outcomes.

The primary goals of the Perinatal Support Services Program

- Improve early entry into perinatal care
- Reduce infant mortality and low birth weight outcomes
- Increase the number of term infants and healthy pregnancy outcomes
- Increase conceptual spacing
- Decrease the incidence of maternal complications
- Increase the rate of healthy deliveries
- Increase the proportion of full-term infants weighing 2500 grams or more

Outcome goals related to pregnancy, which are to be monitored and reported

- HEDIS® indicators
- Low-birth weight rate (percentage of babies born weighing between 1500 and 2500 grams)
- Cesarean section rate (percentage of births delivered by cesarean section)
- Incidence of newborns born before 37 weeks gestation
- Additional indicators required by each health plan or state

Target areas for improvement include

- Screen and perform risk/health assessment on all identified pregnant Members to determine appropriate interventions for example, high-risk, smoking, substance abuse, social issues
- Reduce complications related to maternal substance abuse
- Coordinate and provide case management services to Members identified as complex high risk
- Increase Member's compliance with prenatal visits
- Increase the availability of family planning education for Members, but particularly for adolescents

A referral for a Member's initial comprehensive prenatal visit with an OB/GYN, is made by the Member's Primary Care Physician. Upon completion of this initial prenatal visit, the obstetrician need only submit a completed copy of the Member's Pregnancy Notification Report (PNR) to CalOptima's case management department to have the Member enrolled in the Perinatal Support Services Program. Upon receipt of this document, CalOptima will open the Member's case so that the Member can begin to receive perinatal support services.

ANCILLARY PROVIDERS

Ancillary Providers include pharmacy, home health, durable medical equipment, infusion care, transportation, therapy, home and community based service providers and other non-physician providers. CHA has developed a comprehensive ancillary provider network that PCPs and specialists are required to utilize.

Responsibilities of the CHA Ancillary Provider

- Verifying Member eligibility prior to the delivery of services by calling CalOptima at (714) 246-8540, viewing online at https://eznet.rchsd.org, or by calling the CHA Member Services Department at (800) 387-1103. Failure to verify Member eligibility and PCP assignment may result in the denial of claims.

- Render covered services to all CHA Members in an appropriate, timely, and cost effective manner. The provider will cooperate and participate in CHA quality management, utilization review, and complaint procedures.

- Obtain prior authorization from CCS when rendering services to a CCS eligible Member for a CCS eligible condition.

- Maintain sufficient facilities, equipment and personnel to provide timely access to medically necessary covered services.

- Maintain all licenses, certifications, permits and other prerequisites required by law to provide covered services and submitting evidence that they are in good standing upon the request of CHA.

- Provider shall not exclude any Member from participation in or, deny benefits, or otherwise discriminate against any Member in the delivery of covered services based on the Member's status as a participant in a publicly financed health benefits program, if diagnosed as having an HIV positive status, AIDS or, having a disability, age, race, color, religion, sex, national origin or any other classification protected by applicable law.

- Check the Member's ID card each time the Member presents for service. The ID card does not guarantee that the Member is still enrolled with CHA. Verify the identity of the person presenting the ID card with other form(s) of identification for example, driver's license or other photo identification.

- Providers are responsible for identifying any other insurance and billing the other insurance company before billing CHA.

- Ancillary providers shall indicate prior authorization number on claim form at time of submission. Provider will attach a copy of the referral form if appropriate.

- Bill all services provided to a CHA Member on a CMS1500 or a UB04/CMS 1450.

PRIOR AUTHORIZATION AND REFERRAL PROCEDURES

Prior Authorization (PA) Department

The primary responsibility of the PA Department staff is to evaluate Providers' requests for PA. The evaluation includes:

- Verification that the Member is enrolled in CHA and that the requested service is a covered benefit for the Member
- Verification that the requested provider is a participating Provider
- Assessment of medical necessity based on CHA's medical review criteria (Milliman Care Guidelines, CHA Policies, & Medi-Cal Guidelines)
- Assessment of the appropriateness of the service location

The prior authorization department is also responsible for receiving and documenting notifications from facilities of inpatient admissions.

PCPs are responsible for initiating and coordinating authorizations and referrals of Members for medically necessary services beyond the scope of their contract or practice. PCPs are also responsible for assisting CHA in identifying and referring Members with CCS eligible conditions to the local CCS office for case management and treatment authorizations. PCPs are to monitor the progress of referred Members' care and see that Members are returned to the PCP's care as soon as medically appropriate.

If a specialist provides services to a CHA Member and recommends further treatment, the CHA specialist must request the authorization from CHA. Emergencies do not require authorization; a health professional will perform emergency services and immediately refer the Member to the nearest and most appropriate facility without regard to prior authorization. However, CHA must be notified if these services result in an admission at which point CHA must be notified of the admission with twenty four hours.

All authorizations should be submitted through the CHA provider portal at https://eznet.rchsd.org. If you do not have a username or password to access the CHA website, please contact EZ-NET Support at eznetsupport@rchsd.org. If a contracted health professional is not available, CHA may Authorize services to a non contracted provider. Family Planning services do not require prior authorization. For additional inquiries about EZ-NET access, please contact CHA’s Provider Relations Department at providerrelations@chochealthalliance.com.

Requesting Prior Authorization (PA)

- Always check Member benefits & services to see what is covered before requesting an authorization and remember to verify Member eligibility prior to the provision of services.

- Non contracted Providers must obtain PA before rendering any service outside a hospital setting. Contracted Providers must obtain PA before rendering any service that is on the prior authorization guideline list.

- To check the status and/or submit a prior authorization request, please visit https://eznet.rchsd.org. If you do not have a username and password to access the CHA web login portal, download a registration form from www.chochealthalliance.com and click on the "new registration form" link.

- Urgent and emergent prior authorization requests are to be submitted online. If a contracted health professional is not available, CHA may authorize services to a non- contracted provider. Providers are not required to obtain PA before rendering emergency services; however, hospitals are to notify the PA department within 24 hours of rendering emergency department treatment.

- If a Member receiving emergency department treatment requires emergent inpatient care, the provider facility **must** notify the CHA PA Unit within 24 hours of inpatient admission, whether or not notification of ED treatment has already been given.

- The PCP initiates and coordinates requests for PA, however, CHA recognizes that specialists and other providers may need to contact the PA department directly to verify PA or to request authorization for additional services in their specialty scope.

- CPT and diagnosis codes are reviewed and updated on an as needed and/or annual basis.

Referrals to an Obstetrician (OB)

The PCP must submit a request for prior authorization for a pregnant Member for an OB immediately after a pregnancy is confirmed. The OB Provider is responsible for the Member's obstetrical care.

An OB may send a Member back to a PCP for medical services that are outside the scope of the OB's practice; PA is not required.

OBs are to schedule an initial appointment with pregnant Members within the applicable time frame after the request for the appointment. Return visits for Members with high-risk pregnancies are to be scheduled according to the needs of the Member. An OB shall notify CHA within seven (7) business days if the OB determines that a Member is carrying multiple fetuses.

Referrals to Ancillary Providers

Contracted Providers may make referrals to ancillary service providers, according to Title 22 guidelines as follows:

- Laboratory Referrals - members are to be referred to the CHA preferred, contracted laboratory facility. Referrals to contracted laboratory facility for medically necessary testing do not require PA, with the exception of genetic testing.

- Dental or Vision Referrals - vision and Dental services are not the financial responsibility of CHA. Contracted PCPs may send medically necessary referrals directly to CalOptima contracted dental or vision providers. Enrolled Members may self refer to dental and vision providers or be referred by the PCP.

- Radiology - members are to be referred to a contracted radiology provider.

- Member Transportation - requests for medically necessary transportation are to be submitted to the CHA Prior Authorization Department.

PERIOD OF AUTHORIZATION

Authorizations are valid beginning with the date the request is approved, for typically a period of 90 days. Authorization requests should be submitted prior to rendering services. Retroactive authorization requests should be submitted only if there are extenuating circumstances for the delay, and are reviewed on a case by case basis. Urgent requests should only be submitted when medically urgent, and there is a risk of substantial harm to the patient. Requests submitted for non-medically urgent services, may be modified to routine. To obtain a copy of the criteria used by CHA when making determinations on Authorization Requests, please contact the Prior Authorization Department at (800) 387-1103, option 2.

ENTERAL NUTRITION & DIAPER AUTHORIZATION REQUESTS

Enteral Nutrition

When requesting an authorization for enteral nutrition, you must include the member's growth chart. These services will not be authorized without this clinical information.

Diapers

Quantity limits for incontinence supply coverage are based on CHA's incontinence medical supplies policy. All requests for incontinence supplies require prior authorization. Please note the medical criteria for incontinence supplies as follows:

- Incontinence supplies are covered for children five years and older with a chronic medical condition leading to incontinence and based on medical necessity.

- Authorizations for incontinence supplies may be approved for a six month period.

- A new prescription signed by the prescribing practitioner is required every six months.

- Requests for pull on must certify that the Member is ambulatory and must address bowel/bladder training. Requests for liner/pads/shields must include clinical notes justifying medical necessity.

Denial Reconsideration

Providers may request reconsideration of a pre-service denial by submitting a formal appeal to the Prior Authorization Department unit by fax, at (855) 867-0868. Providers must submit additional information or documentation for review by the medical director with this request.

CALIFORNIA CHILDREN'S SERVICES (CCS) PROGRAM

California Children's Services (CCS) is a State program that provides medically necessary care and case management services to children, up to the age of 21 years, with certain diseases or handicapping conditions who meet program eligibility requirements. CCS services are delivered by CCS paneled providers in approved hospitals and tertiary care facilities that meet CCS program standards. CCS services are excluded (carved out) from the managed care contracts, therefore the goal is to ensure that CHA Members with emerging or identified CCS eligible conditions be referred to the CCS program to receive appropriate care in a timely manner.

When Members are referred to CCS, treatment of their CCS eligible condition will be authorized by the CCS program once the Member is determined to be CCS eligible, however CHA continues to provide primary care and services unrelated to the CCS eligible condition. Examples of CCS eligible conditions are listed below.

The CCS program is administered as a partnership between county health departments and the California State Department of Health Care Services. The CCS program requires authorization for health care services related to a Member's CCS eligible medical condition. Providers must submit a Service Authorization Request (SAR) to the CCS office, except in an emergency. A SAR number authorized to a Physician may be used for reimbursement by other health care Providers from whom the Physician has requested services, such as laboratory, pharmacy or radiology Providers. The rendering Provider will use a Physician's SAR number and bill with the authorized Physician's provider number indicated as a referring Provider. Providers submit their bills to fiscal intermediary agency for processing and payment of services.

Only active Medi-Cal Providers may receive authorizations to provide CCS program services. Services may be authorized for varying lengths of time during the member's CCA eligibility period. Providers may fax, mail or hand deliver SARs to the CCS office, and after review, Providers will receive a hard copy authorization approval or denial. For more information on how to become a CCS Provider, please call (714) 347-0300.

California Children's Services Eligible Medical Conditions

Condition	Description
Infectious Diseases	Involves the central nervous system and produce disabilities requiring surgical and/or rehabilitation services involving bone, the eyes and leads to blindness and congenitally acquired and for which postnatal treatment is required and appropriate.
Neoplasms	All malignant neoplasms, including those of the blood and lymph systems. Benign neoplasms when they constitute a significant disability, visible deformity, or interfere with function.
Endocrine, Nutritional, and Metabolic Diseases, and Immune Disorders	Diseases of the pituitary, thyroid, parathyroid, thymus, adrenal, pancreas, ovaries and testes; growth hormone deficiency, diabetes mellitus, diseases due to congenital or acquired immunologic deficiency manifested by life-threatening infections, inborn errors of metabolism; cystic fibrosis. Nutritional disorders such as failure to thrive and exogenous obesity are not eligible.
Diseases of Blood and Blood Forming Organs	Sickle cell anemia, hemophilia, aplastic anemia. Iron or vitamin deficiency anemias are only eligible when they present with life threatening complications
Mental Disorders and Mental Retardation	Conditions of this nature are not eligible except when the disorder is associated with or complicates an existing CCS eligible condition.
Diseases of the Nervous System	Diseases of the nervous system when they produce physical disability (e.g., paresis, paralysis, ataxia) that significantly impair daily function. Idiopathic epilepsy is eligible when the seizures are uncontrolled, as per regulations. Treatment of seizures due to underlying organic disease for example, brain tumor, cerebral palsy, inborn errors of metabolism, is based on the eligibility of the underlying disease. Specific conditions not eligible are those which are self-limiting and include acute neuritis and neuralgia; and meningitis that does not produce sequelae or physical disability. Learning disabilities are not eligible.
Diseases of the Eye	Strabismus when surgery is required. Chronic infections or diseases of the eye are eligible when they may produce visual impairment and/or require complex management or surgery
Diseases of the Ear and Mastoid	Hearing loss, as defined per regulations as perforation of the tympanic membrane requiring tympanoplasty, mastoiditis and cholesteatoma.
Diseases of the Circulatory System	Conditions involving the heart, blood vessels, and lymphatic system.
Diseases of the Respiratory System	Lower respiratory tract conditions are eligible if they are chronic, cause significant disability, and respiratory obstruction; or complicate the management of a CCS-eligible condition. Chronic lung disease of infancy and chronic lung disease of immunologic origin, as per regulations.
Diseases of the Digestive System	Diseases of the liver, chronic inflammatory disease of the gastrointestinal (GI) tract and most congenital abnormalities of the GI system are eligible; and gastroesophageal reflux, as per regulations. Malocclusion is eligible when there is severe impairment of occlusal function and is subject to CCS screening and acceptance for care.
Diseases of the Genitourinary System	Chronic genitourinary conditions and renal failure and acute conditions when complications are present.
Diseases of the Skin and Subcutaneous Tissues	These conditions are eligible if they are disfiguring, disabling, and require plastic or reconstructive surgery and/or prolonged and frequent multidisciplinary management.
Diseases of the Musculoskeletal System and Connective Tissue	Chronic diseases of the musculoskeletal system and connective tissue. Minor orthopedic conditions such as toeing-in, knock knee, and flat feet are not eligible however, these conditions may be eligible if expensive bracing, multiple casting, and/or surgery is required.
Congenital Anomalies	Congenital anomalies of the various systems if the condition limits a body function, is disabling, disfiguring, amenable to cure, correction, or amelioration, as per regulations.
Perinatal Morbidity and Mortality	Neonates who have a CCS-eligible condition and require care in a CCS-approved neonatal intensive care unit (NICU) because of the eligible condition. Critically ill neonates who do not have an identified CCS-eligible condition but who require one or more of the following services in a CCS-approved NICU:

	• Invasive or non-invasive positive pressure ventilatory assistance • Supplemental oxygen concentration by blood of greater than or equal to 40% • Maintenance of an umbilical artery (UA) or peripheral arterial catheter (PAC) for medically necessary indications, such as monitoring blood pressure or blood gases • Maintenance of an umbilical venous catheter or other central venous catheter for medically necessary indications, such as pressure monitoring or cardiovascular drug infusion • Maintenance of a peripheral line for intravenous pharmacological support of the cardiovascular system • Central or peripheral hyperalimentation • Chest tube Neonates and infants who do not have an identified CCS-eligible condition but who require two or more of the following services in a CCS-approved NICU: • Supplemental inspired oxygen • Maintenance of a peripheral intravenous line for administration of intravenous fluids, blood, blood products or medications other than those used in support of the cardiovascular system • Pharmacological treatment for apnea and/or bradycardia episodes • Tube feedings
Accidents, Poisonings, Violence, and Immunization Reactions	Injuries of the central or peripheral nervous and vital organs may be eligible if they can result in permanent disability or death. Fractures of the skull, spine, pelvis, or femur which when untreated would result in permanent loss of function or death. Burns, foreign bodies, ingestion of drugs or poisons, lead poisoning, and snake bites may be eligible

Prior Authorization and Payment for CCS Services

All services covered under the CCS program require prior authorization from CCS. Only providers who have been approved by CCS are eligible for reimbursement under the CCS program. CCS reimbursement is separate from any funds received under the CalOptima program and is billed directly through CCS.

How to Make a CCS Referral
To refer a CHA Member to CCS, you may call the Orange County CCS Office at (714) 347-0300. When making the referral, please know that the child must use a CCS paneled provider to receive CCS covered services. Completed CCS referrals must include appropriate medical reports to confirm the medical condition, and can be mailed to California Children's Services at 200 W. Santa Ana Blvd. Ste 100 Santa Ana, CA 92701, or can be faxed to (714) 347-0301.

CHA Primary Care Providers must continue to provide for the primary care needs of Members who qualify for CCS and must continue to coordinate the Member's care, should the Member require services from a CCS paneled provider.
***CCS coverage ceases when Member no longer meets medical criteria.**

THE REGIONAL CENTER OF ORANGE COUNTY (RCOC)

The Regional Center of Orange County (RCOC) is a nonprofit agency under contract with the California Department of Developmental Services that provides support and care for persons with or at risk for developmental disabilities in Orange County. Any resident of Orange County who has

or may have a developmental disability, before 18 years of age, is entitled to receive an assessment to determine eligibility. To be eligible for services, a person must have a disability that is substantially handicapping; examples include mental retardation, epilepsy, cerebral palsy, autism, and related neurological conditions. The RCOC does not cover handicapping conditions that are solely physical in nature. Those individuals who are diagnosed with a developmental disability, according to law, become "consumers" of RCOC and can receive continuing services.

Services Available Through the RCOC

Services are offered to consumers based upon Individual Program Plans and may include:

- Case management and individual program planning
- Infant development programs
- Residential care, group homes, independent & supported living services
- Respite care
- Prevention services
- Support services and advocacy

How to Refer a Member to RCOC

Providers who believe a Member should be referred to the RCOC should contact the RCOC offices by calling (714) 796-5100. To obtain more information about the RCOC, visit RCOC's website located at www.rcoc.com.

CLAIMS REIMBURSEMENT

Billing Procedures

Providers are required to submit claims for all services rendered, whether the services are capitated or fee-for-service. **Claims should be filed electronically through a CHA EDI vendor.**

CHOC Health Alliance has contracts with data clearinghouses, listed below, to receive EDI claims. **To register for a login and password to submit claims electronically, contact one of the vendors listed below:**

Emdeon	Office Ally	RelayHealth
(877) 363-3666 www.emdeon.com Payer ID: 33065	(866) 575-4120 www.officeally.com Payer ID: CHOC1	(866) 735-2963, option 1 www.relayhealth.com Payer ID: 33065

The following are requirements for claims filing for CHOC Health Alliance:

1. Contracted Providers must submit claims within the specified timeframe as documented in their individual contracts to avoid denial for late billing. Providers are required to submit claims for all services rendered, whether the services are capitated or fee-for-service

2. For claims with attachments, please mail to:

CHOC Health Alliance
Rady Children's Hospital –San Diego
Attention Claims Department
3020 Children's Way, MC 5144 San Diego, CA 92123

Definitions of a Completed Claim

- "*Complete claim"* means a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides "reasonably relevant information" as defined by Section 1300.71(a)(10) of Title 28 of the California Code of Regulations "information necessary to determine payor liability" as further defined in section (a)(11).

- *"Reasonably relevant information"* means the minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any government information requirements.

- *"Information necessary to determine payer liability"* means the minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claims adjudicator or other individuals with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements.

If a claim is considered "incomplete," the Examiner will contest the claim.

Definitions of a Contested Claim

A contested claim is one that CHOC Health Alliance cannot adjudicate or accurately determine liability because more information is needed from either the provider or a third party.

- *"Incomplete claims"* or claims that require additional information are contested in writing by CHOC Health Alliance in the form of an Explanation of Benefits (EOB) to the provider. If CHOC Health Alliance needs additional information before the claim can be adjudicated, the necessary information must be submitted within 365 days of the date of the EOB that reflects the contested claim, in order to have the claim considered by CHOC Health Alliance.

- To submit additional information for a claim, please mail additional information, along with a copy of the claim to:

CHOC Health Alliance
Rady Children's Hospital –San Diego
Attention Claims Department
3020 Children's Way, MC 5144
San Diego, CA 92123

Claim Receipt Verification

1. For verification of claim receipt by CHA the Provider may do the following:
   - Allow two (2) working days of the receipt of an electronic claim
   - Allow fifteen (15) working days of the receipt of a paper claim
   - Acknowledgement of electronic claims is provided via a 277CA file to the clearinghouse

2. Contacting CHOC Health Alliance Regarding Claims.
   - For claim status inquiries, call 800-387-1103
   - Providers may verify claims receipt by accessing the Provider Portal at: https://www.eznet.rchsd.org (login credentials are required)

Methods of Reimbursement

CHOC Health Alliance may pay providers on a fee-for-service (FFS) or capitated basis. Under this arrangement, the Providers furnish healthcare services to Members and then send a bill or claim to CHOC Health Alliance for reimbursement for services performed.

Capitated Arrangements

CHOC Health Alliance will pay a capitated provider a monthly capitation payment for the delivery of covered services during the term of his/her agreement based on the number of Members assigned to the provider on the first day of the month. Questions concerning monthly capitation payments should be directed to the attention of the CHOC Health Alliance Provider Relations Team.

Fee-for-Service Arrangements

CHOC Health Alliance will pay a fee-for-service provider a payment for each approved claim that is submitted. Reimbursement will be based on the applicable Medi-Cal fee schedule in effect on the date of service as outlined in the Provider Services Agreement.

Authorization does not ensure payment if the Member is not enrolled on each date of service or if documentation submitted by the provider does not support the medical necessity of the requested procedure. The provider must verify Member enrollment prior to rendering service.

Reimbursement depends on medical necessity, the Member's enrollment on the date(s) of service, plan policies and procedures, and plan limitations and exclusions as stated in the rules and regulations governing the plan. Plan exclusions include services related to occupational illnesses and injuries, and excessive, inappropriate or unallowable charges.

CHA Payment Policies

- Contracted Capitated Providers
  - Primary Care Providers may be reimbursed through a capitation model for primary care services
  - Services outside the scope of capitated services may be billed fee for service
  - All services will be paid in accordance with the Provider's contract with CHA

- Contracted Fee For Service Providers
  - All other non-capitated Providers will be reimbursed fee for service
  - Providers will be paid fee for service for covered and/or approved services in accordance with the Provider's contract with CHA

- Non-Contracted Providers
  - Pre-authorized services are paid at the agreed upon rate and in accordance with the Letter of Agreement (LOA) between CHA and the provider of service
  - If an LOA is not on file, CHA will attempt to negotiate a rate with the provider of service. If successful, the claim(s) is paid at the negotiated rate, less any non-allowable charges.
  - All Urgent and Emergency services, that are the risk of CHA for payment, will be paid at 100% of the applicable Medi-Cal fee schedule in effect on date of service, less any non-allowable charges.
  - CHA does not negotiate rates for services that require prior authorization and were rendered without a prior-authorization. Claims Examiners will deny the claim for lack of prior authorization.

In some circumstances, a claim may be pended (in EZ-NET, claim status shows as System Hold Status 2). This may happen for the following reasons:

- The service date is outside of the patient's eligibility period
- A service requires an authorization
- The authorization that is being referenced by this claim is denied, deferred, canceled, requested, or on system hold; or the auth payment status is closed
- The service was performed after the authorization expiration date
- The financial amount for this claim causes the total claim amount against an authorization to exceed the total authorized financial amount
- The number of units on this claim causes the total claim units against the authorization to exceed the total requested/ authorized units
- The claim may be a duplicate claim
- The provider's contract was not in effect on the service date
- The yearly or lifetime limits for a particular Benefit type for this member are exceeded by this claim
- Member is on Provisional status

In some circumstances, a claim may be placed on a manual hold (in EZ-NET, claim status shows as Manual Hold Status 3). An Examiner may place a claim on manual hold for Letter of Agreement, authorization research, documentation review or dollar amount review.

Identifying Payable Claims

A payable claim is defined as a complete and clean claim that has been adjudicated in EZ-NET to be paid. A clean claim is a payable claim that does not require research or additional information from any external parties for the claim to be processed and paid by CHA. All necessary information is provided with the original claim, and all elements provided on the claim are appropriate for the member, date of service, and service or benefit provided. Note: clean claims may require manual intervention by CHA staff, including intervention for duplicate review or manual pricing, as long as all information required to review and approve the claim is submitted with the original claim. A claim becomes a payable claim when the last piece of information needed to process the claim is received by CHA.

CLAIMS RESUBMISSION

If a Provider has met the initial submission requirements as stated in his/her contract, the Provider has up to 12 months from the date of service to resubmit the claim.

To resubmit a claim, the following is required:

- A copy of the claim marked re-submission
- A copy of the remittance advice

CHA does not accept any handwritten remarks on claims. Please provide the nature of the request for resubmitting the claim for example, medical records, invoice, corrected CPT/HCPC code, etc.

The provider must mail the claim and all attachments to:

Rady Children's Hospital – San Diego
Attention: Claims Resubmissions
3020 Children's Way MC 5144
San Diego CA 92123

Claims Payment Timeframes
CHOC Health Alliance pays at least 90 percent of all clean claims within 30 working days from the date of receipt.

CHOC Health Alliance pays 100% of all clean claims within 45 working days from the date of receipt.

Interest Payments

Any payable claim that is paid beyond 45 working days is paid with interest in accordance with Medi-Cal policy. Interest payments are calculated with the following formula:

# of Delayed Days X Total Claims Payment X Interest Rate (15%) / 365

The interest must be paid on the same check as the claim requiring an interest payment. If the interest is not paid on the same check as the claim payment, an additional $10.00 fee must be added to the interest payment.

All Emergency claims requiring interest are paid at the greater of 15%/365 or 15.00.

Claims Payment & Notification
CHA provides notice of its approval / payment decisions to providers on a weekly basis via an Remittance Advice, along with payment. Electronic claims submitted direct by clearinghouses are also provided an 835 payment file (electronic remittance advice) with HIPAA standard transaction codes for each payment/denial.

Provider Disputes
It is CHA's policy to have a fast, fair, and cost effective dispute resolution mechanism to ensure processes are in place for contracted and non-contracted providers. Additionally, it is CHA's policy to have a separate dispute resolution process for claims versus other types of disputes. CHA will not discriminate against, retaliate or charge providers who make disputes. CHA has designated a principal officer to review provider dispute operations and prepare reports.

Claim(s) Over-Payment(s)

- Notice of Overpayment of a Claim
  - If CHA determines that it has overpaid a claim, CHA will notify the provider in writing through a separate notice clearly identifying the claim, the name of the patient, the Date of Service(s) and a clear explanation of the basis upon which CHA believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

- Contested Notice
  - If the provider contests CHA's notice of overpayment of a claim, the provider, within 30 Working Days of the receipt of the notice of overpayment of a claim, must send written notice to CHA stating the basis upon which the provider believes that the claim was not overpaid. CHA will process the contested notice in accordance with CHA's contracted provider dispute resolution process.

- No Contest
  - If the provider does not contest CHA's notice of overpayment of a claim, the provider must reimburse CHA within thirty (30) working days of the provider's receipt of the notice of overpayment of a claim.

- Offsets to Payments
  - CHA may only offset an uncontested notice of overpayment of a claim against a provider's current claim submission when the provider fails to reimburse CHA within the timeframe set forth above, and CHA's contract with the provider specifically authorizes CHA to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions. In the event that an overpayment of a claim or claims is offset against the provider's current claim or claims pursuant to this section, CHA will provide the provider with a detailed written explanation identifying the

specific overpayment or payments that have been offset against the specific current claim or claims.

Prohibited Claims

Except in specified circumstances, Providers and / or any affiliates shall not submit a claim or demand, or otherwise collect reimbursement for any services provided under this Contract to a Medi-Cal Member. The Provider shall not hold Members liable for the Provider's debt if the Provider becomes insolvent. In the event the Provider becomes insolvent, the Provider shall cover continuation of services to Members for the duration of the period for which payment has been made, as well as for inpatient admissions up until discharge.

COORDINATION OF BENEFITS

Billing CHA after Other Health Coverage

These principles must be followed when billing CHA after other health coverage:

- The other health coverage benefit must be used completely.
- CHA may be billed for the balance, including other health coverage co-payments, other health coverage coinsurance and other health coverage deductibles.
- CHA will pay up to the limitations of the CHA program, less the other health coverage payment amount, if any.
- CHA will not pay the balance of a provider's bill when the provider has an agreement with the other health coverage carrier/plan to accept the carrier's contracted rate as a "payment in full."
- An Explanation of Benefits (EOB) or denial letter from the other health coverage must accompany the CHA claim, except for pharmacy providers.
- The amount, if any, paid by the other health coverage carrier for all items listed on the CHA claim form must be indicated in the appropriate field on the claim. Providers should not reduce the charge amount or total amount billed because of any other health coverage payment.

Other Health Coverage Explanation Of Benefits (EOB) or Denial Letter

- When billing CHA for any service partially paid or denied by the recipient's other health coverage, the other health coverage EOB or denial letter must accompany the claim.
- When a service or procedure is not a covered benefit of the recipient's other health coverage, a copy of the original denial letter or EOB is acceptable for the same recipient and service for a period of one year from the date of the original EOB or denial letter.
- A dated statement of non-covered benefits from the carrier is also acceptable if it matches the insurance name and address and the recipient's name and address and clearly states the benefits not covered.
- It is the provider's responsibility to obtain a new EOB or denial letter. Claims not accompanied by proper documentation will be denied.

BALANCE BILLING

With the exception of charges for non-covered services delivered on a fee-for-service basis, subject to written disclosure and informed Member consent to assume financial responsibility for Non-covered Services, Provider shall in no event, including, without limitation, nonpayment by or insolvency of CHOC Health Alliance, or breach of this Agreement, bill, charge, collect a deposit, or attempt to bill, charge, collect or receive any form of payment or surcharge from any Member for Provider Services.

Provider shall not maintain any action at law or in equity against any Member or DHCS to collect any sums owed by CHA to Provider for services rendered to CHOC Health Alliance Members. CHA may require Provider to return to CHOC Health Alliance Members all sums collected from the Member, other than any applicable charges for Non-covered Services. If Provider collects or receives any form of payment, other than for Non-covered services, CHOC Health Alliance may take all appropriate action to eliminate such payments, including requiring Provider to return the payment and termination of the Provider's Agreement.

PROVIDER DISPUTES FOR CLAIMS ISSUES

Definition of a Contracted Provider Dispute

A contracted provider dispute is a Provider's written notice to CHOC Health Alliance challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested; seeking resolution of a billing determination or other contract dispute; or disputing a request for reimbursement of an overpayment of a claim.

Each contracted provider dispute must contain, at a minimum, the following information:

- Provider's name
- Provider's identification number
- Provider's contact information

If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from CHOC Health Alliance to a contracted Provider, the following must be included a clear identification of the disputed item, the date of service; and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect.

f the contracted provider dispute is not about a claim, a clear explanation of the issue and the Provider's position on such issue; and if the contracted Provider dispute involves a Member or group of Members, the name and identification number(s) of the Member or Members, a clear explanation of the disputed item, including the Date of Service and Provider's position on the dispute, and the Member's written authorization for Provider to represent the Member.

Sending a Contracted Provider Dispute to CHA

Contracted Provider disputes submitted to CHOC Health Alliance must include the information listed above for each contracted Provider dispute. All contracted provider disputes must be sent to the attention of Claims Appeals Department at the following:

Via Mail:
CHOC Health Alliance
Claims Appeals Department
Rady Children's Hospital - San Diego
3020 Children's Way, MC 5144
San Diego, CA 92123

Via Physical Delivery:
CHOC Health Alliance
Rady Children's Hospital - San Diego
5855 Copley Drive, Suite 100
San Diego, Ca. 92111
Attn: Claims Appeals Department

Provider Disputes are not accepted electronically or by fax.

Period for Submission of Provider Disputes

Contracted Provider disputes must be received by CHOC Health Alliance within 365 days from the action that led to the dispute (or the most recent action if there are multiple actions) that led to the dispute, or in the case of CHOC Health Alliance's inaction, contracted Provider disputes must be received by CHOC Health Alliance within 365 days after the Provider's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

Contracted Provider disputes that do not include all required information as set forth above may be returned to the submitter for completion. An amended contracted Provider dispute that includes the missing information may be submitted to CHOC Health Alliance within thirty (30) working days of the Provider's receipt of a returned contracted Provider dispute.

Acknowledgment of Contracted Provider Disputes

CHOC Health Alliance will acknowledge receipt of all contracted Provider disputes within fifteen (15) working days of the date of receipt by CHOC Health Alliance. Provider disputes are not accepted electronically or by fax.

Instructions for Filing Substantially Similar Contracted Provider Disputes

Substantially similar multiple claims, billing or contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted in the following format:

- Sort disputes by similar issue
- Provide a cover sheet for each batch of similar issues. Individually number and list the required information for the type of dispute for each disputed item within the batch
- Number each cover sheet
- Provide a cover letter for the entire submission; should describe each Provider dispute and reference the applicable numbered cover sheets

Time Period for Resolution & Written Determination of Contracted Provider Disputes

CHOC Health Alliance will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) working days after the date of receipt of the contracted provider dispute or the amended contracted provider dispute.

Past Due Payments

If the contracted provider dispute or amended contracted provider dispute involves a claim and is determined in whole or in part in favor of the provider, CHOC Health Alliance will pay any outstanding amounts determined to be due, and all interest and penalties required by law or regulation, within five (5) working days of the issuance of the written determination.

MEDICAL MANAGEMENT

The CHA Medical Management Department monitors and evaluates the utilization, quality, and continuity of the medical services provided to Members through the network of Providers. The Medical Director, prior authorization and case management staff, and consultants contribute strong, effective support services to assist Providers in the utilization of medical resources.

Committees

The committees below support the CHA medical management program. A Physician who wishes to participate on a committee should contact the CHA Medical Director.

Utilization Management (UM) Committee

The Utilization Management Committee includes the CHA Medical Director, the UM/QI Manager, a quality management representative, and four or more participating Physicians who represent varied specialties. Physicians may serve two or more years and the committee meets at a minimum of once a quarter.

Utilization management committee activities are directed toward improving medical outcomes for Members. The activities may include:

- Reviewing and recommending criteria to use in the concurrent review process
- Recommending studies to evaluate medical care provided to Members
- Reviewing the results and outcomes of studies
- Assisting in the development of practice parameters
- Reviewing and approving medical review criteria
- Evaluating and recommending actions on peer review issues
- Reviewing and making recommendations based on physicians' requests to remove prior authorization requirements from tests or procedures

Quality Improvement Committee

The Quality Improvement Committee in an advisory role assists the Medical Director in overseeing CHA's statewide quality management program. Major functions of the committee include:

- Medical record standard review outliers
- Review patient services, identify problems, make recommendations to the medical director
- Review quality issues/adverse outcomes
- Review credentials referred by credentialing committee
- Peer review
- Review Member/provider and CalOptima complaints related to delivery of care and service
- Review standards/guidelines
- Review and evaluation of of results of quality improvement activities
- Review and approval of studies, standards, clinical guidelines, trends in quality and utilization management indicators and satisfaction surveys
- Recommend policies for development, review and approval

The Quality Improvement Committee meets monthly and physicians who have an interest in participating in this committee are encouraged to contact the CHA medical director.

QUALITY IMPROVEMENT (QI)

CHA's Quality Assessment and Performance Improvement (QAPI) program is an ongoing, objective and systematic process of monitoring, evaluating and improving the quality, appropriateness and effectiveness of care. CHA uses this approach to measure conformance with desired medical standards and develop activities designed to improve patient outcomes. Quality Improvement (QI) is performed through a formal program with involvement of organizational components and committees. The primary goal of CHA's QI program is to improve the health status of Members or maintain current health status when the Member's condition is not amenable to improvement.

CHA's QI program is a continuous quality improvement process that includes comprehensive quality assessment and performance improvement activities. These activities continuously and proactively review clinical and operational programs and processes to identify opportunities for continued improvement. CHA's continuous quality improvement process enables CHA to:

- Assess current practices in both clinical and non-clinical areas
- Identify opportunities for improvement
- Select the most effective interventions
- Evaluate and measure on an ongoing basis the success of implemented interventions; refining interventions as necessary

The use of data in the monitoring, measurement and evaluation of quality and appropriateness of care and services is an integral component of CHA's quality improvement process.

CHA's QI Program uses an integrated and collaborative approach, involving the senior management team, functional areas within the organization and committees from the Board of Directors to the Member Advisory Council. This structure allows Members and Providers to offer input into CHA's quality improvement activities. CHA's Medical Director oversees the QI program. CHA's Vice President is supported in this effort by CHA's Medical Director, QI department and the Quality Improvement and Utilization Management committees.
CHA's QI staff develops and implements an annual work plan, which specifies projected quality improvement activities. Based on the work plan, CHA conducts an annual QI program evaluation, which assesses the impact and effectiveness of quality improvement activities. CHA's QI activities include, but are not limited to, peer reviews, performance improvement projects, and provider profiling. Utilizing these tools, CHA, in collaboration with participating health providers, is able to monitor and reassess the quality of care and services provided to Members. The QI program is designed to correct significant systemic problems that come to our attention through internal surveillance, complaints, or other mechanisms. In addition, CHA's QI and UM departments maintain ongoing coordination and collaboration regarding quality initiatives, case management and disease management activities involving the care of special needs populations.

Identifying Opportunities for Improvement

CHA identifies and evaluates opportunities for quality improvement and determines the appropriate intervention strategies through the systematic collection, analysis and review of a broad range of internal and external data sources. The types of data CHA monitors to identify opportunities for quality improvement may include:

- **Internal review of individual Member or Provider issues** - in addition to receiving grievances and appeals from Members, providers and other external sources, CHA proactively identifies potential quality of care issues for review through daily operations. Through established formalized review processes for example, grievances, appeals and quality of care, CHA is able to identify specific opportunities for improving care delivered to individual Members.
- **Findings from internal program assessments** - CHA conducts formal assessments/reviews of network operations that are used to identify opportunities for

improvement. This includes, but is not limited to: ambulatory medical record reviews of contracted providers, credentialing / re-credentialing of providers, oversight reviews of delegated activities, inter-rater reliability audits of medical review staff, annual quality management program evaluation, and assessment of cultural competency, and provider accessibility and availability.

- **Findings from external program monitoring and formal reviews** - as a result of externally initiated review activities, such as an annual external quality program assessment or issues identified through the State's ongoing contract monitoring oversight process, CHA is made aware of specific program activities/processes needing improvement.
- **Clinical and non-clinical performance measure results** - CHA uses an array of clinical and non-clinical performance standards to monitor and evaluate Member outcomes including, HEDIS®, call center response times, and claim payment turnaround times. Performance through frequent monitoring and trending of performance measure results enables CHA to identify opportunities for improvement in clinical and non-clinical operational functions.
- **Data trending and pattern analysis** - with CHA's innovative information management systems and data mining tools, CHA makes extensive use of data trending and pattern analysis for the identification of opportunities for improvement.

Medical Records Review

CHA's standards for medical records have been adopted from the NCQA and Medicaid Managed Care Quality Assurance Reform Initiative (QARI). These are the minimum acceptable standards within the CHA Provider Network. Below is a list of CHA's medical record review criteria. Consistent organization and documentation in the Member's medical record(s) is required as a component of the CHA QI initiatives program to maintain continuity and effective, quality Member care.

Provider paper and electronic medical records must be maintained in a legible, current, organized and detailed manner that permits effective Member care and quality review. Providers must make records pertaining to CHA Members immediately and completely available for review and copying by the department and/or federal officials at the provider's place of business, or forward copies of records to the department within ten calendar days upon written request for a single Member record without charge. Providers must provide the department with access to all Member medical records within 15 calendar days of request. Providers must also make Member records available to other in or out of network providers to facilitate continuity of care.

Clinical Practice Guidelines

CHA uses evidence based clinical practice guidelines that consider the needs of Members, opportunities for improvement identified through the QI program, and feedback from participating Providers. CHA's decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with current medical standards in the community, and are updated as appropriate.

Performance Measures

CHA collects and reports clinical and administrative performance measure data. CHA evaluates its network performance and the performance of the Providers on HEDIS®, excellence, people, stewardship, infrastructure and compliance to assess the quality of care provided to Members. CHA routinely disseminates the results of these measures and conducts follow up with Providers who may benefit from a collaborative approach to improve performance.

HEDIS®

CHA monitors, evaluates and reports all HEDIS® performance measures that pertain to Members as a part of the QI program. CHA works with Network Providers to continuously improve performance on HEDIS® scores. CHA follows the most current version of HEDIS® technical specifications and discontinues measures when retired. Providers are expected to provide relevant portions of the Member's medical record, as requested, for the purpose of HEDIS® data collection and other quality studies. For your reference, please see the following list of HEDIS® measures:

AWC	Adolescent Well Care Visits
CWP	Appropriate Testing for Children with Pharyngitis
CIS	Childhood Immunization Status
HPV	Human Papillomavirus for Female Adolescents
IMA	Immunization for Adolescents
LSC	Lead Screening in Children
URI	Appropriate Treatment of Children with Upper Respiratory Infections
W15	Well Child Visits in the First 15 Months of Life
W34	Well Child Visits in the Third, Fourth, Fifth & Sixth Years of Life
ADHD	ADHD Medication Follow-Up Care
AMR	Asthma Medication Ratio
ASM	Appropriate Asthma Medication
WCC	Weight Counseling for Children

Surveys

CHA participates in Member and Provider satisfaction surveys to gain feedback regarding Members and Providers' experiences with quality of care, access to care, and service/operations. Each survey is described below. CHA uses Member and Provider satisfaction survey results to help identify and implement opportunities for improvement.

Member Satisfaction Surveys

CHA will be utilizing the CAHPS survey for children, for Provider/office specific results and will continue to participate in the HEDIS®/Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys for children, including the Children with Chronic Conditions Survey. The CAHPS surveys are a set of standardized surveys that assess patient satisfaction with the experience of care. The CAHPS survey is a subset of HEDIS® reporting. An NCQA certified vendor, contracted with CalOptima, administers the survey according to HEDIS® survey protocols. Both surveys are based on randomly selected Members and summarize satisfaction with the health care experience.

Provider Satisfaction Surveys

CHA Providers participate in a confidential survey regarding their satisfaction with CHA's operational processes. Topics include utilization management procedures, claims processing, and CHA's timely response to Provider inquiries. CHA reviews and disseminates results internally through the QI committee. Results are also shared with applicable departments.

CREDENTIALING

To participate in the CHA Network, a provider must be contracted and his/her credentials must be approved by the Credentialing and Performance Committee. Physicians and non-physician medical practitioners including physician assistants, nurse practitioners and ancillary providers are responsible for the completion of CHA's credentialing application along with all required attachments, including, but not limited to, copies of the following documents:

- Current Curriculum Vitae (CV)
- California Medical License
- Drug Enforcement Administration (DEA) certificate, if applicable
- National Provider Identifier (NPI)
- Current Professional Liability Insurance face sheet ($1,000,000 per occurrence/$3,000,000 annual aggregate)
- IRS Taxpayer Identification W-9 form
- Admitting Hospital Verification Form (physicians who does not have hospital admitting privileges only)
- Non-physician Medical Practitioner Agreement or Delegation of Service Agreements (physician assistants and nurse practitioners only)

At the time of re-credentialing, which occurs every 36 months, after the initial credentialing date or the last re-credentialing approval date, the Provider will receive a pre-populated application from CHA's Credentialing Department. The Provider will be required to complete identified areas of the application and verify that the pre-populated information is correct and current. The Provider will be instructed to forward a completed re-credentialing application to CHA's Credentialing Department along with requested supporting documents. Completed and verified credentials are reviewed by CHA's Medical Director, the Credentialing and Performance Committee and the CPN Advisory Board.

In conducting the credentialing and re-credentialing process, CHA will verify the following including, but not limited to:

- Valid California Medical License
- Valid Drug Enforcement Administration (DEA) certificate (if applicable)
- Active enrollment in Medi-Cal / DHCS
- Education and training, including evidence of graduation from the appropriate professional school and completion of a residency or specialty training
- Board certification (if claimed at time of application)
- Work history
- Clinical privileges in good standing, including review of past history of curtailment or suspension of medical staff privileges

- Current Professional Liability Insurance face sheet ($1,000,000 per occurrence/$3,000,000 annual aggregate)
- Information from the National Practitioner Data Bank (NPDB)
- Exclusions, suspension of ineligibility to participate in any state or federal health care program
- Sanctions or limitation on licensure from state agencies or licensing boards
- Member complaints
- CalOptima conducted Facility Site Reviews (FSRs) for PCPs at the time of initial credentialing, and at least every three years thereafter as part of the re-credentialing process including Medical Records Reviews (MRRs)

Participating Health Providers (PHPs) are required to notify CHA's Credentialing Department immediately by phone, with a follow-up in writing, of the following actions:

- **Notice of Commencement of Proceeding**: PHP shall notify CPN within ten (10) business days of PHP's receipt of notice of any legal or administrative, proceeding that may result in revision, revocation, censure, dismissal, suspension or limitation of PHP's license(s) to provide the covered services, CLIA license, license to dispense narcotics and/or controlled substances, hospital or other clinical privileges, or eligibility to participate in Medicare or Medicaid.

- **Notice of Result of Proceeding**: PHP shall notify CPN within one (1) business day of PHP's receipt of notice of any action, recommendation or decision that results in the revision, revocation, censure, dismissal, suspension or limitation of PHP's license(s) to provide the covered services, CLIA license, license to dispense narcotics, hospital or other clinical privileges, or eligibility to participate in Medicare or Medicaid.

- **Notice of Felony Charge**: PHP shall notify CPN within one (1) business day of the filing of any criminal complaint charge(s) against PHP including, but not limited to, acts of physical violence or illegal sexual behavior.

- **Notice of Lawsuit**: PHP shall notify CPN within five (5) business days of notice of any lawsuit or complaint submitted to a regulatory agency including Centers for Medicare and Medicaid Services (CMS), State of California or CalOptima / Medi-Cal or to a court, provided that the lawsuit or complaint was filed by a Member or a representative of the Member against the PHP.

Peer Review

CHA's peer review activities are evaluated by the credentialing and performance committee, which is chaired by CHA's Medical Director and includes health professionals with the same or similar expertise as the Providers being reviewed, including primary care and high volume specialists. The credentialing and performance committee has the option of inviting additional specialty practitioners, if necessary, for peer review. Credentialing and performance committee participants are bound by confidentiality and conflict of interest rules.

If the credentialing and performance committee should make a decision that alters the condition of a health professional's participation with CHA based on issues of quality of care

or service, the provider may appeal the adverse decision. CHA will send a letter to the Provider with the results of the committees review and findings. Health professionals who are reviewed and disagree with the results will receive an opportunity to appeal the committee's recommendation. Information on how to appeal the committee's recommendations will be included in the findings letter. Providers should state the reason(s) they do not agree with the committee's findings in their appeal letter.

GLOSSARY OF TERMS

Access - Access is a Member's ability to obtain medical care. The ease of access is determined by several components, including the availability of medical services and their acceptability to the Members, the location of facilities, transportation, and hours of operation.

Aid Codes - The two-digit number which indicates the aid category under which a person is eligible to receive Medi-Cal benefits. Aid Code(s) is determined by the State.

Ancillary Provider Services - Supplemental health care services for example, pharmacy, medical supplies, durable medical equipment, transportation, laboratory; either prescribed or referred by a physician.

Appeal - A formal process that allows a member and / or provider the right to dispute a decision.

Authorization - An administrative process whereby CHA gives approval of medical services rendered to Members.

Auto Assignment - An automated method of enrolling CalOptima Members with a Health Network and a PCP, according to CalOptima policy.

Billed Charges - Charges billed by a provider rendering services to a CHA Member.

Board Certified - A physician who has successfully completed a required residency in an approved training facility and meets, or is in the process of meeting, the experience requirements for examination of the respective board.

CalOptima - Orange County's Medi-Cal Managed Care Health Plan.

CalOptima Direct - CalOptima's Fee-For-Service Health Plan that is responsible for CalOptima Members who have not been enrolled into a health network.

Capitation Payment - A predetermined periodic payment to providers by CHA, for providing covered services for a specific period. Also the mode of payment by which CalOptima reimburses CHA based on the contractual arrangement through which CHA agrees to arrange for the provision of specified services to Members enrolled in CHA.

Capitated Service - Any Medi-Cal covered service for which a contracted capitated provider receives capitation payment.

CHA - CHOC Health Alliance; the Physician Hospital Consortium (PHC) composed of Children's Hospital of Orange County (CHOC) and CHOC Physicians' Network (CPN).

CHDP - Child Health and Disability Prevention Program; covers screening and diagnostic services to determine physical or mental defects in children under the age of 21 years and to ascertain health care treatment and other measures to correct or ameliorate any discovered defects or chronic conditions.

Clean Claim - A claim that contains all requirements for adjudication as defined by CHA and CalOptima policy.

Complaint - A written, formal dispute of dissatisfaction arising from an adverse action, discussion, or policy.

Concurrent Review - A type of medical care evaluation study performed while a Member is still hospitalized, that may involve process or intermediate outcome criteria and regular data collection.

Contract – The Agreement between CHOC Health Alliance (CHA) and CalOptima for the purpose of providing health care services under the Medi-Cal program.

Covered Services - Those specific services delineated in the provider contract or mentioned in Medi-Cal / CalOptima Rules and Regulations.

CCS - California Children's Services; a state program for physically disabled recipients under the age of 21 years. Under CCS regulations Children under the age of 21 who meet medical, residential and financial criteria are eligible for specialty diagnostic, treatment, case management, and physical/occupational therapy services.

DHCS - California Department of Health Care Services is the State agency responsible for administering the Medi-Cal program.

Discharge Planning - Identification of the need and provision for a Member's health care requirements after he/she is discharged from the hospital.

Disenrollment - The discontinuance of a Member's entitlement to receive covered services from a Provider. The Member's name is deleted from the approved list of Members furnished by CalOptima to the health network.

DME - Durable Medical Equipment; includes wheelchairs, oxygen equipment, hospital beds, walkers.

EPSDT - Early Periodic Screening, Diagnosis and Treatment (EPSDT) is the federally mandated program designed to facilitate early identification of health issues through periodic well-child assessment, immunization and follow-through care to resolve any identified health problems.

Elective - Usually refers to medical procedures, particularly surgery, not immediately necessary to maintain life or health; procedures which can often be scheduled weeks or months in advance.

Emergency Medical Services - Those services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could be expected to result in placing the Member's health in serious jeopardy, serious impairment of bodily functions, and or serious disjunction of any bodily organ or part

Encounter - A record of medical services provided to a Member.

Enrollment - The process by which a person who has been determined eligible becomes a Member in a health network under CalOptima.

Fee-For-Service Payment - A payment to a provider by CHA for certain covered services that is the lower of the provider billed and usual charge or CHA fee schedule.

HEDIS® - The Healthcare Effectiveness Data and Information Set, which is a set of standardized measures designed by the National Committee for Quality Assurance (NCQA) to evaluate performance of health plans and their providers. It allows for assessment based on quality and performance.

Home Health Care/Home Health Services - Medical care services provided in the home, often by a visiting nurse, usually for Members with chronic disease or disability, recovering or aged homebound Members.

Hospital - A health care institution licensed by the Department of Health Services and certified as a provider under Title 22 of the Social Security Act, as amended, or is currently determined to meet the requirements of such certification.

Inpatient - A Member admitted to an overnight medical facility such as a hospital.

Length Of Stay (LOS) **-** The number of days a Member is an inpatient, per episode; the length of time a Member is hospitalized. The total number of days a Member is hospitalized, either in total or in a particular unit or level of care; abbreviated as LOS.

Medicaid - A federal/state program providing federal matching grants, at state's option, for a medical assistance program for recipients of federally aided public assistance, recipients of SSI benefits and medically indigent persons; and includes certain minimal programs and services to receive federal matching funds, however, states may optionally include any additional services at state expense.

Medically Necessary - Those covered services required to preserve and maintain care of the Member based on criteria.

Medicare - A federal program under Title XVIII of the Social Security Act which provides health insurance for persons aged 65 and older and for other specified groups. Part A of Medicare covers hospitalization and is compulsory and Part B of the program covers outpatient services and is voluntary.

Member - Medi-Cal eligible individual who is enrolled in CalOptima. Used interchangeably with enrollee and beneficiary. Also refers to an individual who has been determined CalOptima eligible and enrolled with CHA to receive services pursuant to the agreement.

NCQA - National Committee for Quality Assurance is a private, independent, non-profit health care, quality oversight organization committed to measurement, transparency, and accountability and uniting diverse groups around a common goal, improving health care quality.

Occupational Therapy - Medically prescribed treatment concerned with improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning.

Outpatient - A person who goes to a licensed health care institution or a facility for care and services, but who does not occupy an inpatient bed.

Participating Health Professionals - Those Primary Care Physicians, Physician Specialists, Medical Facilities, Allied Health Professionals and Ancillary Service Providers under contract with CHA to provide specific covered services to Members, and represent those individuals and entities to be utilized through the CHA prior authorization and referral policies and procedures.

Pharmaceutical Services - Medically necessary medications prescribed by a Provider and dispensed in accordance with California Law. Pharmaceutical services are not the direct financial responsibility of CHA.

Physician Hospital Consortium (PHC) - A physician group(s) contractually aligned with at least one (1) hospital.

Physician Services - Services provided within the scope of practice of medicine or osteopathy as defined by State law or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

PIPS - Performance improvement projects are designed to achieve and sustain a demonstrable improvement in the quality or appropriateness of services over time. It is CHA's responsibility to develop, implement, track, and evaluate the effectiveness of its own PIPs.

PQoC - A Potential Quality of Care case is a concern raised by anyone internal or external to the Health Plan that requires investigation as to whether or not the competence or professional conduct of an individual CHA Network Practitioner, organizational provider, or vendor adversely affects, or could adversely affect, the health or welfare of a member.

PQoC concerns fall into one of the following categories:

- Unexpected outcome(s) or adverse event(s)
- Surgery related event(s)
- Mental health and or substance abuse concern(s)
- Delay of Care / Service
- Extension of length of facility stay
- Member reported event(s)

Preventive Health Care - Those health care activities aimed at protection against, and early detection and minimization of, disease or disability.

Primary Care Physician - A physician such as a family practitioner, pediatrician, internist, or general practitioner.

Prior Authorization (PA) - A department under the direction of the Utilization Management Department which is an essential component of any managed care organization. Prior Authorization is the process where health care providers seek approval prior to rendering services as required by CHA policy.

Provider - Physicians, hospitals, facilities, who provide medical services to CHA Members.

Quality Improvement - Methodology used by professional health personnel that reviews the degree of conformance to desired medical standards and practices; and activities designed to improve and maintain quality service and care, performed through a formal program with involvement of and from multiple organizational components and committees.

Retrospective Review - After the fact, used often with respect to utilization management; as with retrospective review and approval or denial of emergency room use.

Specialist - A physician duly licensed in the State of California and that has completed a residency or fellowship in his or her specialty and has been approved to sit for the board examination for the specialty.

Third Party Recoveries - A general term applied to health care benefit payments. It derives from the fact that under normal market transactions, there are only two (2) parties, the consumer and the supplier, but under a benefit plan, a third party (e.g., government, an insurance company, an employer) is ultimately responsible to pay the costs of services provided to covered person(s).

Title XIX- Section of Social Security Act, which describes the Medicaid program's coverage for eligible persons.

Utilization Management (Utilization Review/Utilization Control) - Systematic means for reviewing and controlling Members' use of medical care services, and providers' use of medical care resources. Usually involves data collection, review and/or authorization, especially for services such as specialist referrals, emergency room use and particularly costly services such as therapies or hospitalization.

Utilization Review - System of review conducted by professional health personnel, of the appropriateness, quality of and need for health care services rendered to Members covered by Medicare or other third party payers, including CalOptima.